Public Trust Board

Thu 25 May 2023, 10:00 - 13:00

Velindre University NHS Trust Headquarters, Nantgarw

Agenda

10:00 - 10:10
10 min

1. STANDARD BUSINESS

1.1. Apologies

Led by Professor Donna Mead OBE, Chair

1.2. In Attendance

Led by Professor Donna Mead OBE, Chair

1.3. Declarations of Interest

Led by Professor Donna Mead OBE, Chair

1.4. Minutes from the Public Trust Board meeting held on 30.03.2023

Led by Professor Donna Mead OBE, Chair

1.4.0 Draft Public Trust Board Minutes 30.03.23 v3- LF.DM.MB.pdf (12 pages)

1.5. Action Log

Led by Professor Donna Mead OBE, Chair

1.5.0 PUBLIC TRUST BOARD ACTION LOG_Final.pdf (1 pages)

1.6. Matters Arising

Led by Professor Donna Mead OBE, Chair

10:10 - 10:25
15 min

2. KEY REPORTS

Led by Professor Donna Mead OBE, Chair

2.1. Chair's Report

Led by Professor Donna Mead OBE, Chair

- Veteran Champions Report

2.1.0 Chair Update May 2023 (v4DM) FINAL.pdf (5 pages)
2.1.0a Armed Forces Champion Update cover.pdf (3 pages)
2.1.0b Armed Forces and Veterans Board Champion Annual Report.pdf (6 pages)

2.2. Chief Executive's Report

Led by Steve Ham, Chief Executive Officer

2.2.0 Chief Executive's Report May 2023 (v3SH).pdf (4 pages)

10:25 - 11:50
85 min

3. QUALITY, SAFETY & PERFORMANCE

3.1. VUNHST Risk Register

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

(including deep dive from Cath O'Brien MBE, Chief Operating Officer)

- 3.1.0 RISK REGISTER - TB - 25.05.2023 - V03.pdf (8 pages)
- 3.1.0a Appendix 1 - Risk Register - 25.05.2023 - V01.pdf (5 pages)
- 3.1.0b Appendix 2 -Risk Level Data - TB - 25.05.2023.pdf (2 pages)

3.2. Brachytherapy Review and Action Plan

Led by Cath O'Brien MBE, Chief Operating Officer

- 3.2.0 Brachytherapy Peer Review (005).pdf (5 pages)
- 3.2.0a Report of the Clatterbridge Cancer Centre Peer Review of the Velindre Cancer Centre Brachytherapy Service (FINAL).pdf (43 pages)
- 3.2.0b Brachytherapy Recommendations Action Plan April 2023.pdf (13 pages)

3.3. Performance Management Framework (March 2023)

Led by Cath O'Brien MBE, Chief Operating Officer

- 3.3.0 Trust Board 25.05.23 MARCH PMF Performance Report FINAL version 006a.pdf (63 pages)

3.4. Financial Report (March 2023)

Led by Matthew Bunce, Executive Director of Finance

- 3.4.0 Finance Report Trust Board 25 May.pdf (45 pages)

11:50 - 12:45
55 min

4. PLANNING & STRATEGIC DEVELOPMENT

4.1. Nursing Strategy

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

- 4.1.0 Nursing Strategy.pdf (3 pages)
- 4.1.0a Nursing Strategy 23-26 Final print.pdf (12 pages)

4.2. Integrated Medium Term Plan

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

- 2023-2026 Welsh Government Approval Status - Progress Update (oral)
- Quarter 4 2022-2023 Progress Report

- 4.2.0 Trust Board Quarter 4 VCC WBS Update against IMTP Actions version 006a.pdf (49 pages)

4.3. Full Business Case for Radiology Informatics Systems Programme (RISP)

Led by Carl James, Executive Director of Strategic Transformation, Planning & Digital and Carl Taylor, Chief Digital Officer

- 4.3.0 RISP Business Case (cover paper public) FINAL.pdf (5 pages)
- 4.3.0a RISP FBC V3 REDACTED.pdf (104 pages)

4.4. Public Audit Committee Highlight Report 25/04/2023

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

- 4.4.0 Audit Committee Part A Public Highlight Report 25 April 2023 Final.pdf (3 pages)

12:45 - 12:55
10 min

5. CONSENT ITEMS

5.1. CONSENT FOR APPROVAL

Led by Professor Donna Mead OBE, Chair

5.1.1. Chair's Urgent Actions Report

Led by Professor Donna Mead OBE, Chair

- 5.1.1 Chairs Urgent Action Report_May 2023.pdf (4 pages)

5.1.2. Commitment of Expenditure Exceeding Chief Executive's Limit

Led by Matthew Bunce, Executive Director of Finance

- 5.1.2 Trust Board May 2023_Commitment of Expenditure Cover Paper.pdf (4 pages)
- 5.1.2 Appendix 1 - Commitment of Expenditure_Beckman-Coulter (1).pdf (7 pages)
- 5.1.2 Appendix 2a - FF Ward.pdf (5 pages)
- 5.1.2 Appendix 2b - Commitment of Expenditure FF Ward Enhanced Ventilastion.pdf (8 pages)
- 5.1.2 Appendix 3 - Commitment of Expenditure CT Sim.pdf (7 pages)
- 5.1.2 Appendix 4 - Commitment of Expenditure - second linac and bunker refurb.pdf (7 pages)
- 5.1.2 Appendix 5 - Commitment of Expenditure Over Chief Executive Limit.pdf (8 pages)
- 5.1.2 Appendix 6 - Commitment of Expenditure.pdf (11 pages)

5.1.3. Amendment to Trust Standing Orders - Schedule 3

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

- 5.1.3 Amendments to Trust Standing Orders - Schedule 3 - Cover Paper.pdf (6 pages)
- 5.1.3 Appendix 1 - QSP with track changes.pdf (13 pages)
- 5.1.3 Appendix 2 - RDI& with track changes.pdf (9 pages)
- 5.1.3 Appendix 3 - CFC with track changes.pdf (8 pages)
- 5.1.3 Appendix 4 - QSP without track changes.pdf (13 pages)
- 5.1.3 Appendix 5 - RDI& without track changes.pdf (9 pages)
- 5.1.3 Appendix 6 - CFC without track changes.pdf (8 pages)
- 5.1.3 Appendix 7 - No amendments Audit Committee Terms of Refernce.pdf (9 pages)

5.1.4. Memorandum of Understanding - for the Operational Delivery Network (ODN) as part of the Spinal Services Operational Delivery Network for South Wales, West Wales and South Powys

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

- 5.1.4 SWSN Cover Paper.pdf (2 pages)
- 5.1.4 Appendix 1 - SWSN Briefing to accompany MoU v7 Final.pdf (3 pages)
- 5.1.4 Appendix 2 - SWSN MOU v7 Final.pdf (18 pages)

5.2. CONSENT FOR NOTING

5.2.1. Trust Wide Policies

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

- 5.2.1 TRUST WIDE POLICIES UPDATE_ May 2023 v1.pdf (3 pages)
- 5.2.1a PP01a Fire Prevention_Arson Prevention protocol v.2_March 2023.pdf (19 pages)
- 5.2.1b PP07 Bomb Threats_Suspicious Packages protocol_v3.2_130323.pdf (22 pages)
- 5.2.1c QS08 Management of Allegations & Concerns about Practioners and those in a Position of Trust_v2_Apr 20.pdf (21 pages)
- 5.2.1d QS12 Safeguarding and Public Protection Policy_v3_March 23.pdf (20 pages)

5.2.2. NHS Wales Shared Services Partnership Committee - Assurance Report

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

- 5.2.2 NWSSP - SSPC Assurance Report 23 March 2023.pdf (4 pages)

5.2.3. Trust Seal Report

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

5.2.3 Trust Seal Report April-May 2023 v1.pdf (3 pages)

5.2.4. Nurse Staffing Levels (Wales) Act 2016

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

5.2.4 Nurse Staffing Levels - final.pdf (13 pages)

5.2.5. Public Quality, Safety & Performance Committee Highlight Report 16/05/2023

Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

5.2.5 Public Quality Safety Performance Committee Highlight Report 16.05.23 (v2).pdf (9 pages)

5.2.6. Public Strategic Development Committee Highlight Report 04/05/2023

Led by Stephen Harries, Vice Chair and Chair of the Strategic Development Committee

5.2.6 Highlight Report SDC 04.05.2023-lf.pdf (2 pages)

5.2.7. Public Charitable Funds Committee Highlight Report 21/03/2023

Led by Professor Donna Mead OBE, Chair and Chair of the Charitable Funds Committee

5.2.7 Charitable Funds Committee Public Highlight Report 21 March 2023 V2.pdf (5 pages)

12:55 - 12:55
0 min

6. ANY OTHER BUSINESS

Led by Professor Donna Mead OBE, Chair

(Prior approval required by the Chair)

12:55 - 12:55
0 min

7. DATE OF NEXT MEETING

The next meeting of the Public Trust Board will take place on Thursday, 27th July 2023

12:55 - 12:55
0 min

8. 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 intertest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67)

12:55 - 12:55
0 min

9. LUNCH (The Board meet and greet for lunch with Representatives of the RISP Business Case Team)

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

MINUTES PUBLIC TRUST BOARD MEETING – PART A
VELINDRE UNIVERSITY NHS TRUST LIVE STREAMED
30 MARCH 2023 AT 10:00AM

PRESENT	
Professor Donna Mead OBE	Chair
Professor Andrew Westwell	Independent Member
Gareth Jones	Independent Member
Hilary Jones	Independent Member
Martin Veale	Independent Member
Carl James	Executive Director of Strategic Transformation, Planning and Digital
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director
Sarah Morley	Executive Director of Organisational Development and Workforce
ATTENDEES	
Lauren Fear	Director of Corporate Governance and Chief of Staff
Cath O'Brien MBE	Chief Operating Officer
Tina Jenkins	Interim Deputy Director of Nursing
Kay Barrow	Corporate Governance Manager
Liane Webber	Business Support Officer, Secretariat

1.0.0	**STANDARD BUSINESS**	**ACTION LEAD**
1.1.0	**Apologies noted:** • Steve Ham, Chief Executive • Stephen Harries, Vice Chair • Vicky Morris, Independent Member • Nicola Williams, Executive Director of Nursing, AHPs and Health Science	
1.2.0	**In Attendance** Regular Attendees: • Katrina Febry, Audit Wales Lead • Stephen Wyndham, Audit Wales • Stephen Allen, Chief Officer, Community Health Council (CHC) • Emma Rees, Deputy Head of Internal Audit • David Cogan, Patient Liaison Representative The Chair extended a warm welcome to Tina Jenkins, Interim Deputy Director of Nursing, Quality and Patient Experience deputising for Nicola Williams. The Chair also welcomed Alan Prosser, joining the meeting for item 5.1.0 (Welsh Blood Service Five-Year Strategy 2023/24-2027/28) and Phil Hodson, joining the meeting for items 5.2.0	

	(Integrated Medium-Term Plan 2023-2026) and 5.2.0 (Integrated Medium-Term Plan 2022-2023 Quarter 3 Update). The Chair also noted that this would be the last meeting attended by Stephen Allen in his current role of Chief Officer, Community Health Council and gave sincere thanks, on behalf of the Board, for his service and support.	
1.3.0	**Declarations of Interest** There were no declarations of interest to **NOTE**.	
1.4.0	**Minutes from the Public Trust Board meeting held on 31.01.2023** A point of clarity was noted, as follows: ***2.1.4 Amendment to Standing Orders – Schedule 3 –*** *"The Trust Board* ***APPROVED*** *the amendments to the Trust Board Standing Orders"* to be amended to read *"…the Trust Standing Orders"*. ***2.2.4 Audit Committee Highlight Report dated 12.01.2023 –*** It was NOTED that the Audit Committee Highlight Report had not been previously circulated as was stated in the minutes but had instead been included within the papers for this meeting. The Trust Board **APPROVED** the Minutes of the meeting held on **31.01.2023** as an accurate and true record.	
1.5.0	**Action Log** Action 7.2.0 from meeting held 27/01/2022 was highlighted **(Cardiff Cancer Research Hub, Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust)** Assurance was sought around the inclusion of branding of Velindre within the Heads of Terms. It was **NOTED** that although Velindre branding is not currently specifically referenced, collaborative discussions are taking place and will be agreed prior to formal sign off of all three parties. Action 7.1.0 from meeting held 24/11/2022 was highlighted **(Brachytherapy)** Following a Trust-commissioned review into Brachytherapy services it was NOTED that the resulting report, associated action plan and details of progress so far will be presented to the Trust Board at its meeting on 25th May 2023. Board members confirmed there was sufficient information contained in the log to provide assurance that the actions identified as	

	completed could be **CLOSED** and **NOTED** the updates provided. The Action Log was **APPROVED**.	
1.6.0	**Matters Arising** There were no matters arising.	
2.0.0	**KEY REPORTS**	
2.1.0	**Chair's Update** The Chair reported that the Audit Wales report of Betsi Cadwaladr University Health Board and the resulting recommendations had been reviewed amongst the Board, with comments recorded and submitted to the Chair of Chairs who has, in turn, collated and circulated the responses of all NHS Wales organisations. This report will be circulated to the Board following the next meeting of the chair's peer group and further discussions will continue. The Chair wished to extend the Trust's congratulations to Dr Hilary Williams who, since the Chair's report publication, has been appointed as Vice President of the Royal College of Physicians, Wales. The Trust Board **NOTED** the content of the update Report.	**LF**
2.2.0	**Chief Executive's Update** Carl James acknowledged the Integrated Medium-Term Plan and the end of the financial year and wished to extend thanks to all staff and partners for their hard work and resilience in what has been a challenging but ultimately successful year. The Trust Board **NOTED** the content of the update Report.	
3.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
3.1.0	**VUNHST Risk Register** In presenting the risk register, Lauren Fear highlighted the following: • Risk register is presented in the new format paper template, currently being trialled and due for discussion and refinement at an upcoming Board Development session. • Quality, Safety and Performance (QSP) Committee have agreed to conduct deep dives into a small number of particular risks at each meeting going forwards. The criteria for selecting deep dives is to be considered at QSP Committee, whilst including consideration of the longer-standing risks. Discussions and comments regarding the risk register: • Risk 2800 (water main) – it was noted that since publication of the papers this is no longer a risk but is now an issue, following confirmation that the water main does have to be moved. • Risk 2612 (AOS workforce gaps) – The Chair raised concern around the September review date for this risk, however the Board	

	were advised that this risk is a constant focus of work and is a dynamic situation that is regularly changing. The Board were assured that as well as reorganising consultant timetables, new appointments had been made and new ways of providing seamless cover are always being sought and that there are ongoing national pieces of work which will provide more clarity in September. • Risk 2579 (performance and service sustainability) - In response to a query from the Chair, clarification was provided that, due to a change in the curriculum, there is a need for trainees in oncology to be exposed to areas of work which require support by consultants. This is good practice but is creating a risk for cover, although the Board were assured that this is being managed and monitored. • Risk 2465 (emails received by consultants re clinical issues) – The Board were assured that an audit is being undertaken to look at the email issues and this is ongoing. • Risk 2389 (airway maintenance) - The Chair raised concern about safety levels whilst acknowledging the issues around capacity. The Board were assured this risk has been flagged for some time and an extensive amount of work has been undertaken. Members noted that some CNSs are trained to manage airways, which has increased confidence in care. The risk is due to be reviewed at the end of April although given the level of work undertaken and ongoing, it was agreed to bring the review forward. • Risk 3011 (continuation of safe patient care) – it was agreed that the statement / title of this risk is too broad and needs to be reviewed and updated, as per the guidance on Datix, to fully illustrate the risk. The Board were advised that this risk has now progressed and that the technical issue around data shredding has been resolved. • Risk 3048 (patient records in WPAS) – The Board were informed that following bedding in of DHCR a number of issues have arisen, an example of which being a technical issue with the data warehouse, which is now stable, and data validation is ongoing. The live reporting of the data and validation of the legacy data is being considered. New COSC targets will be implemented and it will be clear what the targets are going forward. An impact assessment is being undertaken; some of the software is immature and when this is used more widely than the development stages more issues may evolve. A plan is being developed and has been agreed at project board. The Trust Board: • **NOTED** the risks level 20, 16 and 15 as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in the paper. • **NOTED** the welcomed the on-going developments of the Trust's risk framework.	**COB/JA**
3.2.0	**Trust Assurance Framework** Lauren Fear gave an overview of the development work during the January-March reporting period, which was discussed as follows:	

	• It was highlighted that in a number of the risks, the residual risk score remains unchanged since the previous review with no specific evident trend emerging in the data. It was queried whether this meant that the planned actions to mitigate the risk are not working. Lauren Fear advised that whilst the information to track this is not currently available, implementation of the SMART action plan in the template will record whether planned actions have impacted the risk score or enhanced the level of assurance. It was noted however, that, typically the strategic risks will be long-term impact in terms of the actions and would not necessarily be expected to reduce in the short-term. This was agreed, although the importance of acknowledging the expected timescale and applying realistic target dates was expressed. • The Chair highlighted the TAF dashboard on Organisational Culture noting that culture is a Board responsibility but that this is not clear in the dashboard. Sarah Morley advised that there has been a further update of TAF 04 since the papers were published which clearly states the Board's ownership of the various elements. The Trust Board: a. **DISCUSSED AND REVIEWED** the progress made and next steps in supporting the continued development and embedding of the Trust Assurance Framework, as outlined in section 2.1. b. **DISCUSSED AND REVIEWED** the update to the Trust Assurance Framework Dashboard, included at **Appendix 1.**	
3.3.0	**Performance Management Framework (January 2023)** Carl James outlined the Performance Management Framework and recently work undertaken. Cath O'Brien MBE gave an overview of the performance figures, as follows: **Velindre Cancer Services** • Implementation of the new Digital Health Care Record (DHCR) is continuing and is stable. • Systemic anti-cancer therapy (SACT) performance has been sustained at target in the midst of increasing and variable demand. • Radiotherapy data is not present in the report, however validated February data recently made available shows scheduled care at 83% and unscheduled treatment pathway at 75%. Availability of data is limited due to the considerable amount of manual work necessary in order to produce validated datasets, although this work is being done and is expected to be presented at the next Board cycle. Discussion: • Concern was expressed over the appearance of red columns in the scorecards which may give a false negative impression and the achievability of the set baselines was queried. The Board were assured that much work had been undertaken to ensure baseline targets were set accordingly, although many of the targets are nationally prescribed targets as in the case of healthcare acquired	

infections, which, appropriately, has a zero-tolerance baseline, although this does not take into account individual circumstances, such as a largely immunosuppressed patient population. The Board were further assured that, following a full review, it was confirmed that there had been no practice issues identified which could have contributed to the recently reported spike in healthcare acquired infections.

- It was clarified that the paragraph in the cover paper which states "…emergency SACT being 1% below the 98% target" should instead state "…1% *point* below the 98% target".

Welsh Blood Service

- The Welsh Blood Service (WBS) has continued to maintain stocks amidst difficult circumstances.
- A working group has been established to review data, stock levels and variations in demand and will return with progress at future Board meetings.
- There is continued improvement in the recruitment of bone marrow volunteers and good progress is being made with the new strategy for the registry to further examine the leadership role in the UK and our activity in Wales.
- Antenatal turnaround times have now returned to expected levels.
- Although good progress is noted, there is still some work to be done around stem cell collection and this is underway and ongoing.

Workforce and Organisational Development (WOD)

Sarah Morley highlighted the following key points from the November 2022 Performance Report.

- Sickness absence from the most recent figures is at 6.2%. Efforts to manage these matters on a case by case basis continue. Systemic factors on sickness levels are continually being addressed. A piece of work around minimising staff harm, initiated by Aneurin Bevan University Health Board, is being undertaken, which looks at workforce processes and policies in terms of their potential impact on individual, teams and services as a result and seeks to find a different approach to minimise harm.
- PADRs currently at 77% and the Pay Progression Policy has now been fully implemented and proactive work with managers to ensure they are completing PADRs in a timely manner is ongoing.

Discussion:

- Concern was expressed around the PADR data presented as an aggregate figure which therefore does not indicate departmental PADR percentages. It was explained that reporting of the data has been refined in order to ensure that it is presented where it is to be appropriately managed and to ensure that the committees are carrying out the work on behalf of the Board.
- Further information was sought around the action being taken to support staff in returning from long-term sickness absence. Sarah Morley reassured the Board that staff are actively supported in

	returning to work, either by phased return to their substantive role, or by returning in a different role if and where appropriate, alongside support from Occupational Health and other wellbeing professionals accordingly. The Trust Board **NOTED:** • the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 6. • the new style PMF Performance reports will continue to be developed by the PMF Project Group, taking account of suggested changes and ensuring ownership at all levels and full engagement with both Independent Members and CHC representatives.	
3.4.0	**Financial Report (January 2023)** In presenting the report, Matthew Bunce highlighted the following: • The January 2023 report reflects the Trust is still forecasting the revenue position to remain at breakeven. • In terms of Capital, all allocated funding expected to be spent fully. • The recent dip in PSPP compliance figures is under investigation which is expected to support a quick recovery in order to meet the 95% target by the end of the financial year. • Contingency plans have been put in place for the two savings schemes relating to service redesign and supportive structures to ensure that the savings target is met. Discussions and clarifications: • Agency spend is below last year's figures, although has risen slightly over the last two months due to a backlog of essential Estates maintenance for which additional capacity was required. • A late allocation of c£700k funding from Welsh Government for energy funding and COVID response in November created a significant sum non-recurrent funding this year, along with the rise in interest rates generating extra bank interest income of c£800k, leading to a total of c£1.5m non-recurrent extraordinary income this year. Given this extraordinary non-recurrent income, there will be a reduction in the recharges to the charity, increasing the charity reserves this year. • COVID Capacity – as the income protection is anticipated to cease in part or fully in 2023-24, the Trust is forecasting a financial shortfall of c£1.5m from April '23 between income and costs which will need to be met next year through the 1.5% discretionary uplift, marginal income from further activity growth beyond currently forecast, additional Trust savings or disinvestment from a proportion of the COVID recovery staffed capacity. The Trust Board **NOTED:**	

	• the contents of the November 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover COVID backlog additional capacity costs. • The £1.5m extraordinary income in 2022-23 which has enabled a and £1.5m reduction in costs recharged to the Charity • the TCS Programme financial report for November 2022 attached as Appendix 1.	
3.5.0	**Quality, Safety & Performance Committee Highlight Report 16.03.2023** The Trust Board DISCUSSED and NOTED the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 16th March 2023.	
4.0.0	**INTEGRATED GOVERNANCE**	
4.1.0	**Audit Wales 2022 Structured Assessment and 2022 Audit Annual Report** Katrina Febry presented the Structured Assessment and the following was noted: • Attention was brought to Recommendation 2 regarding reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies. Tina Jenkins assured the Board that this has since been addressed. Steve Wyndham presented the Audit Annual Report noting the following key findings: • An unqualified opinion on the Trust accounts was issued. • No significant control weaknesses were identified. • Whilst a qualified opinion was issued on the regularity of the financial transactions within the Trust's 2021-22 accounts, this was in line with many other NHS bodies. The Trust Board **NOTED**: • the recommendations in the 2022 Audit Wales Structured Assessment. • the Audit Wales 2022 Audit Annual Report.	
4.2.0	**Audit Wales 2022 Structured Assessment Management Response** The Trust Board **NOTED** the Management Response to the 2022 Structured Assessment.	
5.0.0	**PLANNING AND STRATEGIC DEVELOPMENT**	
5.1.0	**Welsh Blood Service Five Year Strategy 2023/24-2027/28** Cath O'Brien MBE gave an initial introduction to the Welsh Blood Service Five Year Strategy, noting in particular that it covers not only	

	the aspirations for service delivery, but also aspirations for research and for system leadership which gives a strong ambition for the Service. Alan Prosser presented the Strategy which has been tested not only with CHC but also with donors and the general public. Discussion: • It was noted that a number of past donors who are unable to continue to donate have enquired as to whether there would be a role for them to continue to support the Service on a voluntary basis. Alan Prosser agreed that past-donor engagement is certainly a focus and advised that a Donor Strategy is currently under development in which a donor engagement framework will be included. • Whilst it is understood that there will be programmes of work specific to WBS, the need to avoid creating two distinct research and innovation strategies was highlighted, as much of the research infrastructure is a Trust-wide initiative. • The omission of specific planned strategic development programmes was highlighted. Alan Prosser advised that these will form part of the WBS Futures programme and will be presented to the Strategic Development Committee in due course. The Chair requested that a short paragraph be included within the WBS Five Year Strategy to signal this. This was agreed The Trust Board: • **NOTED** engagement activities to date. • **APPROVED** the WBS Five Year Strategy 2023/24 – 2027/28.	
5.2.0	**Integrated Medium Term Plan 2023-2026** The Board received a presentation on the work undertaken on the IMTP. The Trust Board: • **APPROVED** the IMTP for submission to the Welsh Government on 31st March 2023 together with the risks to delivery. • **NOTED** that there will be a final QA of the document prior to submission to the Welsh Government; • **APPROVED** the IMTP for submission to the Welsh Government on 31st March 2023 following final quality assurance.	
5.3.0	**Integrated Medium Term Plan 2022-2023 Quarter 3 Update** The Trust Board NOTED the progress made, as of Quarter 3 (2022/2023), in delivering the key Trust actions included within the approved IMTP for 2022/2023.	
5.4.0	**Building our Future Together Portfolio Initiation Document** The Trust Board **APPROVED** the Portfolio Initiation Document for Building Our Future Together.	

6.0.0	**CONSENT ITEMS**	
6.1.0	**CONSENT FOR APPROVAL**	
6.1.1	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chair's urgent action taken between the 31/01/2023–20/03/2023, as outlined in Appendix 1, page 4 of the report.	
6.1.2	**National Imaging Academy Wales – Hosting Agreement Extension** The Trust Board **APPROVED** the extension to the hosting agreement for the National Imaging Academy for Wales until 31 March 2026.	
6.2.0	**CONSENT FOR NOTING**	
6.2.1	**Trust Wide Policies** The Trust Board **NOTED** the policies that have been approved during the period December 2022 to March 2023.	
6.2.2	**Trust Seal Report** The Trust Board **NOTED** the contents of the Trust Board Seal Register included in Appendix 1.	
6.2.3	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report 26.01.2023** The Trust Board **NOTED** the contents of the report and actions being taken.	
6.2.4	**Strategic Development Committee Highlight Report 07.02.2023** The Trust Board **NOTED** the contents of the report and actions being taken.	
6.2.5	**Audit Committee Highlight Report 12.01.2023** The Trust Board **NOTED** the contents of the report and actions being taken.	
6.2.6	**Remuneration Committee Highlight Report 09.02.2023** The Trust Board **NOTED** the contents of the report and actions being taken.	
6.2.7	**Local Partnership Forum Highlight Report 07.03.2023** The Trust Board **NOTED** the contents of the report and actions being taken.	
6.2.8	**Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing 14.03.2023** The Trust Board **NOTED** the contents of the Public briefing dated 14th March 2023, which 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.	
6.2.9	**NHS Shared Services Partnership Committee - Assurance Report 19.01.2023** The Trust Board is asked to **NOTE** the contents of the Assurance Report dated 19th January 2023, which sets out the key matters including achievements and progress considered by the NHS Wales Shared Services Partnership Committee.	
7.0.0	**ANY OTHER BUSINESS**	
	There were no additional items of business brought for discussion.	
8.0.0	**DATE OF NEXT MEETING**	
	Thursday 25th May 2023	

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

VELINDRE UNIVERSITY NHS TRUST

PUBLIC TRUST BOARD MEETING 25th MAY 2023
ACTION LOG

ACTIONS ARISING FROM 30/03/2023					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
2.1.0	**Chair's Update –** Report containing responses of all NHS Wales organisations in relation to recommendations resulting from the Audit Wales report of Betsi Cadwaladr University Health Board to be circulated to the Board.	Director of Corporate Governance and Chief of Staff	**25/05/2023**	**Update 18/05/2023** – Report circulated to Trust Board members.	**CLOSED**
3.1.0	**VUNHST Risk Register –** Review of risk 2389 (airway maintenance) to be brought forward due to concern around safety levels.	Chief Operating Officer / Executive Medical Director	**25/05/2023**	**Update 16/05/2023** – To be addressed within the May 2023 Risk paper. The risk has been downgraded following review.	**CLOSED**
3.3.0	**Performance Management Framework (January 2023) –** Ensure that learning identified from work undertaken around minimising staff harm is included in Workforce & OD item at May 2023 Trust Board.	Executive Director of Workforce & OD	**25/05/2023**	**Update 11/05/2023** – This will be addressed within the Workforce element of the Performance Management Report at the May 2023 Trust Board.	**CLOSED**
3.3.0	**Performance Management Framework (January 2023) –** Ensure clear narrative in the PMF for Trust Board in relation to the potential impact of the implementation of the new COSC targets on perceived performance.	Chief Operating Officer	**25/05/2023**	**Update 16/05/2023** – This will be addressed within the May 2023 PMF report. The June 2023 Board Development Session will also review this.	**OPEN**

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

TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Manager Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff
REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	**DATE**	**OUTCOME**
N/A		

ACRONYMS	

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chair. Matters addressed in this report cover the following areas:

- Board Development Sessions.
- Extraordinary Trust Board meetings.
- Easter Jamboree.
- Coronation Celebrations at the Café Barista Bar.
- All-Wales, Rapid Access Palliative Radiotherapy Showcase Event.
- International Nurses' Day / Velindre University NHS Trust Nurses' Conference.
- Audit Wales Review of Betsi Cadwaladr University Health Board.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1. Board Development Sessions

18th April 2023

A Board Development Session was held on 18th April 2023. Topics discussed were:

- Annual Integrated Board Effectiveness Assessment 2022/23 and maturity rating level in respect of Effectiveness, Governance, Leadership and Accountability.
- Review of progress with developing the Trust Culture.
- Values Workshop – to develop and produce a draft set of Values Statements for the Trust.
- New Velindre Cancer Centre Governance Plan and Approval Process.

2.2. Extraordinary Trust Board Meetings

28th April 2023

The Trust Board held an extraordinary private meeting on the 28th April 2023, at which the following items were discussed:

- New Velindre Cancer Centre overall timeline and approach.
- Land Transfer Proposal – approval of approach and conditions.
- Approval of New Velindre Cancer Centre Business Case changes for May 2023 Health Board submission.
- New Velindre Cancer Centre Gateway Review.

2.3 Easter Jamboree

The Easter Jamboree welcomed some of Velindre Fundraising's Young Ambassadors to the Cancer Centre for a day of fun and activities to initiate our programme events. The event was attended by the Trust Chair and Julie Morgan MS, alongside a number of other Velindre fundraisers and supporters. The newly-built Velindre Roundhouse hosted a range of interactive and educational sessions during the Easter holidays, providing the opportunity to learn more about biodiversity and partake in arts and crafts. We are very grateful to Ray of Light for their contribution to organising craft activities.

2.4 Coronation Celebrations at the Café and Barista Bar

In anticipation of King Charles III and the Queen Consort's special day, the Café and Barista Bar brought out bunting, flags, t-shirts and hats. This was accompanied by a special menu for the occasion, including their own Coronation Trifle and cream teas.

Patients were also treated to a traditional afternoon tea served by our caterers, while watching the historical event on TV with their friends and families.

The team from estates contributed to the festive atmosphere by producing some of the coronation decorations including painting the coronation logo on paths around the cancer centre.

2.5 All-Wales, Rapid Access Palliative Radiotherapy Showcase Event

Teams from all Cancer Centres across Wales have collaborated over the past year, seeking to improve symptom control and better delivery of emergency palliative Radiotherapy. Presentations highlighting and celebrating the work undertaken across Wales to date were delivered at the All Wales, Rapid Access Palliative Radiotherapy Showcase Event, held at the National Imaging Academy.

Velindre Cancer Centre had a significant presence, with the Chair, Chief Executive and Radiotherapy staff in attendance, among others. The event was hosted by the Bevan Commission. Velindre's Dr Mick Button was key to organising the programme. The 3 centres will continue to work together to improve these services for patients.

2.6 International Nurses' Day / Velindre University NHS Trust Nurses' Conference

As part of International Nurses' Day (12th May 2023), the Trust hosted its very first Trust-wide Nursing Conference at Cardiff's All Nations Centre, providing an opportunity for registered nurses, health care support workers and clinic collection assistants to come together to celebrate successes and plan future achievements.

Following endorsement by the Trust's Strategic development committee, the Conference provided an opportunity to launch the Trust-wide Nursing Strategy 2023-2026, which has been developed in consultation with our nursing workforce. Implementation of the strategy will empower nurses to lead compassionately and deliver high quality care to our patients and donors.

The conference was very well attended by Trust nursing staff with over 100 delegates. We are most grateful to nursing staff who held the fort at the cancer centre to enable their colleagues to attend. Both the Chair and Chief Executive were in attendance alongside other Executive colleagues.

The Chair is delighted to announce that the Trust's Paracentesis Team won the CNO Excellence Award for their dedication, innovation and excellence in delivery of services to the population of Wales. The Award was presented by the Welsh Government's Nursing Officer, Gillian Knight. Congratulations go to Rachel Bartley, Matthew Walters, Sarah Owen, Helen Way, Lauren Sheppard, John Davies (Advanced Nurse Practitioners) and Denize Vaile, Jo Ward and Nadia Worsley (Radiographers).

2.7 Since the publication of the Audit Wales Governance review of Betsi Cadwaladr University Health Board, Trust board colleagues have met on several occasions to work through the recommendations to review Governance at Velindre.

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

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	This has been considered. No implications
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this update report from the Trust Chair.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

ARMED FORCES and VETERANS BOARD CHAMPION ANNUAL REPORT

DATE OF MEETING	25th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Professor Donna Mead OBE, VUNHST Chair
EXECUTIVE SPONSOR APPROVED	Professor Donna Mead OBE, VUNHST Chair

REPORT PURPOSE	FOR INFORMATION AND DISCUSSION

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

1. SITUATION

The Trust Board is provided with the first **Annual report** of the Board's **Armed Forces & Veterans Champion**, which provides a detailed summary of achievements over the period **2022-2023** and future plans, for **INFORMATION** and **DISCUSSION**.

2. BACKGROUND

2.1 Board Champion roles

Board Champion roles have been in place since 2003 as a requirement by Welsh Government, and are a mix of statutory and non-statutory roles, to be held at non-executive (independent member), executive director level or both.

Board Champions are designed to engender board level commitment and focus around key areas of service development or delivery. For the Boards' Independent members, this provides an opportunity to gain a deeper level of insight and knowledge around key areas with the aim of better equipping them and the whole Board to fulfil its role.

During 2020 Welsh Government officials undertook a detailed assessment of all Champion roles to assess the need for them to continue. This assessment identified those roles that need to be maintained and included that of the role of **Armed Forces and Veterans.**

2.2 Expected Inputs and Outputs

A key requirement for each assigned Board Champion role is to produce an **Annual Report** to be received by the Trust Board at the end of each reporting period.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION.

3.1 Armed Forces Covenant

The Trust is a signatory of the **Armed Forces Covenant** (a moral obligation between the nation and the Armed Forces ensuring the fair treatment of Armed Forces Veterans and their families) and a positive long standing relationship exists between the Trust and Armed Forces, supported by the Chair of the Trust as the Board Armed Forces & Veterans Champion and Head of Engagement as Trust Lead.

3.2 Achievements 2022/23

Notable achievements during 2022/23 include the Trust's application for the Gold Defence Employer Award (having previously achieved Silver status), the installation of flagpoles at the Velindre Cancer Centre, the development of a formal Memorandum of Understanding to facilitate the continued relationship between the Trust and 203 (Wales Field Hospital) and commitment to the Prince of Wales Cadet Scheme to support Cadets towards employment within Nursing and Health Professions.

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

3.3 Future Plans

A number of future plans are currently in progress, including supporting Veterans and service leaders' transition into the civilian workforce, potential for involvement of Reservists in Business Continuity Planning arrangements, implementation of a scheme to allow Veterans who have volunteered within the Trust to interview for a number of appropriate posts and utilisation of the Trust's communication routes to promote key Armed Forces events.

A programme of events is currently planned for 2023-2024, details of which can be found in the attached report, together with a summary of activity undertaken during 2022 – 2023.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	
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 **DISCUSS and NOTE for INFORMATION** the Annual report of the Board's Armed Forces and Veterans.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Armed Forces & Veterans Board Champion Annual Report 2022-2023

Donna Mead, OBE
VUNHST Chair and
Board Champion for:
Armed Forces & Veterans

Background

Velindre University NHS Trust (VUNHST), as a service provider and employer, is a strong advocate of Defence, advocating internally and externally its forces' friendly credentials, the promotion of the Armed Forces Covenant and ongoing participation in the Defence Employer Recognition Award Scheme. The Trust is a signatory of the Armed forces Covenant and has a long-standing positive relationship with the Armed Forces with the Chair of the Trust as the Board Armed Forces Champion and Lisa Miller, Head of Patient Engagement, as the Trust lead.

The Armed Forces Covenant

The armed forces covenant is described as a moral obligation between the nation and the members of the armed forces. The covenant currently supports 3,300 serving personnel and 140,000 veterans across Wales. The Covenant is a promise from the nation that those who serve or have served in the armed forces, and their families, are treated fairly.

Achievements 2022/23

- Having already achieved, silver status in the Defence Employer recognition scheme, the Trust has submitted its application for the Gold Defence Employer Award with the outcome expected in July 2023.

- The Trust demonstrates its commitment by fostering the relationship with 203 (Wales) Field Hospital, through the development of a formal Memorandum of Understanding (MoU) and annual attendance by 203 (Wales) Field Hospital personnel at the Armistice Day remembrance event at VCC. The MoU describes the joint working relationship which includes the launch of a joint Clinical Excellence Award during 2023. It describes the wider collaborative opportunities including employment opportunities, training, education and research. In the past, the Trust has supported 203 (Welsh) Field Hospital practically with VCC providing a clinical space for blood tests to be taken pre-deployment.

- Recognising the importance of attracting the future workforce, the Trust has committed to the Royal College of Nursing (RCN) Prince of Wales Cadet Scheme which provides nursing cadets structured placements at VCC and the Welsh Blood Service (WBS). This scheme is run in

conjunction with all cadet forces. The scheme aims to develop and prepare young people (16-25) for life and to support them towards employment in nursing and other health professions.

- To further progress its commitment to providing employment opportunities the Trust has joined the Career Transition Partnership and implements a guaranteed interview process for veterans that meet essential skills criteria.

- Regular meetings are held with the Armed Forces Lead in BCUHB and the newly appointed lead in CVUHB to share ideas and best practice.

- An informal Armed Forces Network to support employees who are Reservists, Veterans and their spouses/partners is being established.

- Flagpoles have been put in place at Velindre Cancer Centre.

- Exercise Medical Stretch has been publicised and the Trust has supported some teams to take part. This has resulted in some members of Trust staff becoming Reservists at 203 Field Hospital.

- Colonel Lawrence (203) has attended Trust 'lunch and learn' events for staff in order to describe the role of Reservists and the opportunities and learning for individuals/organisations who employ reservists. This has provided a key opportunity to raise the profile of the skills, knowledge and experience reservists can provide organisations. It may be opportune to invite Colonel Lawrence to meet with the Trust Board.

<u>Future Plans</u>

- We will work in partnership with Acorn, the chosen contractor for the new VCC, as part of its Community Benefits Programme. There is a focus on helping people source and retain sustainable employment whilst working with employers to develop workforces for the future. We will ensure that this is extended to Armed Forces leavers.

- The Trust intends to implement a scheme in which volunteers who are veterans and have volunteered in the Trust for a period of time to be offered an interview for appropriate posts.

- We are currently finalising a mentorship role with Colonel Lawrence (Commanding Officer 203 (Welsh) Field Hospital so we can support veterans and service leavers' transition into the civilian workforce.

- We will consider the involvement of Reservists in Business Continuity Planning arrangements to demonstrate the critical planning and continuity skills such personnel bring to the workplace. (This was demonstrated during the pandemic when service personnel assisted with gold command and logistics planning).

- Encouragement of Reservists and Veterans to wear uniform or regimental items on key remembrance/awareness events.

- Use of the Trust's communication channels including the weekly newsletter, intranet site and social media platforms to promote key events such as Remembrance Sunday, Armed Forces and Reservists Days.

- Celebration of the Silver Award (and hopefully the Gold award in due course) via social media channels with the aim of encouraging others to apply for the Scheme.

Plans for 2023/24

- **Armed Forces/Reservists Days – 21st to 23rd June**

  A draft programme of events for VCC has been developed alongside social media content. Catering staff have indicated a willingness to become involved. A meeting has been arranged with Welsh Blood Service to discuss opportunities to mark these days.

- **Workforce**

  With over 1500 employees, the Trust has identified only a small number of Reservists, Spouses etc. A recent review suggests that the field on the electronic staff record to identify as a veteran is not routinely completed. The Trust newsletter has asked for staff to update this field so we can gain an accurate position.

- **Welsh Patient Administration System (WPAS)**

Armed Forces & Veterans Board Champion Annual Report 2022-2023

Key to providing an appropriate service for Veterans is being able to identify patients who are veterans and to ascertain their needs. Ideally veteran status would be completed during registration with primary care after leaving the service and therefore transferred to all relevant NHS clinical systems. However, this is not a mandatory field in the WPAS system and is a free text field only which is not often completed.

The Health Records Manager has been asked to review the process for capture of this information. If a solution is found, this will be communicated via varied methods, so patients are aware to notify a member of staff that they are a veteran.

A key area for 2023 is to improve the pathways and support for Veterans both within the workforce and for our patients. The Trust is also planning to work towards the Veterans Aware Accreditation.

- **Trust Steering Group**

  In order to improve opportunities for promotion and communication, the Trust is currently setting up an Armed Forces Steering Group which will cover both workforce and patient pathways. A key action will be to implement the use of the current All Wales e-learning on supporting armed forces and veterans.

- **Memorial at Welsh Blood Service (WBS)**

  The proposals for a discrete memorial plaque at WBS has been raised with the General Services Manager. A memorial stone was placed at nVCC in 2019 and provides meeting place for remembrance events (see photograph attached).

- **Blood Donation Session at 203 Field Hospital**

  Discussions are well advanced to host a blood donation session at 203 Field Hospital in the autumn of 2023.

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

Armed Forces & Veterans Board Champion Annual Report 2022-2023

VELINDRE UNIVERSITY NHS TRUST

We, the undersigned, commit to honour the Armed Forces Covenant and support the Armed Forces Community. We recognise the value Serving Personnel, both Regular and Reservists, Veterans and military families contribute to our business and our country.

Signed on behalf of:
Velindre University NHS Trust

Signed: [signature]

Name: CHAIR.

Position: Prof Donna Mead

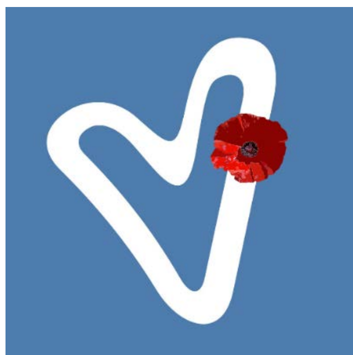
Date: 8TH APRIL 2019

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

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

Armed Forces & Veterans Board Champion Annual Report 2022-2023

https://www.facebook.com/profile/100064558725215/search/?q=rembrance



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

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Steve Ham, Chief Executive Officer
EXECUTIVE SPONSOR APPROVED	Steve Ham, Chief Executive Officer

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	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chief Executive on a number of matters.

Matters addressed in this report cover the following:

- Industrial Action.
- Joint Executive Team (JET) Meeting.
- Patient and Community Engagement Platform Launch.
- Appointment of Head of Operational Services and Delivery.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Industrial Action

Following initial industrial action taken by the Royal College of Nursing (RCN) in Velindre in January 2023, further action planned for the 6th and 7th February was called off following discussions between Trade Unions and Welsh Government. Following a period of negotiation a pay offer of 1.5% consolidated, 1.5% non-consolidated (pay for 2022-23) was accepted by the Welsh Partnership Forum and has subsequently been implemented. However, membership of individual unions did not accept this offer and therefore further discussions took place.

Due to the ongoing nature of the discussions with Welsh Government, the RCN applied to all NHS organisations where a strike mandate had been obtained in 2022 for a three month extension to the mandate from 2nd May 2023, to allow meaningful consultation with union members on any further offers. The Trust approved this request, as did other NHS Wales organisations.

On the 20th April 2023, the Welsh Government Minister for Health and Social Services issued a statement outlining a revised offer for staff subject to Agenda for Change terms and conditions. The additional offer was for a one off NHS Recovery Payment for 2022/23 and for a consolidated increase of 5% for 2023-24.

Following individual ballots by trades unions on this offer, it was announced on the 11th May that the RCN in Wales had rejected the WG pay offer in their recent ballot and they are now planning strike action for 6 and 7th June and 12th and 13th July. The Trust is now awaiting official confirmation from the RCN of these dates. The outcome of other union ballots is not yet known.

In response the Trust has stood up its Industrial Action Cell from the 16th May to plan for these dates.

2.2 JET

The Executive Team are meeting with the Welsh Government Health & Social Care leadership team on 19th May. The agenda will include discussion on:

- Overview of year end position to include quality and safety, performance and finance
- Update on 2022/23 accountability conditions
- Successes and lessons learned in 2022/23
- Plans for 2023/24, including addressing the Ministerial priorities
- Identified risks for 2023/24 and actions in place to mitigate these

The Chief Executive will provide an update on the meeting during the Trust Board meeting.

2.3 Patient and Community Engagement Platform Launch

Velindre Cancer Service is calling on anyone with an interest in helping to shape the future of cancer care in south-east Wales to have their voices heard by joining Velindre Voices - a new patient and community forum. This was a core deliverable of the Patient Engagement Strategy which was approved by the Trust Board last year. The work is now under the leadership of the Director Corporate Governance & Chief of Staff to support the join up across communications and engagement for our patients, community and for staff.

Velindre Voices will deliver a means for anyone to engage with us, influence our work and have their voice heard in a way that suits them. From simply keeping in touch and receiving updates on areas of interest, to becoming part of focus groups, volunteering or becoming a member of the Patient Engagement and Involvement Group or Community Panel, there is no minimum time commitment and members of the panel can be involved in as much or as little as they wish.

The Cancer Centre is particularly interested in engaging with those with seldom heard voices and it will be working closely with third sector organisations to ensure the engagement opportunities offered are accessible and meet everybody's needs.

2.4 Appointment of Head of Operational Services and Delivery

The Chief Executive Officer is delighted to report the permanent appointment of Rachel Hennessy to Head of Operational Services and Delivery (Deputy Director of Velindre Cancer Service). The Senior Leadership Team is very pleased to welcome her as a substantive member of the team.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the content of this update report from the Chief Executive.

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	25.05.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	MEL FINDLAY, BUSINESS SUPPORT OFFICER
PRESENTED BY	LAUREN FEAR, DIRECTOR OF GOVERNANCE AND CHIEF OF STAFF
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the Trust Board to have effective oversight and assurance of the way in which risks are currently being managed across the Trust. • Summarise the final phase in implementing the Risk Framework.

RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **NOTE** the risks level 20, 16 and 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTE** the on-going developments of the Trust's risk framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board	02.05.2023
Quality, Safety and Performance Committee	16.05.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS THE PAPER WAS DISCUSSED AT THE MEETING; FURTHER REVIEW OF RISK WAS TO BE CARRIED OUT AHEAD OF QSP.	

Please complete this section if you have indicated that the report purpose is for ASSURANCE.

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	1 – Action Plan for each risk needs strengthening.						

APPENDICES	
1	Current risk register data.
2	Risk data graphs

1. SITUATION

The report is to inform the Trust Board of the status of risks reportable to Board, in line with the renewed risk appetite levels. In addition, the report will update on progress against the Risk Framework.

2. BACKGROUND

The risks currently held on Datix for the Trust are to be considered by the Trust Board.

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 11 risks to report to Board and Committee on Datix 14, this includes 10 risks with a current score over 15 and 1 risk with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Risk Register

- The risk register detail in Appendix 1 is for consideration by the Trust Board.
- Action plans for risks are continually under review in divisions with transition to SMART actions underway.
- To note all actions in the Datix action plan section have assigned owners – however given named individuals on the system, this is not included in reporting. If any member would like further details, this can be provided.
- To note that during the focus on SMART actions during the previous reporting period resulted in agreement for the need for a more specific guidance section to be added into the Datix How To Guide, this has now been updated and uploaded to the risk area of the intranet DATIX - How To Guide.

4.2 Risk In Depth Review

Following discussion with Independent Members and at the last Quality, Safety and Performance Committee an in depth review was timetabled for the meeting of the Quality, Safety and Performance Committee on 16.05.2023. Two risks were discussed, one Velindre Cancer Centre risk and one Welsh Blood risk. The discussion raised the matter of the length of time some risks have been open, with committee members seeking assurance that risks have moved beyond identifying the problem stage. This feedback will be taken forward in ongoing reviews as an area for consideration.

4.3 Next Steps in Engagement and Embedding

- The approved Policy and Procedure are now on the intranet, with links on both divisional intranet pages.
- Level 1 mandatory training for all staff is complete and is now live in individual ESR Learning Matrixes, as of 17th April 2023. Initial management of completion of training will be tracked via the Trust risk weekly meeting and reported into Executive Management Board. As of 12.05.2023 an Introduction to Risk training has a completion rate of 37% across VCS, WBS and Corporate. Compliant with statutory and mandatory training a period of six months is set for initial completion, the on-going requirement will be to complete the training every two years.

5. IMPACT ASSESSMENT

<table>
<tr><td>RELATED TRUST STRATEGIC GOAL(S)</td><td>Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals.

Please indicate here</td></tr>
<tr><td colspan="2">Please tick all relevant goals:
. Outstanding for quality, safety and experience ☒
. An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐
. A beacon for research, development and innovation in our stated areas of priority ☐
. An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
. A sustainable organisation that plays its part in creating a better future for people across the globe ☐</td></tr>
<tr><td>RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK</td><td>06 - QUALITY & SAFETY</td></tr>
<tr><td>QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Tick all relevant domains.
Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒</td></tr>
</table>

	Patient Cantered ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required
	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.
	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item.

	Please explain if 'other' source of funding selected: Click or tap here to enter text. **Type of Funding:** Choose an item. **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text. **Type of Change** Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text.

6. RISKS

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

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

APPENDIX 1

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

RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.	7	Improvements sustained over time - BAU
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.	6	Outcomes realised in full
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.	5	Majority of actions implemented; outcomes not realised as intended
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.	4	Increased extent of impact from actions
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.	3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.	2	Symptomatic issues being addressed
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.	1	Actions for symptomatic issues, no defined outcomes
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.	0	Enthusiasm, no robust plan

ID	Risk Title - New	Risk Type	Opened	Division	Risk (in brief)	RR - Current Controls	Rating (current)	Rating (Target)	Review date	Action Plan	Number of Days Open	Risk Trend
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	Performance and Service Sustainability	09/02/2022	Velindre Cancer Centre	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas. A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place. An options appraisal is to be agreed through the Brachytherapy Operational Group (15-Mar-2023) to determine the most appropriate service model to meet forecast demand. A workforce paper will be drawn up to staff adequately staff the model and a business case will be submitted if required.	15	5	30/09/2023	workforce review in Q1/2 2023 to look at demand for next 5 years. By September 2023	461	
2612	There is a risk that the full AOS gap specification at Velindre Hospital is not being delivered as a result of resource challenges potentially resulting in periods of time in which the service is not sufficiently covered and other medic's providing a limited service.	Workforce	28/07/2022	Velindre Cancer Centre	There is a risk that the AOS service at Velindre Hospital is not sufficiently resourced. As a result this could result in periods of time in which the service is not sufficiently covered and other medic's providing a limited service. This may lead to medic's becoming overworked and stretched due to their responsibilities and a full AOS gap specification not being delivered.	Consultant on call is made aware of the AOS gap and will take responsibility for the 24 hour period that they are on call. AOS sessions have been put into consultant job plans going forward. Appointments made, which include AOS as part of job plan. Robust cross cover across the week.	15	6	30/09/2023	reset' of local and national AOS programme or work to be undertaken, via Velindre Futures by 30.09.2023	292	
2465	There is a risk to patient care and staff well being as a result of significant increase in email traffic leading to critical emails being missed or not responded to in a timely manner	Safety	05/11/2021	Velindre Cancer Centre	There is a risk of missing critical emails especially critical clinical questions due to the volume of emails. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks.	staff reminded to be considerate when 'replying to all'	16	4	30/06/2023	email etiquette to be developed as part of hybrid working tool kit and shared widely.	557	

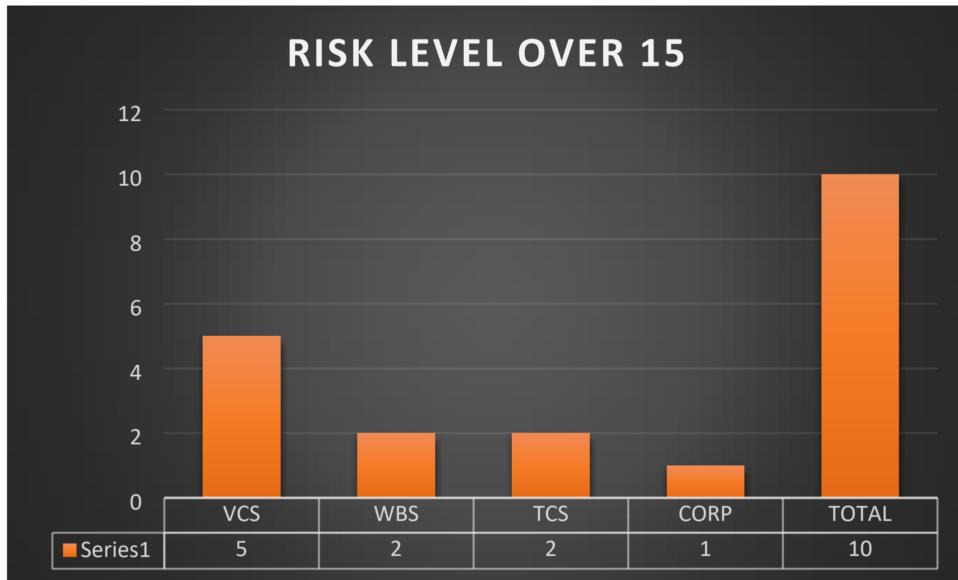
2714	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	Financial Sustainability	09/09/2022	Transforming Cancer Services	Interest Rates There is a risk that increased rates of interest before financial close lead to the costs of the project exceeding the affordability envelope.	1. Discuss with Welsh Government. CAPEX was increased during CD. Complete 2. Undertake a debt funding competition. If required this will be undertaken 3-4 months before financial close. Not started 3. Monitor interest in line with the financial index. Monitor inflation, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	16	12	24/05/2023	Continue to monitor interest in line with the financial index. Due date: 24.05.2023 Progress: Monitoring of the interest rates, maintain the contingency buffer within budget. NB this risk will be the responsibility of the participant after financial close. Ongoing	249	2714 16 16 16 16 16 DEC JAN FEB MAR CURRENT
2774	There is a risk to quality/complaints/audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Welsh Blood Service	(This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety.	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	16	4	01/09/2023	Individual Actions recorded in risk 2776: Secure Funding by 28/04/2023 Tender for replacement LIMS by 31/05/2023 Implement replacement LIMS by 31/07/2024 WHAISIT Project Group to manage. WHAISIT Business case on agenda for DPIF Scrutiny Panel on 08/03/2023 Tender documentation in progress.	201	2774 16 16 16 16 JAN FEB MAR CURRENT
2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Welsh Blood Service	(This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders requests.	Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	16	4	01/09/2023	Tender for Replacement LIMS. Procurement Brief, URS and supporting documnetation in progress. Due date 31.05.2023. Managed by the WHAISIT Project Group	201	2776 16 16 16 16 JAN FEB MAR CURRENT

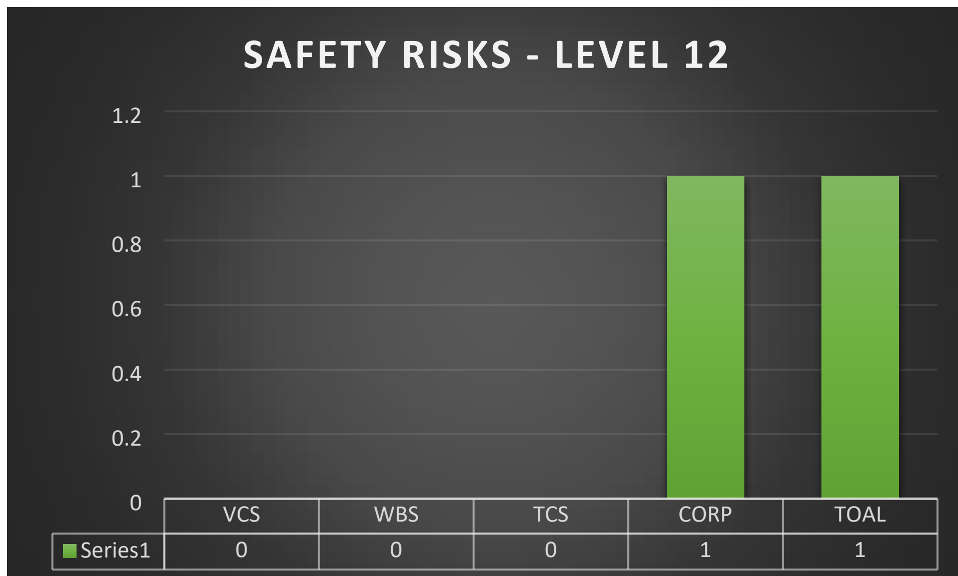
3011	There is a risk that the continuation of safe patient care may be adversely affected resulting in harm as a result of delays in scheduling patient appointments due to a technical error in the processing of Outpatient Oncology Note Outcomes.	Safety	22/12/2022	Velindre Cancer Centre	Technical failure of the data shredding process within the national service has meant that not all clinic outcome instructions are being made available within the Outpatient Oncology Note Report, and therefore not acted upon.	Immediate escalation to DHCW for investigation. 2. Identified bugs to be resolved. 3. An amendment to the shredding scheduler. 4. DHCW to extend the Contractor to apply identified development to support resolution of issue. 5. Rewrite the VCC import process to complete a full reconciliation between what is held by DHCW and what is held by VCC each refresh 6. Patient appointment and test requests to be completed in due date order to reduce risk of missed appointments. 7. Additional support to be identified and put in place to process and book all patient activity. 8. Patients to br contacted by telephone and verbally advised of appointment due within 14 dyas to reduce risk 9. Phlebotomy to be completed at VCC to reduce risk of delay to treatment (where the next appointment is scheduled to take place within 14 days)	15	5	30/06/2023	1. Immediate escalation to DHCW for investigation. 2. Identified bugs to be resolved. 3. An amendment to the shredding scheduler. 4. DHCW to extend the Contractor to apply identified development to support resolution of issue. 5. Rewrite the VCC import process to complete a full reconciliation between what is held by DHCW and what is held by VCC each refresh 6. Patient appointment and test requests to be completed in due date order to reduce risk of missed appointments. 7. Additional support to be identified and put in place to process and book all patient activity. 8. Patients to br contacted by telephone and verbally advised of appointment due within 14 dyas to reduce risk 9. Phlebotomy to be completed at VCC to reduce risk of delay to treatment (where the next appointment is scheduled to take place within 14 days)	145	3011 20 20 20 20 44927 44958 44986 CURRENT
3042	There is a risk that IF the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025 THEN operational delivery of pathology services may be severely impacted RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact. **NATIONAL LINC RISK**	Performance and Service Sustainability	07/02/2023	Velindre Cancer Centre	The current (InterSystems) contract for TrakCare Lab is due to end in June 2025. The LINC programme has been established to deliver a replacement all-Wales LIMS system - the contract has been awarded to Citadel Health. VCC pathology services are provided to Velindre by C&V ULHB. If the Citadel Health solution is not deployed into C&V UHB before June 2025, there is a risk to service delivery for the C&V-managed pathology laboratory. The national DHCW / LINC programme team have requested this risk be recorded on all HB/Trust risk registers, to ensure appropriate visibility and ongoing monitoring.	Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	20	5	07/08/2023	Actions to ensure appropriate delivery of LINC into VCC or mitigations if LINC delayed - due date 30.06.2025 Active ongoing engagement in national programme. Confirmation of internal governance and escalation process across the Trust.	98	3042 20 20 20 44958 44986 CURRENT

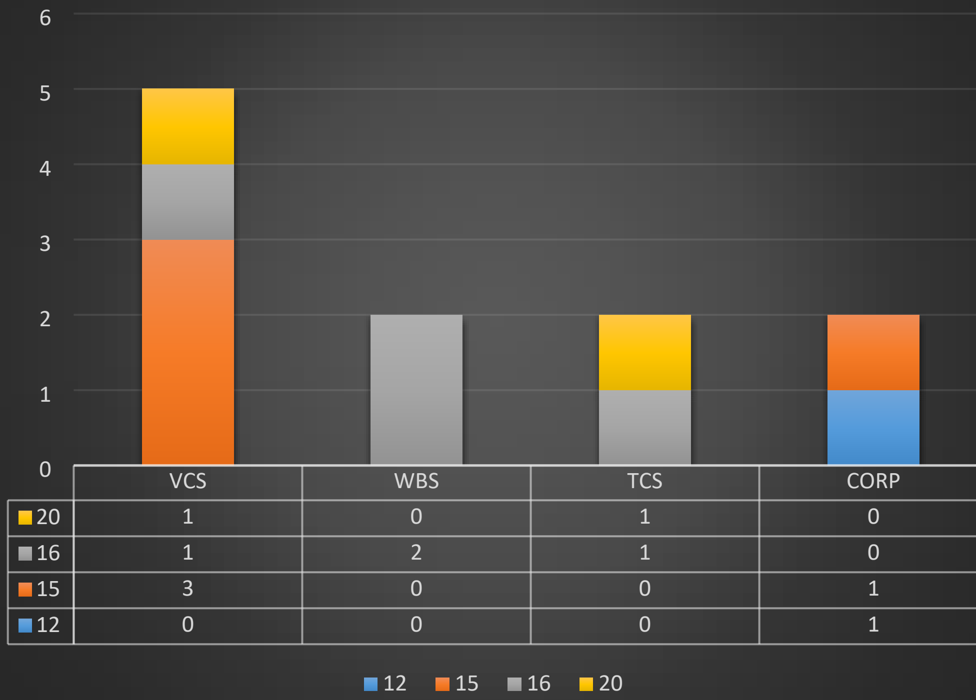
3065	There is a risk to COMPLIANCE as a result of the permanent deletion of email mailboxes for VUNHST staff who have fully left the NHS since September 2021, leading to a potential issue should those emails be required by a 3rd party investigation - e.g. COVID enquiry.	Compliance	10/03/2023	Corporate Services	NHS Wales deployed O365 in July 2019. The national tenancy was established with the intention of ensuring emails / mailboxes for staff who left the NHS (i.e. there O365 account was closed) would be retained for a 7ear year retention period, as per the national NHS Wales Email Policy. Investigations prompted by an enquiry by C&V UHB in February 2023 confirmed that this policy was not what was configured on the NHS Wales tenancy. As such, any emails / mailboxes for staff who have left the NHS will have been deleted after 30 days of account closure, unless another form of manual 'hold' was in place on the account. In VUNHST, 'litigation hold' was in place by default on all accounts up to 22/09/2021, when a national change was made to remove litigation hold for VUNHST O365 accounts. As such, the risk for VUNHST is that staff who have left NHS Wales in the period 23/09/2021 - 17/02/2023 will be that emails for those staff will not be retrievable for (e.g.) FoI, evidence for COVID-19 enquiry etc.	Upon identification of the incident, DHCW have put in place temporary measures - effective from 17/02/2023 - to prevent further deletion of mailboxes for staff leaving the NHS Wales. DHCW are also engaging with Microsoft to explore what, if any, opportunity there is to retrieve the deleted emails/mailboxes.	15	3	01/08/2023	List of impacted mailboxes has been produced by Digital Services - to be reviewed by Head of IG & Head of Digital Delivery to assess overall impact of deletion.	67	3065 15 CURRENT
3087	TCAR 2 - EW and MIM Contractor Usage There is a risk that if the EW and MIM contractors are required to make use of TCAR 2 simultaneously that the volume of traffic may exceed what is allowed by the planning approval, leading to a delay to one or both sets of works.	Quality	24/04/2023	Transforming Cancer Services	TCAR 2 - EW and MIM Contractor Usage There is a risk that if the EW and MIM contractors are required to make use of TCAR 2 simultaneously that the volume of traffic may exceed what is allowed by the planning approval, leading to a delay to one or both sets of works.	1) Volumes of traffic during contractor crossover period are likely to be accommodated by the volume of traffic allowed by planning. 2) Trust to facilitate dialogue between both contractors to manage construction plans to allow simultaneous access if required. 3) There is an opportunity to achieve earlier access via the Asda access road and the Northern access bridge, but this would require and acceleration on both contracts.	20	4	22/05/2023	Trust to facilitate dialogue between both contractors to manage construction plans to allow simultaneous access if required. Due date: 22.05.2023 Progress: It has become apparent as Acorn have redeveloped their construction programme that they require exclusive access. As the enabling works has been delayed it may be that Walters need to amend their work plans so that they can work without access to the TCAR, or a compensation event may be required Ongoing	22	NEW RISK - NOT ENOUGH DATA FOR TREND

ID	Risk Title - New	Risk Type	Opened	Division	Risk (in brief)	RR - Current Controls	Rating (current)	Rating (Target)	Risk Appertite Level	Review date	Amount of Days Open	ACTION PLAN	Risk Trend
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	Safety	09/12/2022	Corporate Services	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. HSE defines stress as 'the adverse reaction people have to excessive pressure or other types of demand places on them'. Staff employed by the Trust have a wide variety of roles including clinical and non-clinical, administrative support and patient/donor facing. Work in carried out at VUNHST premises, donation venues, in outreach centres. Some staff work in an agile way, working both at VUNHST premises and other locations including at home. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work. Not all of this will be work related. The risk relates to all Trust employees HSE identifies six main areas that may lead to work-related stress if not properly managed: demands, control, support, relationships, role and change. Demand – workload, ability to do work required, conflicting priorities, work patterns, physical environment and violence and aggression. Control – pace of work and ability to take breaks. Development and use of professional skills. Support – lack of support for staff from managers and colleagues. Staff not know what support is available and how to access it. Relationship – negative behaviours, interpersonal and/or inter-team conflict, perceived unfairness. Bullying. Poor communication. Resolution procedures not accessed in a timely way. Role – lack of clarity and communication around roles and responsibilities. Change – lack of communication or poorly understood communication about proposed changes. Lack of support for staff during periods of change. Home/family/personal issues which may add to stress at work	Policies and Procedures Managing Attendance @ Work Policy, Training and Toolkit Respect and Resolution Policy, Training and Toolkit Equality, Diversity and Inclusion Policy Managing Organisational Change Policy and Toolkit Hybrid working Flexible working Job descriptions/PADR process Training Development of 'Building our futures together programme' – Leadership Development, Behaviours, Compassionate Leadership Training and education managers on compassionate leadership (Inspire Programme) Access to internal and external training/career development Online resources Wellbeing and Engagement online resources Work in Confidence Platform External awards Corporate Health Standard Platinum Award Time to Change Wales signatory Monitoring of staff wellbeing Annual Staff Engagement Survey Monitoring of sickness absence figures by Board External wellbeing audits Organisational support Staff networks Occupational Health Employee Assistance Programme Mental Health First Aider network Access to Complementary therapy Mindfulness App Individual Stress risk assessments completed by manager Purchase of annual leave Financial advice, Salary sacrifice schemes. Blue light discounts. Car lease scheme. Cycle to work scheme Wellbeing activities/events Wellbeing rooms/facilities Healthy and Engaged Steering Group Clinical Psychologist for staff and teams – including proactive programme of engagement. Dialogue with Trade Unions	12	9	1	31/05/2023	158	Healthy and Engaged steering Group to communicate with Divisions and Departments about stress risk assessments by 30 June 2023.	3001 12 12 12 12 JAN FEB MAR CURRENT

Risk Level Data






ALL RISKS BY LEVEL AND DIVISION
6
5
4
3
2
1
0
VCS
WBS
TCS
CORP
20
16
15
12
1
0
1
0
1
2
1
0
3
0
0
1
0
0
0
1
12
15
16
20

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

Velindre Cancer Service Brachytherapy Peer Review

DATE OF MEETING	25th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Rachel Hennessy, Head of Operational Services & Delivery, Velindre Cancer Service Cath O'Brien, Chief Operating Officer Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists
PRESENTED BY	Cath O'Brien, Chief Operating Officer Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
BRACHYTHERAPY PROJECT BOARD	2022/2023	Overseeing implementation of improvement Plan
VCS SENIOR LEADERSHIP TEAM	March / April 2023	Endorsed Improvement Plan
QUALITY, SAFETY & PERFORMANCE COMMITTEE	16/05/2023	Improvement plan noted

1. SITUATION

The purpose of this paper is to provide Trust Board with the Velindre Cancer Service Brachytherapy Peer Review report and Improvement Plan. During May and June 2022 a peer review of the Brachytherapy Service provided at Velindre Cancer Service was undertaken by the Clatterbridge Cancer Centre and a set of recommendations was received in July 2022. The recommendations were categorized and an action plan to support their implementation has been developed.

2. BACKGROUND

Brachytherapy is a complex Radiotherapy Technique, recommended by the Royal College of Radiology (RCR), involving the insertion or radioactive sources into or near to a tumour. The advantage of Brachytherapy over External Beam Radiotherapy is that in using low energy sources enables a high dose to be delivered to the target area with very low doses delivered to healthy tissue. This improves the outcome of the course of treatment compared to alternative techniques. However, it is only suitable for a relatively small number of patients.

Velindre Cancer Centre is the only centre in Wales with the expertise and infrastructure to deliver Brachytherapy and currently provides a service for gynecological and urological indications.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION.

3.1 Velindre Cancer Service Brachytherapy Project Board

The Brachytherapy Project Board was established in 2021 to undertake a multi-professional review of the Velindre Cancer Service Brachytherapy Service following three serious incidents related to the service. The Project Board consists of senior multi-professional clinicians that work within and are responsible for the service, a critical friend (Senior Therapy Radiographer from Bristol) and is chaired by the Trust Executive Director of Nursing, Allied Health Professionals and Healthcare scientists.

The Project Board (supported by the Trust Executive Team and Velindre Cancer Service Senior Leadership Team) proactively commissioned a peer review of the Trusts Brachytherapy Service in 2022 to place a reflective light on the service and to ensure that all opportunities to improve were identified.

The peer review was commissioned from the Clatterbridge Cancer Centre in 2021 and took place between May and June 2022. The initial report was received on 25th July 2022 and following accuracy checks a final version was received by the Velindre Cancer Centre on 2nd September 2022. Although the Clatterbridge is similar in many respects to Velindre Cancer Service Brachytherapy Service there are also some differences. The report is attached in ***Appendix 1***.

The Peer review consisted of documentation reviews, professional and clinical discussions and reciprocal site visits. It was a positive experience for both organisations and long-term peer relationships have been formed.

3.2 Brachytherapy Peer Review and Improvement Plan

The peer review report made 134 recommendations for the Brachytherapy Service to consider as service improvements. On review of the Clatterbridge report, there were a number of themes identified as follows: Workforce; Safety and Quality Management (Policy / Procedures; Training / Resilience & Professional Development; Capacity & Efficiency; Communication; the estate and the new Velindre Cancer Centre.

The report acknowledged multiple areas of good practice, and the Clatterbridge team also reported implementation of some of the good practices and procedures observed in Velindre Cancer Centre. The peer review did not suggest any fundamental changes to the treatment techniques provided by the Cancer Centre as it was recognised that these are already in line with national recommendations

In response to the Peer Review, the Brachytherapy service developed an Improvement Plan (attached in ***Appendix 2***) to support implementation of the recommendations. Delivery of the Improvement Plan is currently overseen by the Brachytherapy Project Board.

Of the 134 recommendations, 77 have been closed. Seven recommendations were categorised as strongly needing to be implemented and five of these have been closed. Of the two outstanding: one is on track for closure by end of May 2023; and the other (relating to the development of a clinical skills training package for ultrasound brachytherapy) is under discussion with Health Education Improvement Wales (HEIW) as currently, there is no such training programme in Wales. There is a two-year timeframe allocated to this work. A conversation has also taken place with the Clatterbridge to explore if they are able to provide this training but they do not have the available resources.

3.4 Next steps

The next significant step is to finalise the multi-professional Brachytherapy workforce transformation plan to ensure there is a resilient multi-professional brachytherapy team in place to deliver this national service robustly moving forward.

The Improvement Plan implementation is being overseen through the Brachytherapy Project Board (VCS Senior Leadership Team when this is disbanded). All uncompleted improvement actions will be transferred onto the Trust Quality, Safety & Assurance tracker and will be monitored by exception at the Quality, Safety & Performance Committee.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	There is significant positive Quality & Safety impact if all aspects of the Improvement plan are implemented
RELATED HEALTHCARE QUALITY STANDARD	All Health & Care Quality Standards (2023) apply in respect of the delivery of Brachytherapy Services.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	Not required in respect of this peer review process
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The trust has a responsibility to ensure that the Ionising Radiation (Medical Exposure) Regulations (2017) are met in respect of delivery of Brachytherapy Services.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There are funding implications in respect to the workforce transformation that is required within the Brachytherapy Service.

5. RECOMMENDATION

The Trust Board is asked to:

- **NOTE** the Brachytherapy Peer Review report and Improvement Plan
- **NOTE** that the Quality, Safety & Performance Committee through its re-developed Quality, Safety and Assurance Tracker monitor all outstanding improvement actions through to completion.

Report of the Clatterbridge Cancer Centre Peer Review of the Velindre Cancer Centre Brachytherapy Service

July 2022

The Clatterbridge Cancer Centre
NHS Foundation Trust

Clatterbridge Cancer Centre Brachytherapy Team

Sarah Stead	Brachytherapy Clinical Specialist
Kate Rossiter	Brachytherapy Theatre Manager
Louise Bagley	Radiotherapy Treatment Expert Practitioner
Rhydian Caines	Principal Clinical Scientist
Louise Gately	Higher Principal Clinical Scientist
Chris Lee	Lead Consultant Clinical Scientist – Specialist Services

Contents

Clatterbridge Cancer Centre Brachytherapy Team 2
Summary 5
1 Introduction 6
1.1 Overview 7
2 Areas of Good Practice 8
2.1 Nursing & Theatre 8
2.2 Radiotherapy 8
2.3 Physics & Treatment Planning 9
3 Observations and recommendations across the service 9
3.1 Engagement with Improvement 9
3.2 HASS Regulations and Afterloader Source Security 10
3.3 Radiation Safety and Contingency Rehearsal 11
3.4 Document Control and Quality Management System 12
3.5 Reporting of Incidents & Risk Management 13
3.6 Line Management / Reporting Structure 14
3.7 Efficiency & Workflow 14
3.8 New Build Considerations 16
3.9 Workforce 17
4 Nursing & Theatre 20
4.1 Patient Pathway Management 20
4.2 Medicines Management 22
4.3 Training and Professional Development 23
4.4 Miscellaneous 24
5 Radiotherapy 26
5.1 Patient Pathway Management 26
5.2 Demand and Capacity Modelling 27
5.3 Communication and Collaboration 27
5.4 Training and Professional Development 28
5.4.1 Ultrasound 29
5.4.2 Imaging Non-Medical Referrer (NMR) 29
6 Physics & Treatment Planning 30
6.1 RAKR 30
6.2 Use of Off-Label (non-CE-marked) Devices and Software 30
6.3 Digital Security & Best Practice 31
6.4 Treatment Planning (Prostate) 32

6.5 Treatment Planning (Cervix) 35
7 Summary of Recommendations 37
8 List of Abbreviations 39
9 References 41

Summary

Velindre Cancer Centre (VCC) approached Clatterbridge Cancer Centre (CCC) in late 2021 to request a Peer Review of the Brachytherapy Service as part of a larger internal review of the service. The request provided a clear scope covering quality, safety and patient experience, workforce, finance, and performance, and included review by a multi-disciplinary team consisting of theatre, radiotherapy, and physics staff.

Following remote team introductions, documentation was shared and peer-to-peer conversations conducted. Visits to VCC were then facilitated to observe a urology and gynae theatre list. During the visits the teams followed the patient journey, shadowed peers, and further reviewed and observed processes.

Immediate initial feedback was given by CCC to the VCC team at the end of each observational session.

Observations and recommendations have since been developed and collated within this report. The report first sets out what we feel were common issues and themes across the whole service, then subsequently focuses in more detail on aspects of the service within specific professional disciplines. There are 134 recommendations in total. It is stressed at the outset that many of the issues identified within this review are already known to the VCC teams, such that these recommendations confirm in many areas views already held locally.

We also offer these recommendations as a representation of our own professional views, which VCC is of course at liberty to disregard where they feel an alternate position is warranted. Although we have sought to support recommendations with reference to relevant legislation and national guidance where possible, this report and peer review does not hold any intrinsic legal or regulatory weight. Our recommendations are however wide-ranging and if they are to be implemented will require serious investment in resource and time to deliver improvement with 'buy-in' at the senior management level.

A return visit for VCC to attend CCC is being arranged, expected to take place September 2022 which we hope will facilitate a further productive exchange. VCC delivers the only brachytherapy service in Wales currently and as a 'near neighbour' CCC welcomes ongoing discussion and collaboration as themes identified in this report may develop in the coming years. Moreover, the CCC team have taken away ideas for improvement for our own service and advocate ongoing collaboration between both services as being beneficial for all.

We thank the VCC teams for warmly welcoming us into their working environment and for their time in facilitating this review. We trust and hope that the recommendations made and offered in this report are accepted in the collegial and collaborative spirit with which they are intended.

1 Introduction

In October 2021, The Clatterbridge Cancer Centre (CCC) was approached by Velindre Cancer Centre, Cardiff, (VCC) seeking a peer review of the Brachytherapy Service provided by Velindre for gynae (Gynaecology) and Urology patients. This was requested against the current service provision with the stated aim of ensuring that safety and best practice is being met and to ensure robust future planning ahead of the move of the service to the new VCC building. This peer review feeds into the broader remit of the Brachytherapy Project Board of overseeing the review of the Brachytherapy Service and implementation of any changes required, including the development of a revised service specification.

The scope of the review was defined by VCC to explore and provide learning outcomes and recommendations within the following areas:

Quality, Safety and Patient Experience

- Governance (legislation / clinical service framework)
- Management oversight and service ownership of brachytherapy
- Identify service risks, areas of good practice and opportunities to improve
- Data management (all stakeholders)
- Standard operating procedures
- Legislative / regulatory compliance
- Patient pathway management

Workforce

- Service ownership
- Workforce plans / prudent clinical modes of care
- Roles and responsibilities
- Training and professional development
- Commissioning contract information related to resource model and resilience
- Professional regulatory control

Finance

- Funding model and requirements (including commissioning
- Commissioning contract information related to funding model

Performance

- Determine core performance measures of service provision
- Monitoring of standards – to include patient outcome, experience, efficacy, and safety
- Demand and capacity modelling
- Review of commissioning contract information

1.1 Overview

VCC provides a high dose rate (HDR) brachytherapy service for gynae and prostate patients from across Wales (excluding North Wales). VCC is currently the only NHS Trust within Wales providing such a service.

They have one prostate theatre session per week (Monday) and can treat one patient per session, with overall capacity to treat approximately fifty fractions per year, bank holidays Mondays can also cause pressures. They are not yet exceeding this as activity is currently at 20-25 fractions per year. However, this is expected to rise and VCC would like to expand their service to provide two sessions per week.

For gynae, they have one theatre session per week (Thursday) and can treat three patients per session, with overall capacity for 50 patients per year, 150 fractions, each patient receiving three fractions of brachytherapy. Annual activity is currently at approximately 120 fractions per year with short-term activity fluctuating depending on referrals. RCR guidance recommend patients should be treated with combined external beam radiotherapy (EBRT) and HDR within 56 days and capacity is a critical ingredient to delivering care that complies with this recommendation. At VCC it is common to transfer patients to a Monday list to cope with short-term fluctuations in activity and waiting time targets. (For reference, CCC treats a similar number of gynae patients per year, split across two theatre sessions per week).

VCC is an Elekta centre with an equipment suite of applicators and treatment planning performed in Oncentra Brachy V4.5.2 and Oncentra Prostate V4.2.2.4, with a BK3000 Ultrasound scanner and E14 biplanar rectal probe. All treatments are delivered with the Flexitron Iridium-192 HDR remote afterloader with control console running on Windows 7 (upgrading Windows 10 July 2022). Applicators are on a recommended three-year replacement programme. In these aspects the infrastructure is very comparable to CCC.

In agreement with VCC, the peer review was undertaken Spring/Summer 2022 through three main components:

- Review of current quality system documentation and clinical protocols provided by VCC to CCC.
- 1st site visit May 2022 by a multi-disciplinary team comprising nursing, radiography, physics, and managerial staff coinciding with a prostate theatre list with a focus on Urology.
- 2nd site visit June 2022 by a multi-disciplinary team comprising nursing, radiography, physics, and managerial staff coinciding with a cervix cancer theatre list with a focus on Gynaecology.

In addition, multiple peer-to-peer discussions within specific disciplines took place around these dates (e.g., over Microsoft Teams) to facilitate further information gathering and to further identify specific areas of focus. At the conclusion of each of the site visits immediate verbal feedback was given which has already been minuted by the VCC team. In addition, a return site visit for VCC staff to CCC has been offered and is currently being arranged, expected September 2022.

Brachytherapy is in many ways a 'niche' treatment discipline and there is considerable latitude in both a technical and operational sense in seeking to conform to best practice. With that in mind, the suggestions and recommendations made in this report may have multiple solutions or options to explore. There is a wealth of knowledge across the brachytherapy community and other centres may

also be able to support VCC if they would like to reach out more widely than CCC on specific issues and want to explore different ideas.

This report summarises the findings of the peer review as identified in the above components and provides recommendations within the defined scope. There are 134 recommendations made within this report and a summary of the recommendations can be found at the end of this report. Finance and Performance have been covered in less detail reflecting the professional makeup of the staff that have been made available for this review. As such, we have made recommendations based on our own experience and as much as possible with reference to national guidance, legislation and relevant literature where appropriate. It is acknowledged that there is some reference made to guidance for English Trusts and that Welsh Trusts may be governed differently. These references are therefore included to provide context and background to our own professional positions. It is also stressed that many of the issues identified within this review are already known to the VCC teams, such that these recommendations might be expected to confirm in many areas views already held locally.

We also stress at the outset that the staff and clinical teams we met during our initiation and visits are clearly very knowledgeable and compassionate, put the patients first and ultimately deliver safe and effective care. There were detailed and appropriate explanations for patients prior to receiving treatment or care. The processes for treatment and operational challenges are familiar and broadly similar to those at CCC.

2 Areas of Good Practice

There were many areas of good practice identified across the service.

2.1 Nursing & Theatre

- There is a robust process for preparing the patient in terms of pre-operative assessment (POA), bloods etc. This role is carried out by the best-placed staff group who are experienced and qualified within this field.
- Theatre staff are highly skilled, knowledgeable, and work well together.
- There are clearly documented patient pathways that define the patient journey for the different procedures.
- During an intra-operative complication, the team worked together well and discussed options for most appropriate management for the patient.
- Difficulties and challenges with out-of-area patients are resolved so the patients can begin their procedures safely.
- There are good decontamination and sterility processes.
- Good practice is observed in HDR prostate set up, with some take away thoughts for CCC

2.2 Radiotherapy

- Quality assurance (QA) methods carried out by radiographers were well executed each morning prior to the safety brief.
- There is a robust verbal pause and check before switching on.
- Communication between the radiographers works very well.
- Patients are treated with compassion and empathy by the radiographers.
- Radiographers are proud to be part of a specialised service and have good morale and dedication to the service.
- Radiographers are motivated for change and are keen to improve the service.

- Training records for radiographers were available, comprehensive, and up to date. They comprise of two parts, paper-based log sheets and an overarching spreadsheet.
- Commitment to advanced practice by the department.
- Visualisation of gynae applicators on ultrasound was improved by using Hibitane gynae cream, (which serendipitously improves contrast to make instruments brighter) – another takeaway for CCC that we will seek to implement.

2.3 Physics & Treatment Planning

- There is a thorough daily QA programme on the Oncentra Prostate software prior to each patient treatment. This includes verifying that Oncentra Prostate has correctly identified the probe and a manual check of the calibration settings.
- Minimal staff in theatre during Prostate planning contributed to a calm quiet environment as all doors are closed.
- A database is maintained for recording Prostate patient clinical details and plan parameters which looked like a useful resource which could be updated during an MDT meeting.
- Longitudinal scanning for prostate is performed rather than the transverse scanning used at CCC; this seemed a very efficient way to utilise the software and is something we will be investigating.
- Planning staff for gynae HDR were clearly very experienced and competent using the planning tools and software, with high levels of communication and collaboration with the treating clinicians throughout.
- There is a formal gynae outlining peer review process in place in which the two oncologists review each other's outlines and generally work closely together in this regard.
- Source change QA process are comprehensive and thorough.

3 Observations and recommendations across the service

3.1 Engagement with Improvement

VCC have already identified many of the issues identified within this report and raised them on their risk register, which is reassuring. The difficulty and challenge for the team is that improvements are wide-ranging and far-reaching and will require time and resource investment to deliver whilst maintaining a busy, dynamic clinical service.

Furthermore, staff reported across the service that they have ideas and goals for service improvement but currently feel under-resourced to achieve these. They report that they do not have time to update protocols, create and perform training and that their service is in this regard vulnerable. This was evident from our visits and triangulates many of the issues observed by the CCC team. Staff suggest that this is overwhelming, and a clear plan should be put in place including time and resources with support from senior management to make the improvements to the service that are required and recommended.

A culture of continuous and inclusive improvement is linked to improved patient safety, and this should be promoted and embedded throughout the service. Staff should be encouraged to challenge processes and behaviour that could compromise patient safety and the department must be a supportive, open, and transparent environment to support this.

1. **Recommendation: The Brachytherapy Project Board should identify and invest in service improvement.**

2. **Recommendation: Ensure that improvement is led from within the team to encourage ownership of the service by those working within it.**
3. **Recommendation: Consider 'thought boards' in the department, staff surveys, team meetings and team away time to identify areas of improvement and to allow the staff to focus on solutions.**
4. **Recommendation: Consider training and education in service improvement for team members. There are free courses such as NHSEI Improvement Fundamentals, which provide simple tools and insight.**

3.2 HASS Regulations and Afterloader Source Security

The Ir-192 radioactive source used for all brachytherapy treatments at VCC is considered a High-Activity Sealed Radioactive Source (HASS) by the Office for Nuclear Regulation and as such is regulated under the HASS 2005 regulations[1].

The associated security requirements to these regulations issued by the National Counter Terrorism Security Office (NaCTSO) describes medical high dose rate brachytherapy sources as Category 2 / Security Level B, which must therefore be protected from unauthorized personnel with access control and a system of two barriers to provide delay and facilitate security response. There are several further specific recommendations on procedures and equipment given in the ICRP 2005 report (Publication 97)[2].

The Flexitron at VCC is kept within a locked cupboard in the treatment room, which is alarmed overnight. During our visits, it was not locked away between patients. The treatment room door was closed when the room was not in use, although possibly left unlocked. There is no swipe-controlled access to the HDR bunker, or into the control area, and the control area could be accessed through double doors from the corridor. (For reference, at CCC the Flexitron after loader is chained to the wall overnight and both it and the associated control area is sited behind two restricted access swipe points (or one swipe, one key at previous hospital) including intrusion alarm, dedicated CCTV and 24/7 security response and on-call physics phone cover.)

Particular attention should be made to the fact that more than one member of the CCC team was able to take a direct route from the public main entrance and canteen areas to the HDR suite during the working day without stoppage or needing to swipe through doors. We feel there is therefore a risk and possibility of unauthorized access and even unauthorised source removal (as the HDR is a mobile unit). It was not clear to the CCC team whether there are any other measures in place such as CCTV of the immediate area or the corridor leading to the suite.

Lastly, standard operating procedure (SOP) documentation from the Trust quality system was kindly shared with CCC, and it was later noted this included in plain text passwords and Flexitron authorisation alarm codes.

5. **Recommendation: Review current HDR security against the requirements set out by NaCTSO for Category 2 radioactive sources. If, following this review, further security measures are deemed necessary, a risk assessment should be put in place until such time that these can be implemented.**
6. **Recommendation: With regard to the new building planned for 2024/25, VCC should consider whether the current plans for HDR source security adequately align to NaCTSO requirements – this is a key opportunity and time period to specify a facilities infrastructure aligning to best practice.**

7. **Strong Recommendation: Alarm codes and software passwords should be removed immediately from documentation within the quality system and only known to and shared with authorised users.**

3.3 Radiation Safety and Contingency Rehearsal

It was not clear from speaking with staff whether there was specific training for any staff other than the radiographers (e.g. such as nurses) with regards to HDR contingency arrangements (for example the actions required in the event of a source becoming stuck within a patient). Furthermore, there is a single point of failure in the team with only one radiographer fully trained to perform the contingencies that are documented in the Brachytherapy Local Rules. We feel all team members involved in the direct care of HDR patients should be educated in the need for an emergency plan and that practicing and rehearsal of emergency procedures should be introduced and emphasised. IRR17 (Regulation 13) and approved Code of Practice[3] stipulates that, where appropriate, contingency plans are rehearsed at suitable intervals. The radiographers at VCC were not aware of specific radiation procedures in the event of a fire in the HDR suite. There is only one personal dosimeter available for staff to use in contingency, which is worn by a radiographer.

Contingency arrangements also require a full review of the processes and logistics involved with quickly moving the patient out of the treatment room and the role of the anaesthetist during the emergency. Roles and responsibilities are not clear in the documentation, and it is further not clear whether the management of an unconscious patient in this situation has been discussed or agreed with anaesthetic colleagues or if it has it ever been rehearsed as part of emergency planning.

Within the documented contingency procedures, removal of applicators is carried out by radiographers. However, the radiographers are not directly involved in the insertion during theatre so may not be aware of intra-operative processes or potential complications.

Finally, there a different removal process defined in the contingency procedure to the actual process utilised routinely regarding both prostate needle removal and gynae applicator removal. Prostate needles are removed one at a time under normal conditions, which does not match with the contingency emergency procedure (whole grid removal). Similarly, gynae applicators are removed in pieces rather than altogether, yet in contingency it is stated to be removed in one piece. Therefore from a human factors perspective, we feel contingency processes should be similar to routine procedures where possible and appropriate. An incident occurred at CCC whereby a patient suffered from a tear by the insertion of an individual ovoid of the Venezia applicator, whilst in one piece this is less likely to cause trauma. We did not see any patients with needles inserted therefore cannot comment on removal but would again recommend these are also not removed individually but are taken out as a single assembly connected to the ovoids and IU tube.

8. **Strong Recommendation: Complete a full review of HDR radiation safety instructions and emergency procedures (contingencies) and documentation, led by the RPA and RPS and contributed to by wider MDT. HDR contingency and 'business as usual' applicator removal should be aligned where possible and appropriate to do so.**

9. **Recommendation: All staff groups involved in the care of HDR patients should be trained against documented emergency procedures and be clear on their roles and responsibilities.**

10. **Recommendation: All staff should be given time to periodically rehearse contingencies, including the removable of applicators as described in the SOP, and this practice regularly audited.**

11. **Recommendation: Review the staff roles and responsibilities. If radiographers are to be expected to remove and applicator in an emergency then they should be involved in the insertion.**

12. **Recommendation: Purchase additional electronic personal dosimeters that can be worn during contingency procedure including spares in the event of malfunction.**

3.4 Document Control and Quality Management System

We observed numerous policies and procedures as being out of date, some significantly so, and some had been been waiting for extended periods of time to be approved. Some policies such as major haemorrhage and gynae brachy PV bleed were not available at all. The Trust's venous thromboembolism (VTE) policy does not reflect current practice, suggesting dalterparin **must not** be used for any brachytherapy patients and antiembolism stockings **are** to be used. However, in practice dalteparin is now given to all patients at VCC as well as pneumatic intermittent devices being used. The staff did not know if the patients had a VTE assessment and there was no evidence of one in the documentation we were shown. The Theatre LocSSIPs do not meet national standards regarding incident reporting and staff debrief. In the case of the HDR contingency policy, staff cannot progress training as they are waiting for the policies to be approved, as again the draft policies require further review.

The local policy 'Implementation of the Ionising Radiation (Medical Exposures) Regulations (IR(ME)R) 2017' is very comprehensive and refers to a suite of IRMER policies. The clinical protocol for Prostate HDR (QPWI 56a) is authored by physics and authorised by Radiotherapy Management. There does not appear to be obvious clinician (practitioner) authorisation in the document. In the gynae HDR document (QPWI 72), there is a recognised signature for clinical site-specific teams 'SST lead', which appears to be a clinician.

Protocols and work instructions are stored both in an electronic quality management system software (Q-Pulse), in paper folders stored at the planning and treatment workstations, and in the case of shared EBRT protocols also on a third 'H drive' system. Staff were able to demonstrate the various locations of the documentation but reported frustration with difficulty keeping documents synchronised across these domains and in the case of the shared protocols not being notified of changes until after later revisions have been made live.

13. **Recommendation: A full review should be carried out of the policies and procedures available within the quality system and gap analysis performed across the service to identify missing areas of documentation.**

14. **Recommendation: Outstanding draft policies and procedures should be approved in a timely manner, and staff engaged with updates and process changes as part of business as usual.**

15. **Recommendation: Investment should be made and a robust system implemented to anticipate quality system updates rather than to be reactive to overdue deadlines.**

16. **Recommendation: Consider a single electronic source for storage of policies and procedures, such as Q-Pulse, which can automate review reminders, track change requests and capture distribution and acknowledgement of new or updated protocols and work instructions.**

17. **Recommendation: Consider consistent evidencing of clinician (practitioner) authorisation for clinical protocols.**

There was no evidence of audit within the documentation provided or observation at our visits. Suggestions from the CCC schedule include cancer waiting times, PADR and mandatory training compliance, out of date documentation and SOPs (Standard Operating Procedures), WHO observational and documentation, medicines safety and medical devices, planning and treatment observation and documentation, ID, and pregnancy status checks, pause and check and silent cockpit audits.

18. **Recommendation: Key performance indicators for the service should be agreed upon, frequency and schedule created, audits performed and results reported via the governance structure.**

3.5 Reporting of Incidents & Risk Management

Documentation containing Datix reports was shared along with the Risk Register for Brachytherapy. It is reassuring for both teams that there are similarities regarding near misses and minor incident reports in our respective departments, including issues such as documentation, imaging, patient delays, blood work, and minor communication issues. There appear to be significantly fewer Datix incident reports within VCC Brachytherapy compared to CCC (which is a similar size by patient throughput). For example, 16 Datix reports were provided covering an approximately three-year period. In a similar period, CCC would expect to see around 60 such reports, the majority of which would be considered no or low harm.

The Risk Register and Issues log is comprehensive and acknowledges single points of failure in the services, and the risk scores are reflective of the severity of the issue to the clinical service.

Documentation regarding previous Serious Untoward Incidents (SUI) was shared and reviewed by the CCC team. Reviews where comprehensive and had through action plans in place.

During our second visit, an incident involving an unexpected vaginal bleed in theatre during the applicator insertion was observed. This was professionally managed in the theatre, and the patient was subsequently transferred to another hospital for ongoing acute care. Staff were asked by the CCC team about this on several occasions during the day and whilst they acknowledged they had not encountered such an incident before, there appeared to be reluctance to report it as an incident, even as a near miss. Moreover, there was no opportunity for the staff to come together and 'debrief.' We feel staff should be encouraged to view incident reporting positively and as a tool to foster a sense of openness, mutual respect and responsibility. They should be further assured that reporting and raising concerns will not be punished but used to develop a strong safety culture, share when team have done things well (as in this case) and enable change as well as monitoring any trends. Ultimately, effective communication between the clinical personnel is key to minimising risk of truly adverse events.

19. **Recommendation: Staff should be encouraged to systematically capture all information on incidents, on errors and near misses to improve the quality and safety in all areas of the department.**

20. **Recommendation: Questioning and discussion of clinical colleagues irrespective of position and professional hierarchy within the department should be actively encouraged.**

21. **Recommendation: Regular debriefs after each theatre session is advocated as per National Patient Safety Agency (NPSA) whether there is an incident or not.**

22. **Recommendation: Staff are introduced to the Just Culture**[4]

https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

3.6 Line Management / Reporting Structure

The governance structure process map from senior leadership team to brachytherapy management group was shared. Within this document, there is a footnote indicating Nursing and Oncologists do not sit within Radiation Services. The structure below the management group was not shared in the documentation. This was discussed via peers at the visits and the reporting structure for Theatre management is unclear. The Theatre Manager reports that they sit under the Radiotherapy Manager but suggests they do not regularly meet, and appraisals are carried out with the nursing Matron. This contradicts the documentation shared.

Although the documented structure is clearer in radiotherapy, the operational management and leadership of the radiographers is not as evident. Radiographers are line-managed by those who have limited or no knowledge of brachytherapy and this may be contributing to operational challenges and creating barriers to finding solutions.

Clinical radiographers are present on the Brachytherapy Project Board for addressing improvement, but at superintendent level it is reported there is less participation. It was observed that there is limited contact between the treatment floor superintendents and the brachytherapy service other than the superintendent of the day walk around to check staffing levels. CCC staff were not able to speak to superintendents during the visit to triangulate this information. (For reference, the CCC theatre team and radiographers are line-managed by the brachytherapy lead at superintendent level.) The radiographers also report they have been unable to attend departmental meetings, and state they do not have time due to lack of staff and workload pressures. This is creating a feeling of isolation from the main department.

The line management structure within physics was the clearest, and the recent appointment of the Brachytherapy Service Lead is positive. It is acknowledged that organisational structures can, and probably should, differ between Trusts and can work well. However, the key to the delivery of the Brachytherapy Project will be underpinned by a structure that is collaborative and fit for purpose.

23. **Recommendation: Review the staff reporting structure, consider redesign and provide clarity over reporting lines.**
24. **Recommendation: At superintendent level there should be some degree of technical understanding, and understanding of brachytherapy processes and workflow to support operational management, service improvement and integration with main department.**
25. **Recommendation: Staff should have time to attend meetings, planned into the working week, unless unexpected circumstances occur.**

3.7 Efficiency & Workflow

There is evidence of inefficiencies across the service. For example, administrative tasks being performed by trained clinical staff across both theatre and radiotherapy, and different teams within the brachytherapy service working alone rather than collaboratively. This results in task duplication or omission, paper based / white board booking systems, and paper-heavy documentation for theatre, planning and treatment. Trained clinical staff spend a lot of time receiving and initiating patient phone calls and booking transport that should be performed by an administrative support assistant.

We understand from discussions during the visit that there is agreed provision of administrative support for theatre and we would encourage maximum utilisation of this. The scope of admin support once embedded in theatre practice should widen to include the rest of the brachytherapy service.

26. **Recommendation: Perform a comprehensive review of the way the service is delivered to ensure the principle of having the right staff with the right training for the right task at the right time is embedded across the service.**

27. **Recommendation: Perform a comprehensive review of all processes and pathways to identify barriers and bottlenecks. Translate this into project & action plans initially looking for quick wins and small improvements that can be delivered easily. In turn, this will create the momentum and engagement for larger scale improvements that may be required, plus efficiency release from within the team to support larger improvements.**

The clinical workflow for gynae brachytherapy at VCC is currently very 'paper-heavy' involving multiple printouts at each step including treatment plan printouts, radiographer protocol sheets, prescription sheets, plan checking and dose check sheets and needle preparation sheets. One physicist commented that a separate plan copy is printed for storage in the physics records, in addition to the patient's clinical record of treatment.

Inevitably, the use of multiple paper records also involves several manual transcriptions of key treatment planning and dosimetry data introducing a risk of transcription error. For example, planned needle insertion depths are transcribed from the treatment planning system (TPS) onto a needle preparation sheet, and then subsequently transcribed from the sheet to a whiteboard in Theatre. The team should consider whether manual transcribing of values is checked at each stage such that the risk of transcription error is suitably mitigated.

Similarly, it was observed that the radiographer cross-checking processes for switching on used multiple data sources, some of which are secondary or derived, and it was not clear that both checks were independently verifying all the data sources. In particular, there was evidence of some duplication within the checking processes.

28. **Recommendation: VCC should adopt a fully paperless or paper-light workflow removing or reducing the need for manual data transcription and increasing the use of primary data sources where possible. Several studies on paperless environments for radiotherapy are now published[5–7] demonstrating clear safety and efficiency improvements over legacy paper-based systems, and the VCC clinical team are keen to move in this direction:**

https://www.sciencedirect.com/science/article/abs/pii/S1078817409000054

https://www.clinicaloncologyonline.net/article/S0936-6555(11)00441-9/fulltext

https://www.rcr.ac.uk/sites/default/files/paperless_radiotherapy_top_tips_nov2017.pdf

Paperless processes have already been partially implemented for external beam radiotherapy at VCC. However, the above recommendation represents a significant piece of work involving detailed and comprehensive review of all parts of the workflow and it is essential this is properly resourced and supported at the appropriate managerial levels and with multi-disciplinary 'buy in'. The Radiotherapy Board guidance linked to above on implementing paperless working is a useful starting point. Ultimately, we feel paper-light & paperless processes help improve both safety and efficiency, increase utilisation of primary data sources and permit reduction in transcription. Paperless

processes are also much easier to measure and audit against specific performance indicators and longer term this can translate into a release of time for staff for further efficiency improvements.

29. **Recommendation: Use primary sources of data for cross checking as much as possible and avoid duplication of checks, ensure the checking process adds value.**

30. **Recommendation: Consider whether manual transcribing of values is checked at each stage such that the risk of transcription error is suitably mitigated and highlighted as a risk. Eliminate manual transcription and data duplication to the maximum possible extent consistent with the clinical requirements.**

31. **Recommendation: Review checking processes to ensure both radiographer checks are completely independent and both radiographers cross check the same data sources.**

The Treatment Control Console (TCC) currently contains all patient treatment records and has never been archived. As a result, the TCC is now slow and working inefficiently. In addition, the more information held on the TCC the more likely it will become for an incorrect patient to be picked up in the system, regardless of the robustness of the checking processes (for example patients with similar or identical names).

32. **Strong Recommendation: Remove/archive historical data from the TCC and store securely or find an export solution for future patients to be removed.**

Finally, it was observed that staff had limited access to digital workstations in both Theatre and the HDR control area. Staff have time between patients to perform tasks, but lack workstations to do so. One member of staff was standing leaning on a desk working from her laptop, as there was no chair available. Staff waiting to have access to computer terminals to complete work is therefore having an impact on service efficiency.

33. **Recommendation: Investment is required to provide more workstations and chairs for staff to access in both areas**

3.8 New Build Considerations

Having relocated to a new building in 2020, the CCC have recent experience in facilities design and operational challenge. When appropriate, it may be beneficial to share the CCC plans, considerations, issues, and challenges and collaborate further on this. Some initial thoughts have been included here for completeness.

Currently the HDR room at VCC is very small, and there are many considerations that need to be addressed in the initial stages of designing the new hospital. Thoughts need to be given to the size and the layout of the room and due consideration should be given to contingency plans and the most efficient and safe way to deliver them.

The location of the room and theatre is important, and use of public corridors to move patients to imaging and wards should be avoided where possible. In addition, current patient changing area for vaginal vaults is inadequate.

Workstations for staff are also inadequate as noted above and this should be considered in the new building.

There should be specific considerations for the storage of consumables and equipment. Bespoke storage should be considered with a view to links to operational workflow. For example, turning

circles for trolleys should be mapped out to ensure equipment and cupboard space is not obstructing.

34. **Recommendation: Ensure key clinical stakeholders are heavily involved in the design and planning for the new department in the new hospital.**

35. **Recommendation: Ensure the new build is designed with future proofing in mind and takes account of the way VCC may want to work in the future.**

36. **Recommendation: The treatment console control areas for HDR and skin should consider being kept separate but adjacent to each other if services are to be run combined. Review also recommendations within Section 5.3 relating to the use of silent cockpit.**

37. **Recommendation: Ensure adequate and appropriately designed storage for consumables and specialist equipment.**

3.9 Workforce

Consultant Clinical Oncologists consist of one urology consultant with an ARSAC license, and a second consultant who is currently training (working under the first consultant's license with a letter confirming this arrangement). Additional oncologist workforce will be required as part of any business case to increase numbers beyond the current capacity to remain robust. (For reference, CCC is the same size currently with two CCOs and a third in training.)

There are three clinical oncologists in gynae, all ARSAC license holders, who cross cover the service. (For reference, there are three CCOs at CCC plus an associated specialist. Currently one of the CCOs at CCC is an ARSAC license holder with the other two working toward this. A fourth CCO with ARSAC also attends CCC under an honorary contract for North Wales gynae patients that are referred to the Trust.)

Given there is a national shortage of clinical oncologists, the age profile of the current post holders across the service should be considered with respect to timescales and future succession plans.

38. **Recommendation: Explore and implement medical succession planning options including developing own talent in current medical workforce.**

39. **Recommendation: Consider the role of consultant radiographers to support both urology and gynae services.**

There are currently three HDR prostate planners (physicists and dosimetrists), three checkers, two of these checkers are Medical Physics Experts (MPEs). There are a number of operators and MPEs in training. This is currently more than CCC and we recognise the ongoing challenge of timely and appropriate training and would like to collaborate further on this.

For gynae, there is a larger pool of seven operators signed off for gynae and four checkers, a mix of MPE and non-MPEs. There is on-site MPE support for non-MPE checkers. Moreover, there are several operators and MPEs in training. The physics team feel they are relatively well staffed in terms of clinical service provision. These numbers are broadly comparable to CCC, though there are more MPEs signed off at CCC and plan checking is only performed by MPEs. Moreover we utilise a 'Prescription to protocol' framework for gynae HDR, whereby an MPE can authorise a plan on behalf of the clinician if an agreed set of dosimetric parameters have been achieved. This reduces pathway length and handovers, saves on clinician time, and provides role extension for MPEs.

40. **Recommendation: Consider adopting prescription to protocol for MPEs to authorise brachytherapy exposures in accordance with written practitioner guidelines.**

41. **Recommendation: Continue to train physics staff on a regular basis.**

There are four radiographers rostered to the service covering HDR and skin (Band 7, 7, 6, 5 or 7, 6, 6, 5). On occasion staffing is reduced to three radiographers to release support back to the main department. Both services can be treating at the same time, not all senior team members can cover for each other, and there are several single points of failure and a lack of structure to training, leaving the team vulnerable. We are told the brachytherapy service is pausing for two weeks in August while one indispensable member of staff is on holiday. The current advanced practitioner (AP) is not a substantive post holder, they are currently on parental leave. It is not clear how the service will operate when the substantive post holder returns. The skin AP provides limited cover, as she does not have equivalent competencies for brachytherapy. Advanced practice is embedded however role extension and development is not apparent within the rotational staff, and there are a small number of radiographers with treatment competencies only. As a specialist service, advance practice is essential and CCC recognise the challenge of balancing specialist roles and robust service delivery. Role extension can play a part in this model. There are also issues within the service still apparent from a legacy post holder where it appears that service was built around said individual.

For reference, at CCC, there is an 8a service lead within brachytherapy (also working across radiotherapy), one permanent AP, and one rotational AP. One of the three must be present for first and single fraction delivery, and two hold ultrasound (US) competency. Seven rotational band 6s and one band 5 are trained, four of the seven hold advanced competency for leading subsequent / fractionated treatments. Six of the ten in total are trained for subsequent vault insertions and all radiographers hold responsibility for a service improvement project. There are four or ideally five radiographers required to run the combined services and plans to refresh another AP, train another 8a and one rotational radiographer in the next 12 months. Rotation is initially 12 months following a structured training program (3-6 months to gain competency, 6 months consolidation, then rotations annually ranging from 4 weeks to 6 months.)

42. **Recommendation: Develop a clear plan of workforce requirements; this should be robust, have in-built succession planning, and should include a training and development framework.**

43. **Recommendation: Flexible working for team members should be approved in line with business need and not at the detriment of the clinical service.**

44. **Recommendation: Consider creating a stable team for a sustained period to accelerate training and improvement.**

Regarding theatre staffing, we were not able to have sight of an anaesthetic SLA yet it appears to provide one anaesthetist and one ODP/anaesthetic nurse for one session on a Monday (8am-1pm approx.) for prostate and two sessions on a Thursday for gynaecology, although this is broken down to one session operating (8am-1pm) and one session for removal (1pm-6pm). There is downtime between the two sessions while the patient's plan is being produced by Physics.

The VCC theatre team consist of 1 x Band 7 (theatre lead), 4 x Band 6 (variety of scrub and recovery with anaesthetic background) and 1 x Band 3. The team carry out all Pre-Op Assessments (POA). (For reference, CCC have 1 x Band 7, 3x Band 5, 1x Band 3, all at 0.6 WTE and our SLA provides ODP, anaesthetic and 2 x recovery staff)

The VCC theatre team are highly skilled and many can perform more than one role. This is advantageous and gives the team flexibility and resilience.

It was observed on the prostate list, that five theatre staff were present for the one case, excluding the ODP and anaesthetist. AfPP minimum standards for one patient is one scrub nurse and one circulator. Recovery is not required until later in the day but must consist of one qualified practitioner and one other member of staff, which can be Band 3 with skills in this area.

For the gynaecology list, there were five theatre staff present (also excluding ODP and anaesthetist). Where there is more than one patient on the list, two of these staff would recover and escort whilst the rest of the team would continue with the next case. The operating session finishes at 1pm and the patients are nursed on the ward. There is therefore downtime before treatment and removal of applicators.

The VCC service has capacity challenges, and CCC suggest that there is consideration into service redesign. Based on the AfPP recommendations and the current theatre staffing levels, could different ways of working release theatre capacity, such as more efficient use of staffing including restructuring the working day/working week. For example, if alternative pain control were sought for applicator removal, the afternoon theatre session could be reallocated with the associated reallocation of workforce and amendment to the SLA to create an additional gynae theatre session on another morning (job plans permitting).

45. **Recommendation: Review staffing allocation against guidelines.**
46. **Recommendation: Explore service redesign within current staffing model to explore release of theatre capacity.**

4 Nursing & Theatre

The World Health Organisation Five Steps to Safer Surgery is a surgical safety checklist. It involves **briefing, sign-in, timeout, sign-out and debriefing**, and is advocated by the National Patient Safety Agency (NPSA) for all patients in England and Wales undergoing surgical procedures.

An NHS England improvement initiative produced a document in 2015; National Standards for Invasive Procedures (NatSSIPs)[8] provided a deadline for all areas where invasive procedures take place to produce LocSSIPs (local standards). These local standards should involve the five steps to safer surgery[9].

VCC Theatre procedure and guidelines (LocSSIPs) number 36 'WHO Policy' explains the process, but the document and process covers step two, three and four only. The VCC policy does not cover the full standards described within NatSSIPs and omits step one and five.

In practice, the theatre list involves a comprehensive 'safety briefing' but this is not documented and therefore does not fulfil the requirement of step one. The safety briefing does however bring all the relevant staff together and the team is very engaged. The fifth step which is a 'safety debrief' is not carried out at all.

https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf

https://publishing.rcseng.ac.uk/doi/full/10.1308/147870811X599334

47. **Strong recommendation: the policy should be rewritten to reflect the full process; the LocSSIPs should include all five steps**
48. **Recommendation: Standardised 'Team Brief' and 'Debrief' documentation should be produced as part of the policy. Copies of these should be saved for reference and audit purposes.**
49. **Recommendation: Team brief and debrief should be carried out on every session. If formal debrief cannot include all team members, advocate the opportunity for comments or to revisit in the policy and in practice.**
50. **Recommendation: Regular independent peer audit to include observation and documentation of the full five-step process.**

4.1 Patient Pathway Management

There are well-documented and clear patient pathways and they align to the process maps VCC shared. On the days visited, the pathways could be seen to be followed and staff have a good understanding of these. There is a clear pathway for patient optimisation prior to brachytherapy including POA and blood work and corrective therapies.

The theatre manager is clear on patient targets and breaches and suggests none have occurred although the patient booking system often means five gynae patients are scheduled on a session where there is a maximum capacity of three. This result in late date changes, and it was reported these often occur, as there is only one gynae session available. This is exacerbated by a single point of failure with only one sonographer, meaning sessions cannot always be covered. One gynae session per week makes it difficult to move patients to alternate sessions and keep within targets (such as the 56-day RCR recommendation). It therefore becomes necessary to move gynae patients onto a Monday urology list causing knock-on pressures and challenges.

The scheduling system does not appear to be robust or collaborative as dates are given to the brachytherapy radiographers and there is no negotiation or opportunity to discuss, consider or accommodate non-theatre patients who also need treatment. It is acknowledged that securing the theatre slots is the priority, however without better collaboration across the teams this will continue to contribute to capacity pressures across the service and isolation of the radiographers from the theatre team.

51. **Recommendation: Create additional planned gynae capacity via service redesign with the existing workforce and equipment or via a business case for additional resource.**

52. **Recommendation: Take a collaborative approach to scheduling based on an agreed set of priorities that consider the whole MDT.**

There are clear processes for the procedure of prostate insertion. There are also high standards of infection control and sterility and CCC have taken away some aspects of good practice to explore following the visit. The needle insertion takes place within the adjacent theatre as the HDR treatment room is too small to accommodate the equipment to carry out the procedure. Though not ideal, the VCC team are working around this well and it is therefore necessary to transfer the unconscious patient. They are moved on a heavy operating table through a doorway and over uneven floor surface whilst the needles are in-situ, and the patient remains connected to anaesthetic machine throughout. The CCC team would expect a risk assessment in place for this, both in terms of anaesthetic safety and precision of the brachytherapy. Mitigation for this exists as the needle lengths are re-measured in the HDR and this is executed very well with two radiographers present.

53. **Recommendation: Ensure there is a risk assessment in place for transfer of an unconscious patient and that all risks mitigated as much as possible.**

54. **Recommendation: Consider specifying within the new building a larger treatment room to allow insertion of needles for prostate cases without moving the patient.**

An unexpected bleed occurred during the gynaecology case we observed. Staff dealt with situation very well and clinical decisions were made in the best interest of the patient. Approximately fifty swabs were used during the procedure (this would ordinarily be five to ten). There is a bleed pack available if required and this can be easily accessed, for use both during insertion and on applicator removal.

Discussions following this procedure with the patient were very considerate, detailed appropriately and were carried out in the correct place ensuring dignity and privacy for the patient.

55. **Recommendation: Consider purchasing a pre-printed swab board and swab save containers to enable clear counting of swabs.**

Following insertion and scan, patients are nursed on a square four bay ward with two patients opposite each other. On our visit, the gynaecology patients were in bays opposite a male patient. Although theatre staff were aware of the situation, and stated that bed pressures had caused this occurrence, other staff were unaware that there is NHS guidance published in 2019 which does not permit this[10]. Trust is therefore in breach of the guidance if a patient is admitted to an area with the opposite sex. Breaches should be reported to commissioners and plans put in place to avoid further breaches.

https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/NEW-Delivering_same_sex_accommodation_sep2019.pdf

56. **Strong recommendation: Ward areas for the opposite sex to be admitted must be sought. In extreme cases, if this is unavoidable, a risk assessment should be in place along with a reporting system to investigate and track these incidents. Every effort should be made to ensure a private space maintaining patient dignity, for example curtains drawn at all times.**

57. **Recommendation: Consider single bedrooms for brachytherapy patients in the new building.**

Removal of applicators for gynaecology patients occurs under heavy sedation. This requires staff with skills in airway management, and in the case of VCC the anaesthetist. It was discussed briefly during the visit and the VCC team feel this is appropriate pain relief for the type of procedure and consider this best for their patients.

This process requires patients fasted for an extended amount of time whilst remaining supine. Discomfort and pain is not uncommon, potentially with nausea, and patients can have a reduced oral intake, thus increasing risk of dehydration.

In comparison, the CCC process for removal offers a range of pain relief (Oromorph, Paracetamol, Entonox) combined with support and encouragement from staff and breathing exercises. CCC are also currently seeking approval of use of Penthrox. Both Entonox and Penthrox allow the patient to have a degree of control, which can enable them to cope better.

There has been much discussion among the brachytherapy radiographer Special Interest Group (SIG) and sharing of Penthrox protocols. Many centres are moving towards this and report positive feedback.

Alternative removal options will reduce anaesthetic complications, delayed discharges, and late-night transport transfers home. It may also be a way to increase theatre capacity releasing highly skilled anaesthetic staff from the sometimes-long treatment days. Further information regarding this is detailed in elsewhere in the report.

58. **Recommendation: Consider a review of perioperative pathway for applicator removal.**

59. **Recommendation: Consider alternatives to heavy sedation for applicator removal to release theatre time/capacity for patients.**

4.2 Medicines Management

There are medicines management issues throughout the department. These include security issues, medication left unattended and inappropriate storage. This is a breach of Misuse of Drugs Regulations[11] in terms of security.

https://www.legislation.gov.uk/uksi/1973/798/schedule/2/made

One entrance to the anaesthetic room is behind swipe access, accessed via the theatre entrance. The other entrance is locked with a key, which is usually open during the day to allow operational workflow. However, this door could be accessed from the main corridor and one of the CCC team were again able come from the corridor and into the drugs cupboard, which was open and unattended.

It was observed that medication was left out on the side in the HDR control area to be given to a patient later in the day. Ideally, this should be dispensed directly to the patient along with relevant ID and expiry date checks.

There was also out of date medication observed in the medicines cupboard for which there should be a process with pharmacy to remove.

Control of Substances Hazardous to Health (COSHH) legislation[12] was not met; storage of substances as flammable solutions are not located in a flammable cupboard. We did not have sight of COSHH inventory.

https://www.hse.gov.uk/coshh/

Recommendation: Full review of medicine management processes, review access to medicines security, storage, and disposal and dispense of medicines across the whole department.

60. **Recommendation: Perform monthly out of date stock checks and audits.**

61. **Recommendation: COSHH risk assessments to be developed, if not already in place.**

62. **Recommendation: Ensure appropriate storage of any substances.**

4.3 Training and Professional Development

The VCC staff were observed to be very proficient in their roles in theatre, however staff competency or training documents were not available for theatre staff, qualified or unqualified. It is not clear if staff have had formal training in role extension such as POA.

Theatre staff were also unaware of contingency processes or rehearsal and there was no record of attendance.

63. **Recommendation: Develop competency documents for all staff groups and method for ongoing competency updates.**

64. **Recommendation: Consider extended courses, for example POA.**

65. **Recommendation: Human Factors training for those working in theatre environments as recommended by NHS England[13].**

    https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

66. **Recommendation: Full multidisciplinary team to be involved in regular scenario based contingency practices for removal of applicators, resus, local toxicity, bleed, fire evacuation. Attendance should be documented.**

4.4 Miscellaneous

For the gynaecological patients, it is routine that para-cervical blocks are used yet there is no policy or training for local toxicity and staff are unaware that intralipid reversal agent is available.

67. **Recommendation: Policy and guidelines should be available. At minimum, a copy of Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines[14] should be available and easily accessible to staff. Consider a laminate copy of the guidelines to be displayed in the theatre area**

https://anaesthetists.org/Home/Resources-publications/Guidelines/Management-of-severe-local-anaesthetic-toxicity

68. **Recommendation: Staff to have training and be able to locate equipment in the event of local toxicity.**

Anaesthesia / heavy sedation takes place in both theatre and HDR. Equipment is available for difficult airway interventions, however not all in one place.

69. **Recommendation: Consider a portable difficult airway trolley with Difficult Airway Society guidelines available for reference.**

It is frequent practice within the gynaecological procedures that the sonographer breaks the sterile field by leaning over the patient with the probe. A sterile probe cover is cut with non-sterile scissors and put onto the probe, but nonsterile gloves are then used to perform the scan.

70. **Recommendation: Risk assessment to be in place if this is acceptable practice, or do not cut the probe cover and scrub in and use sterile gloves instead.**

It was observed on the gynaecology procedures that there were many staff and traffic in and out of theatre (discounting the CCC visitors).

71. **Recommendation: Reduce number of staff within the perioperative environment and utilise the 'scrub' door instead of theatre doors if at all.**

72. **Recommendation: Staff to work in another area when not directly involved in the procedure.**

Some out of date anaesthetic equipment was seen including sterilised items past their recommended sterility date. Some of the anaesthetic items used are being re-sterilised for multiple patients use when a single use option is now commercially available, such as laryngeal mask airways.

73. **Recommendation: Implement routine checks of all equipment for out-of-date items.**

74. **Recommendation: Consider moving to single patient use airways.**

All patients should be asked if visitors can attend their procedure and the VCC team did obtain this consent and introduce the CCC team members. However, the CCC team did not have sight of a visitors policy or risk assessment on request.

75. **Recommendation: Visitor risk assessment should be in place and available in accordance with the Health and Safety at Work Act (HMSO1974)[15] and the Management of Health and Safety at Work Regulations (HMSO1999)[16].**

Management of medical devices regulations[17] are not being met due to many devices being out of maintenance and service date. Electrical safety testing of non-medical devices were also found to be out of date. Some medical devices did not have any evidence of maintenance on visual inspection.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/982127/Managing_medical_devices.pdf

76. **Recommendation: Ensure the Trust's Medical Devices policy is fit-for-purpose and implemented.**

77. **Recommendation: Perform monthly out medical devices checks and audits.**

5 Radiotherapy

5.1 Patient Pathway Management

The CCC team have recent experience in combining services (HDR and Papillon Contact Therapy) and suggest that whilst reviewing the brachytherapy service, the VCC skin service should be included as the expectation is they will work together. CCC advise it cannot simply be viewed as one service on top of the other, or side by side. It is important to have in-depth understanding of where the services are comparable or different, where practice and process can be aligned so the services fit together efficiently and delivery of both in parallel is not onerous. Scheduling on a sessional basis based on clinician job plans and other restrictions such as anaesthetic SLA will inform an overarching model and adequate workforce to deliver this should be aligned. The VCC team describe that on Monday's skin patients are treated around theatre, with the same arrangement on Thursdays. On Fridays there is a dedicated skin clinic.

The supplied process maps for vaginal vault treatment describe the clinical processes and these are very similar to CCC. The radiographers state that they do their own bookings (HDR and skin), and that this is different to external beam in the main department. The rationale for this is that ad hoc and emergency patients can be accommodated at short notice, and they are very flexible to patients travelling long distances or with specific requirements. Whilst this is thoughtful and considerate of other colleagues and patients it is reactive work for the team.

Every vaginal vault patient is scheduled on an individual basis. There are delays in the pathway waiting for information, lots of unnecessary email traffic and improper and expensive use of senior radiographer time. An email is sent waiting for confirmation of clinician availability, and then booking and transport allocation, phone calls and letters to patients are all completed by the radiographers. This exact process can be performed by suitably trained admin staff. Better still, through service redesign, a template of set sessions including set capacity agreed by job plan could bypass much of the above admin and patients would be booked directly into slots from booking form and appointments communicated. The same improvement could be made regarding skin clinics, via a timetable of OPD (Outpatients Department) clinics and corresponding planning / treatment availability for on-the-day treatment could be mapped and agreed. A clinician can know at what time they have a same day planning slot and admin can book the patient in, radiographer can then be aware of the add on from the schedule and patient expectations can be managed. By creating boundaries and sessional capacity, the team will both be able to accommodate ad hoc work but do so within a more controlled environment with the correct staffing allocation to do so

78. **Recommendation: Review both services from operational perspective; how they work together, resource requirements, and map clinician availability and job plan to treatment sessions.**

79. **Recommendation: Perform capacity and demand review then work out appropriate staffing allocation across the working week.**

80. **Recommendation: Trained staff should not perform routine administrative tasks.**

81. **Recommendation: Perform regular and ongoing reviews of staffing levels and workforce plans and submit business cases to reflect the staffing requirements for the workload.**

82. **Recommendation: Consider electronic rostering and rosters being shared among teams so teams can see when other staff will be available.**

5.2 Demand and Capacity Modelling

Where the service requires review or redesign, consideration should be given to the quality of, and access to, the data required to underpin this review. Paper-based treatment records make it difficult to gather data efficiently for capacity and demand modelling. RTDS data could be used to model HDR treatment activity. As the numbers are relatively low (compared with EBRT) this should be achievable. Clinical stakeholders should be involved in modelling so that data and trends can be verified before data is used to plan services.

83. **Recommendation: Ring fence adequate resource to review activity over the last five years and use modelling tools to predict demand for next five years.**
84. **Recommendation: Revisit modelling annually to ensure it is reflective of service provision.**
85. **Recommendation: Run automated reports (if possible) prospectively and retrospectively and use this to inform ongoing service provision and redesign.**
86. **Recommendation: Embed capacity and demand modelling and workforce planning, as they are dependent on each other.**

5.3 Communication and Collaboration

There appeared to be a non-collaborative approach to working with the whole multi-disciplinary teams. Clinicians and theatre appear to work well together, as do clinicians and physicist, and clinicians and radiographers. The Radiographers appear to be more separated from theatre. Radiographers are not involved in the scheduling of theatre sessions nor present within theatre for the procedures, unless specifically in the ultrasound role. It was observed in some discussions that some team members' views were not valued in the same way as others. Theatre staff did not have robust knowledge of HDR contingency planning or appreciation of the imperative nature of Radiation Safety regarding HDR.

87. **Recommendation: Radiographer involvement with the full patient journey should be promoted including presence within theatre and involvement in the insertion procedure.**
88. **Recommendation: Regular contingency rehearsal should be carried out involving all members of the MDT as described in section 3.3.**

Communication between the theatre and radiographers is limited. Efficient communication between all staff is critical. This is particularly important when the radiographers are operating two services. It was observed that a patient under general anaesthesia was delayed because of a skin patient being treated. Physics gave a brief 5-minute warning that the prostate patient was due to come through to the HDR. The prostate patient was wheeled into the HDR and was ready for treatment. However, there was a skin patient being treated that led to the prostate patient having to wait approx. 15 minutes whilst they finished the skin treatment. There were not enough staff present to run both services simultaneously. In addition, there was another skin patient booked in, so this patient was delayed whilst they then treated the prostate. If there had been clearer timetabling of the services this would have been preventable in the first instance, or with clearer communication between the teams this situation could have been dealt with and managed safely and appropriately for both patients. We acknowledge it is planning processes are dynamic and cannot give exact timings, however overall timing trends will be similar. We suspect this may also be exacerbated by a lack of understanding of the planning process from the radiographer's perspective and the time take for each element. If the radiographers had awareness of the process and timelines, they could check in

with the theatre team, 'see where they are up to' and know the approximate time left on the procedure and therefore whether it is appropriate to treat a skin patient beforehand.

Whilst the skin patient was undergoing their treatment there were numerous members of the theatre staff congregated in the control area and the noise level was unacceptable. The noise level remained high whilst the radiographers carried out their HDR pre-treatment checks during this time and whilst the patient was undergoing treatment. There appears to be a lack of awareness of the safety critical checks taking place by the wider clinical team.

89. **Recommendation: Better communication between teams and better understanding and insight into roles and responsibilities.**

90. **Recommendation: Adopt a silent or 'sterile cockpit' approach[18] during pre-treatment checks and treatment delivery in order to promote a safety culture. This process taken from the aviation industry can be translated to radiotherapy delivery[19].**

    https://www.easa.europa.eu/faq/19134

    https://www.sciencedirect.com/science/article/abs/pii/S1527336908000391?via%3Dihub

91. **Recommendation: Collaborative leadership for the service across the MDT should be emphasised and promoted rather than silo working in small teams.**

92. **Recommendation: Introduction of MS teams, electronic shared calendars, or other electronic methods of team communication should be considered where services are running parallel to each other.**

5.4 Training and Professional Development

Staff report they do not have time for training or improvement, although there is evidence of support for advanced practice. The radiographers treating vaginal vault treatments were not able to explain to the CCC team why they treatment was weighted as per the planning standards (i.e. to create appropriate dose distribution). The radiographers also did not have awareness of how gynae or prostate treatments are planned and optimised or what dose constraints used. Physics attend theatre with responsibilities around needle depths insertion but this could be delegated to suitably trained radiographers releasing physics capacity. There are plans for the advanced practitioner to train is sizing of applicators, on treatment review and dilator counselling.

93. **Recommendation: Protect time for training and writing and updating SOPs should be allocated by factoring this into the workforce plans and job plans for the radiographers.**

94. **Recommendation: Radiographers should not only be trained to check and deliver treatment but should also be educated, have understanding, and be involved in the insertion, planning process and delivery of treatment.**

95. **Recommendation: Radiographers should be integrated further into the brachytherapy MDT: they have a wealth of knowledge and skill and are versatile, and this will cement their underpinning knowledge.**

96. **Recommendation: A brachytherapy training and competency package should be developed to include background knowledge of brachytherapy principles, planning of procedures and pre-treatment pathway. Formal brachytherapy training is limited to a small number of M level modules and the ESTRO teaching course. Radiographers should actively collect and share resources to supplement learning.**

97. **Recommendation: Those working in brachytherapy should join the Society of Radiographers (SoR) Special Interest Group (SIG) for peer support and shared learning.**
98. **Recommendation: Consider further role development and role extension for rotational Band 6 brachytherapy radiographers to help support the service to be more robust. This could include HDR contingency training, insertion of vault applicators, gynae ultrasound, and dilator counselling with appropriate underpinning policy.**
99. **Recommendation: Consider the use of Patient Group Directions (PGDs) for all radiographers to be able to support side effect management and the needs of patients on treatment. Guidance can be sourced from the SoR and the specialist pharmacy services website.**
100. **Recommendation: When implementing further advanced practice responsibilities ensure there is more than one member of staff trained to cover planned unplanned absences.**
101. **Recommendation: Consider, if possible a stable team for a prolonged period to accelerate training and improvement.**

5.4.1 Ultrasound

Ultrasound guided brachytherapy insertion is the gold standard, and the brachytherapy clinical specialist has completed an ultrasound guided brachytherapy module to be recognised for this competency. However, they remain a single point of failure, as the gynae service will close for two weeks whilst the only member of staff competent in ultrasound takes annual leave. There are no other provisions to support or cover ultrasound guidance. Training for ultrasound for another member of staff was described as at least an eighteen-month process until competence was achieved. It was also reported that members of staff have come in whilst sick to cover this service.

102. **Strong Recommendation: Urgently develop an in-house clinical skills training package for ultrasound for brachytherapy to expedite training in a timelier manner and to train more staff to cover this service. Consider then supplementing it with M level module when service is more robust.**
103. **Recommendation: Within advanced practice frameworks, policies, and training, ensure that services have more than one trained member of staff before that service can operate. This will prevent future single points of failure.**

5.4.2 Imaging Non-Medical Referrer (NMR)

Band 6 nurses request all MRI brachytherapy scans on behalf of the doctors. No formal training has been arranged and we were advised that they 'pp' the clinician on the paper form. The CCC team are unsure of the governance around this and unsure as to who requests the Week 5 MRI and the U/S images.

https://www.bir.org.uk/media-centre/position-statements-and-responses/guidance-for-non-medical-referrers-to-radiology/

https://www.sor.org/getmedia/d8891bb3-927d-4a47-9247-60630de48520/Clinical-Imaging-Requests-from-Non-Medically-Qualified-Professionals

104. **Recommendation: Nurses and AHPs should receive the appropriate training prior to being entitled to be an NMR for imaging[20,21]. The training may be delivered in-house, e-learning or a combination of both. A policy or protocol should support the team to deliver this to**

allow trained staff to NMR scans, ensuring several team members are trained to avoid single points of failure.

6 Physics & Treatment Planning

6.1 RAKR

Within both Oncentra Brachy and Oncentra Prostate planning systems, it is local practice at VCC to plan with a 'standard reference source'. This means that each time the software is opened the plan date is set to a specific date (e.g. 01/01/2018) to fix the planned source activity to 10 Ci (nominally 37,240 μGym^2h^{-1} Air Kerma Strength). The final correction for radioactive decay is then made at the Flexitron just prior to treatment based on a ratio of the planned source strength and the current source strength. One benefit of this approach is that plans across time can be compared more directly with each other without having to incorporate source strength decay into the reported dwell time values. It also means that the source strength in the planning system does not need to be updated when it is changed at the machine, typically four times per year.

As part of the plan check process, an independent dose calculation is performed, which is recognised best practice (and indeed required in England for all EBRT treatment under the NHSE service specification[22]). For both the prostate and cervix planning process, this was achieved via export of the DICOM RP file to the VCC Medical Physics Computing Portal and calculation based on BIR dosimetry data independent of the AAPM TG-43 data used within the treatment planning system. However, since the treatment plan refers to a nominal source rather than the source that patient is due to be treated with, the independent dose check does not itself include a decay calculation component and this may be a risk. We believe a final check on the decay correction is still performed via the radiographer protocol sheet, which allows the treatment operator to visually compare against the Flexitron-decayed dwell time values in the pre-treatment report. However, this is a derived rather than primary data source and it was not clear whether there was a tolerance on this check and at what point treatment would be halted if there was a notable discrepancy.

The IPEM code of practice for determination of the reference air kerma rate for HDR Ir-192 brachytherapy sources based on the NPL air kerma standard states that 'it is recommended that the measured RAKR determined with a calibrated well chamber traceable to the NPL Ir-192 primary standard is used in the treatment planning system'[23].

105. **Strong Recommendation: Consider commissioning the live for-treatment source within the Oncentra Brachy and Oncentra Prostate systems instead of a standard reference source, including incorporation of this into regular source change procedures, in line with recommendations within the dosimetry Code of Practice. The software will then decay the source and this decay can be independently verified. This would also allow the planning system to produce dwell times directly comparable to the Flexitron and remove the need for an intermediate radiographer protocol sheet.**

6.2 Use of Off-Label (non-CE-marked) Devices and Software

During prostate treatment, VCC have developed an in-house grid mount to meet infection control requirements and means that the grid can be set to the correct height. The scrub nurse puts the template grid in place and the grid is covered with plastic material to maintain a sterile field. Modifying existing devices or using them for purposes not intended by the manufacturer may have safety implications and will almost certainly transfer liability to the user organisation.

One member of the cervix planning team also reported during the second visit that an in-house gynae vaginal applicator was still in clinical use (or had been until recently).

The MRHA recommends that all medical devices for patient use have a CE (now UKCA) mark as it shows that it has met the legal requirements for safety, quality performance when it is used as the manufacturer instructs[24,25].

https://www.gov.uk/topic/medicines-medical-devices-blood/medical-devices-regulation-safety

https://www.gov.uk/government/publications/medical-devices-off-label-use/off-label-use-of-a-medical-device

106. **Recommendation: Consider if the in-house grid mount is required for prostate and consider reducing and removing use of in-house applicators where possible. If it is considered unavoidable to use non-CE marked devices and software then ensure a risk assessment is in place with appropriate mitigations identified.**

Reasonably extensive use was also made throughout both the prostate and cervix clinical planning pathway of various in-house software applications made available through the VCC Medical Physics Computing Portal, including for independent dose calculation of the treatment plan, independent decay correction of the Flexitron after loader, and for production of a radiographer protocol sheet used for final pre-treatment checks.

The MRHA guidance referenced above (in effect) advises centres to use medical devices with a CE (or UKCA) mark where possible, and that off-label (or in-house) use should be rare, and only if there is no medical device (or software) available for a procedure. Further, we would refer the VCC team to the relevant EU legislation on medical devices[26] (on which the UK (United Kingdom) legislation is still currently based), stating in paragraph 30 that:

"Health institutions should have the possibility of manufacturing, modifying and using devices in-house and thereby address, on a non-industrial scale, the specific needs of target patient groups ***which cannot be met at the appropriate level of performance by an equivalent device available on the market"*** (emphasis added).

https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32017R0745

The last part of this regulation is instructive – in-house is only appropriate if the need cannot be met at the appropriate level of performance by a device available on the market.

107. **Recommendation: Review the advice from MHRA (Medicines and Healthcare products Regulatory Agency) on off-label use of a medical device in the context of the clinical pathways when considering in-house software and in-house manufactured medical devices.**

108. **Recommendation: If it is considered unavoidable to use non-CE marked devices and software then ensure a risk assessment is in place with appropriate mitigations identified.**

6.3 Digital Security & Best Practice

According to the National Cyber Security Centre's 10 steps to cyber security[27], one of the steps is to control who and what can access your systems and data (Identity and access management). For prostate planning, the operator logs on using a generic administrator username and password stored and recorded in the work instruction.

It also appeared that during the cervix planning process both users used the same logged-in Windows and Oncentra accounts for carrying out planning and checking tasks, which can obscure auditability in the event of an error and again is likely not be aligned to current IT best practices.

https://www.ncsc.gov.uk/collection/10-steps

109. Strong Recommendation: Consider individual log-ins designed to minimise the opportunity for unauthorised access.

110. Strong Recommendation: Passwords should be removed immediately from documentation in the quality system and only known to and shared with authorised users.

During the final plan optimisation for the cervix plan we saw, the Oncentra Brachy system unfortunately crashed, resulting in a small delay to final plan approval and treatment. An attempt to load the plan on a neighbouring workstation was also unsuccessful. The plan was ultimately recovered following a reboot but it did highlight the obvious importance of stable and reliable IT infrastructure for real-time planning cases involving anaesthesia and invasive clinical procedure. Microsoft Teams and Outlook email appeared to be running within Windows alongside the planning application, which may have been a confounding factor here. We have known Oncentra Brachy to be similarly unreliable at inopportune moments at CCC and have aimed to keep our systems as free as possible from office and other software not directly involved in the clinical workflow.

111. Recommendation: The team may wish to review whether any rationalisation is required here. A regular backup schedule of the Oncentra databases and key system files is also advisable if not currently in place, as well as documented recovery procedures that can be followed in the event of a non-recoverable system failure.

6.4 Treatment Planning (Prostate)

A prostate planning session was observed during our visits. Technical processes for treatment and planning of HDR prostate resembled closely the CCC processes. There were some differences noted and they are shared for consideration.

The BK Ultrasound equipment gave a fatal error on start-up, which was resolved by re-starting the computer. CCC have experienced something similar; eventually the computer would not re-start and at all and a procedure had to be abandoned.

112. Recommendation: The BK Ultrasound should be returned to the manufacturer for investigation prior to this issue becoming un-recoverable.

Physics are present for the WHO surgical safety brief, which is facilitated by the clinical oncologist. This brief also included useful clinical information, which maybe better shared at a different time.

113. Recommendation: Consider holding the multidisciplinary team (MDT) meeting prior to the theatre session to discuss clinical and technical aspects of the procedure.

Trailing wires in theatre were kept to the left side of the bed and the anaesthetist was to the right, with consultant, physicist, and dosimetrist at the patient’s feet. This kept trailing wires out of the way but made access to left side of bed difficult, which could in turn hinder manoeuvring the patient to optimise set up if this is required. There is a screen above the patient to capture ultrasound images and avoids the consultant having to keep turning round to view the ultrasound image on the trolley and this is something we are going to investigate implementing at CCC to improve our own

set up. The image quality was noticeably better than CCC's image quality, defaulting to 6Hz (CCC default to 9Hz). Lights remained on throughout procedure.

114. **Recommendation: Review room layout to maximise access to all sides of the patient.**

115. **Recommendation: Consider turning the lights down to improve image viewing conditions, this may be helpful particularly for the post implant imaging.**

The initial position was decided by the oncologist, and there was not much discussion with physics and dosimetry. It was observed there was not much space between rectum and prostate and it was unclear if this could have been avoided.

116. **Recommendation: It may be helpful for the oncologist to discuss optimal set up with the physics / dosimetry team, particularly around position of the 1 line in relation to prostate and rectum.**

Initial calibration measurement was performed by physics, but this value was not second checked.

117. **Recommendation: This calibration measurement should be checked independently by a second person.**

Outlining of prostate and urethra (only) was performed by the oncologist and CTVp was grown by physics/dosimetry 0.3 cm in all directions except sup (0 cm) and avoiding rectum. At CCC, we use 0.3 cm margin in all directions avoiding rectum.

118. **Recommendation: Consider use of the prostate outlining model available within Oncentra Prostate as this may be useful for outlining prostate.**

The volume of prostate was 27 cc and 15 needles were used to achieve the plan. There was no calculation performed on the pre-plan. Needles are not loaded outside of CTVp. At CCC we would load 1.0 cm superiorly and inferiorly to prostate to achieve coverage at base and apex.

119. **Recommendation: Planning with fewer needles tends to be better for the patient (less trauma) and provides improved plans by minimising dose to urethra.**

120. **Recommendation: Consider loading needles outside of prostate to improve coverage at base and apex.**

The needle insertions all done with longitudinal scanning and this was very efficient. Two free lengths are checked against screen for calibration purposes. The locking needles were not used to hold the prostate in position.

121. **Recommendation: One of our oncologists finds locking needles useful especially for small prostates, which are prone to move.**

Once all needles are inserted, the patient was re-scanned and the position of base checked in the sagittal image to ensure the needles are far enough in to provide coverage superiorly. There was no re-set up of origin. The patient was scanned in longitudinal mode and the base and apex re-marked on the longitudinal image. The patient was also then re-outlined including rectum and it was noted that the oncologist struggled with image quality at this point.

122. **Recommendation: Turn the lights down to improve image viewing conditions, as this may be helpful particularly for the post-implant imaging. Also, consider adjusting the ultrasound parameters to further optimise image quality.**

As this is a sterile procedure, the physicist (checker) scrubs and performs free length measurements that are entered into Oncentra by the dosimetrist. These free length measurements are not then re-checked until the end of the procedure once the plan has been complete. Once the plan has been completed, the clinician checks the free lengths agree to within 0.2 cm.

123. **Recommendation: Consider this check being done independently by a pair of scrubbed radiographers, one to do the initial measure and one to check. Any discrepancies can be resolved prior to the plan being produced or indeed delivered. Needle measurements are also then independent to those planning the treatment.**

At this point, the team proceeded straight to planning and the position of the needles relative to the image was not checked.

124. **Recommendation: Needle positions should be checked against the underlying ultrasound image and adjusted as necessary so final planned distribution matches delivered distribution as closely as possible. The team would need to ensure that the superior end of the needle is included in scan to achieve this.**

The plan was optimised using DVHO and analysis carried out using isodose lines and traffic lights. Traffic lights included Prostate $D_{90\%}$, CTVp $V_{100\%}$, Urethra $D_{10\%}$ and $D_{30\%}$ as well as Rectum $V_{100\%}$. Rectum $V_{100\%}$ appeared to be particularly problematic. For reference, at CCC 87% of our patient have a Rectum $V_{100\%}$ of 0.0%, and the maximum value over 241 patients audited was 4.8%.

125. **Recommendation: As previously mentioned, it may be helpful for the oncologist to discuss optimal set up with the physics / dosimetry team, particularly around position of the 1 line in relation to prostate and rectum.**

Graphical optimisation is used to finally optimise coverage. Additional source positions were loaded superiorly and inferiorly to improve coverage. For reference and as mentioned above at CCC we load 1.0 cm superiorly and inferiorly to ensure coverage at base and apex.

126. **Recommendation: Suggest exploring options of loading superiorly and inferiorly to improve coverage. Inserting fewer needles may reduce trauma to patient.**

The final plan was accepted and approved. The plan report was printed (excluding DVH data) and sent to Flexitron. An independent dose check was carried out using an in-house spreadsheet and BIR data. This check is carried out on 10 Ci source times not actual times so no check of source decay included.

The physics MPE check was carried out using a tick-list and paper printout, and all checks are paper based. As noted in Section 6.1 there is no check of source decay at this point. A radiographer protocol is used by the radiographers to check the data in Flexitron, but this is not a primary data source and is produced with in-house software.

127. **Recommendation: As noted in Section 6.1, the RAKR should be updated in the TPS software at source change to the actual RAKR of the source, thus only requiring a single and verified entry. The software will then decay the source and this decay can be independently verified.**

128. **Recommendation: As mentioned in Section 6.2 the MRHA recommends that all medical devices for patient use have a CE (UKCA) mark as it shows that it has met the legal requirements for safety, quality performance when it is used as the manufacturer instructs. Therefore, should consider if this in-house software is required.**

129. **Recommendation: As documented in Section 3.7, consider paperless working to improve efficiency and reduce reliance on secondary data sources.**

6.5 Treatment Planning (Cervix)

A cervix planning session was observed during our gynae visit. The core physics treatment planning and dosimetry processes appeared very recognisable and reassuringly familiar to the CCC team. Patients are planned using a T2-weighted MRI sequence acquired immediately post-applicator insertion in line with best practice laid out in both ICRU Report 89[28] and GEC-ESTRO recommendations[29–31] for image-guided brachytherapy to the cervix. We commend VCC for their use of para-cervical image series for outlining and planning. This is a change we have struggled to implement at CCC despite clinician request due to incompatibilities with DICOM structure set transfer between our outlining and planning systems.

Organs at risk (OARs) were delineated by the dosimetrist treatment planner. High Risk CTV (HR CTV) was created by the dosimetrist using a manual Boolean approach following delineation of GTV and whole cervix by the clinical oncologist. We note a point of variance here with CCC practice in which all structure delineation is currently carried out directly by clinical oncologists. However, it is also noted all outlines were reviewed and approved by the treating oncologist prior to treatment delivery. There is an outlining peer review process in place in which the two oncologists review each other's outlines and work closely together in this regard, and there is an increasing body of evidence that supports the benefits of clinician-to-clinician peer review in improving contouring quality[32]. It was not clear whether the case we observed during our visit was prospectively or retrospectively peer reviewed.

Applicator reconstruction was also very similar to current CCC practice including use of the Oncentra Brachy planning system and applicator library models aligned with MR signal voids. Following outlining and initial applicator reconstruction and prior to dose optimisation and plan approval a second reconstruction check was performed to ensure no errors had been introduced. We recognise that partial checks earlier in the planning process can be helpful in catching errors sooner and makes for less costly remediation. However, caution is advised in situations where fast user-switching occurs around a plan that is not currently approved and therefore still in an editable state - the act of checking may in fact introduce an inadvertent change that may not be detected later.

130. **Recommendation: Consider using the plan approval function within Oncentra Brachy to lock the plan while it is being checked, to reduce the risk of introducing an inadvertent change. If a partial intermediate check (e.g. of reconstruction) is required before final optimisation, consider whether additional checks later in the process are also required to ensure the first check remains valid.**

Plan dose optimisation was completed by the dosimetrist with what we felt was very hands-on clinician involvement. We commend this multi-disciplinary approach as real-time guidance from the oncologist in terms of which areas to focus on in the optimisation beyond basic target outlines can be invaluable in arriving at a clinically appropriate plan in an efficient and timely way. It was however also discussed with the team on the day that this level of clinician involvement in the technical optimisation of the plan may not be adequately recognised through the IRMER entitlement procedures for duty holders, since clinicians are not typically entitled as treatment planners in this formal sense. There was also an acknowledged risk that the dosimetrist planner may be tempted in this situation to take a 'back seat' during the optimisation stage in deference to clinician instructions, despite holding legal responsibility for the treatment optimisation under IRMER.

131. Recommendation: Review Employers scope of entitlement procedure for Duty Holders under IRMER and consider whether current practice with respect to operator roles is represented adequately.

The plan we observed was more intensively modulated than similar plans we would produce at CCC, in terms of variation in dwell time weighting and non-standard loading positions. This is likely a reflection of the high level of experience and specialised role held by the treatment planner, including confidence to trial different combinations via forward planning to achieve incremental improvements to the dose-volume parameters and performance against relevant planning constraints. The case observed was also a challenging case with extreme proximity of bladder to target volume anteriorly certainly requiring a baseline degree of plan modulation. One risk with over modulation can be dosimetry errors that are introduced where a substantial proportion of the total activity is delivered through a small number of positions, and this is accordingly recognised in the VCC treatment planning work instructions. For example, during the visit the number of loaded positions on the right-sided ovoid was increased from one to two following discussion with the CCC team, as this was felt to improve plan robustness with respect to the accuracy of those modelled positions.

Discussion was also had during the day of the use of the Venezia vaginal caps, an accessory to the main applicators in in use at CCC and VCC and which we have found to be particularly effective at reducing rectal dose in some patients. Although these also include additional source positions that may be commissioned for more inferior disease volumes, the caps themselves can be used as a simple mechanical rectal spacer, similar to the rectal retractor used with the previous interstitial ring applicators.

132. Recommendation: Consider introducing Venezia vaginal caps to provide additional rectal dose sparing in cases where they may be clinically suitable.

Final dose-volume parameters reported included several, if not most, of those recommended under ICRU89, plus some additional local dose-reporting parameters. However, dose prescription was focused on the HR CTV $V_{100\%}$ parameter, which is a local convention, not recognised in the ICRU guidance which instead favours HR CTV $D_{90\%}$. The plan doses were compared against the mandatory constraints outlined in the EMBRACE II protocol[33], radiobiological adapted for a single brachytherapy insertion and evaluated using the Oncentra DVH pre-sets tool. The EMBRACE II constraints are widely considered within the community to be accepted reference values and best practice guidance for IGBT of the cervix, and for bladder and rectum OARs are based themselves on a retrospective analysis of the earlier EMBRACE trial outcomes. However, no explicit note was made of the optimal constraints also contained in this protocol citing difficulties with encoding two-level constraints within the DVH pre-set. This is a technical issue that we believe can be resolved and have since shared the .xml file used at CCC to encode these planning aims.

133. Recommendation: Consider aligning prescribing practice to ICRU89 recommendations, in particular the use of HR CTV $D_{90\%}$.

134. Recommendation: Consider implementing EMBRACE II optimal constraints for targets and OARs to guide dose optimisation and alert the clinicians where a particular structure maybe outside the optimal range.

Ultimately, we felt the final plan we observed was comparable dosimetrically to what we would have produced at CCC for the same case. To provide further reassurance, a data pack for a previous

planning audit in which CCC participated has since been shared which will allow VCC to benchmark current planning practice against a national cohort.

7 Summary of Recommendations

There are 134 recommendation in this report. Some of the recommendations relate to relevant legislation, guidance and best practice, some are differences in practice noted for reflection, consideration and discussion and others relate to observations based on experience of the CCC team and the scope of the review.

Training and professional development features highly and there are sixteen recommendations overall regarding this. Recommendation 63-66 and 104 cover nursing and theatre specifically, whilst recommendations 93-103 relate to the radiographers.

There are also a number of strong recommendations made across the service. These are highlighted as strong as the CCC team would like to draw specific attention to them.

Recommendation 7 relates to documentation and sharing of the passwords and alarm codes for the Flexitron. Similarly, Recommendation 109 and 110 relates to individual log in's and documentation and sharing of passwords for the Oncentra planning system.

7. Strong Recommendation: Alarm codes and software passwords should be removed immediately from documentation within the quality system and only known to and shared with authorised users

109. Strong Recommendation: Consider individual log-ins designed to minimise the opportunity for unauthorised access.

110. Strong Recommendation: Passwords should be removed immediately from documentation in the quality system and only known to and shared with authorised users.

Recommendation 8 relates to Radiation Safety and HDR contingency processes. Further recommendations 5-7 and 9-12 are also related to HDR source security and HDR contingency, emergency procedures and processes.

8. Strong Recommendation: Complete a full review of HDR radiation safety instructions and emergency procedures (contingencies) and documentation, led by the RPA and RPS and contributed to by wider MDT. HDR contingency and 'business as usual' applicator removal should be aligned where possible and appropriate to do so.

The performance of the Treatment Control Console (TCC) due to lack of archiving and consequent slow performance is detailed in Recommendation 32.

32. Strong Recommendation: Remove/archive historical data from the TCC and store securely or find an export solution for future patients to be removed.

There are two strong recommendations from a theatre and nursing perspective. The first, Recommendation 47 is regarding the VCC Theatre procedure and guidelines (LocSSIPs) number 36 'WHO Policy' which does not cover the full standards described within NatSSIPs and currently omits step one and five. The second, Recommendation 56, is regarding the provision of bed space for brachytherapy patients, same sex accommodation regulations and requirements for appropriate mitigation.

47. Strong recommendation: the policy should be rewritten to reflect the full process; the LocSSIPs should include all five steps

56. Strong recommendation: Ward areas for the opposite sex to be admitted must be sought. In extreme cases, if this is unavoidable, a risk assessment should be in place along with a reporting system to investigate and track these incidents. Every effort should be made to ensure a private space maintaining patient dignity, for example curtains drawn at all times.

Finally, there is a strong recommendations regarding RAKR. Recommendation 105 relates to how decay factor is calculated. It is local practice at VCC to plan with a ‘standard reference source’, fixing the planned source activity to 10 Ci whereby the final correction for radioactive decay is then made at the Flexitron just prior to treatment based on a ratio of the planned source strength and the current source strength.

105. Strong Recommendation: Consider commissioning the live for-treatment source within the Oncentra Brachy and Oncentra Prostate systems instead of a standard reference source, including incorporation of this into regular source change procedures, in line with recommendations within the dosimetry Code of Practice. The software will then decay the source and this decay can be independently verified. This would also allow the planning system to produce dwell times directly comparable to the Flexitron and remove the need for an intermediate radiographer protocol sheet.

8 List of Abbreviations

AAGBI	Association of Anaesthetists of Great Britain and Ireland
AAPM	American Association of Physicists in Medicine
AfPP	The Association for Perioperative Practice
AP	Advanced Practitioner
ARSAC	Administration of Radioactive Substances Advisory Committee.
BIR	British Institute of Radiology
CCO	Consultant Clinical Oncologist
CE	Conformitè Europëenne – mandatory conformity marking within EU
COSHH	Control of Substances Hazardous to Health
CTVp	Prostate primary clinical target volume
$D_{10\%}$, $D_{30\%}$, $D_{90\%}$ etc.	Dose received by 10%, 30%, 90% etc. volume of a given structure
DICOM	Digital Imaging and Communications in Medicine
DVH	Dose-volume histogram
DVHO	Dose-volume histogram-based optimisation
EMBRACE	Clinical Trial (Image guided intensity modulated External beam radiochemotherapy and MRI based adaptive Brachytherapy in locally advanced Cervical cancer
ESTRO	The European Society for Radiotherapy and Oncology
GEC-ESTRO	Groupe Européen de Curiethérapie (GEC) and the European Society for Radiotherapy & Oncology (ESTRO).
GTV	Gross tumour volume
HASS	High-Activity Sealed Radioactive Sources Regulations
HMSO1974	Health and Safety at Work etc. Act 1974
HMSO1999	Management of Health and Safety Regulations 1999
HR CTV	Cervix high-risk clinical target volume
ICRP	International Commission on Radiation Protection
IRMER	Ionising Radiation (Medical Exposure) Regulations 2017
IRR17	Ionising Radiation Regulations 2017
IU	Intra-uterine
LocSSIP	Local Safety Standard for Invasive Procedures
MPE	Medical Physics Export

MRI, MR	Magnetic Resonance Image, Magnetic Resonance
NaCTSO	National Counter Terrorism Security Office
NatSSIP	National Safety Standards for Invasive Procedures
NHSE	NHS England
NMR	Non-medical referral
NPSA	National Patient Safety Agency
OAR	Organs at risk
ODP	Operating Department Practitioner
PADR	Personal Appraisal and Development Review
PGDs	Patient Group Directions
POA	Pre-operative assessment
RAKR	Reference Air KERMA Rate
RCR	Royal College of Radiologists
RTDS	National Radiotherapy Dataset
SIG	Special Interest Group
SOP	Standard Operating Procedure
SoR	Society of Radiographers
SUI	Serious Untoward Incident
TCC	Treatment Control Console
TG-43	AAPM Task Group 43 dose calculation formalism for brachytherapy
TPS	Treatment Planning System
UKCA	UK Conformity Assessed
US	Ultrasound
$V_{100\%}$	Volume of a given structure receiving 100% of the prescribed dose
VTE	Venous thromboembolism
WHO	World Health Organisation

9 References

1. The High-activity Sealed Radioactive Sources and Orphan Sources Regulations 2005. Accessed July 22, 2022. https://www.legislation.gov.uk/uksi/2005/2686/contents

2. Alexakhin PR, Streffer RC, D Boice Jr GJ, et al. ICRP Publication 97 Prevention of High-dose-rate Brachytherapy Accidents. *Ann ICRP Publ behalf lnternational Gommission Radiol Prot*. Published online 2005. doi:10.1177/ANIB_35_2

3. Health and Safety Executive. Work with ionising radiation. Ionising Radiations Regulations 2017: Approved Code of Practice and guidance. *hse.gov.uk*. Published online 2018. Accessed July 22, 2022. https://www.hseni.gov.uk/sites/hseni.gov.uk/files/L121 Work with ionising radiation_0.pdf

4. NHS England » A just culture guide. Accessed July 22, 2022. https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

5. Davies J, Oliver K, Chatterton S, Rushton D, Davidson S. Delivering Radiotherapy in a Fully Networked Paperless Satellite Department. *Clin Oncol*. 2011;23(3):S35. doi:10.1016/J.CLON.2011.01.417

6. Middleton M, Bradford C, Frantzis J, et al. Paperless and paper-based processes in the modern radiotherapy department. *Radiography*. 2009;15(4):300-305. doi:10.1016/J.RADI.2009.02.002

7. *Radiotherapy Board*.; 2017. Accessed July 22, 2022. https://www.rcr.ac.uk/sites/default/files/paperless_radiotherapy_top_tips_nov2017.pdf

8. NatSSIPs. *National Safety Standards for Invasive Procedures (NatSSIPs)*.; 2015. Accessed July 22, 2022. https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf

9. Vickers R. Five steps to safer surgery. *http://dx.doi.org/101308/147870811X599334*. 2015;93(7):501-503. doi:10.1308/147870811X599334

10. Delivering same-sex accommodation. Published online 2019. Accessed July 22, 2022. https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/05/NEW-Delivering_same_sex_accommodation_sep2019.pdf

11. The Misuse of Drugs (Safe Custody) Regulations 1973. Accessed July 22, 2022. https://www.legislation.gov.uk/uksi/1973/798/schedule/2/made

12. Control of Substances Hazardous to Health (COSHH) - COSHH. Accessed July 22, 2022. https://www.hse.gov.uk/coshh/

13. National Health Service. *Human Factors in Healthcare: A Concordat from the National Quality Board*.; 2013. Accessed July 22, 2022. https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

14. Cave DG, Harrop-Griffiths DW, Harvey DM, et al. Management of severe local anaesthetic toxicity. Published online January 1, 2010. doi:10.21466/G.MOSLAT2.2010

15. Health and Safety at Work etc Act 1974 – legislation explained. Accessed July 22, 2022. https://www.hse.gov.uk/legislation/hswa.htm

16. The Management of Health and Safety at Work Regulations 1999. Accessed July 22, 2022. https://www.legislation.gov.uk/uksi/1999/3242/contents/made

17. Medicines and Healthcare products Regulatory Agency. Managing Medical Devices. *Health Policy (New York)*. 2015;(April):60. Accessed July 22, 2022. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/421028/Managing_medical_devices_-_Apr_2015.pdf

18. What are “Sterile Flight Deck Procedures”? | EASA. Accessed July 22, 2022. https://www.easa.europa.eu/faq/19134

19. Hohenhaus SM, Powell SM. Distractions and Interruptions: Development of a Healthcare Sterile Cockpit. *Newborn Infant Nurs Rev*. 2008;8(2):108-110. doi:10.1053/J.NAINR.2008.03.012

20. Clinical Imaging Requests from Non-Medically Qualified Professionals 3rd edition CLINICAL IMAGING REQUESTS FROM NON-MEDICALLY QUALIFIED PROFESSIONALS. Published online 2021.

21. Position Statement on Non-Medical Referrers - British Institute of Radiology. Accessed July 22, 2022. https://www.bir.org.uk/media-centre/position-statements-and-responses/guidance-for-non-medical-referrers-to-radiology/

22. NHS commissioning » Radiotherapy. Accessed July 22, 2022. https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-b/b01/

23. Bidmead AM, Sander T, Locks SM, et al. The IPEM code of practice for determination of the reference air kerma rate for HDR 192Ir brachytherapy sources based on the NPL air kerma standard. *Phys Med Biol*. 2010;55(11):3145. doi:10.1088/0031-9155/55/11/011

24. Medicines, medical devices and blood regulation and safety: Medical devices regulation and safety - detailed information - GOV.UK. Accessed July 22, 2022. https://www.gov.uk/topic/medicines-medical-devices-blood/medical-devices-regulation-safety

25. Off-label use of a medical device - GOV.UK. Accessed July 22, 2022. https://www.gov.uk/government/publications/medical-devices-off-label-use/off-label-use-of-a-medical-device

26. REGULATION (EU) 2017/ 745 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL - of 5 April 2017 - on medical devices, amending Directive 2001/ 83/ EC, Regulation (EC) No 178/ 2002 and Regulation (EC) No 1223/ 2009 and repealing Council Directives 90/ 385/ EEC and 93/ 42/ EEC.

27. 10 Steps to Cyber Security - NCSC.GOV.UK. Accessed July 22, 2022. https://www.ncsc.gov.uk/collection/10-steps

28. ICRU Report 89, Prescribing, Recording, and Reporting Brachytherapy for Cancer of the Cervix – ICRU. Accessed July 22, 2022. https://www.icru.org/report/icru-report-89-prescribing-recording-and-reporting-brachytherapy-for-cancer-of-the-cervix/

29. Pötter R, Haie-Meder C, Van Limbergen E, et al. Recommendations from gynaecological (GYN) GEC ESTRO working group (II): concepts and terms in 3D image-based treatment planning in cervix cancer brachytherapy-3D dose volume parameters and aspects of 3D image-based anatomy, radiation physics, radiobiology. *Radiother Oncol*. 2006;78(1):67-77. doi:10.1016/J.RADONC.2005.11.014

30. Hellebust TP, Kirisits C, Berger D, et al. Recommendations from Gynaecological (GYN) GEC-ESTRO Working Group: considerations and pitfalls in commissioning and applicator reconstruction in 3D image-based treatment planning of cervix cancer brachytherapy.

Radiother Oncol. 2010;96(2):153-160. doi:10.1016/J.RADONC.2010.06.004

31. Haie-Meder C, Pötter R, Van Limbergen E, et al. Recommendations from Gynaecological (GYN) GEC-ESTRO Working Group (I): concepts and terms in 3D image based 3D treatment planning in cervix cancer brachytherapy with emphasis on MRI assessment of GTV and CTV. *Radiother Oncol*. 2005;74(3):235-245. doi:10.1016/J.RADONC.2004.12.015

32. Radiotherapy target volume definition and peer review – RCR guidance | The Royal College of Radiologists. Accessed July 22, 2022. https://www.rcr.ac.uk/publication/radiotherapy-target-volume-definition-and-peer-review

33. Tanderup K, Pötter R, Lindegaard J, et al. Image guided intensity modulated External beam radiochemotherapy and MRI based adaptive BRAchytherapy in locally advanced CErvical cancer EMBRACE-II.

Brachytherapy Recommendations Action Plan April 2023												
Theme	**ID**	**Recommendation**	**Status**	**Target completion date**	**Delivery Group**	**Evidence**	**Actions Completed**	**Date Closed**	**Actions Remaining**	**Governance - DM group**	**Owner**	**Strong Recommendation**
engagement with improvement	4	Consider training and education in service improvement for team members. There are free courses such as NHSEI Improvement Fundamentals, which provide simple tools and insight	closed	28/02/2023	BOG	BOG agenda/minutes	Discussed at BOG. Reminders issued for all staff to discuss training requirements at PADR's and annual appraisals	01/02/2023		SLT	Head of Brachytherapy	
HASS Regulations and Afterload Security	5	Review access route from the HDR room and control area to any adjacent public areas and consider whether any additional access control (e.g. swipe access or fixed partitioning) is appropriate.	open	30/04/2023	BOG	compliance with CCTV and security audit	Daytime access is under key operated control by radiographers and documented within procedures		Investigate with VCC Estates suitable solutions to increase security via physical barriers to area. Compare site security levels (CCTV surveillance, 24/7security response and on call physics phone cover) with CCC provision. Review Operational Services access to treatment room and all other aspects of source security and staff safety.	SLT	Service planning manager Business Continuity Head of Brachytherapy	
Radiation Safety and Contingency Rehearsal	9	All staff groups involved in the care of HDR patients should be trained against documented emergency procedures and be clear on their roles and responsibilities	open	30/04/2023	BOG	Operational Procedure Training logs and schedule monitored by BOG	Transferred to BOG 01-02-23. Staff training logged and schedule monitored by BOG		BOG to identify remaining emergencies and training/schedules required. Time to be identified for all staff involved to train in required procedures Induction training pack under construction (BOG Action BOG 24)	BOG	Head of Brachytherapy	

Radiation Safety and Contingency Rehearsal	10	All staff should be given time to periodically rehearse contingencies, including the removal of applicators as described in the SOP, and this practice regularly audited	open	31/05/2023	BOG	Operational procedure and BOG minutes/audits	Periodic rehearsals commenced for source stick emergencies. Time identified for all staff involved to train in required procedure. RT Brachy Advanced Practitioner removal training schedule monitored by BOG.		Remaining contingency rehearsals to be identified (BOG Action log BOG 23b) and scheduled	BOG	Head of Brachytherapy	
Radiation Safety and Contingency Rehearsal	12	Purchase additional electronic personal dosimeters that can be worn during contingency procedure including spares in the event of a malfunction	open	30/04/2023	BOG	Transferred to BOG 22-03-23 BOG Agenda/minutes/action log	Loan EPDs from RPS until purchased		Purchase of monitors and return of loan monitors - quotes under review RT BAPs Action Log BOG 44	BOG	Head of Brachytherapy	
Document Control and Quality Management System	13	A full review should be carried out of the policies and procedures available within the quality system and gap analysis performed across the service to identify missing areas of documentation	open	30/04/2023	BOG	BOG Agenda/minutes Mar 23/ action log/ list to be compiled	Current theatre policies under review. RT: current reviewed, bar 1 outstanding. 3US WI under constructions Physics list under construction.		Develop list of all relevant policies and procedures . Review and gap analysis for all area. schedule for policy review to be completed at next BOG -April 23 BOG Action 25 &26	BOG	Head of Brachytherapy	
Document Control and Quality Management System	14	Outstanding draft policies and procedures should be approved in a timely manner, and staff engaged with updates and process changes as part of business as usual	open	31/12/2023	BOG	Qpulse	Reviewed exiting processes and procures		ensures process in place for all specialties prior to new Qpulse being implemented	BOG	Head of Brachytherapy	
Document Control and Quality Management System	15	Investment should be made and a robust system implemented to anticipate quality system updates rather than to be reactive to overdue deadlines	open	31/03/2024	Trustwide Adoption Group	Secure Document Store	Consensus Trust QMS / document management system to be extended and utilised in Brachytherapy. JP to escalate through RT physics		Trust procurement process for Qpulse replacement ongoing	SLT	Head of Brachytherapy	

Document Control and Quality Management System	16	Consider a single electronic source for storage of policies and procedures, such as Q-Pulse, which can automate review reminders, track change requests and capture distribution and acknowledgement of new or updated protocols and work instructions	open	31/03/2024	Trustwide Adoption Group	Secure Document Store	Consensus Trust QMS / document management system to be extended and utilised in Brachytherapy. JP to escalate through RT physics		Trust procurement process for Qpulse replacement ongoing	SLT	Head of Brachytherapy	
Document Control and Quality Management System	17	Consider consistent evidencing of clinician (practitioner) authorisation for clinical protocols	open	31/03/2024	Trustwide Adoption Group	Secure Document Store	Consensus Trust QMS / document management system to be extended and utilised in Brachytherapy. JP to escalate through RT physics		Trust procurement process for Qpulse replacement ongoing	SLT	Head of Brachytherapy	
Line Management/ Reporting Structure	23	Review the staff reporting structure, consider redesign and provide clarity over reporting lines	open	30/09/2023	Project Board	BOG minutes	Recommendation considered. Clarity exist for line management reporting as per contracts. Professional accountability remains as per professional group.		A consensus needs to be reached on service model, giving consideration to alternative models.	SLT	Head of Brachytherapy	
Efficiency & Workflow	26	Perform a comprehensive review of the way the service is delivered to ensure the principle of having the right staff with the right training for the right task at the right time is embedded across the service	open	30/06/2023	BOG/BPG	D&C plan BOG minutes and IMTP reporting	Workforce and patient pathway planning workshops underway		D&C plan and forecasting to be developed service delivery model to be reviewed in light of D&C plans	SLT	Head of Planning and Performance Head of Brachytherapy	

Efficiency & Workflow	27	Perform a comprehensive review of all processes and pathways to identify barriers and bottlenecks. Translate this into Project & action plans initially looking for quick wins and small improvements that can be delivered easily. In turn, this will create the momentum and engagement for larger scale improvements that may be required, plus efficiency release from within the team to support larger improvements	open	30/06/2023	BOG/BPG	D&C plan BOG minutes and IMTP reporting	Workforce and patient pathway planning workshops underway		linked to #6	SLT	Head of Planning and Performance Head of Brachytherapy	
Efficiency & Workflow	31	Review checking processes to ensure both radiographer checks are completely independent and both radiographers cross check the same data sources	open	31/03/2024	BOG	Clinical Audit Schedule & BOG minutes	checking processes reviewed by Head of Service		audit to be undertaken of new practice	Heads of RT Treatment and RT Clinical Governance lead	Head of Brachytherapy	
Workforce	38	Explore and implement medical succession planning options including developing own talent in current medical workforce	open	30/09/2023	BOG	Documented succession plan available	Email correspondence with Clinical Director		Discussion required regarding option for extended medical roles	Clinical Director	Head of Brachytherapy	
Workforce	39	Consider the role of consultant radiographers to support both urology and gynae services	open	30/09/2023	BOG	Consultant radiographer Role for Urology and Brachytherapy are included in longer term workforce plan for radiotherapy	reviewed role of consultant radiographers		Consensus between medics and non-medical workforce on extended roles	SLT	Head of RT / RSM	

Workforce	40	Consider adopting prescription protocol for MPEs to authorise Brachytherapy exposures in accordance with written practitioner guidelines	open	30/09/2023	BOG	Email agreement	recommendation reviewed. Decision to consider as part of next round of IMTP planning 2023/24	24/04/2023		Section Managers Assurance Meeting	Head of Brachytherapy	
Workforce	41	Continue to train physics staff on a regular basis, in particular with a view to expanding MPE support	open	30/09/2023	BOG	Agreed model and training plan.	recommendation reviewed. Decision to consider as part of next round of IMTP planning 2023/25	24/04/2023		Section Managers Assurance Meeting	Head of Brachytherapy	
Workforce	42	Develop a clear plan of workforce requirements; this should be robust, have in-built succession planning, and should include a training and development framework	open	30/09/2023	BOG/BPG	Workforce plan available and report through VCC IMTP meetings	Workforce and patient pathway planning workshops currently underway to review the staff currently within the pathway.		Succession plans will be developed in all areas where required including review of possible options including Consultant Radiographer development. 1-5 year plan linked to ID 26	SLT	Head of Brachytherapy	
Workforce	45	Review staffing allocation against guidelines	open	30/09/2023	BOG	D&C plan			linked to #26	SLT	Head of Planning and Performance Head of Brachytherapy	
Workforce	46	Explore service redesign within current staffing model to explore release of theatre capacity	open	30/09/2023	BOG	D&C plan	VCC service improvement staff tasked to review theatre utilisation and develop expansion options		linked to #26	SLT	Head of Planning and Performance Head of Brachytherapy	
Nursing & Theatre	50	Regular independent peer audit to include observation and documentation of the full five-step process	open	30/04/2023	BOG	Transferred to BOG 01-02-2023 BOG agenda/minutes/audit schedule	Incorporated into clinical audit plan for service . Clinical audit on BOG agenda (BOG action log 48)	30/04/2023		Head of Integrated Care	Theatre Nurse Lead	
Patient Pathway Management	51	Create additional planned gynae capacity via service redesign with the existing workforce and equipment or via a business case for additional resource	open	30/06/2023	BOG/BPG	D&C plans			as #26	SLT	Head of Planning and performance Head of Brachytherapy	

Patient Pathway Management	52	Take a collaborative approach to scheduling based on an agreed set of priorities that consider the whole MDT	open	30/06/2023	BOG/BPG	Collaborative working evidenced via emails and BOG minutes D&C plans	Collaborative approach to working in place. Prioritisation linked to D&C planning	01/02/2023	as #26	SLT	Head of Planning and performance Head of Brachytherapy	
Medicines Management	61	COSHH risk assessments to be developed, if not already in place	open	30/04/2023	BOG	current risk assessments			Review current COSHH risk assessments in conjunction with Operational Services - H&S lead	BOG	Service Planning Manager Business Continuity Theatre Lead	
Training & Professional Development	63	Develop competency documents for all staff groups and method for ongoing competency updates	open	30/09/2023	BOG	Competency documents	Physics: Competencies for operators are reviewed March 23. Training packs redesigned.		Theatres: Competency framework will be developed RT: All training documentation and competency assessments provided to KF to incorporate into exemplar training plans Physics Checker/MPE training for review April 23	BOG	Service leads	
Training & Professional Development	66	Full multidisciplinary team to be involved in regular scenario based contingency practices for removal of applicators, resus, local toxicity, bleed, fire evacuation. Attendance should be documented	open	30/09/2023	BOG	Competency documents			review business continuity plan	BOG	Service Planning Business continuity Head of Brachytherapy	
Miscellaneous	70	Sterile probe cover cut with non-sterile scissors, non sterile gloves used to perform scan. Risk assessment to be in place if this is acceptable practice, or do not cut the probe cover and scrub in and use sterile gloves instead	open	01/05/2023	BOG	Risk assessment or BOG minutes (BOG Action log 51)	Staff training and awareness of fields in place . Added to BOG Agenda and action log 51		Risk assessment - brachy APs sonography & JW for issue	BOG	Sonographer Brachy AP/ Theatre Lead	

Miscellaneous	72	Staff to work in another area when not directly involved in the procedure	closed	31/03/2023	BOG/BPG	Establishment review	Recommendation reviewed. Review of nurse establishment complete and additional posts recruited. On the rare occasion there are no patient treatments planned the agreed business process is for staff to report to their line manager for reallocation of duties	31/03/2023		Head of Nursing	Theatre Lead	
Miscellaneous	75	Visitor risk assessment should be in place and available in accordance with the Health and Safety at Work Act and the Management of Health and Safety at Work Regulations	open	Transferred to BOG Apr-2023	BOG	RA and SOP BOG Action 70	The SOP and risk assessment are current and up to date We have a 'Visitors to Theatre policy' clearly displayed at the Theatre entrance and can be found on clinical intranet.			BOG	Theatre Lead	
Miscellaneous	76	Ensure the Trust's medical devices policy is fit-for-purpose and implemented	open	BOG April 2023	BOG	Policy. Governance, BOG Mar 23 agenda/minutes/audit schedule	JR and JMcC contacted and advise given. Theatre/ RT/ Physics med devices inventory created		JR/JP to review on 20th April 2023	Quality and Safety	Medical Devices Lead	
Miscellaneous	77	Perform monthly out medical devices checks and audits	open	Transferred to BOG 01-02-23	BOG	Transferred to BOG 01-02-2023 BOG agenda/minutes/audit schedule	All anaesthetic medical devices are controlled by 'RAS' Respiratory and Anaesthetic support. Daily documented checks in theatres supported by C&V medical devices who undertake audits All HDR equipment is quality assured within the RT Physics ISO9000 system		JR to assist audit set up	Medical Devices Lead	Head of Brachytherapy	

Patient Management Pathway-Radiotherapy (VVBT / Skins)	78	Review both services from operational perspective; how they work together, resource requirements, and map clinician availability and job plan to treatment sessions	open	31/12/2023	BOG	Service delivery model Workforce plan job plans	Initial mapping of resources and staff availability in progress.		Mapping of resources and staff required to meet sustainable service delivery model. Job planning for medical staff required Further review of A4C staff due to staff changes	SLT	Eve Gallop-Evans RSM	
Patient Management Pathway-Radiotherapy (VVBT / Skins)	79	Perform capacity and demand review then work out appropriate staffing allocation across the working week	open	30/06/2023	BPG	Demand and Capacity Plan Workforce plan	Mapping of treatment sessions and capacity completed		Demand and capacity plan to be developed	SLT	Head of Planning and Performance RSM	
Patient Management Pathway-Radiotherapy (VVBT / Skins)	81	Perform regular and ongoing reviews of staffing levels and workforce plans and submit business cases to reflect the staffing requirements for the workload	open	n/a	BPG/BOG	demand tracked via elekta system		n/a	service delivery model to be developed in response to D&C planning	SLT	Head of Planning and Performance Head of Radiotherapy physics	
Patient Management Pathway-Radiotherapy (VVBT / Skins)	82	Consider electronic rostering and rosters being shared among teams so teams can see when other staff will be available	open	30/09/2023	BOG Medical Directorate	Annual leave rota in TEAMS	Annual leave rota for radiation services in Teams and updated weekly	31/08/2023	annual leave for medics to be shared with Radiation services	SLT	Directorate Manager Medics RSM	
Demand & Capacity Modelling	83	Ring fence adequate resource to review activity over the last five years and use modelling tools to predict demand for next five years	open	30/06/2023	BPG/BOG	D&C plan			service delivery model to be developed in response to D&C planning and forecasting	SLT	Head of Planning and Performance Head of Brachytherapy	
Demand & Capacity Modelling	84	Revisit modelling annually to ensure it is reflective of service provision	open	31/12/2023	BPG/BOG	D&C plan	BOG meeting monthly to discuss demand BPG monthly performance meetings		Annual review as part of IMTP forecasting informed through monthly trends	SLT	Head of Planning and Performance Head of Brachytherapy	

Demand & Capacity Modelling	85	Run automated reports (if possible) prospectively and retrospectively and use this to inform ongoing service provision and redesign	open	31/03/2024	IRS/Brachy implementation group	IRS data reports			IRS/Brachy implementation group to be established Analysis system and reporting to be IRS output	SLT	Head of Brachytherapy	
Demand & Capacity Modelling	86	Embed capacity and demand modelling and workforce planning as they are dependent on each other	open	30/06/2023	BPG/BOG	D&C plan	manual data set available D&C discussion at monthly brachy meeting		D&C plan and forecasting	SLT	Head of Planning and Performance Head of Brachytherapy	
Communication & Collaboration	87	Radiographer involvement with the full patient journey should be promoted including presence within theatre and involvement in the insertion procedure	open	31/12/2023	BPG/BOG	Fully trained radiographers and training protocol completed			Develop agreed training plan for radiographers Identify trainers undertake training	SLT	Clinical Director RSM	
Communication & Collaboration	88	Regular contingency rehearsal should be carried out involving all members of the MDT as described in section 3.3	open	31/05/2023	BOG	Duplicate of #10	Duplicate of #10, 66,68		see #10			
Training & Professional Development	93	Protect time for training and writing and updating SOPs should be allocated by factoring this into the workforce plans and job plans for the radiographers	open	31/12/2023	BOG Medical Directorate	Job plans	draft job plan for radiographers with enhanced SPA requirements is complete		to be reviewed alongside medical job plans	SLT	Eve Gallop-Evans RSM	
Training & Professional Development	94	Radiographers should not only be trained to check and deliver treatment but should also be educated, have understanding, and be involved in the insertion, planning process and delivery of treatment	open	31/12/2023	duplicate #87	duplicate #87	duplicate #87	duplicate #87	duplicate #87	duplicate #87	duplicate #87	

Training & Professional Development	95	Radiographers should be integrated further into the Brachytherapy MDT: they have a wealth of knowledge and skill and are versatile, and this will cement their underpinning knowledge	open	30/09/2023	BOG Medical Directorate	job plans to include MDT			Discussions with Medical Directorate required to agree consensus on service delivery model	RT Clinical Governance	Eve Gallop-Evans RSM	
Training & Professional Development	96	A Brachytherapy training and competency package should be developed to include background knowledge of Brachytherapy Principles, planning of procedures, and pre-treatment pathway. Formal Brachytherapy training is limited to a small number of M level modules and the ESTRO teaching course. Radiographers should actively collect and share resources to supplement learning	open	Transferred to BOG	BOG	RT Line Management development and training records,	Requirements were reviewed Oct 2022.	31/05/2023	Knowledge of planning to be addressed. Emailed HP and CT for closure response	RT Clinical Governance	RSM	
Training & Professional Development	98	Consider further role development and role extension for rotational Band 6 Brachytherapy radiographers to help support the service to be more robust. This could include HDR contingency training, insertion of vault applicators, gynae ultrasound, and dilator counselling with appropriate underpinning policy	open	30/09/2023	BOG/ BPG	qualified ultra-sonographer	Rotational rads currently have the opportunity to complete competency in Vault and IGBT removals and dilator counselling. There is now a subsequent insertions training package also available for VVBT which the APs have now completed.		Discussion on intended direction of travel for Trust Ultrasound training: need to identify training delivery resource and agree timeframe	SLT	RSM	

Training & Professional Development	100	When implementing further advanced practice responsibilities ensure there is more than one member of staff trained to cover planned/unplanned absences	open	30/09/2023	BOG/BPG	Line Management development and training records,	Staff now recruited into AP posts within Radiotherapy Training is funded and backfill supported through appointment of Locum Radiographer with Sonography skills (in place until all relevant competencies achieved)		Discussion to take place regarding Trust intention and resilience planning single handed practitioner in physics - need to determine appropriate service model single handed medic gynae - need to determine service model	RT Clinical Governance	Eve Gallop-Evans RSM	
Ultrasound	102	Urgently develop an in-house clinical skills training package for ultrasound Brachytherapy to expedite training in a timelier manner and to train more staff to cover the service. Consider then supplementing it with M level module when service is more robust	open	31/08/2024	BOG	training package developed training records	Currently no training programme in Wales Discussion with Clatterbridge re: providing training, unable to do so due to capacity issues Discussion taken place with HEIW (August 2022) as no ability to provide in-house training		HEIW develop training package and robust QA processes and will need to deliver the training - anticipated timeframe 2years	RT Clinical Governance	RSM	1
Ultrasound	103	Within advanced practice frameworks, policies, and training, ensure that services have more than one trained member of staff before the service can operate. This will prevent future single points of failure	open	30/09/2023	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	duplicate #98 #102	

Digital Security & Best Practice	109	Consider individual log-ins designed to minimise the opportunity for unauthorised access	open	30/05/2023	Section Managers Assurance Meeting	workstations closed when unattended Access to patient planning restricted to Nadax log-on All Oncentra Brachy users have individual, password protected accounts. All operators (planners and checkers) involved in the plan production are recorded for	requirement for individual log-in reviewed in line with recommendation		Risk assessment needs to be completed to document decision	Section Managers Assurance Meeting	Lead Brachytherapy MPE	1
Treatment Planning (Prostate)	117	The calibration measurement should be checked independently by a second person	open	30/05/2023	Section Managers Assurance Meeting	Robust system in place to confirm calibration via independent method. checkers notified to request second check. Operators trained risk assessment in place	review of practice undertaken to confirm compliance with recommendation		to be included in WIs	Section Managers Assurance Meeting	Lead Brachytherapy MPE	
Treatment Planning (Prostate)	123	Free lengths - Consider this check being done independently by a pair of scrubbed radiographers, one to the initial measure and one to check. Any discrepancies can be resolved prior to the plan being produced or indeed delivered. Needle measurements are also then independent to those planning the treatment	open	30/05/2023	Section Managers Assurance Meeting	RA on BOG agenda	way of working reviewed and confirmed in light of the recommendation.		Risk assessment to be completed to confirm management of variation - to be signed off at next BOG	Section Managers Assurance Meeting	Lead Brachytherapy MPE/ CCO	
Treatment Planning (Prostate)	124	Needle positions should be checked against the underlying ultrasound image and adjusted as necessary so final planned distribution matches delivered distribution as closely as possible. The team would need	open	30/04/2023	Section Managers Assurance Meeting	Risk assessment confirm our position and decision to reject recommendation	Reviewed recommendation locally in discussion with Clatterbridge Clatterbridge to adopt our process.	30/04/2023		Section Managers Assurance Meeting	Lead Brachytherapy MPE/ CCO	

		to ensure that the superior end of the needle is included in scan to achieve this										
Treatment Planning (Cervix)	131	Review employers scope of entitlement procedure for duty holders under IRMER and consider whether current practice with respect to operator roles is represented adequately	open	10/05/2023	Section Managers Assurance Meeting	Qpulse record	review of entitlement procedures underway and reported to RPSG		response to outcome from HIW review	Section Managers Assurance Meeting	Lead Brachytherapy MPE	
Treatment Planning (Cervix)	132	Consider introducing Venezia vaginal caps to provide additional rectal dose sparing in cases where they may be clinically suitable	open	31/12/2023	Section Managers Assurance Meeting	Qpulse record and SOP	Applicator project established		Consider as part of applicator replacement project. Pt comfort & emergency procedure impact will need to be considered.	Section Managers Assurance Meeting	Lead Brachytherapy MPE/CCO	
Treatment Planning (Cervix)	133	Consider aligning prescribing practice to ICRU89 recommendations, in particular the use of HR CTV D90%	open	31/03/2023	Section Managers Assurance Meeting/BOG	outcome from audit			Audit to be undertaken of current practice - paused due to resource issues	Quality and Safety	Lead Brachytherapy MPE/CCO	
Treatment Planning (Cervix)	134	Consider implementing EMBRACE II optimal constraints for targets and OARs to guide dose optimisation and alert the clinicians where a particular structure maybe outside the optimal range	open	30/04/2023	BOG	Wis SOP	Project ongoing to adapt to VCC requirements, ensure necessary QA in place and implement in to clinical workflow		Consensus between medics and non-medical workforce on implementation of trial findings required.	Quality and Safety	Lead Brachytherapy MPE/CCO	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT AND SUPPORTING ANALYSIS FOR THE PERIOD TO MARCH 2023

DATE OF MEETING	25/05/23

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance Wayne Jenkins, Assistant Director, Sarah Richards, Interim General Services Manager
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT / Performance Review	19th April 2023	**NOTED**
VCC SLT / Performance Review	20th April 2023	**NOTED**
EMB	2ND May 2023	**APPROVED**
QSP Committee	16th May 2023	**APPROVED**

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

1. VELINDRE NHST PERFORMANCE MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD APRIL TO MARCH 2023

1.1 This paper reports on the yearend performance of our Trust for the period April to March 2023, against a range of national targets, best practice standards and locally identified outcome measures for our cancer and blood and transplant services, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance.

1.2 The Executive Summary, in Section 2, gives a high-level overview, drawing attention to key areas of performance across the organisation as a whole, highlighting the interconnection between many of these areas. The Performance Management Framework (PMF) Scorecards, in Section 5, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.

1.3 **Navigating our PMF Performance Report**

Each QSF domain in the PMF scorecards is populated with a range of KPIs for VCC and WBS services plus a range of KPIs for Support Services functions. Performance is assessed as either 'within standard' ✓ or 'outside standard' ✗ against any particular target or best practice measure for the current month, plus an assessment of the 15 month 'rolling data trend' seen, as either 'improving' ↑ or 'stable ➔ or fluctuating ↑↓ or 'declining' ↓ The actual performance for each KPI is measured against a national standard or local stretch target on a monthly, quarterly or annual improvement basis.

Each KPI is supported by data that explains the current performance, using wherever possible, Statistical Process Control (SPC) Charts or other relevant information to allow the distinction to be made between 'natural variations' in activity, trends or performance requiring investigation. The scorecards incorporate hyperlinks to supporting KPI data, enabling switching from the high-level position to detailed analysis and back.

1.4 Individual VCC and WBS PMF reports were presented initially to the respective VCC and WBS Senior Leadership Teams (SLT), followed by the Chief Operating Officer Divisional Performance Review meetings.

1.5 During 2023/24, the PMF Development Project Group will look to evaluate potential Business Intelligence solutions that automate KPI collection, analysis and reporting, and approach potential benchmarking partners for both tertiary cancer and blood services.

2. VELINDRE NHST PERFORMANCE REPORT EXECUTIVE SUMMARY TO MARCH 2023

The following paragraphs provide a high-level executive summary of our Trust-wide performance against key performance metrics through to the end of March 2023 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2.1 Cancer Centre Services Overview

Targets were met for Pressure Ulcers, Falls, SEPSIS, Healthcare Associated Infections and both SACT waiting times. Targets not met for Radiotherapy and Therapies waiting times, Hospital Acquired Thrombosis and Delayed Transfers of Care.

There have been a number of changes introduced simultaneously within the cancer service for the planning and management of radiotherapy treatment. This includes digital systems, processes and work flows for radiotherapy through the Digital Health and Care Record (DHCR) Project, alongside changes in the national Welsh targets for time to treatment for radiotherapy (RRTT). These new targets simultaneously also defined new categories of patient treatment intent for radiotherapy.

While each of these activities was separate and planned, due to the operational changes, they had to be aligned and as a result there were a number of interdependencies. We are now in the period of bedding in for the use of the DHCR system as well as in the early phases of adoption of new work flows in treatment pathways for reaching the RRTT. Furthermore the shortening of target treatment times required additional capacity to be created to bringing forward the cohort of patients in the system to achieve the new timings.
The definition of the new Radiotherapy Time to Treatment targets (COSC) and the changes from the previous JCCO targets are outlined below.

The revised NHS Wales Radiotherapy Priority Definitions are as follows:

- Emergency – will include patients with Spinal Cord Compression, Superior Vena Cava Obstruction, severe haemorrhage/haemoptysis and stridor
- Urgent – Symptom Control – will include patients with pain and bleeding. These treatments are expected to be delivered with simple treatment fields.
- Scheduled – will include all non-urgent palliative patients and all patients treated with radical intent without an elective delay.
- Elective Delay - patients should be reported separately from ‘Scheduled’ patients and have an Earliest Clinically Appropriate Date (ECAD) to start Radiotherapy.

Comparison of the previous JCCO and the new Radiotherapy Time to Treatment Targets (formerly COSC)

	JCCO Good Practice	Maximum acceptable	COSC 80% optimal	100% mandatory
Emergency	24hours	48hours	24hours	48hours
Urgent symptom control	-	-	48 hours	7 days
Palliative	48 hours	14 days	-	-
Scheduled	-	-	14 days	21 days
Radical	14 days	28 days	-	-
Elective delay	-	-	7 days	14 days

These RRTT changes are in two phases with ambition to reach 100% of all patients in each category and a further stretch target to treat 80% of patients within a shorter time period in a continuous improvement approach.

Since the beginning of January 2023, all radiotherapy bookings have been made with the intent of meeting the new target times to treatment. This change seeks to shorten the time to treatment from the previous targets, changes the categories of treatment and introduces a new target for patients who have to have other interventions prior to their radiotherapy (Elective Delay). Work is being undertaken across the entire patient pathway to streamline the working processes and shorten the pathway. This will continue to be progressed, making incremental changes to improve performance against the new targets. The implementation of the new integrated radiotherapy system (IRS) and the new machines and systems that brings will also contribute to our ability to streamline our pathways. Work is ongoing to scope the trajectory and anticipated improvements in meeting these targets.

Meeting the new targets requires additional capacity to be secured to bring forward the current cohort of patient. The team have been working hard to bring forward additional capacity across the service to bring forward patients (from a 28day target to a 21day target) with active clinical prioritisation of patients using national guidelines. Operational working hours have been extended wherever possible to accommodate additional capacity and responsive dynamic management of capacity is being undertaken to bring forward treatment times as we experience variations in demand on a daily and weekly basis.

A Radiotherapy Capacity Management group has been established. A clear activity plan is being developed to address the ongoing requirements for additional capacity and address the increasing need for more complex planning for patients. The action plans will address the pathway within the radiation services teams and also across other clinical teams including medical colleagues and medical physics that play a role in the pathway. This group will report through Velindre Cancer Services Business Planning Group and on to the

Senior Leadership Team. A briefing session on the work to achieve the new targets will be provided in a forthcoming Board Development Session.

The validated performance for March is provided in this report and the figures show highlight the current progress. A comparison has been calculated against the previous JCCO targets so that assurance can be provided on current service while we reach towards the new targets.

Performance is at 79% for March the previous target for patients on the Scheduled pathway and 100% against the Urgent pathway.

Where there is not sufficient capacity to enable new treatment times to be met, the clinical prioritisation means that all those patients who cannot be treated within the new timescales are patients that are of low risk of harm. For example, urology patients who are receiving hormone treatment while awaiting radiotherapy, although we recognise that any waiting time impacts on patients. Harm reviews are undertaken where there are breaches against the previous JCCO target, however there are currently clinical discussions taking place on the appropriate harm review initiation for the new targets.

Due to data system changes which have occurred because of the transition to the new data warehouse (following implementation of the Digital Health and Care Record - DHCR) and a requirement for a full rebuild of the data warehouse to accommodate reporting functionality for the new RRTT - data remains unavailable for the period November to January 2023. This is because the simultaneous new warehouse provision and move to the new metrics mean that the system is unable currently to produce either standard JCCO (previous reporting metrics) or RRTT patient lists for the transition period. This means that there is no data available that could be usefully validated to produce a comparative performance metric. This does not mean however that patients are not being tracked and monitored as they progress through the treatment pathway. Information on the safeguards has been outlined above.

The introduction of the new Carepath system as part of the Integrated Radiotherapy Solution Programme will be a step forward in enabling the automation of the pathway data. This will enable data points step by step through the treatment pathway. Carepath offers a streamlined process which identifies when individual tasks are achieved within specified and agreed targets, and reporting on performance against the radiotherapy pathway targets will become available. While this system will be in use from the start of the use of the new LINAC in June, the development of analytics and dashboards will be completed in late autumn 2023, all of which will support ongoing continuous improvement.

2.2 Welsh Blood Service Overview

2022/23 has been another challenging year for WBS, however, the service has continued to successfully maintain the supply of blood and blood products to the patients of Wales throughout. Whilst we have had to rely on minimal support from other UK blood services, this has been outweighed by the mutual aid we have provided. In particular, assistance has been provided to Northern Ireland in terms of both red cells and ongoing advice around collection planning and donor engagement techniques.

WBS have continued to perform extremely well across the board throughout 2022/23, despite difficult operational conditions, including but not limited to strike action, COVID restrictions, extreme weather and additional bank holidays. We have ended the year in a stable and strengthening position, which has left us well placed as we enter the 2023/24 financial year.

All clinical demand was met in March. At 96% quality incident investigations closed within 30 days continues to exceed target (90%). There were no reportable events submitted to regulators and no Serious Hazards of Transfusion (SHOT) incidents reported during the month.

At 95% donor satisfaction continues to remain above target. In March, 7,465 donors were registered at donation clinics with 9 concerns (0.01%) reported within this period. No formal concerns were raised and the 9 informal concerns were managed within timelines as ‘early resolution’.

Collection efficiency failed to meet target in March. Contributory factors include the cancellation of clinics due to issues at clinic venues and reduction in venue capacity due to short term staff sickness.

Reference Serology turnaround performance failed to meet the 80% target in March at 70%. All time critical requests were prioritised and completed on time maintaining safety of clinical care. Current performance is due to continued staff sickness, vacancies combined with continued high levels of testing requests from health boards. Additional workforce is now in place and sickness levels are starting to improve, however, the training programme for new recruits will take time to embed.

Antenatal –D & -C quantitation was also just below the 90% target at 83% for the quarter. This was due to a failure to meet target for one month attributed to multiple staff absences. Team resilience is being reviewed to ensure reporting timescales can be met going forward.

All clinical demand for platelets was met representing a strong performance against this metric, however, platelet wastage continues to be above target at 20% (target 10%). Despite not meeting target, the overall number of time expired platelets reduced to the lowest numbers this quarter. The main contributory factor is high variability in demand over the month. A Platelet Strategy project will be established in April 2023 to co-ordinate the work of the two Task and Finish Groups that were convened following the platelet review that took place in November 2022 and other related work programmes in Clinical Services.

The service has over performed against the annual recruitment target for apheresis platelet donors which is testament to the efforts of the collections and recruitment team throughout the year. The number of new blood donors recruited in the financial year did not meet annual target (6,478 against a target of 11,000) by the end of March. This was due in the main to requirements to intensify the appointment management by donor blood type throughout a prolonged O positive and O negative blood shortage blue alert, lasting from March 2022 to August 2022 and delays in returning to educational settings.

Whilst we were not able to meet the annual target for new bone marrow volunteers, performance has been increasing month on month since January 2023, with swab kit returns at a record high at the end of March and conversion rates on donor session showing an upward trend. The number of new donors recruited to the Welsh Bone Marrow Donor Registry (WBMDR) was 320 in March, just below the target of 333, and the highest number this financial year. The conversion rate of eligible blood donors increased again to 30% and swab kits returns were at a record high of 87 (an increase of 30 from February). The Recovery Plan continues to focus on Schools/College/University engagement programme, marketing campaigns aimed at existing donors and engagement with external marketing companies to explore wider recruitment opportunities.

The total stem cells collected in March was 6 (6 additional collections were cancelled in March due to patient reasons). The total stem cell provision for the service was 11 (6 collected and 5 imported for Welsh patients). The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment.

2.3 Workforce and Wellbeing

The key workforce risk for the Trust is the availability of skilled people to provide services and how we support their wellbeing while in the workplace. Trust wide sickness absence data continues to remain high month on month with the current cumulative absence at 6.22% to March 2023 still above the Welsh Government Target of 3.54%. Winter cold and flu viruses have resulted in short-term sickness, throughout the Trust. A raft of wellbeing interventions and actions are taking place across the service.

Trust wide PADRs this month is at 73% and there are ongoing interventions to support managers in completing reviews following the implementation of the All Wales Pay Progression Policy. Statutory and Mandatory training remains above target at 87% and has been consecutively on target for the whole year to March 2023.

2.4 Nursing and Quality

The Trust's Quality & Safety Framework is approved and the Integrated Quality & Safety Governance Group has been established and monthly meeting being held. The Divisions will need to develop Service level Quality and Safety metrics and these to be included within the Performance Management Framework. Corporate and Divisional Quality Hubs are in the process of being established. The Trust's Nursing Standards have been approved and launched.

2.5 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (95%) and 'Your Velindre experience?' (82%) both set against a 95% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 95% that continues to meet the target.

2.6 Finance

The overall position against the profiled revenue budget for 2022-23 was £0.064m underspent. During the period the Trust received full funding towards the temporary increase in Employers NI, the increased energy costs above baseline due to energy price inflation and Covid response costs.

The overall Capital programme achieved the Trust CEL for 2022-23 by reporting a spending of £27.758m against a CEL allocation of £27.760m.
Draft PSSP performance for the Trust was 95.33% against a target of 95%, with the Core Trust excluding NWSSP also achieving 95%.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
	Quality and Safety considerations form an integral part of IMTP 2022/23 to 2025/26 plans and PMF to monitor and report on progress against our strategic objectives
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	VUNHST IMTP 2022/23 to 2025/26 plans must be delivered within the Trust's financial envelope

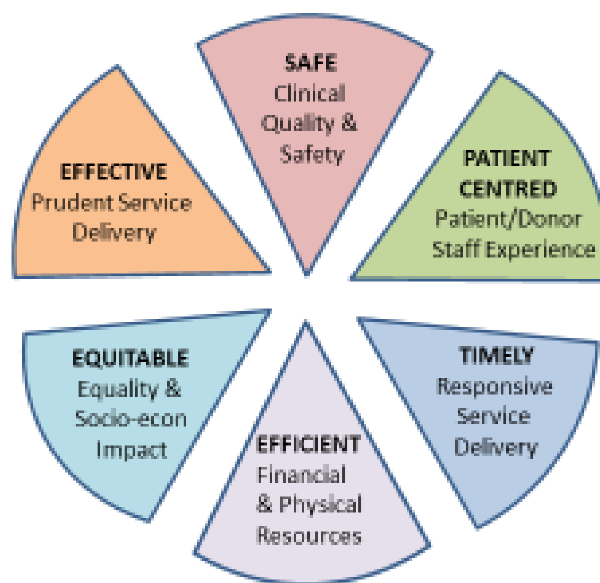
4. RECOMMENDATIONS

4.1 The Trust Board is asked to **APPROVE** the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 3.

4.2 The new style PMF Performance reports will continue to be developed by the PMF Project Group, taking account of suggested changes and ensuring ownership at all levels and full engagement with both Independent Members and CHC representatives.

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework



Trust Board Scorecard as at March (Month 12) 2022/23

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 12 (March 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	85%	85%	87%	✓	↑	WOD.19
Safety	Number of VCC Inpatient (avoidable) falls	National	Monthly	1	0	0	✓	→	KPV.02
Safety	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	0	0	2	✗	↓	KPV.07
Safety	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
Safety	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	0	0	0	✓	→	KPV.01
Safety	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	3	0	0	✓	↓	KPI.30
Safety	Carbon Emissions – carbon parts per million by volume	National	Annually	TBA	TBA	TBA	✓	→	EST.06
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	0	0	1	✗	→	KPV.05
Effectiveness	% Demand for Red Blood Cells Met	Best practice	Monthly	102%	100%	104%	✓	↑	KPI.04
Effectiveness	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.08%	Max 1%	0.02%	✓	↑	KPI.26

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 12 (March 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
	% Time Expired Platelets (adult)	Local	Monthly	16%	Max 10%	20%	✗	↑↓	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	1	7	6	✗	↑	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.31%	3.54%	6.22%	✗	↓	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	69%	85%	73%	✗	↑↓	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	N/A	85%	95	✓	→	KPV.11
	% Donor Satisfaction	Local	Monthly	96%	95%	95%	✓	↑	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100	✓	→	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	100%	✓	→	KPI.03
Timeliness	% Patients Beginning Radical Radiotherapy Within 28 days (JCCO)	National	Monthly	87%	98%	86%	✗	↑↓	KPV.27
	% Patients Beginning Palliative Radiotherapy Within 14 days (JCCO)	National	Monthly	79%	98%	86%	✗	→	KPV.18
	% Patients Beginning Emergency Radiotherapy Within 2 days (JCCO)	National	Monthly	84%	98%	100%	✓	↑↓	KPV.19
	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	N/A	80% 100%	29% 47%	✗	→	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	National	Monthly	N/A	80% 100%	6% 50%	✗	→	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	National	Monthly	N/A	100%	94%	✗	→	KPV.16
	Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	N/A	80% 100%	27% 32%	✗	→	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	69%	98%	98%	✓	↑↓	KPV.20

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 12 (March 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline April '22**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
	% Patients Beginning Emergency SACT within 5 days	**National**	**Monthly**	**100%**	**98%**	**100%**	✓	🡅	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	**Best practice**	**Monthly**	**96%**	**90%**	**96%**	✓	🡆	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	**Best practice**	**Quarterly**	**97%**	**90%**	**83%**	✗	🡇	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	**National**	**Monthly**	**0**	**0**	**(£0.064m)**	✓	🡆	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	**National**	**Monthly**	**0**	**£27,760 M**	**£27,758M**	✓	🡆	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	**National**	**Monthly**	**N/A**	**£0.128 m**	**£0.140 m**	✗	🡆	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	**National**	**Monthly**	**N/A**	**£1.300 m**	**£1.300 m**	✓	🡅	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	**National**	**Monthly**	**95%**	**95%**	**95%**	✓	🡆	FIN.60
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	🡆	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	🡆	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	🡆	WOD.80
	% of Workforce declared Welsh Speakers at Level 1	**National**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	🡆	WOD.81

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

Return to Top

Number of VCC Inpatient Falls per month

Target: 0 Avoidable

Current Performance against Target or Standard

VCC	Jan 22	Feb 22	Mar22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual Number	3	2	9	4	1	1	2	1	3	4	4	5	2	0	4
Avoidable Falls	1	0	0	1	1	0	2	0	1	2	2	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SPC Chart Inpatient Falls per month Target NIL

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months, with a 'special cause' variation of 9 falls in March.

SLT Lead: Head of Nursing

Performance

There were no avoidable falls in March 2023. Target Achieved.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.01

[Return to Top]

Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Jan 22	Feb 22	Mar22	Apr22	My 22	Jun 22	Jul 22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual Number	0	0	1	1	0	1	0	0	4	1	1	1	0	0	1
Avoidable Ulcers	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SPC Chart Acquired Pressure Ulcers per month Target NIL

Measure: 0–5; UCL

10/1/21, 11/1/21, 12/1/21, 1/1/22, 2/1/22, 3/1/22, 4/1/22, 5/1/22, 6/1/22, 7/1/22, 8/1/22, 9/1/22, 10/1/22, 11/1/22, 12/1/22, 1/1/23, 2/1/23, 3/1/23

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months.

Performance

No avoidable Pressure Ulcers in March 2023. Target Achieved.

Service Improvement Actions – Immediate (0 to 3 months)	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +) Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator WOD.19

Return to Top

Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	86	85	85	86	85	86	85	85	85	85	87	87	88	87	87
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

SPC Chart Analysis

The SPC chart shows common cause or normal variation averaging nearly 84% against the 85% target, with the target being met for the last year.

Performance

Assessment of current performance, set out key points:

- Compliance target is being met
- VCC at 85%
- WBS at 95%
- Corporate Services at 88%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Continue to support managers in monthly 121's ensuring compliance is regularly reviewed	Ongoing	People and OD Team

Expected Performance gain - immediate

Improved preformance with all areas across the Trust above the target level.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• The Education and Development team will proactively work on the Stat. & Mand compliance framework in the All Wales network		Head of OD
• The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	**Monthly**	People and OD Senior Business Partner

Expected Performance gain – longer-term

Maintain and continue to improve on statutory and mandatory training compliance across the Trust and within the independent divisions.
Having well trained and developed workforce will ensure the safe and quality delivery of services across the Trust.

Risks to future performance

Set out risks which could affect future performance

- Future predicated wave of COVID and Flu may affect staffing levels and ability to release staff to undertake training.

KPI Indicator KPV.07

Return to Top

Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

Incidence of Potentially (avoidable) Hospital Acquired Thromboses (HAT)

VCC	Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	mar 23
Hospital Acquired Thromboses	1	0	1	0	0	0	1	0	0	0	0	0	0	0	2
Target Nil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

Assessment of current performance, set out key points:

In March there were 2 potentially avoidable HATs identified via root cause analysis. 1 was due to the VTE section of the chart not being completed on admission and therefore no dalteparin prescribed for a medical admission.
The second was a missed dose of dalteparin (blank box on the chart).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Identify the root cause and feedback to the stakeholders, this include always ensuring that a risk assessment is conducted and always ensure that doses are never un-intentionally missed.	1 month	VCC CHAT Group

Expected Performance gain - immediate

Ideally should see an immediate effect, and will be able to assess in 1 month time.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Revise the clerking proforma to include a HAT risk assessment into the proforma	1 month	CHAT group (Jolene Lewis)
Ensure ward nursing staff know that 'critical medications' including thromboprophylaxis cannot be missed (in ward 'big 4')	1-2 months	CHAT group – Rhian Hathaway
Ensure that the important of VTE prophylaxis is covered at induction and potential teaching sessions	3-6 monthly	Pharmacy induction
Implement ESR training for all staff	To start in 3-6 months and repeat every 2 years	Workforce and OD

Expected Performance gain – longer-term

Consistent monthly performance of no potentially avoidable HATs each month

Risks to future performance

Set out risks which could affect future performance

- Change in ward medical staff

KPI Indicator KPV.04

Return to Top

Healthcare Acquired Infections (Inpatients)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Incidence of Healthcare Acquired Infections for the period December 2022 to March 2023

VCC	Jan 22	Feb 22	Mr2 2	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
C.diff	1	0	1	0	0	0	0	0	0	0	0	1	1	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
E.coli	0	0	0	0	0	0	1	0	0	0	0	1	3	1	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg	0	0	0	0	0	0	0	0	0	0	0	1	4	1	0

Performance

Assessment of current performance, set out key points:

- The increase in infections noted is reflective of the national picture
- RCA for all reported infections in progress
- There is no evidence of VCC transmission in the RCA's to date.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Reviewing individual cases using an MDT approach to identify any lessons to be learnt and training.	To be completed within 2 weeks of positive result	IPCT

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- **Engagement with medical colleagues in the RCA process impacted by workload and rotation.**

KPI Indicator KPI.30

Return to Top

Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual	0	1	0	3	0	0	1	1	0	0	0	2	0	2	0
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

Assessment of current performance, set out key points:
There were no reportable events submitted to regulators in March. There were no Serious Hazards of Transfusion (SHOT) incidents reported during the month.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Completion of Corrective Actions and Preventative Actions (CAPA), in respect of SABRE reports, is monitored via existing processes and reported to the Regulatory Assurance and Governance Group (RAGG).	Progress of completion of investigations is monitored via monthly QA metrics reporting into RAGG.	Peter Richardson

Expected Performance gain - immediate
N/A

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
N/A - Actions will be introduced as outcome of root cause analysis of these incidents.		

Expected Performance gain – longer-term
N/A

Risks to future performance
N/A

KPI Indicator EST.06

Return to Top

% reduction in Carbon Footprint/Emissions by 2025 against 2021/22 baseline

Target: -16%

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual Number															
Target -16%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%

[Graph and data to be inserted under development]

Performance

Assessment of current performance, set out key points:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

EFFECTIVENESS

KPI Indicator KPV.05

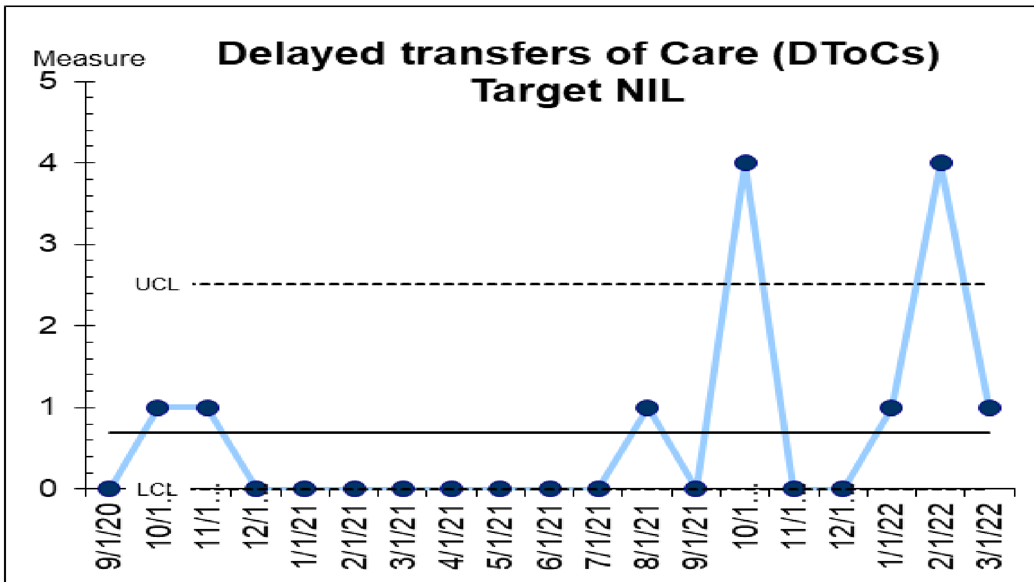
Return to Top

Number of Delayed Transfers of Care (DToC)

Target: NIL

Current Performance against Target or Standard

VCC	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	1	4	1	0	0	0	0	0	0	2	1	0	0	1	1
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

SLT Lead: Head of Nursing

Performance

Assessment of current performance, set out key points:

There was 1 DTOC in March 2023, patient referred for repatriation to the host HB for rehabilitation and discharge planning – delayed by 15 days due to bed availability and service pressures in host HB.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
VCC Nurse leads now have membership of the new Pathways of Care Delays National Group system access has been granted and training has been provided by the DU, BI working with senior nurses to agree data source currently manual collection.	End of June 2023	Matthew Walters Senior Operational Nurse

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Membership of all Wales POCD group, opportunity to discuss with HB colleagues and review national data including VUNHST data identifying themes and patterns.	March 2023	Matthew Walters Senior Operational Nurse

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPI.04

Return to Top

% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	110	100	100	102	102	100	107	112	105	115	115	94	106	103	104
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

SLT Lead: Jayne Davey / Tracey Rees

Performance

All clinical demand was met during this period with a good blood group distribution.

Demand (full weeks) averaged at 1351 units per week which is lower than the February period.

Service Improvement Actions – Immediate (0 to 3 months)

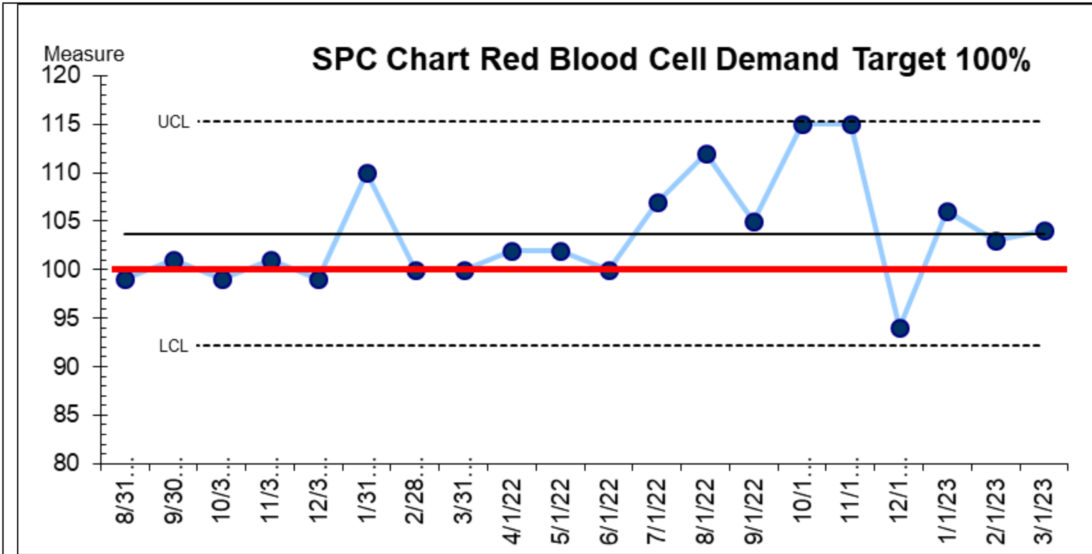
Actions: what we are doing to improve	**Timescale:**
The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain. At the meetings, business intelligence data is reviewed and facilitates operational responses to the challenges identified.	Daily **Lead:** Jayne Davey / Tracey Rees

Expected Performance gain - immediate.
Reviewed daily to support responses to changes in demand.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
N/A	N/A **Lead:** Jayne Davey / Tracey Rees
Expected Performance gain – longer-term	N/A

	Risks to future performance
	Set out risks which could affect future performance. Impact of industrial action on ability to collect sufficient blood donations (ongoing).

	SPC Chart Analysis
	The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 104% consistently exceeding the 100% target.

KPI Indicator KPI.26

Return to Top

Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	0.05	0.04	0.08	0.08	0.00	0.02	0.01	0.03	0.35	0.01	0.33	0.36	0.21	0.06	0.02
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

Performance

Assessment of current performance, set out key points:
Performance of this metric has met target.

Red cell shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Daily monitoring of age of stock as part of the resilience meetings.	Daily (BAU)	Tracey Rees

Expected Performance gain - immediate
Continued effective management of blood stocks to minimise the number of wasted units.

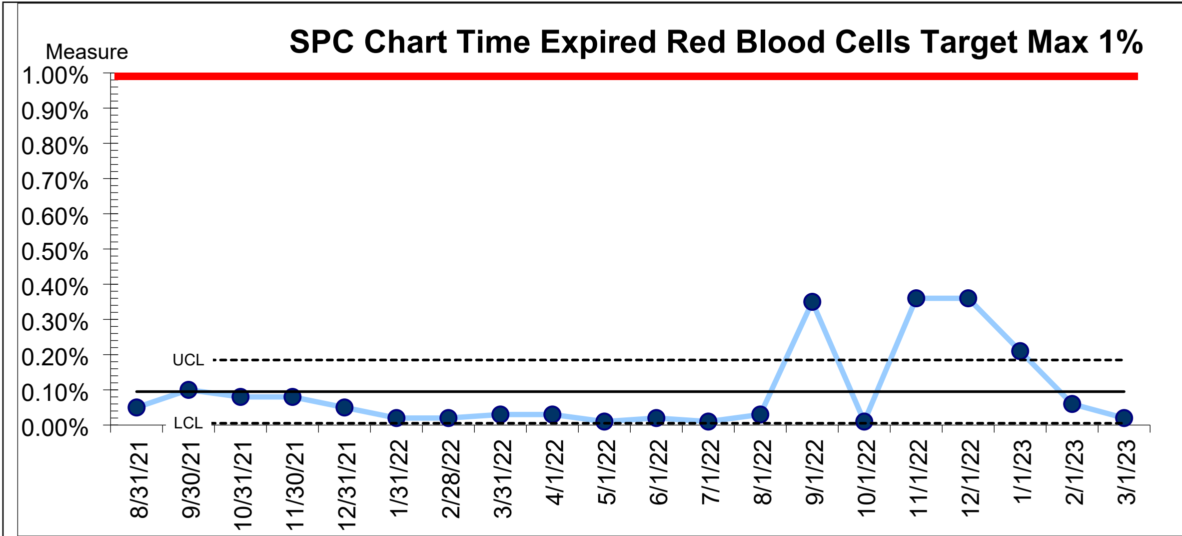
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
N/A		

Expected Performance gain – longer-term
N/A

Risks to future performance

- High stock levels lead to a risk of increased time expiry
- Industrial action also presents a risk – mitigation of the risks from industrial action are to increase stock holding, if the strikes do not affect collection, then stock holding may be higher than optimal levels.



SPC Chart Analysis

The SPC chart shows some special cause variation over the 4 of the last 6 month period. However, the average performance of 0.10% remains well within the maximum 1%

KPI Indicator KPI.25

Return to Top

Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	15	17	14	16	15	23	19	30	25	14	15	27	23	26	20
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

Time Expired Platelets

Month	Value
Apr-22	16.06%
May-22	14.65%
Jun-22	23.32%
Jul-22	19.37%
Aug-22	30.11%
Sep-22	24.56%
Oct-22	13.66%
Nov-22	15.00%
Dec-22	27.00%
Jan-23	23.00%
Feb-23	26.00%
Mar-23	20.00%

NB: Platelet production takes account of the average expected issues and is a balance to ensure sufficiency of supply where production occurs 2.5 days before they are available for issue. This means in shortage there tends to be over production. Decreasing production would reduce waste but increase the probability of shortage, which in turn may create a need to rely on mutual aid support.

Performance

Assessment of current performance, set out key points:
Platelet production was reduced during March in accordance with the production plan and whilst target was not achieved, overall number of time expired platelets reduced to the lowest numbers this quarter.

(NB Platelet expiry is based on a % of production, as platelet production reduces, the % contribution to expiry for each individual platelet increases)

33% of March platelet expiry occurred in the first week, prior to the impact of the reduced production. The week of the 13th of March also saw the lowest platelet issuing figure for several years.

Excess expiry also occurred on Wednesdays (from platelets collected on the previous Wednesday). Production cannot be reduced on these days as these are apheresis platelets.

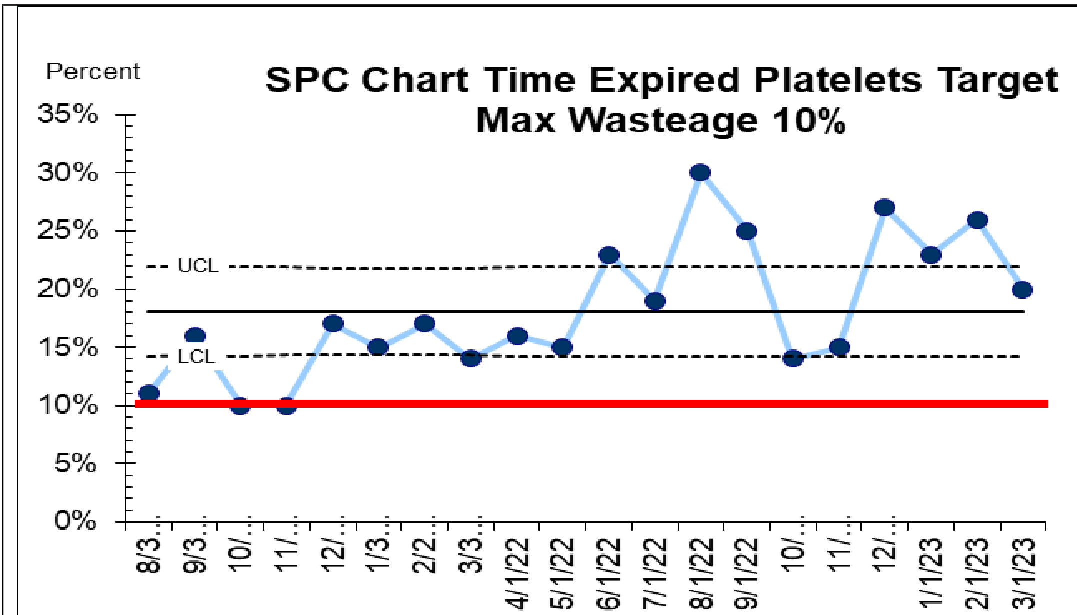
NB

- Production set at 165 per week on the basis that the average demand was impacted by a single exceptional week.
- April will have significant challenges in wastage rates due increased production in readiness for the bank holidays which impact on usual production schedules.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Lead:
• Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings. • Pooled platelet reductions have been implemented and reviewed for March	Tracey Rees / Peter Richardson **Timescale:**

	as a measured approach to the declining demand trend. • A Platelet Strategy Board will be established to co-ordinate the work of the two Task and Finish Groups convened following the November 2022 platelet review and other ongoing work streams in Clinical Services. • Develop a forecasting tool to inform decisions around pooled platelet manufacture (Task & Finish Group 1).	Daily (BAU) Qtr 4 Proof of Concept trial - March 23 onwards
	Expected Performance gain – immediate. Controlled platelet production leading to reduced wastage	
	Service Improvement Actions – tactical (12 months +)	
	Actions: what we are doing to improve Reviewing the clinic collection pan for Apheresis (Task & Finish Group 2) to ensure the clinic times are optimised, given to additional 2-day shelf life of platelets.	**Timescale:** Qtr 1, 2 & 3 onwards **Lead:** Jayne Davey
	Expected Performance gain – longer-term Platelet expiry reduction using a risk-based approach balancing platelet expiry against ability to supply platelets for clinical needs.	
	Risks to future performance	
	Set out risks which could affect future performance Unexpected increases in clinical need Industrial Action Adverse weather	



SPC Chart Analysis

The SPC chart shows special cause variation over 4 of the last 6 month period. With the average performance of 17% consistently exceeding the maximum wastage limit of 10%.

KPI Indicator KPI.13

Return to Top

Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum | **SLT Lead: Tracey Rees**

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Cumulative Actual	39	44	47	4	9	11	14	18	20	22	27	31	35	38	44
Cumulative Target p/a	67	73	80	7	14	20	27	34	40	47	54	60	67	71	80

Stem Cell Collections

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Stem Cell Collection in Wales	4	9	11	14	18	20	22	27	31	35	38	44

Legend: Stem Cell Collection in Wales; Stem Cell Projected Forecast

Performance

Whilst performance for March did not meet target, it was still the busiest month of the 22-23 financial year. 5 collections were cancelled during March for patient reasons and 1 cancelled due to a donor failing a medical examination.
The total stem cell provision for the Service was 11, made up of 6 collections and 5 imported for Welsh patients.

The Service continues to experience a cancellation rate of approx. 30% compared to 15% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being finalised to support the ongoing development of the WBMDR. A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collections see KPI.20	Qtr 4 **Lead:** Tracey Rees

	Expected Performance gain - immediate. As above
	Service Improvement Actions – tactical (12 months +)
	Implementation of the five-year strategy. — **Timescale:** Qtr 1 2023 onwards **Lead:** Tracey Rees
	Expected Performance gain – longer-term. Improved recruitment of new donors to the Register which over time will increase the number of collections
	Risks to future performance
	Set out risks which could affect future performance. Identified risks are being managed.

KPI Indicator WOD.37

Return to Top

Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	5.73	5.81	6.07	6.30	6.36	6.42	6.53	6.50	6.36	6.30	6.19	6.19	6.24	6.36	6.22
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

SPC Chart Analysis

The SPC chart shows a deteriorating trend over the last 15 months with the overall average 5.6% sickness level remains higher than the 3.54% target

Performance

Assessment of current performance, set out key points:

There is a slight decline in sickness this month as the People and Relationship Team continue to support managers in the application of the sickness policy. There is growing concern that short-term absences will continue to grow with the COVID19 guidance that requires 48hour isolation for any cold or flu like symptom. There are ongoing discussions at Covid cell to monitor this activity.

Anxiety/stress/depression/other psychiatric illnesses remain the highest reason for absence across the Trust.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Roll out of fundamentals in managers training including the management of absence under the fundamentals of training package.	31/03/2023	People and OD Team

Expected Performance gain - immediate

As part of the development in the people management training package there will be practical support for managers on managing stress in the workplace and completing stress risk assessments.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Feedback from the Wellbeing sessions, held by the OD team, are being analysed and this will inform future wellbeing plans	31/03/2023	Head of OD

Expected Performance gain – longer-term

The actions above will have an impact on management of sickness absence. Active sickness absence management has been shown to reduce the duration of individual sickness absences.

Risks to future performance

Set out risks which could affect future performance

- Not having enough staff available due to sickness absence could impact on delivery of services across the Trust
- Staff who feel unsupported during absence may chose to leave the organisation increasing turnover

KPI Indicator WOD.36

Return to Top

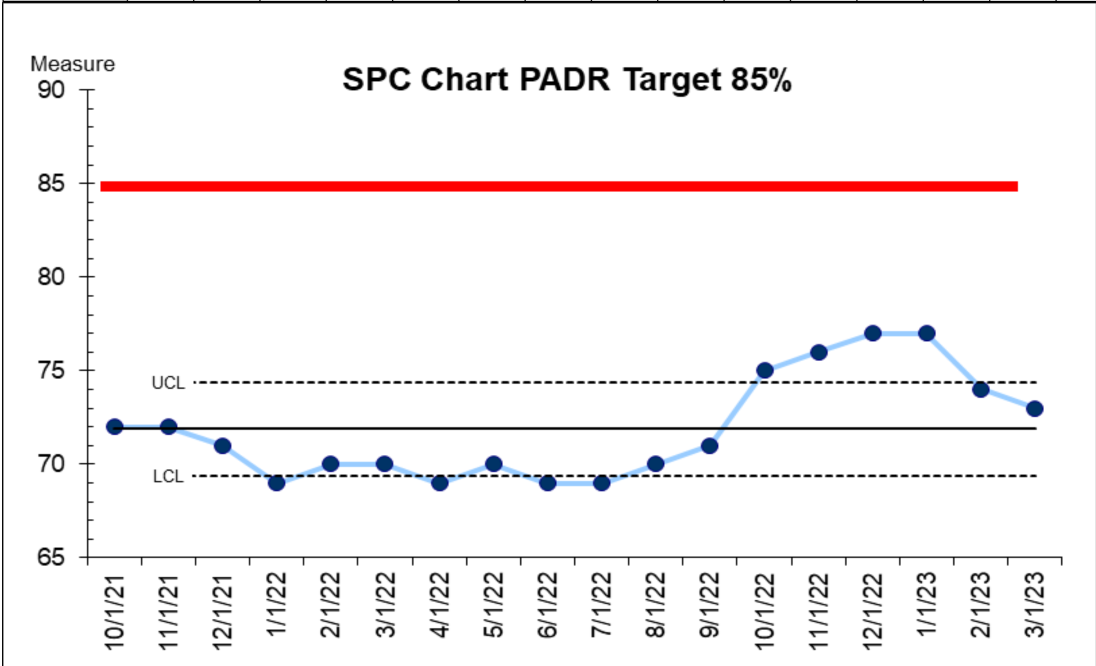
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	69	70	70	69	70	69	69	70	71	75	76	77	77	74	73
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows a special cause deteriorating trend over the last 15months months, averaging 72%, and consistently falling short of the 85% target.

Performance

Assessment of current performance, set out key points:

PADRs have remained relatively stable the past 12 months with an upward trend that has continued following the implementation of the new Pay Progression Policy in October 2022 which ties incremental pay progression into the PADR process for all Agenda for Change Staff.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Support divisions in plans to target hotspot areas (Divisions KPI plans)	31/03/2022	Senior BP

Expected Performance gain - immediate

As the impact of PADR compliance will be related to people's incremental credit progression it is expected that in the short term we will see a growth in compliance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Monthly reports to be presented to Divisions for monitoring and review.	Ongoing Monthly	Business Partner SMT/SLT

Expected Performance gain – longer-term

As regular monitoring and reviews of compliance is defined in the divisional operational meetings, and training is rolled out the Trust's compliance will improve.

Risks to future performance

Set out risks which could affect future performance

- People have lack of clarity and objectives casing them to be less engaged and motivated in the workplace
- Higher turnover rates due to lack of engagement and motivation

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

Return to Top

% of Patients that Rate Experience at Velindre at 9/10 or above

Target: 85%

Current Performance against Target or Standard

VCC	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Would you recommend us? %								89	89	88	nda	nda	93	96	95
Your Velindre Experience? %											nda	nda	84	86	82
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

SLT Lead: Head of Nursing

Performance

Assessment of current performance, set out key points:

There are 2 surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience' The Your Velindre experience uses 0-10 in the question about rating VCC, whereas 'Would you recommend us?' used Very good, good etc. The majority of surveys completed in VCC is the 'Would you recommend us?' one.

The 95% in March was due to 118 survey responses to the VCC 'Would you recommend us? CIVICA survey.

56 patients responded to "Your Velindre Experience" CIVICA survey. Of these 56 responses, 38 responded 9/10 and 10/10. 13 patients responded 7 and 8 out of 10, with 5 patients scoring 5 and below.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Outcomes from CIVICA are reviewed monthly and form part of QSP report	Ongoing	Head of Nursing/SLT
• Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback	Ongoing	SLT
• Directorates to develop plans to increase response rate.	Ongoing	
• Q+S team to work with each directorate to provide further analysis on responses		SLT

Expected Performance gain – immediate

Patient Experience and Concerns manager in post since February 2023.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Patient Engagement Hub to undertake focussed project to understand reason for low response rates	April 2023	Head of OSD

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

KPI Indicator KPI.09

Return to Top

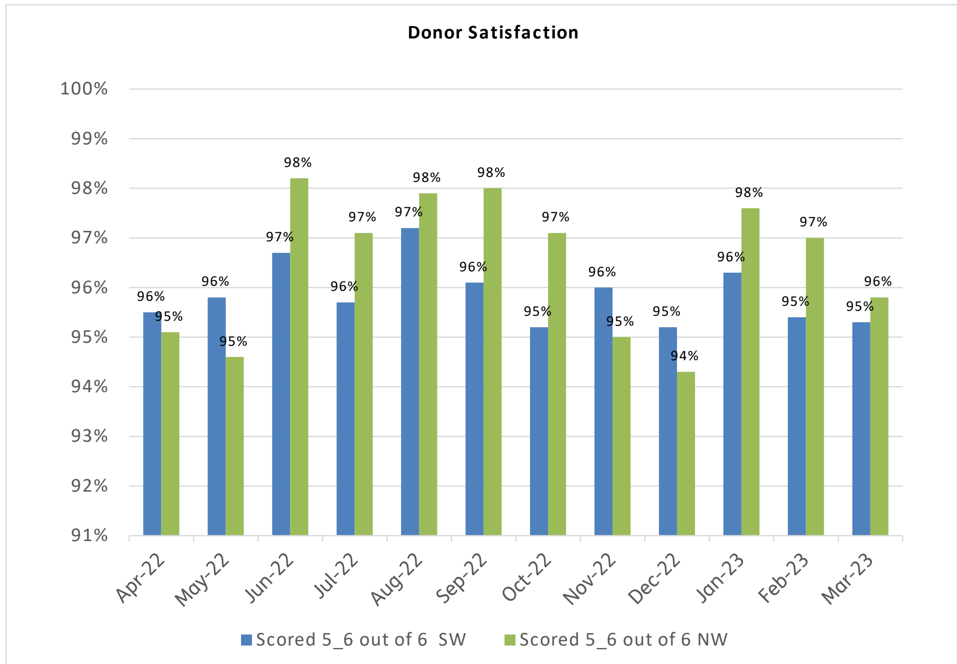
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	95	95	97	96	96	97	96	97	97	96	96	95	97	97	95
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95



Performance

Assessment of current performance, set out key points:

At 95.4% donor satisfaction exceeded target for March.

In total there were 1,064 respondents to the donor survey, 177 from North Wales (scoring satisfaction at 95.8%), and 877 from South or West Wales (scoring satisfaction at 95.3%).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Findings are reported on at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams. 'You Said, We Did' actions are taken from the report.	Business as usual, reviewed monthly	Jayne Davey

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following analysis of the donor satisfaction survey from the Service Improvement team, there are nine metrics statistically linked to the donor satisfaction score. These nine metrics are now being explored to evaluate where improvements can be made in these areas	**Q4 2023/24**	Andrew Harris

Expected Performance gain – longer-term

N/A

Risks to future performance

Set out risks which could affect future performance

N/A

KPI Indicator KPV.12

Return to Top

Number VCC formal complaints received under Putting Things Right within 30 days	
Target: 85%	**SLT Lead: Head of Nursing**
Current Performance against Target or Standard	**Performance**

VCC	Jan 22	Feb 22	Mar 22	Apr 22	M 22	Jun 22	Jul 22	Au g22	Sep 22	Oct 22	No v 22	Dec 22	Jan 23	Feb 23	Ma r 23
Actual %							100	100	100	100	100	100	100	100	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Assessment of current performance, set out key points:

- Target deadline has been achieved

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate
Patient Experience and Concerns manager in post since February 2023

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.03

Return to Top

% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 90%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	n/a	100	n/a	n/a	n/a	100	100	n/a	n/a	100	100	N/A	100	100	N/A
Target 90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: performance against target only shown the month when a formal concern has been raised

NB. Under PTR guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.

Performance

Assessment of current performance, set out key points:
There were no formal concerns raised or due to be closed in March 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:
• Continue to monitor this measure against the '30 working day' target compliance. • Continued emphasis of concerns reporting timescale to all staff involved in concerns management reporting	Ongoing **Lead:** Edwin Massey

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
Continue to monitor and have oversight of concerns management in line with PTR.	Ongoing **Lead:** Julie Reynish

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

TIMELINESS

KPI Indicator KPV.27

Return to Top

Radical Radiotherapy Patients Treated Within 28 Days (JCCO)

Target: 98%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard

Radical RT Patients treated within and outside JCCO 28 day Target98%

Number of RT Patients

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
> 28days	16	16	16	33	20	41	67	55	28	12	0	0	0	40	55
< 28days	184	184	184	218	230	200	173	182	186	233	0	0	0	243	208

Months 1 to 15 Jan 2022 to March 2023

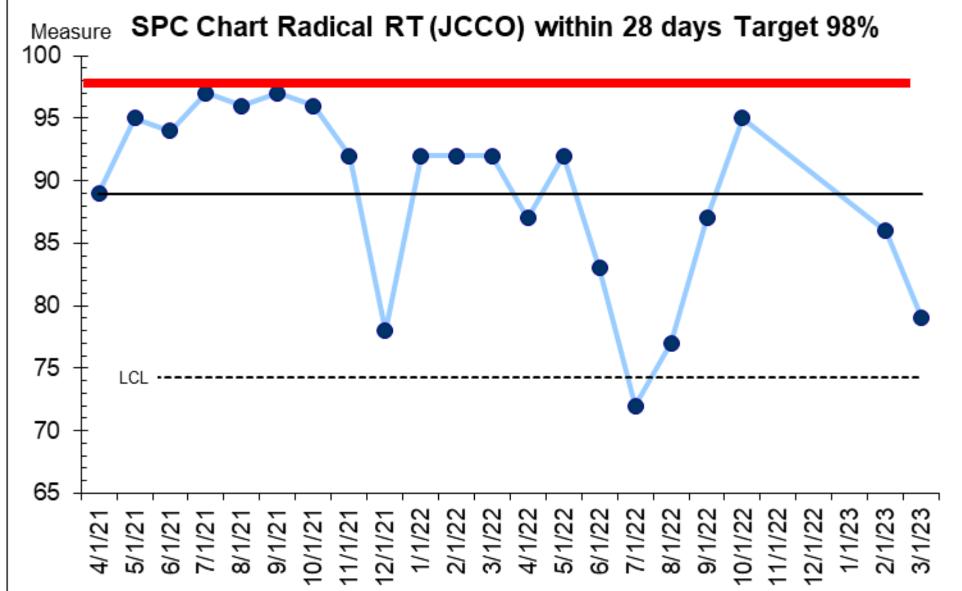
Performance

Assessment of current performance, set out key points:

Due to the implementation of DH & CR, there were no waiting list reports available to accurately report Radiotherapy performance for a period. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during early February. These will be tested and will be followed by a validation of the waiting list reports for November and December, followed by the January position. There will not be a reported position available until the January report is produced. The targets affected by this are the 3 Radiotherapy waiting time targets

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Gradual increase in LINAC capacity by 8% has occurred from Mid-July onwards. Work being undertaken within the Directorate extended working days and increased utilisation of LINAC capacity from 73.5 planned hours in June to up to 76.5 hours delivered in December	January 2023 complete Ongoing	Radiation Services Lead
• Fleet configuration changes to support Breast patient treatment options have been implemented.		
• Escalation processes continue to monitor predicted failures to meet time to treatment metrics and prioritise patients to commence treatment and minimise delay where possible, undertaken through weekly capacity meetings.	Ongoing	
• Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group.	January 2023	



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months. However, the average performance of 89% consistently falls below the 98% target.

• Review of patients who were not ready for treatment to assess whether treatment planned too soon. Collate lessons learnt and review pathway. • The Prostate HDR business case was approved by Senior Leadership Team at the Velindre Futures Programme Board in June 2022. The preferred option of extended days will be the model utilised in the expansion.		SI Manager Radiation Services Manager
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve • Working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options e.g. Brachytherapy, molecular radiotherapy. • Recruitment and appointments in progress for additional front-line resources.	**Timescale:** Q3/4	**Lead:** Heads of Service and SST's Leads
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance • Risks remain however to provide specific Brachytherapy capacity and Radiotherapy Physics capacity and there are significant risks associated with the age of the equipment and potential breakdown, and lack of specialist workforce.		

KPI Indicator KPV.18

Return to Top

Palliative Radiotherapy Patients Treated Within 14 Days (JCCO)

Target: 98%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard

Palliative RT Patients treated within and outside JCCO 14 day Target 98%

Numbers of RT Patients

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
>14 days	25	9	17	21	19	15	14	11	16	14	0	0	0	5	0
< 14days	81	81	73	79	81	73	68	64	89	74	0	0	0	30	36

Months 1 to 15 Jan 2022 to March 2023

Performance

Due to the implementation of DH & CR, there were no waiting list reports available to accurately report Radiotherapy performance for a period. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during early February. These will be tested and will be followed by a validation of the waiting list reports for November and December, followed by the January position. There will not be a reported position available until the January report is produced. The targets affected by this are the 3 Radiotherapy waiting time targets.

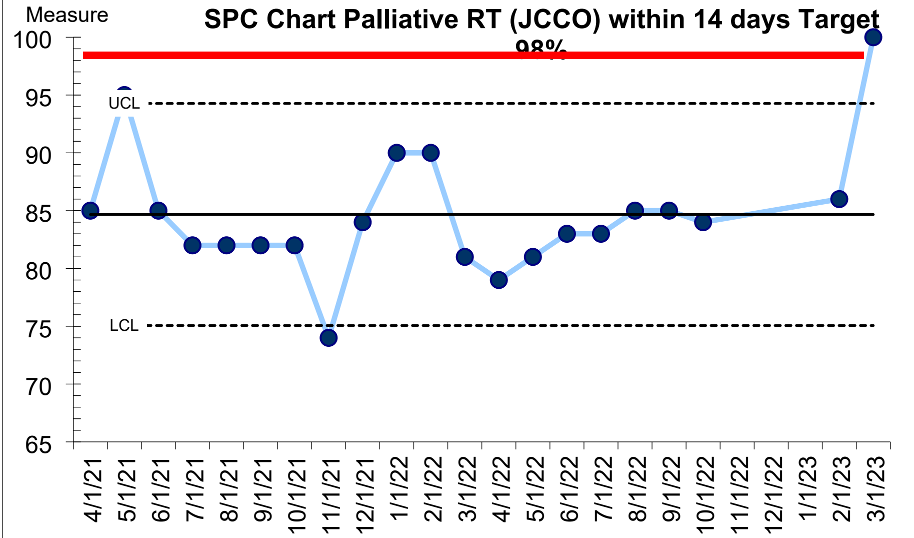
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Review of Palliative Treatment Pathway to access viable and funded models of delivery • In relation to 3D planning: A proposal is being developed following review COSC implications and an improvement programme to support delivery of the revised targets will need to be agreed as a priority (Quality Performance indicators QPIs		Heads of Service / Medical Lead

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:



SPC Chart Analysis

The SPC chart shows common cause or normal variation with a dip in performance June to November. However, the average performance of 84% consistently falls below the 98% target.

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.19

Return to Top

Emergency Radiotherapy Patients Treated Within 2 Days (JCCO)

Target: 98%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard

Emergency RT Patients treated within and outside JCCO 2 day Target

100%

Numbers of RT Patients

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
> 2days	0	2	1	4	3	0	0	1	2	2	0	0	0	0	0
< 2days	25	23	25	19	21	25	21	16	26	35	0	0	0	17	16

Months 1 to 15 Jan 2022 to March 2023

Performance

Due to the implementation of DH & CR, there were no waiting list reports available to accurately report Radiotherapy performance for a period. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during early February. These will be tested and will be followed by a validation of the waiting list reports for November and December, followed by the January position. There will not be a reported position available until the January report is produced. The targets affected by this are the 3 Radiotherapy waiting time targets.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Review of patient whose intent changed to assess if any lessons can be learnt or due to clinical condition.	20th December 2022	Medical RT Lead

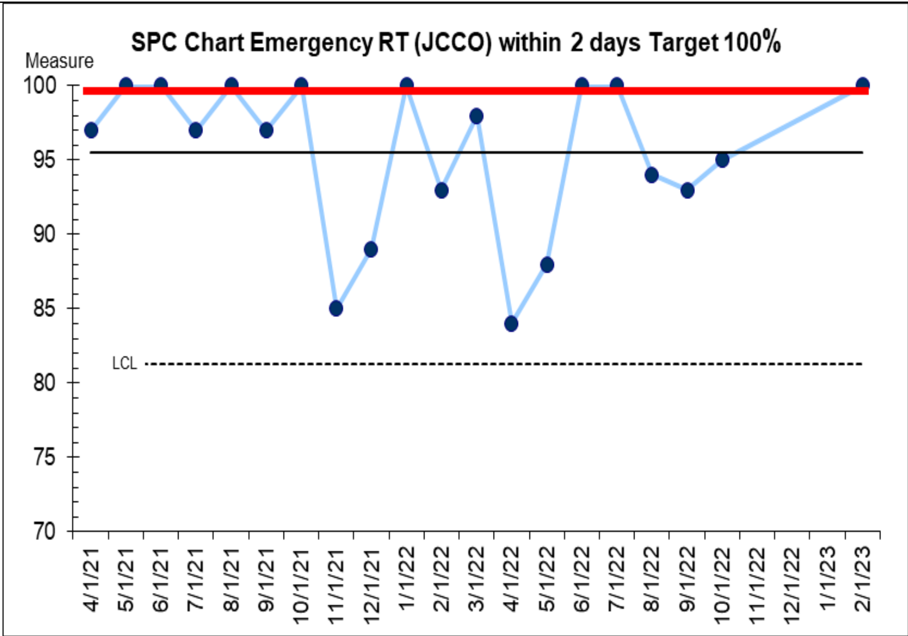
Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**

Expected Performance gain – longer-term

Risks to future performance



SPC Chart Analysis
The SPC chart shows common cause or normal variation over the last 15 months. The average performance of 95% just falling below the 98% target.

Set out risks which could affect future performance

-

KPI Indicator KPV.14

Return to Top

Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

SPC Chart Analysis

The SPC chart analysis is not possible until we have at least 6 months performance data available using the new COSC measures to ensure the results are statistically valid.

Assessment of current performance, set out key points:

Ongoing challenges post DHCR in establishing a fully validated position. User system compliance errors contributing as a result of move to COSC categorisation. Validation resources currently insufficient to address range of issues identified.

Number of referrals	263	
treated within 14 days of referral (80% target)	76	29%
treated within 21 days of referral (100% target)	124	47%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Retraining for clinical teams underway along with pathway review team scrutinising breach reasons.	Commenced and ongoing	Helen Payne
Additional validation resources to be provided.	Commenced	Helen Payne
Task and finish group established to provide detailed action plan to address immediate challenges and short term pathway improvements	Commenced with plan in place by end of May	Kathy Ikin

Expected Performance gain - immediate

Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Pathway change group in place to address changes in process to meet revised patient journey timings with SST leads.	6 months	Tom Rackley

Expected Performance gain – longer-term

Changes to patient pathway in line with cosc timings

Risks to future performance

Set out risks which could affect future performance

Linac replacement programme which has already commenced

KPI Indicator KPV.15

Return to Top

Urgent Scheduled Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Scheduled Urgent RT COSC within 2 & 7 days

Y axis: Number of RT Patients (0% – 100%)

Axis Title	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Patients <2 days	0	0	0	0	0	3	2
Patients <7 days						13	16
Patients >7 days						19	18

50% of RT patients (March) (18) breached the 100% referral to treatment

50% of RT patients (March) (16 + 2) met the 100% referral to treatment within 7 days target

Only 6% of RT patients (March) (2) met the 80% referral to treatment within 2 days target

SPC Chart Analysis

The SPC chart analysis is not possible until we have at least 6 months performance data available using the new COSC measures to ensure the results are statistically valid.

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	36	
treated within 2 days of referral (80% target)	2	6%
treated within 7 days of referral (100% target)	18	50%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
As for scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.16

Return to Top

Emergency Radiotherapy Patients Treated Within 1 Day (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Emergency RT COSC within 1 day

Number of RT Patients

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

Sep-22: 0; Oct-22: 0; Nov-22: 0; Dec-22: 0; Jan-23: 0; Feb-23: 16 / 1; Mar-23: 15 / 1

Axis Title

Patients =1 day Patients >1 day

Only 6% of RT patients (1) breached the 100% referral to treatment within 1 day target

94% of RT patients (16) met the 100% referral to treatment within 1 day target

SPC Chart Analysis

The SPC chart analysis is not possible until we have at least 6 months performance data available using the new COSC measures to ensure the results are statistically valid.

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	16	
% treated within 1 day of referral	15	94%
% treated within 2 days of referral	16	100%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
As for scheduled above		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

Return to Top

Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)

Target: 80%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard

Elective delay is a new recording category and differentiates between scheduled patients referred in to commence treatment as soon as possible, and those referred whilst on another form of treatment

Elective Delay RT Treated COSC within 14 Days and 21 days

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Patients <14 days	0	0	0	0	0	0	20
Patients <21 days							12
Patients >21 days							42

43% of RT patients (March) (20 + 12) met the 100% Elective Delay within

Only 27% of RT patients (March) (20) met the 80% Elective Delay

Number of RT Patients; Axis Title

SPC Chart Analysis

The SPC chart analysis is not possible until we have at least 6 months performance data available using the new COSC measures to ensure the results are statistically valid.

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	74	
treated within 14 days of referral (80% target)	20	27%
treated within 21 days of referral (100% target)	32	43%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
As for Scheduled Above		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.20

Return to Top

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	94	91	71	69	61	59	66	77	89	96	98	96	97	98	98
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days	21	32	118	116	146	147				14	6	12	9	9	8
Within 21 days	329	319	400	375	375	355				341	354	322	336	388	409

The number of patients scheduled to begin non-emergency SACT treatment in August 2022 (409) was higher than the number in July (389).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Attendances	2,189	2,344	2,015	2,315	2,357	2,214	2,316	2,180	2,047	2,276	2,017	1,832
2020/21 Attendances	1,219	1,212	1,375	1,537	1,641	1,696	1,941	1,891	1,982	1,957	1,975	2,253
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,189	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,558							

This high level of activity was a major factor in the improvement in both the overall performance but also the reduction in breaches and the volume of patients treated nearer the target days.

Performance

Of 409 patients treated, 8 patients waited over 21 days = performance of 98%. Target Achieved

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	6	1	1	0

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• The reintroduction of services at Nevill Hall Hospital (NHH) interim facility from April 2023.	In Place April 2023	BT

Expected Performance gain – immediate

Maintain current delivery of targets

Service Improvement Actions – tactical (12 months +)

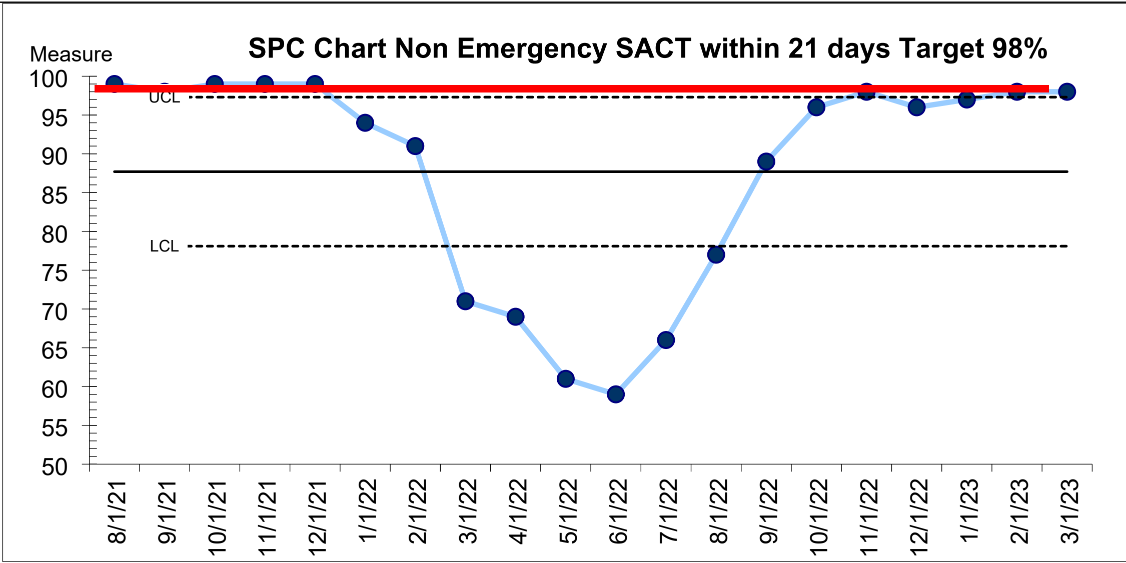
Actions: what we are doing to improve	Timescale:	Lead:
SACT Delivery Group commenced to deliver balanced capacity plan and implement service improvement plans for Nursing, SACT booking and pharmacy.	In place and implementation over next 12 months	Bethan Tranter

Expected Performance gain – longer-term

Improved productivity, balance of capacity and staffing, preparedness for future challenges.

Risks to future performance

Set out risks which could affect future performance



SPC Chart Analysis

The system improvements were maintained for the period May to Dec 2021, but a significant fall and 'special cause' variation trend during the summer with recent recovery.

KPI Indicator KPV.21

Return to Top

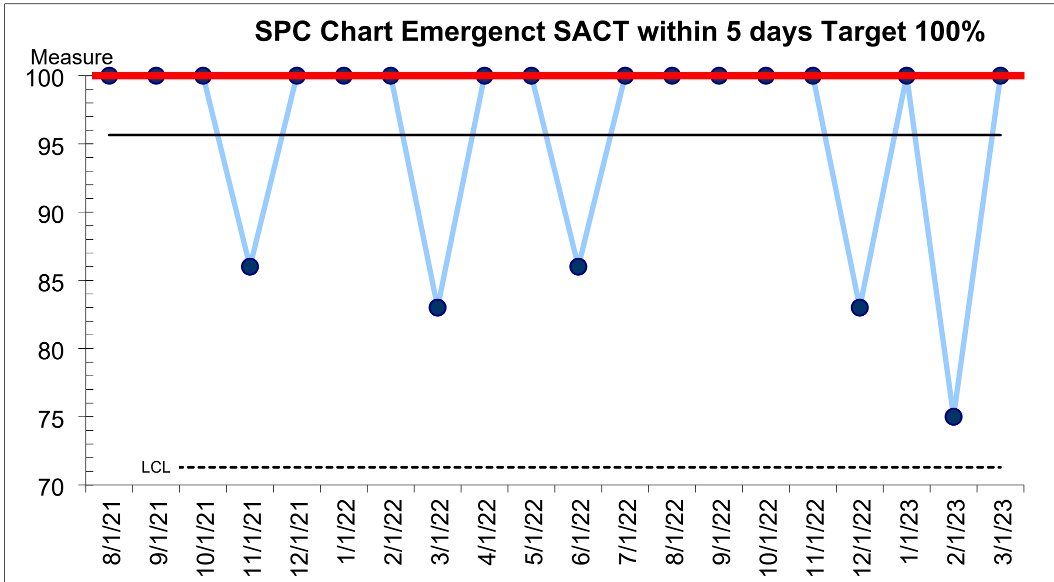
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul2 2	Au2 2	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Ma r 23
Actual %	100	100	83	100	100	86	100	100	100	100	100	83	100	75	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	0	0	1	0	0	2	0	0	0	0	0	1	0	1	0
Within 5 days	10	9	6	7	9	7			0	5	6	5	8	3	



SPC Chart Analysis

The SPC chart shows a fluctuating process with average 95 % against the 100% target, however note small numbers involved.

Performance

7 patients referred for emergency SACT treatment were scheduled to begin treatment in March 2023. All were treated in target = 100% performance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to balance demand and ring fencing with capacity. Other actions as set out in non emergency above.	Ongoing	BT

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPI.18

Return to Top

Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	96	96	96	95	96	95	96	97	97	98	96	87	97	96	96
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Performance

Assessment of current performance, set out key points:
At 96% the turnaround time performance for routine Antenatal tests continued to exceed target in March 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.	Ongoing	Tracey Rees

Expected Performance gain - immediate.
Business as usual, reviewed daily.

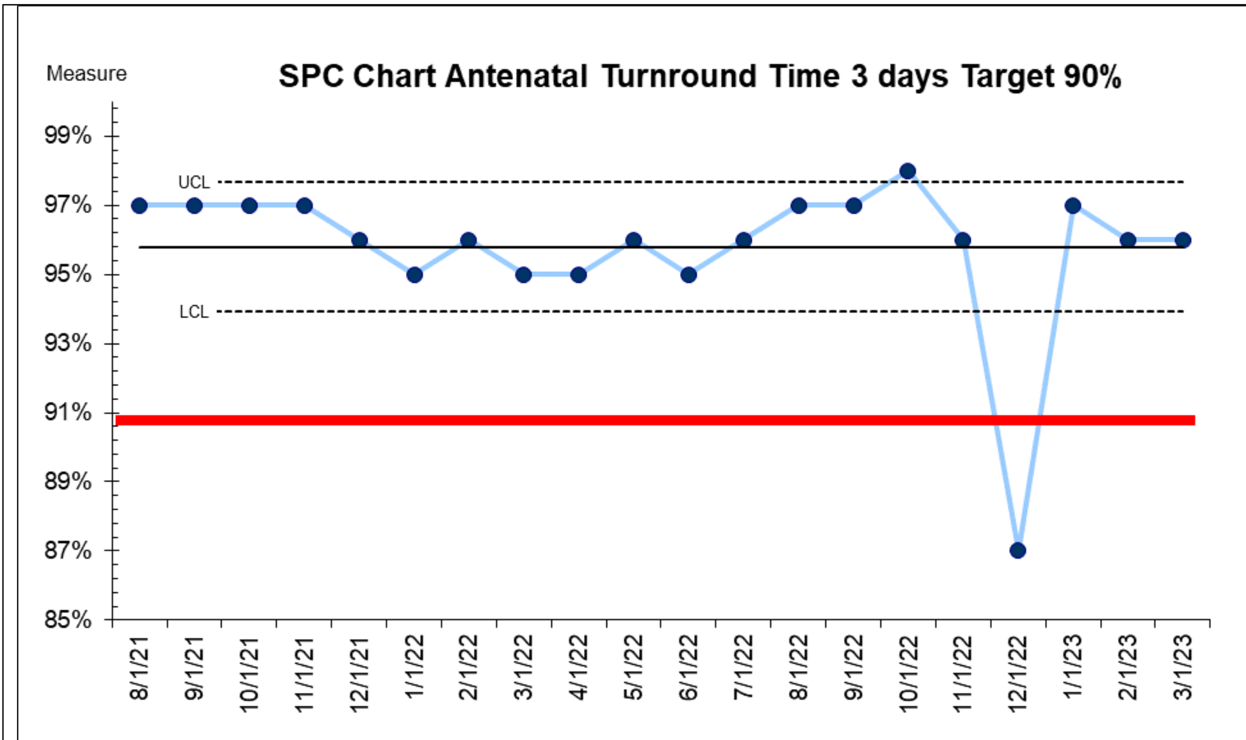
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
N/A		

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. However, a special cause variation has occurred in December (as discussed above). The average performance of 96% exceeds the 90% target.

KPI Indicator KPI.17

Return to Top

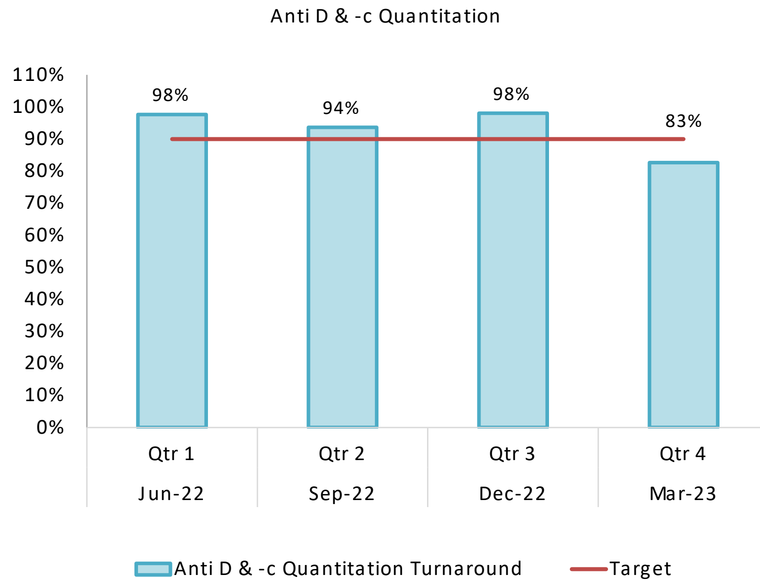
% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	99	99	96	100	99	83	99	96	99	99	96	97	96	60	92
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Performance against this quarterly metric was below target this quarter and is attributed to absence of key staff in February.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Review the resilience of the reporting team within the dept to ensure that reporting function is maintained and completed on time.	Q1	Tracey Rees

Expected Performance gain - immediate.

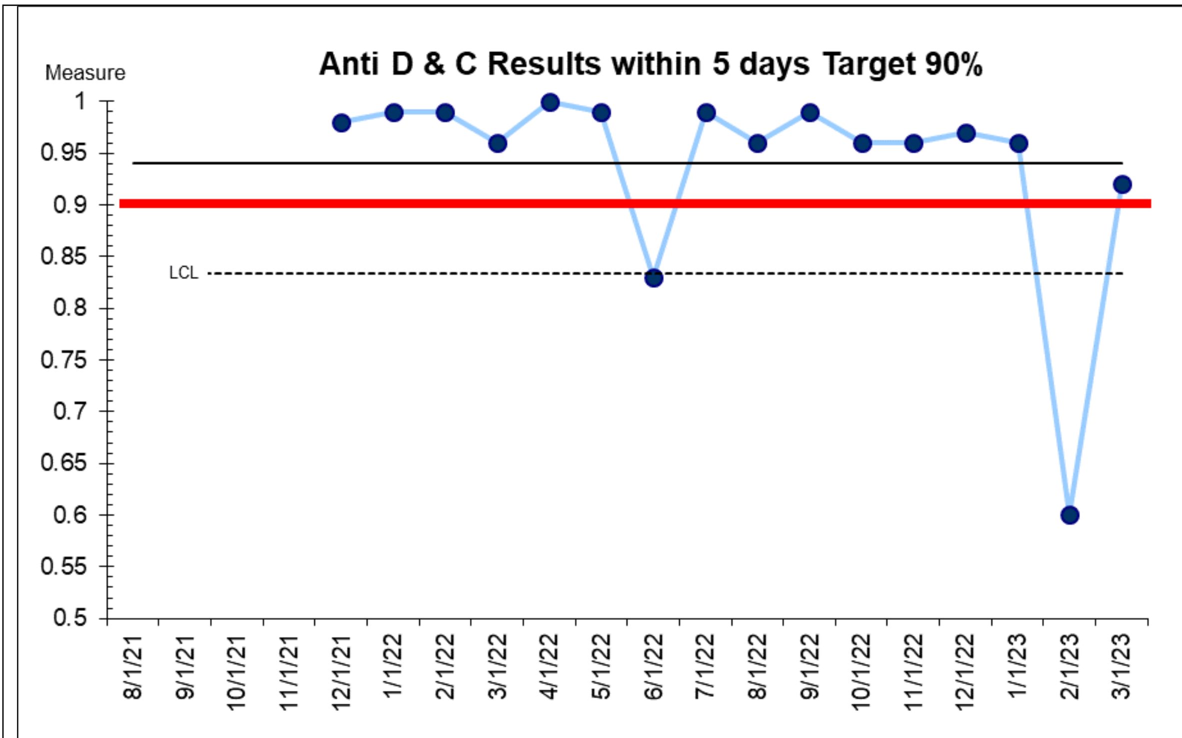
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.



SPC Chart Analysis

The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter two. However, the average performance of 96% exceeds the 90% target overall.

EFFICIENT

KPI Indicator FIN.71

Return to Top

Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

Current Performance against Target or Standard

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual £k	28	1	3	7	6	5	3	5	3	6	2	4	64
Target Net Zero													NIL

Trust-wide Revenue Position for 2022/23

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
VCC	(39.905)	(39.892)	0.014
RD&I	0.149	0.153	0.004
WBS	(21.405)	(21.406)	(0.001)
Sub-Total Divisions	(61.162)	(61.145)	0.017
Corporate Services Directorates	(12.123)	(12.231)	(0.108)
Delegated Budget Position	(73.285)	(73.376)	(0.091)
TCS	(0.695)	(0.564)	0.131
Health Technology Wales	0.000	0.025	0.025
Trust Income / Reserves	73.980	73.980	(0.000)
Trust Position	0.000	0.064	0.064

Performance

Assessment of current performance, set out key points:
The overall position against the profiled revenue budget for 2022-23 was an underspend of £0.064m.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Actions addressed through Divisional Action Plans		M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator FIN.73

Return to Top

Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast

Current Performance against Target or Standard

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	12.4	1.0	1.41 1	3.13 4	**3.98 9**	4.61 5	5.95 4	7.88 4	9.68 1	11.7 96	14.3 46	19. 495	27,75 8
Target £27.760M CEL		1.0	1.41 1	3.13 4	3.98 9	4.61 5	5.95 4	7.88 4	9.68 1	11.7 96	14.3 46	19. 495	27.76 0

Trust-wide Capital Position for 2022/23

	Approved CEL £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme			
nVCC - Project costs	2.394	2.994	-0.600
nVCC - Enabling Works	14.406	13.806	0.600
Canisc Cancer Project	0.579	0.581	-0.002
Fire Safety	0.500	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	8.004	-0.104
WG Priority Year end Spend	0.370	0.361	0.009
WBS Infrastructure OBC Fees	0.157	0.135	0.022
Total All Wales Capital Programme	26.306	26.381	-0.075
Discretionary Capital	1.454	1.377	0.077
Total	27.760	27.758	0.002

SLT Lead: Finance Director

Performance

The overall Capital programme achieved the Trust CEL by reporting a spend of £27.758m against a CEL allocation of £27.760m.

An underspend from last minute slippage on the discretionary programme was utilised against the IRS programme under the All Wales Capital programme.

Slippage on the nVCC Enabling Works has resulted in the Trust returning £7.102m of funding to WG during 2022-23 which will be re-provided next financial year.

The Trust (during November) received the funding award letter from WG in relation to the IRS. The total funding allocated is £41.602m for the period April

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.72

[Return to Top]

Usage of Overtime Bank and Agency Staff within Budget	
Target: Spending within budget	**SLT Lead: Finance Director**

Current Performance against Target or Standard

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	1.906	103	125	130	**154**	146	129	183	179	193	140	173	(332)
Target £1.533M Forecast		128	128	128	128	128	128	128	128	128	128	128	128

Agency actual / f'cast Expenditure 22/23 and Average actual 21/22 & 20/21

Spend £'000

240 220 200 180 160 140 120 100 80 60 40 20 -20 -40 -60 -80 -100 -120 -140 -160 -180 -200 -220 -240 -260 -280 -300 -320 -340

Apr (Act) May (Act) Jun (Act Jul (Act) Aug (Act) Sep (Act) Oct (Act) Nov (Act) Dec (Act) Jan (Act) Feb (Act) Mar (Act)

Spend & F'cast 22/23 | Av. Spend 20-21 | Av. Spend 21-22

Performance

The spend on agency for March '23 was £(0.332)m (February £0.173m), which gives a cumulative full year spend of **£1.323m** for 2022-23 (£1.906m 2021/22). Of these totals the total spent on agency directly relating to Covid was £0.314m (£0.826m 2021-22). Agency costs have decreased this year from the 2021-22 levels which is due to the reduction of agency staff previously recruited to support Covid response. Further reductions in the use of agency were expected in 2022-23 by recruiting staff required on a permanent basis. However, more agency staff were required at the back end of the year in particular to support the running of estates in VCC to ensure delivery of ongoing maintenance and statutory compliance duties. The service has been actively recruiting into this area, so agency costs are expected to be replaced by the use of appointing permanent staff during 2023-24.

During March a review of agency requirement within VCC was undertaken which resulted in the release of a bfwd provision from 2021-22. In addition, a review of system committed orders was undertaken which resulted in several receipted orders being identified as no longer being required. This generally occurs when agency staff leave before their agreed term and the orders need to be closed, consequently a credit is released back into the revenue position

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Actions addressed via Divisional action plans		Matthew Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.74

Return to Top

Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	1.100	0.75	.0160	0.254	**0.355**	0.429	0.592	0.709	0.795	0.945	1.064	1.182	1.300
Target £1.3M Forecast		0.75	0.160	0.254	0.355	0.474	0.592	0.709	0.795	0.945	1.064	1.182	1.300

Overall VUNHST Cost Improvement Programme £1.3M

Performance

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as cost reduction saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

Two VCC workforce schemes which relate to service redesign and support structures continued to be impacted by the Covid legacy of higher than normal sickness levels and significant activity demand pressures during 2022-23 and therefore were turned from RAG rated amber to red due to the inability to deliver.

Service redesign and support structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the VCC Division however, it was recognised due to the current challenges that these saving schemes were not going to be achieved during the financial year.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Actions delivered through Divisional Action Plans		M. Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.60

Return to Top

Public Sector Payment Performance Target Non NHS Invoices paid within 30 days

Target: 95%

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Capital & Revenue Invoices				95	95	96	96	96	96	96	96	95	94	95	95
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

Assessment of current performance, set out key points:

During March '23 the Trust (core) achieved a draft compliance level of **95%** (February 23: 95%) of non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **95%** (draft) for 2022-23 and a final Trust position (including hosted bodies) of **95%** (draft) which will result Trust as a whole met its statutory target of 95%.

PSPP has shown signs of recovery over the last couple of months which is following a dip of performance in the preceding few months and this has resulted in the overall Trust achieving the 95% target. Work between the finance team, NWSSP accounts payable team and the service will need to continue in order to both improve and maintain performance going into 2023/24.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
	31/03/2023	M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Work between Finance, NWSSP and the service will continue into 2023-24 in order to both improve and maintain performance.	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance

-

EQUITABLE

KPI Indicator WOD.81

Return to Top

% Workforce declared Welsh Speakers in Trust at Level 1	
Target: TBA%	SLT Lead: Director of Workforce and OD
Current Performance against Target or Standard	Performance

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

Total VUNHST headcount 1624

Welsh speakers 116 headcount (4%)

SPC Chart Analysis

The SPC chart shows

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator WOD.78

Return to Top

Diversity of Workforce (Gender) % of Women in Senior Leadership positions

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

Total VUNHST headcount 1624

Male 405 (25%)

Female 1219 (75%)

Senior positions (Band 8 +)

Male 94 (37%)

Female 159 (63%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.79

Return to Top

Diversity of Workforce % Black, Asian and Minority Ethnic people applying Wales version of Workforce Race Equality Standard (WRES)	
Target: TBA%	**SLT Lead: Director of Workforce and OD**
Current Performance against Target or Standard	**Performance**

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

Total VUNHST headcount 1624

White 1424 (88%)

Black, Asian and Minority Ethnic people 200 (12%)

SPC Chart Analysis

The SPC chart shows

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.80

Return to Top

Diversity of Workforce – People with a Disability

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

Total VUNHST headcount 1624

People with a Disability 70 (4%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST MARCH (M12)

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	02/05/2023	Noted
Quality Safety & Performance Committee	16/05/2023	Noted

ACRONYMS	
SoFP	Statement of Financial Position
PSPP	Public Sector Payment Performance
IMTP	Integrated Medium Term Plan
LTA	Long Term Agreement
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

nVCC	New Velindre Cancer Centre
EMB	Executive Management Board
MMR	Monthly Monitoring Returns
HTW	Health Technology Wales
CEL	Capital Expenditure Limit

1. SITUATION/BACKGROUND

1.1 The attached report outlines the final financial position and performance for 2022-23.

1.2 The financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as it is directly accountable to WG for its financial performance. Only the balance sheet (SoFP) and cash flow provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

1.3 The figures in this report are currently in draft subject to audit review and sign off.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Total Actual 2022-23	Year End Forecast £m
Revenue	Variance	0.061	0.064	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	10.155	27.758	0.000
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.0%	95.0%	95.0%

2.2 Revenue Budget

The overall position against the profiled revenue budget for 2022-23 was an underspend of **£0.064m**.

Revenue budget Key highlights

During the period the Trust has received full funding towards the temporary increase in Employers NI, the increased energy costs above baseline due to energy price inflation and Covid response costs.

The Trust also received funding towards the 2022-23 pay award that was provided to the Trust in September which left a gap of £0.045m relating to unfunded incremental drift. Whilst the gap will be met this year it will impact on the financial position in future years which will need to be met by Divisions.

Full funding has been provided from WG to support the non-consolidated 1.5% pay award that was received in March 23.

At this stage the Trust is expecting to receive full funding for the 1.5% consolidated pay award which will be processed during May 23 and back dated to April 22.

Whilst still in negotiations any further pay award associated with 2022-23 is expected to be fully funded by WG.

The Trust fully achieved the savings target during 2022-23 with replacement schemes being implemented to support under delivery on two schemes that turned RAG rated red due to the inability to deliver during the period.

The Board were previously made aware of and approved that the recharge to the Charity will be reduced by £1.5m during 2022-23 to offset c£1.5m of non-recurrent income that the Trust accumulated from a number of sources. This was transacted in March 2023.

2.3 PSPP Performance (draft)

Draft PSSP performance for the whole Trust was **95%** against a target of 95%, with the Core Trust excluding NWSSP also recording 95%.

PSPP improved in Feb & Mar ‘23 following a dip of performance in the preceding few months which enabled the overall Trust to achieve the 95% target. Work between the finance team, NWSSP accounts payable team and the service will need to continue in order to both improve and maintain performance going into 2023/24.

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

2.4 Covid Expenditure

Covid-19 Revenue Spend 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.224		0.224	0.375	0.151
PPE	0.070		0.070	0.335	0.265
Cleaning	0.289		0.289	0.427	0.138
Other Covid Response	0.290		0.290	0.967	0.677
Covid Recovery - Internal Capacity		3.167	3.167	6.056	2.889
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.873	**3.428**	**4.301**	**12.310**	**8.009**

The overall gross funding requirement related to Covid for 2022-23 was £4.301m, with £0.873m being funded directly from WG, and the balance of £3.428m largely funded by the Trust Commissioners via LTA as additional income where activity is above 2019-20 baseline, with financial protection from the National Funds Flow framework. T

The £4.301m represents a significant reduction in activity outsourcing costs included in the Trust IMTP plan as of 31st March '22, due to the liquidation of the outsourcing provider Rutherford Cancer Centre (RCC). The lost outsourcing capacity was replaced through creating additional internal capacity and productivity improvements.

Other funding / cost reduction reflects control measures and review of service delivery models during the period to reflect WG Covid de-escalation guidance.

2.5 Reserves

The Trust reserves position delivered a surplus during 2022-23 due to slippage on previously approved commitments. Further, the Trust did not receive confirmation until November '22 that WG would fund exceptional cost pressures relating to Covid and energy costs in particular. In addition, release of recurrent reserves for new investment was not considered possible in 2022/23 as they have been ringfenced to support the 2023/24 expected financial pressures on both energy and Covid recovery staff capacity.

The underspend on reserves was utilised to support the suspension of recharges to the charity during 2022-23.

2.6 Financial Risks

All risks were mitigated during the period to ensure delivery of the financial position.

2.7 Capital

The overall Capital programme achieved the Trust CEL by reporting a spend of £27.758m against a CEL allocation of £27.760m.

An underspend from last minute slippage on the discretionary programme was utilised against the IRS programme under the All Wales Capital programme.

Slippage on the nVCC Enabling Works has resulted in the Trust returning £7.102m of funding to WG during 2022-23 which will be re-provided next financial year.

The Trust (during November) received the funding award letter from WG in relation to the IRS. The total funding allocated is £41.602m for the period April 2022 to March 2026 with £7.900m of the total being provided during 2022-23.

3. IMPACT ASSESSMENT

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

FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust reported a financial position of **£0.064m** for 2022-23 which is in line with the IMTP

4. RECOMMENDATION

Trust Board is asked to:

4.1 **NOTE** the contents of the March 2023 financial report and in particular the yearend financial performance which reported a £0.064m underspend.

4.2 **NOTE** the TCS Programme financial report for 2022-23 which is attached as **Appendix 1** and in particular the reported breakeven position on and the reported £0.131m underspend on the revenue budget.

.

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

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED MARCH 2022 /23

TRUST BOARD

25/05/2023

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, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2022-23.

2. Background / Context

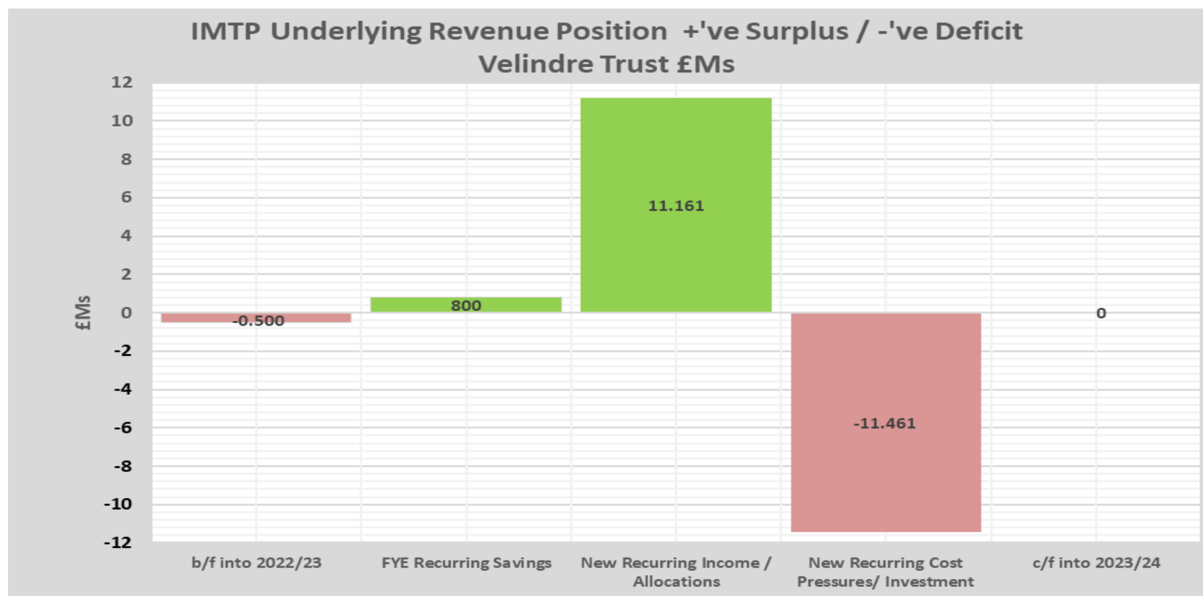
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- The Trust submitted a balanced three-year IMTP, covering the period 2022-23 to 2024-25 to Welsh Government on the 31 March 2022.

- For 2022-23 the Plan (excl Covid) included;
  - an underlying **deficit of -£0.5m** brought forward from 2021-22,
  - FYE **of new cost pressures / Investment** of **-£11.461m,**
  - offset by **new recurring Income** of **£11.161m,**
  - and Recurring FYE **savings schemes** of **£0.8m,**
  - Allowing **a balanced position** to be carried into 2023-24.

- The underlying deficit eliminated during 2022-23 through the discretionary uplift in funding, enabling a balanced position to be carried into 2023-24.

- **To eliminate the brought forward underlying deficit, the savings target set for 2022-23 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or managed through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2022/23	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2023/24
Velindre NHS Trust	-0.500	0.800	11.161	-11.461	0

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

	Unit	Current Month £m	Total Actual 2022-23	Year End Forecast £m
Revenue	Variance	0.061	0.064	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	10.155	27.758	0.000
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.0%	95.0%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	0	0

Revenue

The core Trust reported a **£0.061m** in-month underspend position for March ’23, with a cumulative final reported underspend position of **£0.064m** for 2022-23.

Capital

The final approved Capital Expenditure Limit (CEL) for 2022-23 was **£27.760m**. This represents all Wales Capital funding of £26.306m, and Discretionary funding of £1.454m. The Trust reported actual spend of **£27.758m** ensuring the Trust CEL target was achieved for 2022-23.

The Trust’s CEL for 2022-23 was broken down as follows:

	£m Opening	£m Movement	£m March 2023
Discretionary Capital	**1.454**	**0.000**	**1.454**
All Wales Capital:			
Fire Safety	0.500	0.000	0.500
CANISC Cancer Project	0.000	0.579	0.579
TCS Programme	23.902	-7.102	16.800
IRS		7.900	7.900
Priority year end schemes spend		0.370	0.370
WBS Infrastructure Fees		0.157	0.157
Subtotal All Wales Capital	**24.402**	**1.904**	**26.306**
Total CEL	**25.856**	**1.904**	**27.760**

With WG agreement, slippage on the TCS Programme led to a further £0.709m being handed back during January ‘23, in total £7.102m was provided back to WG during 2022-23. This funding will be re-provided to the programme during 2023-24.

During the period the Trust received approval from WG for the Integrated Radiotherapy Solution (IRS) capital expenditure with £7.900m being provided during 2022-23. The Trust was also awarded £0.370m as part of the request for year-end priority schemes, along with £0.157m, towards the OBC fees for the WBS infrastructure case which gave a revised Trust CEL of £27.760m for 2022-23.

PSPP

During March ’23 the Trust (core) achieved a draft compliance level of **95%** (February 23: 95%) of non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **95%** (draft) for 2022-23 and a final Trust position (including hosted bodies) of **95%** (draft) which will result Trust as a whole met its statutory target of 95%.

PSPP improved in Feb & Mar ‘23 following a dip of performance in the preceding few months which enabled the overall Trust to achieve the 95% target. Work between the finance team, NWSSP accounts payable team and the service will need to continue in order to both improve and maintain performance going into 2023/24.

Efficiency / Savings

The Trust fully achieved the savings target during 2022-23 with replacement schemes being implemented to support under delivery on two schemes that turned RAG rated red due to the inability to deliver during the period.

Revenue Position

2022/23 Financial Position			
£0.064m Underspent			
Type	**Full Year Budget (£m)**	**Full Year Actual (£m)**	**Full Year Variance (£m)**
Income	(185.404)	(184.518)	(0.886)
Pay	83.108	82.118	0.990
Non Pay	102.296	102.335	(0.040)
Total	**(0.000)**	**(0.064)**	**0.064**

The overall final position against the profiled revenue budget for 2022-23 was an underspend of **£0.064m**

4.1 Revenue Position Key Issues

Suspension of expenditure recharges to Charity 2022/23

During 2022/23 the Trust has accumulated c£1.5m of non-recurrent income from a number of sources including significantly higher levels of bank interest income than normal, non-commitment

of all its recurrent discretionary funding, unused recurrent emergency reserve and non-recurrent accountancy gains.

The Trust receives funding from the Charity which supports the supplementation of cancer services, the administration of the funds and investment in research and development. Given the c£1.5m of extraordinary non-recurrent income generated the level of Trust expenditure funded by the Charity in 2022-23 was reduced by £1.5m.

Income Key Highlights

Income in WBS is lower than planned on Bone Marrow where the annual target was not achieved for 2022-23.

VCC and Corporate over achievement on private patient, SACT homecare and bank interest.

nVCC overachievement on interest received from the Escrow bank account.

Overall income overachievement reduced by £1.5m due to the suspension of expenditure recharges to the Charity.

Pay Key Highlights

The total core Trust vacancies as at March 2023 is 125wte, VCC (70wte), WBS (28wte), Corporate (11Wte), R&D (10wte), TCS (0wte) and HTW (6wte).

The Trust received the pay award funding of £3.065m from WG relating to 2022-23. Following review by Divisions the funding gap was £450k which relates to unfunded incremental drift. The funding gap in year was met through the high level of vacancies that have been carried throughout the Trust, along with the release of the additional annual leave provision carried forward from last year. The recurrent financial impact into future years has been considered as part of the IMTP process however the requirement will be that each Division will need to manage this pressure internally.

Full funding was provided from WG to support the non-consolidated 1.5% pay award that was received in March 23.

At this stage the Trust is expecting to receive full funding for the 1.5% consolidated pay award which will be processed during May 23 and back dated to April 22.

Whilst still in negotiations any further pay award associated with 2022-23 is expected to be fully funded by WG.

The Trust received the full funding of £0.339m from WG towards the temporary increase in Employers NI rates (1.25%).

Vacancies throughout the Trust although reducing remained high during 2022-23. A large number of posts in VCC and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work is continuing in both Divisions to understand the likely cancer activity demand and associated income, secure additional funding to support these posts and assessing options to migrate staff into vacancies to help mitigate the financial risk exposure.

Both VCC and WBS hold a £0.450m vacancy factor target, which will need to be achieved during 2022-23 in order to balance the overall Trust financial position.

Non Pay Key Highlights

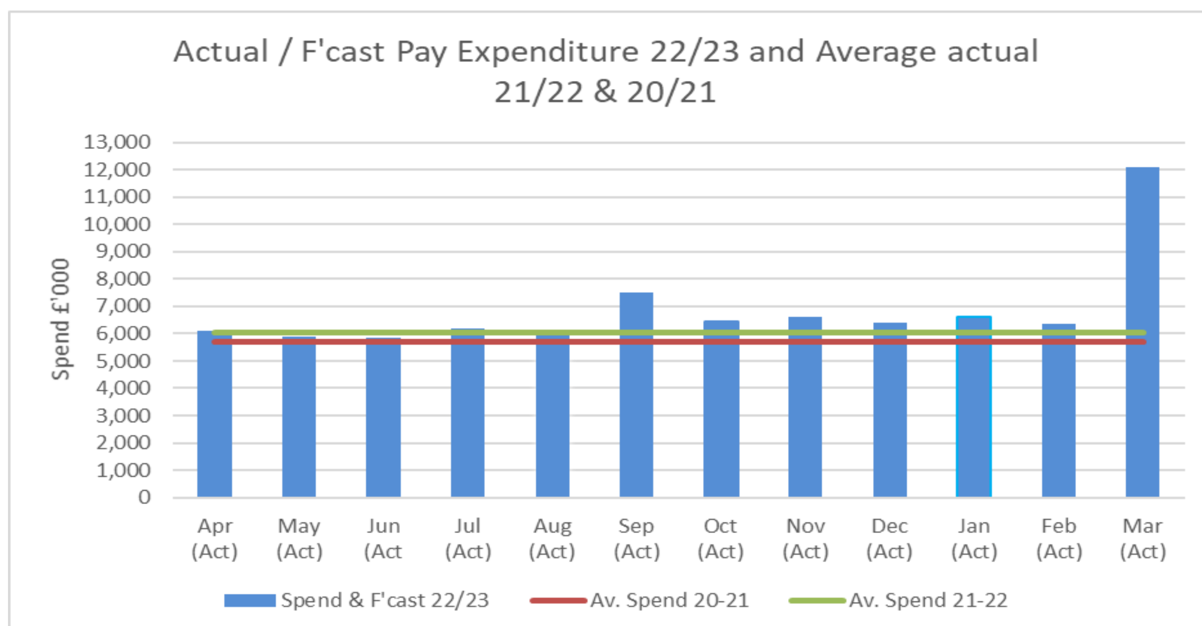
WG provided funding of £0.671m to support the increase in energy costs above the 2021-22 baseline.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust savings target for each Division was set as VCC £0.700m, WBS £0.500m and Corporate £0.100m as part of the IMTP for 2022-23 which were fully delivered, although two VCC workforce schemes for service redesign and support structures could not be delivered due to the high level of gaps due of sickness and vacancies. Replacement schemes were implemented to deliver the savings target.

The Trust reserves and previously agreed unallocated investment funding was distributed out in month 12 to support the divisional income targets that were reduced following the suspension of recharges to the charity.

4.2 Pay Spend Trends (Run Rate)

The pay award for 2022-23 was paid in September (back dated to April) as demonstrated in the spike in pay spend shown in the graph below. The 1.5% Consolidated pay award and additional 6.3% pension both funded via WG explains the surge in the pay during March.

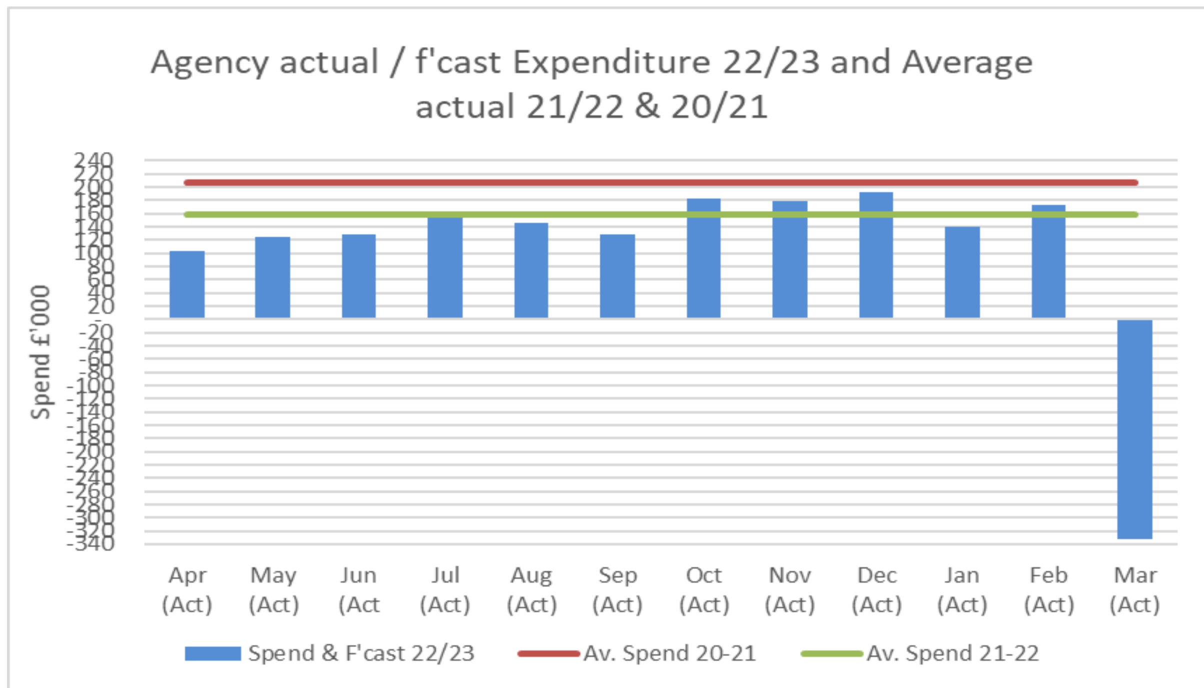


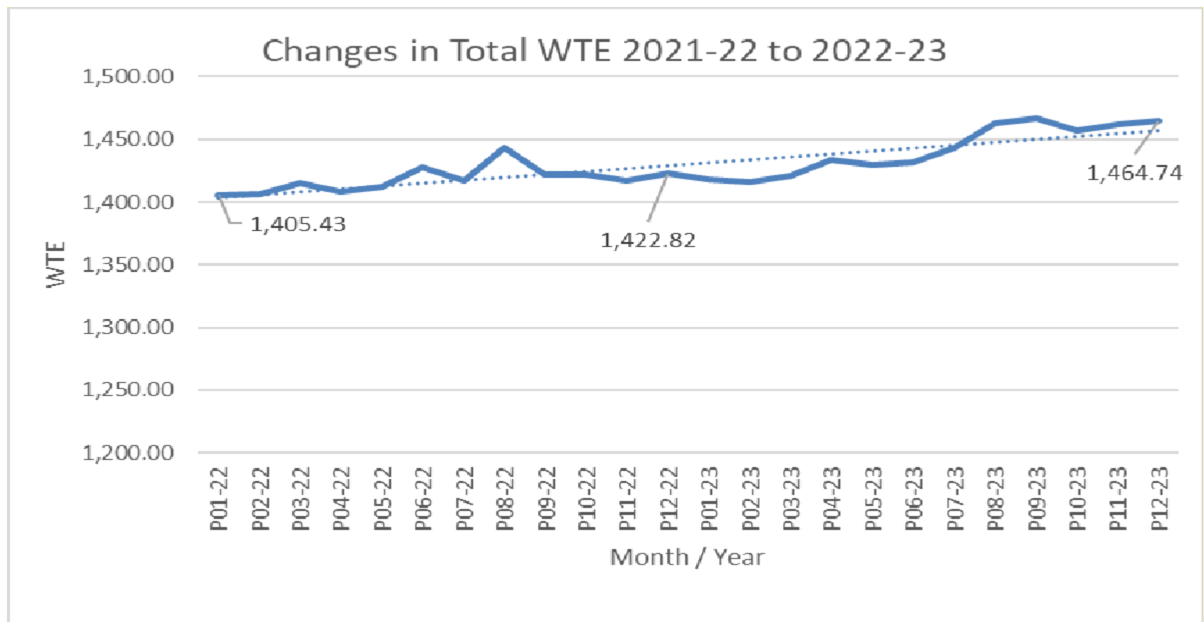
The spend on agency for March '23 was £(0.332)m (February £0.173m), which gives a cumulative full year spend of **£1.323m** for 2022-23 (£1.906m 2021/22). Of these totals the total spent on agency directly relating to Covid was £0.314m (£0.826m 2021-22).

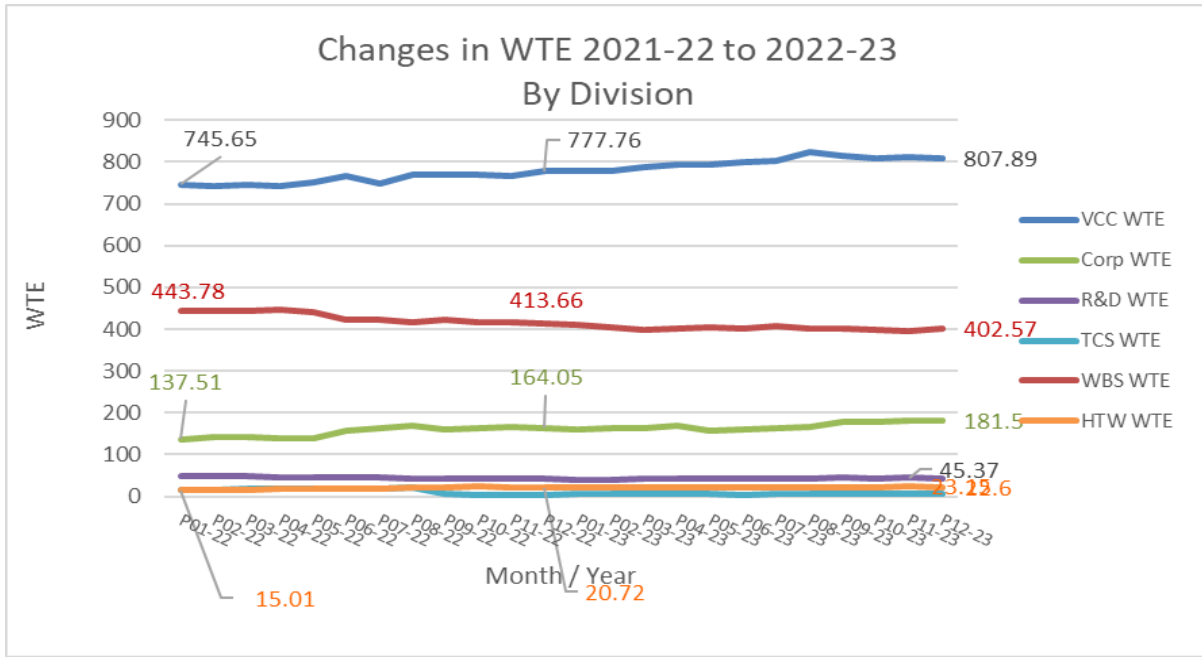
Agency costs have decreased this year from the 2021-22 levels which is due to the reduction of agency staff previously recruited to support Covid response. Further reductions in the use of agency were expected in 2022-23 by recruiting staff required on a permanent basis. However, more agency staff were required at the back end of the year in particular to support the running of estates in VCC to ensure delivery of ongoing maintenance and statutory compliance duties. The

service has been actively recruiting into this area, so agency costs are expected to be replaced by the use of appointing permanent staff during 2023-24.

During March a review of agency requirement within VCC was undertaken which resulted in the release of a bfwd provision from 2021-22. In addition, a review of system committed orders was undertaken which resulted in several receipted orders being identified as no longer being required. This generally occurs when agency staff leave before their agreed term and the orders need to be closed, consequently a credit is released back into the revenue position.



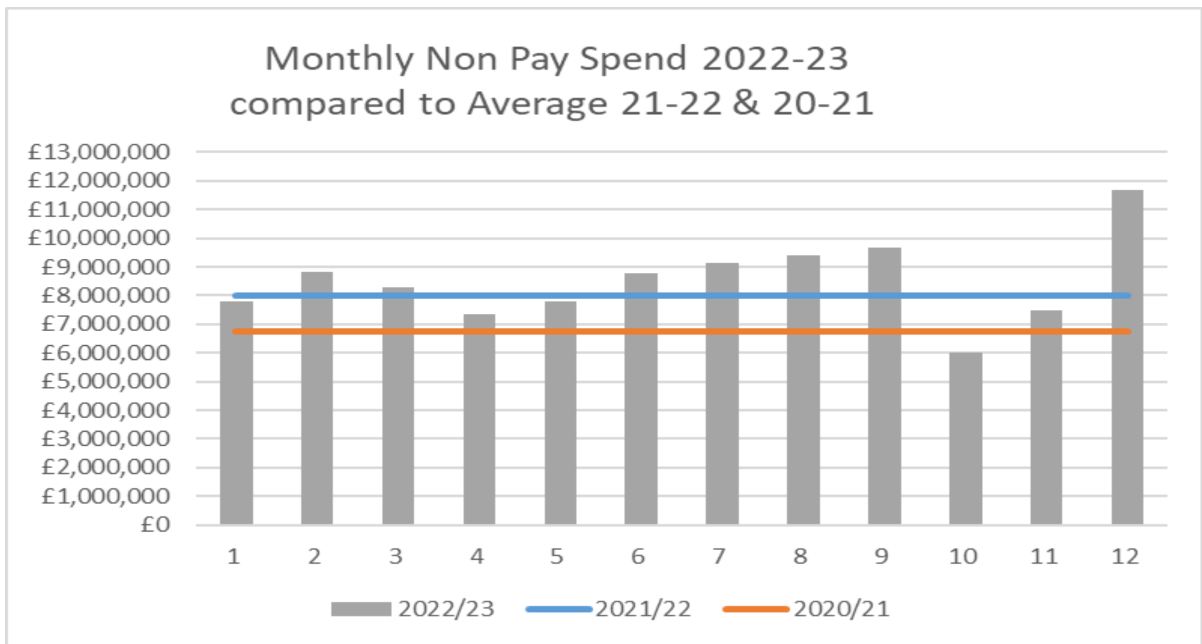




The increase of 20 WTE during November (P08-23) is largely within VCC and relates to the recruitment of Nurses and HCSW into service area's such as inpatients, Chemotherapy and Prince Charles.

4.3 Non Pay

Non-pay 2021-22 (c£96m) average monthly spend of £8m was £1.2m higher than the reported monthly average spend for 2020-21 (£6.8m). The majority of the monthly average increase (circa £0.9m) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and an increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 was £8.5m which is an average increase of circa £0.5m, a large element of this increase relates to the WBS wholesaling costs, along with the growth in energy costs and general inflation.



The non-pay spend reduction in January is due to NICE / High Cost Drugs spend being offset by receipt of rebates on a significantly higher scale than anticipated which was passed on to the Health Boards and WHSSC. In addition, there has been delays in implementation of new NICE drug treatments for SACT compared to the horizon scanning used to forecast patient volumes and cost.

During March a provision of £1.5m was made under nVCC for FBC bidder reimbursement costs, which are expected to be funded by WG.

4.4 Covid-19

The total funding requirement for 2022-23 in relation to Covid was £4.301m. This was a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £4.301m total Covid requirement £0.873m (IMTP plans £2.104m) was funded directly from WG, and the balance of £3.428m (IMTP plans £10.206mwas largely provided by our commissioners via LTA as additional income where activity is above 2019-20 baseline, with financial protection from the National Funds Flow framework.

Covid-19 Revenue Spend 2022/23

	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.224		0.224	0.375	0.151
PPE	0.070		0.070	0.335	0.265
Cleaning	0.289		0.289	0.427	0.138
Other Covid Response	0.290		0.290	0.967	0.677
Covid Recovery - Internal Capacity		3.167	3.167	6.056	2.889
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.873	**3.428**	**4.301**	**12.310**	**8.009**

The Trust received £0.873m funding from WG which supported all associated Covid response costs.

The Trust Covid recovery expenditure for 2022-23 of £3.428m was a result of investment in additional capacity based on activity demand forecast modelling which commenced in 2021-22 and has been updated regularly working with Health Board operational teams. The initial anticipated funding requirement of £4.150m for outsourcing was removed as the Rutherford Cancer Centre (RCC) went into liquidation during the period. The Trust expanded internal capacity at its outreach Centre at Prince Charles Hospital (from October '22) for SACT, with additional cost of £0.261m above that already invested in Covid capacity. In addition, the Trust had developed plans for expanding Radiotherapy capacity internally through use of weekend working which has required existing staff to work additional hours as Waiting List Initiatives (WLIs) with enhanced pay rates. These additional investments in capacity to meet the activity demand from Health Boards was not fully covered through LTA marginal income, despite the National funds flow protection, leading to an additional financial pressure of c£0.500m to the Trust which it managed through use of non-recurrent measures in 2022-23. However, with the anticipated removal of the LTA income protection in 2023-24 there will be a financial risk of c£1.5m which the Trust will need to cover through inflation growth funding and / or savings depending on demand growth and the Trust ability to deliver activity within the current capacity.

Other cost reduction from IMTP plans reflected financial control measures and review of service delivery models to reflect the WG Covid de-escalation guidance.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as cost reduction saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

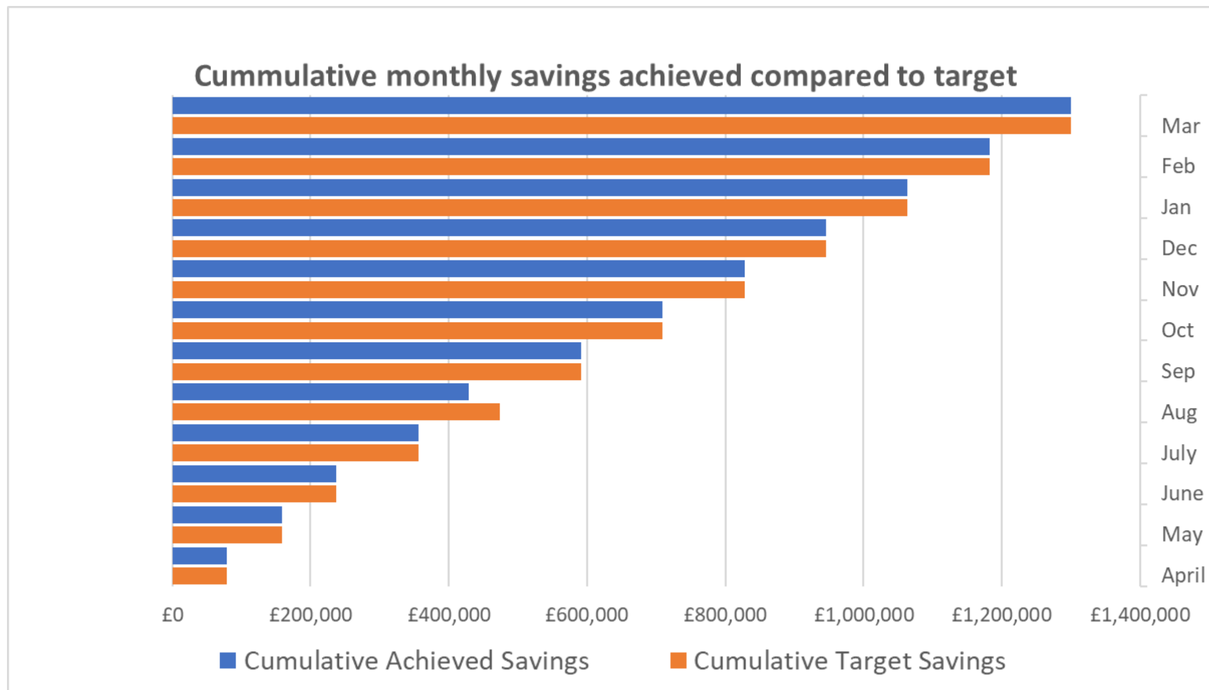
Two VCC workforce schemes which relate to service redesign and support structures continued to be impacted by the Covid legacy of higher than normal sickness levels and significant activity demand pressures during 2022-23 and therefore were turned from RAG rated amber to red due to the inability to deliver.

Service redesign and support structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the VCC Division however, it was recognised due to the current challenges that these saving schemes were not going to be achieved during the financial year.

Contingency measures were put in place during 2022-23 on the realisation that these savings schemes were not going to achieved. **It is important as we move into 2023/24 that divisions take ownership of their respective saving schemes to ensure that they are full delivered during the period.**

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	**700**	**700**	**500**	**(200)**	**500**	**(200)**
			71%		**71%**	
WBS TOTAL SAVINGS	**500**	**500**	**500**	**0**	**500**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**100**	**100**	**100**	**0**	**100**	**0**
			100%		**100%**	
TRUST LEVEL TOTAL SAVINGS			**200**	**200**	**200**	**200**
TRUST TOTAL SAVINGS IDENTIFIED	**1,300**	**1,300**	**1,300**	**0**	**1,300**	**0**
			100%		**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							
Establishment Control (Corporate)	Green	100	100	100	0	100	0
Laboratory & Collection Model (WBS)	Green	50	50	50	0	50	0
Laboratory & Collection Model (WBS)	Green	50	50	50	0	50	0
Stock Management (WBS)	Green	100	100	100	0	100	0
Stock Management (WBS)	Green	150	150	150	0	150	0
Procurement - Supply Chain (WBS)	Green	50	50	50	0	50	0
Service Redesign (VCC)	Red	100	100	0	(100)	0	(100)
Supportive Stuctures (VCC)	Red	100	100	0	(100)	0	(100)
Procurement - Supply Chain (VCC)	Green	50	50	50	0	50	0
Bank Interest (Trust - In Year)	Green		0	167	167	167	167
Vacancy Factor (Trust - In Year)	Green		0	33	33	33	33
Total Saving Schemes		**750**	750	750	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	50	50	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	50	50	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	150	150	150	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	100	100	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	200	200	0	200	0
Total Income Generation		**550**	550	550	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**1,300**	**1,300**	**0**	**1,300**	**0**
				100%		**100%**	



5. Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

The Trust reserves position delivered a surplus during 2022-23 due to slippage on previously approved commitments. Further, the Trust did not receive confirmation until November '22 that WG would fund exceptional cost pressures relating to Covid and energy costs in particular. In addition, release of recurrent reserves for new investment was not considered possible in 2022/23 as they have been ringfenced to support the 2023/24 expected financial pressures on both energy and Covid recovery staff capacity.

The underspend on reserves was utilised to support the suspension of recharges to the charity during 2022-23.

6. End of Year Forecast / Risk Assessment

The Trust reported a small yearend underspend position of £0.064m against its revenue budget for 2022-23. All risks were mitigated during the period to ensure delivery of the financial position.

7. 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 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme			
nVCC - Project costs	2.394	2.994	-0.600
nVCC - Enabling Works	14.406	13.806	0.600
Canisc Cancer Project	0.579	0.582	-0.003
Fire Safety	0.500	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	8.004	-0.104
WG Priority Year end Spend	0.370	0.370	0.000
WBS Infrastructure OBC Fees	0.157	0.139	0.018
Total All Wales Capital Programme	26.306	26.395	-0.089
Discretionary Capital	1.454	1.363	0.091
Total	27.760	27.758	0.002

The approved 2022-23 Capital Expenditure Limit (CEL) for 2023 was £27.760m. This includes All Wales Capital funding of £26.306m, and discretionary funding of £1.454m. The approved CEL increased during the year by a total of £1.904m. This reflects approval of the Canisc Cancer Project (£0.579m), IRS (£7.900m), Velindre's share of the WG yearend spend request (£0.370m) and support fees for the WBS infrastructure OBC (£0.157m). The increased capital allocation was offset by a reduction of £7.102m on the nVCC Enabling Works project to reflect the cash flow requirement for 2022-23. Following agreement with WG the £7.102m will be re-provided to the programme during 2023-24.

WG colleagues agreed a further movement of £0.600m between the nVCC enabling and project costs which is reflected in the table above but represented as a variance rather than a CEL adjustment.

In January 2022 WG informed the Trust that the discretionary allocation would be significantly reduced during 2022-23 (previously £1.911m), which was reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

Following a request from WG a list of prioritised bids was approved by EMB on 26th October for submission to WG should any Capital funding become available. The Trust received confirmation during November that £0.370m of additional funding would be provided to support delivery of the priority one schemes which includes replacement Hemoflows in WBS £0.238m, Patient Monitors in VCC £0.062m and £0.070m towards Digital priorities.

On the 22nd November the Trust received the award funding letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.900m of the total to be provided during 2022/23 with future years funding cash flow to be agreed with WG.

Within the £7.900m of IRS funding, £0.694m has been released back into the discretionary programme which was previously either spent or ringfenced to support the procurement stage of the IRS project. Of the £0.694m, £0.434m was ringfenced from discretionary in 2022-23 and £0.260m will be reimbursed from the WG funding allocation as the spend was incurred last financial year.

The £0.694m will be utilised to support the remaining priority one schemes that were submitted to EMB on the 26th October but not supported by WG.

The Trust CEL was fixed on the 31st October. At this point WG would expect any further slippage to be managed internally by the Trust.

On the 16th December the Trust was awarded funding of £11.400m in respect of the Integrated Radiotherapy Solution (IRS) for the Satellite Centre at Nevil Hall. The funding will be drawn down from 2023-24 and beyond to match the profiled spend.

Yearend performance

The total spend on the All-Wales Capital Programme schemes for 2022-23 was £26.395m which resulted in a small overspend of £0.089m against the approved CEL of £26.306m. Following last minute slippage on the discretionary programme of £0.091m, along with cost savings on the WBS Infrastructure OBC costs (£0.018m) a decision was made to utilise the underspend by bringing forward the purchase of licenses required for the IRS programme.

The Trust discretionary actual spend for 2022-23 was £1.377m against an approved CEL of £1.454m leaving a balance of £0.002m on the overall Capital programme resulting in the Trust achieving its CEL target for 2022-23.

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund. These include:

All Wales Approved and Unapproved Capital Schemes	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works	7.979	0.000	1.547			9.526
Integrated Radiotherapy Solution (IRS)	10.326	15.813	5.634			31.773
IRS Satellite Centre	1.347	10.065				11.412
Total Approved Capital Schemes	**19.652**	**25.878**	**7.181**	**0.000**	**0.000**	**52.711**
All Wales Unapproved Schemes						
TCS nVCC	7.168	34.132	7.147			48.447
TCS nVCC Enabling works	1.000					1.000
WBS HQ	0.120	1.016	12.808	9.996	10.961	34.901
Plasma Fractionation (under development)						0.000
WBS Fleet Replacement		1.400				1.400
WTAIL Lims Case	0.826	0.066				0.892
WBS Blood Establishment Computer System (BECS) (under development)						0.000
WBS Blood Group Analyser Replacement		0.480				0.480
WBS Asset Replacement		0.300	0.400	0.500		1.200
VCC Replacement Brachytherapy Applicators			0.300			0.300
Digital Services	0.650	0.400	0.400	0.400		1.850
Digital Scanning infrastructure	2.536	0.536				3.072
Total Unapproved Capital Schemes	**12.300**	**38.330**	**21.055**	**10.896**	**10.961**	**93.542**
Total All Wales Capital Plans	31.952	64.208	28.236	10.896	10.961	146.253

8. BALANCE SHEET (Including Hosted Organisations)

The Balance Sheet in NHS Financial Statements is known as the Statement of Financial Position (SoFP). 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.

Due to the financial year end the balance sheet is currently not ready to be presented to EMB.

9. CASH FLOW (Includes Hosted Organisations)

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.

As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to

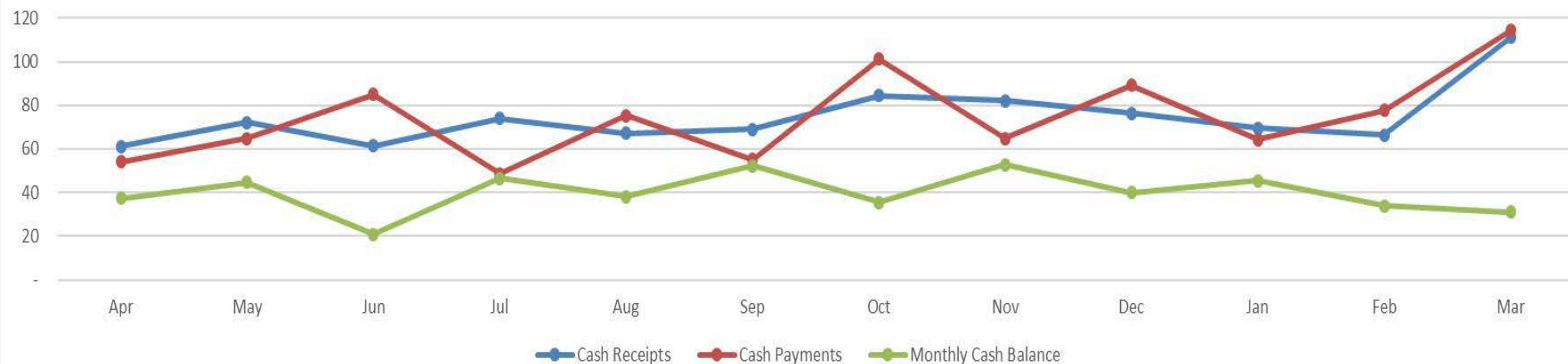
provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the continued uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however have now issued the additional stock and the £4.5m was repaid to WG during February '23.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding bank account during May '22 for the nVCC programme. These funds were consequently drawn down in July '22 from WG to reimburse the Trust ensuring that there was no cash risk to the organisation.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to pay its creditors and meet anticipated commitments.

	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													
LHB / WHSSC income	33,135	40,208	40,042	37,491	47,836	36,522	43,649	41,695	38,513	45,628	44,298	44,698	493,714
WG Income	20,937	24,551	17,010	24,552	15,002	26,148	32,585	33,410	26,654	16,898	15,890	45,123	298,760
Short Term Loans													0
PDC				5,928								12,551	18,479
Interest Receivable	19	27	30	25	37	62	75	105	103	174	157	163	977
Sale of Assets													0
Other	7,106	7,289	4,321	6,094	4,246	6,395	8,220	6,982	11,052	6,891	6,119	8,726	83,442
TOTAL RECEIPTS	**61,197**	**72,074**	**61,403**	**74,090**	**67,121**	**69,127**	**84,529**	**82,192**	**76,323**	**69,591**	**66,464**	**111,262**	**895,373**
PAYMENTS													
Salaries and Wages	21,735	29,243	29,483	29,705	29,549	34,417	36,535	33,118	32,231	32,387	31,821	34,197	374,422
Non pay items	30,543	33,079	54,139	17,703	44,384	20,200	63,158	29,085	55,738	30,845	38,992	71,723	489,589
Short Term Loan Repayment											4,500		4,500
PDC Repayment													0
Capital Payment	1,926	2,567	1,420	1,215	1,428	446	1,469	2,732	1,152	1,105	2,455	8,237	26,152
Other items													0
TOTAL PAYMENTS	**54,205**	**64,889**	**85,042**	**48,623**	**75,361**	**55,063**	**101,162**	**64,935**	**89,121**	**64,337**	**77,768**	**114,157**	**894,663**
Net cash inflow/outflow	6,993	7,185	(23,639)	25,467	(8,240)	14,064	(16,633)	17,257	(12,798)	5,254	(11,304)	(2,896)	
Balance b/f	30,404	37,397	44,582	20,943	46,410	38,170	52,234	35,601	52,858	40,060	45,313	34,009	
Balance c/f	37,397	44,582	20,943	46,410	38,170	52,234	35,601	52,858	40,060	45,313	34,009	31,114	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
VCC	**(39.905)**	**(39.892)**	**0.014**
RD&I	**0.149**	**0.153**	**0.004**
WBS	**(21.405)**	**(21.406)**	**(0.001)**
Sub-Total Divisions	**(61.162)**	**(61.145)**	**0.017**
Corporate Services Directorates	**(12.123)**	**(12.231)**	**(0.108)**
Delegated Budget Position	**(73.285)**	**(73.376)**	**(0.091)**
TCS	**(0.695)**	**(0.564)**	**0.131**
Health Technology Wales	0.000	0.025	0.025
Trust Income / Reserves	**73.980**	**73.980**	**(0.000)**
Trust Position	0.000	0.064	0.064

VCC

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**64.501**	**64.441**	**(0.060)**
Expenditure			
Staff	**46.069**	**46.038**	**0.031**
Non Staff	**58.338**	**58.295**	**0.042**
Sub Total	**104.407**	**104.333**	**0.074**
Total	**(39.905)**	**(39.892)**	**0.014**

VCC Key Issues:

The reported final financial position for the Velindre Cancer Centre during 2022-23 was a small underspend of **£0.014m.**

Income for 2022-23 represented an underachievement of **£(0.060)m**. The divisional savings target offset the additional income received from the VAT savings made from providing SACT homecare,

and the surplus on private patient income due to drug performance, along with several other small overachievements.

VCC reported a **£0.031m** underspend against staff for 2022-23. The Division continues to carry a large number of vacancies with the savings generated being above the divisional vacancy factor target and offsetting the cost of agency (£0.875m) for 2022-23, £0.276m being directly related to Covid). In addition, the savings from vacancies are also supporting the costs of advanced recruitment for implementation staff into the IRS project.

Medical staff costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. Additionally, an enhanced out of hours service for advanced life support, which will be nursing led, currently continues to be covered by Jnr Dr's with transition to nursing having begun being phased in.

Non-Staff Expenditure reported a **£(0.042)m** underspend for 2022-23. Overspends in the period largely related to the facilities management office pressures which were previously supported by Covid, maintenance and repair of the Linacs, and consumable spend from increased activity. The overspends were offset by utilisation of the Divisional reserves, and drug rebate income.

WBS

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**26.759**	**26.315**	**(0.444)**
Expenditure			
Staff	**17.274**	**17.299**	**(0.024)**
Non Staff	**30.889**	**30.422**	**0.467**
Sub Total	**48.164**	**47.721**	**0.443**
Total	**(21.405)**	**(21.406)**	(0.001)

WBS Key Issues:

The reported final financial position for the Welsh Blood Service during 2022-23 was **breakeven**.

WBS reported an income underachievement of **£(0.444)m** where activity was significantly lower than planned on Bone Marrow. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulted in activity being considerably lower than target. There has been a lack of growth in the bone marrow registry largely due to the legacy impact of Covid and inability to grow the panel in sites such as schools and universities, which is currently being addressed through campaigns. The WHSSC income for supressed activity for the first 6 months is reflected as an underspend within the non-pay position which is due to the mechanics of WHSSC allocation and a requirement to set a non-pay budget within the WBS reserves. The WHSSC income support for the underachievement was fully utilised during the first 6 months.

Targeted income generation from plasma sales has recovered following the contract award for a new supplier in October which included an increased selling price. Benefits of new contract reflected with significant upturn in the latter part of the year which resulted in an overachievement being reflected for 2022-23.

Staff reported a **£(0.024)m** overspend for 2022-23. Overspend was a result of posts being supported without identified funding source which includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured. The Trust has now received confirmation of funding from WG to support the Plasma programme (previously fractionation) staffing costs so this pressure has been removed.

Work continues to be underway to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff reported an underspend of **£0.467m** is largely due to reduced costs from suppressed activity underspends within Laboratory Services and WTAIL. WTAIL underspend is inclusive of WHSSC allocation relating to Bone Marrow reflected to contra income underachievement as described above.

Corporate

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**5.799**	**5.534**	**(0.264)**
Expenditure			
Staff	**14.853**	**14.250**	**0.603**
Non Staff	**3.068**	**3.515**	**(0.447)**
Sub Total	**17.922**	**17.765**	**0.156**
Total	**(12.123)**	**(12.231)**	(0.108)

Corporate Key Issues:

The final reported financial position for the Corporate Services division for 2022-23 was an overspend of **£(0.108)m**.

Reported Income underachievement is a result of the suspension of recharges to the Charity which is offsetting the benefits that the Trust is currently receiving from the Bank interest following rate rises.

Significant number of vacancies were bring carried in Corporate over the year (circa 8% of the total divisional workforce) which will led to a large underspend against staff. This also offset use of agency and ensure achievement the divisional savings target.

Non pay reported overspend is **£(0.447)m,** which largely relates to the divisional savings target FYE £(0.160)m, Microsoft agreement, Welsh Risk Pool (WRP) contribution, and the increased running costs associated with the hospital estate.

RD&I

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**3.713**	**3.556**	**(0.157)**
Expenditure			
Staff	**2.865**	**2.576**	**0.288**
Non Staff	**0.700**	**0.827**	**(0.127)**
Sub Total	**3.565**	**3.404**	**0.161**
Total	**0.149**	**0.153**	0.004

RD&I Key Issues

The final reported financial position for the RD&I Division for 2022-23 was a small **£0.004m** underspend.

Staff vacancies remained relatively high although active recruitment slowly reduced vacancy levels across the period, however several posts are not going be filled before the year end. The underspend on staff is offsetting the innovation income target which has not been met this year due to a vacancy in a key position.

Non staff overspend is a combination of multiple small pressures across several cost centres.

TCS – (Revenue)

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**1.897**	**2.004**	**0.107**
Expenditure			
Staff	**0.619**	**0.588**	**0.031**
Non Staff	**1.974**	**1.981**	**(0.007)**
Sub Total	**2.593**	**2.569**	**0.024**
Total	**(0.695)**	**(0.564)**	0.131

TCS Key Issues

The final reported financial position for the TCS Programme for 2022-23 was an underspend of **£0.131m.**

Income overachievement is a result of interest being received on the Escrow account.

During March a provision of £1.5m was made under nVCC for FBC bidder reimbursement costs which is fully funded by WG.

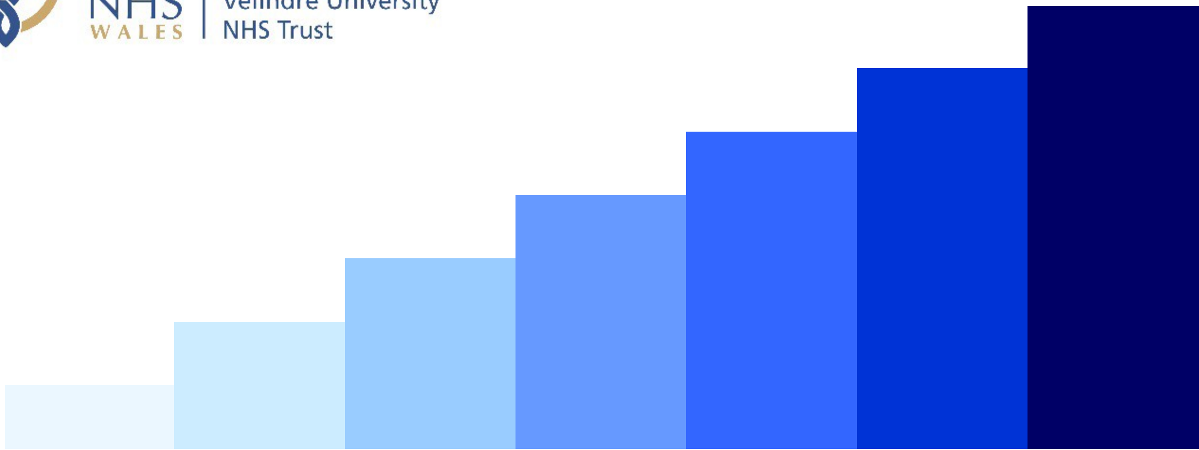
Preapproved reserves budget for strategic transformation £0.060m, non-pay costs of £0.030m, along with the total associated costs of the judicial review £0.033m has now been transferred into the TCS budget for 2022-23.

HTW (Hosted Other)

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**1.664**	**1.596**	**(0.068)**
Expenditure			
Staff	**1.428**	**1.367**	**0.062**
Non Staff	**0.235**	**0.204**	**0.031**
Sub Total	**1.664**	**1.571**	**0.093**
Total	**0.000**	**0.025**	0.025

HTW Key Issues

The final reported financial position for Health Technology Wales was an underspend of **£0.025m**.



TCS PROGRAMME
FINANCE REPORT 2022-23

Period Ending March 2023

Presented to the
EMB Shape Transformation Board on
17th April 2023

Contents Page

1. INTRODUCTION 2
2. EXECUTIVE SUMMARY 2
3. BACKGROUND 3
   Sources of Capital Funding 4
   Sources of Revenue Funding 4
4. CAPITAL POSITION 5
5. REVENUE POSITION 6
6. CASH FLOW 6
7. PROJECT FINANCE UPDATES 7
   Programme Management Office 8
   Enabling Works Project 8
   New Velindre Cancer Centre Project 9
   Integrated Radiotherapy Solution Procurement Project 10
   Service Delivery and Transformation Project 11
8. KEY RISKS AND MITIGATING ACTIONS 11
9. TCS SPEND REPORT SUMMARY 12
APPENDIX 1: TCS Programme Budget and Spend for 2022-23 13
APPENDIX 2: TCS Programme Funding for 2022-23 14
APPENDIX 3: TCS Cumulative Spend Report to 31st March 2022 16

1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2022-23, outlining spend against budget.

1.2 The TCS Programme financial position is continually monitored and updated, with an update provided regularly to both the TCS Programme Delivery Board and Trust Board.

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2022-23 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	2022-23 Full Year		
	Budget	Outturn	Variance
Capital	£16.801m	£16.801m	£0.000m
Revenue	£0.695m	£0.564m	£0.131m
Total	**£17.497m**	**£17.365m**	**£0.131m**

2.2 The overall outturn for the Programme is an underspend of £0.131m for the financial year 2022-23 against a budget of £17.497m.

2.3 The Enabling Works final position reflects an underspend of £0.600m, which has supported the nVCC Project. This has been provided from the Enabling Works QRA. The approach has been agreed with WG.

2.4 A review of the Enabling Works Project funding requirements during the year has resulted in a total virement of £7.102m from 2022-23 into 2023-24, and £0.305m to the nVCC Project, as agreed with WG. This, along with the change in the IRS Procurement Project funding, reduces the overall **capital** funding for 2022-23 to **£16.801m**. The adjustments undertaken by the Enabling Works during 2022-23 are as follows:

- Adjustment of £1.900m in May 2022 – delay in Enabling Works Project;
- Adjustment of £1.472m in August 2022 – delay in the Asda works;
- Adjustment of £3.021m in October 2022 – delay in the Asda works; utilities and Added Value works;
- Adjustment of £0.709m in January 2023 – further delay in the Asda works; utilities and Added Value works; and
- Virement of £0.305m to the nVCC Project.

2.5 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project was closed on 30th November 2022. The final costs for the Project at this time were £0.178m. Therefore, of the £0.434m funding ring fenced from the core Trust discretionary programme for the project in lieu of FBC approval, only the final requirement of £0.178m was drawn down by the Project. However, as there is provision to fund these costs in the IRS FBC, this amount was reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Moreover, the final costs for this Project will now be reported by the IRS

Implementation Project, as this is where the IRS Procurement Project for 2022-23 will therefore be not be reported by the TCS Programme.

2.6 A provisional revenue funding of £0.020m towards annual pay award costs was provided to the Programme in September 2022 from the WG allocation to the Trust. However, following a review of the Programme's revenue budget and forecast expenditure for the year, there are sufficient resources from within the Programme to cover these costs. Therefore, this additional funding has not been drawn down in 2022-23. These increased costs will however be take into account when forecasting future pay costs.

2.7 In February 2023, a non-consolidated pay enhancement of 1½% was awarded to NHS staff in Wales for 2022-23. Revenue funding of £0.021m was provided to the Programme from the WG allocation to the Trust to cover the additional costs. A consolidate pay enhancement of 1½% has also been award in 2022-23.This has been accounted for centrally by the Core Trust for 2022-23 with expectation that the pay award will be fully funded by WG. The pay date for processing the consolidated pay award has been confirmed as May 2023. .

2.8 The Trust has approved a budget of £0.033m for the Judicial Review matter, a decrease of £0.010m from the original budget ring fenced for this matter (further details in Section 7). The overall **revenue** budget is now to **£0.695m** for 2022-23.

2.9 The Escrow bank account for the Enabling Works Project has yielded interest of £0.107m during 2022-23. This has been treated as revenue income to the Enabling Works Project in March 2023.

2.10 Welsh Government has provided revenue funding of £1.560m to cover nVCC bidder reimbursements costs incurred during March 2023. The resulting income and expenditure transactions will have a nil effect in 2022-23.

2.11 There are no outstanding financial risks for the financial year 2022-23.

3. BACKGROUND

3.1 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 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.

3.2 By 31st March 2022, the Welsh Government (WG) had provided a total of £25.904m funding (£23.283m capital, £2,261m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.111m from non-recurrent revenue funding.

3.3 NHS Commissioners agreed in December 2018 to provide annual revenue funding to the Trust to support TCS Programme, with £0.400m provided in 2018/19, increased to £0.420m thereafter.

3.4 The current funding provided to support the TCS Programme in 2022-23 is £17.628m capital and £0.674m revenue, as outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding

Initial Allocation (as at April 2022)

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	£21.813m	£0m	£21.813m
nVCC Project	£2.089m	£0m	£2.089m
IRS Procurement Project	£0m	£0.434m	£0.434m
Total	**£23.902m**	**£0.434m**	**£24.336m**

Overall Change to Allocation

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	-£7.406m	£0m	-£7.406m
nVCC Project	£0.305m	£0m	£0.305m
IRS Procurement Project	£0m	-£0.434m	-£0.434m
Total	**-£7.101m**	**-£0.434m**	**-£7.535m**

Current Allocation (as at March 2023)

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	£14.407m	£0m	£14.407m
nVCC Project	£2.394m	£0m	£2.394m
IRS Procurement Project	£0m	£0m	£0m
Total	**£16.801m**	**£0m**	**£16.801m**

Sources of Revenue Funding

Initial Allocation (as at April 2022)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.240m	£0m	£0m	£0.240m
nVCC Project	£0m	£0.073m	£0m	£0.073m
SDT Project	£0.180m	£0.131m	£0m	£0.311m
Total	**£0.420m**	**£0.204m**	**£0m**	**£0.624m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0m	£0.060m	£0.005m	£0.065m
nVCC Project	£0m	-£0.010m	£0.015m	£0.005m
SDT Project	£0m	£0m	£0.001m	£0.001m
Total	**£0m**	**£0.065m**	**£0.021m**	**£0.071m**

Current Allocation (as at March 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.240m	£0.060m	£0.005m	£0.305m
nVCC Project	£0m	£0.063m	£0.015m	£0.078m
SDT Project	£0.180m	£0.131m	£0.001m	£0.312m
Total	**£0.420m**	**£0.269m**	**£0.021m**	**£0.695m**

4. CAPITAL POSITION

4.1 The capital funding for 2022-23 is outlined below:

- Enabling Works Project £14.407m Capital Expenditure Limit (CEL)
- nVCC Project £2.394m Capital Expenditure Limit (CEL)
- IRS Project £0 See section 7

Total **£16.801m**

4.2 The capital position for 2022-23 is outlined below, with an overall breakeven position.

Capital Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Enabling Works Project	£14.407m	£13.807m	£0.600m
nVCC Project	£2.394m	£2.994m	-£0.600m
IRS Procurement Project	£0m	£0m	£0.000m
Total	**£16.801m**	**£16.801m**	**£0m**

4.3 The overspend of £0.600m for the nVCC Project has been supported by the Enabling Works Project underspend of the same. This has been provided from the Enabling Works QRA. The approach has been agreed with WG and we are awaiting formal approval.

4.4 Following Ministerial approval of the IRS Final Business Case (IRS FBC) during November 2022, the IRS Procurement Project was closed on 30th November 2022. There was final cost of £0.182m for the Project against a budget of £0.178m, with funding ring fenced from the core Trust discretionary programme. However the IRS FBC included provision to fund these costs, therefore the funding was reimbursed back to the discretionary programme, and both the budget and costs for 2022-23 were

transferred to the IRS Implementation Project. Therefore the final budget and outturn for the IRS Procurement Project for 2022-23 is nil.

5. REVENUE POSITION

5.1 The revenue funding for 2022-23 is outlined below:

- PMO £0.305m NHS Commissioners & Trust Reserves
- nVCC Project £0.078m Trust Reserves
- SDT Project £0.312m NHS Commissioners & Trust Reserves

Total **£0.674m**

5.2 Following the implementation of the annual NHS pay award in September 2022, a review of the forecast revenue pay for 2022-23 took place in November 2022. Adjustments were been made in to the relevant pay and non-pay budgets, allowing increased revenue pay costs in 2022-23 to the covered from within the Programme.

5.3 In March 2023, a non-consolidated pay enhancement was awarded to NHS Wales staff for 2022-23, resulting in WG funding of £0.021m allocated to the TCS Programme.

5.4 The revenue position for 2022-23 is outlined below, with an overall underspend of £0.131m against a budget **of £0.695m**.

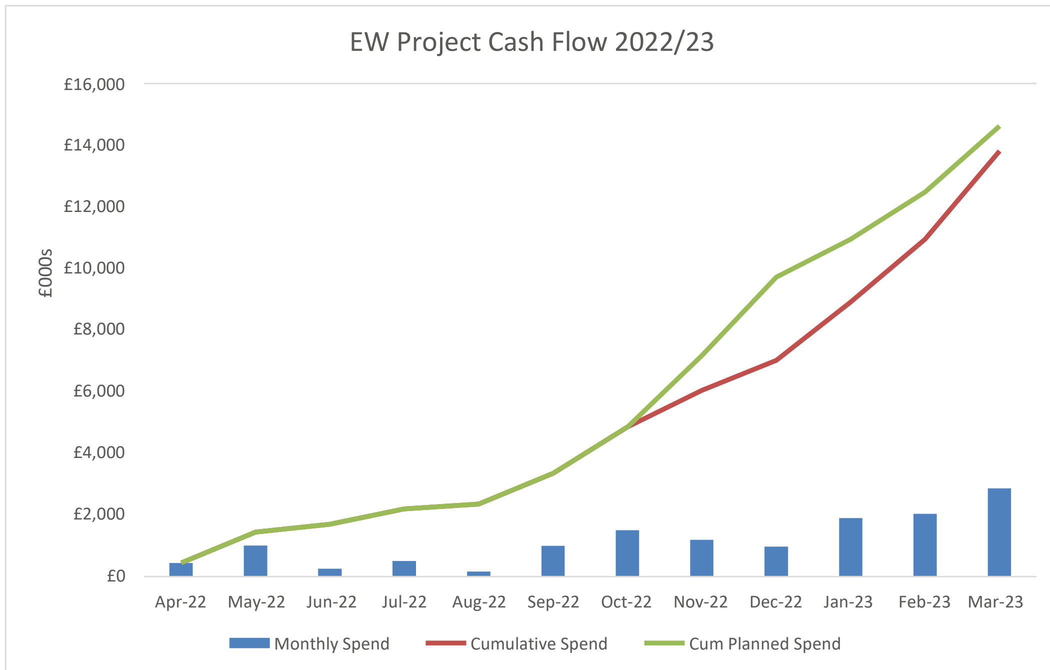
Revenue Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
PMO	£0.305m	£0.288m	£0.016m
Enabling Works	£0m	-£0.107m	£0.107m
nVCC Project	£0.078m	£0.088m	-£0.010m
SDT Project	£0.312m	£0.295m	£0.017m
Total	**£0.695m**	**£0.564m**	**£0.131m**

5.5 There are increased costs for the nVCC Judicial Review, which has resulted in an overspend of £0.010m. However, this has been offset by an underspend elsewhere in the TCS Programme.

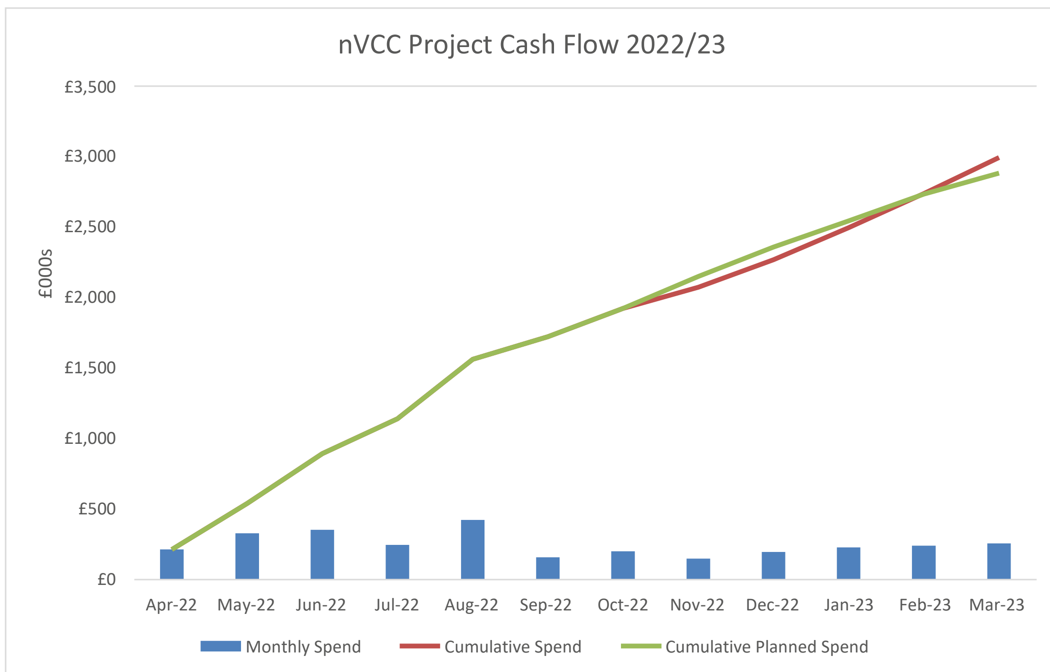
5.6 The Escrow bank account for the Enabling Works Project has yielded interest of £0.107m during 2022-23. This has been treated as revenue income to the Enabling Works Project in March 2023, increasing the expected revenue underspend for the Programme from £0.024m to £0.131m.

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The run rate indicates that, following the capital funding adjustment in January 2023, around 75% of the costs have been incurred in the second half of the financial year. This is due to the delay in the start of the works.



6.2 The capital cash flow for the **nVCC Project** is outlined below. The run rate for the nVCC Project is relatively 'flat' and reflects planned activities in respect of the successful participant stage.



6.3 The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

7. PROJECT FINANCE UPDATES

7.1 A detailed table of budget, spend and variance is provided in Appendix 1.

Programme Management Office

7.2 The total revenue funding for the PMO for 2022-23 is **£0.305m**. £0.0240m of this has been provide from NHS Commissioners' funding, £0.060m from the Trust Reserves, and £0.005m from non-consolidated enhanced pay award funding. The provisional funding of £0.010m for the annual pay award has not been drawn down as the increased costs have been covered from within the PMO financial year.

7.3 There has been no capital funding requirement for the PMO in 2022-23.

7.4 The revenue position for the PMO for 2022-23 is shown below.

PMO Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Pay	£0.291m	£0.280m	£0.011m
Non Pay	£0.013m	£0.008m	£0.005m
Total	**£0.305m**	**£0.288m**	**£0.016m**

7.5 There is an overall underspend of £0.016m for the year due to a delay in project and support work carried out by the PMO. This underspend has been utilised part to offset increased costs incurred by the nVCC Judicial Review.

Enabling Works Project

Capital

7.6 In February 2022, the Minister for Health and Social Services approved the EW FBC. This has provided capital funding of £28.089m in total.

7.7 For 2022-23 the Enabling Works Project initially received a CEL for £21.813m but after several reviews the final CEL is **£14.407m**, with a total virement to date of £7.405m from 2022-23 to 2023-24, as agreed by Welsh Government.

7.8 The Project's capital position for 2022-23. The final position reflects an underspend of £0.600m due to a delay in key activities, which has been used to support the nVCC Project as agreed by WG.

Enabling Works Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Pay	£0.220m	£0.334m	-£0.115m
Non Pay	£14.187m	£13.473m	£0.715m
Total	**£14.407m**	**£13.807m**	**£0.600m**

7.9 The spend relates to the following activities:

Description		£	£	£
PAY				
Project 1b - Enabling Works FBC		219,744	334,432	-114,688
Pay Capital Total		**219,744**	**334,432**	**-114,688**
NON-PAY - PROJECTS				
EF01	Construction Costs	0	40,981	-40,981
EF02	Utility Costs	710,613	47,616	662,997
EF03	Supply Chain Fees	527,481	538,615	-11,133
EF04	Non Works Costs	225,603	369,160	-143,556
EF05	ASDA Works	2,584,385	2,958,907	-374,522
EF06	Walters D&B	8,735,418	8,897,618	-162,200
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	174,000	0	174,000
EFQR	Quantified Risk	922,798	206,258	716,540
EFQS	QRA - SCP	307,200	437,156	-129,956
EFRS	Enabling Works FBC Reserves	0	-23,359	23,359
Enabling Works Project Capital Total		**14,187,499**	**13,472,951**	**714,548**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**14,407,243**	**13,807,383**	**599,860**

Revenue

7.10 The Escrow bank account for the Enabling Works Project has yielded interest of £0.107m during 2022-23. This has been treated as revenue income to the Enabling Works Project in March 2023.

7.11 The Project's revenue position for the full financial year is shown below. The final position reflects an underspend of £0.131m.

Enabling Works Revenue Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
EW Escrow Interest	£0m	-£0.107m	£0.107m
Total	**£0m**	**-£0.107m**	**£0.107m**

New Velindre Cancer Centre Project

Capital

7.12 In March 2021, the Minister for Health and Social Services approved the nVCC OBC. This has provided capital funding of £5.550m in total, with a CEL for 2022-23 of £2.089m. During December 2022 a virement of £0.305m was made to the Project from the Enabling Works Project, increasing the CEL to **£2.394m**.

7.13 The capital financial position for the nVCC Project for 2022-23 is shown below, with a further breakdown provided in Appendix 4. The final position reflects an overspend of £0.600m, which has been supported from the Enabling Works Project as agreed by WG.

nVCC Capital Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Pay	£1.274m	£1.159m	£0.115m
Non Pay	£1.120m	£1.768m	-£0.648m
Total	**£2.394m**	**£2.927m**	**-£0.533m**

7.14 The spend relates to the following activities:

Description				
		£	£	£
PAY				
Project Leadership		208,776	199,632	9,144
Project 2a - New Velindre Cancer Centre OBC		1,065,097	951,897	113,200
Pay Capital Total		**1,273,873**	**1,151,529**	**122,344**
NON-PAY				
nVCC Project Delivery		**84,000**	**86,804**	**-2,804**
Work Packages				
VC08	Competitive Dialogue - Dialogue & SP to FC	731,127	1,560,859	-829,732
VC10	Legal Advice	0	49,272	-49,272
VC11	S73 Planning	0	101,582	-101,582
VC12	nVCC FBC	106,453	102,757	3,697
VCRS	nVCC Reserves	198,547	-59,287	257,834
nVCC Project Capital Total		**1,036,127**	**1,755,183**	**-719,056**
TOTAL nVCC OBC CAPITAL EXPENDITURE		**2,394,000**	**2,993,516**	**-599,517**

Revenue

7.15 No revenue funding has been provided for the nVCC Project by WG in 2022-23. Therefore, the Trust has provided revenue budget of £0.063m from the Trust reserves. This is £0.010m less than was previously reported due to a budget of £0.033m provided for the Judicial Review matter as opposed to the original ring fenced budget of £0.043m. This revised budget was based on a revised forecast spend for the year.

7.16 Further funding of £0.015m has been allocated from the WG funding for the non-consolidated pay award for 2022-23. The final **revenue** budget for the nVCC Project is now **£0.078m**.

7.17 The revenue financial position for the nVCC Project for 2022-23 is shown below, reflecting a forecast overspend of £0.010m against a budget of **£0.078m**.

nVCC Revenue Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
nVCC Pay Award	£0.015m	£0.015m	£0m
Project Delivery	£0.030m	£0.029m	£0.001m
Judicial Review	£0.033m	£0.043m	-£0.010m
Total	**£0.078m**	**£0.088m**	**-£0.010m**

7.18 The overall overspend of £0.010m for the Judicial Review matter has been offset by the overall underspend by the Programme.

Integrated Radiotherapy Solution Procurement Project

7.19 Ministerial approval of the IRS Final Business Case during November 2022, and subsequent signing of the contract with the preferred bidder, instigated the closure of the IRS Procurement Project on 31st November 2022. The overall IRS Project will continue with the IRS Implementation Project, managed by Velindre Cancer Centre.

7.20 The final costs for the IRS Procurement Project are £0.182m, as outlined below.

Pay	£0.083m
Legal Advisors	£0.096m
Other Costs	£0.003m
Total costs	**£0.182m**

7.21 Estimated costs of £0.127m in 2022-23 for bunker refurbishment previously reported by the Project will now be covered directly by funding provided directly from the FBC, and will be reported by the IRS Implementation Project, who will also manage this work.

7.22 The CEL for the IRS FBC has been allocated to the IRS Implementation Project. This includes provision to fund the IRS Procurement Project in 2022-23, therefore the full budget and costs for 2022-23 in full this Project have been transferred to the IRS Implementation Project. The ring fenced funding has been released back to the core Trust discretionary programme for use elsewhere within the Trust.

7.23 The final capital position for the IRS Project for the financial year 2022-23 is **£0m**, with no funding, budget or spend to report for both pay and non pay.

7.24 There is no revenue requirement for the Project in 2022-23.

Service Delivery and Transformation Project

7.25 The total revenue funding for 2022-23 is £0.180m from NHS Commissioners' funding, £0.131 from Trust reserves, and £0.001m from non-consolidated pay award funding. The provisional pay award funding of £0.010m in 2022-23 previously reported will not be drawn down as the increased costs will be covered from within the SDT project for this financial year. The resulting budget is **£0.312m** for this financial year.

7.26 There is no capital funding requirement for the Project in 2022-23.

7.27 The SDT Project revenue position for 2022-23 is shown below.

SDT Expenditure	2022-23 Full Year		
	Budget	Outturn	Variance
Pay	£0.293m	£0.293m	-£0.000m
Non Pay	£0.020m	£0.002m	£0.017m
Total	**£0.312m**	**£0.295m**	**£0.017m**

7.28 There is an overall underspend of £0.017m due to a delay in project and support work carried out by the Project. This has be utilised to offset increased costs incurred by the nVCC Judicial Review.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are no outstanding financial risks for the financial year 2022-23.

9. TCS SPEND REPORT SUMMARY

9.1 At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

9.2 Appendix 3 provides cumulative report to 31st March 2022. The report for the financial year 2022-23 is currently being updated

9.3 The cumulative report shows a total spend for the TCS Programme of £30.352m (£26.481m Capital, £3.871m Revenue). The total pay costs for this period were £11.303m.

9.4 The spend to 31st March 2022 for each Project within the Programme is summarised below.

Programme Management Office £1.656m
Project 1 Enabling Works £10.559m
Project 2 nVCC...£13.234m
Project 3a Integrated Radiotherapy Solution.............£0.1.049m
Project 3b Digital Strategy..£0.200m
Project 4 Radiotherapy Satellite £0.385m
Project 5 SACT and Outreach......................................£0.002m
Project 6 Service Delivery and Transformation £3.266m
Project 7 Decommissioning...£0m

9.5 The five deliverables with the highest spend during this period are:

Project Control...£4.390m
Feasibility Studies £2.734m
Planning and Design £2.669m
Outline Business Case (inc revision and approval) £2.456m
Project Agreement...£1.838m

APPENDIX 1: TCS Programme Budget and Spend for 2022-23

CAPITAL	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY			
Project Leadership	208,776	199,632	9,144
Project 1b - Enabling Works FBC	219,744	334,432	-114,688
Project 2a - New Velindre Cancer Centre OBC	1,065,097	951,897	113,200
Project 3a - Radiotherapy Procurement Solution	0	0	0
Capital Pay Total	**1,493,617**	**1,485,961**	**7,655**
NON-PAY			
nVCC Project Delivery	84,000	86,804	-2,804
Project 1b - Enabling Works FBC	14,187,499	13,472,951	714,548
Project 2a - New Velindre Cancer Centre OBC	1,036,127	1,755,183	-719,056
Project 3a - Radiotherapy Procurement Solution	0	0	0
Capital Non-Pay Total	**15,307,626**	**15,314,938**	**-7,312**
CAPITAL TOTAL	**16,801,243**	**16,800,899**	**343**

REVENUE	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY			
nVCC Pay Award	15,327	15,327	0
Programme Management Office	291,322	279,827	11,495
Project 6 - Service Change Team	292,832	292,862	-30
Revenue Pay total	**599,481**	**588,016**	**11,465**
NON-PAY			
EW Escrow Interest	0	-106,807	106,807
nVCC Project Delivery	30,000	29,417	583
nVCC Judicial Review	33,000	43,380	-10,380
Programme Management Office	13,191	8,313	4,878
Project 6 - Service Change Team	19,624	2,131	17,493
Revenue Non-Pay Total	**95,815**	**-23,566**	**119,381**
REVENUE TOTAL	**695,297**	**564,450**	**130,846**

APPENDIX 2: TCS Programme Funding for 2022-23

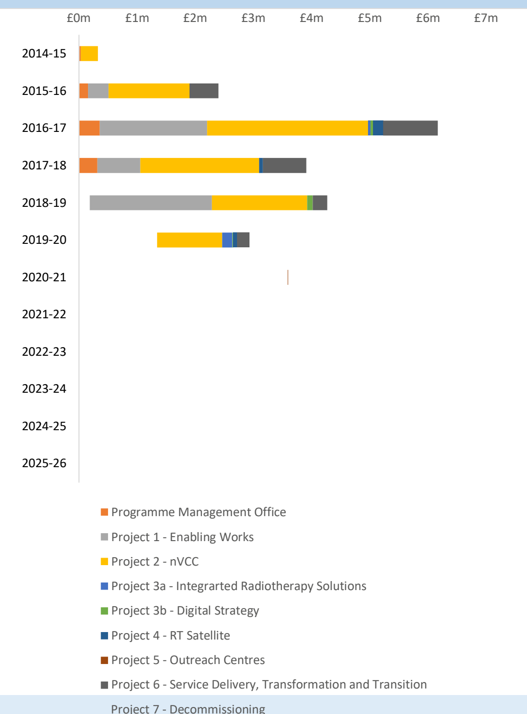
Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0m**	**£0.305m**
Commissioner's funding		£0.240m
Trust Revenue Funding		£0.060m
Pay Award Funding – assumed (September 2022)		£0.010m
Pay Award Funding – reversed (November 2022)		-£0.010m
Non-Consolidated 2022/23 Pay Award Funding		£0.005m
Enabling Works OBC	**£14.406m**	**£0m**
2022-23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£21.813m	
Virement of funds from 2022-23 to 2023-24 financial year (May 2022)	-£1.900m	
Virement of funds from 2022-23 to 2023-24 financial year (August 2022)	-£1.472m	
Virement of funds from 2022-23 to 2023-24 financial year (October 2022)	-£3.021m	
Virement of funds to the nVCC Project (December 2022)	-£0.305m	
Virement of funds from 2022-23 to 2023-24 financial year (January 2023)	-£0.709m	
New Velindre Cancer Centre OBC	**£2.394m**	**£0.078m**
2022-23 CEL from Welsh Government funding for nVCC OBC (March 2021)	£2.089m	
Virement of funds to the nVCC Project (December 2022)	£0.305m	
Trust revenue funding from reserves		£0.063m
Non-Consolidated 2022/23 Pay Award Funding		£0.015m
Integrated Radiotherapy Procurement Solution	**£0m**	**£0m**
Trust Discretionary Capital Allocation	£0.434m	
Reduction in requirement of capital funding	-£0.256m	

Description	Funding Type	
	Capital	Revenue
Reimbursement of funds back to the Trust discretionary programme	-£0.178m	
Radiotherapy Satellite Centre No funding requested or provided for this project to date	**£0m**	**£0m**
SACT and Outreach No funding requested or provided for this project to date	**£0m**	**£0m**
Service Delivery, Transformation and Transition	**£0m**	**£0.312m**
Commissioner's funding		£0.180m
Trust revenue funding from reserves		£0.131m
Pay Award Funding – assumed (September 2022)		£0.010m
Pay Award Funding – reversed (November 2022)		-£0.010m
Non-Consolidated 2022/23 Pay Award Funding		£0.001m
VCC Decommissioning No funding requested or provided for this project to date	**£0m**	**£0m**
Total	**£16.801m**	**£0.695m**

APPENDIX 3: TCS Cumulative Spend Report to 31st March 2022

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

SPEND PER PROJECT PER YEAR



SPEND FOR EACH PROJECT ACROSS ALL YEARS

Programme Management Office
Project 1 - Enabling Works
Project 2 - nVCC
Project 3a - Integrarted Radiotherapy Solutions
Project 3b - Digital Strategy
Project 4 - RT Satellite
Project 5 - Outreach Centres
Project 6 - Service Delivery, Transformation and Transition
Project 7 - Decommissioning

SPEND FOR EACH YEAR ACROSS ALL PROJECTS

£328,450
£2,398,448
£6,428,671
£6,167,590
£3,924,181
£3,909,063
£2,928,426

2014-15
2015-16
2016-17
2017-18
2018-19
2019-20
2020-21
2021-22
2022-23
2023-24
2024-25

TOTAL SPEND BY PROJECT TO DATE	£30,352,092
Programme Management Office	£1,655,897
Project 1 - Enabling Works	£10,559,242
Project 2 - nVCC	£13,234,264
Project 3a - Integrarted Radiotherapy Solutions	£1,049,380
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£385,490
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,266,123
Project 7 - Decommissioning	-

SUPPLIERS WITH HIGHEST EXPENDITURE TO DATE		
1	Payroll	£11,048,740
2	Mott MacDonald	£5,614,021
3	DLA Piper	£3,398,669
4	Non Pay Costs	£1,043,962
5	Price Waterhouse Coopers	£848,084

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

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

TRUST BOARD

NURSING STRATEGY

DATE OF MEETING	25th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
PROFESSIONAL NURSE FORUM	06/04/2023	Endorsed
STRATEGIC DEVELOPMENT COMMITTEE	04/05/2023	Endorsed

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

1. SITUATION

The Trust Nursing strategy is provided to the Trust Board for **APPROVAL**.

2. BACKGROUND

The Trust has been developing its Nursing Strategy over the last 12 months through the Trust's Professional Nursing Forum (PNF). The strategy development is fully aligned with the Chief Nursing Officer priorities.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION.

3.1 Trust Nursing Strategy

The Trust Nursing Strategy is attached in ***Appendix 1***. The strategy is a professional Nursing Strategy and will sit as one of a number of delivery strategies underneath the Trust Clinical & Scientific Strategy when this is developed.

The Allied Health Professionals / Healthcare Science Forum has agreed for the need for the development of an AHP and Healthcare Scientists strategy during 2023/24 with a conference being held in 2024.

The Strategy has been developed from service level up using a proactive engagement and consultative approach with PNF overseeing the development at all stages. The previously approved Nursing standards form a pivotal element of the strategy. The strategy applies to all Trust nursing staff both registered and unregistered (including CCA's).

3.2 Next steps

Following Strategic Development Committee endorsement, the strategy was formally launched at the Trust Nursing Conference held on the 12th May 2023 (conference attendees we advised that the strategy was pending Board approval).

During the conference there was a dedicated breakout session to develop the 3-year work plan that will deliver the strategy aims and priorities. This is now being drafted. The work plan will be monitored by the Trust Professional Nursing Forum. An annual report against deliverables will be produced to the Executive Management Board and Strategic Development Committee.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Standard 2.7 of the Health and Care Standards (Safeguarding Children and Safeguarding Adults at Risk) requires health services to promote and protect the welfare and safety of children and adults who become vulnerable or at risk at any time.
RELATED HEALTHCARE STANDARD	Safe Care
	2.7 Safeguarding adults and children at risk 7.1 Workforce.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The trust has a statutory obligation to comply with the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguarding (2007)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be funding implications as the strategy is implemented. Financial implications for each deliverable will be worked through.

5. RECOMMENDATION

The Trust Board is asked to **APPROVE** the Velindre University NHS Trust 2023-2026 Nursing Strategy.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust Nursing Strategy 2023-26

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Contents

Introduction	3-4
Our standards	5
Our structure and roles	6
Our aims and priorities	7-9
Heads of Nursing pledge	10

Introduction

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

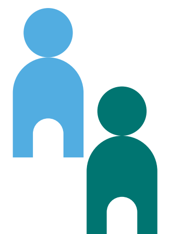
Velindre Cancer Service delivers specialist cancer services for South East Wales and wider using a hub and bespoke model. The hub is the Velindre Cancer Centre. We provide specialist treatment, teaching, research and innovation for non-surgical oncology. We treat patients with chemotherapy, Systemic Anti-Cancer Treatments (SACTs), immunotherapy, radiotherapy and related treatments, together with caring for patients with specialist palliative care needs.

The Welsh Blood Service undertakes a fundamental role in supporting the delivery of healthcare across Wales, through the collection process and supply of blood and blood components, saving the lives of thousands of people.

Our nurses, healthcare support workers and clinical collection assistants provide high quality, safe care and services to our patients and donors. We are very proud of our nursing teams and are committed to growing and developing our nursing staff so that they can be the very best they can be and reach their full potential.

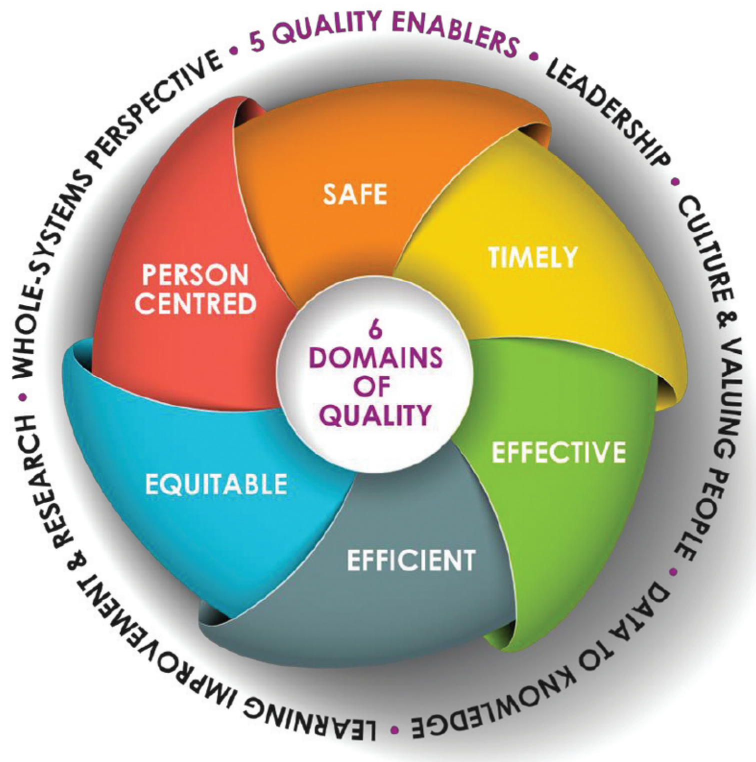
The Trust nursing strategy has been developed by our nurses for our nurses. This strategy sets out our aim and ambition to build on our past achievements and provide a clear strategic direction for 2023-2026.

Our agreed aims and priorities are underpinned by the 4 Ps of the Nursing Midwifery Council (NMC) code of conduct.



Our vision is that the nursing profession is enabled to consistently deliver high quality, safe, person centred care and services.

Our aims and priorities will also encompass the 6 domains of quality (The Duty of Quality Statutory Guidance 2023) **Safe: Timely: Effective: Efficient: Equitable and Person Centred.** This will enhance building a positive culture of quality at the heart of everything we do.



The Trust's Nursing Strategy also encompasses the Chief Nursing Officer for Wales priorities (2022):

1. **Leading the profession.**
2. **Workforce.**
3. **Making the profession more attractive.**
4. **Improving health and social care outcomes.**
5. **Professional equity and healthcare equality.**

We have a strong foundation of excellent staff doing the most amazing things. We need to make sure they have a positive working life, are supported to grow and develop, empowered to lead and develop and are equipped to meet the exciting challenge of providing care fit for the future.

I am very proud of the Nursing Team, there are challenging but exciting times ahead and I know that with the right support we can rise to this.

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

Our standards

As a nurse within Velindre University NHS Trust, you will:

1. Maintain your NMC professional registration (for registered practitioners);
2. Be fully informed and comply with all aspects of NMC/HCSW code and Trust values to uphold the reputation of the profession and the Trust at all times;
3. Assist in fostering an environment where people are able to flourish, where discrimination or any type of abuse is not tolerated and actively challenged;
4. Deliver excellent evidence based, kind, safe and effective care whilst working within the limits of your competence and capability;
5. Be responsible for maintaining compliance with clinical skills, professional development and training required to safely and competently fulfil your role;
6. Help establish what is important to patients and donors* in order to plan, deliver and evaluate individualised care;
7. Be open and candid with patients and donors*, about all aspects of care and treatment, including when any mistakes or harm may have taken place;
8. Demonstrate continued improvement in your care delivery through reflection and learning;
9. Work collaboratively with colleagues to prioritise safety and to deliver harm-free care, challenging any practice or behaviours to ensure the best possible outcomes for patients and donors*.

**Donor/s refers to users of the Welsh Blood service*

Our structure and roles

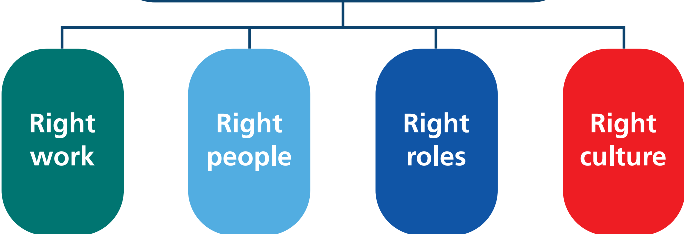
The Nursing team works together to provide care for patients and donors. Our registered nurses are supported by the wider nursing team, this includes Health Care Support Workers, Clinical Collection Assistants and Assistant Practitioners.

Rising demands upon health services, increasingly complex care needs and difficulties with the recruitment and retention of registered nurses, have created significant challenges for NHS Wales. There is a need for an innovative and flexible approach to workforce modernisation and a resultant emergence of new roles, for example assistant practitioners.

Our Trust is committed to developing a career pathway and education framework to support our staff to develop their skills and extend their scope of practice.

We are committed to recruiting the right people, in the right place, at the right time and retaining our nursing workforce by providing opportunities and an environment to flourish.

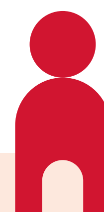
The Trust will endeavour to comply with the Nurse Staffing Levels (Wales) Act 2016 to ensure our nursing teams have the time to deliver the best possible care to our patients.



Examples of nursing roles

Our aims and priorities

1. **Nurses will actively listen to our patients (their carers) and donors and deliver kind, safe and effective evidence-based care**
2. **Nurses will continually develop our knowledge and skills. We will promote psychological safety in our teams to create a workforce fit for the future**
3. **Nurses will maximise research innovation and continual improvement opportunities**



1.

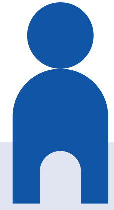
Nurses will actively listen to our patients (their carers) and donors and deliver kind, safe and effective evidence-based care

Our priorities are:

- To deliver individualised care, actively listen and involve patients (their carers) and donors placing them at the centre, making every contact count to strive to improve the health and wellbeing of the population.
- To communicate effectively with patients (their carers) and donors, check their understanding and, share information within multi-disciplinary teams to enhance the experience of patients and donors and deliver safe care.
- To promote equitable treatment for all where discrimination of any kind is not tolerated.
- To be empowered to be strong advocates and to always safeguard patients and donors.
- To ask all patients and donors to provide feedback in respect of care and treatment provided.
- To reflect on feedback received and demonstrate how we have listened to what matters to our patients and donors.
- To ensure that reasonable adjustments are made for patients and donors with additional needs whatever they may be.
- To ensure that the NMC code and the Trust nursing standards are demonstrated in the practices of all.

2.

Nurses will continually develop our knowledge and skills. We will promote psychological safety in our teams to create a workforce fit for the future



Our priorities are:

- To ensure nursing teams (and multi-professional teams) are designed around patients and donors and are regularly reviewed to reflect patient/donor needs including skill mix, maximisation of top of licence working, optimising advanced clinical practice opportunities and introducing new roles such as Nursing associates.
- To promote psychological safety for nurses and develop a supervision and reflective practice framework.
- To demonstrate effective & compassionate leadership and create a nursing workforce that feels valued and respected.
- To develop equitable pathways for personal and professional development through access to training, coaching and mentoring.
- To develop the role of the nurse champion within a supportive framework will allocated time to enhance knowledge and skills and to effectively undertake the champion role.
- To develop highly skilled nurses, with a fair and equitable (through a multi-professional lens) nursing career pathway that is free from discrimination or marginalisation.
- To regularly recognise and celebrate success and ensure that nurses are recognised for achievements and contributions.
- To promote a positive and progressive nursing culture where nurses can voice concerns without fear, and regular health and wellbeing discussions are taking place.
- To create an environment where everyone feels empowered to raise ideas, suggestions and concerns and have these supported/acted on.

3.

Nurses will maximise research innovation and continual improvement opportunities

Our priorities are:

- To provide opportunities for nurses to gain research and audit skills to provide evidence-based care, and to be involved/participate in research studies.
- To provide opportunities for nurses to undertake or be involved in audits, to assure adherence to standards and improve practice.
- To provide nurses with the opportunity to undertake research in their specialist field of work sharing outcomes via a number of platforms.
- To have the opportunity to participate in peer reviews and benchmarking, to learn from others and best practice.
- To be trained in quality improvement methodology and use this to improve patient and donor care, services outcomes and experience.
- To actively take part in patient/donor safety incident reviews and will identify opportunities for quality improvement and learning.
- To provide the infrastructure for nurses to be reflective practitioners through a culture where learning and service improvement is everyone's business.
- To enhance opportunities for the development of enhanced critical thinking and professional judgement through education, evidence based practice and research.

Heads of Nursing pledge

The Nursing Strategy provides us with a clear direction to shape the future of Nursing, to ensure we maximise opportunities to deliver high quality, safe and compassionate care to all our donors and patients. Realising the aims and priorities within the strategy will require the Nursing Teams across the organisation to champion continual improvement and innovation, and develop working environments based upon psychological safety, teamwork, collaboration, kind and compassionate leadership and to celebrate our achievements.

As Heads of Nursing we pledge to fully commit to supporting, empowering and enabling the Nursing Teams to achieve these aims and objectives.

Professionalism

Nursing Standards

1. Nurses will actively listen to our patients (their carers) and donors and deliver kind, safe, and effective evidence-based care.

2. Nurses will continually develop our knowledge and skills. We will promote psychological safety in our teams to create a workforce fit for the future.

3. Nurses will maximise research innovation and continual improvement opportunities.

Next steps

Our next steps are to develop a 3 year workplan and to produce an annual report on our progress each year.

Heads of Nursing

Zoe Gibson
Head of Nursing,
Welsh Blood Service

Viv Cooper
Head of Nursing,
Quality Patient Experience and Integrated Care

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Designed by www.trentpublications.com

Canolfan Ganser Felindre
Velindre Cancer Centre

Gwasanaeth Gwaed Cymru
Welsh Blood Service

TRUST BOARD

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2022 / 2023

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Peter Gorin, Head of Strategic Planning & Performance
PRESENTED BY	Philip Hodson, Assistant Director Planning & Performance
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
VCC Senior Leadership Team	April 2023	Noted
WBS Senior Management Team	April 2023	Noted
Executive Management Board	2nd May 2023	Noted
QSP Committee	16th May 2023	Noted

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

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 The Integrated Medium Term Plan (IMTP) 2022-2025 was approved by the Minister for Health and Social Service in July 2022. Integral to the IMTP was a range of Action Plans to support the delivery of the Trust's Strategic Aims, across our range of cancer services and blood and transplant services.

1.2 Following approval of our IMTP a letter was issued from the Director General and NHS Wales Chief Executive to the Chief Executive of Velindre University NHS Trust. This letter set a number of IMTP Accountability Conditions, including the requirement to report progress against key IMTP action plans.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 This report provides progress against the Quarterly Actions identified in the IMTP for 2022/23 in the form of the monitoring templates for WBS and VCC, included within **Appendices A and B**.

2.2 Due to the timing of the end of Quarter 4 (January to March 2023), this final year end position for 2022/23 has been prepared for the next QSP Committee meeting to be held on 16th May 2023.

2.3 As can be seen from the Appendices A and B, there are a number of actions that are ongoing at the yearend. These actions were reviewed and incorporated into the development of IMTP for 2023 – 2026.

3. IMPACT ASSESSMENT

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 (Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP)
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 year end position in delivering against the key Trust actions included within the approved IMTP for 2022 – 2025.

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

APPENDIX A

Welsh Blood Service IMTP Quarterly Progress Report 2022/23 for Quarter 4 as at 31/03/2023.

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress 2022/23**				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
SP1: Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality and modern	**1.** Develop and introduce Plasma For Fractionation - Medicine Service Model for Wales.	Scope service need. Project group established.	Business case to Welsh Government.	Develop draft service model.	Service model approved.	With agreement from Policy Leads at Welsh Government, WBS has formally expressed an interest in joining the UK Plasma Fractionation contract to supply recovered plasma from whole blood donations. The outcome of the contract negotiations is expected by June 2023. In the meantime, the WBS project plan is underway to enable plasma supply for fractionation to start from April 2025. WBS is now a member of the UK Plasma Programme Board and has contributed to a safety assessment of UK plasma which was published recently. This is likely to play a significant part in addressing regulatory concerns from the EU and reduce the overall risks to the programme.	
	2. Develop and implement Donor Strategy.	Scope service need. Project structure established. Draft strategy produced.	Consultation on strategy.	Implementation plan developed.	Implementation of eDRM phase 1 to support delivery of implementation plan.	Development of the Donor Strategy continues with engagement planned with donors/stakeholders/public via facilitated focus groups.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	3. Develop and implement WBMDR strategy.	Scope service need project structure established draft strategy produced.	Consultation on strategy.	Implementation plan developed.	Implementation commence.	Reappraising the existing collection model and the development of the new 5 year strategy for WBMDR continues under the WBS Futures initiative. UK Stem Cell Strategic Forum recommendations are also being taken forward as part of this work. The Recovery Plan is being implemented to increase recruitment of bone marrow volunteers.	
	4. Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose.	Establish project structure review service models to meet need & undertake service/data review in light of COVID and proposed contract variation.	Undertake service/data review in light of COVID and proposed contract variation.	Complete OCP process in relation to service model.	Complete OCP process in relation to service model.	The first phase of the OCP has been completed. The second phase and agreement of the new clinical model will be taken up under the Collection Services Modernisation Programme a part of WBS Futures initiative.	

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

<table>
<tr><th colspan="8">IMTP Strategic Priorities WBS Service Delivery Framework 2022/23</th></tr>
<tr><th rowspan="3">Strategic Priorities 2022/23 to 2024/25</th><th rowspan="3">Key Deliverables / Objectives</th><th colspan="6">Key Quarterly Actions 2022/23 Timescales and Progress</th></tr>
<tr><th colspan="4">2022/23</th><th>Quarterly Progress Update for Q4 (yearend)</th><th>Progress Rating</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th></th><th></th></tr>
<tr><td>SP2: Meet the patient demand for blood and blood products through faciltiating the most appropriate use across Health organisations</td><td>5. Introduction of ‘live connectivity' to allow ‘real-time’ information to be shared WBS, laboratories and health board transfusion/clinical teams.</td><td>Scope opportunities for digital technology to support sharing real time data and transfer of goods between WBS and customers.</td><td>Establish technology solutions.</td><td>Identify resources to support implementation.</td><td>Implementation commence.</td><td>Governance for the Vein to Vein (V2V) project has been transferred to Digital Healthcare Wales (DHCW) to provide further alignment with the LINC programme.</td><td></td></tr>
<tr><td>SP3: Provide safe, high quality and the most advanced manufacturing, distrbution and testing laboratory services</td><td>6. Assess and implement SaBTO (guidelines 2021 release date) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.</td><td>Confirm role of WBS with Welsh Government establish project structure.</td><td>Complete OCP process in relation to service mode.</td><td>Establish workforce model.</td><td>Implementation.</td><td>Stock swap out completed, all blood components in WBS and Health Boards now Hep B core negative. This element of the Hep B Core project is completed.

There have been 3 confirmed lookbacks identified to date. Completion of lookback documentation by Health Boards is ongoing and actively monitored for compliance by the WBS Blood Health Team.</td><td></td></tr>
</table>

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress 2022/23**				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						Quarterly progress reports continue to be submitted to the WG Oversight Board. SaBTO is currently reviewing the pathway for notification of relatives of deceased recipient patients and updated guidance is expected. WBS continues to attend the OBI UK Forum Implementation Group and work collaboratively across the UK Blood Services to ensure successful completion of this project.	
SP4: Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services	**7.** Deliver WLIMS modules for Blood Transfusion (BT)	Scope service specification.	Undertake procurement.	Undertake procurement.	Complete USR procurement.	This project has been transferred to Digital Healthcare Wales (DHCW) for management and implementation. A new National Steering Group for WLIMS implementation has been set up, the first meeting took place on 30/01/2023. The Local Deployment Board meeting took place on 06/03/2023, whilst the WBS deployment planning workshop with Citadel took place on the 21/03/2023.	

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

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress 2022/23**				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	8. Implementation of Foetal DNA typing.	Engage with Antenatal Screening services to develop implementation plan.	Agree implementation plan.	Take forward implementation.	Take forward implementation.	Procurement for a commercial kit solution will begin in April 2023. The project is expected to go live in as planned January 2024.	
SP5: Provide, services that are environmentally sustainable and benefit our local communities and Wales	**9.** Establish a quality assurance modernisation programme to develop and implement strategy which support more efficient and effective management of regulatory compliance and maximising digital technology.	Project to be scoped. Project structure established. Phased work plan.	Develop implementation plan.	Take forward implementation.		Reconfiguration of RAGG Quality Hub remains under review, and progress reported and monitored via the Trusts' Integrated Quality & Safety Group. The Electronic Signatures (DocuSign) system is being used successfully to date in Phase 1. The eQMS (Quality Management system) user specification (URS) is now complete. Confirmation of an alternative eQMS on the NHS framework has been received. A comparison with a non-WBS system URS has been	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress 2022/23**				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						completed and a further meeting is due to take place 14th April to consider the results of the analysis. The redesign of the document hierarchy is scheduled for Q3.	
	10. Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions.	Submit OBC for Talbot Green infrastructure Project	Procure support to develop FBC.	Appoint Healthcare planner to develop FBC.	FBC submitted to Welsh Government.	Work underway to understand phasing of this programme in light of the Laboratory Modernisation Programme and the Plasma for Medicines programme and the interdependencies with this programme. This work is due to be completed in May 2023.	
SP6: Be a great organisation with great people dedicated to improving outcomes for patients and donors.	**11.** Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning.	Engagement with teams in relation to review of Clinical Services. Review of Facilities model. Review of BI.	Development of service model paper to be developed for approval.	Development of service model paper to be developed for approval.	Implementation plan developed.	WBS senior management consultation begins in April 2023 and is due to end May 2023.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress 2022/23**				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	12. Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS.	Scope programme of work. Establish project structure.	Develop implementation plan.	Business case submitted to WHSSC to support implementation of new standards and guidance in component development lab.	Funding secured.	Programme governance structure in place under WBS Futures initiative. Work underway to understand phasing of this programme in light of the Talbot Green Infrastructure Programme and the interdependencies. This work is due to be completed in May 2023.	
	13. Lead the All Wales approach to implementation of Welsh Government Statement of Intent for Advanced Therapies.	Secure funding review structure and develop work plan 2022/23.	Clinical lead appointed. Implementation of work plan.	Implementation of work plan.	Implementation of work plan.	The Apheresis Status report is progressing with final report expected in August 2023. A vacant “clean room” cell manufacturing facility option has recently become available at a Cardiff location and is currently being explored by key stakeholder organisations for potential usage.	

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

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
						A new ATW programme lead has now been appointed with an expected start date of June 2023. An event is planned for June 2023 in collaboration with the Life Science Hub. The focus of the meeting is planning and delivering advanced therapies, with NHS CEOs, Planners, Clinical leads, Research leads, academia, stakeholder organisations as the target audience. An invitation for public representative to join the ATW Programme Board is in the process of being advertised. The clinical trial sector continues to expand, and ATW are providing support, sign posting, and working group facilitation with NHS organisations across a range of projects and research activity.	

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

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress 2022/23**				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	14. Support UK Infected Blood Inquiry and delivery of its Terms of Reference.	IBI continues	IBI continues	IBI continues	IBI continues	The hearings have now been completed and the Chair has retired to consider the conclusions. Recommendations are expected in the Autumn of 2023. A 2nd Interim Report was published by the Chair on 5th April 2023 that addressed the issues of compensation. Further recommendations were made in relation to additional eligibility for interim payments and the setting up of a body to address future compensation payments. Compensation payments are expected to be met by the UK Government as health had not been devolved when the harm took place. The Trust is continuing to receive documents from the IBI Team requesting permission to share with other core participants.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	Key Deliverables / Objectives	Key Quarterly Actions 2022/23 Timescales and Progress					
		2022/23				Quarterly Progress Update for Q4 (yearend)	Progress Rating
		Q1	Q2	Q3	Q4		
						The Chair is in the process of compiling the final report and part of this process involves the sending of “Warning Letters” to individuals or organisations that may be criticised in the final report. This gives individuals or organisations the opportunity to respond to these criticisms prior to the publication of the final report. Should the Trust receive any, they will respond accordingly.	

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

APPENDIX B

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 4 as at 31/03/2023.

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 1: Access to equitable and consistent care, no matter where; To meet increasing demand	**1. SACT Capacity Plan**	Maintain high level of chair utilisation at VCC to support capacity growth. (see 2023/24)	Implement programme to attract and retain SACT trained staff, and increase nurse led 'protocol' clinics to shift to a greater nurse led are model for SACT	New nursing staff in post and trained	Commence booking service review.	Performance relative to time to treatment measures for new referrals maintained at above target levels throughout quarter 4. Level of chair utilization at VCS and at the Macmillan Unit at the Prince Charles Hospital, Merthyr Tydfil maintained.	
		Finalise interim facility plan at Neville Hall Hospital.	Work with ABUHB to identify appropriate accommodation	Review workforce requirements to support interim service model across PCH and NHH	implement plan to support interim NHH model	Service specification finalised and agreement on total delivery capacity reached. Treatment of patients scheduled to commence in first week of April.	

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

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Commence contract with third party provider to deliver SACT chair capacity while Neville Hall is progressing	Implement staffing review agreed actions.	Develop business case for SACT Consultant Nurse/ Pharmacist.		Objective discontinued when identified third-party partner went into receivership in June 2022.	
		Commence the SACT Improvement / Transformation programme to develop a robust service which is 'fit for the future' to include review staffing model and assess workforce options.	Review of booking clerk capacity to be undertaken	Review of nursing capacity to be undertaken review of pharmacy capacity to be undertaken	Review pharmacy capacity to be completed	Action plan developed. Progress against plan will be overseen by new SACT and Medicines Management demand and capacity working group. Group will formally begin work in April 2023 and will report into novel VCS business planning structure.	

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

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	2. Radiation Services Capacity Plan	Maximise Rutherford contract – revised service	MRI refurbishment in radiology	Streamline plan complexity for certain palliative scenarios.		Objective discontinued when identified third-party partner went into receivership in June 2022.	
		Begin project to increase Linac capacity to 80 hours (73 currently)	Implement 80 hours Linac capacity	Finalise proposals for capacity increase to 80 hours	Implement 80 hours Linac capacity	Linac capacity periodically reduced as various upgrades carried out on TrueBeam machines as part of IRS implementation. Anticipated that 78-hours of capacity will typically be available from March 2023. Radiotherapy specific pathway improvement project to be included as workstream within Centre-wide pathway improvement programme. Programme steering group and radiotherapy workstream to formally begin work in April 2023 (objective fully defined in IMTP for 2023-24).	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Complete Brachytherapy Peer Review and submit Business Case for additional planned capacity to meet demand.	Brachytherapy action plan delivery business case potentially here as will need to follow the action plan from the peer review and workforce review			Workforce recruitment to support prostate service expansion underway. Implementation and staff training ongoing alongside review to inform future service model.	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Review demand and capacity for clinical trials	Explore dose and fractionation schedules and alternative treatment approaches			Review of overall treatment capacity to be undertaken as part of radiotherapy specific pathway improvement work (objective fully defined in IMTP for 2023-24).	
		Review the Linac transition capacity for IRS implementation.	Agree the position on temporary/mobile/ fully commissioned leased bunkers while IRS process takes down fleet.			Recruitment to identified medical physics roles complete.	
	3. Radiotherapy Pathway/COSC target achievement and radiotherapy clinical	Programme to review efficiency of existing pathways continues including reduction in variation in ways	Develop standard operating procedures for pathway management, building on those developed in Lung Pathways and	Evaluate roles for advanced practice particularly Non-Medical Outliners in optimal pathways with SST leads.	Implement agreed pathway and workforce models developed to meet COSC target requirements.	Pathway improvement improvement workstream scheduled to formally commence work in early April. Draft Terms of Reference and draft work plan developed, group members identified.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	treatment developments	of working /action plan developed.	emerging themes/challenges with SST leads.				
		Engage with WHSSC on PRRT service to deliver patient benefit (awaiting WHSSC decision)	Engage with WHSSC on PRRT service to deliver patient benefit	PRRT business case if able to progress	Finalise business case and Delivery of PRRT plan	Response to formal WHSSC appraisal developed in readiness for submission in April 2023. Appraisal panel visit to Velindre site scheduled for April.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Review proposed RT treatment developments including IMRT to establish capacity and commissioning approach	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Clinical lead(s) to be identified to support prioritisation work of new VCS business planning structure. Engagement with health boards on introduction of novel radiotherapy treatments of breast cancers (including IMN) scheduled to begin in May 2023.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/ Objectives	Key Quarterly Actions 2022/23 and Progress					
		2022/23				Quarterly Progress Update for Q4 (yearend)	Progress Rating
		Q1	Q2	Q3	Q4		
	4. Outpatient Services/Medical Directorate	SST and Outpatient Transformation programmes to commence building on pre-pandemic work. (interdependent with radiotherapy projects) Rolling programme of SST 'supportive reviews' to commence to work to ensure that pathways are effective, efficient and smooth, and to inform modernisation of the multidisciplinary workforce model.	The transformation objectives for the SSTs and Outpatient workforce will continue as previously described in quarter 1.	Deliver transformation programmes-estate, pathways and workforce	Deliver transformation programmes-estate, pathways and workforce	Work initiated in Outpatients to describe patient flow, to support development of activity baselines and to determine capacity and capacity constraints. Outpatient work identified as a project/workstream under within new pathway improvement programme. Scope of project and Terms of Reference to be developed (objective fully defined in IMTP for 2023-24). Project to relocate reception desk and introduce outpatient ambulance (non-emergency patient transport) discharge lounge initiated.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Commence workforce modelling and planning within the SSTs and Outpatient teams (and link to radiotherapy); maximising opportunities for enhancing skill mix and embracing more efficient ways of working				Workforce capacity modelling in Outpatients undertaken for CNSs.	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Maximise use of virtual consultations and embed into 'business as usual'. (50% at present).				Virtual consultations continue to be utilised as standard. Rates of utilisation continue to be actively monitored.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Establish optimum levels of Phlebotomy provision and notify HBs of changes in access.				Outpatient nursing team and reception staff have implemented extended working hours to provide support to meet increased demand. Opportunities to increase activity have been explored with further SACT injectable treatment delivered within the Department.	
		Provide increased capacity incl. at evenings/weekends to meet demand initially while the more fundamental pathway changes and ways of working are introduced					

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		pending service improvement efficiency delivery.					
		Work to reduce demand within the Outpatient setting, including: review and streamlining of patient pathways and the implementation of the 'supported self-management' model				Review of workforce and physical capacity utilisation and patient pathways undertaken in Outpatients. Improvement Cymru facilitated lean-style review of Breast-specific pathway undertaken by external consultants. Output of review to inform pathway improvement work from quarter 1 2023-24.	

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

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Re-commence the pre Covid Outreach Clinics	outreach project group to be reestablished outreach project manager to be appointed	review of data assumptions and workforce requirements to support outreach clinics identification of gaps to support service delivery		The majority of outpatient activity previously undertaken at the Royal Gwent Hospital now reinstated at that location. Ongoing discussions with ABUHB on return of outpatient activity to the Nevill Hall site.	
Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments	**5. Digital Health Care Record (CANISC Replacement)**	Finalise development	Testing and training	Commence Go Live Phases– dry run	Review impact of implementation on operational delivery	Operational oversight group created to support development of directorate level action plans focused on optimisation of ways of working / administrative processes.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Functional testing	Operational Go Live planning	Dry run weekend planned Complete Go Live review impact on service delivery and lessons learned	Plan phase 2		(Yellow)
		User Acceptance Testing	Go Live readiness assessment				
			Go Live run through				
		Data Migration	SOP development				
		Operational service change planning					
		Training sign off					
	6. Integrated Radiotherapy Solution	Complete Tender Evaluation and Identify Winning Bidder, issue standstill letter.	Complete hybrid OBC/FBC and submit to WG and await approval.	LA6 Bunker Decommissioning commences	LA6 Bunker Refurb complete.	First replacement linac delivered to site. Commissioning work begun. Anticipated that linac will be available for clinical use in early July 2023.	(Green)

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/ Objectives	Key Quarterly Actions 2022/23 and Progress					
		2022/23				Quarterly Progress Update for Q4 (yearend)	Progress Rating
		Q1	Q2	Q3	Q4		
			Award IRS contract once approval of capital and revenue funding.		Service plans for second machine replacement confirmed.	Actions on track managed through IRS implementation programme board.	
			Receive vendors detailed implementation plans				
					Initial scoping works on TPS/OIS replacement and Phase 1 additional functionality.	Actions on track managed through IRS implementation programme board.	
					Plans for Satellite and nVCC confirmed	Actions on track managed through IRS implementation programme board.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Appoint Radiation Services Programme Manager to lead implementation and commence design of 1st bunker.	Prepare recruitment of IRS implementation posts.	Recruit to IRS implementation posts		Actions on track managed through IRS implementation programme board.	
		Establish Shadow Implementation Board		Commence formal IRS implementation – shadow implementation board stands up as a formal board.		The shadow IRS implementation board continues to meet with good engagement between the procurement team and the implementation team.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	7. Acute Oncology Service- local delivery	Recruit ANPs and other staff	Pathway design with region	Pathway implementation	Pathway implementation	2 new trainee ANPs recruited (quarter 3). ANPs continue active and ongoing training/development.	
	8. Integrated care	Scope bed plans/model for assessment unit aligned to the VCC element of AOS.	Continue to review the unscheduled care patient pathway aligned to the VCC element of AOS.			Work undertaken to develop suite of measures / indicators to support monitoring of activity locally. MSCC pathway identified as eligible for service improvement input as part of the national Safe Care Collaborative initiative. Working group identified and scope of work defined.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Develop plans for delivering national projects e.g. Immuno Oncology (SDEC) Immunohematology Service – Recruit staff	Immunohematology Service Increase capacity	Immunohematology Service- further pathway work with HBs	Immunohematology Service- grow service delivery	Updated plan for optimal SDEC model developed.	

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

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/ Objectives	Key Quarterly Actions 2022/23 and Progress					
		2022/23				Quarterly Progress Update for Q4 (yearend)	Progress Rating
		Q1	Q2	Q3	Q4		

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		(SDEC) Ambulatory Care – finalise staff recruitment	Ambulatory Care- increase weekday opening	Ambulatory Care- weekend opening		Extended hours of operation sustained. Work commenced to develop appropriate suite of performance indicators to support ongoing monitoring of activity and to allow reporting to national structures. Formal reporting of activity via NHS Wales Delivery Unit initiated.	

<table>
<tr><td colspan="8">IMTP Strategic Priorities VCC Service Delivery Framework</td></tr>
<tr><td rowspan="3">Strategic Priorities 2022/23 to 2024/25</td><td rowspan="3">Key Deliverables/ Objectives</td><td colspan="6">Key Quarterly Actions 2022/23 and Progress</td></tr>
<tr><td colspan="4">2022/23</td><td>Quarterly Progress Update for Q4 (yearend)</td><td>Progress Rating</td></tr>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td></td><td></td></tr>
<tr><td rowspan="2"></td><td></td><td></td><td>Deliver requirements of national projects e.g. Immuno Oncology</td><td></td><td></td><td></td><td></td></tr>
<tr><td>9. Palliative Care</td><td>Review Cancer Associated Thrombosis clinic service: establish working SLA with Oncology</td><td>Undertake Peer Review as planned</td><td>Review of Chronic pain service.</td><td>Preparing the move from CANISC (No solution yet identified)</td><td>Cancer and Hospital Acquired Thrombosis Group re-established. Terms of Reference. Group overseeing response to All Wales HAT audit. Audit response to include review of the CAT clinic.</td><td></td></tr>
</table>

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	10. Key Treatment Development – IMN SABR Lutetium PSMA HDR Brachytherapy	Finalise the priority of implementation of key treatments where external funding is required and agree timescales.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Response to formal WHSSC appraisal of potential Velindre PRRT service developed in readiness for submission in April 2023. Appraisal panel visit to Velindre site scheduled for April. Engagement with health boards on introduction of novel radiotherapy treatments of breast cancers (including IMN) scheduled to begin in May 2023.	
	Clinical team priorities – gaps in service therapies access to trials research					New VCS business planning structure in place from April 2023 will support prioritisation and implementation of service developments (support to include project management	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	MDT attendance/cover arrangements					and business case development advise).	
		Commence business case developments for agreed treatments in phased approach according to priority and timetable agreed.	Apply 'Just do it' criteria where appropriate for clinical team	Apply 'Just do it' criteria where appropriate		New business planning function to prioritise service developments and allocate appropriate support. New business planning structure in place form April 2023.	
		Finalise the	Begin development	Continue the		Clinical lead(s) to be identified	

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

<table>
<tr><th colspan="9">IMTP Strategic Priorities VCC Service Delivery Framework</th></tr>
<tr><th rowspan="3">Strategic Priorities 2022/23 to 2024/25</th><th rowspan="3">Key Deliverables/ Objectives</th><th colspan="7">Key Quarterly Actions 2022/23 and Progress</th></tr>
<tr><th colspan="4">2022/23</th><th>Quarterly Progress Update for Q4 (yearend)</th><th>Progress Rating</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th></th><th></th></tr>
<tr><td rowspan="6"></td><td></td><td>priority of clinical team priorities.</td><td>of implementation plans for clinical team priorities requiring support/wider discussions.</td><td>development of implementation plans for clinical team priorities requiring support/wider discussions.</td><td></td><td>to inform prioritisation work of new VCS business planning structure.</td><td>(yellow)</td></tr>
<tr><td rowspan="5">11. Radiotherapy Satellite Centre</td><td>Support Strategic case development and review of FBC.</td><td rowspan="5">FBC approval- WG

implement Arts strategy for RSC

operational model development aligned to IRS</td><td rowspan="5">Ongoing liaison with ABUHB regarding build, IRS alignment

project board, project team meetings</td><td rowspan="5">Operational model delivery plan preparation</td><td rowspan="5">Managed through IRS Implementation Board.</td><td rowspan="5">(blue)</td></tr>
<tr><td>Workforce Plan.</td></tr>
<tr><td>Finance case.</td></tr>
<tr><td>IRS alignment and FBC.</td></tr>
<tr><td>FBC scrutiny and approval by</td></tr>
</table>

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

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		service lead and through Boards					
	12. Radiology	Commission reconditioned MRI scanner. Phase 1 capacity delivery	Review Radiology demand and align to capacity plan		Full additional capacity plan is delivered	Introduction of DHCW and associated disruption to routine activity reporting restricted ability to undertake demand and capacity planning. Software upgrade procured which will improve efficiency and throughput of reconditioned MR scanner.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	13. Patient treatment helpline	Implement new handover arrangement into SACT service.	Develop action plan to address issues identified and changes required.	Implement actions identified.	Implement associated workforce or training plans	Future model of treatment helpline provision to be considered by the VCS Senior Leadership Team. Work to stabilise platform will continue. Digital work to enable recording of calls scoped and completed. Service Improvement work, as part of national Safe Care Collaborative initiative, to continue whilst future model determined.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		Commence review of service functionality and fitness for purpose. Engage with digital team to explore system capability and options for future.	Engage with stakeholders at VCC and externally in developing plans to ensure all calls are appropriately directed from 1st contact.,	Implement any identified telephony systems to allow signposting to all areas.	Roll out new system and ways of working		
	14. Implementation of patient engagement strategy to strengthen our conversations with patients, families and	Commence Patient panel Implement patient panel management	Commence establishment of Patient Engagement Hub and Patient Leadership Group Establish initial Patient Engagement	Patient Leadership Group recruitment and training	Continue to develop Group, staff team and patient engagement delivery. Includes underpinning nVCC.	Individual appointed to work within the Trust's Communications team and focus on developing patient engagement hub pilot. Hub pilot to be launched quarter 1 2023-24 (objective fully defined in IMTP for 2023-24).	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	wider partners	software programme	activity for Velindre Futures projects				
	15. Establish Primary Care project under Velindre Futures					Opportunities for the Centre for Collaborative Learning (CfCL) to support primary care education and development programmes to be scoped. Initial workshop to be held in April 2023 (objective fully defined in IMTP for 2023-24).	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 4: To be an international leader in research, development, innovation and education	**16. R & D Hub (Development at UHW)**	Progress the clinical scientist and clinical academic business cases.	Progress the clinical scientist and clinical academic business cases.	Business case and costs	Establish Governance Arrangements for the Hub.	The Velindre R,D&I team continue to work closely with the Joint Research Office (JRO) to ensure process is in place to efficiently and effectively deliver collaborative research studies that will be delivered through the Cardiff Cancer Research Hub. Engagement with Prehab2Rehab collaborative and with the Wales Cancer Network National Prehabilitation Group continued. Active contribution to work to define the remit and scope of both groups.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/ Objectives	Key Quarterly Actions 2022/23 and Progress					
		2022/23				Quarterly Progress Update for Q4 (yearend)	Progress Rating
		Q1	Q2	Q3	Q4		

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

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/ Objectives	Key Quarterly Actions 2022/23 and Progress					
		2022/23				Quarterly Progress Update for Q4 (yearend)	Progress Rating
		Q1	Q2	Q3	Q4		

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

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	17. TrAMS	Establish VCC programme board and supporting sub groups: - clinical serices model - clinical trials via Trams - workforce and staff impact - finance incl private pt impact	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	National TrAMS service model not now anticipated until quarter 1 2023-24 at earliest due to recruitment timescales of national TRAMS posts. Internal VCC Pharmacy/SACT service change continues in anticipation of most likely service model.	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	18. Therapies incl. collaborative work across region	Participate in regional Prehabilitation programme and scope development plan.	Review funding streams and commissioning models to facilitate prehabilitation service development.	Continue participation in regional service	Bring forward proposals for therapies development	Engagement with Prehab2Rehab collaborative and with the Wales Cancer Network National Prehabilitation Group continued. Active contribution to work to define the remit and scope of both groups.	
	19. Workforce Modernisation:	Establish a workforce modernisation programme – with a 2 phased approach - 'Stabilise and Modernise' Finalise proposals for revised clinical leadership arrangements.	Align workforce plans for regional developments e.g. AOS, RSC. Advanced practice plan the potential for 'pump priming' advanced practice roles to 'kick start' the workforce Advanced Practice Radiographers and Therapeutic Radiographers	Implement Physicians Associate posts. Prepare plan for advanced practice and non-medical Consultant level roles.	Workforce modernisation programme continues	Two new physician's associates recruited. Value Based Healthcare business case unsuccessful in bid to secure funding for new non-medical outlining posts. Further work to be undertaken to demonstrate benefits and to identify alternative means of supporting the innovation being actively explored.	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	Key Deliverables/ Objectives	Key Quarterly Actions 2022/23 and Progress					
		2022/23				Quarterly Progress Update for Q4 (yearend)	Progress Rating
		Q1	Q2	Q3	Q4		
	20. Single Cancer Pathway	Focus on front end of the pathway for all tumour sites:	Develop dashboards and pathway data to make all patients' pathway points visible.	Focus on whole Breast Pathway:	Commence Action plan implementation.	Work on early part of VCC pathways and on administrative interface between referring health boards and VCC identified as a project/workstream for inclusion in new pathway improvement programme. Draft ToRs developed and members of working group identified (objective fully defined in IMTP for 2023-24).	
		Aims to Standardise patient referrals to VCC.		Mapping of Breast Pathway from patient referral to service to treatment commenced.		Engagement with Wales Cancer Network continued. Discussions on recruitment of project resource by the WCN to support activity at VCS advanced. Recruitment to new position to be undertaken in quarter 1 2023-24.	
		Timely receipt of all diagnostic test results and treatment pre-		Identify touch points along pathway and			

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

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
		requisites prior to MDT.		potential bottlenecks			
		Improve patient outcomes by early genomic testing where indicated. Develop training plans		Measure how currently delivering against the National Optimal Pathways (NOP)			
Strategic Priority 5: To work in partnership with stakeholders to improve	**21. Engagement with HB's**	Agree terms of reference and priorities for joint working with each HB.	Share patient pathway challenges in developing improvement plans.			Meetings continued with a more developed focus on key operational issues (this includes the review and	

IMTP Strategic Priorities VCC Service Delivery Framework							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 and Progress**					
		2022/23				**Quarterly Progress Update for Q4 (yearend)**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
prevention and early detection of cancer		Commence meetings to deliver on these priorities.	Agree outreach plans for outpatients and SACT with all HBs.			development of SLAs supporting key services).	GREEN

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

TRUST BOARD

FULL BUSINESS CASE FOR RADIOLOGY INFORMATICS SYSTEMS PROGRAMME (RISP)

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Katherine Lewis Digital Programme Manager David Mason-Hawes, Head of Digital Delivery
PRESENTED BY	Carl Taylor, Chief Digital Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, & Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Senior Leadership Team	5/4/23	ENDORSED FOR APPROVAL
EMB Shape	17/04/23	ENDORSED FOR APPROVAL
Strategic Development Committee	4/5/23	ENDORSED FOR APPROVAL

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

ACRONYMS	
RISP	Radiology Informatics Systems Programme
RIS	Radiology Information System
PACS	Picture archiving and communication system
PDMS	Patient Dose Monitoring System
DHCW	Digital Health Care Wales

1. SITUATION/BACKGROUND

1.1 The purpose of this full business case is to seek approval from the Board at Velindre University NHS Trust following the award of the contract to Phillips for a PACS, RIS and PDMS in January 2023. This contract is for a period of five years, with an option to extend for further two years, in annual increments starting in 2024.

1.2 The RIS is used to record patient demographic details and manage the appointment process. Following the completion of an x-ray or scan, the images are stored in a digital format in PACS, which is then used to manage the clinical reporting process and to display the images and reports for clinicians outside radiology to review. The PDMS, working in conjunction with PACS and RIS, is used to assist health boards in satisfying their legal responsibilities to monitor and manage patient radiation doses and to perform optimisation of all radiological exposures

1.3 The current PACS delivered by Fuji, has been operating since 2013. For VUNHST the current contract with Fuji's ends in August 2025. The current RIS is a national system developed and supported by DHCW

1.4 Radiology services across the country are facing significant pressure in terms of patient demand, and it is essential that staff are supported by the right digital tools that will enable them to work more efficiently. RISP provides the opportunity to not only procure replacement systems, but to also modernise and change the way radiology services are delivered across Wales

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

1.5 The Trust Board are requested to **APPROVE** the full business case and associated costs, attached as Appendices.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 All Health Boards are required to sign a deployment order for a minimum of five years. The DO will set out the timescales for local implementation; the equipment required per health board and associated costs.

2.2 Replacement of image capture devices is outside the scope of the RISP Programme. This may have implications for VUNHST but will be considered in partnership with the National Imaging Programme to identify any service modernisation

2.3 Operating costs for the new RISP platform are broadly in line with the costs incurred by VUNHST for its use of the current RIS and PACS services - there will be a marginal cost increase (~ £3k per annum) once the service is fully deployed. To establish the new service, the Trust is expected to incur some capital and non-recurrent revenue costs, some of which are offset via national Welsh Government capital and revenue funding.

2.4 Over a 10-year period, the Trust is asked to approve the costs as set out in the private paper which are commercial in confidence.

2.5 The attached document – **Appendix 1**– sets out the public Full Business Case for review by the Trust Board.

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

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	• PDMS provide many tools to aid health boards in improving the quality and efficiency of imaging services as well as meeting their legislative requirements such as those under Ionising Radiation (Medical Exposures) Regulations 2017 (IR(ME)R 2017). • Reduced risk of repeat examinations and inappropriate radiation dosage • Improved imaging workflow, enabling timely delivery of service with the ability to share with the clinical referrer across Wales.
RELATED HEALTHCARE STANDARD	Effective Care
	If more than one Healthcare Standard applies please list below: Safe care Timely 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)
	See Appendix 1 – Business Justification Case

4. RECOMMENDATION

4.1 The Trust Board are requested to **APPROVE** the business justification case, attached as Appendices, to include the key risks/matters for escalation outlined.

GIG CYMRU NHS WALES | Iechyd a Gofal Digidol Cymru | Digital Health and Care Wales

GIG CYMRU NHS WALES | Rhaglen Caffael System Gwybodeg Radioleg | Radiology Informatics System Procurement Programme

Radiology Informatics System Programme

Full Business Case

Contents

1. The Strategic Case ....
1.1 Introduction ....
1.2 The Strategic Context ....
1.3 Organisational Overview ....
1.4 Business Strategies & Reports ....
1.5 The Case for Change ....
1.6 Existing Arrangements ....
1.7 Local considerations ....
1.8 Business Needs Current & Future ....
1.9 Solution Scope ....
1.10 Benefits ....
1.11 Risks ....
1.12 Constraints ....
1.13 Dependencies ....
1.14 Business Continuity Plans ....
2. The Economic Case ....
2.1 Introduction ....
2.2 Revisiting the OBC Options ....
2.3 The Procurement Process ....
2.4 The FBC Economic Appraisal ....
2.5 Summary of Options Appraisal Results ....
3. The Commercial Case ....
3.1 Procurement Scope ....
3.2 Procurement Regulations ....

3.3 Procurement Strategy ....
3.4 Required Services, Outputs and Timescales ....
3.5 Risk Apportionment....................
3.6 Payment Mechanisms ....
3.7 Key Contractual Issues ....
3.8 Accounting Treatment ....
3.9 Personnel Implications (including TUPE)....................
4. The Financial Case ....
4.1 Introduction ....
4.2 Overview ....
4.3 Accounting Treatment and Value Added Tax (VAT) ....
4.4 Capitalisation ....
4.5 Capital Charges ....
4.6 Value Added Tax....................
4.7 Baseline Costs ....
4.7 Preferred Bidder Solution Costs ....
4.8 Programme Resource Plan ....
4.9 Local Infrastructure Costs ....
4.10 Ongoing Support for Integration Costs ....
4.11 Impact on Financial Statements ....
4.12 Impact on Income & Expenditure ....
4.13 Overall affordability and funding ....
5. The Management Case ....
5.1 Introduction ....
5.2 Programme Governance ....

5.3 Projects and Workstreams ....

5.4 Technical and Assurance ....

5.5 Benefits Realisation ....

5.6 Outline Arrangements for Risk Management ....

5.7 Outline Arrangements for Post Project Evaluation ....

Appendix S1: Business Strategies & Reports ....

Appendix E1: Economic Model ....

Appendix F1: Financial Model ....

Appendix M1: Programme Board Terms of Reference (Back) ....

Appendix M2: Benefits Management Strategy (Back) ....

Appendix M3: Benefits Register (Back) ....

Appendix M4: RAID (Risks, Actions, Issues and Decisions) (Back) .

Appendix C1: Draft Implementation Plan (Back) ....

Appendix C2: Procurement Route Evaluation (Back) ....

Revision History

Amended by	Version	Status	Date	Purpose of Change
Joao Martins	0.1	Draft	13/04/2023	Single document, all cases added. Document formatting
Joao Martins	0.2	Draft	14/04/2023	Small amendments
Gareth Cooke	1.0	Version 1	14/04/2023	Small amendments
Gareth Cooke	2.0	Version 2	18/04/2023	Updated section on local variations and considerations
Anouska Huggins	3.0	Version 3	25/04/2023	Updated to reflect Version 8.0 of the Financial Model
Gareth Cooke	4.0	Version 4	17/5/2023	Redacted commercial sensitive information

Reviewers

Date	Version	Name	Position
14/04/2023	1.0	Gareth Cooke	RISP Programme Lead
14/04/2023	0.2	John Collins	RISP SME
14/04/2023	0.2	Joao Martins	RISP Principal Project Manager

1. The Strategic Case

1.1 Introduction

The Radiology Informatics System Procurement (RISP) Programme was set up in 2019 to procure replacement PACS, RIS and PDMS systems for all health boards and trusts in Wales, due to the current PACS contract with FUJIFILM ending in 2023/2024 (DHCW provide the RIS). In addition to the procurement exercise, RISP provides the opportunity for national service improvement that will underpin future service delivery models that are based around the separation of acute and planned care facilities and the establishment of regional diagnostic centres. By delivering an "All Wales" view of the radiology record and ensuring that available functionality is not constrained by the setting in which care is being delivered RISP ensures that the ability to work across traditional organisational boundaries is embedded at the heart of the solution and will improve the quality of services delivered to patients and will help drive efficiency by reducing duplication, eliminating the requirement to manually request the transfer of imaging e.g. for regional MDT's or acute trauma or stroke care.

PACS refers to Picture Archiving and Communications System. Following an imaging procedure such as CT scan or X-ray examination, a PACS system stores images and the clinical reports in a digital system. RIS refers to Radiology Information System, which is a system which runs the "business" of imaging from scheduling patient examinations, room and modality utilisation and storing all the patients' imaging reports, records, and associated information. A PDMS refers to Patient Dose Management System, which automatically gathers, stores and analyses information on patients' radiation exposure from medical imaging involving ionising radiation.

This Strategic Case sets out the context and the case for change, together with the objectives for the Programme. This case demonstrates how the RISP programme will deliver the vision of a seamless end-to-end electronic solution that enables the Radiology service to provide a high quality, safe and timely clinical imaging service for the population of Wales.

This Strategic Case will describe the main components of the RISP programme, the risks associated with its development and implementation and how they can be mitigated to ensure success.

1.2 The Strategic Context

Imaging is a crucial clinical diagnostic and surveillance tool to investigate, monitor, and treat diseases and injuries. It is integral to all clinical services -hospital-based clinicians and general practitioners refer patients to radiology departments to undergo a wide range of imaging examinations. The nature of technological development and advances in drug, surgical and medical technologies have meant that there is a key dependency on imaging investigations to deliver timely and accurate diagnoses and assessments, facilitating timely care. The data from these investigations are evaluated, analysed and reviewed by a clinical radiologist, radiographer, or sonographer to produce a clinical report, which the requesting clinician will use to guide the management of the patient.

Diagnostic radiology has evolved over the last century from the plain film x-ray to the modern suite of digital imaging services and different diagnostic procedures, which are integral to healthcare across Wales. Modern diagnostic imaging is vital to diagnosis and treatment in modern patient care. Radiology services have always been delivered from a wide range of healthcare settings in all Health Boards and Trusts across Wales; the anticipated future development of Regional Diagnostic Hubs will expand the range of services provided outside typical hospital environments. Imaging services provide a core diagnostic function, along with therapeutic interventional imaging, in delivering key patient pathways, including screening services, cardiac, stroke, cancer, orthopaedics and emergency care, which facilitates timely diagnosis for patients and facilitate quality patient outcomes.

Equitable access to a robust, quality, and timely imaging service and its output is vital for all clinicians to ensure optimal patient outcomes.

The diagram below illustrates key radiology techniques commonly used across the NHS.

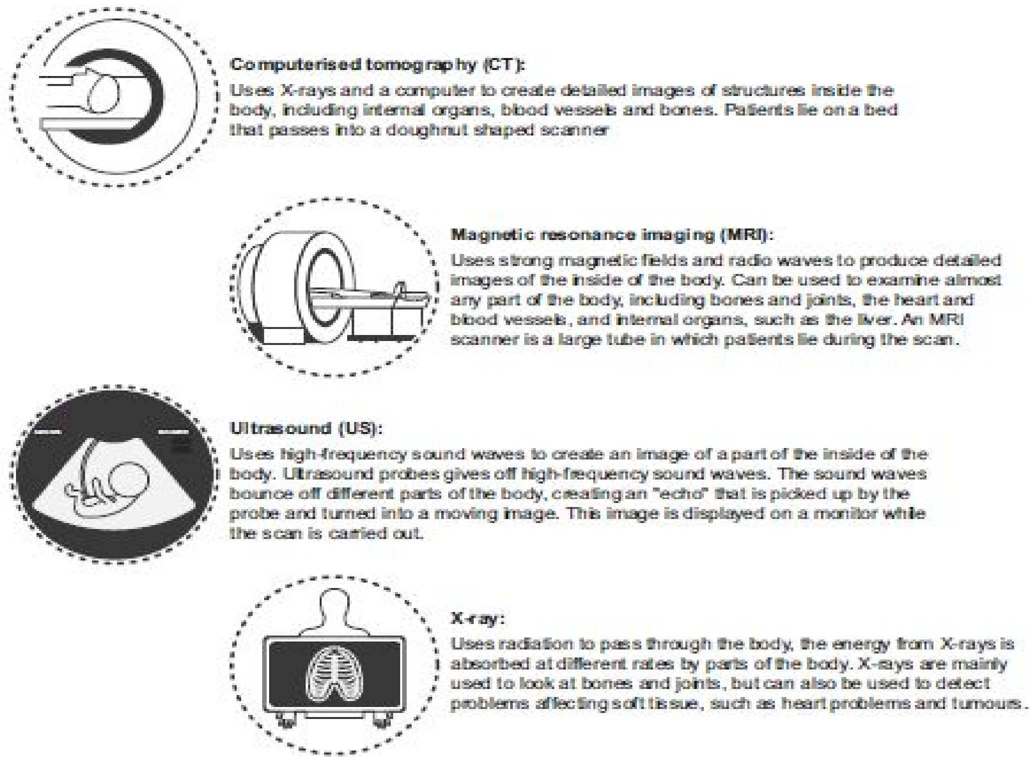


Diagram 1 – Illustration of key radiology techniques

1.3 Organisational Overview

The radiology service across Wales is delivered in several settings. Most radiology activity is provided through District General Hospitals and community sites at the University Health Boards (UHBs) and Trusts. Powys Teaching Health Board operates services from several community hospital sites with clinical and professional support from the adjacent UHBs and Trusts in England; Screening Services operate from fixed locations and several mobile units across the country. Imaging facilities are migrating outside of the secondary care setting based on the model of Community Diagnostic Centres. The rapid adoption of new portable technologies also allows Point of Care (POC) testing at patients' bedside or at home. The solution procured will need to recognise the current mix of rural and urban populations and locations where care is delivered in Wales whilst be able to facilitate and support future diagnostic delivery structures.

The main sites within each organisation are shown below:

- ***Aneurin Bevan UHB:*** The Grange University Hospital, the Royal Gwent Hospital, Nevill Hall Hospital and Ysbyty Ystrad Fawr;
- ***Betsi Cadwaladr UHB:*** Ysbyty Glan Clwyd, Wrexham Maelor Hospital and Ysbyty Gwynedd;
- ***Cardiff and Vale UHB:*** University Hospital of Wales and University Hospital Llandough;
- ***Cwm Taf Morgannwg UHB:*** Prince Charles Hospital, Royal Glamorgan Hospital; Princess of Wales Hospital;
- ***Hywel Dda UHB:*** Bronglais General Hospital, Glangwili General Hospital, Withybush General Hospital and Prince Phillip Hospital;
- ***National Imaging Academy***
- ***Powys Teaching Health Board***: Brecon War Memorial Hospital, Llandrindod Wells County War Memorial Hospital, Machynlleth Community Hospital, Montgomeryshire County Infirmary, Victoria Memorial Hospital, Ystradgynlais Community Hospital;
- ***Public Health Wales Trust***: Breast Test Wales sites in Cardiff, Swansea, Llandudno, Wrexham;
- ***Swansea Bay UHB:*** Morriston Hospital, Neath Port Talbot Hospital, and Singleton Hospital;
- ***Velindre University NHS Trust***, Velindre Cancer Centre.

1.4 Business Strategies & Reports

Several national strategies and reports inform this investment (see Appendix S1 for full list of reports), key ones include:

- A Healthier Wales: Our plan for health and social care (2018)
- The Imaging Statement of Intent (2018)
- Wales Audit Office Radiology Services Report (2018)
- Digital Architecture Review

The Well-being of Future Generations (Wales) Act 2015 requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities,

and each other, and to prevent persistent problems such as poverty, health inequalities and climate change. The purpose of the RISP Programme aligns to delivering the digital needs of A Healthier Wales - one of the seven core well-being goals of the Future Generations Act, and Welsh Government's long-term plan for Health and Social Care; the other well-being goals also resonate with our approach, but we have more to do.

Achieving real digital transformation of public services provides an opportunity to support the ways of working described in the Well-being of Future Generations (Wales) Act. RISP will support the joining up of digital public services to improve patient experience and positive outcomes, notably helping support Mission 6: data and collaboration within the Digital Strategy for Wales.

The recently published NHS Wales Decarbonisation Strategic Delivery Plan demonstrates how NHS Wales can play its part in the recovery and its commitment to the Wellbeing of Future Generations (Wales) Act 2015, which directs the Programme to consider long-term persistent problems such as poverty, health inequalities, and climate change. We will work with the appointed supplier to develop a low carbon approach to implementation and operation of the services and look to minimise reliance on paper-based documents and thereby reduce unnecessary waste. The RISP programme has identified several decarbonisation benefits, including greener energy, more efficient use of energy and reductions in consumables and travel that can be delivered because of the using cloud or large scale data centre -hosted systems, new hardware technologies and remote management and support services.

A Healthier Wales: Our plan for health and social care

A Healthier Wales, the Government's plan sets out a long-term vision of 'a whole system approach to health and social care', highlighting the need for better use of digital, data, and communication technologies.

The Imaging Statement of Intent (ISoI)

Key priority areas to support the development of modern, sustainable Imaging services are set out in the Imaging Statement of Intent published in March 2018 by Welsh Government.

The statement is aligned to "A Healthier Wales" as it sets out clear objectives for radiology including the need for informatics systems to be secure with a robust IT infrastructure that operates pan-Wales.

The Wales Audit Office (WAO) Radiology Services Report

The WAO Radiology Services Report published in November 2018 summarises the key messages from the Auditor General's local work on radiology services. It highlights issues raised by the Health Boards around radiology informatics systems. The findings set out in the Auditor General's separate report on "Informatics Systems in NHS Wales " include:

- Wales-wide radiology IT system challenges and weaknesses in local IT infrastructures inhibit radiology services' efficiency.
- Radiology services are well managed operationally, but there is scope to strengthen board-level scrutiny and the strategic planning of services.

Digital Architecture Review

Welsh Government commissioned a review of digital delivery in Wales following the Public Accounts Committee report on "Informatics Systems in NHS Wales" published in November 2018. The Digital Architecture Review 'explored how digital systems are designed to work together ' across Wales.

RISP will align with these strategies by supporting efficient and effective clinical care and utilising vendor-agnostic and future-proof technologies to deliver the vision of "a seamless end-to-end electronic solution, from receipt of a referral to the delivery of a radiology report" (electronic test request, receipt of radiology referral to delivery and acknowledgement of radiology report) that will enable the transformation of imaging services and other critical areas of work.

Digital Strategy for Wales

The Digital Strategy for Wales aims to ensure people experience modern and efficient public services supported by effective and ethical use of data. The RISP programme will support this strategy by procuring an integrated system that will ensure information is easily transferred

and updated, allowing users to monitor the status of a patient going through diagnosis, treatment, and recovery pathways.

1.5 The Case for Change

Investment Objectives

The following investment objectives have been identified and agreed during discussions in workshops, presentations, and board meetings:

Table 1: Investment Objectives

No.	Investment Objectives
RISP-IO1	To integrate Picture Archive and Communication System (PACS), Patient Dose Management System (PDMS) and Radiology Information System (RIS) systems into one single solution (with the ability for further integration with ETR and results acknowledgement systems) that all Health Boards and Trusts implement in Wales by 2026
RISP-IO2	To improve and optimise patient care by reducing the number of incidents caused due to missing/insufficient clinical information/reports, resulting in fewer misinterpretations and delayed diagnoses, by providing an integrated imaging patient record across Wales for all Health Boards and Trusts in Wales by 2026
RISP-IO3	To reduce the number of administrative resources required to support cross-boundary patient pathways, because of shared access for imaging and reporting, 12 months after contract commencement in a health board area
RISP-IO4	To reduce the carbon footprint of PACS and RIS systems by decreasing the use of paper-based systems for referring and reporting in radiology and utilising fewer devices that have higher energy consumption across all Health Boards and Trusts in Wales by 2026
RISP-IO5	To reduce the number of repeat examinations and hence inappropriate radiation dosage for patients, through improved access to imaging information and a standardised data sharing and recording process, by all Health Boards and Trusts in Wales by 2026

Current position

Radiology services within the current Health Board and Trust structures and configuration tends to drive care delivery within the traditional organisational boundaries.

PACS and WRIS have been deployed in line with these boundaries, and subsequent changes to organisational arrangements have been made more difficult because of a siloed approach.

Delivering cross-organisational working with the current system is possible, but it isn't easy to configure and maintain. As a result, regional working is typically a low-volume, high-

maintenance, and time inefficient activity rather than a core component of our working arrangements.

Increasingly clinical care is delivered across organisational boundaries with, for example, regional MDTs for cancer and non-cancer diagnoses and cross-border referrals to England for tertiary services in stroke, cardiac and neurology, necessitating a more patient and pathway focussed approach to the delivery of digitally enabled clinical systems.

Challenges

- Increasing demand for Radiology services in the form of continuous growth in the number of referrals for CT scans, MRI scans (10% annually) etc., is outstripping scanning and reporting capacity, with the current workforce struggling to keep pace with the change.
- Capacity and demand mismatch results in the utilisation of locums, outsourcing and teleradiology services to deliver timely service. This has resulted in an accelerating cost pressure, and future projections indicate this situation will persist.
- The core Radiology IT system is not meeting health boards' and Trusts' needs to deliver seamless imaging care for patients, which is often delivered across health board boundaries. Further weaknesses are identified in local IT infrastructures that impact on performance and availability of the solutions.
- The lack of a national Radiology dataset hinders the collation of Radiology activity at a national level; this makes painting the national picture difficult and unnecessarily time-consuming.

These challenges illustrated above are expanded upon below:

Demand

There is ever-increasing justified demand for all imaging aimed at earlier diagnosis to improve outcomes; examples include earlier-stage cancer interventions & treatment modification, prevention of unnecessary exploratory surgery, and informing surgical planning to reduce postoperative morbidity and mortality risk with targeted intervention.

Several factors drive this increase in demand, including demographic changes, new clinical guidelines, lower thresholds for referral, advances in technology and understanding how disease features present themselves on diagnostic images.

This increase in demand has meant that in 2019, not one health board in Wales could meet its reporting requirements within the internal reporting capacity available. Clinical Directors of radiology departments at six of the seven health boards (60%) in Wales indicated there were not enough radiologists in their department to deliver safe and effective patient care.[1]

Workforce

The lack of a sufficient radiology workforce is the biggest challenge both Welsh & UK radiology departments face. These shortages vary in severity between the different regions of Wales and negatively impact patient care. Demands for diagnostic imaging have continued to increase for many years and have been further exacerbated by the covid-19 pandemic. The expansion of the imaging workforce and a significant drive to change ways of working are vital to meet these increasing demands (Richards Report). Workforce effectiveness and productivity need to be maximised wherever possible, which is difficult to achieve with the current systems.

The Royal College of Radiologists (RCR) annual workforce survey highlights key concerns for Wales. It suggests Wales' radiologist workforce is understaffed by 38% - the most significant shortfall in any UK nation. It means Wales lags significantly behind the UK and the EU average for the number of radiologists per head of population- Wales has 7.8 radiologists per 100,000; the UK average is 8.6, and the EU average is 12.8. The RCR 2021 Workforce report identified that whilst there has been a steady growth in the UK Radiologist workforce over the last five years, the report highlights that Wales has had some of the slowest growth in the UK in terms of Consultant Radiologist numbers at only 2% per annum. This is further compounded by Wales having an older Clinical Radiology workforce, with the highest number due to retire in the next five years (23%). [Taken from page 23 of the 2021 census report.]

Wales also has the most severe radiologist shortage of any UK nation. If nothing improves, the Royal College of Radiologists (RCR) predicts the UK's 33% actual radiologist shortfall will hit 44% by 2025.

Over the past 5 years since 2016, there has been an increasing reliance on outsourcing and international recruitment, with a reduction of 6% in staff recruitment from the UK and the same % increase in recruitment from non-EEA countries. However, Radiology Service Managers in Wales currently report increasing difficulties in sourcing locum or agency staff, both medical and Radiographers. These difficulties increase for Organisations located in the West and those covering rural areas of Wales.

On patient safety, the College says 60% of Wales's imaging directors do not have enough consultants to keep patients safe. Wales also has the worst interventional radiology (radiologists undertaking procedures) provision of any UK nation, with 60% of health boards unable to provide 24/7 rotas or transfer arrangements for patients needing interventional care. In Wales, the vacancy rate in 2021 has dropped from 10% to 8%. However, it is important to note that vacancy data provides limited insight into the extent of workforce shortfalls. Vacancies do not reflect the entire shortfall as several factors, including budgets or a lack of suitable candidates, constrain vacancies. The effects of the pandemic have magnified these issues.

Waiting Times

The number of patients on radiology waiting lists has increased by 50% since December 2019, with almost 30% of patients waiting longer than 8 weeks at the end of October 2022. There is significant variation between Health Boards and modalities, and these delays and inequalities will likely persist without a more concerted effort to address them. Whilst RISP won’t fundamentally eliminate workforce and equipment short falls by enabling a regional and national view of the patient record, supporting cross-organisational working, improving operational efficiency and providing insights that allow better decisions around resource allocation RISP will maximise the use of the available skills and resources.

Morale

At the start of April 2020, the RCR polled 1,089 consultants around the UK about their feelings about working in the NHS post-Covid. 37 were from Wales, and of those:

- 41% felt demoralised (individuals)
- 43% intended to cut their hours
- 11% say they planned on leaving the NHS in the next 12 months – according to the RCR, this is three times the standard leaving rate.

RCR census 2021 identified that 98% of clinical directors are worried about morale, stress and burnout.

Table 2: Regional breakdown of RCR workforce data[2]

	All radiologists (consultants and trainees) per 100,000 EU average is 12.8	2020 consultant radiologist headcount	2020 full-time equivalent (FTE) consultant numbers	Increase in FTE consultants 2019-2020	2020 FTE % shortfall and consultant numbers needed to meet service and safety needs
UK	8.6	4,277	3,902	+ 170 (from 3,732)	33% (1939)
England	8.5	3,587	3,267	+ 146 (from 3,120)	34% (1675)
Scotland	9.1	354	324	+ 5 (from 319)	29% (130)
Wales	7.8	169	156	+ 0 (from 156)	38% (97)
Northern Ireland	11.1	168	156	+ 19 (from 137)	24% (48)

Table 3: Radiologists availability survey

	Hospital radiology managers who say they do not have enough consultants to provide safe care	Trusts/health boards without the radiologists or transfer arrangements to provide safe 24/7 interventional radiology services
UK	58%	47%
England	58%	47%

Scotland	65%	40%
Wales	60%	60%
Northern Ireland	33%	44%

Reporting Costs

To meet the rising demand for reporting, health boards are turning to insource (additional payment to contracted consultant radiologists to report outside of core contracted hours) and private sector outsourcing companies. Expenditure on outsourcing and insourcing has quadrupled since 2014 to an estimated £8.3 million in 2018 and is forecast to continue to rise. The RISP needs to support a seamless, undisrupted workflow to allow the clinical reporting of imaging to occur most efficiently, given workforce constraints.

RCR identified that in 2020/21, £178m was spent on insourcing, outsourcing and ad-hoc locums across the UK, the equivalent to 1,876 CR Consultant salaries (or half the entire current CR workforce). These short-term fixes are helping to manage workload, but demand for imaging in the UK continues to increase, and these measures will ultimately not be sustainable. For Wales, Health Education and Improvement Wales have again committed to funding 22 additional training places, but this won't be sufficient to meet demand, with there being an estimated shortfall of 77 consultants currently, rising to 146 by 2026.

Informatics

Radiology is a high throughput, capital-intensive service that requires an efficient and effective IT system to deliver an efficient radiology service that maximises the use of expensive equipment.

The diagram below illustrates a typical journey to and through the radiology service. Integration between the individual components of the RISP solution are key to delivering operational efficiency and maximising the use of available resources whilst integration with external systems e.g. referral solutions, clinical portals and results acknowledgement, underpin more efficient clinical pathways across clinical specialities.

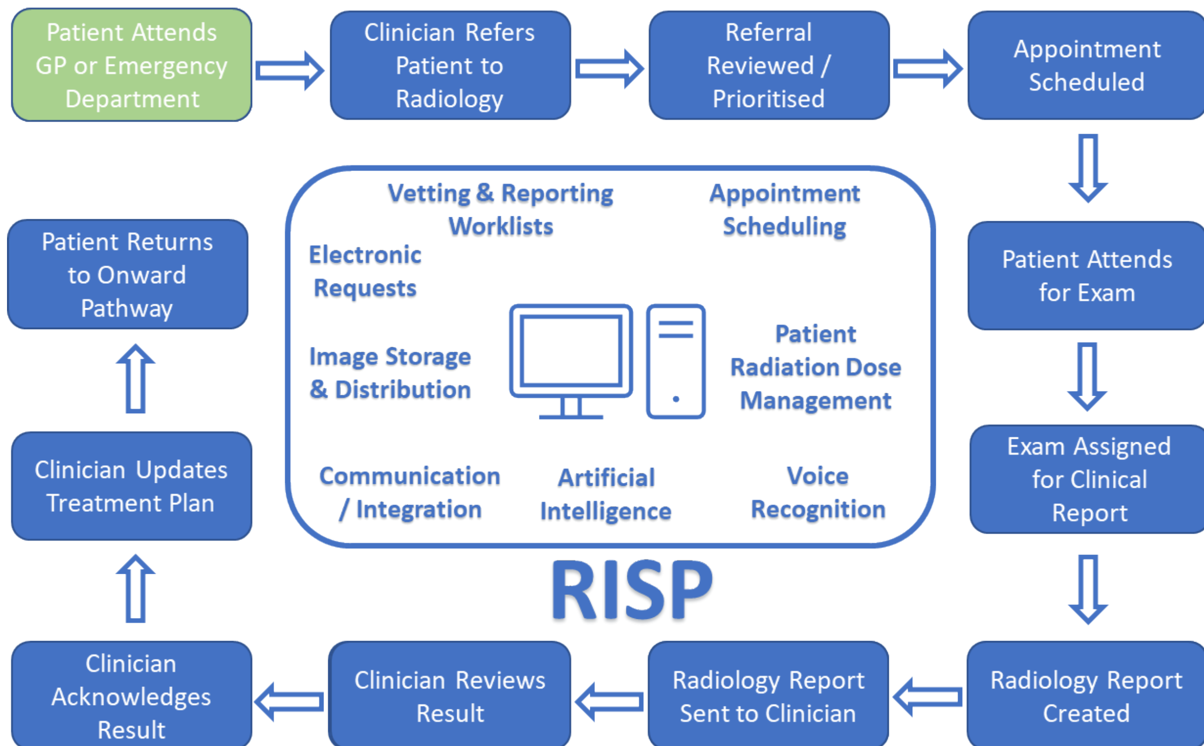


Diagram 2 - Typical clinical pathway to and through radiology

The current radiology IT systems neither enable service planning nationally nor provide the information needed to maximise the utilisation of available resources across NHS Wales health board boundaries. The current IT systems (PACS/ RIS):

- Are disparate with disjointed approaches to coding, administrative process, data collection and analysis and do not readily support strategic planning or service improvement.
- Do not facilitate cross-boundary working resulting in variation in the delivery of radiology services across NHS Wales health boards and trusts, leading to increased waiting time for scans or delays to reporting and diagnosis.
- Make it difficult to share patient information easily between health boards and trusts both within Wales and England, impacting acute/emergency care and MDTs and leading to inefficient care. Manual workarounds are in place to enable the correct information to be available for use in the right place at the right time; these are relatively inefficient and contribute to delays and increased clinical risk.

The Implications of Doing Nothing

The rationale for change:

Senior Consultant Radiologist: "There are many examples across Health Boards of clinical risk to patients that have come to light through incident reports, serious incident investigation and external reviews. Lack of an integrated IT system means that **workarounds** and safety nets (where they exist like the example below) has become the **primary process,** a situation that is completely **unsatisfactory**."

"A cancer patient had imaging in different hospitals. The radiologist reporting the scan in one hospital, compared to a previous study from that hospital and interpreted disease progression. Another scan within weeks was carried out on the same patient for a different reason in another hospital and the radiologist there, compared to a prior scan taken at that hospital, interpreted a response to treatment. Fortunately, this was picked up by an Oncologist in the MDT and was corrected."

"It is essential the new Radiology Informatics System procurement addresses all these elements including a properly functioning electronic end to end system. To have an electronic referral and results alert system that works seamlessly with the new informatics system is absolutely integral to a properly functioning and safe solution".

This user story shows the fragmented nature of our current RIS/PACS systems arrangements.

1.6 Existing Arrangements

PACS National Agreement

A national agreement for the provision of PACS was established in 2012 following a two-year procurement process. The procurement process involved representatives of radiology, ICT, NWIS (now DHCW), legal, and procurement services.

FUJIFILM was selected as the contractor for PACS as part of a national agreement with other elements, including patient dose management (PDMS) as sub-contracted components. The radiology directorates at each health board/trust then used this agreement to establish local deployments of PACS as replacements for their legacy systems. The local deployments were set up to provide PACS for up to nine years; the agreement does not allow any further extensions to the local deployments after this initial period.

All health boards now use the FUJIFILM solution and Trusts following a phased deployment, with Cardiff and Vale UHB and the National Imaging Academy Wales being the last to deploy.

NWIS (now DHCW) are the contracting authority and take overall responsibility for managing the contract. A PACS Service Management Board (PACS SMB) comprising representatives from DHCW and all health boards oversees the management of the service provided by FUJIFILM. Each deployment order holder’s responsibility is to performance manage the service provided to them under the contract and feed this into the PACS SMB.

FUJIFILM provides all the support where it is the supplier's responsibility. The support is provided via the UK FUJIFILM medical support desk, with each issue being assigned a severity as set out in the contract and managed accordingly. Each health board and trust have its own PACS Manager and support staff to enable the service and systems to integrate and function with more comprehensive radiology resources.

Change requests are submitted to, and managed by, the FUJIFILM Business Relationship Manager under the change management process set out in the contract, but are largely determined between each HB/Trust and Fujifilm. This arrangement has meant that it has been difficult to coordinate and deploy some changes because of dependencies on local or national infrastructure, applications or resources.

The current contract includes provision for “Termination Assistance Services” (TAS) where the incumbent supplier continues to provide operational service and support along with additional support as required to enable a smooth transition to the new supplier solution. The termination assistance period can run to a maximum of 42 months after the normal contract end date. In May 2020 DHWC (then NWIS issued a single central termination notice to FUJIFILM, acting on behalf of the health boards and Trusts.

The planned deployment order end dates for each Health Board and Trust are shown in the diagram below. The timelines in Figure 3 reflect the maximum duration of the termination assistance periods exercised in May 2020.

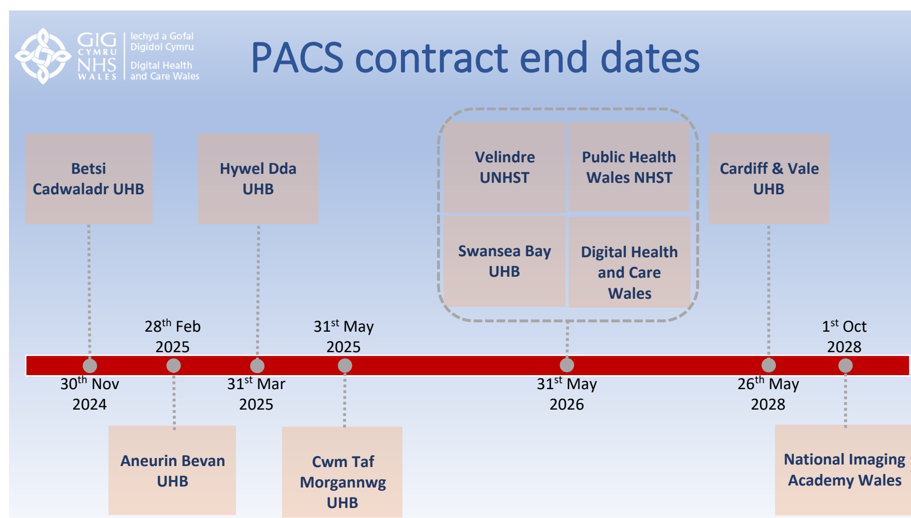


Diagram 3 – Contract End Dates

An extension of the Termination Assistance Services ("TAS") provision for the Deployment Order is required to support Data Migration and transfer to a new solution. Each Authority Party shall have the ability to extend the current Termination Assistance Service ("TAS") for a period of at least three (3) months, with the option for a further three (3) periods of three (3) months of Termination Assistance Services. For the avoidance of doubt, the Change Control Notice ("CCN") has the total effect of extending the Termination assistance period by up to twelve (12) months in total.

Welsh Radiology Information System (WRIS)

In Wales, the RIS is a national system developed and supported by Digital Health and Care Wales (DHCW). All Health Boards use WRIS, which supports the scheduling of radiology investigations, provides a clinical record of imaging performed on patients, including reports, and allows Health Boards to generate business reports and statistics on performance.

The transition activities from the current WRIS to the new RISP solution is likely to cover the pre-population of radiology data to ensure there are three years of data for the go live at each of the live 10 instances, migration of the existing 17 WRIS databases into the new solution as well as any cutover activities identified.

These cutover activities will also include decoupling WRIS from the DHCW electronic radiology requesting integrated solutions currently being rolled out across Wales. Consideration is also needed to determine if a complete national radiology dataset needs to be populated before the move to the new solution; this will involve teams from DHCW, including WRIS, Integration Services and the National Operational Database team. The exact requirements on the work required for DHCW to manage the move to the new RISP solution are yet to be determined, but the timescales and work needing to be undertaken means that many of the tasks will need to be carried out concurrently, resulting in an increased level of resources during this implementation period.

1.7 Local considerations

Whilst the RISP procurement focussed on a solution to be deployed across NHS Wales, there are a number of local considerations that have informed the functional requirements or the business case. These are outlined below:

Integration with locally developed applications:

Aneurin Bevan HB and Cardiff and Vale HB have invested in deploying a locally developed clinical portals and electronic requesting solutions. Integration of the RISP solution adopts a standards based approach and the requirements to integrate with the local solution is included within the scope of the programme. The detailed work plan will be described within the Health Boards own deployment order.

Cwm Taf Morgannwg / Swansea Bay boundary changes:

At OBC stage of the RISP programme the PACS contract baseline costs were still aligned to the predecessor organisations (Abertawe Bro Morgannwg and Cwm Taf). At FBC these baseline costs have been revised to reflect the expected configuration of the new solution as it will be deployed in the Health Boards. As such any cost impacts outlined in the financial case are made on a like for like basis.

Powys Deployment Order:

Under the current Fuji contract Powys do not hold their own deployment order- PACS costs for equipment and support are accommodated within the deployment orders that the neighbouring Health Boards hold with Fuji. The programme implementation plan assumes that Powys will hold their own deployment order for the new solution with Philips. It is anticipated that within their local implementation plan Powys will have four separate go live phases aligned to the go live dates for these Health Boards.

The radiology services at Llandrindod Wells are supported by Wye Valley NHS Trust (WVT). It is anticipated that these will be brought within the scope of the RISP solution but the discussions between Powys and WVT and the impact on their respective SLA's will need to be led by Powys rather than the RISP programme.

Powys has a number of service level agreements with the neighouring Health Boards and with Wye Valley NHS Trust to support their locally delivered radiology services but these SLA's do not identify all of the PACS costs and include reporting services. As such the baseline costs for Powys do not reflect the full cost of current solution for Powys and therefore accentuate the financial impact of the new solution and discussions regarding the impact of the transition to the Philips solution on the detail of the SLA's and any requirements for local PACS/RIS support arrangements within Powys are not within the scope of the RISP programme.

Hywel Dda Legacy PACS Archive:

Hywel Dda maintain a legacy PACS archive for digital mammography images. The demographic data within the archive is not aligned to a reliable index (RIS, PAS or eMPI) and

as such the data quality may be poor. It is likely that additional work will be required from the Health Board and from Philips to bring these records into alignment with the current patient index. The detailed requirements will need to be addressed within the Hywel Dda deployment order.

Swansea Bay Legacy RIS:

Swansea Bay UHB transitioned from a commercial RIS (RadCentre) to RadIS. Whilst the clinical report data was copied into WRRS so it could be made available for review the Health Board continues to maintain a contract with the supplier for access to the legacy system. The RISP programme data migration plan proposes to migrate all data from RIS/PACS instances into the new solution. The Health Board may need to consider whether it is still appropriate to migrate the RadCentre data and whether this will require additional support from the supplier or whether this can be achieved within their current commercial arrangements.

1.8 Business Needs Current & Future

Stakeholder Engagement

There has been significant engagement with the service with 270+ staff attending meetings, workshops and roadshow events held at all health boards and Trusts across Wales and latterly via Microsoft Teams.

The complete list of stakeholder groups engaged, and comments/ feedback received during this process are listed below and include but are not limited to:

Radiologists, Radiographers, Secondary and Primary Care Clinicians, Trainer/ Trainees, Radiology Managers, Administrative staff, Directors of Finance, Directors of Planning, Clinical Directors, Directors of Therapies & Health Sciences, PACS Managers, Informatics Leads, Medical Physics, DHCW and Welsh Government.

Business Needs

The key functional requirements from the engagements with the service has informed this Case. These include:

- “Single patient view” of the Radiology record

- Efficient reporting workflow
- Fully integrated advanced applications – 3D
- Intelligent worklists
- Fully integrated Speech solution
- Peer review solutions
- MDT solutions
- AI-enhanced workflow including clinical decision support
- Full audit trails
- Structured reporting templates
- Business Intelligence

1.9 Solution Scope

The RISP solution is intended to replace the systems currently supporting "Services within the 'footprint' of the current radiology service" includes systems and services that collectively deliver an end-to-end technical solution to support the modernisation of imaging services. The scope is designed to be the minimum required to deliver the programme objectives and benefits and meet the business requirements identified above. The core scope includes:

End-to-End Radiology Solution

A paperless end-to-end solution with functionality of Radiology Information System (RIS) and Picture Archiving and Communication System (PACS) from receipt of request to publishing of the result and receipt of acknowledgement. The solution must deliver an "All Wales" view of the radiology record for any patient irrespective of where the radiology "event" occurred. This is the best solution to meet the business needs of the service, support the delivery of the Imaging Statement of Intent and the recommendations from the Wales Audit Office Radiology Services Report.

Patient Dose Monitoring System (PDMS)

PDMS provide many tools to aid health boards in improving the quality and efficiency of imaging services as well as meeting their legislative requirements, such as those under the Ionising Radiation (Medical Exposures) Regulations 2017 (IR(ME)R 2017); examples include:

- Alerting healthcare professionals to radiation exposures which are of a level significantly greater than that intended or when Diagnostic Reference Levels (DRLs) are consistently exceeded.
- Providing valuable inputs into required quality assurance and optimisation processes potentially improves image quality or reduces radiation exposure for people with multiple imaging procedures.
- Offering substantial improvements in collection efficiency and quality and reducing time for analysis and reporting of radiation dose data compared with manual or semi-automated methods.
- Facilitating the management and harmonisation of imaging protocols and contrast media usage between devices (both within and between health boards)
- Enabling optimisation of equipment utilisation.

Electronic Test Requesting and Results Acknowledgement[3]

Electronic Test Requesting (ETR) systems are designed to enable clinicians to request Diagnostic Imaging (DI) procedures and receive updates on their progress using an IT system, replacing the need for conventional paper-based systems. It enables two-way electronic communication of patient information, clinical and diagnostic decision-making, the progress of the imaging procedure and the image report status progress between the referrer and the hospital radiology department. In Wales, the practice remains paper based.

In many Health Boards, results acknowledgement systems remain primarily manual processes, driven by paper/email, telephone and faxed based triggers tailored to meet local

[3] Optional commercial electronic requesting system, if the WCP cannot be developed to meet the requirements of the Radiology service in line with programme timeline.

clinical needs. The current systems fail to close the diagnostics loop because no automated facility records a result acknowledgement within the RIS. Therefore, urgent, or unexpected findings are frequently escalated manually rather than electronically. The processes are tailored to local clinical demands. The recommendations of NPSA 16 are clear:

- Ensure that the radiological imaging reports of all patients are communicated to and received by the appropriate registered health professional and, where necessary, action is taken in a manner appropriate to their clinical urgency;
- Ensure registered health professionals design' safety net' procedures for their speciality;
- Make it clear to patients how and when they should expect to receive the results of a diagnostic test.

This Programme is an opportunity to address the NPSA 16 recommendations robustly with an electronic, auditable trail of results acknowledgement. This will also mitigate and decrease litigation claims where the analogue system of results acknowledgement has failed. One of the frustrations of the radiology service in Wales is the lack of progress in delivering an in-house electronic referral and results alert system for NHS Wales. There is despondency within the service at the lack of progress in the development of a national electronic requesting system being developed by DHCW to be delivered through the Welsh Clinical Portal (WCP).

Two Health Boards have developed a local solution for electronic requesting, but there is no integration with the WRIS, and the benefits gained are somewhat limited. Following a successful implementation of electronic requesting in Royal Glamorgan Hospital (CTMUHB), a wider rollout across the HB and across other health boards is underway.

The adoption process of e-requesting has been delayed primarily due to constraints within the health boards. However, a fully integrated requesting, notification and results acknowledgement system is essential to deliver the RISP programme's efficiency and patient safety benefits. The ETR programme still raises concerns for RISP- related to the timeline for deployment and adoption of the available functionality and integration of the solution with the newly procured RIS.

1.10 Benefits

The key benefits of delivering RISP include the following:

- Improved patient safety, with an electronic auditable trail from request to results acknowledgement. (NPSA 16 2007 and HSIB reports on failures to acknowledge and follow-up on radiological imaging reports)
- Reduced risk of repeat examinations and inappropriate radiation dosage.
- Effective and efficient MDT meetings supporting cross health board boundary workings and streamlining patient care.
- Improved imaging workflow, enabling timely delivery of service, and the ultimate output of an imaging examination, a report available to the clinical referrer anywhere.
- Enable cross-site and health board reporting to facilitate service transformation and support the work of the Imaging Essential Services Group.
- Improved data quality and analytics on a local and national level.
- Streamlined and reduced training requirements for system use
- Decarbonisation; the supplier has to meet standard ISO 14001.
- Investment in network infrastructure will provide additional capacity and security capabilities that will benefit future digital programmes for NHS Wales.

A Benefits Group has been established and has identified specific benefits and associated measures outlined in detail in the Economic and Management Cases. A mapping exercise was undertaken to align those identified benefits to the wider investment objectives.

Table 4: Strategic Objectives Benefits Map

No	Investment Objective	Benefit ID	Benefit
RISP-IO1	To integrate Picture Archive and Communication System (PACS), Patient Dose Management System (PDMS) and Radiology Information System (RIS) systems into one single solution (with the ability for further integration with ETR and results acknowledgement systems) that all Health Boards and Trusts implement in Wales by 2026	B03	Reduced time to imaging referral contributing to earlier diagnosis (and ultimately patient outcomes)
		B08	Reduced lost time waiting for system to respond
		B22	Contributes to reduced inequalities
RISP-IO2	To improve and optimise patient care by reducing the number of incidents caused due to missing/insufficient clinical information/reports, resulting in fewer misinterpretations and delayed diagnoses, by providing an integrated imaging patient record across Wales for all Health Boards and Trusts in Wales by 2026	B01	Reduced time to imaging referral contributing to earlier diagnosis (and ultimately patient outcomes)
		B06	Reduced risk of missing urgent diagnosis
		B19	Earlier diagnosis and improved clinical decision-making leads to better patient outcomes
		B20	Improved Patient Experience
RISP-IO3	To reduce the number of administrative resources required to support cross-boundary patient pathways, because of shared access for imaging and reporting, 12 months after contract commencement in a health board area	B02	Reduced manual intervention to manage referrals
		B04	Reduced manual intervention for reporting and acknowledgement
		B05	Reduced reporting costs
		B07	Reduced manual intervention to review lists
		B09	Reduced risk of repeat examinations and inappropriate radiation dosage
		B10	Effective and efficient MDT meetings supporting cross Health Board boundary workings and streamlining patient care
		B15	Improved strategic planning / better demand management
		B21	Improved workforce experience
RISP-IO4	To reduce the carbon footprint of PACS and RIS systems by decreasing the use of paper-based systems for referring and reporting in radiology and utilising fewer devices that have higher energy consumption across all Health Boards and Trusts in Wales by 2026	B11	Reduced reliance on paper-based systems leading to paper, printing, and manual storage cost savings
		B12	Reduced reliance on paper-based systems leading to reduced manual intervention
		B28	Greener energy as a result of cloud-based system
		B29	Greater energy efficiency as a result of cloud-based system
		B30	Reduced number of devices
RISP-IO5	To reduce the number of repeat examinations and hence inappropriate radiation dosage for patients, through improved access to imaging information and a standardised data sharing and	B13	Reduced risk of errors
		B14	Streamlined and reduced training requirements
		B16	Improved accuracy of referral codes
		B17	Increased ability for optimisation between patients or devices

	recording process, by all Health Boards and Trusts in Wales by 2026	B18	Reduced amount of unreliable/unusable data leading to increased sample size of dose audits
		B23	Improved ability to accurately and frequently access radiation dosage to evidence statutory compliance
		B24	Increased compliance for recording dosage in PDMS vs manual entry
		B25	Increased accuracy of patient dose record
		B26	Improved personalisation of dose assessments
		B27	Reduced amount of unreliable/unusable data leading to increased sample size of dose audits

1.11 Risks

This Strategic Case highlights the key risks relevant to successfully implementing RISP. The Programme will employ risk management techniques to monitor how risks materialise appropriately. This will support the aims of the Programme and help maximise value for money.

A programme risk register is used to record, and risk assess all Programme and project-level risks. Each risk is documented and evaluated based on the impact and likelihood to the Programme. The risks are discussed and updated monthly via the programmes Working Group, Programme Board and monthly risk rating meeting.

Key risks to the realisation of some of the benefits of the RISP programme:

COVID-19 recovery activity may impact the ability of HBs to release the required resources to join the procurement dialogue teams in Tranche 2. The impact of this could be delays in the procurement process.

Lack of certainty around the financial model associated with a possible cloud solution may mean it is not affordable for health boards. This could lead to delays in the procurement process.

Further slippage to procurement timescales caused by delays could impact the current FUJIFILM PACS contract end dates.

A complete list of Risks, Actions, Issues and Decisions can be found in Appendix M4.

1.12 Constraints

The Programme is subject to the following constraints:

- Lack of resources within DHCW to release staff to support the development of the FBC, the procurement, development, testing and training and to take forward the work.
- Limited financial resources available to the NHS for a new radiology system, to support the procurement and further implementation.
- The Capacity of the Imaging service to support the Programme, and the business change associated with moving to an entirely electronic workflow.

1.13 Dependencies

RISP is subject to the following dependencies that will be carefully monitored and managed throughout the lifespan of the Programme:

- The development of the WCP to deliver electronic requesting, results acknowledgement and notifications to meet radiology requirements in time for deployment of the new RISP.
- The approval of Welsh Government, health boards, trusts and professional bodies to this FBC.

1.14 Business Continuity Plans

The RISP solution is designed to meet a service availability with an uptime target of 99.99% and architected in such a way as to ensure there are no single points of failure. The Contractor will provide a business continuity (BC) solution to all Authority parties (excluding NIAW and PHW), which maintains key service elements if there are issues with the central core services. As a minimum, the BC solution will hold the last two years of clinical data for the Health Board and will allow them to continue to:

- Schedule, acquire and report on acute ED and inpatient requests;
- Acquire and report prebooked studies attending during the period of BC operation;
- Report studies acquired before the period of BC operation;

- Allow non-radiology clinicians to review any image stored within the BC solution; and
- Publish any results generated throughout the period of BC operation to external systems

In addition to the BC facilities, the Contractor will maintain an immutable copy of any clinical data to protect against delayed malware attacks or other data corruption and commit to undertake penetration testing and testing of BC and recovery procedures twice per year or after any significant upgrade or system reconfiguration.

To meet these requirements, the supplier will provide:

- Multiple geographically separated datacentres with high availability infrastructure and automated failover between the DCs,
- A third offline copy of data to protect against data corruption, and
- A local BC instance of RIS and PACS within each HB/Trust to ensure continuity of service if the services delivered from the central DC’s are unavailable.

If the core services are unavailable to one of the HB's (e.g. if its PSBA connection is down), they will be able to continue with the majority of planned and unplanned care activity. Still, they will lose the ability to do so cross-HB work. Other HB's would still be able to see the entirety of the All Wales record until the affected HB went off line.

2. The Economic Case

2.1 Introduction

The purpose of the Economic Case in the FBC is to revisit the options following the results of the procurement process and confirm that the preferred option continues to offer optimal value for public money by:

- Identifying the procurement process and evaluation of Best and Final Offers (BAFOs).
- Revisiting the OBC Options to confirm they remain valid and outline any adjustments.
- Confirming the rankings remain unchanged by updating the Economic Appraisal with latest cost and benefit assumptions, including the results of the procurement process.
- Confirming the Preferred Option.

2.2 Revisiting the OBC Options

As part of the OBC, the Programme Board and key stakeholders identified a shortlist of options to appraise by using the Options Framework to identify and long list of options and test them against agreed criteria which included:

- Was the option likely to deliver the spending objectives and CSFs?
- Was the option likely to deliver sufficient benefits?
- Was the option practical and feasible?
- Was the option deliverable within the constraints of the project?
- Was the option deliverable without incurring an unacceptable degree of risk?

Following this review, the shortlist of options was approved by the Programme Board. The final shortlist of five options is presented below.

Table 5: Shortlist of Options

Options	Option 0 Business as Usual	Option 1 Do Minimum	Option 2 Preferred Way Forward A	Option 3 Preferred Way Forward B	Option 4 More Ambitious
Scope	Do nothing	PACS + PDMS + DHCW RIS	PACS + PDMS + Commercial RIS + ETR and results acknowledgment	PACS + PDMS + Commercial RIS + ETR and results acknowledgment	PACS + PDMS + RIS + ETR and results acknowledgment (+ options for other disciplines)
Technical Solution	Current solution ceases	National DHCW data centre	National supplier data hosted (either data centre or cloud hosted depending on provider)	National supplier data hosted (either data centre or cloud hosted depending on provider)	National supplier data hosted (either data centre or cloud hosted depending on provider)
Service Solution	N/A	Regional Deployment	Regional Deployment	National Deployment	National Deployment
Service Delivery	N/A	In House RIS with PACS + PDMS delivered with supplier full-service management	Supplier Full-Service Management which could be delivered by either: a. Managed Service Contract b. Contract for Service with Maintenance Support		
Implementation	N/A	Phased by Health Board			
Project Funding	N/A	Combination of capital and revenue funding via either a. Revenue funded fully managed service; or b. Capital funded NHS owned assets/Revenue funded support			

The next stage of the OBC involved evaluating the shortlisted options within the economic appraisal, the results are outlined in the table below.

Table 6: OBC Economic Appraisal Results

	Option 0 Business as Usual	Option 1 Do Minimum	Option 2 Preferred Way Forward A	Option 3 Preferred Way Forward B	Option 4 More Ambitious
Capital costs	0	17,285	17,285	17,285	27,965
Revenue costs	61,140	68,942	67,570	67,570	96,676
Total costs	**61,140**	**86,227**	**84,855**	**84,855**	**124,641**
Expected risk value	16,144	141	141	281	141
Total risk adjusted costs	**77,284**	**86,367**	**84,995**	**85,136**	**124,782**
Benefits		-9,720	-9,720	-9,720	-9,720
Net Present Cost (Undiscounted)	**77,284**	**76,647**	**75,275**	**75,416**	**115,062**
Total discounted costs	68,561	76,526	75,377	75,508	109,331
Total discounted benefits	0	-7,917	-7,917	-7,917	-7,917
Net Present Cost (Discounted)	**68,561**	**68,609**	**67,460**	**67,592**	**101,414**
Incremental costs	0	-22,904	-21,755	-21,755	-55,709
Incremental benefits (including risk reduction)	0	22,856	22,856	22,725	22,856
Risk-adjusted Net Present Social Value	**0**	**-48**	**1,101**	**969**	**-32,853**
Benefit Cost Ratio	**0.0**	**1.0**	**1.1**	**1.0**	**0.4**
Rank	**5**	**3**	**1**	**2**	**4**

The following conclusions were reached based on these results and an analysis of non-financial factors:

- **Option 0 (Business as Usual):** Continuing with existing arrangements is not a feasible option as the current PACS contract ends during 2023/24 which poses a catastrophic risk to service continuity. It was included to provide a counterfactual to allow value for money of the other options.
- **Option 1 (Do Minimum):** This option involves continuing with the current DHCW developed and supported application; the Welsh RIS. A comprehensive evaluation was undertaken which confirmed that the commercial RIS scored significantly higher than the DHCW RIS option largely due to available capacity to develop and deploy the additional functionality which posed a risk to timelines and the ability to hold commercial suppliers to account for any failure in an end-to-end solution. Furthermore, the economic appraisal demonstrated that the increased costs of delivering this option would reduce value for money.
- **Options 2 and 3 (Preferred Way Forward):** The preferred way option offered the best value for money since it results in the lowest Net Present Cost and an incremental Benefit Cost Ratio of between 1.0 – 1.1 when compared to the counterfactual (Business as Usual option). The variance between Option 2 (delivering the programme via a regional deployment) and Option 3 (delivering the programme via a national deployment) was found to be immaterial, therefore it was agreed that the final implementation arrangements would be determined based on the final procured solution.
- **Option 4 (More Ambitious):** This option would offer opportunities to incorporate other disciplines. However, as well as a high degree of uncertainty about the likely costs and benefits of this, it is anticipated that this would significantly elongate timelines and risk deployment of a PACS replacement. The increased revenue costs would significantly reduce the value for money.

Therefore Options 2 and 3 were combined and carried forward as the Preferred Option and it was recommended that Options 1 and 4 be discounted on the basis of low value for money and risks to timescales.

2.3 The Procurement Process

Following approval of the OBC, the work commenced to procure the preferred option. The procurement process was undertaken as per the procurement strategy, route and evaluation that was outlined in the Commercial Case of the OBC. The FBC Commercial Case outlines in detail the most economically advantageous tender and sets out the commercial and contractual arrangements that have been negotiated.

2.4 The FBC Economic Appraisal

The HMT Green Book guidance suggests it is only necessary to conduct a full cost benefit analysis on all shortlisted options considered at OBC stage if it is proportionate to do so.

The alternative short-listed options outlined in section 1.2 were re-visited and it was concluded that:

- **Option 1 (Do Minimum):** The conclusions reached in the OBC in terms of this option being discounted because of low value for money and increased timescales remain valid. In fact, costs and timescales would likely increase given the time that has passed since the OBC which would reduce value for money even further and is no longer considered a feasible option.
- **Option 4 (More Ambitious):** The conclusions reached in the OBC in terms of this option being discounted because of low value for money and high degree of uncertainty. In fact, costs and timescales would likely increase given the time that has passed since the OBC which would reduce value for money even further and is no longer considered a feasible option.

As it was anticipated that these assumptions remain largely unchanged since the OBC, it was deemed that it would be disproportionate to revisit the cost benefit analysis for these options, particularly since neither are thought to be feasible any longer given the time that has passed since the OBC.

It was therefore concluded that it would be sufficient to conduct an appraisal of the Preferred Option compared to the baseline counterfactual.

Cost Assumptions

Costs have been updated for the FBC following negotiations with suppliers, selection of the Preferred Bidder and a more developed understanding of other costs.

The calculations and assumptions behind these costs are provided in the Financial Case and are summarised below.

Baseline costs

Baseline costs have been updated to reflect Baseline costs are estimated based on the Financial Commercial paper from February 21 which identified revenue costs for PACS and WRIS of £. These have been uplifted to 2023/24 prices using the HM Treasury GDP Deflator.

Table 7: Baseline Costs

	Total £'000
PACS	
WRIS	
Total Baseline Costs	

Capital Costs

Capital costs have been calculated based on the Preferred Bidder's initial solution charges as well as capitalisable programme resource and local infrastructure requirements. For the purposes of the Economic Case these exclude VAT.

Table 8: Capital Costs

	Option 0 - BAU £'000	Option 1 - Preferred £'000
Solution - Supplier Initial Charges	0	
Programme Resource Plan	0	
Local Infrastructure Costs	0	
Total capital costs excluding VAT	**0**	

Transitional Costs

Non-recurring revenue costs have been calculated based programme resource requirements for roles that cannot be capitalised during the 3-year implementation period.

Table 9: Transitional Costs

	Option 0 - BAU £'000	Option 1 - Preferred £'000
Programme Resource Plan	0	
Total transitional costs	0	

Recurring Revenue Costs

Ongoing revenue costs have been calculated based on the following assumptions:

- Current PACS and WRIS costs of £m p.a. will continue until each Health Board's stable operation date for the new system plus one month of dual running costs.
- Annual service charges of £m p.a. for the new solution are based on tendered costs submitted by the Preferred Bidder, which will be incurred from each Health Board's stable operation date (as outlined in the Financial Case).
- For the purposes of the 10-year appraisal period, it is assumed that the average annual service charge costs will continue at the same level following the contract end date at each Health Board.
- Ongoing revenue consequences of £0.9m p.a. related to investment in local infrastructure is assumed to be incurred from the beginning of 2024/25.
- Ongoing revenue consequences of £0.15m p.a. related to ongoing support for integration is assumed to be incurred from the beginning of 2026/27.

The resulting total revenue costs during the 10-year appraisal period are provided in the table below.

Table 10: Total revenue costs

	Option 0 - BAU £'000	Option 1 - Preferred £'000
Current PACS Costs		
Current WRIS Costs		

	Option 0 - BAU £'000	Option 1 - Preferred £'000
Solution - Supplier Service Charges	0	
Solution - Extend Supplier Service Charges	0	
Local Infrastructure Costs	0	8,047
Ongoing Support for Integration	0	1,050
Total revenue costs (10-year period)		
Equivalent Annual Costs		

Benefits assumptions

As part of the OBC, the main benefits were identified and measures established, and a Benefits Group established agreed to collect baseline data and agree targets and methods of monitoring. The resulting benefits analysis is provided in the table overleaf.

Table 11: Benefits Analysis

ID	Description	Measure	Target Improvement	Value £'000	Assumptions
More streamlined workflow					
B01	Reduced time to imaging referral contributing to earlier diagnosis (and ultimately patient outcomes)	Average time from request to receipt of referral	Reduce from average of 4.6 days to within 1 day	Unmonetised	The introduction of RISP will improve the end-to end process
B03	Reduced time to imaging referral contributing to earlier diagnosis (and ultimately patient outcomes)	Average time from receipt of referral to report availability	Reduce from average of 9.2 days to within 1 day	Unmonetised	The introduction of RISP would improve the end-to end process
B15	Improved strategic planning / better demand management	Not easily measurable	Qualitative	Unmonetised	Electronic vetting should streamline the workflow and automate rules but will still require some level of manual intervention to review and schedule. Multiple factors that may impact on this average time taken such as the number of occasions when appointments need to be vetted before being booked and the number of walk-in cases make it difficult to set an achievable target improvement that is directly impacted by the investment in RISP.
Increased accuracy					
B06	Reduced risk of missing urgent diagnosis	Not easily measurable	Qualitative	N/A	Information from claims managers was found not to be a suitable measure due to the variability.
B13	Reduced risk of errors	Number of obsoleted reports	Reduce by 80%	Unmonetised	A major benefit of RISP will be that it will prevent errors in the digital dictation system reporting against an incorrect patient. However, this would not be eradicated completely as there may be other reasons for a report being obsoleted.
Greater System Reliability					
B08	Reduced lost time waiting for system to respond	Number of Severity 1 and 2 incidents	Qualitative	N/A	Not easily measurable

ID	Description	Measure	Target Improvement	Value £'000	Assumptions
Improved productivity					
B02	Reduced manual intervention to manage referrals	Time spent on request handling	80% reduction in time spent manually transcribing requests	£852k p.a.	It is reasonable to expect RISP will result in a minimal amount of time spent manually transcribing requests into RIS since there will be very few paper requests received, although it should be recognised that the rest of the 'request handling' process, such as appointment scheduling, would only see marginal improvement. On average takes around 2 minutes per request, applying to around 1.9m requests p.a. which are currently managed manually
B04	Reduced manual intervention for reporting and acknowledgement	Time spent on process for the acknowledgement of urgent referrals	50% improvement	£65k p.a.	Currently increased time spent on the process for the acknowledgement of urgent referrals due to the need for printing. ABUHB already has an electronic process in place which has reduced the amount of manual printing requirements significantly. It is anticipated that 2/3 of referrals are printed (the remaining 1/3 being GP referrals which are typically not printed). There are other factors other than just RISP contributing to this improvement, therefore a target reduction of 50% was reasonable.
B05	Reduced reporting costs	Average time between subsequent reports	Between 1% - 5% improvement	£1,127k	Current average 26.7 minutes between subsequent reports. Exact level of improvement difficult to measure and would be relatively small. Therefore, range of scenarios have been modelled to estimate the impact of between 1% to 5% improvement. Prudent estimate has been made at 1%.
Workforce Benefits					

ID	Description	Measure	Target Improvement	Value £'000	Assumptions
B21	Improved workforce experience	Not easily measurable	Qualitative	N/A	Multiple factors impacting staff satisfaction so not easily measurable
Cost Reduction Benefits					
B11	Reduced reliance on paper-based systems leading to paper, printing and manual storage cost savings	Expenditure on paper, printing and manual storage	80% improvement	£11k p.a.	
Patient Safety Benefits					
B09	Reduced risk of repeat examinations and inappropriate radiation dosage	Number of significant accidental and unintended exposures as a result of repeat imaging in a 2-3 year period	10% improvement	Unmonetised	10% improvement target to reflect direct impact on proportion of events (i.e. alert so not imaging people who have already had imaging)
B23	Improved ability to accurately and frequently access radiation dosage to evidence statutory compliance	Time saved manual vs automated audits	80% improvement	£19k p.a.	Based on BCU baseline of 2 weeks spent on audits p.a.
B24	Increased compliance for recording dosage in PDMS vs manual entry	Number of times dosage not recorded	80% improvement	Unmonetised	Currently not recorded in 7% of cases. Will be mandated in functional requirements so would largely be eradicated but there may be some circumstances where booked a procedure with radiated dose but scan abandoned.
B25	Increased accuracy of patient dose record	Not easily measurable	Qualitative	N/A	
B26	Improved personalisation of dose assessments	Time spent dealing with patients flagged for skin injury review	75% improvement	£5k p.a.	Average of 30 p.a. as reasonable baseline for number of patients flagged for skin injury review based on BCU and C&V actuals. It is estimated that currently 2 hours per patient are spent on this which it is estimated could be reduced to 0.5 hours per patient.

ID	Description	Measure	Target Improvement	Value £'000	Assumptions
B27	Reduced amount of unreliable/unusable data leading to increased sample size of dose audits / B18 - Reduced amount of unreliable/unusable data leading to increased sample size of dose audits	Amount of data 'thrown out'	Target to reduce to 5%		Currently 19% of data 'thrown out'. Target improvement to reduce down to 5% (some manual input errors will remain)
B17	Increased ability for optimisation between patients or devices	Not easily measurable	Qualitative	N/A	
Patient Outcome Benefits					
B10	Effective and efficient MDT meetings supporting cross Health Board boundary workings and streamlining patient care	Time spent managing images for MDTs	Save 2 minutes per number of transfers	£113k p.a.	Baseline data includes both PACS and IEP data. RISP will significantly reduce the time spent on this since images will be automatically visible to all sites across NHS Wales with no need for transfers. This will improve cross-site functionality and ensure images are easy to access for MDTs, reducing the risk that MDTs may be delayed as a result of images not being available. Indicative calculation for the scale of this benefit is to assume each transfer currently takes Radiology circa. 2 minutes (in addition to the time spent in clinics having to chase missing images) multiplied by the number of transfers within NHS Wales each year.
B19	Earlier diagnosis and improved clinical decision-making leads to better patient outcomes	Not easily measurable	Qualitative	N/A	It has not been possible to identify the number of patients not discussed at MDTs as a result of not having images available (links to B10)
B20	Improved patient experience	Not easily measurable	Qualitative	N/A	
B22	Reduced inequalities	Not easily measurable	Qualitative	N/A	Combination of B01 and B03 but reported in relation to the benefit to the patient rather than NHS Wales. Availability of reports from all locations would reduce the burden across health boards due to reporting on

ID	Description	Measure	Target Improvement	Value £'000	Assumptions
					backlogs from elsewhere in Wales. This would reduce the variance.
Environmental Benefits					
B28	Greener energy and greater efficiency as a result of cloud-based system	Not easily measurable	Qualitative	N/A	Not easily measurable
B31	Reduced reliance on paper based systems leading to paper savings	Paper usage	80% reduction	N/A	In line with B11

Expected Risk Value

The risks for each option have been assessed and, as far as possible, quantified and expressed in monetary equivalent terms, comprising:

- Existing system is no longer supported.
- Infrastructure does not support supplier solution.

These risks have been quantified by calculating an 'expected value'. This provides a single value for the expected impact of all risks. It is calculated by multiplying the likelihood of the risk occurring (probability) by the cost of addressing the risk (impact) and summing the results for all risks and outcomes.

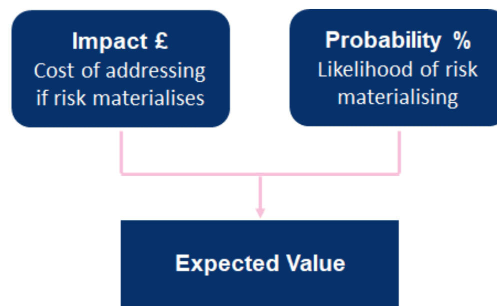


Diagram 4 - Risk quantification approach using single-point probability analysis

The assumptions included to assess the impact and probability of these risks are outlined in the tables below.

Table 12: Risk assumptions

	Option 0 - BAU £'000	Option 1 - Preferred £'000
R1: Existing system no longer supported		
Risk	**System performance deteriorates and ultimately fails impacting on local business continuity**	
Consequence	**Mitigation would involve upgrading PACS**	
Impact	Cost of investing in new PACS (uplifted to 23/24 prices)	No impact – mitigated by investment in new system
Probability	**95%**	**0%**
Timescales	Year 2	
Risk Value £'000		**0**
R2: Existing system no longer supported		
Risk	**Delivery delayed**	

	Option 0 - BAU £'000	Option 1 - Preferred £'000
Consequence	**Increased programme costs and extended double running**	
Impact	N/A	Delay of between 12-24 months x Programme Cost per month
Probability	**0%**	**10%**
Timescales		Year 2
Risk Value £'000	**0**	**299**

Economic Appraisal Results

The indicative assumptions above have been incorporated into a discounted cash flow for each of the options, using DHSC's Comprehensive Investment Appraisal (CIA) model, to support the appraisal of overall value for money and cost-benefit analysis of the shortlisted options.

In line with HMT Green Book requirements:

- Costs, benefits, and risks are calculated over a 10-year appraisal period based on the timeline used within the Preferred Bidder's submission.
- Year 0 is 2023/24.
- Costs and benefits use real base year prices – all costs are expressed at 2023/24 prices in line with the baseline costs.
- The following costs are excluded from the economic appraisal:
- Exchequer 'transfer' payments, such as VAT.
- General inflation.
- Sunk costs.
- Non-cash items such as depreciation and impairments.
- A discount rate of 3.5% is applied.

The economic summary from the CIA model is shown in the table overleaf.

Table 13: FBC Economic Appraisal Results

	Option 0 - BAU £'000	Option 1 - Preferred £'000
Capital costs		
Revenue costs		
Total costs		
Expected risk value		
Total risk adjusted costs		
Benefits		
Net Present Cost (Undiscounted)		
Total discounted costs		
Total discounted benefits		
Net Present Cost (Discounted)		
Incremental costs	0	-26,968
Incremental benefits (including risk reduction)	0	30,419
Risk-adjusted Net Present Social Value	**0**	**3,451**
Benefit Cost Ratio	**0.0**	**1.1**
Rank	**2**	**1**

This demonstrates that the preferred option continues to offer value for money, delivering a lower discounted Net Present Cost of £m over a 10-year appraisal period, which is £m lower than the Business-as-Usual position. It delivers an incremental Benefit Cost Ratio of 1.1 i.e. £1.10 of monetisable benefits is delivered for every £1.00 of incremental costs.

Sensitivity Analysis

A sensitivity analysis has been undertaken on these results in the form of switching analysis which tests the degree to which costs and benefits would need to change to affect the ranking of options. The result of this testing is provided in the table below.

Table 14: Switching Analysis

	Option 0 - BAU	Option 1 - Preferred
Total discounted costs	-15.96%	0.00%
Total discounted benefits	N/A	0.00%
Net Present Cost (Discounted)	**-15.96%**	**0.00%**

This demonstrates that the costs would need to reduce by 15.96% for the Business-as-Usual position to outrank the preferred option. This equates to delivery of the same level of benefits as the preferred option with no investment and so is not feasible.

In addition, several scenarios were run to estimate the impact on the value for money of the preferred option.

Table 15: Sensitivity Analysis

	Incremental NPSV £'000	BCR
Economic appraisal results	3,451	1.1
Scenario 1: Capital increases by 10%	1,228	1.0
Scenario 2: Revenue increases by 10%	145	1.0
Scenario 3: Benefits reduce by 25%	309	1.0
Scenario 4: BAU risk reduced by 25%	1,111	1.0

This demonstrates that even with some relatively significant changes to key assumptions, the preferred option would continue to offer reasonable value for money with a lower Net Present Cost (higher incremental Net Present Social Value) than the Business-as-Usual option.

Therefore, it can be concluded that the value for money of the preferred option is not particularly sensitive to changes in assumptions.

2.5 Summary of Options Appraisal Results

The cost benefit analysis demonstrates that the Preferred Option continues to offer optimal value for public money, following the results of the procurement process and development of more detailed cost and benefits analysis.

It will result in a Net Present Cost of £m over a 10-year appraisal period. This represents an improvement compared to Business as Usual or Net Present Social Value of £m and a Benefit Cost Ratio of 1.1 (i.e. every £1 of incremental cost will realise £1.10 of incremental benefits)

Investment in RISP will deliver a range of financial and non-financial benefits due to more streamlined workforce, increased automation, greater accuracy and reliability, and reduced reliance on paper-based systems. This will result in benefits such as:

- Improved patient safety due to the more accurate records which will reduce the risk of repeat examinations and inappropriate radiation dosage and better support personalisation of dose assessments.
- Contribution to earlier diagnosis leading to better patient experience and outcomes due to reduced turnaround time from referrals to reporting, and more effective MDT working.
- Improved workforce experience and greater staff satisfaction due to more efficient and effective ways of working.
- Productivity gains worth £2.2m due to reduced need for manual interventions to manage activities such as referrals, reporting and providing MDT images. It should be noted that these are not expected to be cash releasing.
- Use of cloud-based system leading to greener and more efficient use of energy.

3. The Commercial Case

The commercial case considers the commercial feasibility of the award recommendation.

3.1 Procurement Scope

Based on an assessment of the current solutions available in this market, the procurement approach envisaged a single “Contractor”-provided service with that Contractor taking prime responsibility for all in-scope aspects of the solution, including the contracting and management of any other required contractors as Sub-contractors to the Contractor.

The service requirement includes the following key components:

- An End-to-End Radiology Solution – A modular paperless end-to-end solution which will include the Radiology Information System (RIS) and Picture Archiving and Communication System (PACS) functionality to support an electronic workflow from “receipt of request to publishing of the result and receipt of acknowledgement”
- A Patient Dose Monitoring System (PDMS)
- Electronic requesting and results acknowledgement as an ‘optional’ service in the event that the Welsh Clinical Portal (WCP) cannot be developed to meet the requirements of the Imaging services in line with the programme’s timeline
- The contract will be for a managed service, with the Contractor responsible for all aspects of the solution and its ongoing performance over the life of the contract

The successfully procured service includes the totality of the deliverables as set out in the Schedule 2.1 – ‘The Authority’s Requirements’ and associated contract schedules.

The Authority’s Requirements includes an option for the provision of electronic test requesting, results acknowledgement and notification. This is included in the Service Catalogue.

The service will provide a national application that will integrate with the national technical architecture to provide a seamless solution from requesting of procedure to results acknowledgment and notification.

3.2 Procurement Regulations

As NHS Wales organisations are public sector bodies; all NHS Wales procurements must comply with Standing Financial Instructions and the Public Contracts Regulations 2015 (PCR2015).

On 1st April 2021, the NHS Wales Informatics Service (NWIS) transitioned to the new Special Health Authority, Digital Health and Care Wales (DHCW), which is the Contracting Authority for the purposes of this procurement.

Approval to proceed with any contract will be governed by the authorisation of a Full Business Case (FBC), of which this document forms a part, by the Welsh Government.

3.3 Procurement Strategy

Purpose of the Procurement Strategy

The purpose of the Procurement Strategy was to set out in a formalised manner the key aspects of the procurement of the Radiology Informatics Solution. It was a high-level document that stated the programme's approach to its procurement activities, its objectives, and key initiatives. The document provided general information on expenditure, procurement structures, and regulatory considerations and contained a statement of its commitment to developing good working relationships and dealing fairly with all potential suppliers. This strategy was developed along with the outline business case and defined the approach to be adopted by the Procurement Project.

An effective procurement strategy is based upon a shared understanding of the role and purpose of the procurement process.

The Procurement Strategy formed an important part of the audit trail for procurement setting out the intentions of the Contracting Authority in advance of the commencement of the formal process.

Prior to the publication of the Contract Notice, DHCW are mandated under its Standing Financial Instructions (SFI's), to Notify Welsh Government of the intended Contract and the

procurement process that will be undertaken. Until the Procurement Strategy was officially "Noted" by Welsh Government, the procurement process could not commence.

Objectives of the Procurement

The principal aim of the procurement is to procure a Radiology Informatics Service to replace the existing legacy solution/s and to provide a service that meets current and future requirements.

The objectives of the procurement are to ensure that the new Radiology Informatics Service will:

- Deliver safe and effective clinical outcomes for patients
- Procure a solution and associated support
- Meet the identified functional characteristics and requirements
- Provide options for additional functional and/or technical capabilities over the contract term (future proofing the solution)
- Offer value for money over its lifetime
- Be "best in class" (where technically, clinically, and financially feasible)
- Be fully interoperable with other national solutions
- Provide the requisite business management functionality as well as clinical functionality
- Meet the investment objectives and critical success factors as set out in the business case
- Contribute to the delivery of the national information and business strategies in accordance with Welsh Government strategies for health
- Be implemented in a fully supported manner within the required timescale for migration off the existing legacy solution(s)

Single Contractor versus Multiple Contractor

Based on an initial assessment of the current solutions available in this market, the procurement approach envisaged a single “Prime” Contractor-provided solution with that Contractor taking full contractual responsibility for all in-scope aspects of the requirement, including those delivered by any Sub-contractors under the contract.

In line with the Welsh Government preference of “*Cloud first*”, consideration for any new investments explored and gave due consideration to this approach but not to the detriment of any clinical services. However, it was anticipated that any hosting of the major Solution components would be provisioned by the Contractor via private or public cloud hosting services. The scope, architecture and options bidders offered were explored as part of the competitive procurement process to ensure performance, functionality, efficiency, and security requirements of NHS Wales have been fully met.

Given the scope and scale of this project, potential suppliers are unable to supply all components and services to fulfil the Solution other than through the use of subcontractors, which the Authority allowed as part of their Bids, subject to said Contractor(s) entering into appropriate subcontracts, including taking full responsibility for the performance of any subcontracted services, i.e. operating as a “Prime Contractor” to the Authority for any and all aspects of their contracted solution. Procuring the solution from a single Prime Contractor achieves:

- A full and seamless end-to-end service, i.e. a managed “Service”
- Flexibility in bringing about business change driving the requirements for the Service and its development within clinically and operationally appropriate timescales.
- Clear responsibility for integration and end-to-end delivery of the service. This approach removes the risk of "boundary disputes"[4] with any other suppliers supporting the Service.

[4] Boundary disputes means which contractual party is contractually obligated to deliver against the requirements in question

Contract Duration

The length of contract for the RISP Procurement is tailored to give best value for money for the project. The agreed contract period will:

- Allow sufficient time to exit off the legacy agreements and transition onto any new solution.
- Allow for adequate flexibility for the Authority during the investment life.
- Attract a sufficient range of bidders for the project.
- Enable a viable return on any investment.
- Ensure continuity of support as a minimum to achieve the potential short to medium term aims of the Programme.

The Contract Notice, published through the UK e-Notification service, stated the duration of the Contract to be for a period of nine (9) years in total with each Authority Party (health board/trust/Special Health Authority, etc.) entering into Deployment Orders with a term of no less than sixty-two (62) months, that being five (5) years and two (2) months, the latter allowing for two (2) months local implementation, followed by a period of five (5) years operational service. All Deployment Orders shall have the option to be extended by a period of up to two (2) years per Deployment Order. Please see Appendix C1 for the indicative implementation plan and roll out across NHS Wales.

Procurement analysis and prior experience of national IT system implementations suggest that the complexity involved with delivering an All-Wales solution and standardising technical processes across organisational boundaries requires a longer-term contract.

Additionally, the expected business criticality of this procurement to NHS Wales lends itself to the stability that a longer contract provides. Finally, the solution may need to flex, in terms of user volumes and data types, but will not materially change its scope. There needs to be flexibility in terms of:

- Extending the initial term of the contract flexibly in order to adapt to the needs of the service.

- Planning for an overlap period between the existing contractor and any new Contractor of at least twelve (12) months to ensure a seamless transition.
- Expanding the scope of the Service to allow more users, data types/flows to be deployed under the contract and/or provide the ability to respond to technical development opportunities, using the same contractual model and performance assumptions.

Value for money has been tested and explored on various options during the procurement phase.

Contracting Approach

The contract form of Agreement is a Master Services Agreement, based on an amended form of the IT Services Contract having regard to the Crown Commercial Services and other best practice guidance of Information Management & Technology (IM&T) procurement.

Advice was sought on the construction of the draft contract using the NHS Wales appropriately commissioned specialist advisers for commercial, legal, and technical aspects. Each NHS Wales participating organisation "Authority Party" will "call off" their requirements from the contract "the Agreement" and via this process will execute their own "Deployment Orders" with the Contractor. All Deployment Orders will be managed centrally in line with the "Once for Wales" approach.

Appropriate internal governance arrangements have been established to ensure that all Authority Parties agree and commit to the implementation plan and other Authority Responsibilities within the Contract, including the payment terms.

Procurement Route

On 31 December 2020, the Transition period for the United Kingdom (UK) ended and the UK left the EU Single Market and Customs Union. The UK Government has published a Green Paper 'Transforming Public Procurement' which details many of the changes that they propose to make to the current procurement framework including consolidating the Public Contract Regulations, the Utilities Contract Regulations, the Concession Contract Regulations

and the Defence and Security Public Contract Regulations into a single set of regulations specifically designed for the UK market and priorities.

However, at the time of writing this commercial case, public bodies must continue to comply with the Public Contracts Regulations 2015, with minor modifications including the requirement to place an advertisement through the UK e-Notification service. Under these regulations there are potentially several alternative procurement routes open to the project which meet this requirement:

- Procurement under an existing Framework Agreement
- Open Procedure
- Restricted Procedure
- Competitive Dialogue Procedure

Following an evaluation of alternative procurement routes (see Appendix C2), it was recommended that this requirement was procured under the Public Procurement Directives 2015 Competitive Dialogue Procedure. This procedure, according to the Public Contracts Regulations 2015, should be used in the case of particularly complex contracts, where purchasers may be aware of their needs but not know in advance, what the best technical, legal, or financial solution for satisfying those needs are.

The RISP Programme was keen to explore a range of technical solutions, in conjunction with bidders, including the introduction of new and potentially innovative solutions, as well as ensuring that the most appropriate commercial deal is secured, and therefore considered the Competitive Dialogue appropriate for this requirement.

Procurement Approach

The following is an outline of the basic procurement approach, which was developed further in a more detailed Procurement Plan:

- **Bidder engagement and market assessment** commenced to validate the proposed approach and test for an adequate level of interest, capability, and capacity to deliver the requirements. Whilst a preliminary engagement was undertaken, further

presentation days were required closer to the commencement of the formal procurement process. The approach was supported through advertisements on national platforms and via the use of social media. Such events were managed formally in line with the spirit of procurement regulations.

- **A RISP Procurement Team** was established with defined members and Terms of Reference.
- **Procurement training and awareness sessions** for key staff on an ongoing basis throughout the Competitive Dialogue process was a requirement. Initial briefing sessions set the scene for ongoing training allowing the RISP Evaluation Team to ascertain the level of experience of this type of procurement and the amount of additional training that will be required. The team augmented the training with ongoing advice and attendance at key meetings during the procurement process.
- **Contract Notice:** A Contract Notice was placed through the UK e-Notification service under the Competitive Dialogue Procedure. At this stage, key documentation also needed to be finalised and published to enable bidders to make an informed decision regarding their participation.
- **Prequalification:** Screening of Bidder Qualification Information was undertaken with the pre-qualification information received from bidders within thirty (35) days of the issue of the Notice (in accordance with the statutory timescale of thirty (30) days for the Notice). Assessment of pre-qualification information (which included details of previous relevant experience as well as financial and technical capability and capacity questions). From this exercise, a long list of five (5) bidding "Prime" Contractors were invited to participate in dialogue.
- **An Invitation to Participate in Dialogue (ITPD)** was issued to the long-listed Bidders. The ITPD required bidder responses to the Authority Requirements, pricing refinement, Contract Terms and Conditions and Draft Contract Schedules, detailed adherence to the Key Commercial Principles governing the procurement and participation in user evaluations.

- **ITPD Evaluation**: ITPD responses were evaluated to arrive at a short list of bidders. From this exercise, a short list of three (3) bidders were invited to participate in the detailed dialogue process with Authority representatives on the full set of contract schedules.
- **Detailed Dialogue:** A second stage of dialogue with shortlisted bidders was then conducted to finalise draft contract offers and identify the commercial terms on which the solution would be provided. The draft contracts are based on an amended version of the Crown Commercial Service (CCS) standard form IM&T contract. This stage commenced with site visits to other Bidder customers, the arrangements were defined and arranged by the Authority. Following this, detailed dialogue took place with each Bidder over two (2) "rounds", per workstream ('Functional', 'Technical', 'Implementation & Service' and 'Commercial, Legal & Financial'), each comprised of the following:
  - Receipt of the Bidder's mark-up on each part of the Agreement,
  - Review by Authority representatives,
  - Discussion with Bidders to seek clarification on submissions and providing Authority feedback on said submission and,
  - Evolution of the Authority's contract documentation identifying any changes made. At the end of this detailed dialogue stage, all shortlisted Bidders with compliant offers were taken forward to the Invitation to the ISFT (Invitation to Submit Final Tender) stage to maintain competition in the process and ensure that the Authority's options were not restricted prematurely.
- **Trial Invitation to Submit Final Tender** was issued to assess the readiness of bidders to proceed to the final ISFT stage. Submissions were not formally evaluated but were reviewed and, feedback was provided where necessary, to ensure compliance, completeness, and appropriate understanding of the Authority's requirements.
- **Invitation to Submit Final Tender (ISFT)** is the stage at which bidders provided their final tender for the Services.

- **Final Tenders** were then evaluated, and a most favoured tender was selected based on the most economically advantageous tender, which was calculated in accordance with agreed weightings for the functional/technical requirements and price.

Subject to clarifications and minor refinements concerning the final tender submission, if required, and approval of the Full Business Case, a contract will be awarded to the bidder with the most economically advantageous tender, executed, and come into force following the ten-day standstill period. The Award Notice will be placed within forty-eight (48) days of the award decision.

Selection and Evaluation

Selection and evaluation criteria guided the evaluation at the three (3) stages of the procurement:

- Bidder Qualification Information – Pre-Qualification Questionnaire (PQQ) and Single Procurement Document (SPD) responses, to select the longlisted bidders
- Invitation to Participate in Dialogue (ITPD) Responses (Dialogue Stage), to select the shortlisted bidders
- Invitation to Submit Final Tenders (ISFT) (at the end of the Detailed Dialogue Stage)

In accordance with PCR 2015, all key documents for the procurement were issued at the start of the procurement, including evaluation criteria for the PQQ/SPD, ITPD and ISFT stages. All evaluation approaches highlighted the criteria and weightings to be used and the methodology for scoring and assessment across the whole procurement.

Contract Award

On conclusion of the ISFT phase and final evaluation of the ISFT responses, a recommendation has been made on the Most Economically Advantageous Tender (MEAT), which has been calculated in accordance with the agreed weightings for functional/technical requirements and price. This recommendation has been recorded in a final evaluation report, which sets out the basis for the award decision and has been signed via the agreed governance process.

Any award is subject to a mandatory ten (10) day standstill period at which time all bidders have been informed of the outcome of the procurement process and the relative advantages of the successful bidder.

Final award is subject to subsequent approvals by the RISP Programme Board and all health boards, trusts and Special Health Authorities (where appropriate), Full Business Case Approval by Welsh Government and notification being provided from the Welsh Government Minister for Health and Social Services. Upon acceptance by the DHCW Board, as the Contracting Authority, the Agreement can then be executed upon signature by the DHCW Chief Executive and the successful Bidder.

Unsuccessful Bidders will be offered an opportunity for a full debrief following the formal decision being ratified and approved.

Following the completion of the formal award process a Contract Award Notice will be placed through the UK e-Notification Service.

3.4 Required Services, Outputs and Timescales

Required Services

The principal aim of the procurement is to procure a Radiology Informatics Service to replace the existing legacy solutions and to provide a service that meets current and future requirements.

The service requirement included the:

- Provision, ongoing development, upgrade and maintenance of an All- Wales Radiology Informatics Service (RIS).
- Provision, ongoing development, upgrade and maintenance of an All- Wales Picture Archiving and Communications System (PACS).
- Provision, ongoing development, upgrade and maintenance of an All- Wales Patient Dose Management System (PDMS).
- Provision, ongoing development, upgrade and maintenance of an Electronic Test Requesting System (ETR) for radiology including integrated decision support tools

relevant to radiology referral pathways. Included as an optional requirement within the procurement scope.

- Deployment of the solution across the multiple organisations that comprise NHS Wales, including, but not limited to, other nationally hosted organisations.
- Any advanced image manipulation and analysis applications that may be required.
- Contractor managed hardware and software environments:
    - Hosted in non-NHS Wales owned or contracted data centres, public or private Cloud, subject to NHS and Welsh Government security requirements.
    - Using the Welsh Public Sector Broadband Aggregation (PSBA) for wide area networking to health boards and trusts.
- Business intelligence and reporting tools.

Timescales

Following the Welsh Government approval of the OBC, the Contract Notice was published in December 2021. The design and development of the new service under the proposed contract took account of the migration/exit off the legacy solutions and in accordance with the RISP Programme Plan. The aim is to complete the full implementation by April 2025, subject to detailed negotiations with the successful Contractor and the commitment of the local health boards. Further details are provided in the Management Case.

The table below shows the high-level timescales for the five (5) Tranches of the RISP Programme:

Table 16: RISP Programme Timescales

Tranche 1	Tranche 2	Tranche 3	Tranche 4	Tranche 5
Pre-Procurement	Procurement	Configuration and Integration	Deployment	Ongoing Contract Management
Jun 2019 – Dec 2021	Jan 2022 – Apr 2023	May 2023 – Apr 2024	May 2024 – Jun 2025	Jul 2025 Onwards
• Programme definition • Outline business case • Procurement documentation	• Procurement • Full business case	• Config and testing • Systems integration • Data migration	• Implementation • Handover	• Business as usual

3.5 Risk Apportionment

While the RISP Programme adhered to the general principle that risks should be passed to the party best able to manage them, a formal risk apportionment exercise was considered as not required for this programme.

3.6 Payment Mechanisms

Charging mechanisms will depend on many factors, one important aspect being the phased deployment of the new Service which is expected to occur over a twelve (12) month period. The implications of this are that each health board and trust will only start paying for the Service once they start using it. This therefore required the Master Services Agreement to be flexible, given that the actual dates for when the Service will commence in some health boards may not end up being the same as the estimated dates currently identified. The selection of a Master Services Agreement specifically supported Service roll out over multiple organisations, with health boards entering into their own Deployment Orders, each of which has the potential to determine local timescales and resources.

3.7 Key Contractual Issues

The development of the Contract was undertaken as part of the Competitive Dialogue process with the short-listed bidders on the basis of an appropriately amended form of the Crown

Commercial Services (CCS) standard IM&T Agreement and taking account of lessons learned from other similar initiatives. Key aspects of the contractual relationship that the RISP programme is seeking to achieve have been reflected in the contract as follows:

- Value for Money (VfM) – the procurement was underpinned by a financial model that provided transparency and certainty around costs for key System and service elements. These costs have been considered alongside how well the System design meets the clinical & technical requirements. The aim was to secure the optimum combination of whole-of-life costs and quality (or fitness for purpose) of the System and services to meet NHS Wales requirements. A key contractual issue when considering the VfM is how risks are allocated between the supplier and NHS Wales.
- Ownership of assets by the Contracting Authority have been driven by the design of the Solution that best meets the clinical & technical requirements to deliver the optimum service solution. There may be additional service benefits to be gained from some ownership of assets and/or improvement in the overall affordability for the Contracting Authority, for this contract any assets owned by NHS Wales have been reflected on the balance sheet of those Authority Parties receiving the Service and/ or where ownership and control of the asset resides.
- Intellectual Property Rights (IPR) – The IPR from the application and the interfaces was not envisaged to have significant value for the Contracting Authority and was not pursued in the contract.
- Warranties and guarantees – this is a high cost deal and the perceivable risk of loss (of the Service) is moderate, given its intended use by all the NHS in Wales. These have been pursued within the contract.

3.8 Accounting Treatment

Accountancy treatment is set out in the Financial Case. The classification of items of cost as capital and revenue have been informed by the Bidder Solution designs as part of the procurement process. This was an iterative process seeking detail through clarification with Bidders, with the accounting classifications that emerge reflected in the Financial Case of the FBC.

The Accounting treatment and Funding model depended on the preferred contract model and the outcome of the procurement process.

The three (3) procurement models that have been considered:

- **Traditional purchase and service support model**: In this model the RISP solutions are purchased outright as capital assets and the hardware and software owned by NHS Wales. The supplier implements the system, but once implemented it would be managed by NHS Wales (i.e., RIS/PACS Administration) with the supplier providing technical & service support under a contract arrangement requiring recurrent revenue funding. The service support contract would still include all the same management responsibilities, KPI's, service credit regimes etc as a Managed Service Provider model.
- **Managed Service Provider model**: In this model, NHS Wales purchases a "service" from the supplier. The supplier then implements and manages the system with charges based on fee-per-service arrangements. NHS Wales does not own the hardware or software. This model moves most of the capital acquisition costs into recurrent revenue budget, spreading that expenditure across the life of the system.
- **Hybrid Managed Service Provider model**: The extent of the Hybrid Managed Service Provider model may be limited. For example, NHS Wales having ownership of an All Wales Enterprise License for the RISP Software and some infrastructure either located in NHS organisations and/or an NHS Data Centre, but with the supplier taking responsibility for management and ongoing service support. As with the Traditional purchase and service support model this would involve capital and revenue accounting treatment of costs and associated funding.

Capitalisation of Salaries

In accordance with IFRS16 only those direct attributable labour costs (employee benefits) that relate to the time spent by employees involved in the acquisition, construction, development and commissioning of the infrastructure and system will be capitalised. The relevant proportion of internal costs relating to staff have also been included within the cost of the asset.

Capitalisation of Interface Development

Costs relating to interface acquisition, development and commissioning required for the specified operational running of the system will be capitalised. Ongoing support and maintenance will be expensed as appropriate via the relevant income and expenditure accounts.

Cloud Delivered Services

This procurement is contracting for Services through a primarily Cloud delivered service, i.e. not relying on elements of the Service being delivered through NHS Wales data centres.

IFRS standards do not contain explicit guidance on accounting for cloud computing arrangements or costs to implement. NHS Wales will need to apply judgement to account for these arrangements and may need to apply various IFRS standards, including IFRS 16 Leases, IAS 38 Intangible Assets, and IAS 16 Property, Plant and Equipment to account for the costs.

NHS Wales will need to evaluate whether the rights granted in a cloud computing arrangement are within the scope of IAS 38 Intangible Assets or IFRS 16 Leases. Otherwise, the arrangement is generally a managed service contract and accounted for as revenue expenditure:

- Significant judgement will be required to determine whether a cloud computing arrangement that is not a lease provides NHS Wales with a resource that it can control i.e., an intangible asset
- If the cloud computing arrangement includes an intangible asset in the scope of IAS 38, NHS Wales should apply the guidance in IAS 38 to evaluate whether to capitalise or expense implementation costs
- If the cloud computing arrangement does not include an intangible asset and does not contain a lease, NHS Wales should expense implementation costs unless they can be capitalised under other IFRS standards.

In line with the Welsh Government preference for "Cloud first", through the competitive dialogue process the project team have given due consideration to this preference, but not to the detriment of any clinical solution requirements.

Current Assessment of Capital and Revenue Accounting

There has been consultation with NHS Finance colleagues through the Deputy Director of Finance Group and an initial assessment of accounting treatment has been carried out which has confirmed that there is likely to be a requirement for both capital and revenue accounting and funding.

The Solution cost, based on the Bidder's ISFT submission, and funding requirements are set out in the Financial Case. The cost estimate and classification of costs as capital and revenue has been informed by the initial market soundings undertaken in January 2021 and responses to PIN in May 2021.

The project team will further assess the various IFRS standards with finance experts and agree a final accounting treatment once the details of the proposed Solution have been confirmed.

It is envisaged that any NHS Wales owned assets underpinning delivery of the service will be recorded on the balance sheet of the Digital Health and Care Wales (DHCW) and the relevant NHS body based on an assessment of ownership and control of the asset, those NHS Bodies receiving the service and Welsh Government requirement.

A letter supporting the balance sheet conclusion was provided by the Deputy Director of Finance Group together with audit review.

Value Added Tax (VAT)

Initial advice was sought from one of the NHS Wales VAT advisors as to the possible VAT accounting treatment for the RISP procurement in order to ascertain the likely VAT treatment of the contract. Initial review of VAT guidance would suggest:

In relation to SaaS and Cloud Services, the current HMRC view still seems to go back to the question - is the solution as a whole something that can be demonstrated to be 'to the

specification of' NHS Wales? If NHS Wales can demonstrate that the answer to this question is yes, as appears to be the case for other PACS Solutions the costs should be VAT recoverable.

This assessment can be a bit subjective as HMRC's view is that the solution should have no application elsewhere however, they do also see that some software solutions are not entirely stand alone and integrate into a number of other solutions so that can complicate matters as to what really is the entire solution.

For the purposes of the Business Case, it was assumed that all capital costs (excluding capitalised staff) are not deemed VAT recoverable. Whilst ongoing service provision, support and maintenance will be VAT recoverable as per COS Heading 14 – Computer services supplied to the specification of the recipient.

This assumption regarding VAT accounting will be confirmed with NHS Wales VAT Advisors as the procurement concludes and the design of the solution and contract terms are finalised.

3.9 Personnel Implications (including TUPE)

A Senior Project Manager has been appointed to lead the Procurement Project working to the RISP Programme Lead. The Project Manager will manage the procurement and contract award process, working with the Procurement Lead allocated by DHCW Commercial Services and specialist advice as required. An estimate of costs for the external specialist advisers has been included in the costs for the economic analysis.

Specific individuals have been involved across multiple activities and undertaken more than one role in order to ensure consistency and assist in securing an appropriately robust outcome. The combined staff and consultancy team covered the following roles for the procurement:

- **RISP Programme Team:** Comprising the Senior Responsible Owner, Clinical Lead, Programme Lead, the RISP Programme Management Office (PMO) and Subject Matter Experts.
- **RISP Procurement Project (RPP) Team:** A full time RPP Project Manager will be appointed to manage the project and deliver the planned outputs as expected within

quality, time, and budget constraints. The RPP Project Manager will report to the RISP Senior Programme Manager and be supported by the RISP PMO.

- **Legal Advisers:** RISP utilised DHCW's legal services partner, Blake Morgan LLP to provide the required legal advice, with support including assistance with Contract drafting and contractual discussions with Bidders.
- **Commercial Advisor**: This resource was secured under an existing DHCW contract with In-form Solutions Limited, who has led a number of competitive dialogues for NHS Wales.
- **Radiology Informatics Subject Matter Experts:** Radiology specialists, who understand the requirements for the new system and are experienced with the procurement of the extant solution, have informed the specification of requirements and acted as a link to other subject matter experts from the range of disciplines within the scope of the project.
- **Financial Expert:** A financial expert assisted with the financial modelling required for this project.
- **DHCW Procurement Team:** Comprising two (2) full time staff, including administrative support for the procurement.

Specialist teams were created, as required at key stages during the procurement process, to provide the specific skills and expertise required to support the procurement, including:

- **Requirements Definition Teams**: Specifying the service and technical requirements to be delivered by the new system utilising Radiology Subject Matter Experts (SMEs), DHCW technical experts and IT experts from across NHS Wales.
- **RISP Procurement Team**: Screening the PQQ/SPD responses, score responses against the ITPD and evaluate the final tenders.
- **RISP Dialogue Team**: To negotiate the draft Contracts including representation from the Evaluation Team, Commercial, Legal and Technical Advisers.

It is not expected that any activities will fall under TUPE – Transfer of Undertakings (Protection of Employment) Regulations 1981.

4. The Financial Case

4.1 Introduction

The purpose of the Financial Case is to outline the financial implications of the preferred option and confirm it remains affordable when considering the final cost of delivery for the project, following negotiations with suppliers and a more developed understanding of other costs, benefits and risks.

As such it sets out updated capital requirements and revenue consequences of the proposed scheme, along with final underpinning assumptions. It outlines anticipated funding arrangements and presents the impact on the NHS Wales organisations' financial statements.

As outlined in the Economic and Commercial Cases, the preferred option involves procuring a seamless end-to-end solution from the Preferred Bidder which will replace the existing PACS and WRIS systems. The Financial Case outlines the costs involved in procuring and implementing the solution as well as the resulting ongoing costs.

4.2 Overview

In summary, based on the tendered costs from the Preferred Bidder and updated programme costs, delivery of the preferred option requires capital investment of £25.9m and non-recurring revenue funding of £2.1m from Welsh Government.

Overview - Capital Requirements

Capital funding of £25.9m is requested from Welsh Government to invest in the Preferred Bidder's initial solution charges as well as capitalisable programme resource and local infrastructure requirements. This assumes that VAT is not recoverable on either the solution charges or the infrastructure costs.

This is a £5.3m increase on the £20.6m capital funding committed by Welsh Government at OBC as a result of:

- £1.7m additional Programme resource requirements that have been identified to ensure a robust implementation programme is in place to deliver the programme.

£3.6m additional local infrastructure costs (including VAT) that have been identified to ensure the appropriate infrastructure is in place to support the preferred solution.

Overview - Non-recurring Revenue Requirements

One-off revenue funding of £4.3m is required to invest in programme resource that cannot be capitalised during the 3-year implementation period.

This includes:

- £2.1m requested from Welsh Government, which is a £0.9m increase on the £1.2m committed at OBC.
- £2.2m Health Board contribution during 2023/24 to 2025/26. Given that Health Boards have already contributed £0.7m during 2022/23 (not included in the figures above), this represents a £0.9m increase on the £2.1m identified at OBC.

Overview - Ongoing Revenue Implications

As outlined at OBC, there are minimal revenue implications for Health Boards since the current PACS/WRIS costs of £m p.a. will cover the ongoing solution service charges of £m, the infrastructure revenue costs of £0.9m p.a. and the ongoing support for integration of £0.2m p.a.

There will however be a cost pressure during 2024/25 and 2025/26 of £m due to double running of the existing systems and implementing the local infrastructure. It should be noted that this may be reduced depending on phasing of infrastructure costs.

The following sections outline the main assumptions behind these numbers.

4.3 Accounting Treatment and Value Added Tax (VAT)

The financial schedules reflect the appropriate financial treatment in accordance with standard NHS reporting rules, however it should be noted:

4.4 Capitalisation

Capitalisation of Salaries

In accordance with IAS 16 only those direct attributable labour costs (employee benefits) that relate to the time spent by employees involved in the acquisition, construction, development and commissioning of the infrastructure and system have been capitalised. The relevant proportion of internal costs relating to staff have also been included within the cost of the asset.

Capitalisation of Interface Development

Costs relating to interface acquisition, development and commissioning required for the specified operational running of the system have been capitalised. Ongoing support and maintenance will be expensed as appropriate via the relevant income and expenditure accounts.

Capitalisation of Cloud Hosting, Compute & Storage Costs

Cloud Hosting, Compute & Storage costs that were identified as part of the PIN pricing response have been assumed to be all revenue costs based on the assumption that NHS Wales will not be able to manage or control the underlying cloud infrastructure including network, servers, operating systems, storage, and individual application capabilities. NHS Wales would not have decision-making rights about which hardware (or infrastructure) the Supplier / 3rd party cloud provider will use to run RIS on. When accounting for Cloud Hosting, Compute & Storage the distinction between whether NHS Wales has "control" over an asset is what will allow for its capitalisation under specific Accounting Rules. Unless the Supplier / 3rd Party Cloud Provider specifically contracts to allow NHS Wales to retain control over underlying

assets these costs cannot be capitalised under IAS's. If, however, assets hosted by the Supplier and / or Cloud provider are reserved exclusively for use by the Trust then it's possible to demonstrate that the Trust has sufficient control over the underlying assets and some of the costs may be capitalised.

Implementation costs

Implementation costs, such as initial delivery and handling costs, and installation costs which under FRS 15 are considered "directly attributable" to the development of the asset, are capitalised.

4.5 Capital Charges

Depreciation

Depreciation estimates are based on a straight-line basis over 5 years in line with the planned contract term and commence from 2026/27 once all Health Boards are deployed and associated assets capitalised. Accelerated depreciation is assumed in 2031/32 to reflect asset write down at the point that all contract deployment periods come to an end.

4.6 Value Added Tax

VAT

Initial advice will be sought from one of the NHS Wales VAT advisors as to the possible VAT accounting treatment for the RIS procurement in order to ascertain the likely VAT treatment of the contract. Initial review of VAT guidance would suggest:

In relation to Software as a Service (SaaS) and Cloud Services, the current HMRC view is based on the question - is the solution as a whole something that can be demonstrated to be 'to the specification of' NHS Wales? If NHS Wales can demonstrate that the answer to this question is yes, as appears to be the case for other PACS Solutions across the UK, the costs should be VAT recoverable.

It is assumed that all capital costs (excluding capitalised staff) are not deemed VAT recoverable whilst ongoing service provision, support and maintenance will be recoverable as per COS Heading 14 - Computer services supplied to the specification of the recipient.

4.7 Baseline Costs

FBC Costs

Baseline costs are estimated based on the Financial Commercial paper from February 21 which identified revenue costs for PACS and WRIS of £m. These have been uplifted to 2023/24 prices using the HM Treasury GDP Deflator. Baseline costs have also been adjusted from the February 21 paper to reflect a realignment of the organisational boundaries between Swansea Bay and Cwm Taf and recognising the support for Powys provided by neighbouring health boards within the current PACS contracts. As a result, the baseline costs more accurately reflect the future configuration of RISP deployment orders.

Table 17: Baseline Costs

	PACS £'000	WRIS £'000	Total £'000
Aneurin Bevan UHB			
Betsi Cadwaladr UHB			
Cardiff and Vale UHB			
Cwm Taf Morgannwg UHB			
DHCW			
Hywel Dda UHB			
National Imaging Academy Wales			
Powys Teaching HB			
Public Health Wales			
Swansea Bay UHB			
Velindre University NHS Trust			
Total Baseline Costs			

It is anticipated that these costs will continue until each Health Board's stable operation date for the new system plus one month of dual running costs. The table below shows the stable operation date for each of the Health Boards and the number of months that the current PACS/WRIS costs are incurred during the three-year implementation period.

Table 18: Stable Operation Date

	Stable Operation Date	Number of months of current PACS/WRIS costs incurred during implementation period		
		2023/24	2024/25	2025/26
Aneurin Bevan UHB	Jan-25	12	10	0
Betsi Cadwaladr UHB	Oct-24	12	7	0
Cardiff and Vale UHB	Jul-25	12	12	4
Cwm Taf Morgannwg UHB	Mar-25	12	12	0
DHCW	N/A	12	12	4
Hywel Dda UHB	Feb-25	12	11	0
National Imaging Academy Wales	Jul-25	12	12	4
Powys Teaching HB	Jun-25	12	12	3
Public Health Wales	May-25	12	12	2
Swansea Bay UHB	Jun-25	12	12	3
Velindre University NHS Trust	Apr-25	12	12	1

As a result, the following total costs are included in the 10-year appraisal period for the existing PACS/RIS system.

Table 19: Existing PACS/RIS costs (2023/24 – 2025/26)

	Capital £’000	Revenue £’000	Total £’000
Aneurin Bevan UHB	-		
Betsi Cadwaladr UHB	-		
Cardiff and Vale UHB	-		
Cwm Taf Morgannwg UHB	-		
DHCW	-		
Hywel Dda UHB	-		
National Imaging Academy Wales	-		
Powys Teaching HB	-		
Public Health Wales	-		
Swansea Bay UHB	-		
Velindre University NHS Trust	-		
Total Legacy Costs	**-**		

Changes since OBC

These final costs have been compared to the estimated values which were included in the OBC.

Table 20: Legacy Solution Costs Compared to OBC

	Initial Charges including VAT £'000	Service Charges £'000	Total £'000
FBC Legacy Costs	-		
OBC Legacy Costs	-		
Movement since OBC	-		

Legacy costs in the FBC are £m lower since OBC, which is largely driven by the number of years considered in the appraisal period.

4.7 Preferred Bidder Solution Costs

FBC Costs

Solution costs are based on tendered costs submitted by the Preferred Bidder. The Preferred Bidder has allocated these costs as follows:

- **Initial Charges:** Includes initial investment in hardware and software, professional services for testing, training, PM, data migration and implementation during the implementation period (2024/25 – 2025/26). Current assumption is that VAT is not recoverable on the initial charges although this is under investigation.
- **Service Charges:** Includes ongoing annual maintenance and support during the term of the contract.

Costs have been allocated to Health Boards based on the contract value apportionment and stable operation dates provided to the Preferred Bidder as part of the procurement process.

The resulting costs are outlined in the table below.

Table 21: Solution Costs

	Initial Charges £'000	Service Charges £'000	Total £'000
Aneurin Bevan UHB			
Betsi Cadwaladr UHB			
Cardiff and Vale UHB			
Cwm Taf Morgannwg UHB			
DHCW			
Hywel Dda UHB			
National Imaging Academy Wales			
Powys Teaching HB			
Public Health Wales			
Swansea Bay UHB			
Velindre University NHS Trust			
Total Solution Costs excluding VAT			
VAT			
Total Solution Costs including VAT			

Changes since OBC

These final costs have been compared to the estimated values which were included in the OBC.

Table 22: Solution Costs Compared to OBC

	Initial Charges including VAT £'000	Service Charges £'000	Total £'000
FBC Solution Costs			
OBC Solution Costs			
Movement since OBC			

This demonstrates an increase in solution costs of £m since OBC, which is largely driven by slightly higher service charges than anticipated.

For the purposes of the 10-year appraisal period, it is assumed that the average annual service charge costs will continue at the same level following the contract end date at each Health Board.

4.8 Programme Resource Plan

FBC Costs

The Resource Plan for delivery of the Programme has been updated as part of the FBC based on

- The resource plan required to deliver RISP including the key functions and requirements as outlined in the table below.
- Pay costs based on 2023/24 Agenda for Change pay scales including on costs plus 2.5% annual inflation.

Table 23: Resourcing Requirements

Function	Requirements
Programme Management Office	• Programme Director • Programme and Project Management • Project Support • Commercial Manager • Radiology SME • Business Change Manager • Clinical Leads
Technical Support	• Application architecture • Infrastructure and networking architecture • Integration and reference application teams • Applications development • RADIS teams (Team leads, developers, analysts, testers) • Service management • Data standards • Information governance and patient safety
Local Deployment Teams	• Project managers • IT support • PACS/RIS support

Costs have been allocated to Health Boards based on the contract value apportionment used by the Preferred Bidder within the solution costs.

The resulting costs for the programme resource plan are presented in the table below.

Table 24: Programme Resource Costs

	Capital £'000	Revenue WG Funded £'000	Revenue HB Funded £'000	Total £'000
Aneurin Bevan UHB	315	165	308	788
Betsi Cadwaladr UHB	286	84	347	717

	Capital £'000	Revenue WG Funded £'000	Revenue HB Funded £'000	Total £'000
Cardiff and Vale UHB	515	381	394	1,290
Cwm Taf Morgannwg UHB	286	169	262	717
DHCW	0	0	0	0
Hywel Dda UHB	286	105	325	717
National Imaging Academy Wales	172	258	0	430
Powys Teaching HB	114	172	0	287
Public Health Wales	372	415	145	932
Swansea Bay UHB	429	268	378	1,075
Velindre University NHS Trust	86	58	71	215
Total Programme Resource Costs	**2,861**	**2,075**	**2,232**	**7,168**

Changes since OBC

These final costs have been compared to the estimated values which were included in the OBC.

Table 25: Programme Resource Costs vs OBC

	Capital £'000	Revenue WG Funded £'000	Revenue HB Funded £'000	Total £'000
FBC Programme Resource Costs	2,861	2,075	2,232	7,168
OBC Programme Resource Costs	1,154	1,222	2,122	4,498
Movement since OBC	1,707	853	110	2,670

Following a full review of the programme resource requirements an additional £2.7m.

4.9 Local Infrastructure Costs

FBC Costs

Infrastructure costs have updated as part of the FBC based on estimated capital and revenue costs for PSBA networks, network switches, firewalls.

Costs have been allocated to Health Boards based on actual requirements.

The resulting costs for the infrastructure are presented in the table below.

Table 26: Infrastructure Costs

	Capital £'000	Revenue £'000	Total £'000
Aneurin Bevan UHB	717	1,080	1,797
Betsi Cadwaladr UHB	784	2,668	3,452
Cardiff and Vale UHB	1,059	2,572	3,630
Cwm Taf Morgannwg UHB	818	825	1,642
DHCW	-	-	-
Hywel Dda UHB	374	348	722
National Imaging Academy Wales	-	-	-
Powys Teaching HB	214	272	486
Public Health Wales	571	-	571
Swansea Bay UHB	92	99	191
Velindre University NHS Trust	413	184	597
Total Infrastructure Costs	**5,042**	**8,047**	**13,088**
Irrecoverable VAT	1,008		1,008
Total Infrastructure Costs including VAT	**6,050**	**8,047**	**14,097**

Changes since OBC

These final costs have been compared to the estimated values which were included in the OBC.

Table 27: Infrastructure Costs vs OBC

	Capital £'000	Revenue £'000	Total £'000
FBC Infrastructure Costs	6,050	8,047	14,097
OBC Infrastructure Costs	2,423	-	2,423
Movement since OBC	3,627	8,047	11,674

Following a full review of the local infrastructure requirements an additional £3.6m of capital investment requirements have been identified, including VAT.

This will incur £0.9m of annual revenue consequences. Although these were not identified separately in the OBC, they have been offset by reduced legacy costs compared to the OBC.

4.10 Ongoing Support for Integration Costs

FBC Costs

DHCW has estimated that an additional £150k p.a. of costs will be incurred for the ongoing support for integration.

Costs have been allocated to Health Boards in line with the solution contract value allocation.

The resulting costs for the ongoing support for integration are presented in the table below.

Table 28: Ongoing Support for Integration Costs

	Capital £'000	Revenue £'000	Total £'000
Aneurin Bevan UHB	-	116	116
Betsi Cadwaladr UHB	-	105	105
Cardiff and Vale UHB	-	189	189
Cwm Taf Morgannwg UHB	-	105	105
DHCW	-	0	0
Hywel Dda UHB	-	105	105
National Imaging Academy Wales	-	63	63
Powys Teaching HB	-	42	42
Public Health Wales	-	137	137
Swansea Bay UHB	-	158	158
Velindre University NHS Trust	-	32	32
Total Ongoing Support for Integration	**-**	**1,050**	**1,050**

Changes since OBC

These costs were not included at OBC-stage.

4.11 Impact on Financial Statements

Impact on Balance Sheet

The proposed accounting treatment for the preferred option is that £25.9m of assets will be capitalised and brought on balance sheet (including VAT where appropriate).

For this contract any assets owned by NHS Wales will be reflected on the balance sheet of those Authority Parties receiving the Service and / or where ownership and control of the asset resides. It is anticipated that as with other All Wales procurements the successful

supplier will require the total All Wales capital cost to be included in the deployment order for the first Authority Party in which the new System is to be implemented. This Authority Party has not been agreed at this stage, but the Total All Wales Asset Value for the new System will need to be recorded on the balance sheet of that party and then the respective share of the asset value transferred to the Balance Sheet of each Party once the new System has been implemented and is operation in each organisation.

4.12 Impact on Income & Expenditure

As outlined at OBC, there are minimal recurring revenue implications overall since the current PACS/WRIS costs of £m p.a. will cover both the ongoing solution service charges of £m and the infrastructure revenue costs of £m p.a. resulting in a net overall saving to NHS Wales from 2026/27 onwards of £m p.a.

However, there are non-recurring revenue impacts during the implementation period including:

- Programme resource costs of £4.3m during 2023/24 – 2025/26 which it is anticipated will be funded as follows:
  - £2.2m from Health Boards allocated based on the 2022/23 contribution of £744k continuing for the next 3 years.
  - The remaining £2.1m is requested from Welsh Government.
- £2.1m cost pressure during 2024/25 and 2025/26 due to double running of the existing systems and the revenue consequences of implementing the local infrastructure. It should be noted that this may be reduced depending on phasing of infrastructure costs.

The impact to Health Boards, based on the allocation of costs outlined in the previous sections, is outlined in the table below.

4.13 Overall affordability and funding

As outlined in section 1.2, based on the tendered costs from the Preferred Bidder and updated programme costs, delivery of the preferred option requires the following funding:

- £25.9m capital investment requested from Welsh Government, a £5.3m increase on the funding committed at OBC.
- £2.1m non-recurring revenue requested from Welsh Government, which is a £0.9m increase on the £1.2m committed at OBC.
- £2.2m Health Board contribution during 2023/24 to 2025/26. Given that Health Boards have already contributed £0.7m during 2022/23, this represents a £0.9m increase on the £2.1m identified at OBC.

As outlined at OBC, there are minimal revenue implications for Health Boards since the current PACS/WRIS costs of £m p.a. will cover the ongoing solution service charges of £m, the infrastructure revenue costs of £m p.a. and the ongoing support for integration of £m p.a.

There will however be a cost pressure during 2024/25 and 2025/26 of £2.1m due to double running of the existing systems and implementing the local infrastructure. It should be noted that this may be reduced depending on phasing of infrastructure costs.

5. The Management Case

5.1 Introduction

This section of the Full Business Case sets out the approach that will be taken to support the successful delivery of the Programme, in accordance with best practice. The programme structure has been designed to ensure compliance with the guidance set out in the Treasury Green Book and Welsh Government Five Case Model. It is assumed there will be flexibility to support any new developments and discoveries as they emerge.

A Strategic Outline Case (SOC) was not required for RISP, as it is driven by the need to re-procure a new radiology system. This Full Business Case (FBC) further evolves the approach to managing and delivering this programme, as originally set out in the Outline Business Case (OBC).

5.2 Programme Governance

Following a review period by the steering group overseeing the NHS Executive, it was agreed that the RISP programme would not transfer into the NHS executive but d into Digital Health and Care Wales, on 1st January 2023. The programme is managed in accordance with Managing Successful Programmes (MSP) and PRINCE2 standards, which are tailored to suit the needs of the service.

Diagram 2 below outlines the Programme Board reports to DHCW Executive Board. The Programme also reports to the National Imaging Strategy Programme Board on progress as part of its responsibility to deliver the Informatics element of the Imaging Statement of Intent and, as it is clinically led, to meet the requirements to provide a comprehensive clinical imaging service for patients and healthcare service in Wales.

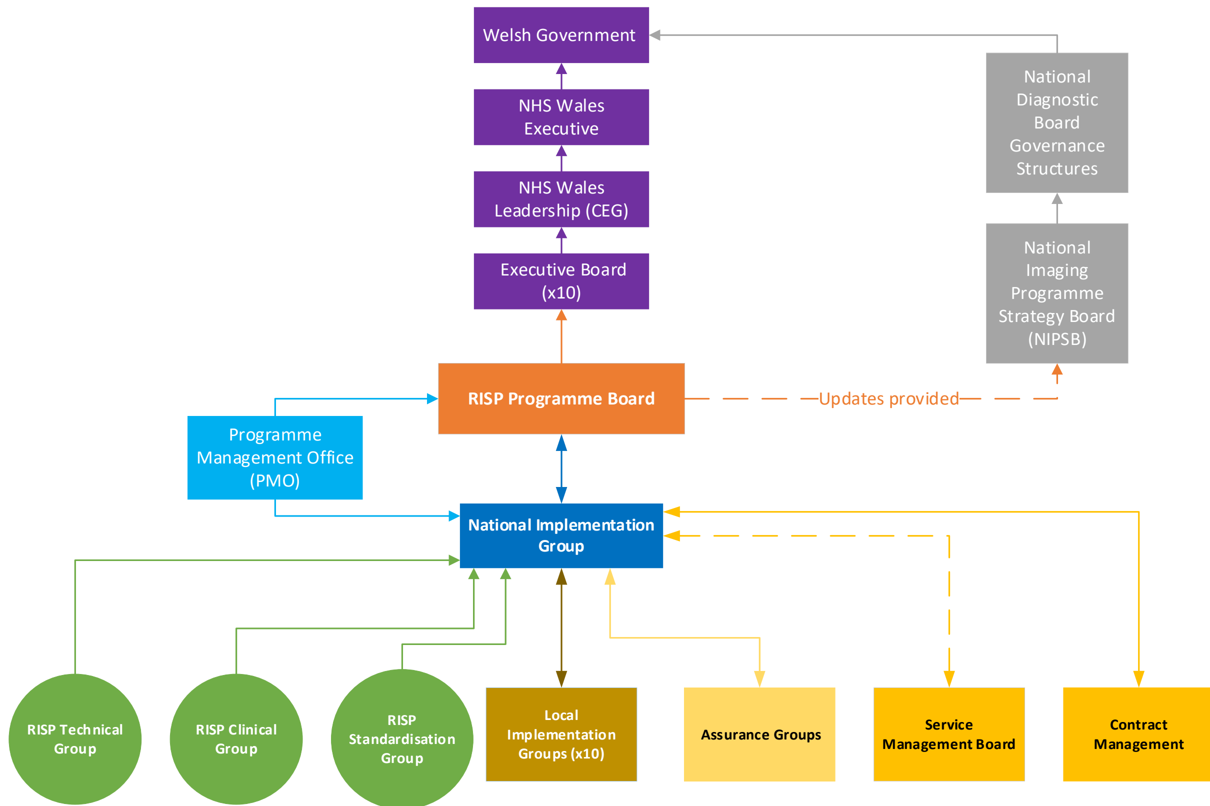


Diagram 5 – Programme Structure

A RISP Programme Board is well established with a remit to provide oversight and direction and to review and assure the Programme's progress. Membership comprises senior representatives from each health board and trust, nominated by CEOs with key stakeholder groups also represented. The RISP Senior Responsible Owner (SRO) is Matt John (Head of Digital SBUHB), who chairs the RISP Programme Board, oversees all projects within the Programme, and will provide strategic direction and leadership to the Programme.

A list of the Board members can be found in Programme Board Terms of Reference Appendix M1.

RISP Programme Management Structure

A RISP Programme Management Office (PMO) team is responsible for managing and driving the delivery of the Programme. The Programme team is led by the National Programme Lead, Gareth Cooke and overseen by a Programme Director, Alison Maguire. The role of the PMO is to plan, coordinate and manage the Programme on a day-to-day basis and adds value

through its staff's knowledge, experience and skills. The PMO sets and maintains standards for project management throughout the Programme to ensure best practice.

Following a review of the PMO resources as initially outlined in the OBC, it is proposed that an additional Principal Project Manager is appointed to support the complex work of implementation and the number of support workers is reduced from 3 to 2 as more efficient use of time and resources is adopted. From 2023/24, the Programme Management Office (PMO) will comprise of:2 Principal Project Managers, focussing on programme implementation; supported by

- Two Project Managers focussing on Commercial, Business Change and implementation projects
- Two Support Workers that support programme governance and assurance
- 1 Subject Matter Expert who works with the Radiology Departments on business change projects, as well as participates in the procurement, development, testing, training, and deployment of the new solution
- 0.5 FTE Commercial Manager who will manage the contract and support implementation following on from the procurement exercise
- 1 Business Change Manager who will be responsible for supporting the change process and developing training to support the implementation

RISP Programme Management Structure 2023

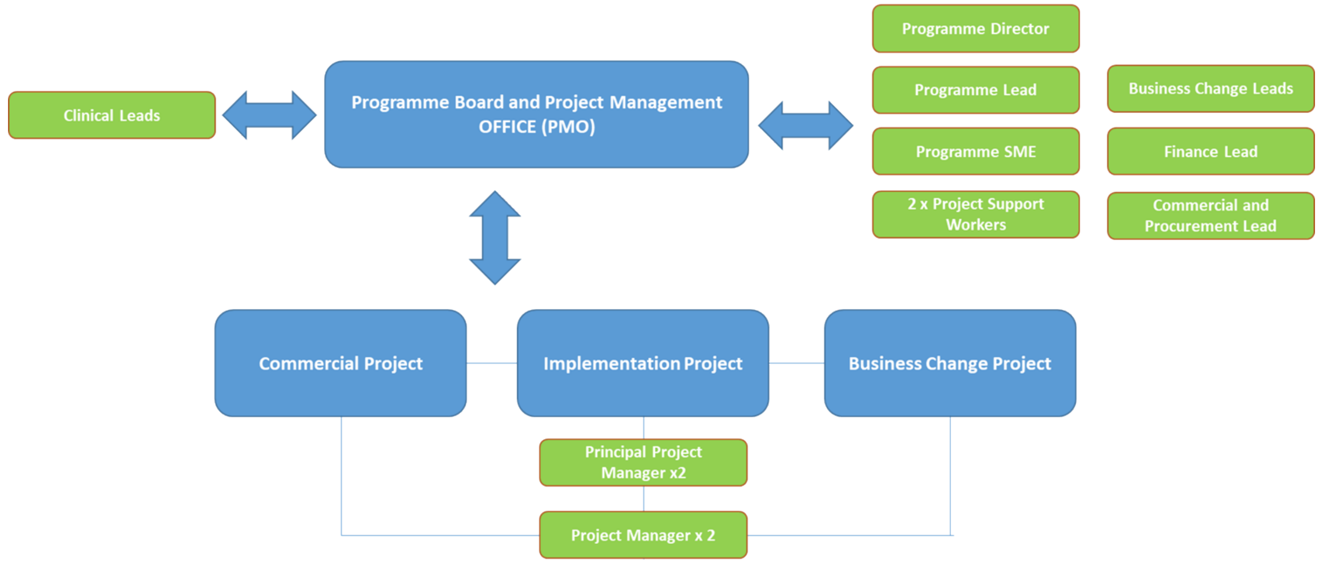


Diagram 6 – Programme Management Structure

Radiology Clinical Leads

Three (3) Consultant Radiologists are appointed to work with the Programme on a sessional basis. These include:

Dr Sian Phillips (Consultant Radiologist CTMUHB, Chair of Medical Imaging Scientific Committee (MISC)) supported by Dr Balan Palaniappan (CTMUHB) and Dr Tishi Ninan (SBUHB). The clinical team will engage the clinical partners within Radiology and the wider NHS clinical service in defining the requirements, designing the standard solution, and supporting the deployment of the developed solution. Their continued support of the Programme will facilitate transitioning from legacy systems to the preferred bidder. They will support HBs in developing and optimising the new system service and business change/ modernisation.

Technical Advisors

The RISP Programme has a small team of experts from across Public Health Wales, National Imaging Academy Wales, and NHS Wales Shared Services Partnership (NWSSP), that support the procurement and implementation of the Programme.

- Archus Ltd has supported the development of the financial and economic cases.

Implementation

As the procurement process has progressed, it has become clear that further and more detailed consideration was needed to be given to programme implementation, hence why a separate project has been set up dedicated to implementation.

In order to successfully transition from the current systems to the new systems, it has been identified that a number of technical posts are required:

- Application Architects – Implement systems integration across applications /interoperability
- Infrastructure – to support design and implementation of DHCW infrastructure configurations required to deliver the solution (e.g., connectivity between NHS Wales networks and Contractor hosting locations, configuring of security systems such as firewalls, and national NHS-side monitoring systems). Also to provide NHS-side infrastructure-specific subject matter expertise and leadership to support implementation of the RISP solution, both within the national programme and to local implementation projects
- Software engineers – supporting Integration Services (Development, testing and deployment of messaging software and flows. Ongoing maintenance and updates). Integration Services (assisting with Testing of new flows and the comparison with existing functionality. Deployment of flows to environments, Service Management, connection and validation testing process for go live. Live support and reporting.)
- RADIS transition
    - Pre population of PACS/ RIS:
        - Analysis of requirements for data extraction and new feed
        - Document deliverables for data extraction and feed
        - Data extract build, test and execution
        - New feed build, test, implementation and support

- Data migration for cutover
  - Analysis of requirements for data migration
  - Document deliverables for data migration
  - Data migration build, test, execution
- National Radiology Data
  - Analysis of requirements
  - Document deliverables
  - Build, test and implement the solution

- Testing – although some testing will be undertaken at a health board level, at a national level, User Acceptance Testing will need to be conducted before implementation

Service Management

Current PACS and WRIS Service Management Boards (SMB) will continue until all of the HB's have implemented the preferred system. A New Service Management Board superseding PACS & WRIS SMB will be set up upon initial implementations as seen in diagrams 8 and 9 below:

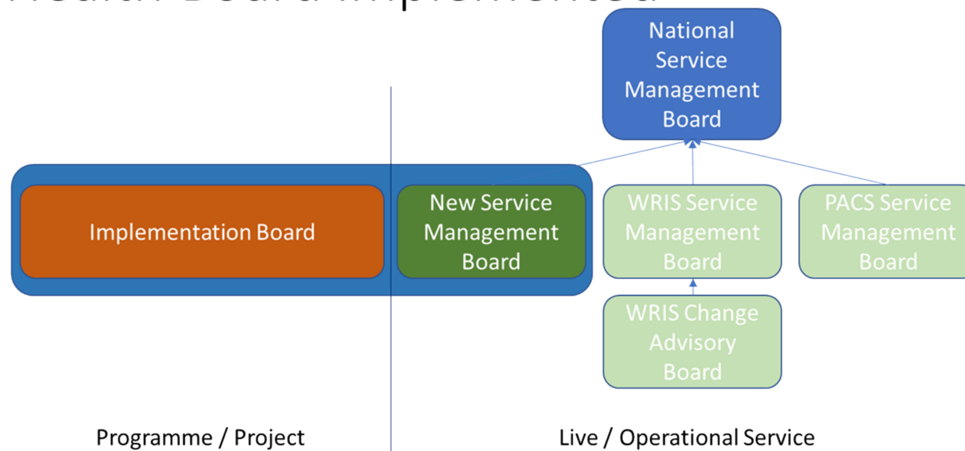


Diagram 7 -Transition SMB

Once all health boards are live, the new structure will be as follows:

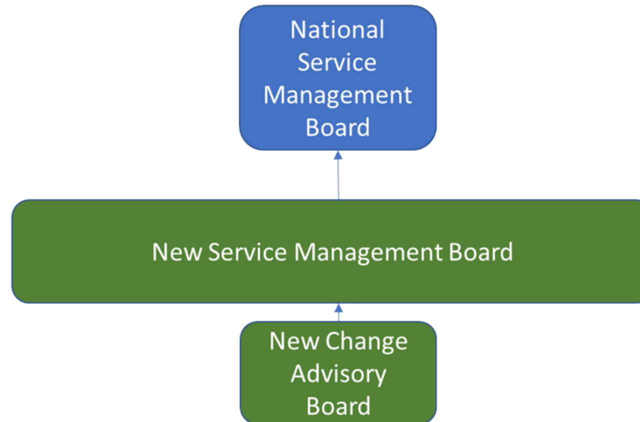


Diagram 8 – New SMB when all Organisations are live

Concerning Change Requests, CCNs with only a local impact are to be formally logged to the Supplier & copied to the central change log. CCNs with wider reaching impact will be taken to SMB for approval before being submitted officially to the Supplier and copied to the central change log. The Supplier will determine the local/national impact of each CCN.

Local Implementation

Underpinning the National SMB will be local implementation groups set up in each health board, 12 months before implementation.

These local groups will be supported by the Programmes PMO, but will also receive dedicated funding through the Programme for new or existing posts:

- 1 x FTE dedicated band 7 project manager for 12 months
- 1 x FTE IT support (band 6) for 3-6 months
- 1 x FTE PACS/RIS support (band 7) for 3-6 months

Individual health boards will be responsible for recruiting and employing/back filling these roles.

Under the current PACS agreement with Fuji, there are some computerised and digital Radiology hardware components that are not within the scope of the RISP Programme. This equipment will be replaced under a separate Programme of work.

5.3 Projects and Workstreams

In the OBC, the Programme identified several key projects as set out below:

- **Commercial:** to develop and deliver the commercial case, manage the pre-procurement documentation and the procurement of the new service and the Contractor.
- **Technical and Functional**: to define and deliver the output-based specification for the design and delivery of a seamless end-to-end solution from electronic requesting to results acknowledgement; develop the new solution at a national level, migrate the data and develop the local ICT model required to be in place to deploy the new solution.
- **Clinical**: to engage the Radiology and wider NHS service in defining the requirements, take forward standardisation to eliminate all unwarranted variation in service, design the standard solution, and deploy the developed solution.
- **Information and Business Intelligence**: to deliver the Business Intelligence (BI) requirements for the new Radiology Informatics System and to baseline the status of business processes within Radiology to include receipt of the radiology request, vetting, appointments (scheduling), reception and room procedures, reports and validation, MDT and peer review.
- **Business Change:** to define and realise the benefits of the new Radiology Informatics System, whilst also determining a set of harmonised codes, interface specifications, working practices and performance indicators to deliver the outcome of seamless care across organisational boundaries and support development of new and innovative service models built on a sound basis of service related metrics.

Underpinning all these workstreams is the Programme Governance workstream ensuring the RISP Programme is professionally managed and assured.

Now that the procurement process has been completed, a proposed new project structure has been developed, with a particular focus on implementation:

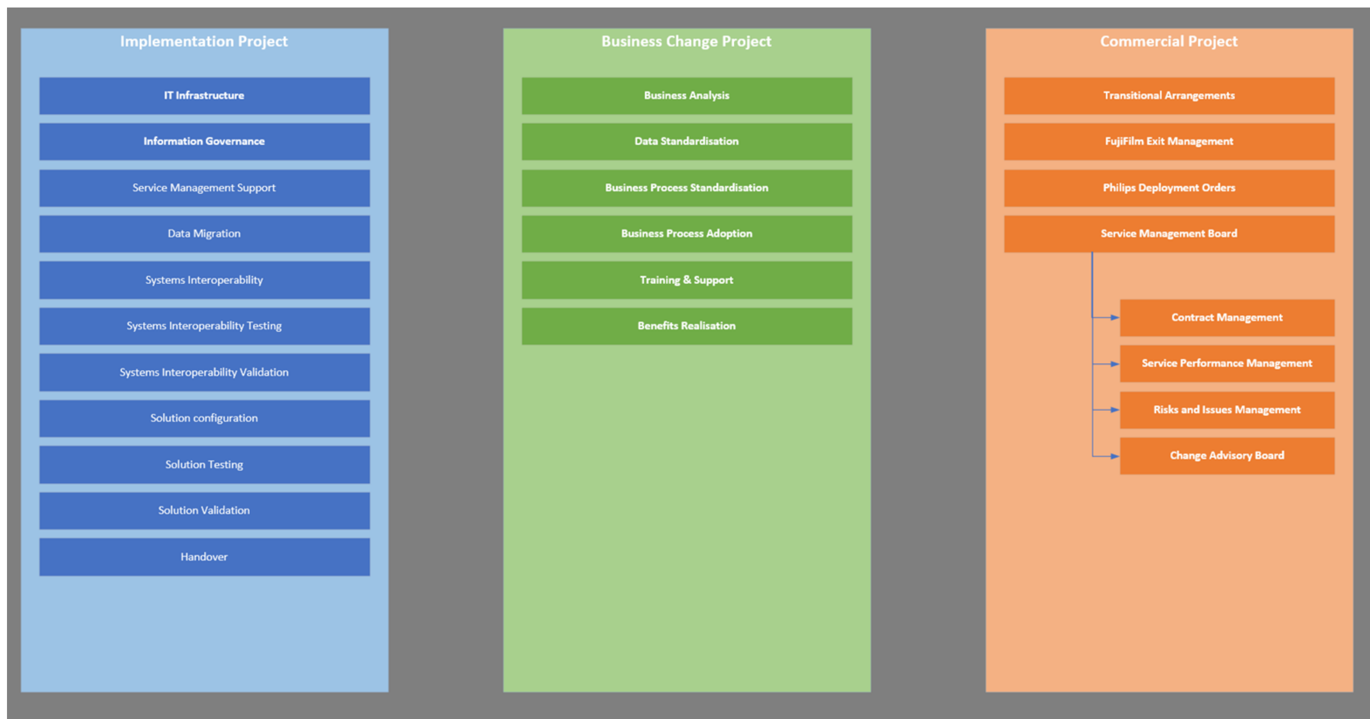


Diagram 9 – Proposed RSIP Project Structure

Implementation Project

This takes the technical aspect of the Programme's implementation and will ensure a smooth transition from existing to new systems and suppliers. This complex project involves several systems that need to be integrated.

Implementation timescales are challenging, and once the contract is awarded, it can be revisited with the successful Supplier.

Sitting underneath the National Service Management Board

Business Change

Building on the existing business change project, this project will measure and report on programme benefits and ensure standardisation for PACS and RIS systems across Wales. This will involve interoperability, adopting core datasets, developing shared working practices,

vetting and reporting, e-requesting, results viewing, and enterprise viewing. The Programme will not mandate that health boards adopt universal standards but instead recommends that these are adopted to maximise the full benefits of the Programme. This project will also support health boards regarding change management processes and work closely with the implementation project to ensure business processes are standardised.

Commercial Project

This new project will focus on contract management, supplier relationship and service management. This project will work closely with the Service Management Board (SMB – Diagrams 3&4) to oversee any contract changes.

The Programme Board will approve which projects are needed, and the Programme Management team will ensure the appropriate project governance and management arrangements are in place following established best practice.

The Programme Lead and Programme Director will be responsible for appointing the Project Managers, with the approval of the Board. They will support the Project Managers in establishing their project teams. The Programme Board will ensure there is appropriate representation from RISP specialist teams across all the projects, depending on the requirements of each project. The RISP resources and project structures will be regularly reviewed throughout the Programme.

5.4 Technical and Assurance

Medical Devices

Some parts of the RISP solution e.g. the PACS software and diagnostic workstation displays, fall under the remit of the Medical Devices Regulations 2002 (SI 2002 618, as amended. The Contractor is required to comply with relevant Medical Devices Regulations for any such devices. Before contract award the Contractor is specifically required to provide evidence demonstrating that software components are UKCA or CE marked, provide evidence of conformity against ISO 14971:2019 (Medical Device Risk Management) and ISO 13485:2016 (Medical Devices – Quality Management Systems); and to ensure appropriate management

of clinical safety issues through provision of post marketing surveillance, field safety notices and documented clinical safety management processes.

The Programme will work with the Wales Informatics Assurance Group and other national and Health Board teams to ensure compliance with requirements in all areas relating to equality, safety, technical architecture, infrastructure, service management, systems integrations, information governance, information standards, cyber security standards and Welsh language.

Systems and Integration

Diagram 11 below shows how the RISP solution interfaces with the various technical systems to support the clinical workflow.

Clinical Review

- Patient reviewed by clinician
- Clinician reviews result history in WCP (WCP “pulls” test and results from WRRS)
- Clinician makes new radiology request (e-request launched from WCP, and pulls reference data from RIS then posts new request to WRRS)

Exam Attendance

- WRRS posts request into RIS- if patient demographics don’t match a known RIS patient then RIS can “query” EMPI for demographics or post new patient identifier to EMPI
- When patient attends for exam- RIS posts study details to modality and to PACS
- When exam complete, modality sends images to PACS and PACS forwards them to PDMS.
- PDMS may post “summary data” back to RIS

Radiology Reporting

- Images reviewed in PACS
- PACS launches nuance VR
- PACS viewer may launch WCP to view external data- e.g. pathology results

- Radiology report created in PACS and posted to RIS
- RIS posts result to WRRS

Result Review

1. WRRS updates "My results" list in WCP
2. Clinician review result- WCP pulls data from WRRS
3. Clinician may review images by launching PACS viewer from within WCP
4. Clinician acknowledges radiology report in WCP
5. WCP acknowledgment posted back to RIS

The complexity and integration of the various systems is detailed in Diagrams 11 and 12.

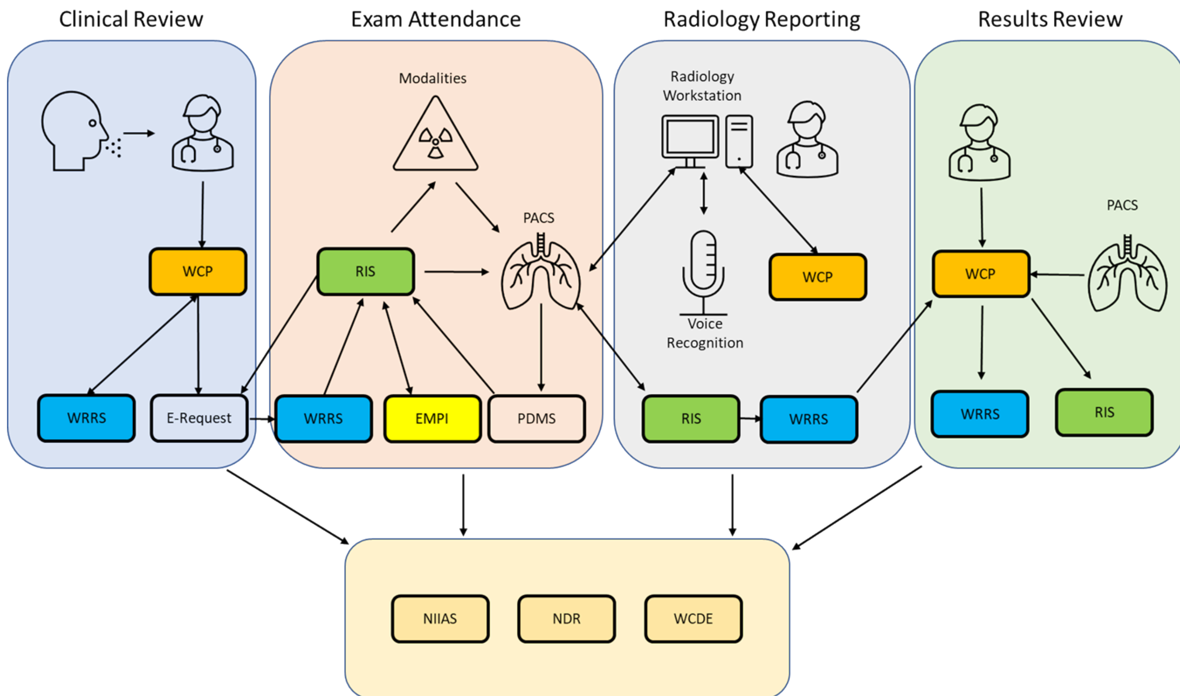


Diagram 10 – RISP solution Interfaces

Diagram 12 below shows a further detailed systems map of the RISP Programme. Some details may be subject to change following technical discussions with the supplier

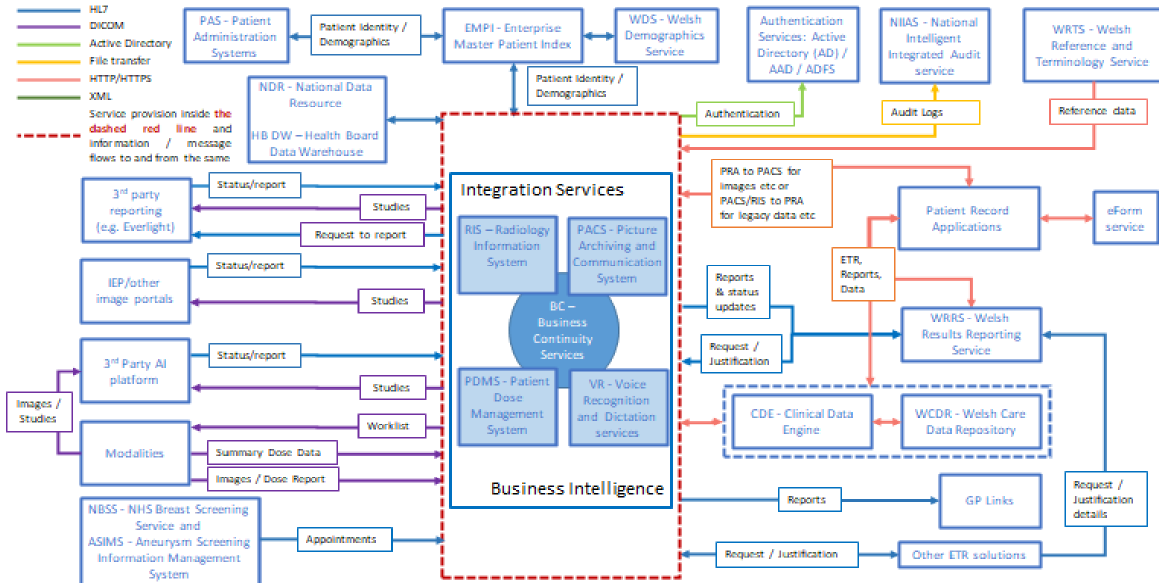


Diagram 11 – RISP Integrations

5.5 Benefits Realisation

A vital responsibility of the Programme Management Office and Programme Board has been establishing a Benefits Management Strategy and framework for monitoring and managing the benefits the Programme will enable. This includes a benefits register and profiles identifying how each benefit will be assessed and who will be responsible for delivering each benefit.

A Benefits Project is established and will run throughout the life of the Programme. As part of the FBC, benefits have been identified, measures set, and a plan agreed to collect baseline data and agree targets and monitoring methods. The Benefits Register and Strategy are attached at Appendix M3 and Appendix M2.

5.6 Outline Arrangements for Risk Management

The strategy, framework, and plan for dealing with the management of risk are as follows:

- Risks can be raised by anyone on the programme and added to the risk register through the PMO.
- The risk register has been designed in accordance with good practice guidelines within PRINCE2 and DHCW standards.
- The risks are reviewed at least once a month by the PMO and Programme Board members at the Working Group and Programme Board.
- The Programme Lead will escalate any risks that the PMO cannot manage and require urgent action to the Programme Director. If needed, they will escalate to the SRO and jointly decide on the appropriate action.
- In liaison with the SRO, the Programme Director will escalate any risks that cannot be dealt with at the level of the Programme Board to DHCW Executive Board for corporate decision.
- The Programme RAID log, containing the Risk Register is attached at Appendix M4.

The high-level Programme risks are identified below:

Table 29:Programme high-level risks

High level risk	Mitigation
If funding is not identifed to upgrade the current firewall and PSBA infrastructure within each health board to the minimum contractor requirements, Then health boards may be unable to implement the new system, Resulting in delays to programme benefits and wider implementation	Some health boards have already begun to upgrade their infrastructure. Reconsider minimum requirements from Philips vs future proofing i.e. 1GB PSBA instead of 10GB.
If an extension to the termination assistance clause is not signed by the existing supplier, Then there will be even less time for implementation, Resulting in increased pressure on all health boards to implement within shorter timescales	Engage with Fuji in order to negotiate termination assistance clause.
If there are any delays in the sign off procedures within health boards, Then the contract start date will be delayed, Resulting in a delay in implementing the new contract	Ensure HB's are aware of timescales through national implementation meetings. Support HB's to set up local implementation meetings.
If there is no contingency plan to replace the existing Computerised/Digital Radiology equipment that belongs to the existing supplier the when new contract begins, Then some health boards may be without CR/DR equipment, Resulting in them not being able to undertake imaging, and potentially putting patients at risk (noting this has a greater impact on rural areas)	Continue to work with the National Imaging Board and HB's in order to develop replacement equipment and/or reconfiguration of service delivery models
If both LINC and RISP implementation timescales continue as planned, Then there may not be sufficient technical and project resources available to support both programmes, Resulting in delayed implementation	Continue to work closely with the LINC programme to ensure sufficient time in between implementation dates for each health board
If the Philips solution does not maintain the patient identity across multiple instances, Then patients may be incorrectly identified, Resulting in compliance failure, patient safety issues and the solution not going live	Proceed with FBC development and approval processes whilst clarification is sought from Philips.

Contingency Plans

If this programme fails, the current commercial arrangements will no longer be able to be relied upon, as the termination assistance period will have been exhausted. The programme

will seek urgent legal advice to ensure service continuity is provided within the legal framework and the appropriate replacement contracts are put in place.

The risk is the current provider will no longer wish to support NHS Wales without significant investment, as some elements of the service may no longer be in production and/or supported.

5.7 Outline Arrangements for Post Project Evaluation

Post Implementation Review (PIR)

Initial lessons learned and evaluation reviews will be conducted for each health board implementation. These reviews ascertain whether the anticipated benefits have been delivered and are scheduled between March and September 2025.

Project Evaluation Reviews (PERs)

PERs appraise how well the project was managed and delivered compared with expectations and are timed to take place between March and September 2025.

Gateway Review Arrangements

Gateway reviews are planned for the end of each tranche of the Programme, which began with the Gateway 2 review in June 2021 to ensure the delivery strategy and Gateway 3 in February 2023.

Contingency Plans

If this Programme fails, the ongoing commercial arrangements will no longer be able to be relied upon, as the termination assistance period will have been exhausted. The Programme will seek urgent legal advice to ensure service continuity is provided within the legal framework and the appropriate replacement contracts are implemented.

The risk is that the current provider will no longer wish to support NHS Wales without significant investment, as some service elements may no longer be in production and supported.

Appendix

Appendix S1: Business Strategies & Reports

S2.1 A Healthier Wales- our plan for health and social care:

S2.1
a-healthier-wales-acti

S2.2 Imaging statement of intent:

S2.2
imaging-statement-of

S2.3 Wales Audit Office Report: Radiology Services in Wales (2018):

S2.3 Auditor General
for Wales Report - Ra

S2.4 Digital Architecture Review (2019):

S2.4 Digital
Architecture Review R

S2.5 Academy of Medical Colleges: Alerts and notification of imaging reports Recommendations (2022):

4.
Alerts_notification_i

S2.6 Safer Practice Notice- NPSA 16:

npsa-16.pdf

Appendix E1: Economic Model (Redacted)

Appendix F1: Financial Model (Redacted)

Appendix M1: Programme Board Terms of Reference (Back)

RISP Programme Board ToRs Tranche 2

Appendix M2: Benefits Management Strategy (Back)

M3 RISP Benefits Management Strategy

Appendix M3: Benefits Register (Back)

Appendix M3- Benefits Register.xls

Appendix M4: RAID (Risks, Actions, Issues and Decisions) (Back)

Appendix M4- RAID log.xlsx

Appendix C1: Draft Implementation Plan (Back)

This implementation plan is provided for indicative purposes only, the plan will be refined and further developed for approval following award to the successful Contractor.

National Implementation

Betsi Cadwaladr University Health Board

Aneurin Bevan University Health Board

National Imaging Academy Wales (NIAW)

Hywel Dda University Health Board

Cwm Taf Morgannwg University Health Board

Velindre University NHS Trust

Public Health Wales

Swansea Bay University Health Board

Cardiff and Vale University Health Board

Powys Teaching Health Board 1st Deploy (BC)

Powys Teaching Health Board 2nd Deploy (AB)

Powys Teaching Health Board 3rd Deploy (HD)

Powys Teaching Health Board 4th Deploy (SB)

month count

Configuration and Integration

Local Implementation

"Go Live"

"Stable Operations"

Extension Option

Last month of "Old" PACS Termination Assistance

NB Organisation names added only to gain visibilty of current contract end dates. The Implementation order may change

NB Powys implementation reflects their dependancy on the supporting 4 x HB's BCUHB, ABUHB, HDUHB and SBUHB

Appendix C2: Procurement Route Evaluation (Back)

The Public Contracts Regulations 2015:

https://www.legislation.gov.uk/uksi/2015/102/contents/made

https://www.legislation.gov.uk/uksi/2015/102/regulation/29/made

https://www.legislation.gov.uk/uksi/2015/102/regulation/30/made

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

AUDIT COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Martin Veale, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 25 April 2023.

Key highlights from the meeting are reported in Section 2.

The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Audit Committee held on the 25 April 2023:

ALERT / ESCALATE	**2022/23 INTERNAL AUDIT PROGRESS UPDATE** The AUDIT Committee were informed that there has been good engagement by management during planning and fieldwork but that improvements are needed around

	the management responses to draft reports and that the 15 working day deadline is regularly being missed. KPI 4 (Management Response) is RAG rated red, reported at 47%. This has deteriorated from the January 2023 reported position (50%).
ADVISE	**AUDIT ACTION TRACKER** The AUDIT Committee expressed concern at the lack of update provided for some outstanding audit recommendations. It agreed that some older recommendations should be reviewed to check if they were still relevant. **AUDIT WALES AUDIT PLAN 2022/23** The AUDIT Committee noted the delayed date for the audit of account – the date for certification is now set for 31 July 2023. Draft accounts are due 05 May 2023 and then will work toward the Audit. The Draft Annual Governance Statement due 12 May 2023. Audit Wales were unable to bring an actual audit plan and brought an outline plan with a promise to provide the Audit Plan at the July 2023 Audit Committee meeting and will circulate to management and committee members prior to then. The AUDIT Committee were advised that a new Engagement Director, Richard Harries has replaced Clare James. **ANNUAL AUDIT REPORT 2021/22** The Audit Wales report explained that the annual accounts for 2021/22 gave an unqualified opinion, with no significant control weaknesses identified. Audit Wales did however qualify the regularity opinion on the Trust, and was noted to the Committee that this was a Wales-wide NHS Audit issue and outside the control of the Trust, resulting from a ministerial direction regarding the accounting treatment of clinician's tax liabilities. The committee expressed disappointment that the report did not point out that this was in line with all NHS Wales health boards. **INTERNAL AUDIT PLAN 2023/24** The AUDIT Committee **APPROVED** the 2023/2024 Internal Audit Plan and the Internal Audit Charter and as a requirement to the standards **NOTED** section 5 of the plan around resources, informing the Committee resources are available to undertake the plan that's being agreed. **AMENDMENT TO STANNDING ORDERS – SCHEDULE 3** The AUDIT Committee **ENDORSED** the report for Board approval.
ASSURE	**TRUST RISK REGISTER** The AUDIT Committee received an oral update on the ongoing work to the Trust Risk Register template. **TRUST ASSURANCE FRAMEWORK** The AUDIT Committee received an oral update on the ongoing work to the Trust Assurance Framework template. The AUDIT Committee were assured, that in terms of the content, the risks are being reviewed with input across the Leadership Teams from the divisions, as well as

	Executive Management Board. The Audit Committee were advised a shaping discussion would be taking place in the Strategic Development Committee to get input into the overall view of strategic risk. The relevant risks will be reviewed to each Committee and then be brought back to Trust Board. This will be taken to Audit Committee as a substantial paper in July 2023.
INFORM	**INTERNAL AUDIT REPORTS** The Committee received the following internal audit reports: • Clinical Audit Report – Reasonable Assurance • Clinical Audit All-Wales Analysis Audit Report – Reasonable Assurance • Information Governance Final Internal Audit Report – Reasonable Assurance • Capital Systems Audit Report – Reasonable Assurance **OTHER BUSINESS:** The Committee also received written reports under the following agenda items: • Procurement Protocol - Notification of the Risk of Legal Challenge to the Award of All Wales Contracts Pursuant to the Public Contract Regulations 2015 (PCR 2015) • Structured Assessment – External Audit Report • Counter Fraud Progress Report Quarter 4 22/23 • Counter Fraud Annual Report 22/23 • Counter Fraud Annual Plan 23/24 • Private Patient Service Review • Private Patient Service Debt Position • Losses and Special Payments Report • Procurement Compliance Report • Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria
APPENDICES	**NONE**

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	**CONSIDER** and **ENDORSE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board Members – Via Email	31/03/2023 and 03/04/2023	Approved

ACRONYMS	
nVCC	New Velindre Cancer Centre
RIBA	The Royal Institute of British Architects
SO	Standing Orders
SFI	Standing Financial Instructions

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 Director of Corporate

Governance & Chief of Staff, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Director of Corporate Governance & Chief of Staff 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 This report details Chair's Urgent Action taken between the **30/03/2023 – 16/05/2023.**

2. ASSESEMENT / 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	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.
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 between the **30/03/2023 – 16/05/2023** as outlined in ***Appendix 1 of this report***.

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

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. nVCC and Enabling Works Contractual Matters

The Trust Board were sent an email and Chair's Urgent Action Report on the **31/03/2023** regarding the nVCC and Enabling Works Projects and a range of contractual matters that required new approvals relating to:

- **MDA Consult Ltd** – commissioned to provide engineering advisory support for the Enabling Works and nVCC Project(s).
  - **APPROVE** a commitment to spend of **£213,600**

- **Architectural Consultancy Advice** – architectural advisory support for the nVCC Project.
  - **APPROVE** a commitment to spend of **£100,000**

- **Phil Roberts** – commissioned to provide design advisory support for the nVCC Project.
  - **APPROVE** a commitment to spend of **£40,000**

- **Mott MacDonald** – commissioned to provide technical advisory support for the nVCC Project.
  - **APPROVE** a commitment to spend of **£70,000**

Trust Board Independent Member, Hilary Jones did not feel able to approve the sums as requested, however advised was content to approve the work based on the breakdown provided irrespective of timescales and not add a contingency for the work we do not know is required e.g.

MDA Consult Ltd

- RIBA Stage 3 design development completion & review - £20,000
- Commentary and review for Financial Close –- £10,000
- RIBA Stage 4 design development completion & review –- £40,000
- Statutory approvals – planning & licences £20,000
- EW Project Technical Director – April to September - £52,000

Total comes to £142,000 – however approval is requested for £213,600

A point of clarity was also requested in relation to the VAT position and it was confirmed by Mark Ash, Assistant Project Director that the sums requested for approval were exclusive of VAT as VAT is recoverable on fees.

Due to the query raised, the Trust Board were subsequently sent an email and revised Chair's Urgent Action Report on the **03/04/2023** regarding the nVCC and Enabling Works

Projects and a range of contractual matters that required revised sums for approvals relating to:

- **MDA Consult Ltd** – commissioned to provide engineering advisory support for the Enabling Works and nVCC Project(s).
    - **APPROVE** a commitment to spend of **£142,400**

- Architectural advisory support for the nVCC Project.
    - **APPROVE** a commitment to spend of **£68,600**

- **Phil Roberts** – commissioned to provide design advisory support for the nVCC Project.
    - **APPROVE** a commitment to spend of **£40,000**

- **Mott MacDonald** – commissioned to provide technical advisory support for the nVCC Project.
    - **APPROVE** a commitment to spend of **£70,000**

Trust Board Independent Member, Professor Andrew Westwell pointed out a discrepancy in the revised report issued and the sums requested for approval for the Architectural advisory support. In points 2.11, 2.13 of the revised report issued and the second bullet point of the report's recommendations stated the sum requested for approval was **£68,600** however, the itemisation in point 2.12 totalled **£68,000**.

Carl James, Acting Chief Executive Officer confirmed the correct sum was the lesser amount of **£68,000.**

Recommendation subsequently Approved by:

- Stephen Harries, Acting Chair
- Carl James, Acting Chief Executive Officer
- Gareth Jones, Independent Member
- Andrew Westwell, Independent Member

To Note:
Trust Board Independent Member, Hilary Jones still did not feel able to approve the sums as requested, however was content to approve the work based on the breakdown provided irrespective of timescales e.g.

MDA Consult Ltd

- RIBA Stage 3 design development completion & review - £20,000
- Commentary and review for Financial Close - £10,000
- RIBA Stage 4 design development completion & review - £40,000
- Statutory approvals – planning & licences £20,000
- EW Project Technical Director – April to September - £52,000

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 25 May 2023 to 27 July 2023

DATE OF MEETING	25 May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, ***(Appendix 1,3,4 & 5)*** Chief Operating Officer Carl James, (***Appendix 2***) Executive Director of Strategic Transformation, Planning & Digital Matthew Bunce, (***Appendix 1-6***) Executive Director of Finance

REPORT PURPOSE	**APPROVAL**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS Capital Planning Group ***(Appendix 1)***	05/04/2023	Endorsed
WBS Senior Management Team ***(Appendix 1)***	12/04/2023	Endorsed

Executive Management Board ***(Appendix 2)***	06/09/2021	Endorsed (***ref. Appendix 2a – section 1***)
Quality, Safety & Performance Committee ***(Appendix 2)***	16/09/2021	Endorsed (***ref. Appendix 2a – section 1***)
Trust Board ***(Appendix 2)***	30/09/2021	Approved with conditions (***ref. Appendix 2a – section 1***)
Ventilation Group ***(Appendix 2)***	06/09/2022	Endorsed (***ref. Appendix 2a – section 1***)
Executive Management Board ***(Appendix 2)***	01/09/2022	Endorsed (***ref. Appendix 2a – section 1***)
Quality, Safety & Performance Committee ***(Appendix 2)***	15/09/2022	Endorsed (***ref. Appendix 2a – section 1***)
Trust Board ***(Appendix 2)***	29/09/2022	Approved (***ref. Appendix 2a – section 1***)
Executive Management Board ***(Appendix 1-4)***	02/05/2023	Endorsed
Executive Management Board ***(Appendix 5)***	15/05/2023	Endorsed

ACRONYMS	
AHU	Air Handling Units
BJC	Business Justification Case
CBA	Cost Benefit Analysis
DHCW	Digital Health and Care Wales
FF	First Floor
HTM	Health Technical Memoranda
IP&C	Infection Prevention and Control
IRS	Integrated Radiotherapy Solution
M&E	Mechanical Engineer
NWSSP	NHS Wales Shared Services Partnership
nVCC	New Velindre Cancer Centre
PMO	Project Management Office
SACT	Systemic Anti-Cancer Therapy
SFIs	Standing Financial Instructions
STA	Single Tender Action
VEAT	Voluntary Ex-Ante Notices (VEATs)
VUNHST	Velindre University NHS Trust
WNWPS	Wales National Workforce & Reporting System

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust (VUNHST) has a Scheme of Delegation, as set out in its Standing Orders, together with its Standing Financial Instructions (SFIs), which ensures that there are effective governance arrangements in place for the delegation of financial authority.

1.2 Financial limits apply to the commitment of expenditure. If expenditure is greater than an individual's financial limit, and is more than the limit delegated to the VUNHST Chief Executive, the planned expenditure will require VUNHST Board approval. For extensions

of existing contracts in place, this only applies if the provision for extension was not included in the original approval granted by the Trust Board.

1.3 The decisions expected during the period **25 May 2023 to 27 July 2023** are highlighted in this report.

1.4 In line with the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are received by the Executive Management Board to ensure Executive oversight and scrutiny, to provide the Board with supporting recommendations and additional assurance.

2. ASSESEMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendices 1 - 6** for the detailed appraisals undertaken of the expenditure proposals that the Trust Board is asked to **APPROVE**. The table below provides a summary of the decisions sought from the May 2023 meeting of the VUNHST Board:

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (Inc. VAT)
Appendix 1	Welsh Blood Service	Beckman Coulter Consumables and Services	Start: 01/07/2023 End: 31/06/2029 Option to extend: Plus one, plus one, plus one.	£3,422,051.43 (whole life cost)
Appendix 2a & 2b	Corporate Estates, Environment and Capital	First Floor (FF) Ward Enhanced Ventilation Solution	Start: 14/05/2023 End: 21/09/2023 Option to extend: Possibility to extend once the Trust is sighted on the tender returns, lead order times of equipment etc. Any extension would be minimal.	£320,000
Appendix 3	Velindre Cancer Service, Radiation Services	CT SIM – Radiotherapy Satellite Centre	Start: 01/05/2025 End: 01/01/2035 Option to extend: N/A	£1,440,000
Appendix 4	Velindre Cancer Service, Radiation Services	Replacement of 2nd linac at VCC and associated bunker refurbishment works	Start: 08/11/2022 End: 07/11/2035 Option to extend: N/A	£3,805,506.00
Appendix 5	WBS Project Management Office	Project Management Office Software tool	Start: 01/07/2023 End: 30/06/2025 (30/06/2026 if the 12-	£195,000

	Software Tool		month extension option is exercised) Option to extend: 24 months with option to extend a further 12 months	
Appendix 6	NWSSP	Primary Care workforce intelligence reporting system	Start: 10/7/2023 End: 09/7/2026 Option to extend for an additional 2 years	£3,932,697

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	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	Yes (Include further detail below)
	Further details are provided in Appendix 1-6 of this report.

4. RECOMMENDATION

4.1 The Board is requested to **AUTHORISE** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices **and AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	BECKMAN COULTER CONSUMABLES AND SERVICES
DIVISION / HOST ORGANISATION	Welsh Blood Service
DATE PREPARED	Monday, March 6, 2023
PREPARED BY	Michelle Evans
SCHEME SPONSOR	Peter Richardson

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Welsh Blood Service (WBS) manufactures blood components for transfusion to patients across Wales. To reduce the risks to some patient's white blood cells are removed during the manufacturing process by filtration. Blood components are subsequently tested to verify the filtration process is effective. This testing forms part of the quality control checks using Flowcytometry technology and a certified test system that is supplied by Beckman Coulter.

In addition to this WBS operates patient services including, Patient Services and Immunohaematology operating flowcytometry technology test kits and reagents that are supplied by Beckman Coulter.

To ensure continuity of service to patients in Wales, a procurement action has been set up to procure a contract to purchase test kits and reagents to support this business-critical testing. Designed to take full advantage to control costs of testing kits and delivery, whilst minimising risks associated with supply chains and administrative overheads.

This paper seeks approval to create a contract, establishing the Board authority to enter the contract with the supplier identifying and managing operational risks.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal	☐

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

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/07/2023
Expected End Date of Contract	31/06/2029
Contract Extension Options **(E.g. maximum term in months)**	Plus one, plus one, plus one.

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☒
If not, please explain the reason for this in the space provided. This is business as usual that is covered under revenue expenditure.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED Please mark with a (x) in the box the relevant principles for this scheme. Click here for more information									
Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
1. Do nothing – continue to purchase using 12-month blanket agreement. This option has become unsustainable because it does not incorporate any terms for forecasting capacity to improve supply. Combined with unnecessary administration to renew that can be avoided. 2. Establish a purchasing agreement that takes full advantage of long-term control of costs and terms that include forecasting capacity to improve supply together with the reduced administrative burden to the business.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Establishing a contract imposes NHS procurement terms and conditions on this business-critical supply including the benefits of: • Managed costs over time • Removes the need to complete STA • Collaborate on forecasting capacity to improve supply • Supports the continued development of supply chain sustainability improvements

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
R1 – inconsistency of supply	R1 – establish a method of regular touchpoints with customer manager
R2 – lack of availability of testing kits	R2 – retain high stock levels on site accepting the space this ustilises in temperature-controlled environments
R3 – High value requisition on the P2P system imposes approval checks on directors of business when this can be avoided	R3 – consider an alternative approach to ordering that avoids high value requisitions if possible

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.

Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy
This procurement is to award a compliant contract that covers the whole life needs of the Flow cytometry devices which were procured against an NHSBT contract, specifically this contract will cover test kits, reagents and any additional maintenance requirement. There is an NHS Supply Chain (NHSSC) National Framework Agreement in place covering Point of Care Testing against which we could award a Direct Call Off contract to Beckman Coulter UK Ltd. The pricing obtained will be benchmarked against current NHS Wales pricing to determine best value for money. In the event that NHS Wales pricing is preferential to the national framework agreement a VEAT notice will be published awarding this contract. It is not feasible to undertake a competitive tender exercise as the majority of the products required are OEM from Beckman Coulter UK Ltd to use on their devices.
6.3 What is the approximate timeline for procurement?
3 months from approval of this paper.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Joanne Liddle, Assistant Head of National Sourcing
Signature:	[signature]
Date:	23/03/2023

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)**	**Including VAT (£k)**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

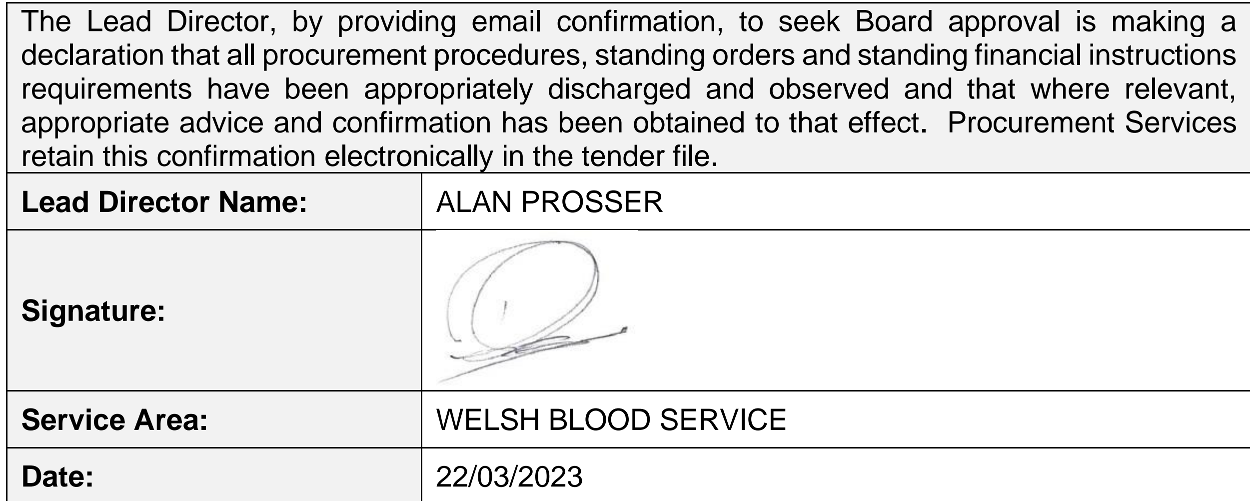
	2022-23	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	2029-30	2030-31
	projected full year effect	Projected	Projected	Projected	Projected	Projected	Projected	Projected	Projected
Total spend Business as usual	£201,804.29	£221,984.72	£250,842.73	£283,452.29	£320,301.09	£361,940.23	£408,992.46	£462,161.47	£522,242.47
Total spend Project 10%	£20,180.43	£22,198.47	£25,084.27	£28,345.23	£32,030.11	£36,194.02	£40,899.25	£46,216.15	£52,224.25
calculated increase in costs @3%PA		£6,659.54	£7,525.28	£8,503.57	£9,609.03	£10,858.21	£12,269.77	£13,864.84	£15,667.27
Total annual spend	£221,984.72	£250,842.73	£283,452.29	£320,301.09	£361,940.23	£408,992.46	£462,161.47	£522,242.47	£590,133.99
Whole life cost									£3,422,051.43

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	At the point of award, a change will be recorded and iHUB (Innovation hub) resource will be assigned to support the project through implementation. Following implementation, the operational team will monitor performance using the contact performance indicators and governance

	arrangements to WBS Senior Management Team (SMT).

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE



The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	ALAN PROSSER
Signature:	
Service Area:	WELSH BLOOD SERVICE
Date:	22/03/2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
CPPG	05/04/2023
Divisional Senior Management Team	12/04/2023
Executive Management Board	02/05/2023
Trust Board	

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	
HTW – Senior Management Team	

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

APPENDIX 2A: – OPTION APPRAISAL COMMITMENT OF EXPENDITURE SUPPORTING DETAIL

CAPITAL SCHEME FOR VENTILATION AT VELINDRE CANCER CENTRE CBA

1. SITUATION / BACKGROUND

1.1 A Business Justification Case (BJC) was presented to the Velindre University NHS Trust Board in September 2021. The BJC requested approval to submit a Business Justification Case to the Welsh Government for £2.2m of capital investment to support the implementation of compliant mechanical ventilation systems within the inpatient and outpatient areas at the Velindre Cancer Centre.

The Executive Management Board received a paper on 1st September 2022 which revisited the position given the time between the Board decision in principle and the current position. The Executive Management Board considered the following information:

Still no likely start date for the implementation of the Ventilation Scheme at VCC due to:

- the continuing impact of COVID on service delivery i.e. backlog and increased waiting times.
- the increasing demand for services. The SACT demand also impacts the potential decant options during the period of construction i.e. proposed decant areas will be required for the delivery of SACT treatments.
- Continued uncertainty surrounding future waves of COVID as we move out of the summer months into the winter season. This is likely to be see an increase in Covid prevalence together with seasonal flu.
- The proposed project programme for the delivery of the permanent ventilation scheme is 48 weeks. This will cause major disruption to the delivery of services at VCC during this period.
- The effectiveness of the interim ventilation solution which has improved patient and staff comfort through the provision of filtered temperature controlled air into the space.
- The continued progress of the nVCC with an expected opening date of 2025.

1.2 Given this position, the Executive Management Board concluded that the scheme would not proceed as there is still no likely start date given the continuing prevalence of Covid and the priority to treat patients as quickly as possible; the stable nature of the interim solution; the likely significant impact of the scheme compared the reduced likely benefits given the move to the nVCC in 2025 i.e. the completion of the planned ventilation scheme is not likely to be completed until 2024 given approvals, procurement and delivery of the scheme).

1.3 The Executive Management Board are committed to enhancing the current interim ventilation solution at VCC, ensuring that is meets required IPC standards by seeking to purchase the equipment permanently (currently leased) through any capital slippage in 2022/2023 or allocation of Trust discretionary capital in 2023/2024. A cost/benefit analysis will be undertaken to inform the optimum option

1.4 Discussion at the Quality, Safety and Performance Committee

The Committee discussed the proposal at its meeting on the 15th September 2022 and were assured on the key matters set out relating to the recommendation:

- the inability to reduce the capacity on the impatient ward for a prolonged period of time given the need to treat patients as quickly as possible in light of the delays caused/still being managed by the Covid-19 pandemic.
- the effectiveness of the existing solution in reducing air temperature and supporting improved ventilation.
- the data and information over the period which indicates that the current arrangements are robust in supporting effective infection prevention and control.
- the confidence that the new Velindre Cancer Centre project will go ahead.

1.5 The Committee also inquired about the cost benefit analysis of a revenue versus capital based solution regarding the current solution which will be deployed permanently if the decision not to progress the major capital scheme is support. This appraisal will be undertaken to inform the way forward.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Development of Interim Ventilation Solution has been pursued, in support of defining initial inputs and indicative costs for a cost benefit analysis for the proposed solutions listed below.

Progression has centered on the previously deployed interim solution with consideration given to a number of potential options including:-

1. Hire of equipment previously used.

2. Purchase of previously used hire equipment.

3. Enhanced design on the previously used solution.

Sell back or repurpose of equipment following closure of the existing site is also a primary consideration to inform decisions.

Table 1 below outlined the key consideration for the various option compared over a four year period. Maintenance and utility costs have not been included and they will apply to all options, with negligible difference.

Table 1 - Benefits Analysis of options

Propose Solution	Cost over 3 Years	Benefit	Dis - benefit	Re-purpose
Option 1 Equipment Hire	£316,226 (based on last year's hire cost no inflation included)	Break down covered by lease.	Not a recommended long term solution as it doesn't achieve basic compliance standards. Requires separate heating and cooling systems that have to be decoupled for winter/summer running No optimised control	Return to Hire Firm
Option 2 Purchase Hire Equipment	£280,000 (Estimated based on conversation with Hire firm, includes purchase of heating equipment, cooling equipment, and air handling plant)	Cheapest option Ease of install and set up.	Not a recommended long term solution as it doesn't achieve basic compliance standards. Requires separate purchase of heating and cooling systems that have to be decoupled for winter/summer running	Sell back to hire firm/ unlikely to be used by NHS organisation due to compliance issues

			No optimised control	
Option 3 Develop and install enhanced solution	£300,000 (Design and install)	Meets the compliance requirements for the space. Designed to best suit site needs, air flow and temperature coefficients, optimised control	Requires temporary planning application	Yes design, allows for the Trust to repurpose this equipment following closure of VCC. The unit will be design to comply with HTM.

The solution recommended by the Trust Ventilation Group is option 3 - Enhancing design on previously used solution

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The proposed investment be a betterment on the current position providing an element of compliance with HTM 03 (Healthcare Technical Memorandum)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	£300,000 supported by Welsh Government Funding

4. RECOMMENDATION

4.1 The Trust Board is asked to approve:

i. Progression of the recommended option.
ii. In doing so approve expenditure as defined within ***Appendix 2b*** - Commitment of Expenditure Exceeding Chief Executives Limit.

DocuSign Envelope ID: 92E1D277-7B5E-4143-8810-4CC34B730CAB

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	FF WARD ENHANCED VENTILATION SOLUTION
DIVISION / HOST ORGANISATION	Corporate Estates, Environment and Capital
DATE PREPARED	13/03/2023
PREPARED BY	Jason Hoskins Assistant Director Estates, Environment and Capital
SCHEME SPONSOR	Carl James Director of Strategic Transformation, Planning, and Digital

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

- **FF WARD ENHANCED VENTILATION SOLUTION**

  Installation of a compliant ventilation plant to the FF ward to meet minimum compliance standards to improve quality of air and improve Enviromental condition for both patients and staff.
- Replace the temporary ventilation system with a permanent installation as a betterment until the service relocation to the New Hospital.
- It has been proposed that the air circulation be supplied at the end of the wards and extract through the Store Rooms to meet requirements of HTM
- The works are to be undertaken to cause minimal / no service disruption (Bed losses) during the works – Relocation of patients to day rooms for short period whilst undertaking localised work would be acceptable.
- The AHU units to be designed to include Hepa filters, a degree of "in Ward" temperature control, all necessary links to the Fire Alarm etc.
- AHUs located on the Roof would require planning permission. (Confirmed by early liaison with the Planning Department)
- To install the permanent installation, the majority of the works would be external, utilising the windows (with modified / replacement frames) to accommodate supply and extract grills / louvres.
- There would be some disruption to the ward (Replacement of windows, but depending on the distribution scheme progressed, we believe this could be limited to relocation of some

DocuSign Envelope ID: 92E1D277-7B5E-4143-8810-4CC34B730CAB

patients from cubicles to day rooms for a number our hours whilst works are completed. (Similar to the methodology
for the temporary vent installation). All works will be planned in conjunction with clinical requirements.

- The North ward exit, now the supply, will render the existing extract installed previously (Due to med gases) redundant. Utilising the whole of the top panel over the door may provide sufficient area for the supply requirements.
- The South ward window, proposed to be a new supply grill, would need to be replaced with a new arrangement to accommodate a supply grill at high level.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	14/05/2023
Expected End Date of Contract	21/09/2023
Contract Extension Options **(E.g. maximum term in months)**	Possibility to extend once the Trust is sighted on the tender returns, lead order times of equipment etc. Any extension would be minimal

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐

Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

This scheme is included as part of the Major Capital Schemes Programme mitigate the risk that exists within the First Floor ward at Velindre Cancer Centre. Key features addressed by the installation of AHU;

- Provides filtered air into the space reducing risk of respiratory viruses and provides a level of compliance in line with HTM
- Provides chilled air during the summer months to prevent the space overheating

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES

This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐

DocuSign Envelope ID: 92E1D277-7B5E-4143-8810-4CC34B730CAB

Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.									☒
FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED Please mark with a (x) in the box the relevant principles for this scheme. Click here for more information									
Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Option 1 – Do Nothing. Risks from infection and overheating. *Option 2 – Hire AHU - Not a recommended long term solution as it doesn't achieve basic compliance standards. Requires separate heating and cooling systems that have to be decoupled for winter/summer running. No optimised control* *Option 3 – Purchase Hire Equipment - Not a recommended long term solution as it doesn't achieve basic compliance standards. Requires separate purchase of heating and cooling systems that have to be decoupled for winter/summer running. No optimised control* *Option 4 - Meets the compliance requirements for the space. Designed to best suit site needs, air flow and temperature coefficients, optimised control. Endorsed by the Trust Ventilation Group and EMB. Funding secured from Welsh Government* *Option 4 presents the preferred approach.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Supports addressing safety, and regulatory compliance • Improve business effectiveness, efficiency, and service quality • Supports recruitment and retention of staff • Complies with good practice • Provides a high quality building

DocuSign Envelope ID: 92E1D277-7B5E-4143-8810-4CC34B730CAB

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
• Non compliance with Regulatory Bodies • Increased risk of respiratory virus • Loss of efficiency of service • Limitations on service development	• Risks cannot be fully mitigated without capital investment

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☒	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			
A technical specification has been developed and will be tendered to the open market			
6.3 What is the approximate time line for procurement?			
Approximately 6 weeks			

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Claire Salisbury, Assistant Director of Procurement Services and Executive Procurement Lead - CVU
Signature:	pp Julie Winterburn
Date:	28-Apr-23

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)**	**Including VAT (£k)**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below:		

DocuSign Envelope ID: 92E1D277-7B5E-4143-8810-4CC34B730CAB

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Design/Planning including Architect - £24,500 Structural Engineer -£6500 Cost Adviser - £12,000 M&E Designer - £15,980	£60K				£60K	£72K
Construction phase installation of AHU and associated M&E/Builders Works		£206.7K			£ 206.7K	£248K
Overall Total	£60K	206.7K			£266.7K	£320K

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*This project will be managed against organisational SFI's and the estates project management process.*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Carl James
Signature:	[signature]
Service Area:	
Date:	16/03/23

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
Business Planning Group or local equivalent	
Divisional Senior Management Team	
Executive Management Board	02/05/2023

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	
HTW – Senior Management Team	

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

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	CT SIM – RADIOTHERAPY SATELLITE CENTRE
DIVISION / HOST ORGANISATION	Velindre Cancer Centre, Radiation Services
DATE PREPARED	25/04/2023
PREPARED BY	Kathy Ikin, Head of Radiation Services
SCHEME SPONSOR	Cath O'Brien, Chief Operating Officer

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Procurement of CT SIM for the Radiotherapy Satellite Centre at Nevill Hall Hospital

Velindre University NHS Trust is committed to the development of Radiotherapy Satellite Centre at Nevill Hall Hospital.

There is substantial equipment and infrastructure required to deliver a safe effective and fully functional service. One of the key substantial pieces of equipment is the CT SIM. This equipment is required to complete imaging and treatment planning, for targeted radiotherapy treatment. This essential equipment is included in the full business case for the new build programme, and within the funding allocation award from Welsh Government.

There are multiple dependencies, which support the need for the procurement process to begin. Specifically, there are lengthy leads time for suppliers following contract award for this equipment, national supply challenges, and the need to inform the build plan with the specific specification for the selected equipment. The current programme plan is for CT SIM installation to the new centre in November 2024, and therefore expenditure is not expected until financial year 2024-2025.

Commencing the procurement process now, will ensure the planning timescales are met for the new satellite centre, and will support the opening of new patient treatment services to open as planned.

The servicing and maintenance contract commences one year post treatment start on the machines, as there is a one year warranty in place for the first year. **Summary of Estimated Contract Charges (Excl. VAT)** The estimated cost of CT SIM purchase is £600k capital spend with a further £600k revenue spend for support and maintenance, which reflects 10% of the capital costs and will be spread over a 10 year period.					
1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal ☐

1.2 Period of contract including extension options: 10 years	
Expected Start Date of Contract	01/01/2025
Expected End Date of Contract	01/01/2035
Contract Extension Options **(E.g. maximum term in months)**	N/A

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES
This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.

Objective	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED
Please mark with a (x) in the box the relevant principles for this scheme.
Click here for more information

Prevention	☐	Long Term	☒	Integration	☒	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED
Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining

CT SIM Procurement

Option 1 - Do Nothing – If the contract is not initiated, the investment in the IRS solution will not be achieved, as the CT SIM is essential equipment for a patients' treatment pathway.

Option 2 – Award contract – Awarding the contract with a provider for the CT SIM will facilitate the development of an optimum patient treatment pathway, at the Satellite Radiotherapy Centre.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The benefits of the procurement will, • Support deliverability, affordability and value for money services as set out in the Full Business Case for the Radiotherapy Satellite Centre • Support completion of the satellite centre on time • Optimised patient treatment pathways • Care close to home and the provision of localised cancer services • Supports the creation of increased capacity for treatment for Radiotherapy Patients • Support facilities of high quality care, and in support of research, education and improved utilisation of technology advances

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Not proceeding will severely affect the implementation timelines for the Satellite Centre, and had potential to negatively impact on patient treatment capacity because of any delays. There is a reputational risk to Velindre that we will not deliver on the commitments made within the business case submitted to Welsh Government, resulting in negative impact on patient care, reputational damage and loss of access to funding as a result.	There is no mitigation. If the contract is not in place, in a timely manner the potential risks will be realised.

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

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☒	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			
This will be through a mini competition against a compliant framework.			
6.3 What is the approximate time line for procurement?			
The procurement timelines is to :- • Develop specification to conclude 31st May 2023 • Issue notice June 2023 • Supplier demonstrations July 2023 • Evaluation to conclude by 30th August 2023 • Award contract October 2023			

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Claire Salisbury
Signature:	
Date:	27/04/2023

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£1,200k total**	**Including VAT (£k)** **£1,440k total**
The nature of spend	**Capital** ☒	**Revenue** ☒

How is the scheme to be funded? Please mark with a (x) as relevant.

- Existing budgets ☒
- Additional Welsh Government funding ☐
- Other ☐

If you have selected 'Other' – please provide further details below:

For clarity, funding is specifically identified for the procurement of a CT SIM in the Full Business Case award for the Radiotherapy Satellite Centre.

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

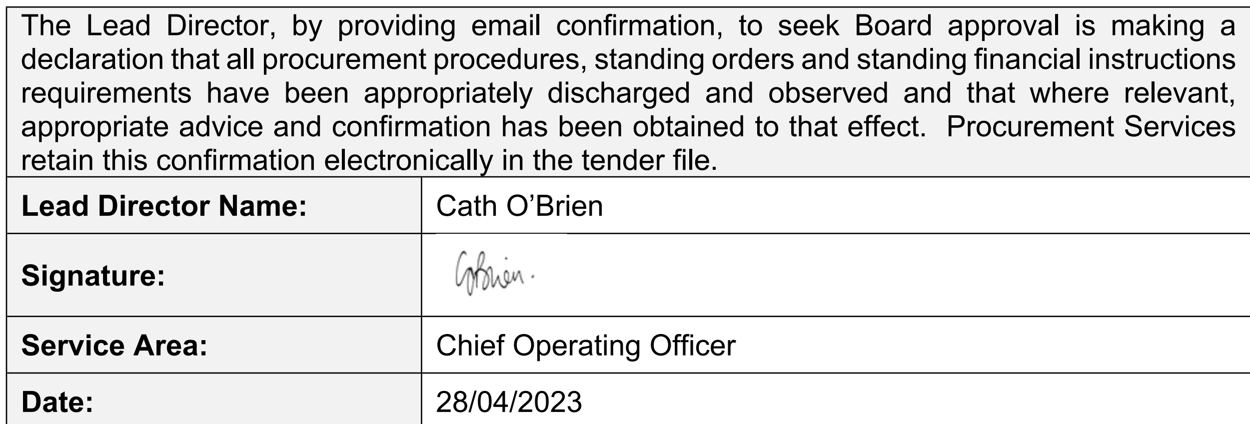
EXPENDITURE CATEGORY	**Year 1 2024-2025 (exc. VAT) £**	**Years 1 to 10 2025-2035 (exc. VAT) £**	**Total (exc. VAT) £**	**Total (inc. VAT) £**
CAPITAL CT SIM – equipment / scanner	£600,000		£600,000	£720,000
REVENUE CT SIM – maintenance and servicing contract		£600,000 (10% capital cost - £60k per annum over 10 years)	£600,000	£720,000
TOTAL	**£600,000**	**£600,000**	**£1,200,000**	**£1,440 ,000**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	Project Management for the CT SIM will be supported by a project manager, from within the Programme Management Office in Velindre Cancer Centre.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE



The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Cath O'Brien
Signature:	
Service Area:	Chief Operating Officer
Date:	28/04/2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
VCC SLT	
EMB RUN	02/05/2023

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	REPLACEMENT OF 2ND LINAC AT VCC AND ASSOCIATED BUNKER REFURBISHMENT WORKS
DIVISION / HOST ORGANISATION	Velindre Cancer Centre, Radiation Services
DATE PREPARED	25/04/2023
PREPARED BY	Angharad Boundford, IRS Programme Manager
SCHEME SPONSOR	Cath O'Brien, Chief Operating Officer

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Purchase of a second Linac @ VCC within the Integrated Radiotherapy Service contract and the associated Bunker Refurbishment works

Phase 1 of the implementation of IRS involves the commissioning of two linear accelerators with associated construction phases for bunker refresh for each machine. This has now commenced and our aim following the successful acceleration the LA6 replacement is now to continue to meet the aims of previously agreed recommendations to replace the second Linac at VCC.

The FBC for the IRS Implementation has been fully approved internally and by Welsh Government. The contract has been executed between the Trust and Varian so there is full approval in place to move forward phase 1 of the programme and the decision that the second linac to be replaced will be LA5/

This paper now seeks authorization to raise the order for the second linac and the necessary refurbishment works to the existing bunker.

Summary of Estimated Contract Charges (Excl. VAT)

The cost of the linac is £2,611,255.00 this include removal and disposals costs, necessary upgrades and warranties.

The anticipated cost of the bunker refurb is £560,000.00 we would seek to build in a 10% cost tolerance to this forecast.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time This is an existing contract	☒	Contract Extension	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	08/11/2022
Expected End Date of Contract	07/11/2035
Contract Extension Options **(E.g. maximum term in months)**	N/A

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**

	☒	☐

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☒
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED Please mark with a (x) in the box the relevant principles for this scheme. Click here for more information									
Prevention	☐	Long Term	☒	Integration	☒	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Linac purchase and bunker refurbishment Option 1 - Do Nothing – this will constrain the progress of the programme and IRS contract implementation and result in the objectives and improvements for patients and staff to be unmet. Option 2 – purchase the linac and commence the bunker refurbishment as per programme plan – this will allow us to maintain the pace and delivery of the programme and its objectives within the agree and approved funding budget and within the contract.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The benefits of the procurement will, • Support deliverability, affordability and value for money services as set out in the Full Business Case for the IRS programme • Support completion of Phase 1 of the IRS implementation to plan • Optimised patient treatment pathways • Supports the creation of increased capacity for treatment for Radiotherapy Patients • Support facilities of high quality care, and in support of research, education and improved utilisation of technology advances

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
Not proceeding will severely affect the implementation timelines for the IRS programme, and had potential to negatively impact on patient treatment capacity because of any delays. There is a reputational risk to Velindre that we will not deliver on the commitments made within the business case submitted to Welsh Government, resulting in negative impact on patient care, reputational damage and loss of access to funding as a result.	There is no mitigation. If the contract is not in place, in a timely manner the potential risks will be realised.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.	
Competition	**Single source – contract already in place**
3 Quotes ☐	Single Quotation Action ☐
Formal Tender Exercise ☐	Single Tender Action ☐
Mini competition ☐	Direct call off Framework ☐
Find a Tender ☐ (replaces OJEU Public Contract regulations 2015 still apply)	All Wales contract ☐
Click here for link to Procurement Manual for additional guidance	
6.2 Please outline the procurement strategy	
There is already a contract in place and this purchase is within the agreed time and budget agreed and approved	
6.3 What is the approximate time line for procurement?	
There is no formal procurement required this will be deployment of an agreed and awarded contract via a approved procurement route	

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Claire Salisbury
Signature:	[signature]
Date:	27/04/2023

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract (this element)	**Excluding VAT (£k)** **£3,177,255.00**	**Including VAT (£k)**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below: .		

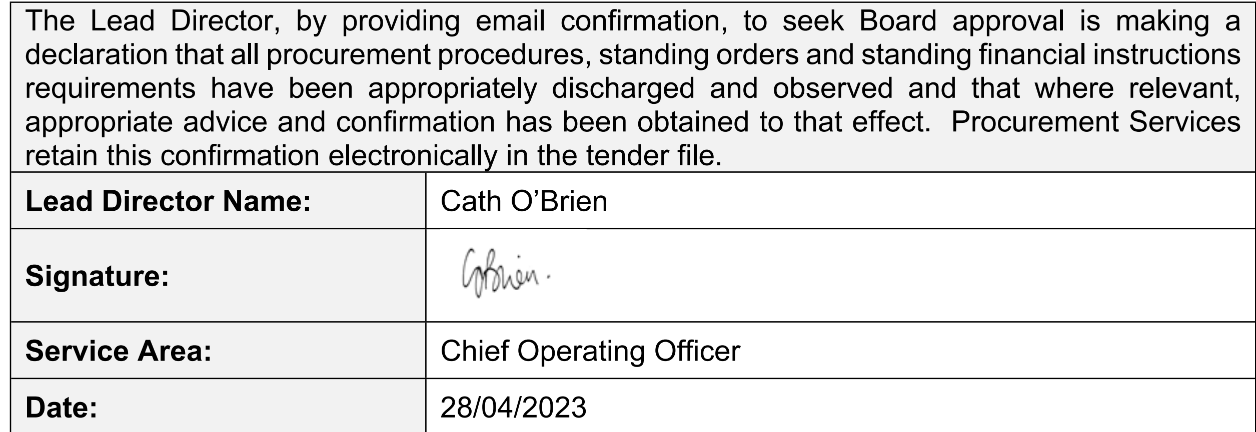
PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 2023 - 24 (exc. VAT) £	Total (exc. VAT) £	Total (inc. VAT) £
CAPITAL	£3,171,255.00	£3,171,255.00	£3,805,506.00
TOTAL	£3,171,255.00	3,171,255.00	£3,805,506.00

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	There is a full programme structure in place for IRS implementation of which this project will be supported by through to delivery.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE



The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Cath O'Brien
Signature:	C O'Brien.
Service Area:	Chief Operating Officer
Date:	28/04/2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
VCC SLT	
EMB RUN	02/05/2023

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	PROJECT MANAGEMENT OFFICE SOFTWARE TOOL
DIVISION / HOST ORGANISATION	Welsh Blood Service
DATE PREPARED	20 April 2023
PREPARED BY	Huw Lovett (Interim Programme Manager)
SCHEME SPONSOR	Sarah Richards (Interim General Services Manager)

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The purpose of this paper is to seek approval for the continuing supply of software used to manage projects, deliver changes and support business planning within WBS.

In autumn 2019, in partnership with several other NHS Wales Trusts and Local Health Boards (LHBs), WBS took part in a collaborative procurement exercise. Its purpose was to provide a Framework for the supply of a cloud-based Project Management Office (PMO) software solution to support the management of projects and programmes across NHS Wales.

The exercise resulted in the award of a single supplier Framework Agreement to TMI Systems Ltd for the supply of their VERTO project management software.

The Framework was awarded for a 4-year period commencing 30 March 2020 with any subsequent Call Off contracts having a period of two (2) years with the option to extend for a further 12 months (i.e. 2+1). In addition the Framework allowed for Call Off contracts to extend beyond the Framework end date up to the maximum period (2+1) provided those contracts were awarded before the Framework end date (March 2024).

The reason for participating Trusts and LHBs only awarding Call Off contracts for 2 years was because after this it was envisaged that they would be able to use the Microsoft PMO tool for Office 365, which Digital Health and Care Wales (DHCW) had been in the process of implementing as part of the Enterprise Agreement. Although this was expected to have been implemented during the lifetime of the initial Call Off contract, at the time of writing it has still not been implemented and there is currently no agreed implementation date in sight.

In March 2020 WBS awarded a direct Call-Off contract, which was due to expire on 29 March 2023. As the anticipated Microsoft PMO tool for Office 365 solution has still not been implemented WBS now wishes to renew the call-off contract for a further 2 years with a 1-year extension option. Awarding a contract renewal will result in the total contract spend exceeding £100k, thereby triggering the need for this paper. A 3-month extension from April 2023 to July 2023 was agreed with TMI Systems Ltd to provide continuity of service whilst allowing sufficient time for this paper to progress through the approval process.

This contract renewal option will allow WBS to 'lock-in' the current contract price for up to a further 3 years, thereby avoiding a potential cost increase in the region of £20k per annum (up to a maximum £60k over the life of the renewal period). It will also allow for a potential future expansion of Velindre licences across Velindre Cancer Services and Corporate Functions/Trust Department.

Finally renewing will align the WBS contract end date more closely with NHS Wales Shared Services Partnership's (NWSSP) Verto Call Off contract, which is due to end in January 2025. This will enable WBS over the next 2 years to partner with NWSSP, and any other Trusts/LHBs wishing to take part, in a joint procurement exercise for a replacement Framework.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/07/2023
Expected End Date of Contract	30/06/2025 (30/06/2026 if the 12-month extension option is exercised)
Contract Extension Options **(E.g. maximum term in months)**	24 months with option to extend a further 12 months

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.

Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☒
If not, please explain the reason for this in the space provided. This scheme does not relate to a specific strategic objective identified in the IMTP but rather to a tool that will be used to support delivery of IMTP objectives.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐

Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED
Please mark with a (x) in the box the relevant principles for this scheme.
Click **here** for more information

Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☒	Involvement	☐

3. OPTIONS CONSIDERED
Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining

Do nothing – do not exercise the option to extend the call-off contract for the final year of the Framework.
Not recommended as it will leave WBS without suitable software with which to manage projects, deliver changes and support business planning. WBS will also need to develop a process to retrieve and store all documentation currently stored by VERTO on the cloud. A replacement solution is likely to be far more expensive than the current solution.

Alternative Option A – carry out a procurement exercise for a replacement solution
Not recommended as WBS will need to conduct a procurement exercise for its own software package or wait until DHCW has completed implementation of the Microsoft PMO tool for Office 365. Until the procurement exercise is completed WBS will be without suitable software with which to manage projects, deliver changes and support business planning. A process will also need to put in place to transfer the records currently held on VERTO to the newly procured software package. Finally any alternative software solution is likely to cost more as WBS will not be able to take advantage of the economies of scale that are usually inherent in a Framework agreement.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
1. Anticipated cost savings due to utilising existing prices under a Framework agreement 2. Alignment with other NHS Wales organisations through use of the same PMO software. This also allows the sharing of knowledge and best practice through participation in a VERTO User Group. 3. Continuity in terms of staff using a software tool with which they are familiar and which supports WBS Change Management Framework.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
WBS will not have suitable software with which to manage projects, deliver changes and support business planning.	Carry out procurement exercise to secure an alternative software solution.
Should an alternative software solution be sought it is likely to be more expensive as it will not be available on a Framework agreement.	Negotiate hard to secure a lower price. However, this is likely to have limited effect.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Please click here for link to Procurement Manual for additional guidance
6.2 Please outline the procurement strategy
Call-off contract award off Framework
6.3 What is the approximate time-line for procurement?
Existing Framework in place,. Framework renewal process due to begin May 2023 under the direction of the NHS Wales Shared Services Partnership's (NWSSP) National ICT team.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Joanne Liddle (Assistant Head of National Sourcing – Clinical)
Signature:	[signature]
Date:	30/03/2023

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £163	**Including VAT (£k)** £195
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

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

7. FINANCIAL ANALYSIS

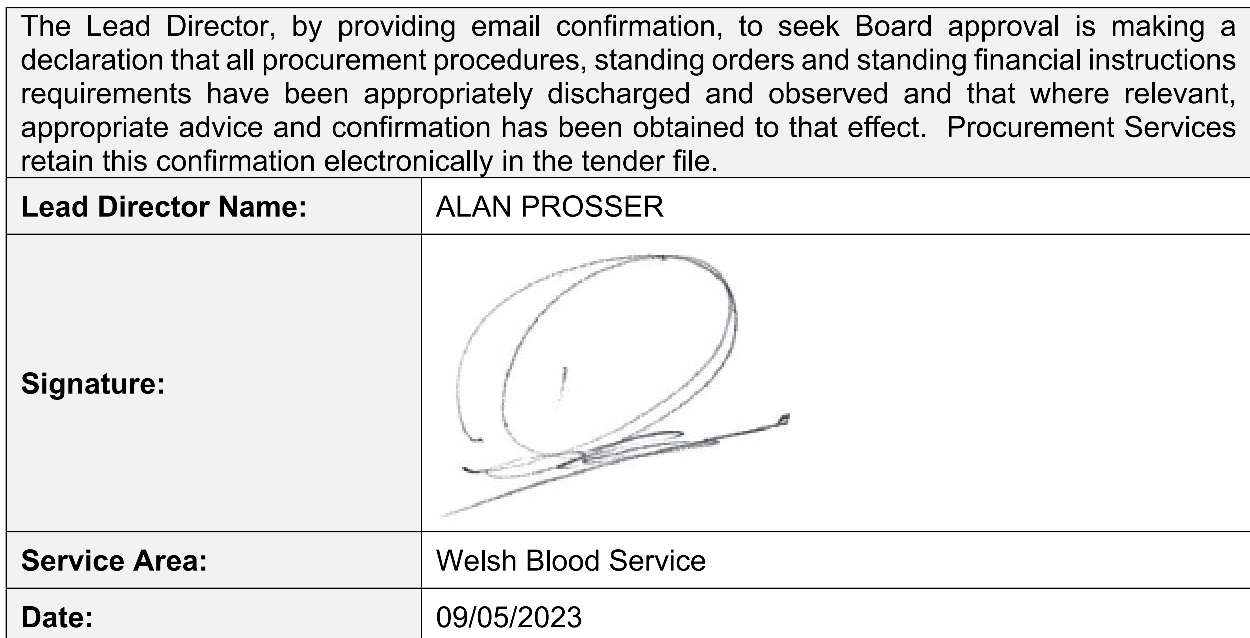
PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Previous Expenditure	£82				£82	£98
Revenue (Licences) for further 2 years, plus 1 year extension		£27	£27	£27	£81	£97
Overall Total	£82	£27	£27	£27	£163	£195

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	Not applicable

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	ALAN PROSSER
Signature:	
Service Area:	Welsh Blood Service
Date:	09/05/2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
Business Planning Group or local equivalent	05 May 2023
Divisional Senior Management Team	10 May 2023
Executive Management Board	16 May 2023

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	PRIMARY CARE WORKFORCE INTELLIGENCE REPORTING SYSTEM
DIVISION / HOST ORGANISATION	NWSSP
DATE PREPARED	12/05/2023
PREPARED BY	Peter Stephenson, Head of Finance & Business Development, NWSSP
SCHEME SPONSOR	Andrew Evans – Director of Primary Care Services

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Data from both the Performers List and Pharmacy Database (Primary Care Services) and the Welsh National Workforce Reporting System (Employment Services) is used routinely by Welsh Government, Health Boards and Trusts, Independent Contractors and Health Education and Improvement Wales, and involve data collected from the same primary and community care service providers.

The existing Performers List and Pharmacy Database solution provided by DHCW is built on legacy technology, and whilst the solution can continue to be supported "as is" by DHCW for the foreseeable future, the legacy nature of the technology limits capacity for service change, self-service, and interoperability with other solutions.

The Wales National Workforce & Reporting System (WNWRS) captures the multi-disciplinary workforce of GP Practices across Wales and is being extended to all contractor services in 2023. This system is built on a 3rd party supplier platform (Argyle) whose contract has been extended to March 2024, to allow the procurement of a joint Workforce Intelligence System to replace both current offerings and introduce new declaration of interest self-service portal.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	10/7/2023
Expected End Date of Contract	09/7/2026
Contract Extension Options **(E.g. maximum term in months)**	Option to extend for an additional 2 years

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☐
If not, please explain the reason for this in the space provided.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED Please mark with a (x) in the box the relevant principles for this scheme. Click **here** for more information									
Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining

Option No:	Option Name:	Description:
1	Do Nothing	No capacity for service growth or development, service costs will grow overtime due to inefficiencies. discounted.
2	DHCW Development	Concerns over delivery timeframe and ability to provide on-going support once implemented
3	Commercial Provider Contract – Performers List only	More expensive option, wouldn't harmonize the stakeholders' requirements
4	Commercial Provider Contract – Single system	Strategic fit and delivers a seamless solution to Primary Cares needs

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

Benefits

- Continued delivery of legislative requirements around performers' professional registration
- Continued delivery of commissioned service by Welsh Government including GMS contractual requirements for GMPI purposes
- Integration and inter-operability across processes within NWSSP with consistent links to other, dependent, services (single data entry reduces duplication)
- Combining server hosting and development budget for three digital services will reduce combined costs for the joint solution and a single system will be more cost effective
- Remove the need for manual data quality checks and introduce a single data source to inform service planning, delivery, and performance monitoring. single source of truth for medical, dental, ophthalmic and pharmacy performers and contractors
- Improved user experience with a focus on end user experience delivering automated, self-service, process for with service point customer satisfaction measures

- Improve user experience with providing interactive dashboards for planning and performance monitoring, through increased customer satisfaction measures
- Improvement staff efficiency through task management visibility, staff can prioritise workload and focus on added value tasks)
- Data usage can be controlled and managed via a single system (all GDPR requirements managed in one place)
- Improved communication to service users and strategic partners through built-in workflows
- Improved compliance with existing Primary Care Service Key Performance Indicator's
- Improved access for performers/providers to their own data ensuring transparency of the data held about individuals
- Ability to provide self-service flexible reporting functionality/data dashboard to key stakeholders, as currently receive ad-hoc requests from stakeholders regarding data held within the system
- Employment services and Primary Care Services staff will be able to forecast workload and appropriately redirect resource to meet service needs
- Manual process will no longer be required such as writing out to all contractors on an annual basis
- Process efficiencies for service user by managing datasets through one system
- Accessible Data through attribute-based access. Live data dashboards reflecting end user persona needs.
- API with other service systems automating combining of datasets e.g. Locum Hub Wales
- Open and transparent assessment of conflict of interest under 'Do no harm

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

5. RISKS & MITIGATION

<table>
<tr><th colspan="2">5.1 Please state risks of not proceeding with the scheme</th><th>5.2 Please state any mitigation to reduce the risk if the scheme is not approved</th></tr>
<tr><td>We won't be able to:</td><td>Implications:</td><td rowspan="5">Mitigation will take the form of continuing with the current two systems with the current suppliers. This will not eliminate the risks but will ensure that the current level of service provision is maintained.</td></tr>
<tr><td>Electronically capture Declarations of Interest</td><td>Unable to meet Welsh Government requirements</td></tr>
<tr><td>Develop additional functionality within the outdated Performers List legacy system</td><td>Unable to: -
Meet Primary Care Contract Reform regulations
Provide modern seamless interfaces into dependent solutions to meet the interoperability principles defined by the All-Wales Infrastructure Programme
Provide the self-service functionality to deliver a user experience that meets the access principles defined by the All-Wales Infrastructure Programme</td></tr>
<tr><td>Provide a single system for our users to update critical information</td><td>Continued duplication for users and an inability to provide a seamless approach to updating information</td></tr>
<tr><td>Develop real time reporting information</td><td>Limited information provided to key stakeholders to inform service change /</td></tr>
</table>

	service need or future workforce	
Provide Data Quality Assurance	Continuation of the risk of data entry error due to paper-based manual application processes resulting in limited quality assurance to key stakeholders	
Provide full compliance with Welsh Language standards	End users and NWSSP	
Align to Welsh Reference Data Service (WRDS)	Will not be able to meet future strategic plans	
Achieve optimum combination of whole life costs and quality to deliver best value for money	Increased Capital costs (as the Performers List system will need replacing in any case)	
Generate NWSSP process efficiencies	Unable to release staff to focus on added value tasks to meet key stakeholder needs.	

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☒	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			

6.2 Please outline the procurement strategy

Following the Public Contract Regulations 2015 the Open Procedure was used to tender the requirement. Award criteria were set against the technical/functional and service specification requirements. An FTS Open Notice was published on the 20th of December 2022 Ref: 127522.

The Notice advertised the intention to procure a contract, the term of which would be a three (3) year contract with an optional extension of a further two (2) years. The contract is to be awarded to the most economically advantageous tenderer (M.E.A.T) based on a split of 40% quality and 60% cost. Responses received to the technical specification were evaluated using the scoring model detailed in the ITT documentation.

The formal issue and receipt of tender documentation relating to this requirement was conducted via the eTenderWales Bravo Solution secure e-Tendering Web Application in accordance with the Velindre NHS Trust's Electronic Tendering Code to the following timescales: -

6.3 What is the approximate time line for procurement?

Date	Activity
20/12/2022	ITT published
20/12/2022	Clarification period starts
23/01/2023	Closing date for suppliers to submit clarification questions
02/02/2022	Tender Closing date
06/02 – 05/05/2023	Evaluation of Tender Submissions and post-tender clarifications
24/04/2023	Welsh Government capital allocation approval
15/05/2023	Ratification approval
25/05/2023	Velindre Board approval
16/06/2023	Welsh Government approval
16/06/2023	Standstill start
26/06/2023	Standstill end
10/07/2023	Contract Signature
10/07/2023	Contract start date

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

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Lena Boghossian
Signature:	*L Boghossian*
Date:	15.05.2023

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k) £3,821,118**	**Including VAT (£k) £3,932,697**
The nature of spend	**Capital** ☒	**Revenue** ☒

How is the scheme to be funded? Please mark with a (x) as relevant.

Existing budgets	☒
Additional Welsh Government funding	☒
Other	☐

If you have selected 'Other' – please provide further details below:

7. FINANCIAL ANALYSIS

The preferred supplier costs of combining the two systems and incorporating declaration of interest (based on outcome of procurement tender) are shown overleaf based on a 5-year contract.

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
OPERATIONAL COSTS						
Internal Admin Users	43,278	43,278	43,278	43,278	43,278	216,392
External Concurrent Users	35,526	94,739	94,739	94,739	94,739	414,481
Training Provision (150 delegates)	21,053					21,053
WNWRS contract extension	128,700					128,700

Data migration	52,631					52,631
Welsh languages	10,000					10,000
DHCW Performers List	3,102					3,102
Annual fee	29,684	29,684	29,684	29,684	29,684	148,421
Address Validation	23,100	23,100	23,100	23,100	23,100	115,500
Staff costs - PCS	283,029	256,685	203,998	203,998	203,998	1,151,708
Staff Costs - ES	200,247	200,247	200,247	200,247	200,247	1,001,235
TOTAL	**830,251**	**647,733**	**595,046**	**595,046**	**595,046**	**3,263,223**
RECURRENT FUNDING:						
Staff Costs	483,276	483,276	483,276	483,276	483,276	2,416,378
DHCW Performers List	6,204	6,204	6,204	6,204	6,204	31,020
WG Funding WNWRS	192,000	192,000	192,000	192,000	192,000	960,000
TOTAL RECURRENT FUNDING	**681,480**	**681,480**	**681,480**	**681,480**	**681,480**	**3,407,398**
REVENUE FUNDING (SHORTFALL)/SURPLUS	**(125,771)**	**56,846**	**109,533**	**109,533**	**109,533**	**259,675**
Capital Costs Year 1 only	557,895	0	0	0	0	557,895
Capital funding Ring fenced by WG	557,895	0	0	0	0	557,895
CAPITAL FUNDING (SHORTFALL)/SURPLUS	**0**	**0**	**0**	**0**	**0**	**0**

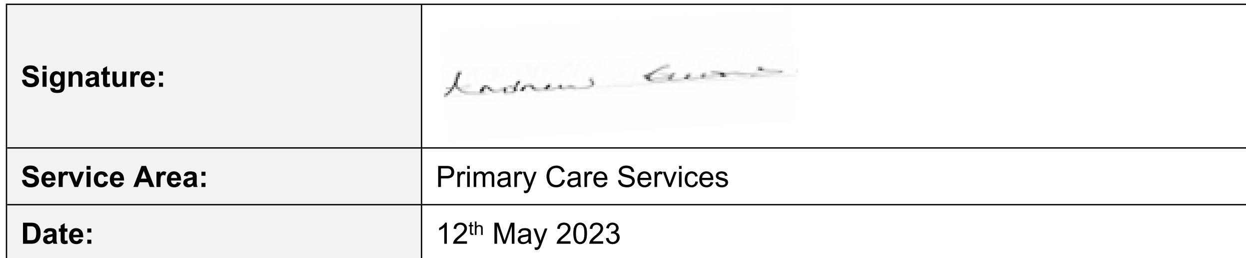
8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*NWSSP will be implementing the project using Prince 2 methodology with the support of DHCW.*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Andrew Evans

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



Signature:	
Service Area:	Primary Care Services
Date:	12th May 2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
Business Planning Group or local equivalent	Not applicable
Divisional Senior Management Team	Not applicable
Executive Management Board	Not applicable

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	25 August 2022
HTW – Senior Management Team	Not applicable

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

AMENDMENT TO STANDING ORDERS – SCHEDULE 3 ANNUAL REVIEW COMMITTEE TERMS OF REFERENCE:

- Quality, Safety & Performance Committee
- Research, Development & Innovation Sub-Committee
- Charitable Funds Committee
- Audit Committee

DATE OF MEETING	25th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer Sandra Cusack, Business Support Officer Alison Hedges, Business Support Officer Sarah Townsend, Head of Research & Development Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff Nicola Williams, Executive Director of Nursing, AHPs & Health Science Dr. Jacinta Abraham, Executive Medical Director Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR APPROVAL

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	02/03/2023	ENDORSED
Research, Development & Innovation Sub-Committee ***(Appendix 2 & 5)***	15/11/2022	ENDORSED
Quality, Safety & Performance Committee ***(Appendix 1 & 4)***	16/03/2023	ENDORSED
Charitable Funds Committee ***(Appendix 3 & 6)***	21/03/2023	ENDORSED
Audit Committee	12/01/2023 ***(Appendix 7)*** 25/04/2023 ***(Appendix 1-6)***	ENDORSED

ACRONYMS	
	N/A

1. SITUATION

The purpose of this report is to outline the required changed to the Trust Standing Orders – **Schedule 3**, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the:

- **Quality, Safety & Performance Committee**
- **Research, Development & Innovation Sub-Committee**
- **Charitable Funds Committee**
- **Audit Committee**

Ref. ***Appendix 1, 2 & 3*** [with track changes] & ***Appendix 4, 5, 6 & 7*** [without track changes]. The purpose of the report is to seek formal **APPROVAL** by the Trust Board.

2. BACKGROUND

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

The amendments detailed in this report have been formally received and **ENDORSED** for Board **APPROVAL** by the Quality Safety & Performance Committee, Research, Development & Innovation Sub-Committee, Charitable Funds Committee, and Audit Committee, included at ***Appendix 1 – 7***.

The annual review cycle for the Terms of Reference for each Committee will now be March each year in line with the Trust full annual reporting cycle. However, once work that is being undertaken by the **Trust Integrated Quality & Safety Group** on the meeting structure is concluded, the Quality Safety & Performance Committee organogram will need to change and these changes will be brought for further approval. It is anticipated that this work will be concluded by July 2023.

Tables 1 - 3 provide a high level summary of the key changes to the Quality, Safety & Performance Committee, Research, Development & Innovation Sub-Committee and Charitable Funds Committee Terms of Reference respectively. The Trust Audit Committee Terms of Reference were also reviewed in January 2023, however **no** amendments were required arising from their annual review and are included for completeness and transparency of reporting.

Please refer to each of the Tables provided overleaf for the high level summary of amendments made:

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

Table 1: Quality, Safety & Performance Committee

Terms of Reference & Operating Arrangements	Summary of Amendments
Quality, Safety & Performance Committee	**Section 6 (Relationships & Accountabilities with the board and its Committees / Groups):** Addition of confirmation that the Committee has approved the establishment of an Integrated Quality & Safety Group, to support the Committee in effectively executing its responsibilities by undertaking quality and safety intelligence triangulation / analysis and learning assurance to facilitate enhanced efficiency of reporting to the Committee (**ref. 6.6**).
Quality, Safety & Performance Committee	**ANNEX 2 – Wider Governance & Accountability Framework:** Addition of Trust Integrated Quality & Safety Group and associated reporting structure.

Table 2: Research, Development & Innovation Sub-Committee

Terms of Reference & Operating Arrangements	Summary of Amendments
Research, Development and Innovation Sub-Committee	**Section 3:** - Removal of reference to the Chief Executive's Financial limit / delegated authority in the context of business cases that are received by the Committee (**ref.3.2**). More clearly articulated and clarified role of Committee in reviewing and scrutinising financial bids for approval.
Research, Development and Innovation Sub-Committee	**Section 4:** - Membership revised to state a minimum of **3** members, including **2** Independent Members of the Board. - Staff Side Representative no longer listed as a Standard Attendee of the Committee.

Research, Development and Innovation Sub-Committee	**Section 6:** - Addition and clarification of the role of the Advancing Radiotherapy Fund Programme Board and Advancing Radiotherapy Fund Advisory Group with the RD&I Sub-Committee and Charitable Funds Committee (**ref.6.4**) **Appendix 1 - RD&I Meeting Structure** Added **Advancing Radiotherapy Fund Programme Board** and **Charitable Funds Committee** to organogram.

Table 3: Charitable Funds Committee

Terms of Reference & Operating Arrangements	**Summary of Amendments**
Charitable Funds Committee	**Section 5: Authority** - Date of the Financial Services Act updated to state 2021. **Section 5.4: Sub Committees** - The inclusion of the relationship of the Advancing Radiotherapy Fund Programme Board with the Charitable Funds Committee **Section 6.2: Attendees** - Inclusion of: o Executive Director of Nursing, AHPs & Health Science o Head of Financial Planning & Reporting

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Evidence suggests there is a correlation between governance behaviours in an organisation and the level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.

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

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Trust Board is asked to **APPROVE** the amendments to the Trust Standing Orders – **Schedule 3,** as outlined in section **3** of this report, and included in ***Appendix 1-7,*** following which they will be adopted into the Trust Standing Orders and published on the Trust website**.**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2023
Approved:	
Next Review Due:	March 2024

1. INTRODUCTION

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

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:

  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects regarding the workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021) and the Duties of Quality and Candour;

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes / outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.

- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

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

Authority

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

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

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

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

Access

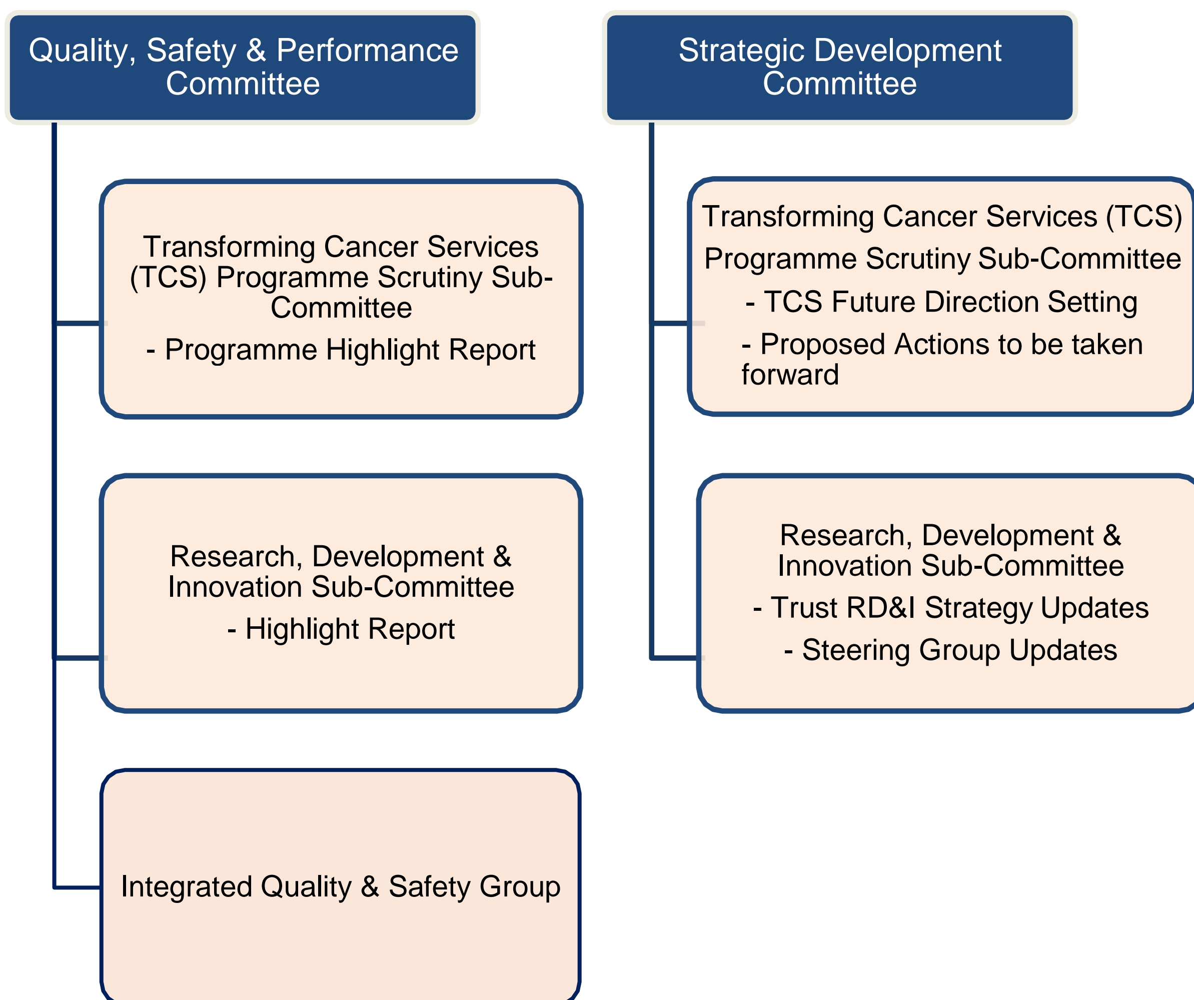
3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the:
- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.
- Integrated Quality & Safety Group.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at ***Annex 2***.

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



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

4. MEMBERSHIP

Members

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

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

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

4.2 Attendees:

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- Welsh Blood Service and Velindre Cancer Centre Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Deputy Director of OD & Workforce
- Chief Digital Officer (*also cyber/data outages/performance)*
- Head of Quality, Safety & Assurance
- Head of Corporate Governance

4.3 By invitation

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.
The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales

- Trade Unions
- Community Health Council

Secretariat

4.4 Secretary - as determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

Support to Committee Members

4.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

  Ensure the provision of a programme of development for Committee members as part of the Trust's overall OD programme.

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and

accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

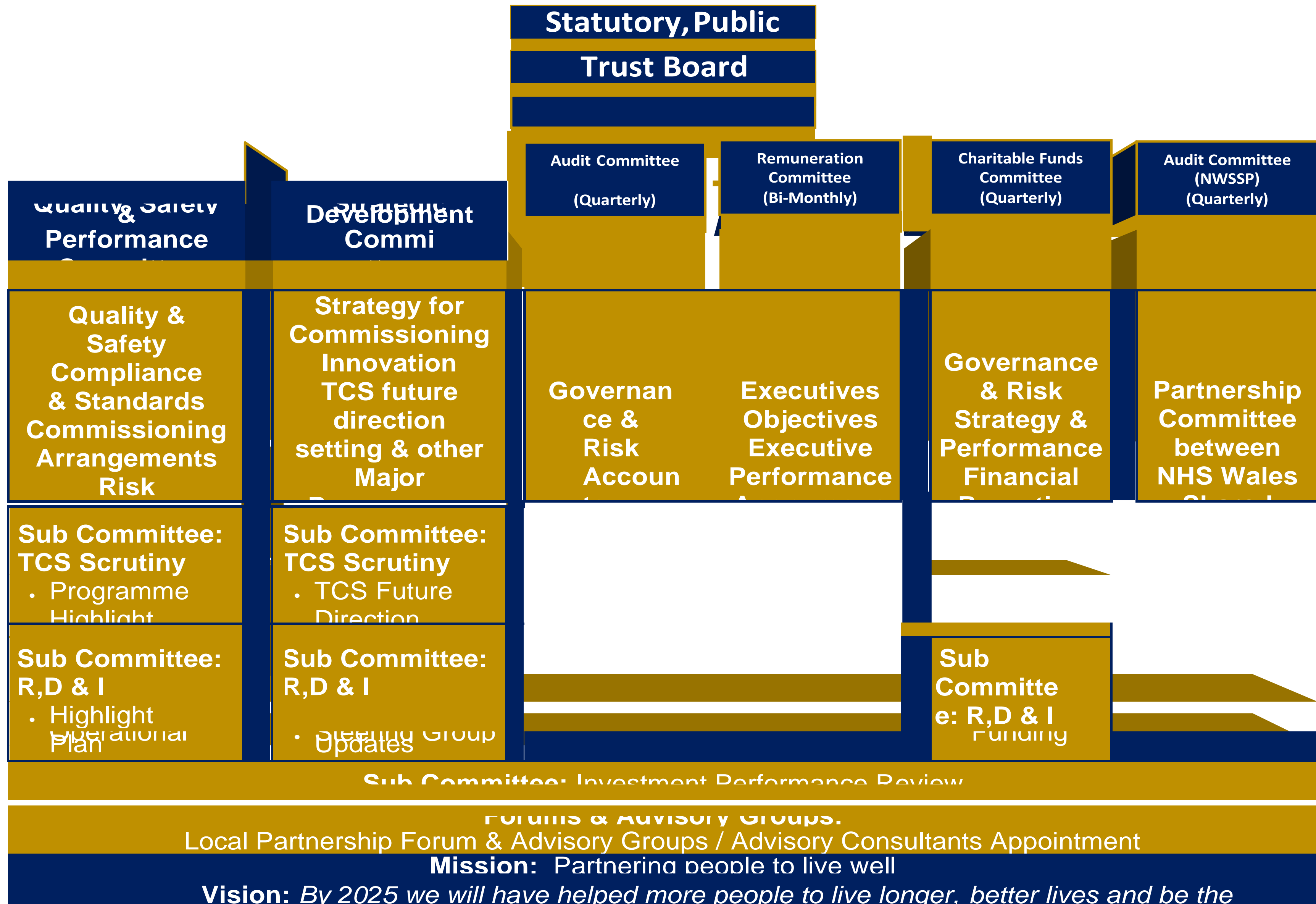
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

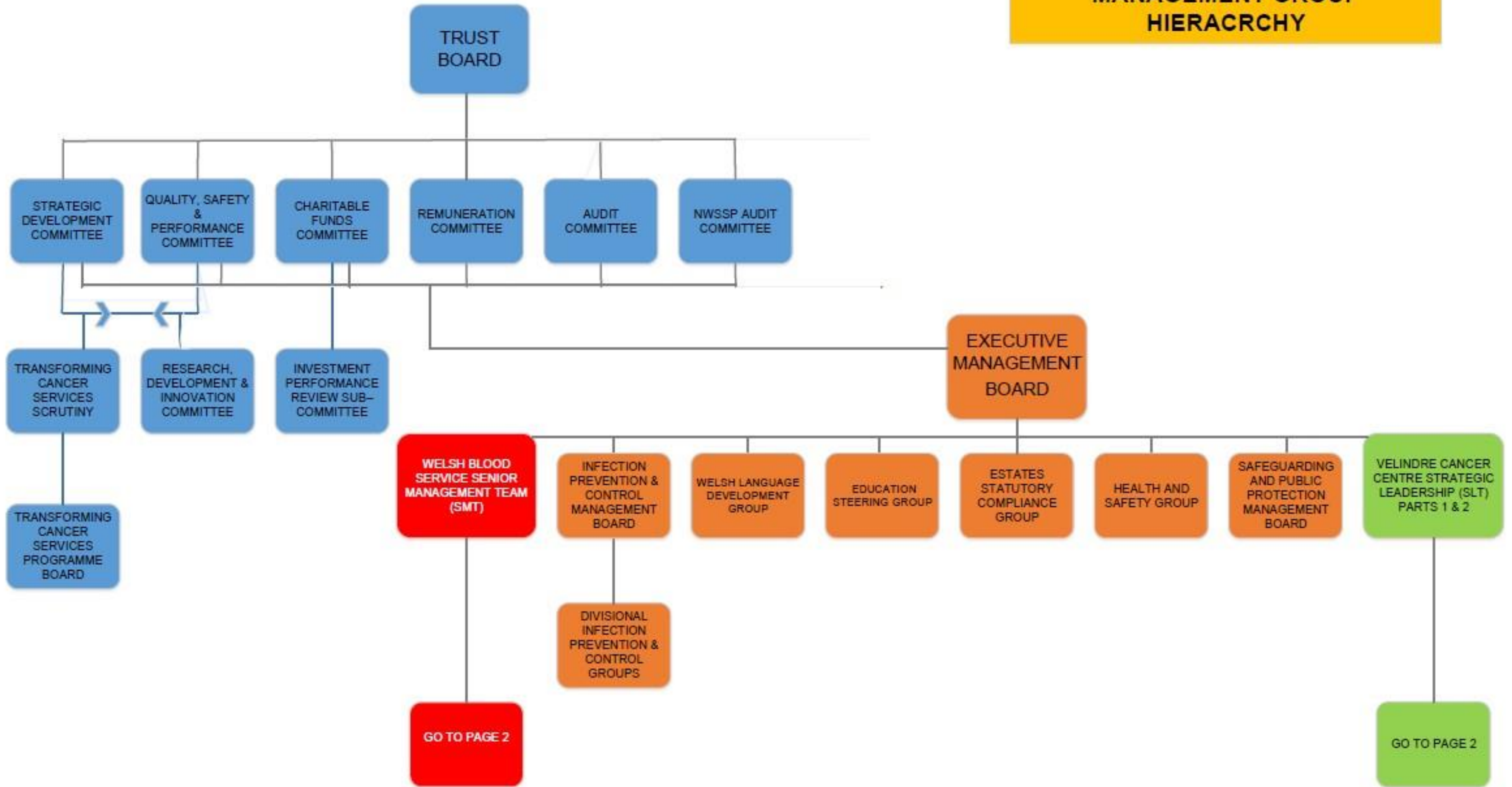
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf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

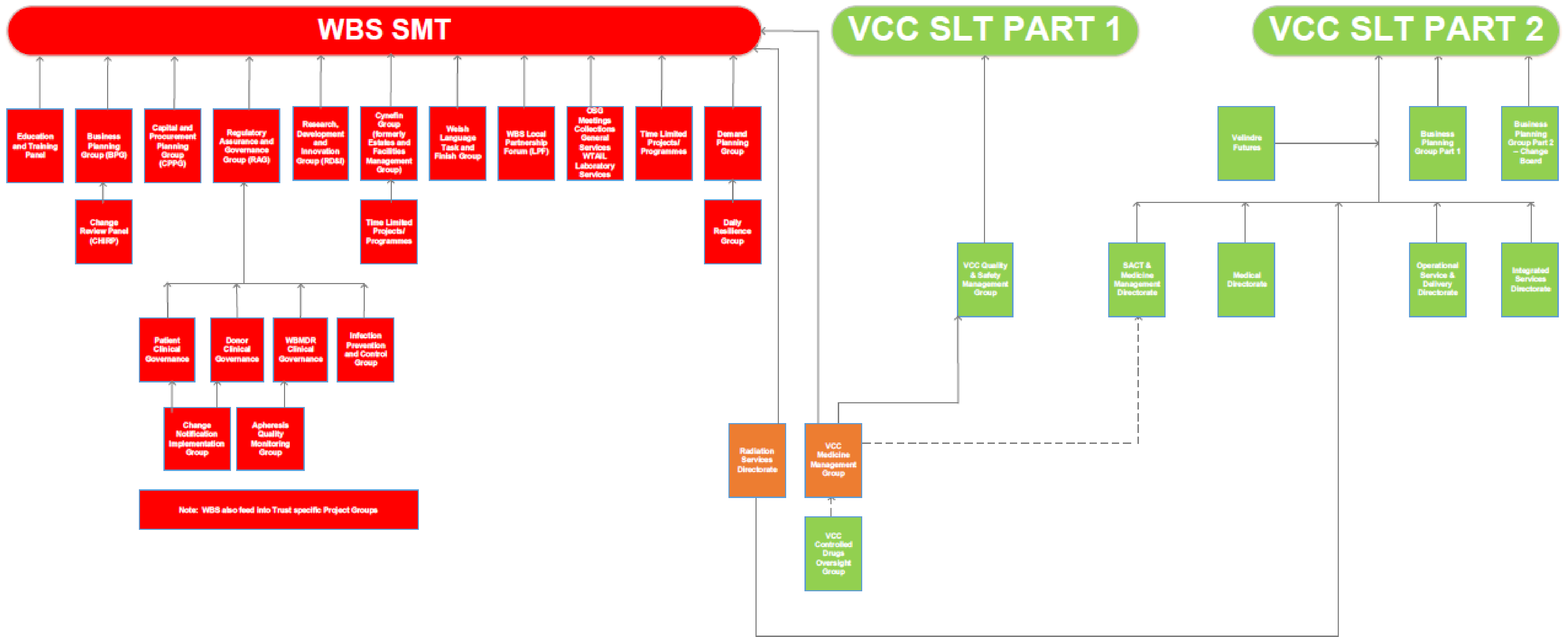
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK




WBS SMT
VCC SLT PART 1
VCC SLT PART 2
Education and Training Panel
Business Planning Group (BPG)
Capital and Procurement Planning Group (CPPG)
Regulatory Assurance and Governance Group (RAG)
Research, Development and Innovation Group (RD&I)
Cynefin Group (formerly Estates and Facilities Management Group)
Welsh Language Task and Finish Group
WBS Local Partnership Forum (LPF)
OSG Meetings Collections General Services WTAIL Laboratory Services
Time Limited Projects/ Programmes
Demand Planning Group
Change Review Panel (CHRP)
Time Limited Projects/ Programmes
Daily Resilience Group
Patient Clinical Governance
Donor Clinical Governance
WBMDR Clinical Governance
Infection Prevention and Control Group
Change Notification Implementation Group
Apheresis Quality Monitoring Group
Note: WBS also feed into Trust specific Project Groups
Velindre Futures
Business Planning Group Part 1
Business Planning Group Part 2 – Change Board
VCC Quality & Safety Management Group
SACT & Medicine Management Directorate
Medical Directorate
Operational Service & Delivery Directorate
Integrated Services Directorate
Radiation Services Directorate
VCC Medicine Management Group
VCC Controlled Drugs Oversight Group

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

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

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 2024

1. INTRODUCTION

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

1.2 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.

1.3 As part of the aforementioned Committee functions, the **Research, Development & Innovation (RD&I) Sub-Committee** has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:

- oversee and maintains oversight of the RD&I Strategy on behalf of the Strategic Development Committee.
- oversee the development of an annual implementation plan that operationalises the Strategy and monitor the Division's performance and delivery on behalf of the Quality, Safety & Performance Committee.
- review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.

1.4 Research, Development and Innovation are defined as follows:

- **Research and Development**, from a healthcare perspective - refers to systematic investigation and study to generate new knowledge and insight to drive improved patient care.
- **Innovation**, from a healthcare perspective - refers to the application of original research into new or improved health policies, practices, systems, products and technologies, services or delivery methods for improved patient outcomes.

2. PURPOSE

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

- Provide strategy and policy oversight for RD&I activities undertaken by the Trust reporting to the Strategic Development Committee.

- Provide assurance on the performance of RD&I activity reporting to the Quality, Safety & Performance Committee.

- Promote and encourage a RD&I ethos and culture which is integral to the Trusts vision, mission and values including the identification of new and enhanced funding opportunities to grow the significance and reach of the Trust's RDI activities.

- Provide assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the UK Policy Frameworks for Health & Social Care Research as amended from time to time.

- Consider relevant matters with reference to the parameters identified for risk appetite in relation to RD&I as set by the Board.

- The RD&I Sub-Committee is underpinned and informed through the work of a number of Management Groups and Assurance Processes as set out in ***Appendix 1***.

3. DELEGATED POWERS AND AUTHORITY

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

3.1 Strategy & Policy Development

- Promote and encourage a RD&I ethos and culture within the Trust.

- Oversee the development of all RD&I strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of RD&I activity.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

- Ensure that matters of strategic development are escalated as appropriate to the Trust Strategic Development Committee and on to Trust Board for assurance and approval as required.

3.2 Strategy & Policy Approval

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

- Scrutinise RD&I Business cases ~~which exceed the delegated limits of the Chief Executive to consider prior to formal Trust Board approval~~for any legal and / or ethical implications that need to be considered, access, finance and ensure alignment with the Trust overarching ten year strategy ***'Destination 2032'*** including the benefit / impact it will make for patients / donors / staff and service users.

3.3 Monitoring and Review

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

- To achieve this, the Sub-Committee will need assurance that the following aspects of RD&I are being effectively managed:

  - The safety, rights, dignity and wellbeing of participants in Innovation and Research development projects is above all other considerations.

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

  - The diversity of the organisation's patients, service users, donors and staff are valued and that their active involvement in the development of Research, Development and Innovation as appropriate.

  - There is close collaboration with partner Organisations in higher education to improve quality, promote joint working for best RD&I outcomes and avoid unnecessary duplication of functions. In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board.

  - The organisation ensures compliance with appropriate legislation and regulation such as the, UK Policy Framework for Health and Social Care Research 2017 the EU Clinical Trials Directive 2004 as amended, Good Laboratory Practice, Good Manufacturing Practice in manufacturing products for clinical trials and Good Clinical Practice in the conduct of all clinical Research and Innovation activities as appropriate.

  - Systems are in place to monitor compliance with regulatory requirements of the Trust as well as organisational standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Research and Innovation activity.

  - Research and Innovation investment and expenditure is accounted for and complies with audit requirements as well as the requirements of external funders or sponsors as appropriate.

  - The Committee will scrutinise research and/or innovation proposals and/or business cases that are seeking charitable funding PRIOR to submission to the Charitable Funds Committee, in order to provide assurance on the quality and safety of RD&I related activity.

  - When research or innovation findings have commercial potential, the Trust takes action to protect and exploit them in collaboration with its Research and Innovation partners and where appropriate commercial Organisations.

3.4 **Access**

The Chair of the RD&I Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

4. MEMBERSHIP

Members

4.1 A minimum of two (3~~2~~) members to include:

Chair — Independent member of the Board (University) or delegated Independent Board member

~~One~~ Two Independent Members of the Board

Attendees

4.2 In attendance

- Executive Director with responsibility for RD&I currently Medical Director
- Executive Director of Finance or nominated officer with RD&I funding responsibilities
- Associate Medical Director with responsibility for R&D
- Clinical Director (or Nominated Deputy) – Velindre Cancer Centre
- Executive Director of Nursing AHP and Health Sciences
- Director of Corporate Governance
- Trust Head of Innovation
- Head of Velindre Cancer Research Strategy
- Trust Head of Research & Development
- Research Delivery Manager
- Research, Development and Innovation Finance Business Partner
- Representative - Velindre Cancer Centre Strategic Leadership Team
- Representative – Welsh Blood Service SMT Lead for RD&I
- Representative – Welsh Blood Service Lead Clinician for RD&I
- WBS RD&I Facilitation Lead
- Service User/Lay Representatives
- ~~Staff Side Representative~~

4.3 **By invitation**

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

- Head of Information Governance (in advisory capacity)
- Divisional Directors
- Representatives of stakeholder organisations

As well as others internal or external to the Organisation who the Sub-Committee consider should be in attendance, taking account of the matters under consideration at each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise

necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

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

4.6 **Support to Committee Members**

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

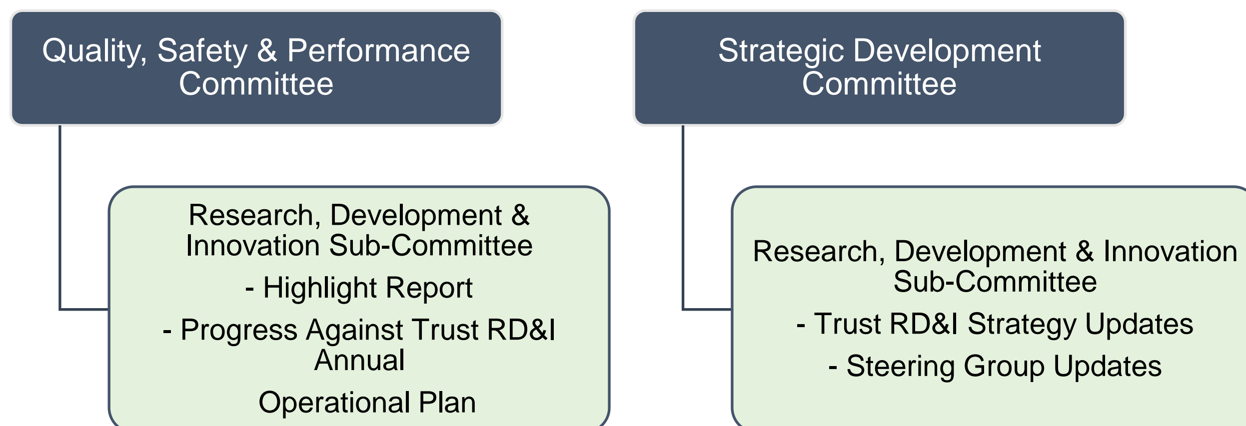
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational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

5. SUB-COMMITTEE MEETINGS

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

- Research, Development & Innovation Sub-Committee

The Sub-Committee will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as follows :



Although the Research, Development & Innovation Sub-Committee, is a sub-committee with dual reporting lines, it will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee is also accountable to the Trust Charitable Funds Committee in relation to ensuring business cases are aligned with RD&I strategy and Trust's strategic objectives. Further details are set out in each of the respective Terms of Reference. In addition, the wider governance and accountability reporting arrangements in place at a divisional level that feed upwards into the RD&I Sub-Committee structure are also summarised at **Appendix 1.**

5.1 **Quorum**

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

5.2 **Frequency of Meetings**

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

5.3 **Withdrawal of individuals in attendance**

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

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

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

6.2 The Sub-Committee is directly accountable to the Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee for its performance in exercising the functions set out in these terms of reference.

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

6.4 The Sub-Committee is supported by the **Advancing Radiotherapy Fund (ARF) Programme Board,** established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the RD&I Sub-Committee that is subject to formal endorsement by the RD&I Sub-Committee prior to the formal approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the RD&I Sub-Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board is also supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where

appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

Report formally, to the:

i. Quality, Safety & Performance Committee on the performance and delivery of RD&I quarterly.
ii. Strategic Development Committee Board on strategic development and updates to the RD&I Strategy quarterly and
iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives.

7.2 The Sub-Committee shall receive:

i. A briefing from the Executive Medical Director with responsibility for RD&I
ii. A quarterly RD&I Integrated Performance Report (following presentation at EMB)
iii. A quarterly Highlight Report from the Advancing Radiotherapy Fund Programme Board on the activity of the programme.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

9. REVIEW

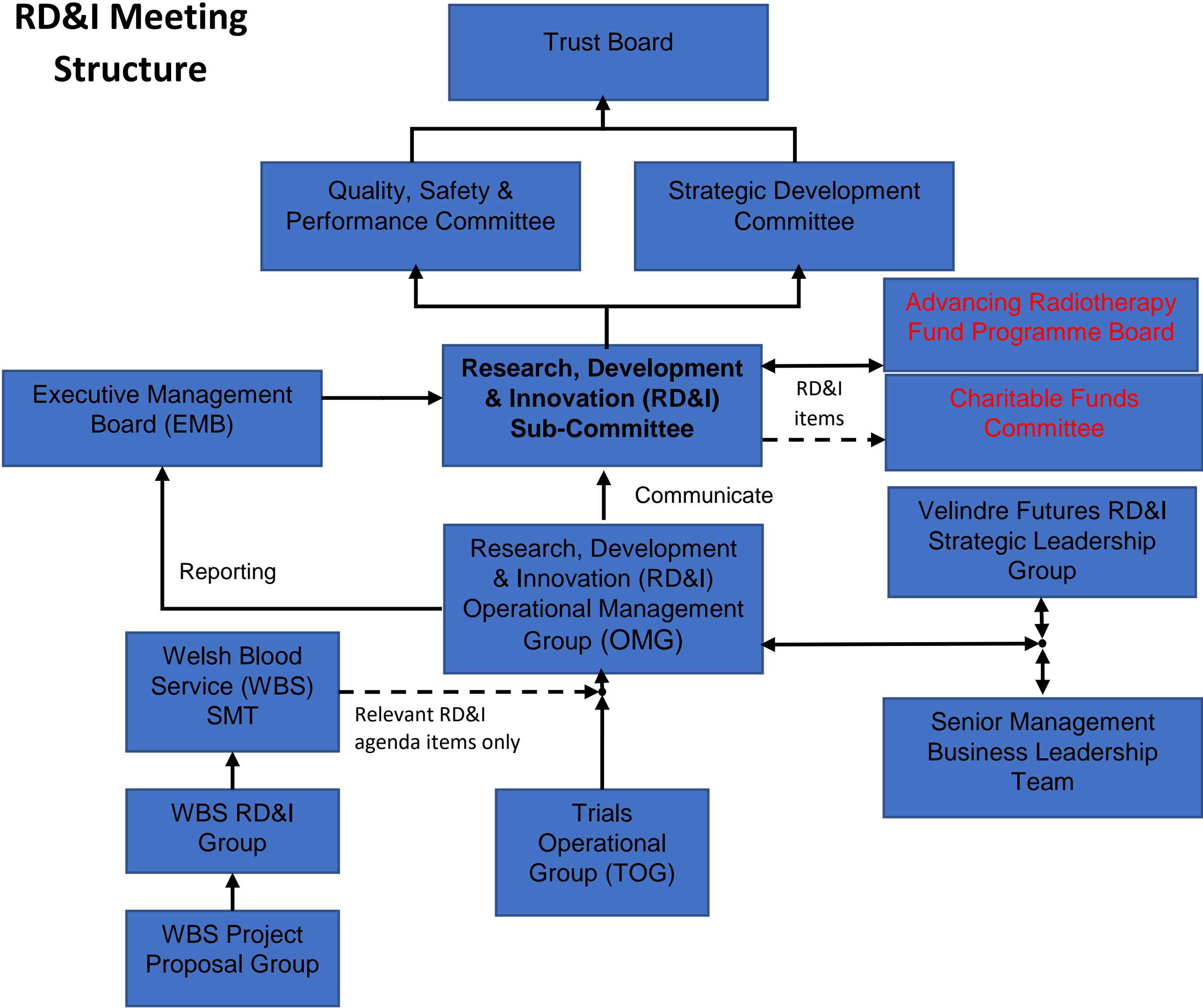
9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

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

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

APPENDIX 1



Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2023
Approved:	
Next Review due:	March 2024

1. INTRODUCTION

1.1 The Trust's Standing Orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In accordance with standing orders (and the Trust's Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

Deleted: s

Deleted: o

Deleted: s

Deleted: d

2. CONSTITUTION

2.1 The Velindre University NHS Trust Board was appointed as corporate trustee of the charitable funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and that its Board serves as its agent in the administration of the charitable funds held by the Trust.

2.2 The purpose of the Committee" is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

3. SCOPE AND DUTIES

3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the Charitable Funds in accordance with their respective governing documents.

3.2 To ensure that the Trust policies and procedures for Charitable Funds investments are followed. To make decisions involving the sound investment of Charitable Funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The terms outlined in the Velindre NHS Trust Charity's Governing Documents

3.3 At least twice a year, receive highlight reports from the Executive Director of Finance in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.

3.4 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.5 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

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

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

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

5. AUTHORITY

5.1 The Committee is empowered with the responsibility for:

- Overseeing the day to day management of the investments of the Charitable Funds in accordance with the investment strategy set down from time to time by the Trustees and the requirements of the Trust's Standing Financial Instructions.
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power the Committee must ensure that:

  a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
  b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
  c) The performance of the person or persons exercising the delegated power is regularly reviewed.
  d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2021.
  Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

- Ensuring that the banking arrangements for the Charitable Funds are kept entirely

Commented [MB(DoF1]: Act updated revised in 2021

Deleted: 12

distinct from the Trust's NHS funds.

- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.

- Obtaining appropriate professional advice to support its investment activities.

- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

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

5.4 **Sub Committees**

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the ***'Charitable Funds Investment Performance Review Sub Committee'***, to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

The Charitable Funds Committee is also supported by the **Velindre Charity Senior Leadership Group**, whose purpose on behalf of the Board of Trustees is to support the development of the strategic direction, take forward strategic delivery and operational management of all Charitable Funds held within the Trust.

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

The **Advancing Radiotherapy Fund (ARF) Programme Board** has also been established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the Charitable Funds Committee, and whilst is not a formal Sub-Committee of the Charitable Funds Committee, it is directly accountable to the Committee for its performance in exercising the functions set out in its formal Terms of Reference as part of good governance arrangements, which are formally approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the Charitable Funds Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board will be supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

Deleted: ¶

6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

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

Formatted: Indent: Left: 5.12 cm, Bulleted + Level: 1 + Aligned at: 1.37 cm + Tab after: 2.01 cm + Indent at: 2.01 cm, Tab stops: Not at 2.01 cm

Deleted: ¶

Attendees

6.2 In attendance

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

- Charity Director
- Chief Operating Officer
- Executive Director of Nursing, AHPs & Health ScienceDirector Velindre Cancer Service (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Senior Finance Business Partner
- Deputy Director of Finance

Deleted: ¶

Deleted: Centre

Deleted:

- Head of Financial Planning & Reporting
- Head of Fundraising
- Head of Corporate Governance (Charity Governance Lead)
- Head of Communications

By invitation, The Committee Chair may invite:

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

Secretariat

6.3 Secretary As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

6.6 In order to demonstrate that there is a visible independence in the consideration of decisions and management of charitable funds from the Trust's core functions, the Board should consider extending invitations to the Charitable Funds Committee to individuals outside of the Board. One option might be to seek representation from the Patient Liaison Group.

Support to Committee Members

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

Deleted:

7. COMMITTEE MEETINGS

Quorum

7.1 At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member and one must be the Executive Director of Finance or Nominated Representative.

Frequency of meetings

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

Deleted: s

Withdrawal of individuals in attendance

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

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

8.1 The Committee will only consider Research, Development and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation Sub-Committee. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.

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

8.3 The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and appropriate sharing of information in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in their capacity as Trustees. This may include, where appropriate, a separate meeting with the Board.

9.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year.

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

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

11. REVIEW

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

12. CHAIR'S ACTION ON URGENT MATTERS

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

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

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2023
Approved:	
Next Review Due:	March 2024

1. INTRODUCTION

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

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:

  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects of workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021);

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes/outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

  Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.
- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide

the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

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

Authority

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

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

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

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

Access

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

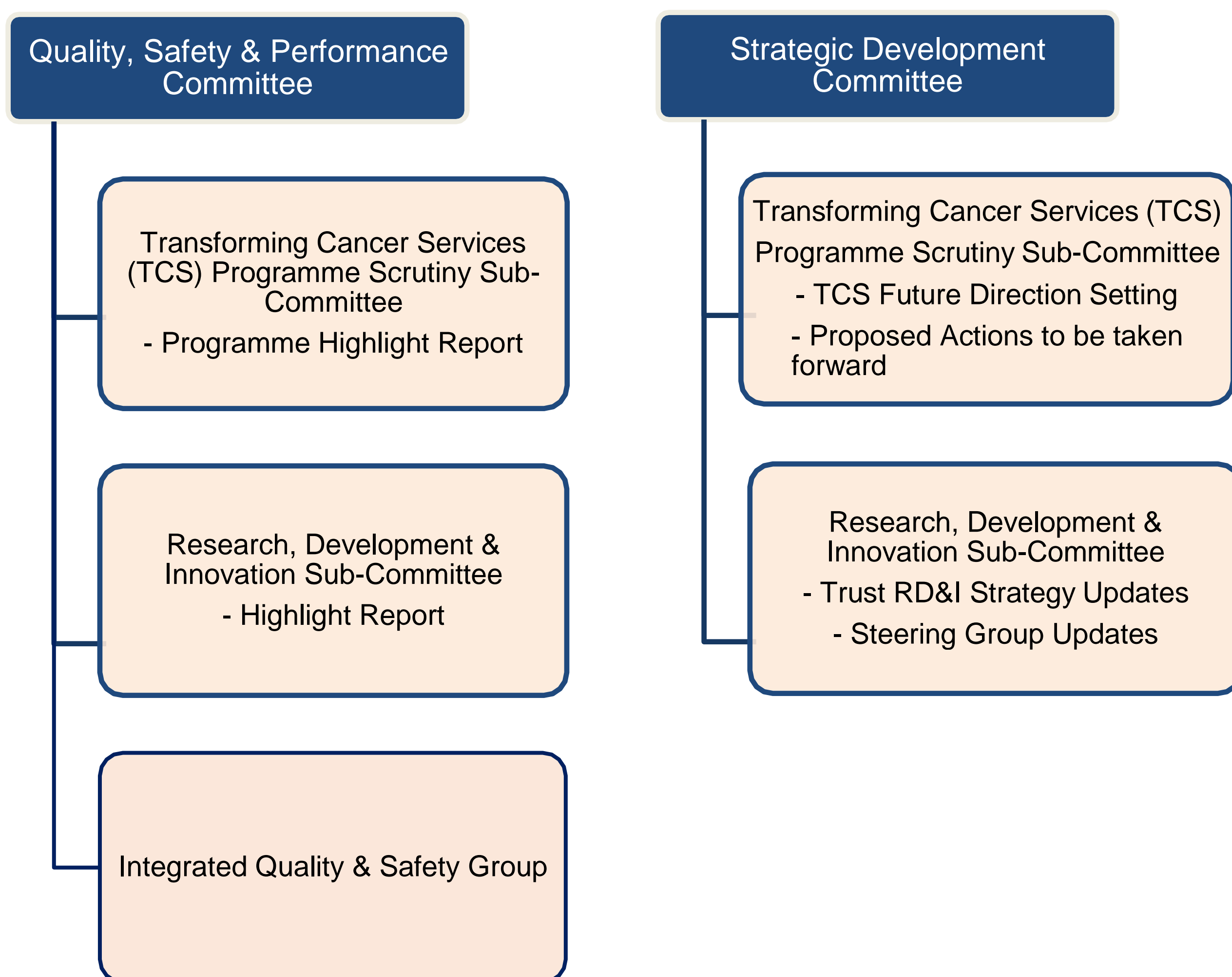
Sub Committees

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

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

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at ***Annex 2***.

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



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

4. MEMBERSHIP

Members

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

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

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

4.2 Attendees:

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- Welsh Blood Service and Velindre Cancer Centre Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Chief Digital Officer (*also cyber/data outtages/performance)*
- Quality & Safety Manager
- Head of Corporate Governance

4.3 By invitation

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.
The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales

- Trade Unions
- Community Health Council

Secretariat

4.4 Secretary - as determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

Support to Committee Members

4.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

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

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and

accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

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

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

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

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

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

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

6.6 The Committee has approved the establishment of an Integrated Quality & Safety Group to support the Committee in effectively executing its responsibilities by undertaking quality and safety intelligence triangulation / analysis and learning assurance to facilitate enhanced efficiency of reporting to the Committee.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

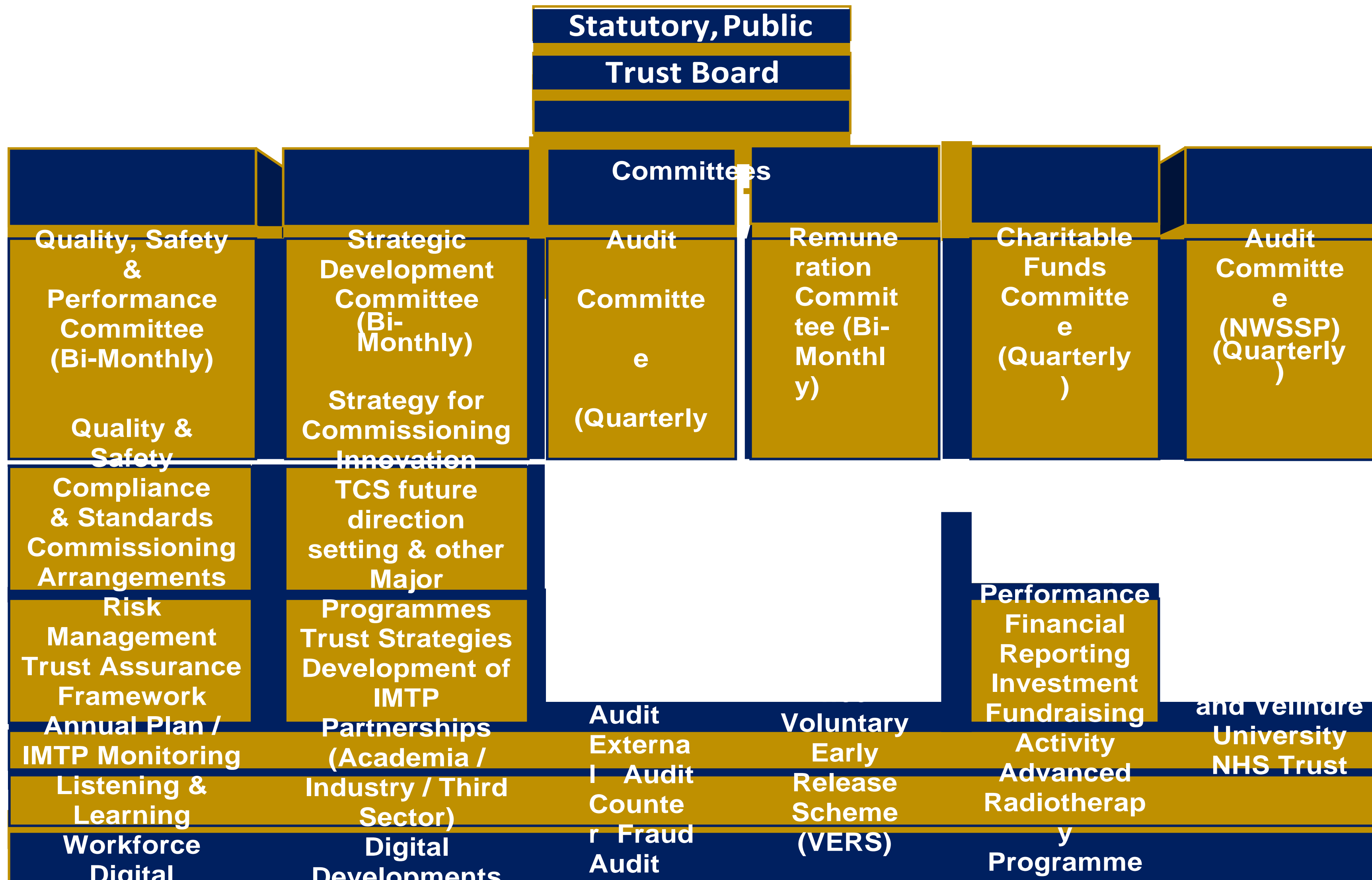
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

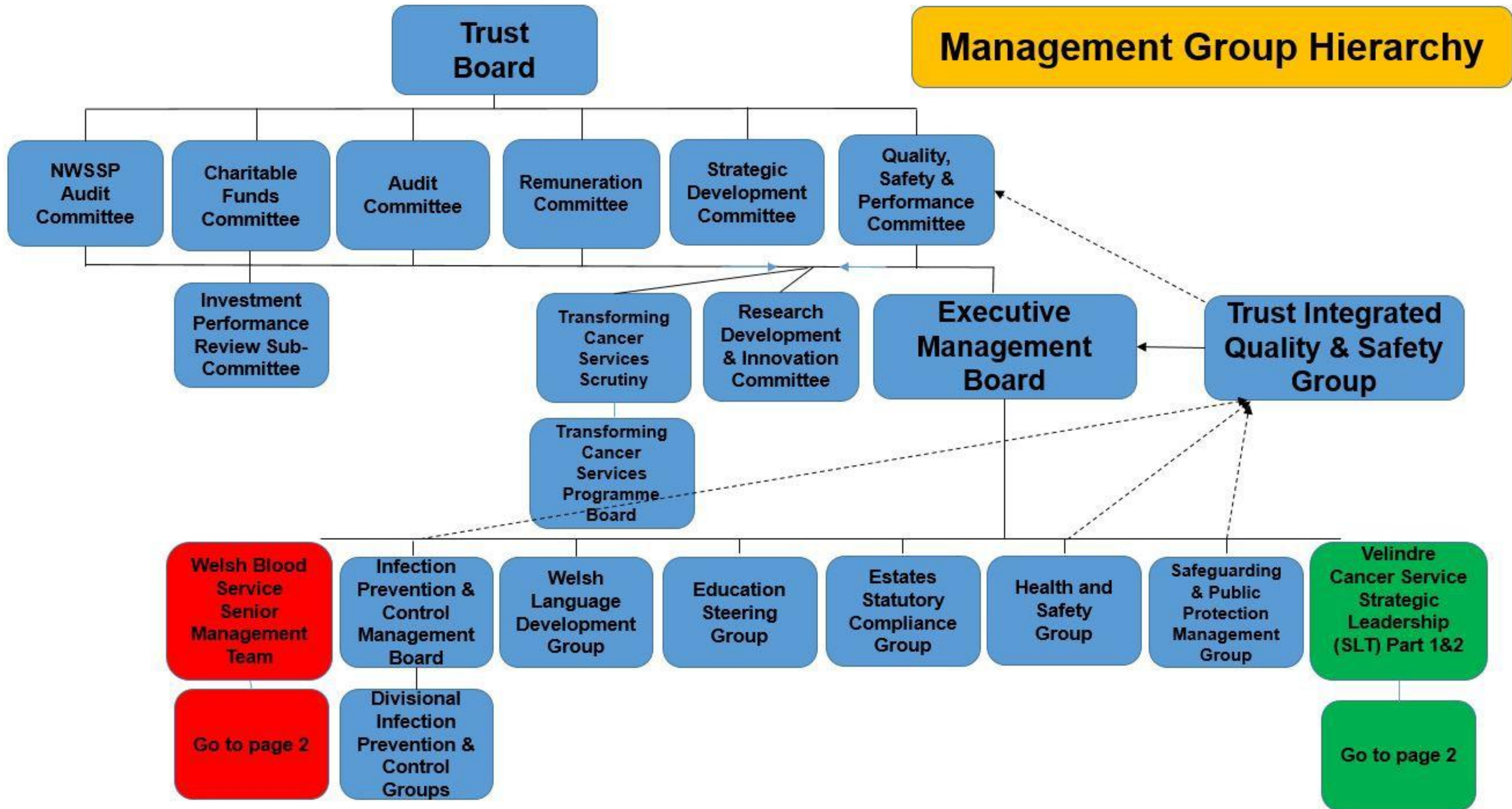
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf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

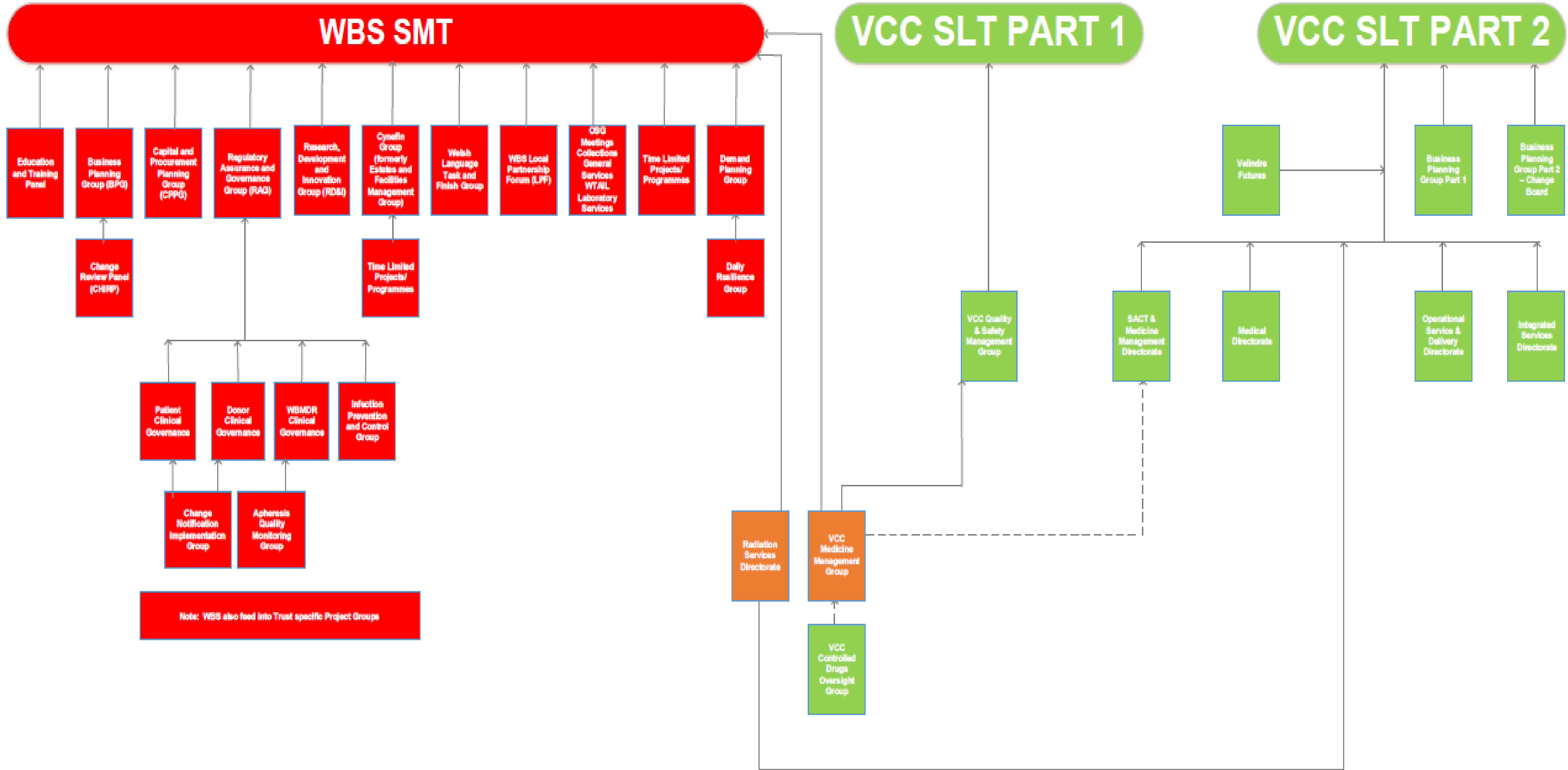
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK





WBS SMT
VCC SLT PART 1
VCC SLT PART 2
Education and Training Panel
Business Planning Group (BPG)
Capital and Procurement Planning Group (CPPG)
Regulatory Assurance and Governance Group (RAG)
Research, Development and Innovation Group (RD&I)
Cynefin Group (formerly Estates and Facilities Management Group)
Welsh Language Task and Finish Group
WBS Local Partnership Forum (LPF)
OSG Meetings Collections General Services WTAIL Laboratory Services
Time Limited Projects/ Programmes
Demand Planning Group
Change Review Panel (CHRP)
Time Limited Projects/ Programmes
Daily Resilience Group
Patient Clinical Governance
Donor Clinical Governance
WBMDR Clinical Governance
Infection Prevention and Control Group
Change Notification Implementation Group
Apheresis Quality Monitoring Group
Note: WBS also feed into Trust specific Project Groups
Velindre Futures
Business Planning Group Part 1
Business Planning Group Part 2 – Change Board
VCC Quality & Safety Management Group
SACT & Medicine Management Directorate
Medical Directorate
Operational Service & Delivery Directorate
Integrated Services Directorate
Radiation Services Directorate
VCC Medicine Management Group
VCC Controlled Drugs Oversight Group

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

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

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 2024

1. INTRODUCTION

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

1.2 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.

1.3 As part of the aforementioned Committee functions, the **Research, Development & Innovation (RD&I) Sub-Committee** has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:

- oversee and maintains oversight of the RD&I Strategy on behalf of the Strategic Development Committee.
- oversee the development of an annual implementation plan that operationalises the Strategy and monitor the Division's performance and delivery on behalf of the Quality, Safety & Performance Committee.
- review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.

1.4 Research, Development and Innovation are defined as follows:

- **Research and Development**, from a healthcare perspective - refers to systematic investigation and study to generate new knowledge and insight to drive improved patient care.
- **Innovation**, from a healthcare perspective - refers to the application of original research into new or improved health policies, practices, systems, products and technologies, services or delivery methods for improved patient outcomes.

2. PURPOSE

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

- Provide strategy and policy oversight for RD&I activities undertaken by the Trust reporting to the Strategic Development Committee.

- Provide assurance on the performance of RD&I activity reporting to the Quality, Safety & Performance Committee.

- Promote and encourage a RD&I ethos and culture which is integral to the Trusts vision, mission and values including the identification of new and enhanced funding opportunities to grow the significance and reach of the Trust's RDI activities.

- Provide assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the UK Policy Frameworks for Health & Social Care Research as amended from time to time.

- Consider relevant matters with reference to the parameters identified for risk appetite in relation to RD&I as set by the Board.

- The RD&I Sub-Committee is underpinned and informed through the work of a number of Management Groups and Assurance Processes as set out in ***Appendix 1***.

3. DELEGATED POWERS AND AUTHORITY

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

3.1 Strategy & Policy Development

- Promote and encourage a RD&I ethos and culture within the Trust.

- Oversee the development of all RD&I strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of RD&I activity.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

- Ensure that matters of strategic development are escalated as appropriate to the Trust Strategic Development Committee and on to Trust Board for assurance and approval as required.

3.2 Strategy & Policy Approval

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

- Scrutinise RD&I Business cases for any legal and / or ethical implications that need to be considered, access, finance and ensure alignment with the Trust overarching ten year strategy ***'Destination 2032'*** including the benefit / impact it will make for patients / donors / staff and service users.

3.3 Monitoring and Review

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

- To achieve this, the Sub-Committee will need assurance that the following aspects of RD&I are being effectively managed:

- The safety, rights, dignity and wellbeing of participants in Innovation and Research development projects is above all other considerations.

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

- The diversity of the organisation's patients, service users, donors and staff are valued and that their active involvement in the development of Research, Development and Innovation as appropriate.

- There is close collaboration with partner Organisations in higher education to improve quality, promote joint working for best RD&I outcomes and avoid unnecessary duplication of functions. In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board.

- The organisation ensures compliance with appropriate legislation and regulation such as the, UK Policy Framework for Health and Social Care Research 2017 the EU Clinical Trials Directive 2004 as amended, Good Laboratory Practice, Good Manufacturing Practice in manufacturing products for clinical trials and Good Clinical Practice in the conduct of all clinical Research and Innovation activities as appropriate.

- Systems are in place to monitor compliance with regulatory requirements of the Trust as well as organisational standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Research and Innovation activity.

- Research and Innovation investment and expenditure is accounted for and complies with audit requirements as well as the requirements of external funders or sponsors as appropriate.

- The Committee will scrutinise research and/or innovation proposals and/or business cases that are seeking charitable funding PRIOR to submission to the Charitable Funds Committee, in order to provide assurance on the quality and safety of RD&I related activity.

- When research or innovation findings have commercial potential, the Trust takes action to protect and exploit them in collaboration with its Research and Innovation partners and where appropriate commercial Organisations.

3.4 Access

The Chair of the RD&I Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

4. MEMBERSHIP

Members

4.1 A minimum of two (3) members to include:

Chair Independent member of the Board (University) or delegated Independent Board member

Two Independent Members of the Board

Attendees

4.2 In attendance

- Executive Director with responsibility for RD&I currently Medical Director
- Executive Director of Finance or nominated officer with RD&I funding responsibilities
- Associate Medical Director with responsibility for R&D
- Clinical Director (or Nominated Deputy) – Velindre Cancer Centre
- Executive Director of Nursing AHP and Health Sciences
- Director of Corporate Governance
- Trust Head of Innovation
- Head of Velindre Cancer Research Strategy
- Trust Head of Research & Development
- Research Delivery Manager
- Research, Development and Innovation Finance Business Partner
- Representative - Velindre Cancer Centre Strategic Leadership Team
- Representative – Welsh Blood Service SMT Lead for RD&I
- Representative – Welsh Blood Service Lead Clinician for RD&I
- WBS RD&I Facilitation Lead
- Service User/Lay Representatives

4.3 **By invitation**

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

- Head of Information Governance (in advisory capacity)
- Divisional Directors
- Representatives of stakeholder organisations

As well as others internal or external to the Organisation who the Sub-Committee consider should be in attendance, taking account of the matters under consideration at each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

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

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

4.6 **Support to Committee Members**

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

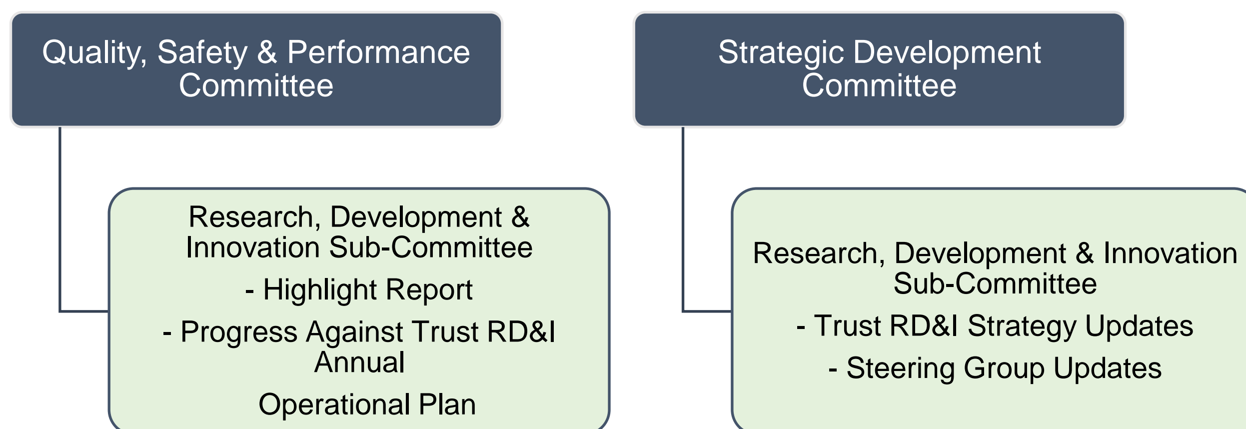
- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational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

5. SUB-COMMITTEE MEETINGS

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

- Research, Development & Innovation Sub-Committee

The Sub-Committee will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as follows :



Although the Research, Development & Innovation Sub-Committee, is a sub-committee with dual reporting lines, it will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee is also accountable to the Trust Charitable Funds Committee in relation to ensuring business cases are aligned with RD&I strategy and Trust's strategic objectives. Further details are set out in each of the respective Terms of Reference. In addition, the wider governance and accountability reporting arrangements in place at a divisional level that feed upwards into the RD&I Sub-Committee structure are also summarised at **Appendix 1.**

5.1 **Quorum**

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

5.2 **Frequency of Meetings**

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

5.3 **Withdrawal of individuals in attendance**

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

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

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

6.2 The Sub-Committee is directly accountable to the Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee for its performance in exercising the functions set out in these terms of reference.

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

6.4 The Sub-Committee is supported by the **Advancing Radiotherapy Fund (ARF) Programme Board,** established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the RD&I Sub-Committee that is subject to formal endorsement by the RD&I Sub-Committee prior to the formal approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the RD&I Sub-Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board is also supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

Report formally, to the:

i. Quality, Safety & Performance Committee on the performance and delivery of RD&I quarterly.
ii. Strategic Development Committee Board on strategic development and updates to the RD&I Strategy quarterly and
iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives.

7.2 The Sub-Committee shall receive:

i. A briefing from the Executive Medical Director with responsibility for RD&I
ii. A quarterly RD&I Integrated Performance Report (following presentation at EMB)
iii. A quarterly Highlight Report from the Advancing Radiotherapy Fund Programme Board on the activity of the programme.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

9. REVIEW

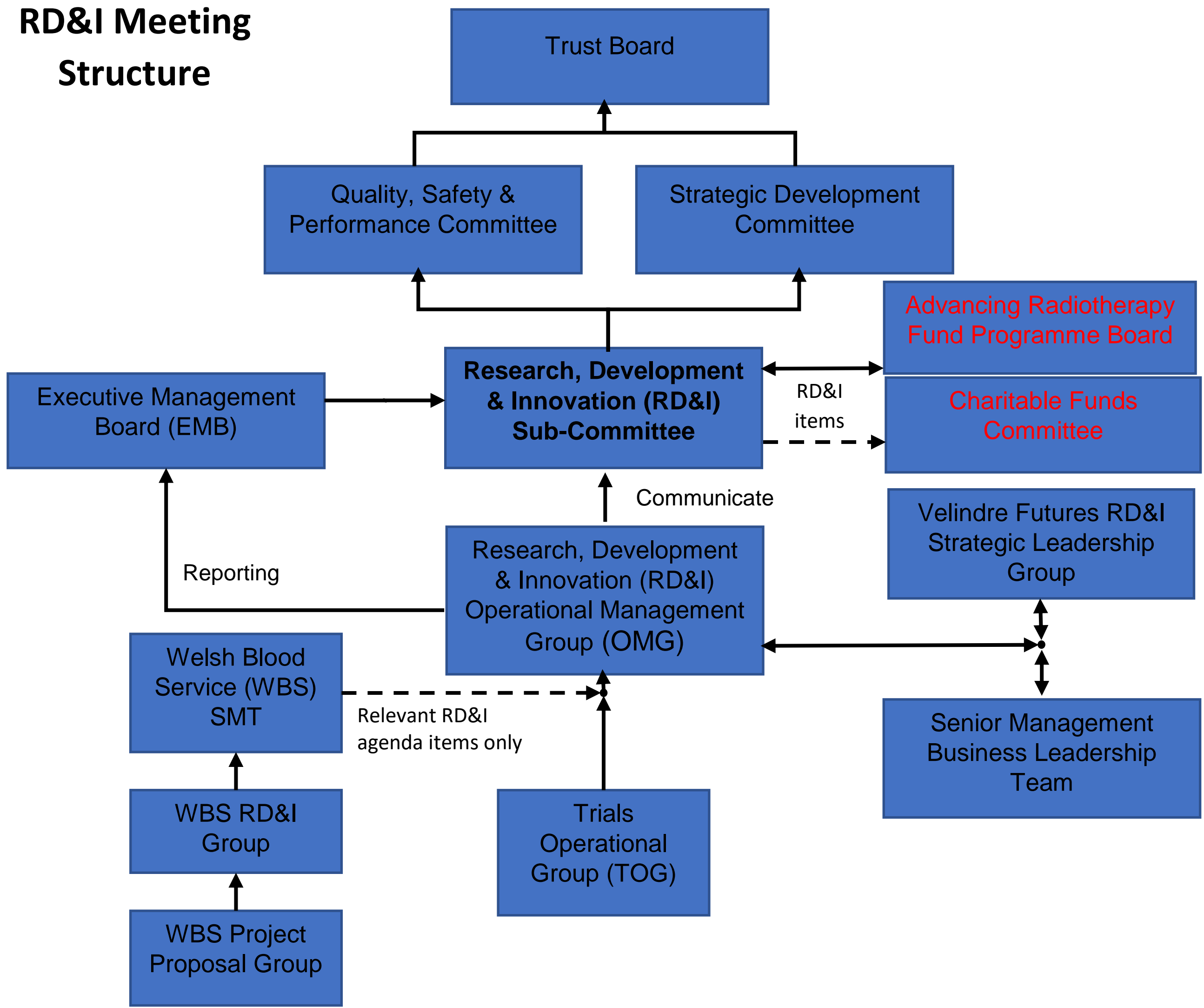
9.1 These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

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

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

APPENDIX 1


RD&I Meeting Structure
Trust Board
Quality, Safety & Performance Committee
Strategic Development Committee
Advancing Radiotherapy Fund Programme Board
Executive Management Board (EMB)
Research, Development & Innovation (RD&I) Sub-Committee
RD&I items
Charitable Funds Committee
Communicate
Velindre Futures RD&I Strategic Leadership Group
Reporting
Research, Development & Innovation (RD&I) Operational Management Group (OMG)
Welsh Blood Service (WBS) SMT
Relevant RD&I agenda items only
Senior Management Business Leadership Team
WBS RD&I Group
Trials Operational Group (TOG)
WBS Project Proposal Group

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2023
Approved:	
Next Review due:	March 2024

1. INTRODUCTION

1.1 The Trust's Standing Orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In accordance with standing orders (and the Trust's Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. CONSTITUTION

2.1 The Velindre University NHS Trust Board was appointed as corporate trustee of the charitable funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and that its Board serves as its agent in the administration of the charitable funds held by the Trust.

2.2 The purpose of the Committee" is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

3. SCOPE AND DUTIES

3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the Charitable Funds in accordance with their respective governing documents.

3.2 To ensure that the Trust policies and procedures for Charitable Funds investments are followed. To make decisions involving the sound investment of Charitable Funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The terms outlined in the Velindre NHS Trust Charity's Governing Documents

3.3 At least twice a year, receive highlight reports from the Executive Director of Finance in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.

3.4 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.5 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

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

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

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

5. AUTHORITY

5.1 The Committee is empowered with the responsibility for:

- Overseeing the day to day management of the investments of the Charitable Funds in accordance with the investment strategy set down from time to time by the Trustees and the requirements of the Trust's Standing Financial Instructions.
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power the Committee must ensure that:

  a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
  b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
  c) The performance of the person or persons exercising the delegated power is regularly reviewed.
  d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2021.
  Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

- Ensuring that the banking arrangements for the Charitable Funds are kept entirely

distinct from the Trust's NHS funds.

- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.

- Obtaining appropriate professional advice to support its investment activities.

- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

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

5.4 **Sub Committees**

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the ***'Charitable Funds Investment Performance Review Sub Committee'***, to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

The Charitable Funds Committee is also supported by the **Velindre Charity Senior Leadership Group**, whose purpose on behalf of the Board of Trustees is to support the development of the strategic direction, take forward strategic delivery and operational management of all Charitable Funds held within the Trust.

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

The **Advancing Radiotherapy Fund (ARF) Programme Board** has also been established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the Charitable Funds Committee, and whilst is not a formal Sub-Committee of the Charitable Funds Committee, it is directly accountable to the Committee for its performance in exercising the functions set out in its formal Terms of Reference as part of good governance arrangements, which are formally approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the Charitable Funds Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board will be supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

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

Attendees

6.2 In attendance

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

- Charity Director
- Chief Operating Officer
- Executive Director of Nursing, AHPs & Health ScienceDirector Velindre Cancer Service (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Senior Finance Business Partner

- Deputy Director of Finance
- Head of Financial Planning & Reporting
- Head of Fundraising
- Head of Corporate Governance (Charity Governance Lead)
- Head of Communications

By invitation, The Committee Chair may invite:

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

Secretariat

6.3 Secretary As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

6.6 In order to demonstrate that there is a visible independence in the consideration of decisions and management of charitable funds from the Trust's core functions, the Board should consider extending invitations to the Charitable Funds Committee to individuals outside of the Board. One option might be to seek representation from the Patient Liaison Group.

Support to Committee Members

6.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

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

7. COMMITTEE MEETINGS

Quorum

7.1 At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member and one must be the Executive Director of Finance or Nominated Representative.

Frequency of meetings

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

Withdrawal of individuals in attendance

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

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

8.1 The Committee will only consider Research, Development and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation Sub-Committee. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.

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

8.3 The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and appropriate sharing of information in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in their capacity as Trustees. This may include, where appropriate, a separate meeting with the Board.

9.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year.

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

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

11. REVIEW

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

12. CHAIR'S ACTION ON URGENT MATTERS

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

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

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

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	January 2023
Approved:	
Next Review Due:	March 2024

1. INTRODUCTION

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

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:

  - the organisation's ability to achieve its objectives,

  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by the Welsh Government and others,

- the reliability, integrity, safety and security of the information collected and used by the organisation,

- the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

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

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

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

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that

- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust's operations are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

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

Authority

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

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

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

4. MEMBERSHIP

Members

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

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

Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*

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

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

Attendees

4.2 In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.)*
Executive Director of Finance
Director of Corporate Governance and Chief of Staff
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation — The Committee Chair may invite:

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

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

Support to Committee Members

4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

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

5 COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

assurance arrangements.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

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

7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

9 REVIEW

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

10 CHAIR'S ACTION ON URGENT MATTERS

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

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

TRUST BOARD

MEMORANDUM OF UNDERSTANDING (MOU) SPINAL NETWORK

DATE OF MEETING	25 May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

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

REPORT PURPOSE	APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB Shape	15/05/2023	ENDORSED

ACRONYMS	
~	~

1. SITUATION/BACKGROUND

1.1 The Memorandum of Understanding for the **Operational Delivery Network (ODN)** as part of the **Spinal Services Operational Delivery Network** for **South Wales**, **West Wales** and **South Powys** will enable the establishment of a coordinated regional strategy for these services across the region. It aims to improve service resilience and sustainability and to enhance patient outcomes and experience. Please refer to ***Appendix 1*** for accompanying brief with further details, context and information.

1.2 The South Wales Spinal Network will be hosted by Swansea Bay University Health Board, and will be commissioned by the Welsh Health Specialised Services Committee.

1.3 The purpose of this report is to seek Trust Board **APPROVAL** for Velindre University NHS Trust to become an established partner and member of the South Wales Spinal Network and the Trust Accountable Officer to sign the **Memorandum of Understanding** (ref. ***Appendix 2***), on behalf of the Trust.

1.4 The Operational Delivery Network (ODN) membership comprises six Health Boards and two NHS Trusts – Welsh Ambulance Service NHS Trust and Velindre University NHS Trust. The six Health Boards have delegated the responsibility for commissioning the ODN to the Welsh Health Specialised Services Committee.

2. ASSESEMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to ***Appendix 1 and 2*** for further details and supporting information*.*

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
LEGAL IMPLICATIONS / IMPACT	Yes
	Further details are provided in Appendix 1-2 of this report
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Further details are provided in Appendix 1-2 of this report.

4. RECOMMENDATION

4.1 The Board is requested to **AUTHORISE** the Chief Executive to sign the **Memorandum of Understanding** – for the Operational Delivery Network (ODN) as part of the Spinal Services Operational Delivery Network for South Wales, West Wales and South Powys, included at ***Appendix 2.***

Briefing – MoU Spinal Network

As clinical directors we are delighted to support the introduction of a new Spinal Network for South Wales, West Wales and South Powys.

By working together in a co-ordinated and more efficient way, this represents a real opportunity to improve the way spinal services are delivered.

Spinal disorders represent a significant medical, social and economic problem because of the increasing incidence within the general population. There are a wide range of disorders, some of which can result in significant life changing problems, such as paralysis if patients are not diagnosed and receive timely and appropriate treatment. There is a further impact on the ageing populations in South Wales, West Wales and South Powys as the prevalence of complex degenerative spinal disorders increases with age.

Spinal disorders cost the NHS more than £1000 million per year[1] and patient mostly present to primary care, and are managed either within primary or secondary care through a complex interaction of multidisciplinary pathways. A proportion of patients will be referred into the spinal surgery centres for assessment for complex or non-complex surgery. A smaller but significant group of patients will be referred directly to spinal surgery services for management of highly time-critical, complex spinal surgical conditions including spinal trauma.

A total of 2,000 patients per annum in South Wales, West Wales and South Powys receive spinal surgical interventions.

Table 1 - Spinal Surgery Activity – 2019/20

	South East			South West	
	ABUHB	**CVUHB - Spinal**	**CVUHB - Neuro**	**SBUHB**	**Total**
Adult deformity and specialised orthopaedic spinal surgery	0	90	0	50	140
Cauda Equina	97[2]			50	147
Infection	12	12	0	10	34
Intradural Pathology	0	10	25	10	45
Metastatic Spinal Cord Compression (MSCC)	5	15	0	12	32
Major Trauma		50		25	75
Non Specialised Cervical Spine	67	115	60	138	380
Non Specialised Lumbar Spine	202	490	65	344	1101
Total					**1954**

There is currently no coordinated regional strategy for these services across South Wales, West Wales and South Powys, and patient flows have been largely determined by historic demand. These arrangements are widely acknowledged to be unsatisfactory, and there is consensus across the clinical community that

[1] https://www.nice.org.uk/guidance/ng59/update/NG59/documents/low-back-pain-update-draft-scope2
[2] Total activity in South East region.

they need to be improved to improve service resilience and sustainability, and to enhance patient outcomes and experience.

Following discussion at the NHS Wales Health Collaborative Executive Group, the Cardiff and Vale UHB and Swansea Bay UHB Regional and Specialised Services Provider Planning Partnership (RSSPPP) established a project to develop recommendations for delivering a safe, effective and sustainable model for spinal surgery in South Wales, West Wales and South Powys.

The project concluded in March 2021, and one of the key recommendations was to establish an operational delivery network with the operational authority to:

- maintain and coordinate patient flow across the spinal surgery pathway.
- lead the development, and coordinate implementation and delivery of standards and pathways.
- promote and support cross-organisational and clinical multi-professional collaboration.

In response to these recommendations, the six Health Boards in South Wales, West Wales and South Powys agreed to establish a spinal services operational delivery network – the South Wales Spinal Network (SWSN).

The SWSN will act as an overarching network for the South East Wales and the South West Wales regional spinal surgery networks for residents within the following areas:

- South East Wales:
    - Aneurin Bevan University Health Board
    - Cwm Taf Morgannwg University Health Board
    - Cardiff & Vale University Health Board, and
    - South Powys
    -
- South West Wales:
    - Swansea Bay University Health Board
    - Hywel Dda University Health Board, and
    - South Powys

Each region contain the following elements of service provision:

- Non-Spinal Partner Hospitals - Hospitals with an emergency department but without any surgeons undertaking spinal surgery on site.
- Spinal Partner Hospitals - These hospitals may have Spinal Consultants offering 'non-specialised' +/- 'specialised' spinal surgery and may offer an emergency service without a 24/7 emergency on-call.
- Spinal Hubs - These hospitals are where the 24/7 emergency spinal service is located but not necessarily where all the emergency work for the region is done. Spinal Hubs can provide regional or supraregional services.

The SWSN will develop, monitor, and review the pathways for each region, and clarify the roles of non-spinal and spinal partner hospitals and the regional and supraregional spinal hubs.

The SWSN will be a partnership between participating organisations, working collaboratively to improve patient outcomes by developing a Value-Based healthcare approach to the management of spinal disorders, delivering care at the most effective part of the pathway. The aim is to develop an inclusive, collaborative, world leading spinal services network, with quality improvement, informed through evidence-based medicine and lessons learnt from others.

The SWSN will be hosted by Swansea Bay University Health Board, and will be commissioned by the Welsh Health Specialised Services Committee.

SBUHB has established an Implementation Board to oversee the establishment of the SWSN. The aim is to have the network established and operational by the end of summer 2023 with a formal launch in September 2023.

Mr. Iqroop Chopra
Joint Clinical Director - Interim Spinal Network,
Consultant Spinal Neurosurgeon, Cardiff and Vale UHB

Mr. Navin Verghese
Joint Clinical Director - Interim Spinal Network,
Consultant Spinal Surgeon, Swansea Bay UHB

Memorandum of Understanding – for the Operational Delivery Network (ODN) as part of the Spinal Services Operational Delivery Network for South Wales, West Wales and South Powys

This Memorandum of Understanding is made on 27/2/23

Between

SWANSEA BAY UNIVERSITY HEALTH BOARD as host of ODN
1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot
SA12 7BR

and

ANEURIN BEVAN UNIVERSITY HEALTH BOARD
Headquarters, Headquarters, Lodge Road, Caerleon, Newport
NP18 3XQ

CARDIFF AND VALE UNIVERSITY HEALTH BOARD
Headquarters, Cardigan House, University Hospital of Wales, Heath Park, Cardiff
CF14 4XW

CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD
Headquarters, Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taff CF45 4SN

HYWEL DDA UNIVERSITY HEALTH BOARD
Headquarters, Ystwyth Building, Hafan Derwen, St Davids Park, Jobswell Road, Carmarthen SA31 3BB

POWYS TEACHING HEALTH BOARD
Headquarters, Glasbury House, Bronllys Hospital, Brecon, Powys LD3 0LU

SWANSEA BAY UNIVERSITY HEALTH BOARD Headquarters, 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot SA12 7BR

WELSH AMBULANCE SERVICE NHS TRUST
Headquarters, Ty Elwy, St. Asaph Business Park, St Asaph, Denbighshire, Wales, LL17 0LJ

VELINDRE UNIVERSITY NHS TRUST

Headquarters, Velindre University NHS Trust, Unit 2, Charnwood Court, Parc Nantgarw, Nantgarw, Cardiff, CF15 7QZ

Collectively established as the Spinal Services Operational Delivery Network for South Wales, West Wales and South Powys

(1) Swansea Bay University Health Board has been identified as the host health board to establish and manage the Operational Delivery Network (ODN). The primary purpose of the ODN is to provide the management function for the network, to maintain and coordinate patient flow across the spinal pathway, lead the development, and coordinate implementation and delivery of standards and pathways, and promote and support cross-organisational and clinical multi-professional collaboration. Further detail of the role and responsibilities of the ODN are described in paragraph 2 below.

(2) This Memorandum of Understanding (MoU) should be read in conjunction with the board paper that was approved by each ODN member organisations in November 2022.

(3) The purpose of this MoU is to outline what the accountability arrangements and resulting responsibilities will mean for both SBUHB and all ODN member organisations.

(4) The ODN membership comprises six Health Boards and two NHS Trusts – Welsh Ambulance Service NHS Trust and Velindre University NHS Trust. The six Health Boards have delegated the responsibility for commissioning the ODN to the Welsh Health Specialised Services Committee.

Contents

1 Background 4
2 Responsibilities of Swansea Bay University Health Board (SBUHB) 5
3 Employment of Staff 9
4 Operational Authority 9
5 Governance Arrangements 9
6 Reporting Arrangements 11
7 Delivery Assurance Group meetings 11
8 Engagement 12
9 Clinical Governance Arrangements 12
10 Data requirements 12
11 Spinal Services ODN Policies 12
12 Clinical Guidelines 13
13 Budget and Funding 13
14 Ownership of Assets 13
15 Duty of Care 13
16 Legislation 14
17 Audit 14
18 Management of Concerns 14
19 Management of FOIA/GDPR Requests 14
20 Dispute 15
21 General 15
22 Review 15
23 Abbreviations 15

1 Background

1.1. The vision for the establishment of the Spinal Services Operational Delivery Network (ODN) is to enhance patient outcomes and experience, by maintaining and coordinating patient flow across the spinal pathway. The network will improve patient outcomes by developing a Value-Based healthcare approach to the management of spinal disorders, delivering care at the most effective part of the pathway. The network will be a partnership between participating organisations, working collaboratively to achieve this common goal and purpose. The aim is to develop an inclusive, collaborative, world leading spinal services network, with quality improvement, informed through evidence-based medicine and lessons learnt from others.

1.2. Following the reorganisation of neurosurgery in South Wales, there have been a number of attempts to improve the organisation and delivery of spinal surgery services. Unfortunately, for a variety of reasons, none of these initiatives were successful, and there remained a lack of clarity around the pathway for elective and emergency spinal care.

1.3. The establishment of an interim network (funded by CVUHB and SBUHB) to take forward the work of the project, and to support the establishment of the ODN (funded by the six Health Boards in Mid, South and West Wales) were approved by members of the NHS Wales Collaborative Executive Group (CEG) in July 2021. The CEG subsequently wrote to WHSSC requesting that WHSSC be asked to commission the ODN on behalf of the networks, as WHSSC has significant expertise commissioning complex and specialised services – see letter at ***Appendix 1.***

1.4. The programme for the Spinal Services ODN was established, following full endorsement by all six health boards in the region, of the following recommendations made by the South and West Wales spinal surgery project:

- An Operational Delivery Network should be established with the operational authority to:
  - maintain and coordinate patient flow across the spinal surgery pathway (elective and non-elective).
  - lead the development, and coordinate implementation and delivery of standards and pathways.
  - promote and support cross-organisational and clinical multi-professional collaboration.

1.5 On the 7 September 2021 the WHSSC Joint Committee approved that WHSSC commission a spinal services operational delivery network (ODN) on behalf of the six Health Boards in Mid, South and West Wales. With the required funding identified and invested in through the WHSSC Integrated Commissioning Plan (ICP) 2022-2025.

1.6 All members of the ODN have freely agreed to abide by this MOU. In accordance with the WHSSC Standing Orders any decision taken and approved by the Joint Committee in respect of the provision of the Relevant Services is binding on the constituent LHBs and may not be undermined by any subsequent decision or action taken by a constituent LHB. (SO 1.1.5)

1.7 Swansea Bay University Health Board (SBUHB) was designated as the host of the Operational Delivery Network (ODN) The primary purpose of the ODN is to maintain and coordinate patient flow across the spinal pathway, lead the development, and coordinate implementation and delivery of standards and pathways, and promote and support cross-organisational and clinical multi-professional collaboration.

2 Responsibilities of Swansea Bay University Health Board (SBUHB)

2.1. Role of SBUHB as host of the Operational Delivery Network (as distinct from SBUHB as provider of Spinal Services) is to manage the ODN in line with the service specification: CP Spinal Services Operational Delivery Network as prepared by the Welsh Health Specialised Services Committee (WHSSC), commissioner of the ODN on behalf of:

- ANEURIN BEVAN UNIVERSITY HEALTH BOARD

  Headquarters, Headquarters, Lodge Road, Caerleon, Newport

  NP18 3XQ

- CARDIFF AND VALE UNIVERSITY HEALTH BOARD

  Headquarters, Cardigan House, University Hospital of Wales, Heath Park, Cardiff

  CF14 4XW

- CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD

  Headquarters, Ynysmeurig House, Navigation Park, Abercynon, Rhondda Cynon Taff CF45 4SN

- HYWEL DDA UNIVERSITY HEALTH BOARD

  Headquarters, Ystwyth Building, Hafan Derwen, St Davids Park, Jobswell Road, Carmarthen SA31 3BB

- POWYS TEACHING HEALTH BOARD

  Headquarters, Glasbury House, Bronllys Hospital, Brecon, Powys LD3 0LU

- SWANSEA BAY UNIVERSITY HEALTH BOARD

  Headquarters, 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot SA12 7BR

2.2. To undertake the role and responsibilities as detailed below:

Service Specification

- The specifications will need to be in place before the ODN becomes operational (i.e. before Day 1). Each element will be ongoing from the point of implementation, unless otherwise stated.
- Essential - These aspects are considered essential and are critical to the successful delivery of the ODN and its key investment objectives.

Strategic planning

- Provide professional and clinical leadership across the network.
- Collaborate with other relevant networks to ensure coproduction of phases of pathways that may have cross cutting themes.
- Develop and implement an effective framework for monitoring quality and performance; and to establish a network-wide audit programme.
- Develop a value-based healthcare approach to the management of spinal disorders, delivering care at the most effective part of the pathway, and reducing interventions of limited efficacy.
- Provide advice on future service provision to commissioners and providers, including the commissioning, delivery, designation of regional and supra-regional spinal services, e.g. in response to changes in legislation or guidance, emerging published evidence or technological developments.
- Host a risk and issues register and undertake risk and issue management across the network.
- Produce quarterly and annual reports for the Network Board Delivery Assurance Group and WHSSC
- Develop an annual working plan for the network to deliver against the quality and delivery framework.
- Contribute to a comprehensive evaluation programme of the network.
- Develop a longer-term plan (5-10 years) to ensure new capabilities can be brought into core operations as quickly and efficiently as possible.

Operational delivery

- The ODN will have the operational authority to maintain, coordinate and when necessary, direct/arbitrate patient flow across the spinal surgery pathway.
- Lead the development, and coordinate implementation and delivery of standards and pathways.
- Ensure improved access and equity of access to spinal services.

- Be responsible for monitoring of day-to-day capacity across the network, agreeing and working to an escalation plan (with agreed thresholds for escalation triggers) both within and across the network to monitor and manage surges in demand.
- Support capacity planning and activity monitoring across the whole of the spinal pathway.
- Support workforce monitoring to ensure minimum standards are met in line with network specifications and policies, for areas providing spinal services across the pathway e.g. FCPs, triage & treat APP/ESP/AMP spinal specific appointments, Spinal surgical hub team junior surgeon and medical/ Orthogeriatric cover.
- Ensure the quality of the network is monitored and subject to a process of continuous quality improvement through clinical audit and peer review.
- Deliver a Spinal Services Network Annual Report and intended work plan to ensure consistent evaluation and development.

Tactical (local) advice and support to commissioners

- Development of both clinical and operational policies, and specifications to support the commissioning of spinal services.
- Improved availability of quality and performance data to inform the commissioning of spinal services.

Improved quality and standards of care

- Mandate the use of the British Spine Registry across the pathway in line with network and pathway specific specifications.
- Develop and implement network protocols for patients.
- Develop value-based healthcare outcomes
- Deliver a robust clinical governance framework across the ODN.
- Evaluate and ensure consistent revision of policies and protocols where appropriate to support the delivery of spinal services.
- Ensure on-going service improvements and best practice models are embedded and contribute to improved quality performance.
- Ensure on-going workforce establishment infrastructure, training and best practice models are embedded and contribute to improved quality performance e.g. Frailty and medical models.
- Use both clinical and operational process and outcome measures to compare and benchmark providers.
- Deliver an annual quality improvement and audit programme.

Partnership development

- Engage with patient representatives and all relevant third sector organisations.
- Promote and support cross-organisational and clinical multi-professional collaboration.
- Link with other relevant networks across NHS Wales and NHS England.
- Embed communication strategies and key communication deliverables.
- Monitor and performance manage active engagement by members in the network to improve performance against agreed outputs.
- Participate in relevant national policy or guideline development.

Desirable/aspirational areas of development

- Instigate a research programme for the spinal pathway.
- Instigate a spinal health promotion scheme.
- Support development of spinal networks in other parts of Wales.
- Design and develop an effective and fully integrated digital infrastructure for spinal services.
- Design and develop an effective training and education programme for spinal services across South Wales, West Wales and South Powys.
- Work with all providers across the spinal pathway to review current practice and evaluate the evidence base for non-surgical and surgical interventions.

2.3. The full draft WHSSC Service Specification is aligned to this document. Note: the service specification remains draft at the time of writing this MoU, any significant changes in the specification will lead to a change in this document.

2.4. Swansea Bay University Health Board responsibilities continued:

- To have in place appropriate governance arrangements and a Scheme of Delegation as necessary and required on the part of SBUHB to enable the ODN to carry out its duties.
- To hold and manage the budget for the ODN making payments and receiving income as necessary.
- To be the legal entity which enters into agreed procurement arrangements to include, but not restricted to, procurement contracts, quotations, terms of engagement commissioned by the ODN and to ensure that the individuals appointed and employed to support the functions of the ODN.
- To be authorised to appoint lawyers and other professional advisors and to agree the terms and conditions from time to time on behalf of the ODN/MTN.

2.5. SBUHB will *not* be responsible or accountable for the planning, funding or providing of clinical services within the ODN.

2.6. In fulfilling its obligations and responsibilities under this MoU, SBUHB shall not be required to or not do and shall not do or omit to do anything which does not comply with SBUHB's statutory powers and duties, Standing Orders and Standing Financial Instructions, corporate governance requirements generally, procurement requirements or any legal obligations not covered by the foregoing.

3 Employment of Staff

3.1. To appoint and employ staff in line with the posts agreed through the Operational Delivery Network (ODN) Board.

3.2. New staff appointed to work within the ODN will be employed by SBUHB, they will be entitled to be treated as any other SBUHB employee. They will be expected to abide by all SBUHB policies, procedures and guidance including, but not limited to, fire safety and health and safety procedures. ODN staff will benefit from access to all applicable policies and procedures including training and development.

3.3. The ODN staff will be accountable for their performance to the Interim Associate Service Director who, for this role, is accountable to the ODN SRO.

3.4. The ODN team will be situated on a non-hospital site.

3.5. ODN staff members will be expected to maintain professional CPD, complete all mandatory training and uphold competencies in line with the requirements of the role.

3.6. ODN staff will be subject to all SBUHB HR policies including annual appraisals/PADR and disciplinary processes.

3.7. Where there are unavoidable long term ODN staff absences (> three weeks) network member health boards will contribute to the unplanned costs of cover.

4 Operational Authority

4.1. Where there is a difference of opinion with patients waiting to be admitted into a spinal surgery service or an inability of a health board to accept a patient back into their 'home' health board, the Network Clinical Director will have the final say on the action to be taken.

5 Governance Arrangements

5.1. SBUHB will have in place appropriate governance arrangements and schemes of delegation as may be necessary and required on the part of the health board to enable the ODN to carry out its functions.

5.2. The ODN will be accountable to the SBUHB for all arrangements pertaining to the running of the ODN. This will include, but not be limited to, employment of staff to work within the ODN, provision of all employment and corporate services, accommodation and training.

- The ODN will report quarterly into the SBUHB Senior Leadership Team (SLT) meeting to provide assurance and evidence that the service is being delivered in line with expectations.
- The SRO of the ODN will report twice yearly into the SBUHB Quality and Safety Committee providing assurance on the on-going compliance with the clinical governance requirements of the service specification. This reporting will include a summary of issues escalated via the Network Board (NB) to the Delivery Assurance Group (DAG).

5.3. The ODN will be held to account by the Delivery Assurance Group (DAG) for delivery of all elements of the Service Specification. In discharging its accountability role the ODN will:
- Ensure any significant matters under consideration by the NB are brought to the attention of the DAG.
- Seek assurance that actions have been taken by ODN member organisations and appropriate Executives (Health Board and Commissioners) of any urgent or critical matters that may compromise patient care and affect the operation of the ODN or the reputation of NHS Wales.

5.4. The ODN will discharge its responsibilities for delivery via the following framework of meetings:
- The DAG will meet on a bi-monthly for the first year and quarterly thereafter. The DAG will be chaired by a WHSSC Executive or WHSSC Independent member. Attendance at the DAG will include the ODN Clinical Director and ODN Manager as a minimum.
- The NB will meet on a monthly basis. Attendance from the ODN will include the ODN SRO, the ODN Clinical Director and service specific Clinical Leads and the ODN Manager. The NB will be chaired by an independent chair, appointed by Host Organisation. Representation from all of the network health boards (including SBUHB) will include the COO along with senior representation from Welsh Ambulance Services Trust (WAST) and Velindre NHS Trust.
- Note the frequency of the meetings may change, with the agreement of all ODN member organisations, depending on the needs of the network.

5.5. The ODN will 'employ' on a sessional basis a Network Clinical Director. This post will not necessarily be clinicians that are substantively employed by SBUHB, rather they are likely to be clinicians employed by other network ODN member organisations. Where this is the case, SBUHB will require written confirmation from the substantive employer that all competence monitoring is up to date and that by taking on the sessional responsibility for the ODN they will not be exceeding the Working Time Directive.

6 Reporting Arrangements

6.1. The ODN will discharge its accountability to the DAG via reporting through the Network Board (NB) which will be organised and managed by the ODN.

6.2. The DAG report formally to the WHSSC on the DAG's activities and will make recommendations to the Joint Committee on behalf of the DAG relating to the commissioning of services. This includes updates on activity, the submission of DAG minutes and written reports as well as quarterly reports
6.3. The DAG will bring any significant matters under consideration by the DAG to the Joint Committee's attention,
6.4. The DAG Ensure appropriate escalation arrangements are in place to alert the relevant Director (HB and WHSSC, where relevant) of any urgent or critical matters that may compromise patient care and affect the operation or reputation of the Joint Committee
6.5. Escalation from the NB of clinical concerns will be considered by the DAG and referred to the WHSSC Quality and Patient Safety Sub-Committee as deemed necessary by the DAG in order to provide assurance to the Joint Committee.

7 Delivery Assurance Group meetings

7.1Frequency of meetings

Meetings shall be held monthly or as the Chair deems necessary in accordance with the work programme.

7.2 Quorum

At least two members from each of the provider organisations and three HB representatives must be present for the DAG to be quorate.

7.3 Dealing with Members interests during Meetings

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

7.4 Withdrawal of individuals in attendance

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

7.5 Circulation of Papers

The Chair and Secretariat will ensure that all papers and reports are distributed at least five working days prior to the meeting.

The confirmed Minutes of the Committee will be sent to the Joint Committee for information.

8 Engagement

The Chair must ensure that the DAG's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual

DAG members must demonstrate, through their actions, that their contribution to the DAG's decision making is based upon the best interests of the NHS in Wales.

9 Clinical Governance Arrangements

The ODN will not have statutory responsibility for clinical governance arrangements within each health board within the Spinal Services ODN. The ODN will be responsible for ensuring regular and complete reporting into the NB on clinical governance matters relating to the ODN.

All network members will provide the information requirement outlined in the Network Clinical Governance and Quality Improvement Structures document, enabling the ODN to be compliant with reporting requirements.

All network members will provide confirmation to the ODN that clinical governance information and incidents have been reported to their own organisations Quality and Safety Committee.

All network members will report and share learning from concerns and serious incidents into the NB.

10 Data requirements

10.1 Full details of data sharing requirements as per the Wales Acord on the Sharing of Personal Information (WASPI) will be shared with each network member organisation's Information Officer once completed.

10.2 All organisations will be required to report against parameters set out in the clinical governance policy

10.3 In the event of a SUI involving the ODN, ODN member organisations will:

- provide information as required enabling the ODN to complete investigations following SUI;
- Disseminate learning following the outcome of the investigation by the ODN

11 Spinal Services ODN Policies

11.1 The policies listed below will be developed collaboratively and approved by the ODN Network Board. All health board are expected to adopt each policy/agreement through their own processes at or before go-live of the ODN.

- Clinical Governance Policy
- Data sharing agreement

11.2 The policies will be accessible on the SharePoint website to all ODN member organisations. New policies and updates to existing policies will be developed and approved through the ODN governance structure. Each health board will be responsible for ensuring it has a process in place for receiving and implementing notifications of new policies and updates to existing policies.

12 Clinical Guidelines

12.1 All clinical guidelines will be developed collaboratively with the process of development having been approved by the ODN Board. Each health board should acknowledge access to the guidelines.

12.2 The ODN will update the clinical guidelines as required and provide notification to all ODN member organisations. ODN member organisations are responsible for having in place a system of receiving updates to clinical guidelines.

13 Budget and Funding

13.1 WHSSC will transfer funds to SBUHB on a quarterly basis in advance to allow SBUHB to perform its functions as the Operational Delivery Network, provided that WHSSC may attach conditions to the expenditure of such funds.

13.2 SBUHB will set up and manage an income and expenditure account for the ODN. This includes all income received from WHSSC and health boards and all ODN expenditure. This account will be separate from all other SBUHB funds.

14 Ownership of Assets

14.1 All assets (including intellectual property rights) acquired by SBUHB in connection with the ODN shall belong to SBUHB but be held upon trust for the ODN.

14.2 SBUHB shall, to the extent it is legally entitled to do so, transfer ownership and any other rights in such assets to such party or body as the commissioner shall require and within such timescales as are reasonably required.

14.3 In the event that any income is derived from such assets or from their disposal, such revenues shall be regarded as part of the ODN income and accounted for accordingly.

15 Duty of Care

15.1 SBUHB shall be responsible for ensuring that all reasonable skill, care and diligence are exercised in carrying out those services which it is required to perform under the agreement properly and efficiently in accordance with this Memorandum of Understanding and its overall responsibilities under the National Health Service (Wales) Act 2006 and all other appropriate legislation. SBUHB shall keep the Commissioner informed of any foreseeable or actual changes in circumstances which are likely to affect its ability to comply with the terms of this MoU as the Host health board.

16 Legislation

16.1 SBUHB shall ensure that it, and its employees and agents, shall in the course of this MoU comply with all relevant legislation, Welsh Government directions and Guidance and procedures.

17 Audit

17.1 SBUHB, through the Shared Services arrangements, will provide an effective independent internal audit function as a key source of its internal assurance arrangements. This will be in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Government.

17.2 SBUHB will ensure that relevant external audit arrangements are in place which give due regard to the functions of the ODN.

18 Management of Concerns

18.1 Where a matter is received into the ODN and is regarded as an individual concern, SBUHB will only be responsible for the management of those concerns where qualifying liability in Tort is established, which relates to its geographical area of responsibility. In such circumstances, the Chief Executive of SBUHB will be responsible for investigating and responding to the concern in accordance with The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulation 2011.

18.2 Individual concerns received into the ODN and relating to patients resident outside SBUHB's geographical area of responsibility will be referred to the Chief Executive of the health board in the appropriate geographical area.

18.3 Where a matter is regarded as a concern and where qualifying liability in Tort has been established, SBUHB will only be responsible for managing the arrangements for redress arising from its own resident population.

18.4 Where a matter is considered to be a review of funding decisions it will be dealt with in accordance with the Review Process set out in the All Wales Policy for Making Decisions on Individual Patient Funding Requests (IPFR).

19 Management of FOIA/GDPR Requests

19.1 Where a request under the Freedom of Information or General Data Protection Regulations is received by the ODN, the request will be dealt with in accordance with SBUHB's procedures. Where the request is considered to be an issue relating to information which is held by other ODN member organisations, then the request will be forwarded to the Board Secretary of the respective health board to respond in accordance with the Freedom of Information Act Code of Practice.

20 Dispute

20.1 In the event of a dispute between the ODN and any of the ODN member organisations that cannot be resolved locally, the issue will be referred up to the DAG and if necessary the Joint Committee.

20.2 In resolving the dispute, WHSSC will rely on the Business Framework included within its hosting agreement with all health boards in Wales.

20.3 A dispute may include non-adherence to this MoU.

21 General

21.1 This MoU shall be capable of being varied only by a written instrument signed by a duly authorised officer or other representative of each of the parties.

21.2 In line with usual NHS arrangements, a notice period of 6 months will apply to a variation or termination of agreement to abide by this MOU.

21.3 No third party shall have any right under the Contracts (Rights of Third Parties) Act 1999 in connection with this MoU.

21.4 This MoU shall be governed and construed in accordance with the laws of England and Wales. Subject to paragraph 18 above, the parties hereby irrevocably submit to the exclusive jurisdiction of the Courts of England and Wales.

21.5 In the event of SBUHB's determining (acting reasonably) that the performance by SBUHB of its obligations under this MoU is having a detrimental effect on SBUHB's ability to fulfil its core functions, SBUHB may instruct the ODN SRO and SBUHB's Chief Executive to review the operation of this MoU.

21.6 In carrying out a review of this MoU further to paragraph 21.4 above, the ODN SRO and SBUHB's Chief Executive shall consider the source and manner of any detriment identified by SBUHB's Board further to paragraph 21.4 and shall put forward such amendments and variations to this MoU and the associated governance arrangements between the ODN and SBUHB as they may consider appropriate.

21.7 SBUHB's Board shall consider the recommendations made further to paragraph 21.5 and may recommend to the ODN SRO and the Chief Executive of SBUHB that this MoU and the associated governance arrangements are amended accordingly.

22 Review

The MOU will be reviewed annually by the DAG.

23 Abbreviations

CPD	Continued Professional Development
DAG	Delivery Assurance Group
FOIA	Freedom of Information Act
GDPR	General Data Protection Regulations
IPFR	Individual Patient Funding Request
MoU	Memorandum of Understanding
NB	Network Board
OD	Operational Delivery Network
QI	Quality Improvement
SBUHB	Swansea Bay University Health Board
SRO	Senior Responsible Officer
WAST	Welsh Ambulance Service Trust
WHSSC	Welsh Health Specialist Services Committee

Signed for and on behalf of
ANEURIN BEVAN UNIVERSITY HEALTH BOARD

Signature: ....

Name: ....

Position: ....

Date: ....

Signed for and on behalf of
CARDIFF AND VALE UNIVERSITY HEALTH BOARD

Signature: ....

Name: ....

Position: ....

Date: ....

Signed for and on behalf of **CWM TAF MORGANNWG UNIVERSITY HEALTH BOARD**

Signature: ....

Name: ....

Position: ....

Date: ....

Signed for and on behalf of
HYWEL DDA UNIVERSITY HEALTH BOARD

Signature: ....

Name: ....

Position: ....

Date: ....

Signed for and on behalf of
POWYS TEACHING HEALTH BOARD

Signature: ....

Name: ....

Position: ....

Date: ....

Signed for and on behalf of
SWANSEA BAY UNIVERSITY HEALTH BOARD

Signature: ....

Name: ....

Position: ....

Date: ....

Signed for and on behalf of
WELSH AMBULANCE SERVICE NHS TRUST

Signature: ....

Name: ....

Position: ....

Date: ....

Signed for and on behalf of
VELINDRE UNIVERSITY NHS TRUST

Signature: ....

Name: ....

Position: ....

Date: ....

TRUST BOARD

TRUST WIDE POLICIES UPDATE

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	03/04/2023 02/05/2023	APPROVED
Quality, Safety & Performance Committee	16/05/2023	APPROVED

ACRONYMS	
EMB	Executive Management Board
QSPC	Quality, Safety & Performance Committee

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

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 during the period **April 2023 to May 2023.**

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Following approval at the relevant forum the policies below were uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

2.2 The list of Policies **APPROVED** since the last Trust Board are outlined below:

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
PP01a: Fire Safety Protocol: Prevention of Fire & Arson	Executive Director of Strategic Transformation, Planning and Digital	Executive Management Board	03/04/2023	**1**
PP07: Protocol for Dealing with Suspect Packages and Bomb Threats	Executive Director of Strategic Transformation, Planning and Digital	Executive Management Board	03/04/2023	**2**
QS12: Safeguarding and Public Protection Policy	Executive Director of Nursing, AHPs and Health Science	Quality Safety and Performance Committee	16/05/2023	**3**
QS08: Policy for the Management of Safeguarding Allegations / Concerns about Practitioners and those in a Position of Trust	Executive Director of Nursing, AHPs and Health Science	Quality Safety and Performance Committee	16/05/2023	**4**

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

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 Trust's documents
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Each policy has been individually assessed to ensure compliance with EQIAs
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the policies that have been approved during the period **April 2023 to May 2023**.

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

Ref: PP01A

FIRE SAFETY PROTOCOL
PREVENTION OF FIRE & ARSON

Executive Sponsor & Function:	Director of Strategic Transformation, Planning, Performance and Estates
Document Author:	Trust Fire Safety Manager
Approved by:	Executive Management Board
Approval Date:	TBC
Date of Equality Impact Assessment:	13th February 2018
Equality Impact Assessment Outcome:	No negative impact
Review Date:	February 2023
Version:	02

CONTENTS **PAGE**

1	STATEMENT OF INTENT	3
2	SCOPE OF PROTOCOL	3
3	AIMS & OBJECTIVES	3
4	ROLES & RESPONSIBILITIES	3
5	FIRE PREVENTION	3
5.1	*General Principles of Prevention*	3
5.2	*Housekeeping*	4
5.3	*Control of Potential Sources of Heat/Ignition*	4
5.4	*Control of Potential Sources of Fuel*	8
5.5	*Control of Potential Sources of Oxygen and Oxidising Agents*	14
6	SECURITY AND PREVENTION OF ARSON	15
7	EQUALITY IMPACT ASSESSMENT	17
8	RELATED POLICIES	17
9	RELEVANT LEGISLATION	17
10	REFERENCES	18
11	GETTING HELP	19

1 STATEMENT OF INTENT

1.1 This protocol provides guidance on practical means to prevent the occurrence of fires including arson in any premises owned, managed or under the control of Velindre NHS Trust or its hosted bodies excluding a single private dwelling.

2 SCOPE OF PROTOCOL

2.1 This protocol applies wherever Velindre NHS Trust or its hosted bodies have a duty of care to service users, staff or other individuals.

3 AIMS & OBJECTIVES

3.1 This protocol aims to support implementation of the Trust fire safety policy (PP02) by providing guidance on measures to reduce the incident of fire from occurring throughout all activities provided by or on behalf of Velindre NHS Trust or its hosted bodies.

4 ROLES & RESPONSIBILITIES

4.1 All staff should refer to the Trust fire safety policy (PP01) with regard to their roles and responsibilities for fire prevention and the Trust security policy (PP) with regard to their roles and responsibilities for security.

5 FIRE PREVENTION

5.1 *General Principles of Prevention*

In order to address the risk of fire and arson, consideration must be given to the following:

a) where possible, avoiding the risk;

b) evaluating risks which cannot be avoided;

c) combating the risk at source;

d) adapting to technical progress;

e) replacing the dangerous by the non-dangerous or less dangerous;

f) developing a coherent overall prevention policy which covers technology, organisation of work and the influence of factors relating to the working environment;

g) giving collective protective measures priority over individual protective measures; and

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

h) giving appropriate instructions to employees

5.2 *Housekeeping*

5.2.1 Good housekeeping not only improves the ambience of premises but also lower the chances of both a fire occurring and the opportunity for malicious activity including arson; some of the practices that should be considered to protect against the risks are:

- in rooms/areas where combustible materials and/or flammable substances are stored, ensuring that there are orderly methods of stacking to reduce the risk of fire spread and to assist firefighting;
- avoid the storage of equipment etc. in plantrooms, services voids and shafts, corridors or lobbies;
- ensure that storage does not obstruct escape routes, fire exits or fire-fighting equipment including fire alarm call points;
- ensure that for the accumulation of rubbish in out-of-sight spaces such as lift wells, behind radiators etc. does not occur;

  where identified, accumulation of waste and unauthorised storage should to be dealt with promptly;
- regular cleaning of workplaces, machinery and equipment spaces, and checks for the accumulation of debris, grease/oil deposits etc.

5.3 *Control of Potential Sources of Heat/Ignition*

- The control of heat sources is a critical element in fire prevention since the presence of heat can represent the means by which fuels are ignited to cause a fire; in addition to the general principles outlined above, the following control measures should be considered to reduce the risk of ignition:

5.3.1 Electrical Appliances

- The incorrect use or failure of an electrical appliance may provide sufficient heat to ignite nearby combustible materials. In order to prevent the incidence of fire, electrical appliances should always be used in accordance with the manufacturer's instructions.
- Only electrical appliances procured and supplied by the Trust are to be used on Trust premises. The use of any extension lead obtained other than through the Trust's authorised procurement is prohibited unless there is sufficient justification for use (i.e. staff need to use personal mobile phones for work purposes).

- Care should be taken to ensure that the ventilation of any appliance is not obstructed, and that foreign objects cannot enter the appliance by means of the ventilation openings.
- If any electrical appliance, including the electrical cable and plug supplying that appliance, is damaged, it should be removed from service until such time as the damage has been properly repaired by qualified service/maintenance personnel.
- Ensure that plugs have the correctly rated fuses.

5.3.2 Observance of Religious Festivals

- The Trust recognises that during some religious festivals, there is a use of candles and lights, therefore naked flames, i.e. Advent/Christmas and Diwali: staff, patients, donors and visitors who wish to celebrate these should use electronic (battery powered) candles in preference to naked flames.

5.3.3 Portable Heaters

- Where heaters (either portable or fixed) are used, care must be taken to ensure sufficient ventilation and air movement around the heating appliance.
- Combustible materials should be kept a minimum of *0.5m* away from any heater.
- Particular attention should be given to portable convection heaters that require sufficient clearance beneath then to allow air to be drawn across the heating elements. If any damage occurs to the convention heater feat, the heating appliance should be removed from service immediately.
- Portable heaters must not be located beneath desks or other such obstructions that would be subjected to the heat rising from the heater.
- Portable heaters must not be plugged into multi-way extension leads.

5.3.4 Battery Powered Appliance Chargers

- Battery powered appliances such as mobile phones, tablet computers etc. **must** only be charged using the manufacturer recommended charger. Generic chargers may not be fully compatible with the appliance being charged and must therefore not be used.
- When charging, combustible materials should be kept a minimum of *0.3m* away from the battery powered appliance, and care should be taken to ensure that the ventilation of the appliance and/or charger is not obstructed.
- When charging is complete, or when the appliance is disconnected from the charger, the charger must be switched off and unplugged.

5.3.5 Extension Leads and Adaptors

- The use of multi-way electrical adaptors and wound extension leads is prohibited in premises occupied by the Trust, except where approved 110V extension leads are used by contractors or maintenance personnel.
- The use of extension leads should be minimised with additional fixed electrical sockets being provided where necessary. Where the use of extension leads is unavoidable care must be taken to ensure that their use does not increase the potential for a fire to occur.
- Where multi-socket extension leads are used, they must be of an approved, industrial type in line and fused at the block, and the total current used by the appliances plugged into the extension lead must not exceed the extension lead rating. If in doubt, seek advice via the Estates Helpdesk prior to using any extension lead.
- Any extension lead must only be plugged directly into a switched wall socket, and never into another extension lead. The switched wall socket must be readily accessible to allow the power to the extension lead to be easily switched off.
- Care must be taken to ensure that the extension lead cable is not routed where it may come into contact with a source of heat or where it may be damaged. Particular attention should be given to extension leads that may run beneath desks which may be inadvertently damaged by crushing beneath the feet of anyone using the desk, or by the castors of chairs.

5.3.6 Cooking/Food Warming Appliances and Kitchen Appliances

- The inappropriate use and/or lack of supervision of cooking/food warming appliances have resulted in many incidents of fire and false alarms in healthcare premises. The use of cooking/food warming appliances must always be appropriately controlled to minimise the likelihood of fire. Such controls include ensuring that these appliances are only used in specifically designated areas that are provided with appropriate fire precautions:
- Cooking appliances and white goods should only be used in a designated kitchen area which is provided with appropriate fire detection and fire resisting construction.
- Cooking appliances and white goods should be used in accordance with manufacturer’s instructions; **DO NOT** use cooking appliances for anything other than their intended use.

  NB: ALWAYS READ INSTRUCTIONS as some manufacturer’s literature clearly state that appliances are not suitable for non-domestic use.

- Cooking appliances should never be left unsupervised whilst in use; commercial hobs, hot-plates and deep fat fryers should not be left unattended unless the appliance has cooled to room temperature.
- Where possible, cooking appliances and white goods should either be provided with fused spurs or unplugged when not in use.
- Cooking appliances and white goods should be free from obstruction to allow adequate ventilation; especially when they are in use.
- Combustible materials should be kept a minimum distances from cooking appliances:
  - *0.5m* away from a hot plates or cooking hobs
  - *0.3m* away from a toaster
  - *0.3m* away from a microwave
- Combustible materials should not be placed upon any cooking appliance, even when the appliance is not in use.
- Cooking appliances should not be located under cupboards etc. which could be subjected to rising heat.
- Cooking appliances **must be** of the Trust approved design:
  - Toasters - all metal body.
  - Microwaves - low wattage below 800W and metal body
  - Kettles – where possible, wall mounted boilers with fused spurs should be used in preference to kettles.
- Care should be taken to ensure that the controls are set appropriately,
- All cooking appliances should be kept clean and free from build-up of combustible detritus.
- Where refrigerators or freezers are used care must be taken to ensure sufficient ventilation to the rear and/or front vents of the appliance. The appliance vents must be periodically cleaned to prevent the build-up of lint and other detritus which may prevent sufficient air circulation through and around the appliance.
- The door to any refrigerator or freezer must be kept shut whilst the appliance is on except for short period when the contents are being accessed. Any damage to the door seals should be repaired a qualified service personnel as soon as possible or the appliance removed from service.
- Where a freezer is provided with a “fast freeze” function, the facility should only be engaged for the minimum period required to freeze the appliance contents.

- Should either a refrigerator or freezer begin emitting unusual noises such as hissing or mechanical noise, the appliance should be inspected by suitably qualified service personnel as soon as possible or the appliance removed from service.

5.3.7 Smoking

- The Trust operates under a “smoke-free” policy in which smoking is prohibited anywhere on the Trust’s premises. However, staff must be vigilant since illicit smoking presents an even greater potential for fires to occur than the previously accepted practice of controlled smoking in designated areas.
- Where illicit smoking is suspected, staff should check that any smoking materials have been fully extinguished and properly disposed of. Particular attention should be given to waste receptacles where carelessly discarded smoking materials may ignite any combustible contents. If the perpetrator can be identified, staff should ensure that they are reminded of the “smoke-free” policy and where necessary should escalate the issue by referral to their manager.

5.3.8 Hot Works

- Any process involving hot works must be subject to an appropriate assessment of fire risk and suitably controlled so as to minimise the likelihood of a fire occurring. Refer to the Trust’s and/or landlord’s procedures permit for hot works for specific guidance and code of practice.

5.4 *Control of Potential Sources of Fuel*

- The control of fuels in the form of combustible materials is another critical element in fire prevention since a fire can only start and develop if there is sufficient fuel available.
- Whilst many of the combustible materials present in the healthcare environment are either naturally fire retardant or treated with fire retardant chemicals to limit their potential for fire spread, such properties do not prevent those items from being ignited. In the presence of a sustained heating or in an oxygen enriched atmosphere, such fire retardancy is likely to be overcome.

5.4.1 Combustible Materials and Waste

- Paper goods and many other disposable items represent a significant source of fuel given their abundance and near universal availability in the healthcare environment.
- Such combustible items must be kept away from any sources of heat and in particular and items with the potential to produce a naked flame or sparks, or any item whose operation produces elevated temperatures such as heaters or cooking appliances.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

- Care must be taken to ensure that significant quantities of paper goods and other combustible disposable items are stored in designated storage areas which are provided with appropriate fire detection and fire resisting construction.
- The quantity of paper goods and other combustible disposable items stored in any area should be kept to the minimum quantity necessary to meet operational requirements.
- The modern healthcare environment generates considerable volumes of combustible waste and regular collection of waste material is essential, from wards and patient treatment areas and from designated holding points.
- Wherever possible, the volume of combustible waste that may be present in ward and patient treatment areas should be minimised. Where practicable, this may be achieved by removing the outer packaging of supplies prior to delivery to the ward or patient treatment area.
- Waste materials must only be placed in officially provided containers, and at designated collection points such as disposal holds and refuse stores.
- In no circumstances should combustible waste be allowed to remain in corridors, even on a temporary basis, unless stored in a designated waste bin. Designated waste bins with lockable lids are provided for depositing waste and staff should ensure that the waste bin lids remain locked at all times, particularly where the waste bin is located in a publically accessible area.
- Waste bins must not be allowed to overflow such that the bin lid cannot be locked shut. If additional waste bins are required contact relevant department (Operational Services, Facilities etc.) to request a waste collection.
- Combustible waste must not be placed in any cage or other such open structure unless contained within a designated secure disposal hold or refuse store which is provided with appropriate fire detection and fire resisting construction.

5.4.2 Linen

- As with paper goods, linen represents a significant source of fuel given its abundance and near universal availability in the in-patient, healthcare environment.
- Items such as bedding, clothing, towels etc. will exhibit some degree of fire retardancy, however, these items must be kept away from any sources of heat and in particular and items with the potential to produce a naked flame or sparks, or any item whose operation produces elevated temperatures such as heaters or cooking appliances.

- Linen must only be stored in designated storage areas which are provided with appropriate fire detection and fire resisting construction.
- The quantity of linen stored in any area should be kept to the minimum quantity necessary to meet operational requirements.

5.4.3 Curtains, Drapes and Screens

- Such items will exhibit some degree of fire retardancy, however, their vertical orientation means that should fire can spread more rapidly along these items than if they were in a horizontal orientation.
- Particular care should be taken to ensure that curtains, drapes and screens are kept away from potential sources of heat and specifically that they are not allowed to be draped over electrical equipment where they may block ventilation openings or otherwise prevent appropriate air movement around equipment.
- Staff should be mindful of the potential for air movements from open windows to deflect curtains and drapes such that they may unintentionally come into contact with sources of heat.
- Curtains, drapes and screens must only be stored in designated storage areas which are provided with appropriate fire detection and fire resisting construction.
- The quantity of curtains, drapes and screens stored in any area should be kept to the minimum quantity necessary to meet operational requirements.

5.4.4 Furniture

- Whilst generally the majority of furniture in the healthcare environment is constructed using combustible materials, the main cause for concern relates to upholstered furniture since such items have the potential to burn rapidly once involved in a fire.
- The upholstered furniture provided in healthcare premises should meet a minimum standard for fire retardancy and with the exception of relatively low risk areas such as offices, should meet the fire performance standards relating to ignition sources 0, 1 & 5. This should be clearly identified on a label permanently affixed to the furniture item. In low risk areas the fire performance standards relating to ignition sources 0 & 1 should be met.
- Despite the fire retardancy and tested fire performance of items of furniture, it is important to ensure that items of furniture are kept away from any sources of heat and in particular any item whose operation produces elevated temperatures such as heaters.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

- Particular care should be taken to ensure that patient bedhead light units do not come into contact with items of furniture, or are not turned on when in close proximity to furniture where the heat produced from the light unit may be sufficient to ignite the furniture or cause it to char or smoulder.
- Upholstered furniture is particularly vulnerable to fire when the outer cover has become damaged whether through wear or vandalism. If the cover fabric is damaged and the filling material is exposed, the item of furniture should be withdrawn from use and repaired as soon as possible, irrespective of its location. Items that cannot be economically repaired should be disposed of.
- Furniture not in use must only be stored in designated storage areas which are provided with appropriate fire detection and fire resisting construction and the quantity being stored in any area should be kept to the minimum quantity necessary to meet operational requirements.

5.4.5 Flammable/Highly Flammable Substances

- The control of flammable liquids is particularly important since they are generally more volatile and can be used to accelerate the development of a fire. Whilst flammable liquids generally represent a greater fire hazard that a comparable quantity of solid combustible material, their availability is usually much lower than that of other combustible materials.

5.4.6 Alcohol Sanitisers

- Whilst readily available, the quantities of sanitiser present in any one discrete dispenser do not represent a significant fire hazard. However, where sanitiser liquids and gels are brought into contact with permeable combustible items such as paper goods, textiles of upholstered furniture coverings, the fire risk increases significantly. Hence, care should be taken to limit the potential for sanitiser fluids to inadvertently contaminate other combustible materials, and staff should be vigilant for potential acts of deliberate contamination.
- All sanitiser fluids that are readily accessible should be contained within an appropriate dispenser positioned in a suitable location. The quantity of sanitiser made available should be kept to the minimum necessary to meet operational requirements.
- Sanitiser fluids not fitted within approved dispensers must only be stored in designated storage areas which are provided with appropriate fire detection and fire resisting construction, and the quantity being stored in any area should be kept to the minimum quantity necessary to sustain immediate operational requirements. In

any case, the total volume of sanitiser fluids present in any patient accessed department (quantity in dispensers and being stored) must not exceed 25 litres.

5.4.7 Cleaning Solvents

- Although the majority of cleaning products in use do not contain flammable solvents, there may be instances where their use cannot be avoided. In such cases, care must be taken to ensure that such solvent based liquids are not used on surfaces with elevated temperatures such as heaters or cooking appliances.
- Any cleaning cloths or other permeable materials that have been contaminated with solvent based fluids must be thoroughly aired and, where possible, thoroughly rinsed through to remove any solvent residue, prior to their storage or disposal.
- Solvent based cleaning fluids must only be stored in designated storage areas which are provided with appropriate fire detection and fire resisting construction, and the quantity being stored in any area should be kept to the minimum quantity necessary to meet immediate operational requirements.

5.4.8 Fats & Oils

- Generally any significant quantities of fats and oils will only be present in the main catering facilities.
- When cooking with fats and oils it is important to ensure that the temperature of the cooking appliance is appropriately set to prevent ignition.
- Care should be taken when filling cooking equipment such as deep-fat fryers with oil to avoid overfilling and spills. Any spills should be immediately cleaned up.
- Before emptying oils from deep-fat fryers, the oil must be allowed to cool, preferable overnight. The oil should be drained into a suitably sized metal or heat resistant container provided with a secure lid and appropriate carrying handles or other means for the safe transportation of the waste oil.
- All oils and fats must only be stored in designated storage areas which are provided with appropriate fire detection and fire resisting construction. Waste oils must only be stored in designated storage areas which if inside the building must be provided with appropriate fire detection and fire resisting construction, and if outside must be suitably secured to prevent unauthorised access.
- The quantity of oils and fats stored, including waste oils, in any area should be kept to the minimum quantity necessary to meet immediate operational requirements.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

5.4.9 Aerosols

- Butane and propane gasses are widely used as propellants in aerosols; these and other similar products are extremely flammable. It is important therefore to ensure that aerosols are used carefully and never sprayed at or near items with the potential to produce a naked flame or sparks, or any item whose operation produces elevated temperatures such as heaters or cooking appliances.
- Wherever possible, products packaged in pressurised aerosol containers should be replaced with non-aerosol sprays.
- Pressurised aerosol containers must be kept away from all items potential heat sources, even when empty.
- Pressurised aerosol containers must not be disposed of in the general waste but must be kept separately for collection and appropriate disposal.
- Where multiple pressurised aerosol containers are to be stored, they must only be stored in designated storage areas which are provided with appropriate fire detection and fire resisting construction. The quantity of pressurised aerosol containers being stored in any area should be kept to the minimum quantity necessary to meet immediate operational requirements.

5.4.10 Paraffin based skin products

- Skin products containing paraffin based products, for example White Soft Paraffin, White Soft Paraffin plus 50% Liquid Paraffin or Emulsifying ointment in contact with dressings and clothing are easily ignited with a naked flame or a cigarette.

  Care is also essential if the patient is also receiving oxygen therapy as even in minute quantities, skin products containing paraffin based products may ignite in the presence of high pressure oxygen or nitrous oxide.
- Fire safety information should be displayed prominently in every clinical area.
- All such products should be clearly labelled in accordance with NHS National Patient Safety Agency (NPSA) recommendations.
- If prescribed by the Trust, information should be given on the first occasion that such treatment is prescribed, dispensed or administered by a healthcare professional and a record kept confirming that such advice has been given. A check should be made on subsequent occasions that the advice has been received previously and understood.
- Advise patients not to: smoke; use naked flames (or be near people who are smoking or using naked flames); or go near anything that may cause a fire while skin products are in contact with their medical dressings or clothing

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

- If, against advice, a patient from the wards intends to leave the ward to smoke, they should be informed of the risk and advised to wear a thick outer covering that has not been contaminated with paraffin based products.
- Relatives or carers should be informed if a patient does not comply with safety advice.
- Change patient clothing and bedding regularly—preferably daily.

5.5 *Control of Potential Sources of Oxygen and Oxidising Agents*

- Whilst it is generally not possible or desirable to remove oxygen from the premises, the presence of higher concentrations of oxygen can increase the likelihood that a fire may start and increase the intensity of a fire once ignited. It is therefore important to limit the potential for oxygen concentration to rise above that normally present in atmospheric air.
- Patients receiving medical gases with a higher that atmospheric concentration of oxygen through a mask, must be warned of the potential dangers of using products containing volatile substances such as paraffin based lip balms and some topical skin treatments.

5.5.1 Piped Medical Gas Supplies (MGPS)

- Care should be taken to ensure that the piped medical gas outlets are turned off when not in use.
- Before connecting or operating the medical gas system care should be taken to ensure that hands are clean and that any hand sanitiser has fully evaporated.
- Where patients are receiving medical gas by means of a mask or nasal cannula, patients should be made aware of the particular dangers of removing the mask or cannula and placing it upon their bedding, clothing or other permeable fabric whilst the gas is still being supplied. Bedding that has become saturated with oxygen is readily ignited with the oxygen enriched atmosphere effectively overcoming any fire retardancy of the fabric.

5.5.2 Gas Cylinders

- Where medical gas cylinders are in use care must be taken to ensure sufficient ventilation in the immediate vicinity of the gas cylinder and in the room of use to prevent an increase in oxygen concentration.
- Before handling or operating any medical gas cylinder care should be taken to ensure that hands are clean and that any hand sanitiser has fully evaporated.

- When in use cylinders should be firmly secured to a suitable cylinder support.
- Cylinders should not be placed on patients beds, they must `be placed in specifically designed holders where they can be kept away from direct contact with combustible materials.
- Medical gas cylinders should be stored in appropriate storage racks or trolleys to prevent them being knocked over, and away from combustible materials. Cylinders larger than size AE, or where more than two smaller cylinders are to be stored, should be stored in a designated room provided with appropriate fire detection, fire resisting construction and ventilation.

5.5.3 Oxidising Agents

- Although most oxidizing materials do not burn themselves, they can produce very flammable or explosive mixtures when combined with combustible materials.
- Oxidising substances (e.g. peroxides and nitrates) should be stored in a COSHH metal cabinet well away from organic matter such as wood and paper. Oxidising agents should never be stored in a wooden cabinet or be stored with flammable solvents or reducing agents since this may result in fire or explosion, particularly if a spillage occurs, even without a naked flame or heat present.
- The volume of oxidising agents being stored should be kept to the minimum quantity necessary to meet operational requirements.

6 SECURITY AND PREVENTION OF ARSON

6.1 Arson is a significant cause of fire in all types of premises. It is a cause for concern to those who are required to meet the costs of such fires – especially healthcare providers because of the inherent life risk in most of the premises they occupy and the impact that fire damage may have on the wider provision of healthcare.

In many cases, arsonists are likely to start a fire whenever they are presented with a casual opportunity. These are circumstances where:

- there is an ample supply of fuel, for example, waste bags awaiting disposal in a corridor;
- they have an ignition source, for example, matches or cigarette lighter; and
- they feel they are unlikely to be discovered, for example, no visible surveillance, no-one is around and there is an escape route available.

6.2 It is worth remembering that implementing measures against arson will also work against other forms of criminality, such as theft, burglary and countering terrorism. Where

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

possible, additional security measures should be integrated with the existing security regime.

6.3 Measures to reduce the risk of arson include the following:

- Compliance with relevant Trust Policies, protocols and local procedures
- Preparation of local fire procedures;
- Regular assessment of the risk;
    - isolated or disused premises;
    - premises situated in run-down or socially deprived areas; and
    - premises in areas where large crowds congregate at night or where disturbances frequently occur.
- Provision of a secure environment (such as window locks, secure entry doors out of hours, securing external stores of flammable materials and waste, securing internal sources of flammables out of hours, secure site boundaries etc.):
    - lock unoccupied offices, rooms and store cupboards; secure potential sources of fuel internally and externally;
    - remove automatic entry rights from staff who have been dismissed;
    - make sure all combustible rubbish is removed and stored securely; do not place rubbish skips adjacent to the building and secure waste bins in a compound separated from the building;
    - keep public, communal and external areas (such as exits, entrances, lavatories, service corridors and yards) clean, tidy and well lit; thoroughly secure all entry points to the premises, including windows and the roof, but make sure that any people working alone still have adequate escape routes; pruning vegetation and trees, especially near entrances and exits will help.
- Increase in staff awareness through training etc.; encourage them to report people acting suspiciously;
- Installation of security systems, such as intruder alarms, CCTV etc.:
    - Ensure systems are routinely inspected and maintained;
    - ensure that security alarm/fire-detection systems are monitored and acted on;
    - regular review of CCTV systems to ensure that it is working and has sufficient coverage both internally and externally;
- Presence of trained security personnel, especially out of hours.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

7 EQUALITY IMPACT ASSESSMENT

7.1 The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its Employees reflects their individual needs and does not discriminate against individuals or groups.

7.2 The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

7.3 The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

7.4 With regard to fire safety, the Trust recognises that during some religious festivals, there is a use of candles and lights, therefore naked flames, i.e. Advent/Christmas and Diwali, the Trust would recommend that staff, patients, donors and visitors, that wish to celebrate use electronic (battery powered) candles; additionally, any electronic main adapter lights are subject to PAT testing.

8 RELATED POLICIES

8.1 This protocol supports the implementation of the following Trust policies:

- Fire Safety policy (PP01)
- Security policy (QS08)
- Smoking-free policy (GC08)
- Control of Substances Hazardous to Health policy (QS33)
- Work Equipment policy (QS36)
- Waste Management policy (QS20)
- Business Continuity Management policy (GC12)
- Electrical (LV) policy (tbc)
- Medical Gases policy (tbc)

9 RELEVANT LEGISLATION

9.1 This protocol supports the implementation of the following legislation:

- The Regulatory Reform (Fire Safety) Order 2005

- The Health and Safety at Work etc. Act 1974
- The Building Act 1984
- The Housing Act 2004
- The Equality Act 2005
- The Fire and Rescue Services Act 2004
- The Construction (Design and Management) Regulations 2015
- The Smoke-Free Premises etc.(Wales) Regulations 2007
- The Management of Health and Safety at Work Regulations 1999 (as amended)
- The Dangerous Substances and Explosive Atmospheres Regulations 2002

10 REFERENCES

- (W)HTM 00 – Policies and principles of healthcare engineering
- (W)HTM 02 – Medical gas pipeline systems
- The Firecode (Health Technical Memorandum 05 - fire safety in the NHS) suite of documents builds upon the Welsh Assembly Government's Fire Safety Policy statement; Firecode comprises:
  - 05-01: Managing healthcare fire safety (Welsh Edition) -
  - 05-02: Guidance in support of functional provisions for healthcare premises
  - 05-03: Operational provisions (Parts A to L)
- (W)HTM 06 – Electrical services supply and distribution

  http://howis.wales.nhs.uk/sites3/page.cfm?orgid=254&pid=53549

- HM Government Fire Risk Assessment Guidance documents -:

  The following premises types are covered:

  - Offices & Shops
  - Places of Assembly (small)
  - Places of Assembly (large)
  - Sleeping Accommodation

  https://www.gov.uk/government/collections/fire-safety-law-and-guidance-documents-for-business

- Crowded Places guidance – National Counter Terrorism Security Office (NaCTSO) 2017: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/619411/170614_crowded-places-guidance_v1.pdf

11 GETTING HELP

11.1 Further information and support is available from the Trust Fire Safety Manager (robin.weaver@wales.nhs.uk) on 029 2061 5888 (ext. 4156) / WHTN 01875 6585.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

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

Ref: PP07

PROTOCOL FOR DEALING WITH SUSPECT PACKAGES AND BOMB THREATS

Executive Sponsor & Function:	Chief Operating Officer
Document Author:	Trust Fire Safety Manager
Approved by:	Executive Management Board
Approval Date:	TBC
Date of Equality Impact Assessment:	TBC
Equality Impact Assessment Outcome:	No negative impact
Review Date:	TBC
Version:	03 **[DRAFT]**

CONTENTS

1 INTRODUCTION
2 PURPOSE OF THIS GUIDANCE
3 THE HAZARD: SUSPECT ITEMS
4 THE HAZARD: CRB SUBSTACNES
5 PREVENTION – HOUSEKEEPING PRINCIPLES
6 RESPONSE – DISCOVERY OF SUSPICIOUS ITEM
7 RESPONSE – RECEIPT OF SUSPECT ITEM THROUGH POST/COURIER
8 RESPONSE – RECIEPT OF BOMB THREAT
9 RESPONSE – SEARCH PLANNING
10 RESPONSE – EVACUATION OR INVACUATION
11 ROLE OF THE POLICE
12 TRAINING
13 EQUALITY IMPACT ASSESSMENT
14 RELEVANT LEGISLATION
15 RELATED POLICIES
16 REFERENCES
17 GETTING HELP / USEFUL INFORMATION

DRAFT

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

1 INTRODUCTION

1.1 At present, the terrorism threat faced by the United Kingdom is considered to be significant; attacks can take place at any time and any place without warning.

NHS and other healthcare premises are not immune to such attacks, and everyone has a role to play by taking appropriate steps to maintain a safe and secure environment for our service users, staff and others.

1.2 Whilst it is acknowledged that the concept of absolute security is almost impossible to achieve in combating the threat of terrorism, it is possible to reduce the risk to as low as reasonably practicable.

1.3 It recognised that there is a need for the Trust to maintain environments which are friendly and welcoming, and it is not intended to create a fortress mentality; however, a balance needs to be struck and proportionate protective security measures introduced to mitigate and respond to the risk of terrorism.

1.4 It is also worth considering that implementing measures for countering terrorism will also work against other forms of criminality, such as theft, burglary and arson.

This protocol also considers the potential risk posed by violence and aggression incidents including more extreme manifestations of behaviour resulting from individuals with mental health issues.

Where possible, additional security measures should be integrated with the existing security regime.

1.5 This protocol also be considered the potential

2 PURPOSE OF THIS GUIDANCE

2.1 This protocol supports the Trust's response to ProtectUK the UK's counter-terrorism strategy, the aim of which is to reduce the risk faced from terrorism so that people can go about their lives freely and with confidence.

2.2 The protocol provides advice on:

a) Housekeeping practices
b) How to identify suspicious items
c) How to deal with the discovery of suspicious items
d) How to deal with suspicious items received through the post
e) How to deal with receipt of a bomb threat
f) Appropriate responses:
   - Evacuation, Invacuation or "RUN-HIDE-TELL-STAY"
   - Search procedures.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

DRAFT

2.3 If you are based on premises not directly managed by the Trust, it is likely that there are local procedures in place; you need to familiarise yourself with the procedures specific to the site you are on.

3 THE HAZARD: suspect items

3.1 Bombs and hazardous substances can be sent through the post, sent by courier or delivered by hand/left on site; the following characteristics may suggest that an item presents a threat – *refer to figure 1*:

- Discolouration, crystals or surface, strange odours or oily stains
- Envelope with powder or powder-like substance
- Excessive tape or string
- Unusual size and/or weight given size
- Lopsided or oddly shaped envelope
- Postmark which does not match return address
- Restrictive endorsements such as "Personal" or "Confidential"
- Excessive postage
- Handwritten, block-printed or poorly typed address
- Incorrect titles
- Title but no name
- Misspellings of frequently used words

3.2 A quick indicator that something received through the post or delivered to site may be suspect is to think of the *7 S's*:

- *Size*
- *Shape*
- *Sender*
- *Stamps*
- *Seal*
- *Staining*
- *Smell*

3.3 Refer to section 7 for the appropriate response to this type of incident.

DRAFT

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

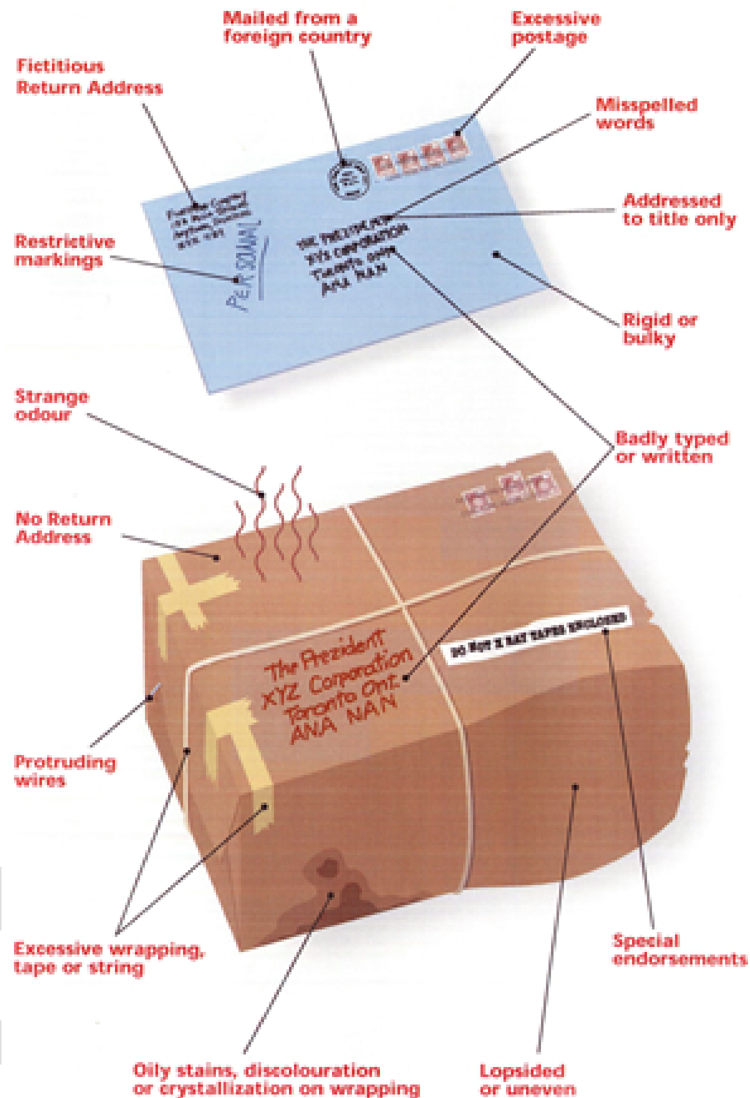


FIGURE 1

4 THE HAZARD: Chemical, Biological and Radiological (CBR) substances

4.1 Although the use of CBR substances as a means of attack are difficult to conduct, they have the potential to cause significant harm and disruption.

4.2 What are CBR substances?

a) *Chemical*: poisoning or injury caused by chemical substances, including harmful industrial or household chemicals

b) *Biological*: illnesses caused by the deliberate release of dangerous bacteria or viruses or by biological toxins

c) *Radiological*: illness caused by exposure to harmful radioactive substances

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

d) Within the wider definition of CBR, the term 'White Powders' is often used in a mail context to describe the potential presence of a noxious substance/hoax material in a letter or parcel that is designed to cause significant harm or disruption; however, some materials may not be white and may not be powders

4.3 Indicators of a CBR substances are present include:

- Odd smells or tastes
- Individuals showing unexplained signs of skin, eye or airway irritation, nausea, vomiting, twitching, sweating, disorientation, breathing difficulties
- The presence of hazardous or unusual materials/equipment
- Unexplained vapour, mist clouds, powder, liquids or oily drops
- Withered plant life or vegetation
- Distressed birds or animals.

4.4 Refer to section 9 for the appropriate response to CBR materials.

5 PREVENTION – housekeeping practices

5.1 Good housekeeping reduces the opportunity for placing suspicious items and also helps deal with false alarms and hoaxes.

Items left unsecure on sites, such as flammable/highly flammable substances, tools, scaffolding and ladders, could be used during an attack.

5.2 The following actions should be taken;

- Keeping public and communal areas such as reception areas, stairwells, corridors, toilets and external areas clean and tidy;
- Reduce the number of places where suspect items can be hidden by restricting the amount of furniture to the minimum and keeping vegetation and trees especially near entrances and exits pruned;
- Maintaining site security by keeping unoccupied areas / rooms such as offices, meeting rooms, store rooms and cleaners' cupboards secure when not in use;
- Regular removal of rubbish from bins especially during periods of heightened threat which may necessitate the removal of litter bins;
- Use of clear refuse sacks which also need to be removed on frequent basis.

Staff should be encouraged and supported to report anything which they believe to be suspicious or out of place.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

6 RESPONSE – discovery of a suspicious item

6.1 If you believe that an item is suspicious, the "*4Cs*" protocol should be applied - *CONFIRM*, *CLEAR*, *COMMUNICATE* and *CONTROL*.

A. ***CONFIRM*** whether or not the item exhibits recognisably suspicious characteristics – is the item ***H.O.T*****? –** *refer to figure 2*

a) Is it ***HIDDEN***?

- Has the item been deliberately concealed or is it obviously hidden from view?

b) Is it ***OBVISIOUSLY*** suspicious?

- Does it have wires, circuit boards, batteries, tape, liquids or putty-like substances visible; refer to section 4 above for other suspect traits.
- Do you think the item poses an immediate threat to life?

c) Is the item ***TYPICAL*** of what you would expect to find in this location?

- REMEMBER most lost property is found in locations where people congregate – ASK IF ANYONE HAS LEFT THE ITEM
- If the item is assessed to be unattended rather than suspicious, examine further before applying lost property procedures.

DRAFT

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

UNATTENDED ITEMS:
LOST... or SUSPICIOUS?

H

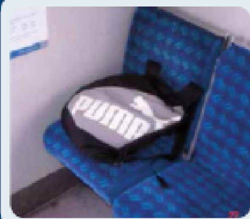
Hidden?

- Has it been concealed or hidden from view?
- Bombs are unlikely to be left in locations such as this – where any unattended item will be noticed quickly.

O

Obviously suspicious?

- Does it have wires, circuit boards, batteries, tape or putty-like substances?
- Do you think the item poses an immediate threat to life?



T

Typical?

- Is the item typical of what you would expect to find in this location?
- Most lost property is found in locations where people congregate.

If after applying the HOT protocols you still believe the item to be suspicious, call 999.

NaCTSO
National Counter Terrorism Security Office

FIGURE 2

B. **CLEAR** the immediate area
   - Do not touch the item
   - Take charge and move people away to a safe distance; even for a small item such as a briefcase move *at least 100m* away from the item starting from the centre and moving out.
   - Keep yourself and other people out of line of site of the item; it is a broad rule, but generally if you cannot see the item then you are better protected from it.
   - Think about what you can hide behind; pick something substantial i.e. solid brick/block walls or other structural elements and keep away from glass such as windows and skylights.
   - Cordon off the area.

C. ***COMMUNICATE*** – call 999
   - Inform the appropriate person i.e. most senior manager on site; security etc.
   - If used on site; do not use radios or mobile phones within *30 metres* of the item.

D. ***CONTROL*** access to the cordoned area
   - Other members of staff and the public should not be able to approach the area until it is deemed safe
   - Try and keep any eyewitnesses on hand so they can tell police what they saw.

7 RESPONSE – receipt of suspicious item through the post or courier

7.1 As identified previously, incidents of this nature are extremely rare, but it is important that everyone maintains awareness of the characteristics that are common to suspicious packages/letters and awareness of the correct procedures to follow; if you believe an item received through the post is suspicious, you need to take action and take personal responsibility.

7.2 Care needs to be taken when opening mail:

- Open all mail with a letter opener (preferably non-metal) or other method that is least likely to disturb contents
- Try to open letters and packages with a minimum amount of movement
- Do not blow into envelopes or shake / pour out contents

- Keep hands away from nose and mouth whilst opening mail
- Wash hands after handling mail

If you are in any doubt about an item – DO NOT touch it, move it or open it – notify the most senior manager/person on site and contact the police (9)999

7.3 *Procedure - on receipt of a suspect package/letter which is undamaged and unopened*

- Do not open it but DO NOT drop it or throw it away; place it on a flat surface in unobstructed view and isolated from other items
- Notify everyone else in the immediate area and evacuate; also notify occupants of each adjacent room, including rooms above and below.
- Leave doors and windows OPEN ***UNLESS*** it is suspected that there is a Chemical, Biological or Radiological (CBR) risk – refer to section 4 above.
- If possible and safe to do so, mark the route to the suspect item with tape, string or similar.
- Notify the most senior manager/person on site of the incident; provide as much information as you can about the item and circumstances as this information will be requested by the police.

  Avoid using mobile phones or radios within *30 metres* of the item.
  The relevant person should notify the police on the emergency number (9) 999 and provide additional instruction if given by the police.
- Make sure that others are prevented from approaching the item and/or accessing cleared areas and await further instructions.

8 RESPONSE - bomb threats

8.1 Bomb threats are commonly made over the phone and are generally one of two kinds:

- Hoax threats intending to disrupt, assess reactions or divert attention; or
- Threats warning of a genuine device which are either attempts to avoid casualties or enable the attacker(s) to place blame on others if there are casualties.

  However genuine threats can provide inaccurate information about where and when a device might explode.

Although a vast majority of threats are hoaxes made as practical jokes, ***any threat should be treated as real, no matter how ridiculous or unconvincing***

DRAFT

8.2 If you receive a threat, take the following actions:

a. Stay calm and listen
b. If available, switch on the recording facility
c. Obtain as much information as possible – try to get the caller to be precise about details – *refer to the checklist in Appendix A*

   If possible, keep the caller talking.

d. At the end of the call, try to get the number, either by using the 1471 facility and/or automatic caller display; If you are unable to record the call, record information on the checklist in *Appendix A*
e. Report the incident immediately to the most senior manager/person on site who should then contact the police and decide what action needs to be taken; if the threat is immediate and you cannot contact the most senior manager/person on site, make a "999" emergency call to the police and give as much information as you can.
f. Unless you are instructed to evacuate by the police or the most senior manager/person on site – Remain at your work area until the most senior manager/person on site and/or the police arrive;
g. Cooperate fully with the police.

NB: it is recommended that relevant staff have access to / sight of action cards to support them in the event of receiving this type of call.

9 RESPONSE - incidents involving Chemical, Biological and Radiological (CBR) substances – *refer to Figure 2*

9.1 As identified previously, incidents of this nature are extremely rare, but it is important that everyone maintains awareness of the characteristics that are common to suspicious packages/letters and awareness of the correct procedures to follow.

9.2 If it is suspected that there has been exposure to a CBR substance use caution and maintain a safe distance to avoid exposure; tell those exposed to REMOVE, REMOVE, REMOVE; swift action can save lives:

a) ***REMOVE themselves*** from the immediate area to avoid further exposure; FRESH AIR IS IMPORTANT

   - If the skin is itchy or painful, find a water source.
   - CLOSE doors and windows to the affected room; where possible and safe to do so,

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

- Also if practicable, shut down any air-conditioning/ventilation and any equipment with fans such as computers to prevent further distribution of the substance.
- Move those directly affected by an incident to a safe location (i.e. away from the incident/source of contamination). If safe and practical to do so, then the safe location should be selected so as to minimise spread of contaminants from the scene of the incident.
- Separate those directly affected by an incident from those not involved so as to minimise the risk of inadvertent cross-contamination.
- Ask people not to wander off – though you cannot contain them against their will.

b) ***REMOVE outer clothing*** if affected by the substance

- Try to avoid pulling clothing over the head if possible; DO NOT PULL OFF CLOTHING STUCK TO SKIN
- Take into account environmental conditions and the privacy of the affected person.
- DO NOT eat, drink or smoke

c) ***REMOVE the substance*** from skin using a dry absorbent material to either soak it up or brush it off

- Rinse continually with water if the skin is itchy or painful
- It is not necessary to make any special arrangements beyond normal first aid provision. The emergency services will take responsibility for treatment of casualties.
- When the emergency services arrive act upon their instruction as you may need further decontamination and medical help.

9.3 *Procedure - if there has been exposure to a potentially harmful substance*

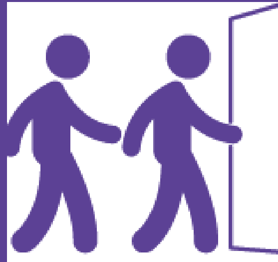
a. Remain calm; however, it is also essential that the incident is reported quickly.
b. Do not attempt to clear up any spilled materials
c. Avoid contact with eyes, nose and mouth or other parts of the body
d. If clothing is contaminated, do not attempt to remove contamination and remove only remove clothing on instruction of the emergency services
e. Evacuate to unoccupied room/area adjacent.
f. Notify the most senior manager/person on site that there has been exposure
g. Wash hands with warm soapy water at the earliest opportunity
h. Seek medical attention on arrival of the emergency services.

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

If you think someone has been exposed to a **HAZARDOUS SUBSTANCE**

Use caution and keep a safe distance to avoid exposure yourself.

TELL THOSE AFFECTED TO:



REMOVE

THEMSELVES...

...from the immediate area to avoid further exposure to the substance. Fresh air is important.

If the skin is itchy or painful, find a water source.

REPORT... use M/ETHANE

REMOVE

OUTER CLOTHING...

...if affected by the substance.

Try to avoid pulling clothing over the head if possible.

Do not smoke, eat or drink.

Do not pull off clothing stuck to skin.

REMOVE

THE SUBSTANCE...

...from skin using a dry absorbent material to either soak it up or brush it off.

RINSE continually with water if the skin is itchy or painful.

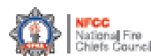
REMEMBER: Exposure is not always obvious. **SIGNS CAN INCLUDE:**

The presence of hazardous or unusual materials.

A change in environment, such as unexplained vapour, odd smells or tastes.

Unexplained signs of skin, eye or airway irritation, nausea, vomiting, twitching, sweating, disorientation, breathing difficulties.

ACT QUICKLY. These actions can **SAVE LIVES.**



supported by JESIP

FIGURE 3

10 RESPONSE - search planning

10.1 Regular searches of premises, proportionate to the risks faced, will enhance a good security culture and reduce the risk of a suspicious item being placed or remaining unnoticed for prolonged periods. Additionally, if you receive a bomb threat and depending upon how credible it is, you may decide to conduct a 'search' for suspicious items.

10.2 The following should be considered when developing a plan for building searches:

- Ensure plans are in place to conduct an effective search in response to a bomb threat
- Identify who in your venue will coordinate and take responsibility for conducting searches
- Initiate a search by messaging over a public address system (coded messages avoid unnecessary disruption and alarm), by text message, personal radio or by telephone cascade
- Divide premises into areas of a manageable size for 1 or 2 searchers. Ideally staff should follow a search plan and search in pairs to ensure nothing is missed
- Ensure those conducting searches are familiar with their areas of responsibility. Those who work in an area are best placed to spot unusual or suspicious items
- Focus on areas that are open to the public; enclosed areas (e.g. cloakrooms, stairs, corridors, lifts etc.) evacuation routes and assembly points, car parks, other external areas such as goods or loading bays
- Develop appropriate techniques for staff to be able to routinely search public areas without alarming any visitors or customers present
- Under no circumstances should any suspicious item be touched or moved in any way. Immediately start evacuation and dial 999
- Ensure all visitors know who to report a suspicious item to and have the confidence to report suspicious behaviour

10.3 Remember: it is vital that regular drills are conducted to ensure all are familiar with bomb threat procedures, routes and rendezvous points.

10.4 Disabled/impaired staff should have personal evacuation plans and be individually briefed on their evacuation procedures. Similarly all visitors should be briefed on evacuation procedures and quickly identified and assisted in the event of a threat.

10.5 Familiarising through testing and exercising will increase the likelihood of an effective response to an evacuation and aid the decision-making process when not to evacuate/invacuate.

DRAFT

11 RESPONSE – Evacuation, Invacuation or "RUN-HIDE-TELL-STAY"

11.1 Responsibility for the initial decision making regarding the movement of building occupants who may be placed at risk remains with the management of the location being threatened.

Do not delay your decision-making process waiting for the arrival of police; the police will assess the credibility of the threat at the earliest opportunity. All bomb threats should be reported to the police and their subsequent advice followed accordingly.

11.2 Options to manage the risk include:

a) External evacuation

- Leaving the venue will be appropriate when directed by police and/or it is reasonable to assume the threat is credible, and when evacuation will move people towards a safer location.
- **AVOID** using radio / mobile phone within 15m radius of suspect item
- Depending on size of item, maintain a safe distance:
  - Small i.e. a Bag – 100m radius
  - Medium i.e. Car/Wheelie Bin – 200m radius
  - Large i.e. Van/Lorry – 400m radius
- It is important to appoint people, familiar with evacuation points and assembly (rendezvous) points, to function as marshals and assist with emergency procedures.
- At least two assembly points should be identified in opposing directions, and *at least 500 metres* from the suspicious item, incident or location.

  Assembly/rendezvous points ***SHOULD NOT*** be in direct sight of the item etc.
- Where possible the assembly point should not be a car park. You may wish to seek specialist advice, which can help to identify suitable assembly points and alternative options as part of your planning.
- It is essential that evacuation plans exist; they should be event and location specific; evacuation procedures should also put adequate steps in place to ensure no one else enters the area once an evacuation has been initiated.
- The police will establish cordons depending upon the size of an identified suspect device. Always follow police directions and avoid assembly close to a police cordon.

DRAFT

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

b) *Internal or inwards evacuation ('invacuation')*

- There are occasions when it is safer to remain inside.

  Staying in the building and moving people away from external windows/walls is relevant when it is known that a bomb is not within or immediately adjacent to your building.

- If the suspect device is outside the building, people may be exposed to greater danger if the evacuation route inadvertently takes them past the device.

  A safer alternative may be the use of internal protected spaces. This type of inwards evacuation needs significant pre-planning and may benefit from expert advice to help identify an internal safe area within your building. These locations should be in your plans.

  If the location of the device threatened is unknown, evacuation represents a credible and justifiable course of action.

c) *Run – Hide –Tell – Stay*

If the incident involves individuals with weapons, the safest option is "RUN-HIDE-TELL-STAY":

- Try to leave the building by the nearest, safest exit and contact the police, giving as much detail about the person and situation as you can.
- Warn others who may be trying to enter the building and encourage them to stay with you.

- If you and others are unable to leave the building], find a room [ideally a room with a solid wall and door] and
- Secure the entrance [lock or barricade the door], move away from the door and remain silent.

- Put your phone on SILENT and dial 999; you will need to speak quietly and may be asked to press "55" if the call handler cannot confirm a response.
- It is important to answer any question precisely, giving as much specific and accurate information as you can.

Remain in place until the police arrive at the room and follow **ALL** instructions they give you – they treat and speak to you in a hostile manner until they are certain that you do not pose a threat.

d) *Decision not to evacuate or inwardly evacuate*

- This will be reasonable and proportionate if, after an evaluation by the relevant manager(s), the threat is deemed implausible (e.g. a deliberate hoax). In such circumstances police may provide additional advice and guidance relating to other risk management options.
- It may be considered desirable to ask staff familiar with the site to check their immediate surroundings to identify anything out of place, see search considerations (section10) above.

12 ROLE OF THE POLICE

- Once contacted, the police will undertake a threat assessment which will determine whether there is a credible threat or not and determine what further action is required and which other agencies need to be involved.
- If there is no credible threat, the police will advise that no further action is required, and the item can be handled and disposed of.
- If there is a credible threat, the police will advise other agencies and take control of the incident. It is likely that the package and contents will be sent to a national specialist laboratory for testing of environmental samples.
- Anyone exposed to the potentially hazardous substance will undergo decontamination and receive medical attention.

13 TRAINING AND EXERCISES

13.1 All staff should be made aware of this protocol as part of their induction.

13.2 Staff should receive refresher training every *12 months*.

13.3 This procedure should be validated every *3 years* through formal exercise.

14 EQUALITY IMPACT ASSESSMENT

14.1 The Trust recognises that despite providing equality and diversity training and cultural awareness, there will be a disposition to racially and religiously stereotype some people and raise concerns as a result. This is in partway supported by media coverage of terrorist incidents; the Trust acknowledges that this is a risk and continues to educate staff in order to dispel these stereotypes and to instead

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

concentrate on the advice contained in the procedure irrelevant to someone's race and religion.

14.2 If the Trust feels that staff have used the procedure as a catalyst to raise concerns of a malicious nature, they will be subject to standard disciplinary action.

14.3 The Trust recognises that there is also a risk that the staff member dealing with an incident may have a bias which could impact on the way information is recorded and understood; within the Trust Equality and Diversity training, unconscious bias is discussed and explained, it is hoped that once staff understand what this is they can help to ensure that it does not impact in their dealings at work.

14.4 The procedure is linked to current Government guidance and supports staff to respond correctly and safely in the event of receipt of bomb threat or discovery of a suspicious package.

15 RELATED POLICIES

- Security policy (PP02)
- Business Continuity Management policy (PP06)

16 RELEVANT LEGISLATION

- The Health and Safety at Work Act 1974
- The Management of Health & Safety at Work Regulations 1999

17 REFERENCES

- ProtectUK, Counter Terrorism Alliance
- Protecting against terrorism (Third Edition), Centre for the Protection of National Infrastructure, (2010)

18 GETTING HELP / USEFUL INFORMATION

18.1 Further information and support is available from:

- Trust Fire Safety Manager (robin.weaver@wales.nhs.uk) on 01875 4156.
- WBS Business Continuity lead (andrew.mapstone@wales.nhs.uk) on 01797 2080

18.2 Further guidance on responses to suspects packages /bomb threats and similar events [including emergency first aid is available through the citizenAID website *[https://www.citizenaid.org/https://www.citizenaid.org/] and app (available through either Google Play or Apple app Store.)*

DRAFT

Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure the version to hand is the most recent.

APPENDIX A – Bomb Threat checklist

Protective Marking: Restricted when Completed

Form 5474

ACTIONS TO BE TAKEN ON RECEIPT OF A BOMB THREAT

1 Remain calm and talk to the caller

2 Note the caller's number if displayed on your phone

3 If the threat has been sent via email or social media see appropriate section below

4 If you are able to, record the call

5 Write down the exact wording of the threat:

When Where What How Who Why Time

ASK THESE QUESTIONS & RECORD ANSWERS AS ACCURATELY AS POSSIBLE:

Question	Answer
1. Where exactly is the bomb right now?	
2. When is it going to explode?	
3. What does it look like?	
4. What does the bomb contain?	
5. How will it be detonated?	
6. Did you place the bomb? If not you, who did?	
7. What is your name?	
8. What is your address?	
9. What is your telephone number?	
10. Do you represent a group or are you acting alone?	
11. Why have you placed the bomb?	
Record time call completed:	

INFORM BUILDING SECURITY/ COORDINATING MANAGER

Name and telephone number of person informed: ______

DIAL 999 AND INFORM POLICE

Time informed: ______

This part should be completed once the caller has hung up and police/ building security/ coordinating manager have all been informed

Date and time of call: ______

Duration of call: ______

The telephone number that received the call: ______

ABOUT THE CALLER:

Male	Female	Nationality?	Age?
☐	☐	______	______

THREAT LANGUAGE:

Well-spoken	Irrational	Taped	Foul	Incoherent
☐	☐	☐	☐	☐

CALLER'S VOICE:

		Calm ☐	Crying ☐	Clearing throat ☐	Angry ☐	Nasal ☐
Slurred ☐	Excited ☐	Stutter ☐	Disguised ☐	Slow ☐	Lisp ☐	*Accent ☐
Rapid ☐	Deep ☐	Familiar ☐	Laughter ☐	Hoarse ☐	Other *(please specify)* ______	

*What accent? ______

If the voice sounded familiar, who did it sound like? ______

BACKGROUND SOUNDS:

		Street noises ☐	House noises ☐	Animal noises ☐	Crockery ☐	Motor ☐
Clear ☐	Voice ☐	Static ☐	PA system ☐	Booth ☐	Music ☐	

Factory machinery ☐ Office machinery ☐ Other *(please specify)* ______

REMARKS:

ADDITIONAL NOTES:

Signature: .... Print Name: .... Date:

ACTIONS TO BE TAKEN ON RECEIPT OF A BOMB THREAT SENT VIA EMAIL OR SOCIAL MEDIA

1. DO NOT reply to, forward or delete the message
2. If sent via email note the address
3. If sent via social media what application has been used and what is the username/ID?
4. Dial 999 and follow police guidance
5. Preserve all web log files for your organisations to help the police investigation (as a guide, 7 days prior to the threat message and 48 hours after)

Signature: .... Print Name: .... Date: ....

SAVE AND PRINT – HAND COPY TO POLICE AND SECURITY/ COORDINATING MANAGER

Retention Period: 7 years
MP 925/10

QS 08

POLICY FOR THE MANAGEMENT OF SAFEGUARDING ALLEGATIONS /CONCERNS ABOUT PRACTITIONERS AND THOSE IN A POSITION OF TRUST

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Science
Document Author:	Head of Safeguarding and Vulnerable Groups
Approved by:	Quality & Safety Committee
Approval Date: 16/5/23	**Date of Equality Impact Assessment:** 2nd February 2020
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Documents to read alongside this policy:	There is a link to al of the appropriate forms and additional reading material within the appendices to the policy.
Review Date:	March 2026
Version	Version 2

Contents

Policy Statement	Page 3
Scope of Policy	Page 3
Aims and Objectives	Page 3-4
Responsibilities	Page 4
Definitions	Page 5
Implementation/Policy Compliance • Allegations of abuse of a child • Allegations of abuse of an adult • Sharing information - Page 11 • Referral to DBS and professional bodies – Page 11	Page 5-11
Equality Impact Assessment Statement	Page 12
References	Page 12
Getting Help	Page 13
Related Policies	Page 13
Information, Instruction and Training	Page 14
Main Relevant legislation	Page 14
Appendix 1: Flowchart	Page 15
Appendix 2: Guidance notes on completion of Risk Assessment Form for Allegations against an employee	Page 16-17
Appendix 3: Protection of Vulnerable Adults Professional Strategy Meeting Minutes Template	Page 18 - 21

1. Policy Statement

As an employer and provider of services, Velindre University NHS Trust has a duty to protect individuals in our care from abuse. This policy relates to the management of allegations of abuse made against an employee of the Trust and will enable the organisation to ensure that all instances of concerns or alleged abuse or neglect of children and adults are risk assessed, to ensure patient / donor safety.

Where a concern or abuse is alleged to have occurred in the employee's private capacity (i.e. outside of their Trust employment) careful consideration will need to be given to whether the employee presents any risk to patient's / donors within their working environment in the Trust, and if they may be in breach of their professional code of practice (regulated employees).

2. Scope of Policy

This Policy applies to all Velindre University NHS Trust employees, bank, locum and agency, students, contractors, honorary contracts holders, volunteers, trainees and Trust staff undertaking duties overseas as part of a Trust supported health link staff, regardless of role or whether or not their employment brings them into direct contact with vulnerable adults or children.

This Policy applies in all cases of alleged abuse of a child or adult by an employee of the Trust regardless of whether the abuse is alleged to have taken place in work or in their private lives. In every incident of alleged abuse of a child or adult staff must comply with the Wales Safeguarding Procedures.

http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/

3. Aims and Objectives

This policy has been developed to ensure that employees of Velindre University NHS Trust are aware of their responsibilities and the processes for identifying and reporting professional abuse of children and adults at risk either within the workplace or in the employee's home / external environment. The policy has been developed to ensure a robust and consistent approach in responding to allegations of actual or potential abuse.

- To ensure that all incidents of abuse and neglect of a child or adult at risk are dealt with within the appropriate framework.
- To safeguard children and adults at risk from abuse and avoidable neglect by Trust employees.

- To ensure an equitable, fair and consistent response when concerns are raised.
- To support employees who have made a referral or who have had a referral made against them; and
- To raise awareness of all Trust employees of the possibility of abuse of children and adults at risk, by professionals and other healthcare workers.

4. Responsibilities

Velindre University NHS Trust has a legal obligation to ensure that the protection and safeguarding of children and adults at risk is of paramount importance. Situations may arise where the privacy rights of others may have to be balanced against the needs of the child / adult at risk.

The Trust has a responsibility to notify the police when concerns are raised, if it is in the public interest, even if the individual concerned does not wish the police to be involved.

- **Executive Director of Nursing, Allied Health Professionals and Health Science**

The Executive Director of Nursing, Allied Health Professionals and Health Science has delegated responsibility for ensuring the safeguarding of children in accordance with Section 28 of the Children Act (2004) and for safeguarding under the Social Service and Wellbeing (Wales) Act (2014).

- **Employee Responsibilities**

In line with the Social Services and Wellbeing (Wales) Act (2014), all staff have a duty to report all incidents of alleged abuse of children and adults at risk.

All employees must take positive and decisive action when witnessing incidents, experiencing concerns or receiving information alleging abuse or inappropriate care of a child or adult at risk. Employees can obtain advice and support about concerns they may have with their line manager, the Trust Safeguarding Lead or via the processes set out in NHS Wales Trust Procedure for NHS Staff to Raise Concerns.

Employees also have a responsibility to comply with their relevant professional Code of Conduct which will include the standards of behaviour expected outside of work.

All employees must comply with their statutory and mandatory training requirements, including Safeguarding Adults and Safeguarding Children training.

- **Managers**

Line managers are responsible for complying with this Policy and, in all circumstances should notify the Trust Senior Nurse for Safeguarding & Public Protection or the Deputy Director of Nursing, Quality & Patient Experience in order to gain the required support / advice / multi agency involvement.

In some cases, the line manager may feel it appropriate to make a referral to the Occupational Health Service to provide appropriate support for any employee concerned or involved in the process. This must be done with their consent. A management or self-referral to the Occupational Health Service / Employee Assistance Programme should be in addition to and not instead of the processes set out in this Policy.

Managers should ensure that employees who find themselves overstretched in their caring responsibilities outside of work are made aware of support available to them (e.g. Occupational Health Service, Employee Assistance Programme, Flexible Working Policy, third sector organisations).

- **Trust Senior Nurse Safeguarding & Public Protection**

The Trust Senior Nurse for Safeguarding and Public Protection must provide support, oversight and direction to line managers when managing situations in line with this policy and ensure that the Executive Director of Nursing, Allied Health Professionals & Healthcare Scientists is notified and kept updated.

5. Definitions

5.1 Abuse: This describes physical, sexual, psychological, emotional or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, institution or any other place).
(Wales Safeguarding Producers 2019)

5.2 A child is defined as “any person under the age of 18” *(UN Convention on the Rights of the Child 1989).*

5.2 Section 130 (4) defines a “child at risk” as a child who;
(a) Is experiencing or is at risk of abuse or neglect; and
(b) Has needs for care and support (whether or not the authority is meeting any of those needs)

5.3 Section 126(1) defines an adult at risk;
An “adult at risk”, for the purposes of this Part, is an adult who:- (c) Is experiencing or is at risk of abuse or neglect;

(d) Has needs for care and support (whether or not the authority is meeting any of those needs); and
(e) As a result of those needs is unable to protect himself or herself against the abuse or neglect of the risk of it.

6. Implementation / Policy Compliance

6.1 The Trust needs to be able to recognise and respond appropriately to allegations raised against an employee. Allegations could be identified in a number of ways, including (but not limited to) the following:

- by the Police;
- by Social Services;
- from an adverse incident and/or completed DATIX report that may identify a potential allegation;
- a concern made by a patient / donor or carer;
- a concern made by another employee;
- by adults disclosing historical abuse which they experienced as a child; or
- a professional or regulatory body.
- an individual involved in a Trust supported international health partnership link.

6.2 During weekday working hours

Allegations of abuse by an employee must be reported without delay to the appropriate line manager who will take any remedial action and have an initial discussion with the Trust Senior Nurse, Safeguarding & Public Protection / Deputy Director of Nursing, Quality & Patient Experience.

A decision will be made at this initial discussion to confirm if this policy needs to be evoked and, who will inform Local Authority or the Police.

Out of hours

Allegations of abuse by an employee must be reported immediately to the On-Site Manager who may refer the matter to the On-Call Manager for advice / support. The on Site and On Call Managers can be contacted via switchboard.

The immediate priority is the protection and safety of a child or adult at risk and managing any associated staff issues. Any immediate risks must be considered, and action taken to mitigate that risk where appropriate. However, under no circumstances should internal enquires into the allegation be commenced until advice has been received from the on-call Managers.

If it is felt that the alleged abuse may be criminal, there must be no delay in reporting the matter to the Police, who will advise on preserving the scene for evidence**.**

All actions taken should be clearly recorded. It is essential that all records are written clearly, accurately, legibly and contemporaneously with all details recorded, to provide as full a picture of the account as possible throughout this process. All records should be signed and dated if not written contemporaneously then the date they were written should be made clear, as well as the date of the contact.

6.3 On being informed of the allegation of abuse, the Trust Risk Assessment form attached as ***Appendix 2*** must be completed to inform Trust action. The Workforce and OD Department will provide advice and support to the relevant line manager in determining if the employee can continue in work, should be moved temporarily to another role or if they should be suspended. Any decision taken to suspend an employee must be taken in line with the relevant Disciplinary Policy.

6.4 When determining the appropriate action to be taken, consideration must be given to:

- how the person's protection is to be ensured.
- whether there are other children or adults who might be at risk.
- what support the employee may require;
- the right of the employee who has had an allegation made against them in respect of their privacy and confidentiality.

In addition, Trust employees who have an allegation made against them need to:

- understand the concerns expressed;
- know the procedures/processes being operated;
- know the timescale set for the process;
- be told what support is available to them;
- be clearly informed on the outcome of any investigation and the implications for disciplinary/capability processes;

Procedures need to be applied with common sense and judgement, and full decision-making documentation.

6.5 The Professional Strategy Discussion

The professional strategy meeting will be convened when safeguarding allegations have been raised about a practitioner/person in positions of trust. A Professional Strategy discussion will take place with the Police;

any other appropriate partners and employers. The focus of the Strategy discussion is as follows:

- Whether the matter meets the threshold for progressing to a formal Professional Strategy meeting
- Identification of any activities or caring responsibilities for children or adults that the subject of the allegation is involved in outside of their paid employment
- Consideration of interim safeguards whilst further enquiries are made
- Decision about what information can be shared with the subject of the allegation, the child or adult at risk and their parent/carer
- Decision about employer involvement with the process
- Review adequacy of safeguards in place
- Agree any actions to be taken or any further information needed prior to the Professional Strategy meeting
- Decide whether immediate briefings to senior managers are required

6.6 Professional Strategy Meeting

The professional strategy meeting will be convened by the Local Authority Designated Officer for Safeguarding when safeguarding allegations/concerns have been raised about a practitioner/person in positions of trust. This can either be in a personal or professional capacity, where the individual has wider contact with children or with adults at risk.

The main functions of the strategy meeting are to:

- Ensure the proper co-ordination of child, adult protection, criminal and employment procedures
- Share all relevant information about the allegation/concern in question
- Consider what action may be required to protect the child or adult at risk in question
- Consider the likelihood of harm to other children or adults at risk with whom the person has contact at work or other activities, and agree any actions that are required
- Consider and evaluate the risk of harm to the subject's own children or adults they may have caring responsibilities for, and agree any actions that are required
- Discuss any previous allegations or other concerns.
- Plan any enquiries needed and allocate tasks and set timescales
- Decide who is to be interviewed and lead agency
- Identify a lead contact manager within each agency
- Decide what information can be shared with whom, when and who will do this

- Agree timescales for actions and/or dates for further meetings
- Consider the employees suitability to continue working with children or adults at risk in his or her current position has been called into question
- Consider whether there are disciplinary issues to be followed up
- Agree at what stage in the process the disciplinary issues should be followed up
- Consider any other factors that may affect the management of the case e.g. consideration of the need for a media strategy where there is likely to be press interest.
- Confirm arrangements regarding who will communicate with the person about whom there are concerns and ensure appropriate support is provided • Ensure that the appropriate referrals are made to the Disclosure and Barring Service and registering bodies of the professional involved (this can be completed at any point throughout the process
- The employer/voluntary organisation or registering body may need to consider suspending the employee without prejudice.

The immediate priorities of the Professional Strategy Meeting are to ensure the protection and safety of the child/children or adult's at risk, and to also discuss whether the allegation may have a bearing on the individual's employment. The Trust should not decide in isolation to progress the matter through the relevant Disciplinary Policy. Discussion must take place with the police and social services prior to commencement of proceedings.

6.7 Who will be invited to the Professional Strategy Meeting?

The Professional Strategy Meeting will be chaired by the Local Authority Designated Officer for Safeguarding for children or adults, who will also identify who will attend.

Where the allegations involve concerns or alleged abuse of a child or adult at risk by a Trust employee the employee's line manager, a senior Workforce and OD representative and the Safeguarding Lead, as a minimum must be in attendance at the Professional Strategy Meetings.

6.8 Informing the individual

The person who is the subject of the allegation should generally be informed that they are subject of an allegation at the earliest opportunity. This should be done by the line manager. However, specific details of the allegation cannot be provided until the timings for doing so have been agreed with Children's or Adults Services/Police. This will be considered during the interim safeguarding arrangements discussed and agreed by the Police and the Designated Officer for Safeguarding. In determining when to inform the individual, consideration should be given to any potential risks to the child or adult involved in the allegations, or to any other children or adults connected to the individual's home, work or community life.

When informing the individual careful consideration should be given to the following:

- The person subject to the allegation should be given appropriate support by their employer or nominated individual;
- The person who is the subject of the allegation should be treated fairly and honestly and helped to understand the concerns expressed and processes involved;
- Information about the adult, child or family should not be shared with the individual against whom the allegation was made or anyone representing them;
- Consideration should also be given to the potential for the individual to impede any investigation, remove or interfere with evidence or to intimidate or coerce potential witnesses;
- If suspended, the individual will be kept up to date about events in the workplace by a named contact;
- As soon as possible after an allegation has been received, the accused member of staff should be advised to contact their Trade Union or professional association;
- Workforce &OD should be consulted at the earliest opportunity in order that appropriate support can be provided via the organisation's occupational health, employee welfare arrangements, or individual agency's own safeguarding arrangements;

6.9 Informing parents / carers, children, adults at risk or their representatives

- The general principle is that the parents or carers of the adult or children involved and the adult or children where appropriate, should be informed about the allegation as soon as possible but only following discussion with the Designated Officer for Safeguarding responsible for safeguarding allegations/concerns against practitioners and those in positions of trust.
- Parents/carers of the adult or children involved and the adult or children where appropriate, must be informed of the outcome of the strategy discussion/meeting and should, when necessary, be helped to understand the decisions reached. It will be agreed in the Strategy Discussion or Strategy meeting who will undertake this.
- Examples where it may not be appropriate to inform parents, carers, adults or children or their representative immediately could include where the allegation made is against a family member, or if the Police investigation could be hampered by informing the parent/carer, child, adult at risk or their representative. In these cases the timings for the parents or carers being told must be confirmed with the relevant social services and Police.

6.10 Concluding the process

An Outcome Professional Strategy Meeting should be held to decide, whether on the balance of probabilities the concerns are substantiated. If the concerns are not deemed to be substantiated, then the outcome should be recorded as unsubstantiated, unfounded or deliberately invented or malicious. The following definitions will guide strategy meetings in determining which outcome applies; Allegations will have outcomes within the following four categories:

Substantiated – a substantiated allegation is one which is established by evidence or proof.

Unsubstantiated – an unsubstantiated allegation is not the same as an allegation that is later proved to be false. It simply means that there is insufficient identifiable evidence to prove or disprove the allegation. The term, therefore, does not imply guilt or innocence.

Unfounded – this indicates that the person making the allegation misinterpreted the incident or was mistaken about what they witness. Alternatively, they may not have been aware of all the circumstances. For an allegation to be classified as unfounded, it will be necessary to have evidence to disprove the allegation.

Deliberately invented or malicious – this means there is clear evidence to prove there has been a deliberate act to deceive and the allegation is entirely false.

The outcomes discussion would normally precede any decision by the employer to invoke disciplinary procedures. Where the concerns are substantiated, employing or volunteer agencies should consult if not already done so with the Disclosure and Barring Service and other relevant professional bodies about the requirement for a referral. (Further information and guidance from the DBS can be obtained from their website at www.homeoffice.gov.uk/dbs).

If the Professional Strategy Meeting concludes there is to be no further action from a multi-agency perspective then the appropriate Trust manager will need to determine whether there are disciplinary issues in relation to the member of staff concerned that need to be addressed in accordance with the relevant Disciplinary Policy. Consideration also needs to be given as to whether the Professional Registered Body of the member of staff needs to be informed.

Where a criminal investigation results in no further action but it is determined that a disciplinary investigation is to take place subsequently, a request can be made to the police for permission to use the information gained from the criminal investigation in the disciplinary investigation. The police will consider any request on a case by case basis.

6.11 Cross boundary issues

This is an area of work that is best supported by sound inter-authority working. Where child or adult protection enquiries have been made in one area, but the

alleged perpetrator lives or works within other areas, there will be need for information to be shared between the two areas. The Delegated Officer for Safeguarding must ensure that they share all information with their counterpart in the other Local authority. Due regard is to be had to the relevant data protection principles which allow sharing of personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). It is usually the responsibility of the Local authority where the alleged abuse took place /concern arose to hold the Professional Strategy Meeting. After discussion between the Designated Officers for Safeguarding it will be decided and recorded which authority will be responsible for convening the Professional Strategy Meeting and the reasons why.

7. Confidentiality and Record of the Professional Strategy Meeting

In view of the potential sensitivity of the information and the lessons of the Bichard Inquiry (2004), (www.police.homeoffice.gov.uk/publications/bichard-inquiryreport) care should be taken in recording the concern and the outcome of the process.
A record of the meeting will be made and retained by the local authority in accordance with their record, retention and disposal policy. Attendees representing the employer should receive a copy of the summary and recommendations of the meeting with the child's or adult at risk's name removed. All other attendees will receive a copy of the summary and recommendations.

The Designated Officer for Safeguarding will consider any request for a full record of the meeting and ensure that in the event of disclosure, an appropriately redacted version of the record is disclosed.

Where the person makes a data subject access request for the record of the Professional Strategy Meeting, this will be considered, and the nominated Designated Officer for Safeguarding will ensure redaction the document prior to disclosure. Other meeting attendees will be made aware of the request and can be sent a copy of the redacted document where requested

8. Referral to Disclosure and Barring Service (DBS) and Professional Bodies

The Trust, like all employers have a legal duty to refer information to the DBS if an employee has harmed or poses a risk of harm to vulnerable groups and where they have dismissed them or are considering dismissal. Employers also have a duty to refer where an individual has resigned before a formal decision to dismiss them has been made. **Failure to refer such matters to the DBS is a criminal offence.**

Please refer to the Disclosure and Barring Checks on Trust Post Guidance

Further information about the referral process is also available on the DBS website at www.homeoffice.gov.uk/agencies-public-bodies/dbs/services/dbsreferrals/

The Trust may also have a duty to report an employee to other relevant Professional Bodies such as the General Medical Council, Nursing Midwifery Council and the Health and Care Professions Council.

9. Equality Impact Assessment Statement

The Trust is committed to ensuring that as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that any impact from the policy would have a positive effect to the equality groups mentioned.
Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation

10. References

- Adapted from ABMU Policy for the Management of Allegations of Abuse of Children or Adults by Professionals and Members of Staff (2016);
- Children's Act (2004);
- General Data Protection Regulations (2018);
- Social Service and Wellbeing (Wales) Act (2014);
- Wales Safeguarding Procedures (2019)

11. Getting Help

Contact the Safeguarding Lead for Velindre University NHS Trust: Senior Nurse Safeguarding and Public Protection.

12. Related Policies

- Data Protection and Confidentiality Policy (2017)
- Disciplinary Policy (2017)
- Disclosure and Barring Checks on Trust Post Guidance

- NHS Wales Procedure for NHS Staff to Raise Concerns
- Wales Safeguarding Procedures (2019)
- Violence, Domestic Abuse and Sexual Violence Workplace Policy and Procedure (2018)
- Safeguarding and Public Protection Policy (2019)
- Records Management Policy (2018)
- Serious Crime Act (2015)
- Duty of Candour (2023)

13. Information, Instruction and Training

13.1 Training

Employee awareness of safeguarding issues and responsibilities will be undertaken through both safeguarding children and adults at risk mandatory training. All Trust staff who have direct contact with patients are required to complete Level 2 Safeguarding Adults and Children training. Certain groups of staff will require extra training in accordance with the NHS Safeguarding Training Framework. It is the responsibility of the line manager to ensure that employees are made aware of these requirements.

13.2 Audit

This policy may be subject to audit and will be assessed in line with normal audit planning processes. The outcomes of any audits undertaken will be reported to the Safeguarding & Public Protection Management Group.

14. Main Relevant Legislation

General Data Protection Regulations (2018)
Children's Act (2004)
Safeguarding Vulnerable Groups Act (2006)
Social Service and Wellbeing (Wales) Act (2014)
Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act (2015)
Serious Crime Act (2015)

Appendix 1

Flowchart: Referrals about people whose work brings them into contact with children or adults at risk

Concerns reported to Social Service

↓

Designated Officer for Safeguarding receives notification

↓

Consideration of information and further action required

YES → Strategy Discussion Commences

NO → No Further Action → Record and Update Referrer

Strategy Discussion Commences → Proceed Risk Assessment → Investigation → Outcome Strategy Meeting → Further Recommendations / Actions

Strategy Discussion Commences → NO → Inform HR/Employer → Arrange Professional Strategy Meeting → No Further action- record discussion and decision

Appendix 2

Safeguarding Children and Adults

Guidance Notes on the Completion of a Risk Assessment Form following Allegations Against an Employee

RISK is a combination of the likelihood and severity of a specified event (incident).

This form is used to undertake a detailed risk assessment when potential risks have been identified at a Professional Strategy Meeting and Wales Safeguarding Procedures 2019 and/or when a member of staff is considered to be a risk.

All sections of this form should be completed by the employee's line manager, with support from the appropriate Safeguarding Lead and Workforce and OD as part of the Professional Strategy Meeting proceedings. The objective of this form is to establish whether the individual poses a risk to children/adults at risk, and if so, to establish what appropriate, additional controls can be put in place to ensure that the risks are reduced to an acceptable level. The completed form must be kept in the employees' confidential file.

NATURE OF ALLEGATIONS

TYPE OF ABUSE ALLEGED Select the type of abuse that is being alleged.

SEVERITY OF THE ABUSE ALLEGED
Select severity of abuse alleged as appropriate. If unsure, please contact the Safeguarding Lead

HOW MANY TIMES HAS THE ABUSE OCCURRED
Select whether the abuse has occurred on one occasion or more than one occasion. This information will be shared at the Professional Strategy Meeting.

EXPLANATIONS GIVEN
Select whether no explanation provided, or if explanation provided, whether the explanation is inconsistent or consistent. This information will be shared at the Professional Strategy Meeting.

PERSONS PRESENT AT TIME OF INCIDENT
Select whether the employee was the sole carer at the time of the incident, or whether there were other people present. This information will be shared at the Professional Strategy Meeting.

LEGAL PROCEEDINGS
Select whether care proceedings or criminal proceedings are in place. This information will be shared at the Professional Strategy Meeting.

EMPLOYMENT ISSUES

ROLE WITHIN TRUST Select whether administrative, academic, clinical or other. If other, please give details

ACCESS TO CHILDREN
If employee has access to children or young people under the ages of 18 years, in any capacity whilst in his role in the Trust select yes. If employee only has access to people aged 18 years and above, then select no

UNSUPERVISED ACCESS TO CHILDREN
If the employee does have access to children or young people under the age of 18 years, select how often this access is unsupervised/employee sole staff member present

ACCESS TO ADULTS AT RISK
If the employee has access to adults at risk, select how often this access is unsupervised/employee sole staff member present

RISK ASSESSMENT MATRIX

1. PROBABLE LIKELIHOOD RATING (PLR)

Taking account of the controls in place and their adequacy, how likely is it the individual will harm a patient or visitor during the course of their work for the Trust? Score according to the following scale:

Score	Descriptor	Description
5	Almost Certain	Likely to occur on many occasions
4	Likely	Will probably occur but is not a persistent issue
3	Possible	May occur occasionally
2	Unlikely	Do not expect it to happen but it is possible
1	Rare	Can't believe that this will ever happen

2. PROBABLE CONSEQUENCE RATING (PCR)

Taking account of the controls in place and their adequacy, how severe would the consequence be of such an incident if it were to occur? Apply a score according to the following scale:

Level	Descriptor	Actual or potential impact on individual	Actual or potential impact on organisation
5	Catastrophic	Death or national adverse publicity	National adverse publicity, possible investigation
4	Major	Permanent physical / psychological injury	Service closure Local adverse publicity, possible investigation
3	Moderate	Semi-permanent injury or harm	Needs careful PR
2	Minor	Short term injury or harm	Risk to organisation
1	Insignificant	No injury or adverse outcome	No risk at all to the organisation

RISK LEVEL ESTIMATOR/ RISK RATING (RR)
LIKELIHOOD of Adverse Event Occurring X SEVERITY of Outcome = Risk Rating

Likelihood (PLR) / Severity (PCR)	Almost Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
Catastrophic 5	25	20	15	10	5
Major 4	20	16	12	8	4
Moderate 3	15	12	9	6	3
Minor 2	10	8	6	4	2
Insignificant 1	5	4	3	2	1

RR Score	RISK LEVEL	ACTION AND TIMESCALE
1 - 5	LOW	Provide support for the individual. Continue normal working activity with close monitoring

6 - 10	MODERATE	Provide support for the individual. Consider redeployment to low risk area or work with continuous supervision whist enquiries undertaken
11 - 25	UNACCEPTABLE	Provide support for the individual Suspension pending further enquiries

SAFEGUARDING CHILDREN / ADULTS – EMPLOYEE RISK ASSESSMENT FORM

Name of Individual ☐ Designation ☐ Unit/ Department ☐

Nature of Allegations

Type of abuse alleged: *(please tick)*

Neglect ☐ Emotional Abuse ☐ Sexual Abuse ☐ Physical Injury ☐ Domestic Abuse ☐

Financial ☐

Severity of alleged abuse *(please tick)*

Mild ☐ Moderate ☐ Severe ☐

Has the abuse occurred on: *(please tick)*

One occasion ☐ More than one occasion ☐

Explanations given: *(please tick)*

None ☐ Inconsistent explanation ☐ Consistent explanation ☐

Persons present at time of incident: *(please tick)*

Individual - sole care ☐ Individual and another – shared care ☐

Legal Proceedings: *(please tick)*

None ☐ Care Proceedings ☐ Criminal Proceedings ☐

Employment Issues

Role within Trust: *(please tick)*

Administrative ☐ Academic ☐ Clinical ☐ Other *(please state)* ☐

Access to children/adults at risk: Yes ☐ No ☐
(please tick)

Unsupervised Access to children/adults at risk: Never ☐ Occasional ☐ Regular ☐
(please tick))

Initial Risk Rating

Given the information above, what level of risk does the employee pose to the organisation and its service users? *(see page 2)*

Probable Likelihood Rating (PLR) ☐ X Potential Consequence Rating (PCR) ☐ = Initial Risk Rating (IRR) ☐

Risk Level (*please delete*): LOW / MODERATE / UNACCEPTABLE

Safeguards to minimise risk

Safeguards needed to minimise/eliminate risk: *(see page 2 for suggested actions)*

Feasibility of implementing safeguards:

Revised Risk Rating

With the above action implemented the risk rating figure would be reduced to:

Probable Likelihood Rating (PLR) ☐ X Potential Consequence Rating (PSR) ☐ = Revised Risk Rating (RRR) ☐

Revised Risk Level (*please delete*): LOW / MODERATE / UNACCEPTABLE

Recommendations

Joint Assessment made by:

Name	Signature	Position

Date of Assessment		Review Period		Dates of Review			

Further information on review:	Risk Rating	*Date & Signature*

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

QS12

SAFEGUARDING AND PUBLIC PROTECTION POLICY

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Science
Document Author:	Head of Safeguarding and Vulnerable Groups
Approved by:	Quality & Safety Committee
Approval Date: 16/5/23	**Date of Equality Impact Assessment:** 2nd February 2020
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	March 2026
Version	Version 2

Contents	Page
1. Policy Statement	3
2. Scope of Policy	3
3. Aims & Objectives	3
4. Responsibilities	4
5. Definitions	4-5
6. Implementation 6.1. Safeguarding Children 6.2. Safeguarding Adults 6.3. Cardiff and Vale Regional Safeguarding Board Policies & Procedures 6.4. Individual Roles & Responsibilities to Safeguard Children & Adults at Risk 6.5. Concerns about the behaviour of a member of staff 6.6. Deprivation of Liberty Safeguards Procedures (DoLS) 6.7. Multi Agency Public Protection Arrangements (MAPPA) 6.8. Violence Against Women Domestic Abuse Sexual Violence Procedures (VAWDASV) 6.9. Information Sharing.	6-8
7. Equality Impact Assessment	8
8. Getting Help	9
9. Related Policies	9
10. Training and Education	9
11. Legislation and NHS Requirements	9
12. Review and Audit	10
13. Acknowledgements	10
Appendix 1 - Duty to Report Process	11
Appendix 2 – OfW Adult Safeguarding Report	12-15
Appendix 3 – OfW Young Person Safeguarding Report	16-19

1. POLICY STATEMENT

Velindre University NHS Trust (hereafter 'the Trust') has statutory duties to comply with legislation in relation to safeguarding and public protection. It discharges these duties by working within regional partnership arrangements and complying with both UK Government and Welsh Government Codes of Practice and national safeguarding procedures.

2. SCOPE OF POLICY

This Policy applies to all staff employed by or working within the Trust, regardless of whether or not their employment brings them into direct contact with adults or children at risk. The principles set out in this Policy will also apply to other individuals and groups, including bank staff and agency workers, students, contractors, honorary contract holders, volunteers and trainees. In every incident of alleged abuse of a child or adult at risk, staff must comply with the Wales Safeguarding Procedures.

3. AIMS AND OBJECTIVES

To ensure that all staff who work within the Trust understand their responsibilities in relation to safeguarding children and adults at risk, and in relation to public protection.

This document will ensure that staff are clear about their statutory duties and about action they must take in response to safeguarding and/or public protection concerns.

To enable the Trust to fulfil its statutory duties safely and competently it must:

- Ensure effective measures are in place to safeguard people and protect children and adults at risk; and,

- Ensure appropriate systems and processes are in place, including those to support sharing of information, to enable staff to work effectively and in partnership with other agencies with regard to safeguarding and public protection.

4. RESPONSIBILITIES

Governance & Reporting Arrangements

The Trust's governance and reporting structure is set out below.

Executive Responsibility	• The Chief Executive Officer has overall responsibility for safeguarding and public protection. • The Executive Portfolio is delegated to: Executive Director of Nursing, Allied Health Professionals and Health Science. • Supported by: The Deputy Director of Nursing, Quality & Patient Experience.
Operational Responsibility	• Director, Velindre Cancer Centre • Supported by: The Director of Operations, Velindre Cancer Centre • Director, Welsh Blood Service • Supported by: The Head of Nursing
Named Lead	Head of Safeguarding & Vulnerable Groups, or the Deputy Director of Nursing, Quality & Patient Experience will provide advice, guidance, and support for any safeguarding or public protection concerns disclosed, witnessed or suspected within the Trust.

The Trust has a legal obligation to ensure that the protection and safeguarding of children and adults at risk is of paramount importance. Situations may arise where the privacy rights of others may have to be balanced against the needs of the child / adult at risk.

Employee Responsibilities

The Social Services and Wellbeing (Wales) Act (2014) states that everyone has a duty to report all incidents of alleged abuse of children and adults at risk.

All employees must take positive and decisive action when witnessing incidents, experiencing concerns or receiving information alleging abuse or inappropriate care of a child or adult at risk. Employees can obtain advice and support about concerns they may have with their line manager or the Safeguarding Lead.

Employees also have a responsibility to comply with their relevant professional Code of Conduct which will include the standards of behaviour expected outside of work.

All employees must comply with their statutory and mandatory training requirements, including Safeguarding Adults and Safeguarding Children training.

5. DEFINITIONS

Safeguarding involves working with partner agencies to protect children and adults at risk of abuse, neglect or other kinds of harm, and involves activities to actively prevent individuals from becoming at risk of abuse, neglect or other kinds of harm.

Public Protection includes actions taken to protect, promote and improve the health, safety and well-being of the population.

Safeguarding Children
A child is defined by the Children Act 1989 as anyone less than 18 years of age.

A 'child at risk' is defined in the Social Services & Wellbeing (Wales) Act 2014 as a child who:

a) Is experiencing or is at risk of abuse, neglect or other kinds of harm; and
b) Has needs for care and support (whether or not the Local Authority is meeting any of those needs).

Safeguarding children is the responsibility of everyone working in the Trust. This responsibility extends to children who are patients, children who are visitors to the Trust, children of any adults who are patients or donors of the Trust, and children of staff members.

Adults at Risk An 'adult at risk' is defined in the Social Services & Wellbeing (Wales) Act 2014 as an adult who:

a) Is experiencing or is at risk of abuse or neglect;
b) Has needs for care and support (whether or not the Local Authority is meeting any of those needs); and
c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Statutory Duty to Report
From April 2016 the Social Services & Wellbeing (Wales) Act 2014 introduced the statutory duty for all who work for the Trust to report to the Local Authority any concerns that a child or an adult is at risk. See Appendix 1

Deprivation of Liberty Safeguards (DoLS)
The process to protect people who, for their own safety and in their own best interests, need care and treatment that may deprive them of their liberty, but who lack the capacity to consent to that care and/or treatment, and where detention under the Mental Health Act 1983 is not appropriate.

Multi Agency Public Protection Arrangements (MAPPA)
The Trust is required to discharge its duties as a Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency under s325 Criminal Justice Act 2003.

MAPPA is the process through which the police, probation and the prison services (Responsible Authority) work together with other agencies that have a duty to cooperate to manage the risks posed by violent and sexual offenders living in the community, in order to protect the public.

A MAPPA Strategic Management Board (SMB) covering the South Wales Police Force area is responsible for overseeing MAPPA related activity, including agreeing the role and representation of different agencies within the SMB, and developing protocols and memoranda of understanding which formalise these. The Trust is not represented on the MAPPA Strategic Management Board.

MAPPA offenders are managed on a multi-agency basis through Multi-Agency Public Protection meetings at Level 2 and 3:

- MAPPA 2: High risk of harm – monthly meetings
- MAPPA 3: Very high risk of harm – on a basis of need

Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The Violence against Women Domestic Abuse and Sexual Violence (Wales) Act 2015 definitions are:

Gender Based Violence–

a) Violence, threats of violence or harassment arising directly or indirectly from values, beliefs or customs relating to gender or sexual orientation.
b) Female genital mutilation.
c) Forcing a person (whether by physical force or coercion by threats or other psychological means) to enter into a religious or civil ceremony of marriage (whether or not legally binding);

Domestic Abuse is abuse where the victim of it is or has been associated with the abuser.

Sexual Violence includes sexual exploitation, sexual harassment, or threats of violence of a sexual nature.

6. IMPLEMENTATION

6.1 Safeguarding Children and Adults at Risk:

The Wales Safeguarding Procedures describe in detail actions to be taken at all stages of the child and adult safeguarding process.

They are available via the Trust's policies page and on the Trust's safeguarding & public protection intranet pages. The procedures must be adhered to in all safeguarding matters.

http://www.myguideapps.com/projects/wales_safeguarding_procedures/default/

6.2 Cardiff and Vale Regional Safeguarding Board Polices & Procedures All multi-agency safeguarding policies and procedures are approved by the Cardiff and

Vale Regional Safeguarding Board, of which the Trust is a member agency. They are available via their website at www.cardiffandvalersb.co.uk

6.3 Individual Roles & Responsibilities to Safeguard Children & Adults at Risk

All staff must know who to contact to express concerns and how to report those concerns to the Local Authority

- If it is believed the child or adult **is or may be at risk** this must be **reported immediately by telephone** to the relevant Local Authority.

- The **reporting** of concerns should be **discussed with** the child's **parents** and the child as appropriate to their age and understanding. Or with the **adult at risk** or their family/representative if they lack mental capacity to make decisions for themselves.

- The **exception** to this is if such a discussion would place the child/adult at greater risk of harm.

- The telephone report must be **confirmed in writing** within **24 hours** using the referral Forms (available on the Safeguarding and Public Protection website).

- If, having made the initial report in writing the report maker has not received an acknowledgement from social services **within 7 working days**, they must contact social services.

- Referrers who are **not satisfied** with the response from the Local Authority must discuss this with the Trust's Safeguarding Lead.

- All staff must discuss any **uncertainty** about concerns or **differences of opinion** with the Trust's Safeguarding Lead.

- If the Trust's Safeguarding Lead is **unavailable** the concern must be discussed with the relevant Local Authority Social Worker.

- After this discussion a **decision** must be made as to whether or not the child or adult meets the definitions of a child or adult at risk.

- If it is believed that the child or adult is **not at risk** consider if they would benefit from additional services and with their **consent** make the appropriate referrals.

See Trust Adult at Risk and Child Risk Reporting forms. APPENDIX2&3

6.5 Concerns about the behaviour of a member of staff

If the behaviour of a member of the Trust staff, in or out of work, causes concern and may pose a risk to children or adults at risk, staff are instructed:

- Do not dismiss concerns;

- Do escalate your concerns
- To discuss concerns with the Trust's Safeguarding Lead or if not available a senior member of the Workforce and OD Team.
- The Trust Safeguarding Lead or the Workforce Business Partner will act in accordance with the Trust Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust.

6.6 Deprivation of Liberty Safeguards Procedures [DoLS]

The Trust flowchart describes the actions to be taken in the Cancer Centre with regards to the Deprivation of Liberty Safeguards process.

They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.7 Multi Agency Public Protection Arrangements [MAPPA]

The Trust has a flowchart for when high risk offenders or prisoners are admitted to hospital.
They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.8 Violence Against Women Domestic Abuse Sexual Violence Procedures [VAWDASV]

The Trust has Policy and Guidance to support victims of violence against women, domestic abuse and sexual violence. The policy and guidance is designed to promote the safety of victims of domestic and sexual violence who are receiving services provided by the Trust, and explains the processes and procedures that staff will use to identify and respond to violence against women, domestic abuse & sexual violence.
They are available via the Trust's Policies Page and on the Trust's Safeguarding & Public Protection intranet pages.

6.9 Information Sharing

Information must be shared in accordance with the Data Protection Regulations 2018 and the common law duty of confidentiality. Both allow for the sharing of information and should not be automatically used as a reason for not doing so.

In exceptional circumstances, personal information can be lawfully shared without consent where there is a legal requirement or the practitioner deems it to be in the public interest. One of the exceptional circumstances is in order to prevent abuse or serious harm to others. It is not possible to give guidance to cover every circumstance in which sharing of confidential information without consent will be justified. You **must** make a judgement on the facts of the individual case. Where there is a clear risk of significant harm to a child or serious harm to an adult, the public interest test will almost certainly be satisfied. There will be other cases where you will be justified in sharing limited confidential information in order to make decisions on sharing further information or taking action – the information shared should be necessary for the purpose and be proportionate.
Safeguarding information will be retained in line with Trust information governance related policy.

https://gov.wales/information-sharing-safeguard-children-and-adults-leaflet

You should seek advice from the Information Governance Lead and Safeguarding Lead if you are unsure

6 EQUALITY IMPACT ASSESSMENT

The Trust is committed to ensuring that as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that any impact from the policy would have a positive effect to the equality groups mentioned.
Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation

7 GETTING HELP

Contact Senior Nurse Safeguarding and Public Protection

[See Safeguarding and Public Protection Guidance Booklet for referral process flowcharts]

8 RELATED POLICIES

- Data Protection and Confidentiality Policy (2017)
- Disciplinary Policy (2017)
- Disclosure and Barring Checks on Trust Post Guidance
- NHS Wales Procedure for NHS Staff to Raise Concerns
- Wales Safeguarding Procedures (2019)
- Violence, Domestic Abuse and Sexual Violence Workplace Policy and Procedure (2018)
- Records Management Policy (2018)
- Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust

9 TRAINING AND EDUCATION

Safeguarding and Public Protection training is vital in protecting our patients and donors, their families and our communities from harm.

Safeguarding training is available both on a single agency and a multi-agency basis in line with the NHS Safeguarding Training Framework.

10 LEGISLATION AND NHS REQUIREMENTS

The Trust has to comply with relevant legislation, external standards and good practice guidance including:

- Social Services & Well-being (Wales) Act 2014 and the related Codes of Practice; Part 6 [Looked After Children] & Part 7 [Safeguarding Children & Adults at Risk]
- Children Act 1989, section 47 [child protection investigations]
- Children Act 2004 sections 25, 27 and 28 [duty to cooperate to safeguard & promote welfare of children]
- Mental Capacity Act 2005 as amended in the Mental Health Act 2007 [Supervisory Body and Managing Authority requirements for the Deprivation of Liberty Safeguards]
- s325 Criminal Justice Act 2003 [Multi-Agency Public Protection Arrangement (MAPPA) Duty to Co-operate Agency]
- Violence Against Women, Domestic Abuse, Sexual Violence (Wales) Act 2015 [develop and implement a local strategy with the Local Authority]
- s5B of the Female Genital Mutilation Act 2003 (amended by Serious Crime Act 2015) [mandatory reporting of FGM in under 18s to the police]
- Counter Terrorism & Security Act 2015 [to address those drawn into, or at risk of being drawn into terrorist and extremist behaviour]
- Safe Care Standard 2.7 of Health & Care Standards in Wales
- Duty of Candour 2023 (To be open and honest with people they are caring for if things go wrong and harm has occurred.)

11 REVIEW AND AUDIT

Review of this policy will be undertaken no later than three years after the date of approval. The policy may be subject to audit and will be assessed in line with normal audit planning processes, the outcome of any audits undertaken will be reported to the Trust Safeguarding and Public Protection Management Group.

12 ACKNOWLEDGEMENTS

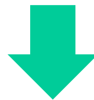
This policy has been informed by a similar policy: Cwm Taf UHB Safeguarding and Public Protection Policy (2018)

Appendix 1

<u>An overview of the duty to report process</u>

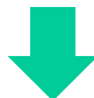
I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

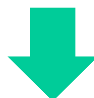


I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?



I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?



I am aware of a child or adult that may be at risk of harm? of a child or adult that may be at risk of harm? What evidence do I have: disclosure; observation; information?

F1

Appendix 2

Details of the person making the report	
Name	
Designation	
Contact Telephone Number	
Email Address	
Date of Report	

Reason for report	
Report in relation to:	
Type of Abuse	
Does this involve a professional concern?	
Reason for the report / nature of concerns	
Did you discuss the views and wishes with the victim	
What are their views and wishes and what would they like the outcome to be?	
If not discussed, why not?	
Does the adult at risk have/need an advocate?	
Adult at risk advocate details	
Is the adult at risk subject to legislative powers, such as DoLS, MHA or Power of Attorney?	
If yes, please provide details	
Is the adult at risk aware of the report?	
If No, please explain why	
Is there any evidence to suggest that the adult at risk lacks mental capacity to consent to this report?	
Do they consent to their information being shared with other agencies?	

Is there an overriding reason to share this concern without consent?	

Where the abuse occurred

Where did the alleged Abuse occur?	
Address if not Home/Hospital	
If this occurred in an NHS Service, if so, please state which service and where	
Service	Location
Other - Please State:	

Details of the person affected

Who has been affected by the alleged abuse?	
What type of person is affected	
NHS Number	
Subtype of Person Affected	
Forename	
Surname	
Gender	
Date of Birth	
Address Line 1	
Address Line 2	
Address Line 3	
Email	
Primary Contact Number	
Secondary Contact Number	
Preferred Language	
Is interpreter required	
Ethnicity	
Are there Other Adults or Children at the Property?	
If Yes, are they also at risk	
Please give details of this risk	
Are there any disability considerations?	
Persons Circumstances	
Disabilities	
Any other relevant information:	
Was the person injured in the incident?	
Injury – Check Merge code	
Body Part Check Merge code	
Treatment Check Merge code	

Care and Support	
Does the individual have care and support needs and as a result of those needs are they unable to protect themselves against the abuse, neglect or harm or the risk of it?	
What are those care needs and how are they met?	
Why are they not able to protect themselves?	
Is the individual experiencing or is at risk of abuse, neglect or other kinds of harm?	
What action has been taken to safeguard the individual?	

Other Person(s) Affected	
Are there adults or children at the property?	
Are they also considered at risk?	
If yes - what is the risk?	

Associated Persons	
Is the associated person a member of the same household?	
Are they a Service User/Relative/ Member of the Public/Employee or member of staff?	
Title	
Forenames	
Surname	
Address	
Telephone Number	
Language	
Disabilities (if any)	
Relevant Risk Factors *(including Substance Misuse, Mental ill-health, Physical ill-health, Domestic Abuse, History of violent behaviour)*	

Employees	
Contact Role	
Contact Type	
Subtype	
Relationship to Individual at Risk	

Title	
Forenames	
Surname	
Email	
Address Line 1	
Address Line 2	
Address Line 3	
Telephone Number	
Other Employer Details	
Does the alleged person of concern have any **contact with children** in any employment role?	
Does the alleged person of concern have any **contact with adults** in any employment role?	
Is the alleged person of concern aware of the report?	
Any other relevant information about this individual Put N/A if there is no other information	

Witnesses

Type (Service User/ Relative/ Public/ Employee/ Other)	
Forenames	
Surname	
Address	
Postcode	
Telephone	
Relationship to victim:	
Is witness a child?	
Is witness aware of report?	

Agency Involvement

Agency Role	
Contact Number	
Contact Email	

Local Authority Reporting to	

Appendix 3

Details of the person making the report	
Name	
Designation	
Contact Telephone Number	
Email Address	
Date of Report	

Reason for Report	
Report in relation to:	
Type of Abuse	
Does this involve a professional concern?	
Reason for the report / nature of concerns	
Did you discuss the views and wishes with the victim	
What are their views and wishes and what would they like the outcome to be?	
If not discussed, why not?	
Has consent for report been obtained from the person with the parental responsibility?	
Has consent been obtained from the child/young person?	
Is there an overriding reason to share this concern without consent?	
If yes, please explain why	
Views of the person with the parental responsibility about making this report	
Views of the Child / Young Person about making this report:	

Where the abuse occurred	
Where did the alleged Abuse occur?	
Other Please state:	

Address if not Home/Hospital	
If this occurred in an NHS Service, if so, please state which service and where	
Location	
Secondary Location	
Service Submitting report	
Service Responsible for Individual at Risk	

Details of the person affected

Details of the person affected	
Who has been affected by the alleged abuse?	
What type of person is affected	
NHS Number	
Forename	
Surname	
Gender	
Date of Birth	
Address Line 1	
Address Line 2	
Address Line 3	
Email	
Primary Contact Number	
Secondary Contact Number	
Has the family resided in another area	
If yes, why and where?	
Has the Child / Young Person arrived from overseas?	
Immigration Status:	
If yes, Date of Arrival?	
Home Office Registration Number:	
Preferred Language	
Is interpreter required	
Communication Needs	
Cultural Needs:	
Ethnicity	
CP Register	
Are there any disability considerations?	
Persons Circumstances	
Disabilities	
Any other relevant information:	
Looked after?	
Injuries	
Injury	
Body Part	

Treatment	

Care and Support	
Does the individual have care and support needs and as a result of those needs are they unable to protect themselves against the abuse, neglect or harm or the risk of it?	
What are those care needs and how are they met?	
Why are they not able to protect themselves?	
Is the individual experiencing or is at risk of abuse, neglect or other kinds of harm?	
What action has been taken to safeguard the individual?	

Other persons involved

Are there Other Adults or Children at the Property?	
If Yes, are they also at risk	
Please give details of this risk	

Associated Persons	
Is the associated person a member of the same household?	
Relationship	
Are they a Service User/Relative/ Member of the Public/Employee or member of staff?	
Contact Subtype	
Title	
Forenames	
Surname	
ID Number Type	
ID Number	
Gender	
Date of Birth	
Date of Death	
Email	
Address	
Postcode	
Primary Telephone Number	
Secondary Telephone Number	
Language	
Disabilities (if any)	
Relevant Risk Factors *(including Substance Misuse, Mental ill-health, Physical ill-health, Domestic Abuse, History of violent behaviour)*	

Witnesses	
Type (Service User/ Relative/ Public/ Employee/ Other)	
Forenames	
Surname	
Address	
Postcode	
Telephone	
Relationship to victim:	
Is witness a child?	
Is witness aware of report?	

Agency Involvement	
Agency Role	
Contact Number	
Contact Email	

Local Authority Reporting to	

Partneriaeth Cydwasanaethau
Shared Services Partnership

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	**Shared Service Partnership Committee**
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	23 March 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising – Recruitment Update

The Recruitment Modernisation Plan is positively impacting performance, with the time to hire for new recruits effectively being halved at the initial sites where the changes have been fully implemented. Actions have included the training of over 1800 Recruitment Managers across NHS Wales in the last twelve months and the provision of regular and dedicated communications. One area still in need of improvement is to receive more comprehensive forecast information from Health Boards, Trusts, and Special Health Authorities, in terms of recruitment plans for the medium and longer term.

The Committee **NOTED** the update.

Chair's Report

The Chair updated the Committee on attendance at recent meetings, both within NWSSP and externally. The Chair also confirmed the dates of further Committee development sessions, on the 9th of June and the 10th of November.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The number of fleet electric vehicles has increased but the UK Government trial of electric HGVs is stalled.
- Consultation with staff has started regarding the move from Companies House to Cathays Park.
- Brecon House accommodation in Mamhilad continues to have structural issues

with the concrete roof structure which means that we will need to look for alternative accommodation to store the primary care records.

- Welsh Government have confirmed that the required capital is not available to support the OBCs for the Laundry Service, and we are therefore working on an alternative "do minimum" plan which will allow us to refurbish three of the existing sites but within a substantially reduced capital envelope.
- There is an ongoing conversation with colleagues in Welsh Government around PPE storage, stock management, ordering, delivery, and the links to supplies to Primary Care and Social Care.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

Duty of Quality

The Committee discussed and **APPROVED** a paper setting out the proposed approach that NWSSP will adopt to take forward compliance with the Duty of Quality. This includes the role of the Partnership Committee to provide oversight and the twofold role NWSSP will have in providing evidence under Duty of Quality.

Chair's Action – Telephony and Contact Centre

This relates to a joint procurement led by DHCW to award a new contract for telephony and contact centre systems that just missed the deadline for the January Committee. Approval had been given under Chair's Action on behalf of both the Committee and the Velindre Trust Board.

The Committee **RATIFIED** the contract award.

Energy Procurement

Eifion Williams attended to present this item. Following the withdrawal of British Gas from the commercial energy market, alternative options had been presented to Directors of Finance and a decision taken to establish a revised procurement arrangement with Crown Commercial Service (CCS), due to their substantial presence in the energy market across the public sector. The new arrangements will come into force in October of this year, NHS Wales would participate in fixed price energy baskets to cover the first 18 months of the contract removing financial uncertainty. Existing forward purchases with British Gas will be sold back to the supplier generating a surplus for NHS Wales. The Directors of Finance also suggested a change in governance arrangements and consequently the Energy Price Risk Management Group will be replaced by the Welsh Energy Group and the Welsh Energy Operating Group, with the former being a sub-committee to the Partnership Committee.

The Committee **APPROVED** the transfer to CCS, the fixed purchase price of energy, the sale back of existing forward purchase to British Gas, and the establishment of the Welsh Energy Group and the Welsh Energy Operating Group.

Items for Noting
Chair's Appraisal The Chair's appraisal was conducted earlier in the month and included feedback by Committee members. A summary of the appraisal was provided to Committee members. The Committee **NOTED** the paper.
Overpayment Policy The Committee Members discussed the Overpayments update report presented by the Director of Finance. It was agreed that further work was needed to develop an all-Wales Overpayment policy as well as to review the end-to-end processes and streamline procedures which would make it easier for managers to submit termination documentation. It was agreed that further updates would be provided to the Committee members once the various Task and Finish Groups and Service Improvement Team had looked into the issues in more detail. The Committee **NOTED** the paper.
Finance, Performance, People, Programme and Governance Updates
Finance –The position at M11 forecasts a break-even position with £2m re-distributed to Health Boards. The Welsh Risk Pool forecast outturn position remains as forecast in the IMTP, and all allocated capital funding should be utilised by the end of March. **People & OD Update –** Sickness absence rates remain very low, and there has been an increase in Statutory and Mandatory Training compliance to 91%. PADR completion is almost at green. The only area of concern is staff turnover, which is higher than expected, and a review is being undertaken to investigate the reasons for this. **Performance** – The in-month (January) performance was generally good with 32 out of 37 KPIs achieving target. The one red-rated indicator was Payroll call-handling, but steady improvements are now being noted in this area. **IMTP Q3 Progress Report -** 78% of required actions are either complete or on-track, with those actions that are off track are assessed during the quarterly review process within NWSSP. **Project Management Office Update** – The Case Management System and the Laundry Transformation Projects remain red-rated and are also included as red risks on the Corporate Risk Register. All other projects are on track. **Corporate Risk Register –** There remain seven red-rated risks covering areas such as energy costs and provision, industrial action, insufficient staff resource, the Legal and Risk and Laundry project risks, and an issue with the roof of Brecon

House that may require the lease to be terminated. The Committee **NOTED** the above Reports.	
Papers for Information	
The following items were provided for information only: • Audit Committee Assurance Report; • Finance Monitoring Returns (Months 10 and 11).	
AOB	
N/a	
Matters requiring Board/Committee level consideration and/or approval	
• The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.	
Matters referred to other Committees	
N/A	
Date of next meeting	18 May 2023

TRUST BOARD

TRUST SEAL REPORT: APRIL 2023 – MAY 2023

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

1. SITUATION/BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal request (**period April to May 2023**).

1.2 Board members are asked to view the contents of the report. Further information or queries should be directed to the Director of Corporate Governance and Chief of Staff.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal/Analysis: Please refer to the Seal Register at **Appendix 1**.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.
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 contents of the Trust Board Seal Register included in Appendix 1.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 1 – Seal Register

Date	Document Details	Signed
26 April 2023	Supplemental Agreement with The County Council of the City of Cardiff and Velindre University NHS Trust relating to a non-technical correction to the land license for Longwood Drive, Cardiff and Hollybush Estate, Cardiff	Prof. Donna Mead OBE, Chair Mr. Steve Ham, Chief Executive

GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

TRUST BOARD

NURSE STAFFING LEVELS (WALES) ACT 2016

DATE OF MEETING	25th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-Applicable

PREPARED BY	Rhian Wright, Nurse Staffing Programme Lead
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Professional Nurse Forum	6th April 2023	Content agreed
Executive Management Board	2nd May 2023	NOTED
Quality, Safety & Performance Committee	16th May 2023	NOTED

1. SITUATION

This paper is to provide the Trust Board with the annual assurance that all statutory requirements of the Nurse Staffing Levels (Wales) Act 2016 are being met. This report provides the position from the 6th of April 2022 to the 5th of April 2023.

The Trust Board is asked to **NOTE** the position in respect of the Trust's compliance with the Nurse Staffing Levels (Wales) Act 2016 for the period 6th April 2022 – 5th April 2023.

2. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nursing and other staff; and;
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Since the 1st April 2021 the Velindre Cancer Service First Floor Ward was re-classified as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical ward and therefore, the ward and Trust are now required to meet the full Act reporting requirements. Through establishment reviews of all nursing areas, a triangulated approach to each area has been considered despite not requiring national reporting this information is vital to quality indicators. The full detailed report will follow however part of this is considered in the assessment/summary below.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Nurse Staffing Act Reporting

To facilitate the preparation of the statutory three yearly report to Welsh Government, there is an agreed All Wales requirement that an annual assurance report be prepared to provide assurance to the Board that all statutory requirements are being met. The Nurse Staffing Levels (Wales) Act 2016 Annual Assurance Report has been completed and the report (using the national reporting template) is attached in ***Appendix 1***. This report highlights:

- Nurse staffing levels have been calculated using the triangulated approach bi-annually.
- ***No impact on patient care relating to the quality indicators reported due to not maintaining staffing levels***
- There have been no incidents of harm relating to the quality indicator of pressure damage, no medication never events aligned with staffing and there has been one fall resulting in harm. The investigation into this is yet to be concluded and will be reported on in next year's Annual Assurance Report.
- There has been one complaint concerning nursing care managed through the

Putting Things Right complaints regulations. This complaint was not solely related to nursing care and was not attributable to the nurse staffing level on the ward. Learning has been shared in relation to this complaint and a task and finish group was set up to improve quality and safety in relation to enteral feeding.

- There have been occasions when the required roster has not been met mainly due to sickness absence and increased acuity. Every effort (reasonable steps) has been made to fill any gaps in the roster. ***There have been no incidences relating to quality indicators reported where staffing levels have impacted adversely of the First Floor Ward to provide the required care or treatment to patients.***
- The implementation of SafeCare on first floor in March 2023 has enabled us to bring together the elements of nurse staffing and acuity to help deliver safe and effective care for inpatients being cared for at Velindre Cancer Centre (SafeCare is the national system that is being implemented within Wales to enable boards/trusts to meet the requirements of the Nurse Staffing Levels (Wales) Act 2016. It allows for real time visibility of staffing levels taking into account patient numbers and acuity, thus helping to ensure an awareness of whether we have the correct staffing levels to care for patients safely and sensitively). SafeCare will be utilised for data retrieval for the next Annual Assurance Report, this report has been compiled using the existing Health Care Monitoring System.
- Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for first floor. There are no financial concerns in relation to the staffing of first floor.

3.2 Establishment Reviews

Following each national benchmarked acuity review (twice yearly) an establishment review is undertaken across all areas of the Trust that require registered nurses in front line care / treatment delivery (both Divisions) chaired by the Executive Director of Nursing, AHP & Health Science and relevant Head of Nursing. The establishment reviews are reported on a template for agreement at each level. Each establishment review includes an overview of:

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster
- Patient Feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
- KPI review
- Service plans or Clinic Templates as applicable (not all areas)

In summary, there were no incidents relating to the quality indicators or complaints effecting care linked to nurse staffing levels for the reporting period. PADR compliance overall was good (100% in some areas) First Floor PADR compliance was reported at

93.02% during the last establishment review in October 2022. There was a plan to undertake all outstanding PDAR's where 100% was not achieved. Training compliance was overall good. Discussions were held around achieving top of licence working and the implementation of Band 4 Associate Practitioners based on NHS Wales agreed standards.

3.3 Electronic Rostering

Health roster is fully utilised in six nursing areas and for the nurse bank. Rostering Key Performance Indicators (KPI's) are produced electronically which are scrutinised locally to assess rostering efficiency and effectiveness. An overview of these KPIs are also taken as part of establishment reviews. Health Roster also facilitates rapid and robust assurance that staffing levels are safe across all nursing areas. These rosters are legible, auditable and viewed in one centralised location for visibility of responsible staff.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	There is a strong evidence base that links nurse staffing levels with patient experience and outcomes
RELATED HEALTHCARE STANDARD	Safe Care
	Individual care, Timely care, Dignified Care, Staff & resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required in respect of reporting compliance with legislation
	However, a wider nurse workforce equality review is required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Given the duty of the act, in the event of patient acuity and / or numbers increasing the staffing levels will need to be increased accordingly. This will have a financial impact

5. RECOMMENDATION

The Trust Board is asked to **NOTE** the Annual Nursing Staffing Levels (Wales) report for 2022/2023 as assurance that the necessary processes and reviews have taken place for Velindre NHS Trust to remain compliant with its duties under the Nurse Staffing Levels (Wales) 2016 Act.

GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board	Velindre University NHS Trust		
Date annual assurance report is presented toBoard	4th May 2023 Reporting period 6th April 2022 to the 5th April 2023		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	1		
During the last year the number of occasions (for section 25B wards)where the nurse staffing level has been reviewed/ recalculated outside the bi-annual calculation periods	0		
The process and methodology used to calculate the nurse staffing level.	Velindre University NHS Trust has one medical inpatient ward that falls under Section 25B of the Nurse Staffing Levels (Wales) Act 2016 which is the First Floor Ward, Velindre Cancer Centre. The triangulated methodology prescribed in section 25C of the Nurse Staffing Levels (Wales) Act 2016 and documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels. A quality improvement approach is central to the bi-annual establishment review process. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Patient acuity data and patient flow is discussed and bed occupancy rates are also considered. Key performance indicators are analysed during the review process. Following the bi-annual acuity audit process, establishment reviews take place with the senior nursing team and the ward management team and include detailed professional discussions on whether the current establishment is appropriate to deliver safe and effective care. In accordance with statutory guidance, the ward manager has remained supernumerary throughout the reporting period. In addition to the ward manager a band 6 nurse coordinator is also additional to the planned roster, however, they do assist with patient care and on occasions are included in the planned roster if the need arises. The current whole time equivalent establishment includes the required 26.9% uplift as mandated by the Nurse Staffing Levels (Wales) Act 2016.		

	The ward has not changed its 'primary purpose' during the reporting period. At the start of the reporting period, First Floor had 22 beds open to patients (to account for social distancing and COVID 19 restrictions). Due to the relaxation of national COVID 19 guidance and increasing demand, the ward increased back to full capacity of 32 beds in September 2022. During the reporting period acuity data was recorded once a day. Since March 2023 acuity has been scored twice a day using the SafeCare module which will facilitate richer data and real time data capture. Acuity levels have remained fairly consistent over the last two years with an increase in patients scoring level 3 and 4 acuity levels and a slight decrease in Level 5 acuity.
Informing patients	Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward informing patients and relatives of the nurse staffing numbers calculated for the identified period and the date that the calculation was undertaken and signed off by the designated person. The posters are updated following each bi-annual re-calculation. In addition, copies of the All Wales FAQ's on Nurse Staffing Levels are available for patients and visitors to the ward. Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.

Level	Description
Level 5	**One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day
Level 4	**Urgent Care** - The patient is in a highly unstable, unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex Care** - The patient may have a number of identified problems, some of which interact, making it difficult to predict the outcome of individual treatment
Level 2	**Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors.

The percentage of patients assigned to each level as a proportion of the total data captured

WLOC Level	2021-2022	2022-2023	Trend
Level 5	9.8%	6.5%	↓
Level 4	39.9%	46.7%	↑
Level 3	41.1%	43.8%	↑
Level 2	9.1%	3.1%	↓
Level 1	0.2%	0.02%	↓

Section 25E (2a) Extent to which the nurse staffing level has been maintained As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provideassurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.				
Extent to which the required establishment has been maintained within adult acute medical and surgical wards. NB: First cycle: spring 2022 following January audit Second cycle: autumn 2022: following June audit		**Period Covered – April 2022 – April 2023**		
		Number of Wards:	**RN (Wte)**	**HCSW (Wte)**
	Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle (May)	1	23.68	23.68
	WTE of required establishment of adult acute medical and surgical wards funded following first (May) calculation cycle	1	23.68	23.68
	Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle (Nov)	1	28.42	14.21
	WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	1	28.42	14.21
	The nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor. In-patient bed capacity was reduced 22 beds during the pandemic. After undertaking a review of the current funded nursing establishment against the required establishment for First Floor Ward, the Integrated Care Directorate is of the opinion that the current establishment is sufficient to manage and deliver care sensitively to 32 beds from September 2022.			

Extent to which the planned roster has been maintained within adult acute medical and surgical wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not Appropriate	Data completeness
TOTAL	*652*	*414* *64%*	*36* *5%*	*72* *11%*	*130* *20%*	*89% (due to spanning two data capture systems)*

The data shows that 64% of shifts were reported where the planned roster was met and it was deemed appropriate. There is a slight variation in the data showing that the night shifts displayed better compliance with the planned roster. 5% of shifts that reported the planned roster was met but not appropriate, the accompanying narrative in relation to these shifts predominantly highlighted increased patient acuity. The planned roster was not met but was appropriate in 11% of shifts. It was reported that the planned roster was not met and not appropriate in 20% of shifts. On such occasions temporary staffing is considered and requested, however, it is not always available especially if staff sickness is reported near shift commencement or during a shift. Analysing the data and accompanying narrative it is important to note that the planned roster is not met on many occasions due to vacant beds on the ward. Analysis of the Health Care Monitoring System (HCMS) data indicates that the average bed occupancy from September 2022 to April 2022 was 61%, hence the planned roster is not always deployed. To ensure consistency of approach Welsh Levels of Care acuity scoring and reporting training continues to be delivered to ward staff.

Implementation of SafeCare to First Floor in Velindre was complete in March 2023. Health Care Monitoring System (HCMS) has been utilised for data capture for the current reporting period. SafeCare data will be utilised for future reporting periods. SafeCare system, is now the national system that is being implemented within Health Boards/Trusts to enable organisations to meet the requirements of the Nurse Staffing Levels (Wales) Act 2016.

During April 2022 to April 2023 Velindre University NHS Trust has recorded acuity daily using the Health Care Monitory System and commenced acuity recording in the pilot phase of SafeCare implementation from March 2023.

When the second duty of the Nurse Staffing Levels (Wales) Act 2016 (the Act) came into force in April 2018, there was no consistent solution to extracting all of the data explicitly required under section 25E of the 2016 Act, and health boards/trust were using a variety of e-rostering and reporting systems. During the first reporting period health boards/trusts in Wales worked as part of the All Wales Nurse Staffing Programme, to enhance the Health Care Monitoring system (in lieu of a single ICT solution) to enable each

	organisation to demonstrate the extent to which the nurse staffing levels across the health board/trust. Over the last 3 years extensive work has been undertaken to inform the development of the Safecare system that continues to be implemented within health boards and trusts within Wales through a phased approach. Velindre implemented Safecare on First Floor Ward from March 2023. The national implementation of Safecare will ensure consistency in recording and reporting data across organisations in Wales. During year 1 of the current reporting period (April 2021-April 2022) heath boards/trusts have utilised 2 systems to enable the capture and analysis of data – the HealthCare Monitoring System and Safecare. Due to the COVID-19 pandemic health boards/trusts have experienced extreme operational pressures which has impacted on the organisation's ability to implement Safecare within the desired timeframe and data capture has not been consistent throughout that period. During April 2022 to April 2023 Velindre University NHS Trust has recorded acuity daily using the Health Care Monitory System and commenced acuity recording in the pilot phase of SafeCare implementation from March 2023.
Process for maintaining the Nurse staffing level	There are risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level as per the requirements of the Act. Reasonable steps are considered and staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is used to help determine whether staffing levels are appropriate for the acuity of the patients. Operational steps to maintain the nurse staffing level include: • There are clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills. • Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse co-ordinator and practice educator to provide direct patient care. • Utilising bank and agency. • Incentivised pay for substantive staff during the reporting period has contributed to additional staffing capacity.

Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels in adult acute medical & surgical inpatients wards						
Incidents of patient harm with reference to quality indicators and any complaints about care provided by nurses	**Total number of incidents/ complaints during last year**	**Number of closed incidents/ complaints during current year**	**Total number of incidents/ complaints not closed and to be reported on/during the next year**	**Increase (decrease) in number of closed incidents/ complaints between previous year and current year**	**Number of incidents/ complaints when the nurse staffing level (planned roster) was not maintained**	**Number of incidents/complain tswhere failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor**
Hospital acquired pressure damage (grade 3, 4 and unstageable)	0	0	0	No change	0	0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	1	0	1	No change	0	0
Medication errors never events	0	0	0	No change	0	0
Any complaints about nursing care	1	1	0	Increase of 1	0	0

NOTE: *Complaints refers to those complaints made under NHS Wales complaints regulations (Putting Things Right (PTR)*

There have been no incidents of harm relating to the quality indicator of pressure damage. No medication never events have occurred during the reporting period. There has been one fall resulting in harm which is yet to be concluded and will be reported on in next year's Annual Assurance Report. There has been one complaint concerning nursing care managed through the Putting Things Right complaints regulations. This complaint was not solely related to nursing care and was not attributable to the nurse staffing level on the ward. Learning has been shared in relation to this complaint and a task and finish group was set up to improve quality and safety in relation to enteral feeding.

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	When nurse staffing levels have not been able to be maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g. the utilisation of temporary workforce, using a risk based approach to move staff. In addition: • All incidents related to inpatient falls and pressure damage are reviewed by a monthly scrutiny panel, nurse staffing is considered as a possible contributing factor of the investigations carried out. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are held to discuss complaints, concerns and compliance with the Putting Things Right process. • During the COVID 19 pandemic bed capacity was reduced to 22 beds on the ward to aid social distancing.
Conclusion & Recommendations	• The planned roster and ward establishment has not changed during the reporting period. • The nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor. • Due to the unprecedented challenges of the COVID 19 pandemic, beds on First Floor were reduced to 22, they are now open to the full capacity of 32 beds. • There have been reported shifts where the planned roster was not met and not appropriate mainly due to staff sickness and/or increased acuity. Bed occupancy figures reveal that the ward usually has empty beds so the planned roster would not necessarily have been appropriate on all occasions. It is evident that all 'reasonable steps' were taken to maintain the nurse staffing levels. • An upward trend in the level of acuity is apparent for levels 3 and 4, however there has been a decrease in level 5 patients during the reporting period. • There have been no instances of pressure damage in relation to the reportable quality indicators and no medication never events. • There has been one fall which is yet to be concluded and will be reported on in subsequent reports. • One complaint in relation to nursing care has been received for First Floor. This was not as a result of staffing, key learning has been shared and plans to improve quality and safety in this area have been enacted. • SafeCare is now established on First Floor ward and will be utilised for future reporting. • Welsh Levels of Care training continues to be delivered to ward staff with the aim of improving consistency of recording and reporting.

GIG CYMRU NHS WALES | Staff Nyrsio Nurse Staffing

Annual Assurance Report Appendix: Summary of Required Establishment

Health board/trust:	Velindre University NHS Trust		
Period reviewed:	Start Date: 6th April 2022	End Date: 5th April 2023	
Number of wards where section 25B applies:	**Medical:**	**Surgical:**	**Paediatric:**
	1	0	0

To be completed for EVERY ward where section 25B applies

Adult Acute Medical inpatient wards

Ward	**Required Establishment at the start of the reporting period (as at April 6th 2022)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?***	**Required Establishment at the end of the reporting period (as of April 5th 2023)**		**Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?***	**Biannual calculation cycle reviews, and reasons for any changes made**			**Any reviews outside of biannualcalculation, if yes, reasons for any changes made**		
	RN WTE	**HCSW WTE**		**RN WTE**	**HCSW WTE**		**Completed**	**Changed**	**Rationale**	**Completed**	**Changed**	**Rationale**
First Floor	23.68	23.68	Yes	28.42	14.21	Yes.	Yes	No	Figures differ due to previous miscalculation	No	NA	NA

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	25th May 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR DISCUSSION

ACRONYMS	
VCS	Velindre Cancer Service
WBS	Welsh Blood Service
ESR	Electronic Staff Record
KPI	Key Performance Indicator
SACT	Systemic Anti-Cancer Therapy

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 16th May 2023.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. Following its annual review in October 2022, the Committee continues to mature, actively seeking opportunities for continuous improvement, together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHTS FRO MEETING HELD ON 16th MAY 2023

3.1.1 Triangulated themes

The following were the triangulated themes from the meeting:

- ***Effective management and reporting of risk***

  There was evidence throughout the papers that robust and reliable mechanisms for the management and reporting of high risks remain under development. Positive process changes have been made and further work is required to develop and integrated risk based approach across the Trust.

- ***Trust Performance Positive performance issues outlined within reports but also challenges with the implementation of new stretch targets***

  Overall positive performance positions and positive outcomes and experiences were reported across a number of papers covering both Divisions despite a number of challenges including workforce availability, ability to recruit into highly specialist roles, increasing or unpredictable service demand. The challenges of meeting new stretch targets also featured.

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

3.2 Further Information

Board members who are not members of the Committee and require further detail are able to access the agenda and papers for the May 2023 Quality, Safety & Performance Committee meeting at:

https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-committee-2023/quality-safety-performance-committee-papers-16052023/

3.3 *Summary of Committee Highlights*

The following areas were highlighted for reporting to the Trust Board by the Committee:

ALERT / ESCALATE	There are no items to alert or escalate to the Board.
ADVISE	• **Trust Risk Register** Significant discussion took place in respect of the extract of the risk register provided. The report covered progress made to date in respect of the oversight and assurance of the management of risks across the Trust, and the implementation of the Trust risk framework. A verbal in-depth discussion took place in respect of the following risks that included planned actions and mitigation: ○ **Risk 2465 (VCS)** – The number of emails medics are receiving, especially those related to clinical tasks; ○ **Risk 2774 (WBS)** – Risk to quality/complaints/audit resulting from the use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice; ○ **Risk 2776 (WBS)** – Risk to performance and service sustainability as a result of ongoing use of outdated legacy systems, leading to the inability to enhance services to meet business needs. The Committee were advised that a formal 'deep dive' will be timetabled into the Risk programme of work and documented within future reporting and that level one mandatory risk training is now live in all staff ESR learning matrices; This has been completed by 272 staff to date.

- **Triangulated Workforce & Organisational Development Performance Report / Finance Report**

  A comprehensive report was received and discussed, highlighting current key challenges around the supply and shape of the Velindre workforce (and associated financial risks), providing updates against the Trust Workforce Development Framework actions and outputs. The following was highlighted:

  - Continued emphasis on recruitment and retention (via the development of a standard toolkit for NHS Wales) within both Divisions.
  - Widening Access, engaging with local educational establishments in relation to career opportunities within the Trust, in addition to accepting Nursing Cadet placements (commencing Summer 2023).
  - Continued robust workforce planning.
  - Employee relations review, including improvement of processes to minimise employee harm.
  - A reduction in Trust vacancies (in particular within SACT) from 9% to 7.8% over the past year.
  - A reduction in agency spend over the past year (from £1.9m to £1.3m), triangulating with the recruitment of permanent new staff.

- **Finance Report**

  The finance report outlined the Trust's financial position at year end (March 2023) and highlighted delivery against all Key Performance Indicators (Revenue, Capital, Public Sector Payment Performance). The overall year end position against the profiled revenue budget 2022-23 was an underspend of £0.064m.

  Discussions took place in relation to the Divisional Savings Target, indicating a higher target following non-delivery of two Workforce schemes during 2022-23. These were, however, replaced with alternative schemes. It was identified that a number of schemes will deliver from April 2023. Although, a number are also subject to delay.

  The Committee commended the successful year end position.

- **Integrated Medium Term Plan (IMTP) Q4 2022-2023 Progress Report**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

<table>
<tr><td></td><td>The IMTP 2022-23 year-end report was discussed in detail. It was identified that the key deliverables had, in the main, been achieved and, those not yet achieved will be included in the 2023-24 plan review process. It was recognised that a number of projects relate to regional and national services and are therefore not entirely under the control of the Trust.

The Trust will seek to further improve the 'cause and effect' relationship between the plan, outputs and outcomes going forward.

Overall quality of service continues to be sustained.

• Body Storage Review and Recommendations (November 2022)

The Committee received an outline of the Velindre Cancer Service self-assessment response to Welsh Government, following the Body Storage Facilities review and subsequent recommendations received in November 2022.

It was identified that further work is required in relation to a number of areas of governance and an appropriate action plan was developed. An update in relation to delivery of actions will be provided at a future Committee meeting.</td></tr>
<tr><td>ASSURE</td><td>• Anti-Racist Wales Action Plan

A progress report in respect of Trust implementation of its Anti-Racist Action Plan was received and the following highlighted:

○ Further development and rollout of the Trust's Equality Impact Assessment process is underway.
○ Revitalisation of staff networks.
○ Active participation in a national review of Workforce policies from an anti-racist standpoint and subsequent implementation of these.
○ Mapping of recommendations and actions against the 7 levels of assurance ahead of the next update at the November Quality, Safety & Performance Committee.

• Velindre Cancer Service Quality & Safety Divisional Report

A comprehensive and detailed report was received and discussed that covered key quality, safety and performance outcomes and metrics for</td></tr>
</table>

	Velindre Cancer Service for the period November 2022 to March 2023. The following was highlighted: o An overall positive position, with continued achievement of Tier 1 targets o Timely investigation into incidents categorised as 'severe' or 'moderate', with appropriate associated reporting. o Implementation of additional resource to support managers with the effective and speedy investigation, improvements and closure of incidents o No healthcare acquired pressure ulcers for the reporting period. o Progress with Business Intelligence colleagues to ensure the required national mortality reporting could be undertaken. o 100% compliance with investigating and responding to formal concerns within 30-working days. o Further work with CIVICA to obtain department-specific information. o A routine Ionising Radiation (Medical Exposure) Regulations (IRMER) inspection was undertaken by Healthcare Inspectorate Wales in Radiotherapy on the 10th and 11th May 2023. Positive verbal feedback was received (formal report will be provided by end of June 2023). Positive patient feedback received, no immediate assurances identified, the inspection team was assured that the service was safe, a number of areas of good / exemplary practice identified as well as some areas for further improvement. o HIW has revised its IRMER reporting thresholds which will result in fewer no harm incidents relating to Linac error needing to be reported. Following investigation no harm had been identified from all such IRMER reportable incidents reported to HIW. o The Brachytherapy peer review improvement plan was provided. • **Integrated Quality & Safety Group** The Committee received a comprehensive report from the Trust's Integrated Quality & Safety Group, that covered meeting outputs for March and April 2023 and the plans to develop the Trusts Quality Management System. It was identified that the Group continues to mature and still has some way to go before it is fully effective. The following areas were highlighted: o Work is underway to develop the Trust's automated electronic integrated quality metrics dashboard this includes developing the

	dashboard, the links to the Performance Management Framework, and ensuring identification of the required high level harm, safety, outcome and experience measures including mortality. ○ Early development within the five Trust Safe Care Collaborative Projects; 1) Safety Culture (Trust-wide), 2) Donor Adverse Event Reporting (WBS), 3) Haemochromatosis (WBS), 4) Malignant Spinal Cord Compression Pathway (VCS) and 5) SACT Telephone Helpline (VCS). ○ The current status of the Trust in relation to the implementation of the Duty of Candour and Duty of Quality, that were enacted on 1st April 2023. Good progress in respect of implementation of the Duty of Candour and further development work required in respect of Duty of Quality. • **Quality & Safety Quarter 4 Report** The Quarter 4 Quality & Safety report provided an overview of delivery against the Trust's responsibilities in relation to key elements of Quality & Safety for the period 01/01/2023-31/03/2023. The committee were advised that: ○ There had been a decrease in the number of new Ombudsman cases referred to the Trust. ○ There was a slight reduction in the number of concerns received during the period. ○ 100% compliance had been achieved in relation to the 2 day and 30-day formal concern response timescales. ○ Work was underway within the Velindre Cancer Service to facilitate completion of investigations, followed by timely closure in Datix and some improvements had been seen during the quarter. • **Trust Clinical Audit Plan 2023-2024** The Committee received and APPROVED the Trust 2023-24 Clinical Audit Plan and were advised that the plan had been developed utilising outcomes from analysis of some core Quality & Safety 2022-23 outcomes.

	• **Information Governance Assurance Report** The Committee received a comprehensive Information Governance Report, which provided assurance in relation to management of patient, donor and staff information and associated compliance with legislation and standards covering the period 01/10/2022-31/03/2023. The three current main areas of focus within the Information Governance Assurance Framework are Patient Records, Freedom of Information Act and Information Governance Internal Audit. The Committee were assured that, focusing on these areas will drive improvements in Information Governance systems and processes. • **Health and Care Standards 2022-2023** The Trust's overall 2022-2023 Health and Care Standards level 4 status was APPROVED and the plan to take forward all legacy actions during 2023-2024 via the recently re-instated Quality & Safety Improvement Tracker was ENDORSED. The Trust is currently considering its approach to the implementation of the new Health and Care Quality Standards (2023). • **Patient Nosocomial COVID-19 Update** The Committee received an update regarding the current position in relation to patient nosocomial COVID-19 reviews. 48 of 49 potential incidences of patient nosocomial infection within the Cancer Centre had been investigated and scrutinised and, following this a small number of cases are being considered by Legal and Risk Services for Putting Things Right advice. • **Nurse Staffing Levels (Wales) Act 2016 Annual Report** The Committee received the Nurse Staffing Levels (Wales) Act 2016 report, providing an overview of the position in relation to Trust compliance in respect of the Act for the period 06/04/2022 – 05/04/2023. The Committee NOTED that there had been no impact on patient care relating to the maintenance of nurse staffing levels for the period.

INFORM	• **Velindre Cancer Service – Patient Story** A power point story was provided that outlined the experience of a Velindre Cancer Service Nurse 'Jenny' who was also a patient. The outlined the advantages, challenges and learning that the care and treatment of a colleague had brought the service. The Committee conveyed its sincere thanks to Jenny for sharing her powerful and thought-provoking story and endorsed the recommendation to explore research options in relation to caring for patients who are also a nurse. • **Clinical Governance and a Just Culture (making it a reality)** The Committee received a comprehensive presentation from the Interim Head of Quality, Safety & Assurance, in relation to learning gained via her current MSc studies. This outlined how Organisations can successfully implement a 'just culture' as part of their Clinical Governance and Quality and Safety structure. • **Policies for endorsement** The Committee APPROVED the following two policies that had been slightly revised: ○ QS12 – Safeguarding & Public Protection Policy ○ QS08 – Policy for the Management of Safeguarding Allegations / Concerns about Practitioners and those in a Position of Trust. The agenda and papers for the Quality, Safety & Performance Committee (all meetings) can be accessed at: https://velindre.nhs.wales/about-us/quality-safety-performance/
APPENDICES	N/A

4. RECOMMENDATION

The Trust Board is asked to **DISCUSS** and **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 16th May 2023.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Vice - Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
		Choose an item.

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee held on 4th May 2023.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**School of Oncology Update and Business Case** The Committee **noted** the update of the position relating to the Velindre School of Oncology including: - The change of name to: 'Velindre Oncology Academy', - The proposal that Advancing Radiotherapy Academy (ARC) will be a subsidiary (sit under as an arm) of the 'Velindre Oncology Academy' - The tripartite (accreditation) partnership with University of Wales Trinity St David **Trust Nursing Strategy** The Committee **endorsed** the Trust Nurse Strategy for Trust Board approval.
ASSURE	**Radiology Informatics System Procurement – Full Business Case** The committee **endorsed** the Radiology Informatics System Procurement – Full Business Case. Assurance was provided to the committee that the Radiology Informatics System Procurement has been accounted for and budgeted within the financial plan.
INFORM	**Building our Future Together** The committee **noted** the implementation of governance and engagement mechanisms for Building our Future Together. **Digital Programme: Digital Phase** The Committee **noted** the update on the discovery exercise for the digital programme and progress made across the workstreams. **Integrated Medium Term Plan 2023 – 2026** The Committee **noted** the verbal update on **Integrated Medium Term Plan 2023 – 2026.** **Trust Assurance Framework** The Committee **noted** the progress of the Trust Assurance Framework.
APPENDICES	**NOT APPLICABLE**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	25/05/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Charitable Funds Committee at its Public meeting held on the 21st March 2023.

Key highlights from the meeting are reported in Section 2.

The Board is requested to **NOTE** the contents of the report and actions being taken.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Charitable Funds Committee held on the 21 March 2023:

<table>
<tr><td>ALERT / ESCALATE</td><td>There were no items for alerting or escalating to the Trust Board.</td></tr>
<tr><td>ADVISE</td><td>FUNDRAISING
• CHARITY ANNUAL DELIVERY PLAN
The plan focusses on what the Charity aims to achieve during 2023/24 in the context of its agreed 5-year strategy for 2022-2027. It includes:

➢ Governance Delivery Plan – activity to review and improve systems and processes to provide assurance

➢ Fundraising Delivery Plan 2023-24 – Programme of events and other activities, with 25% of the planned activity being new developments. In particular, the Charity is aiming to develop its ability to deliver through digital and regular giving channels. The aim is to raise the £3.5m target income for the unrestricted fund for the year to support the commitments made

➢ Financial Delivery Plan 2023-24 – the financial plan for the year which sets out the opening fund balances (£9.5m), forecast income (£4m), forecast commitments (£7.9m) and forecast closing fund balances (£5.6m)

The Charitable Funds Committee APPROVED the 'Velindre University NHS Trust Charity Annual Delivery Plan 2023/24' subject to following amendments:

➢ Visions and Mission statement to reflect WBS
➢ The objective 'Staff - For the relief of sickness by promoting the efficient and effective performance and duties of Velindre University NHS Trust staff.' to be changed to 'Staff – the promotion of staff wellbeing'

• FINANCIAL POSITION
The Charitable Funds Committee NOTED the Financial Update Report for the period 01 April 2022 – 31 January 2023. This included the financial performance of the Charity for the period ending 31st January 2023, the current and forecast balances of the funds for 2022-23, and the current position and performance of the Charity's investment portfolio as at 31st January 2023.</td></tr>
</table>

Income Performance:

- The Charity has had a successful year and are on course to achieve the highest income performance since the Charity was first established, £4 million being achieved to date.
- The Charity received a significant one-off legacy of £1.6 million which has notably helped performance.
- £3.9m has been received against the Charity's unrestricted fund against a planned target of £2.3 million for this stage of the year.

Expenditure for the period to January 23 was lower than planned by £0.450m. The underspend is due to project slippage which is either due to delay in projects starting or as a result of staff vacancies.

Balance Sheet:

- Investment portfolio performance has improved. The Charity was underperforming following the outbreak of conflict in Ukraine at about 7%. This has since rebounded slightly and is currently running at a downturn position of 4.7% which equates to £0.291m, As such, the Charity is on an upward trajectory, however still has some way to go to achieve performance pre-Ukraine conflict levels.
- Total funds held in the Charity as at 31st January total £8.5m. Just under £6 million is held in the Investment Portfolio, £3.4m is held in cash with the balance made up between the Charity's debtors and creditors -£0.9m.
- Cash balance of £3.4million is significant, this is due to uncertainty in the current investment market with advice from the Charity investment managers that now is not the time to invest further funds into the portfolio,

Reserve Policy:

- Making sure continue to run for a minimum of 4 months.
- Overachieving by about £0.610m.
- High balance but committed a lot of expenditure in the last Committee.

Summary of Commitments:

- Opening balance at £2.6 million on unrestricted funds. On target to achieve income of circa £4.4 million this year.
- Following board approval, the cost recharge to the Charity has reduced by £1.5 million during 2022/23 due to extraordinary non recurrent revenue income in the Trust. This is on the basis that this funding is available back to the Trust in 2023-24 or future years)

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

	• Income growth is based on the Charity Strategy, however given the current financial climate planned growth for 2023/24 has been reduced from £4 million to £3.5 million. As per earlier note, post Committee DoF review has revised The £3.5m down to £2.85m. Future years income growth per the 5-year Strategy assumed £5.5m (24-25) and £7m (25-26), but a prudent approach was taken with a reduction to £4.5m and £5m respectively to ensure that funds don't become over committed. • **ONBOARDING OF THE INVESTMENT MANAGERS** The Charitable Funds Committee **REVIEWED** the financial circumstances risk questionnaire and **APPROVED** the medium risk strategy which has been proposed by the new investment managers, Abrdn, and supported by the Charitable funds Investment Performance Review Sub-Committee. **BUSINESS CASE AND EXPENDITURE PROPOSALS** The Charitable Funds Committee **APPROVED four** Business Case and Expenditure proposals: **1. Arts Co-Ordinator Post Business Case** The Committee **AGREED** to **APPROVE** the Business Case to fund £76.3k with the following caveats: ○ More work to be completed to flesh out the costs and funding to understand how much funding may be required in subsequent years, and what contributions might come from the Transforming Cancer Services Programme. ○ Completion of the Equality Impact Assessment. **2. Business Case for part-funding Clinical Research Fellow (Brain Radiotherapy) from Headfirst Appeal/Brain Research Sub Fund** The Committee **AGREED** to **APPROVE** the Business Case to fund £39.4k subject to re-wording Section 3 Impact Assessment from a PhD to MD. **3. Stem Cell Donors Business Case** The Committee **AGREED** to **APPROVE** the Business Case to fund £25k with the possibility of a further bid for inclusion of donor experience as part of the design. **4. Business Case: Clinical Nurse Specialist (CNS) Navigators** The Committee **AGREED** to **APPROVE** the Business Case to fund £611k, subject to further work being undertaken to develop the Exit Strategy. **BUSINESS CASE ANNUAL EVALUATIONS** The Charitable Funds Committee **APPROVED two** Business Case Annual Evaluation Reports: **1. Consultant Radiographer in H&N Cancer and Late Effects (2019-08 Business Case)**

	The Committee **RECEIVED** and **ACCEPTED** the Business Case Annual Evaluation in relation to the Consultant Radiographer in Head and Neck Cancer and Late Effects post. **2. Advanced International Fellowship Programme - Medical Training Initiative (MTI) (2022-04 Business Case)** The Committee **AGREED** to **APPROVE** the Business Case Annual Evaluation following clarification that the post holder is due to commence employment in May 2023. Post Committee this has since been confirmed.
ASSURE	There were no items required to report for assurance to the Trust Board.
INFORM	**AMENDMENT TO TRUST STANDING ORDERS – SCHEDULE 3** The Charitable Funds Committee: • **ENDORSED** the amendments to the Trust Board Standing Orders – Schedule 3 following the annual review of the Committee's Terms of Reference. • The revised Terms of Reference have been received at the Trust Audit Committee and were formally **ENDORSED** for the amendments required to the Trust Standing Orders. These have been included for formal Board **APPROVAL** at the May 2023 Trust Board. **CHARITABLE FUNDS COMMITTEE EFFECTIVENESS QUESTIONNAIRE** The Committee were informed they would be receiving the Effectiveness Questionnaire and were reminded of the importance of completing this

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.