Public Trust Board

Thu 27 July 2023, 10:00 - 15:10

Velindre University Trust Headquarters, Nantgarw

Agenda

10:00 - 10:15
15 min

1. PRESENTATIONS

1.1. Health Technology Wales Annual Report

Peter Groves, Chair of Health Technology Wales

- 1.1.0 HTW ANNUAL REPORT 22-23 - Velindre Board July 2023 - FINAL.pdf (16 pages)
- 1.1.0a 5 yr review report to HTW-FINAL.pdf (27 pages)

10:15 - 10:25
10 min

2. STANDARD BUSINESS

2.1. Apologies

Professor Donna Mead OBE, Chair

2.2. In Attendance

Professor Donna Mead OBE, Chair

2.3. Declarations of Interest

Professor Donna Mead OBE, Chair

2.4. Minutes from the Public Trust Board meeting held on 25.05.2023

Professor Donna Mead OBE, Chair

- 2.4.0 Draft Public Trust Board Minutes 25.05.23 v3.0_ES_LF_DM.pdf (15 pages)

2.5. Action Log

Professor Donna Mead OBE, Chair

- 2.5.0 PUBLIC TRUST BOARD ACTION LOG v1.pdf (3 pages)

2.6. Matters Arising

Professor Donna Mead OBE, Chair

There are no matters arising.

10:25 - 10:55
30 min

3.
Accountability Report and Annual Accounts 2022-2023

3.1.
Cover Paper for Accountability Report and Annual Accounts 2022-2023

Lauren Fear, Director of Corporate Governance and Chief of Staff and Matthew Bunce, Executive Director of Finance

3.1.0 Accountability Report & Annual Accounts - Cover Report July 2023.pdf (7 pages)

3.1.1.
Accountability Report 2022-2023

Lauren Fear, Director of Corporate Governance & Chief of Staff

***To note - In relation to Financial Accountability, a section will be added at a later date which is currently under review*

3.1.1 Final Draft - Accountability Report_2022-23.pdf (105 pages)

3.1.2.
Velindre University NHS Trust Final Accounts 2022-2023

Matthew Bunce, Executive Director of Finance

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

3.1.3.
Appendix 1 - Letter of Representation 2022-2023

Matthew Bunce, Executive Director of Finance

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

3.1.4.
Appendix 2 - Trust Response to Audit Wales Regarding Trust Governance & Management Arrangements

Matthew Bunce, Executive Director of Finance

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

3.2.
Annual Performance Report 2022-2023

Carl James, Executive Director of Strategic Transformation, Planning & Digital and Cath O'Brien, Chief Operating Officer

3.2.0 - Trust Annual Performance Report - Cover Report 27th July 2023.pdf (6 pages)
3.2.0a 2022-2023 FINAL DRAFT for TB - Velindre UNHST Annual Performance Report version 019.pdf (70 pages)

10:55 - 11:25
30 min

4.
Audit Wales & Internal Audit

4.1.
Audit Wales ISA 260 Report 2022-2023

Steve Wyndham, Audit Wales

4.1.0 Covering paper ISA 260 June 2023 Trust Board.pdf (3 pages)
4.1.0a Audit of Accounts Report - VUNHST - 22-23 .pdf (18 pages)

4.2.

NWSSP Audit & Assurance Services - Head of Internal Audit Opinion & Annual Report 2022-2023

Simon Cookson, Director, Audit & Assurance Services (NWSSP) and Emma Rees, Deputy Head of Internal Audit (NWSSP)

- 4.2.0 VT 22-23 HIA Annual Report and Opinion COVER.pdf (5 pages)
- 4.2.0a VT 22-23 HIA Annual Report and Opinion (1).pdf (25 pages)

11:25 - 12:00
35 min

5.
KEY REPORTS

5.1.
Chair's Report

Professor Donna Mead OBE, Chair

- 5.1.0 Chair's Update July 2023 (v3).pdf (5 pages)

5.2.
Vice Chair's Report

Stephen Harries, Vice Chair

- 5.2.0 202307_Vice Chair Update.pdf (3 pages)

5.3.
Chief Executive's Report

Steve Ham, Chief Executive

- 5.3.0 Chief Executive's Report July 2023 (v2).pdf (3 pages)

5.4.
Research & Innovation Board Champion Report

Professor Andrew Westwell, Independent Member and Research & Innovation Board Champion

- 5.4.0 Trust Board Champion Research_July 2023.pdf (4 pages)

12:00 - 12:40
40 min

6.
QUALITY, SAFETY & PERFORMANCE

6.1.
VUNHST Risk Register

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.1.0 RR -TRUST BOARD -Trust Risk Register - 27.07.2023- V02.pdf (9 pages)
- 6.1.0a APPENDIX 1 - RISK REGISTER - 27.07.2023 -V05.pdf (12 pages)

6.2.
Performance Management Framework (May 2023)

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

- 6.2.0 Trust Board 27 July May PMF Final Format version 028.pdf (179 pages)

6.3.
Financial Report (May 2023)

Matthew Bunce, Executive Director of Finance

- 6.3.0 Month 2 Finance Report Cover Paper - Trust Board 27.07.2023.pdf (6 pages)
- 6.3.0a M2 VELINDRE NHS TRUST FINANCIAL POSITION TO MAY 2023 - Trust Board.pdf (19 pages)

12:40 - 13:15
35 min

7.
LUNCH

13:15 - 14:10
55 min

8.
ANNUAL REPORTS 2022-2023

8.1.
Annual Patient / Donor Experience Report 2022-2023

Nicola Williams, Executive Director of Nursing, AHPs and Health Science and Jade Coleman, Quality, Safety & Assurance Manager

- 8.1.0 Patient and Donor Experience Annual Report 2022-23.pdf (20 pages)

8.2.
Putting Things Right Annual Report 2022-2023

Nicola Williams, Executive Director of Nursing, AHPs and Health Science and Zoe Gibson, Interim Head of Quality, Safety & Assurance

- 8.2.0 Putting Things Right Annual Report 2022-23 (004) (003).pdf (33 pages)

8.3.
Local Partnership Forum Annual Report 2022-2023

Sarah Morley, Executive Director of Organisational Development & Workforce

- 8.3.0 LPF Annual Report 2023 - Board.pdf (7 pages)

8.4.
Equality, Diversity & Inclusion Annual Report 2022-2023

Sarah Morley, Executive Director of Organisational Development & Workforce

- 8.4.0 Board Annual Equality Report 2023.pdf (11 pages)

8.5.
Gender Pay Gap Annual Report 2022-2023

Sarah Morley, Executive Director of Organisational Development & Workforce

- 8.5.0 Board cover paper Gender Pay Gap 2023.pdf (5 pages)
- 8.5.0a Gender Pay Gap Report 2023.pdf (9 pages)

8.6.
Welsh Language Annual Report 2022-2023

Sarah Morley, Executive Director of Organisational Development & Workforce

- 8.6.0 Trust Board cover paper for WL Annual Report 22 23.pdf (6 pages)
- 8.6.0a WL annual performance report 22-23 ENG v1.pdf (12 pages)

8.7.
Professional Regulation / Revalidation Assurance Report 2022-2023

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

8.7.0 Professional Registration - revalidation 2022-23 annual report.pdf (8 pages)

14:10 - 14:50
40 min

9.
PLANNING & STRATEGIC DEVELOPMENT

9.1.
Approval of replacing a 3rd Linac @ VCC

Cath O'Brien, Chief Operating Officer

9.1.0 Replacement of a 3rd Linac at VCC Cover Paper - final version BOARD.pdf (7 pages)

9.2.
Velindre Oncology Academy

Nicola Williams, Executive Director of Nursing, AHPs and Health Science

9.2.0 Velindre Oncology Academy -July 23.pdf (6 pages)

9.3.
Framework Scheme of Delegation for Major Capital Programmes

Matthew Bunce, Executive Director of Finance

9.3.0 Framework Scheme of Delegation for Major Capital Projects and Programmes_Trust Board_July 2023.pdf (8 pages)
9.3.0a Appendix B_IRS Programme Scheme of Delegation and Governance Framework Jul 23.pdf (10 pages)

9.4.
Bone Marrow Transplant - Strategic Outline Case

Carl James, Executive Director of Strategic Transformation, Planning & Digital and Professor Mererid Evans

9.4.0 TB BMT Business Case - 27 july 2023 - Final.pdf (11 pages)
9.4.0a 230706 Haem SOC v11 (002).pdf (119 pages)

14:50 - 15:10
20 min

10.
CONSENT ITEMS

10.1.
CONSENT FOR APPROVAL

Professor Donna Mead OBE, Chair

10.1.1.
Chair's Urgent Actions Report

Professor Donna Mead OBE, Chair

10.1.1 Chairs Urgent Action Report_JULY 2023.pdf (3 pages)

10.1.2.
Commitment of Expenditure Exceeding Chief Executive's Limit

Matthew Bunce, Executive Director of Finance

10.1.2 Public Trust Board July 2023_Commitment of Expenditure Cover Paper.pdf (3 pages)
10.1.2a Appendix 1 - IBP1_Commitment of Expenditure Over Chief Executive Limit 2.0.pdf (8 pages)
10.1.2b Appendix 2 - TB Commitment of Expenditure July 2023 - TRAC Contract Renewal.pdf (10 pages)

10.1.3.

Variation to Standing Orders Velindre University NHS Trust

Lauren Fear, Director of Corporate Governance & Chief of Staff

10.1.3 Revisions to Trust Model Standing Orders_Trust Board_July 2023_Cover Report v2.pdf (7 pages)
10.1.3a NHS Trusts Model Standing Orders, Reservation and Delegation of Powers - June 2023 v6 0.1 Draft for agreement.pdf (79 pages)

10.1.4.
Variation to NHS Wales Shared Services Partnership Standing Orders

Lauren Fear, Director of Corporate Governance & Chief of Staff

10.1.4 NWSSP Standing Orders Jul 23.pdf (3 pages)
10.1.4a 20230714 Standing Orders Operat SSPC.pdf (111 pages)

10.1.5.
Velindre University NHS Trust Business Continuity and Emergency Planning Policy (PP06)

Cath O'Brien, Chief Operating Officer

10.1.5 VUNHST Board Cover Paper_BC EP Policy_PP06.pdf (3 pages)
10.1.5a VUNHST Business Continuity Emergency Planning Policy_3.0 final.pdf (8 pages)

10.2.
CONSENT FOR NOTING

Professor Donna Mead OBE, Chair

10.2.1.
NHS Wales Shared Services Partnership (NWSSP) Committee Assurance Report (18/05/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

10.2.1 SSPC Assurance Report 18 May 2023.pdf (5 pages)

10.2.2.
Emergency Ambulance Services Joint Committee (EASC) Briefing (16/05/2023)

Lauren Fear, Director of Corporate Governance & Chie

10.2.2 Chair's EASC Summary from 16 May 2023.pdf (8 pages)

10.2.3.
Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing (18/05/2023)

Lauren Fear, Director of Corporate Governance & Chie

10.2.3 JC Briefing (Public) 16 May 2023.pdf (7 pages)

10.2.4.
Public Quality, Safety & Performance Committee Highlight Report (13/07/2023)

Vicky Morris, Independent Member and Chair of QSP Committee

10.2.4 Public Quality Safety Performance Committee Highlight Report 13.07.23 (approved).pdf (7 pages)

10.2.5.
Public Strategic Development Committee Highlight Report 06/07/2023)

Stephen Harries, Vice Chair and Chair of Strategic Development Committee

10.2.5 Highlight Report SDC 06.07.2023-LF 2.pdf (4 pages)

10.2.6.
Public Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Report (20/04/2023 and 19/06/2023)

Stephen Harries, Vice Chair and Chair of TCS Scrutiny Sub-Committee

- 10.2.6a Highlight Report - PUBLIC TCS 20.04.23 LF SH Trust Board.pdf (3 pages)
- 10.2.6b Highlight Report - PUBLIC TCS 19.06.2023 Trust Board.pdf (2 pages)

10.2.7.
Remuneration Committee Highlight Report (28/06/2023)

Professor Donna Mead OBE, Chair and Chair of the Remuneration Committee

- 10.2.7 Highlight Report REMCOM 28.06.2023_.pdf (2 pages)

10.2.8.
Public Charitable Funds Committee Highlight Report (08/06/2023)

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

- 10.2.8 MB Review Charitable Funds Committee Public Highlight Report Draft 08 June 2023_ES.pdf (4 pages)

15:10 - 15:10
0 min

11.
ANY OTHER BUSINESS

Professor Donna Mead OBE, Chair

Prior approval by the Chair required.

15:10 - 15:10
0 min

12.
Date of Next Meeting

Thursday, 28th September 2023

15:10 - 15:10
0 min

13.
CLOSE

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

ANNUAL REPORT 2022/23

Technoleg Iechyd Cymru
Health Technology Wales

Professor Peter Groves
Chair, HTW

The HTW Team

HTW remit

To provide a strategic, streamlined & nationally coordinated approach for the identification, appraisal & adoption of medical technologies across Wales.

Identification

Appraisal

Adoption

19/20

Budget: £1M

Headcount: 20 =18.5 WTEs

21/22

Budget: £1.65M

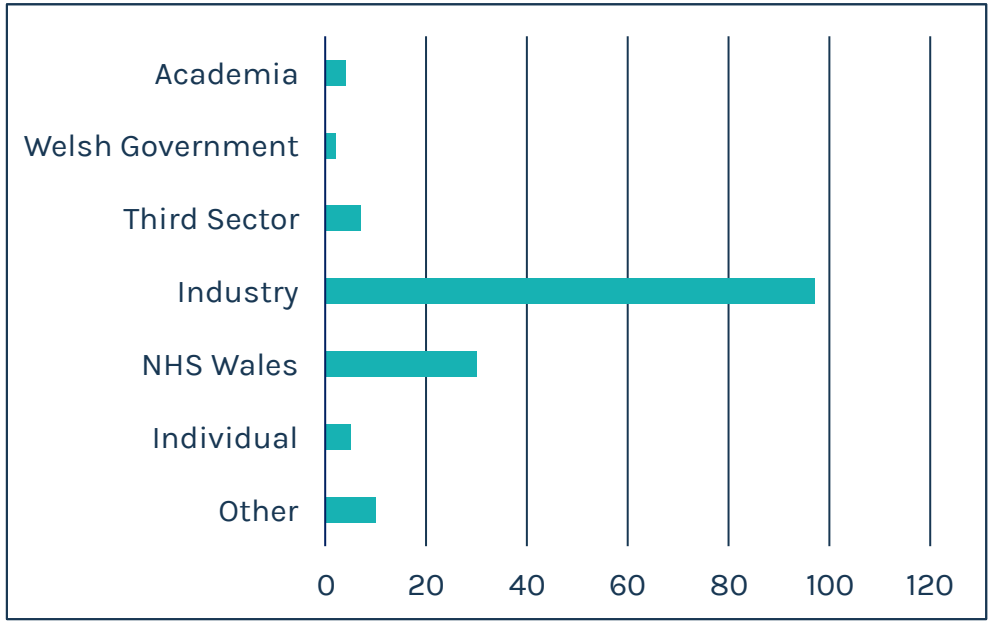
Headcount: 30 = 28.5 WTEs

IDENTIFICATION

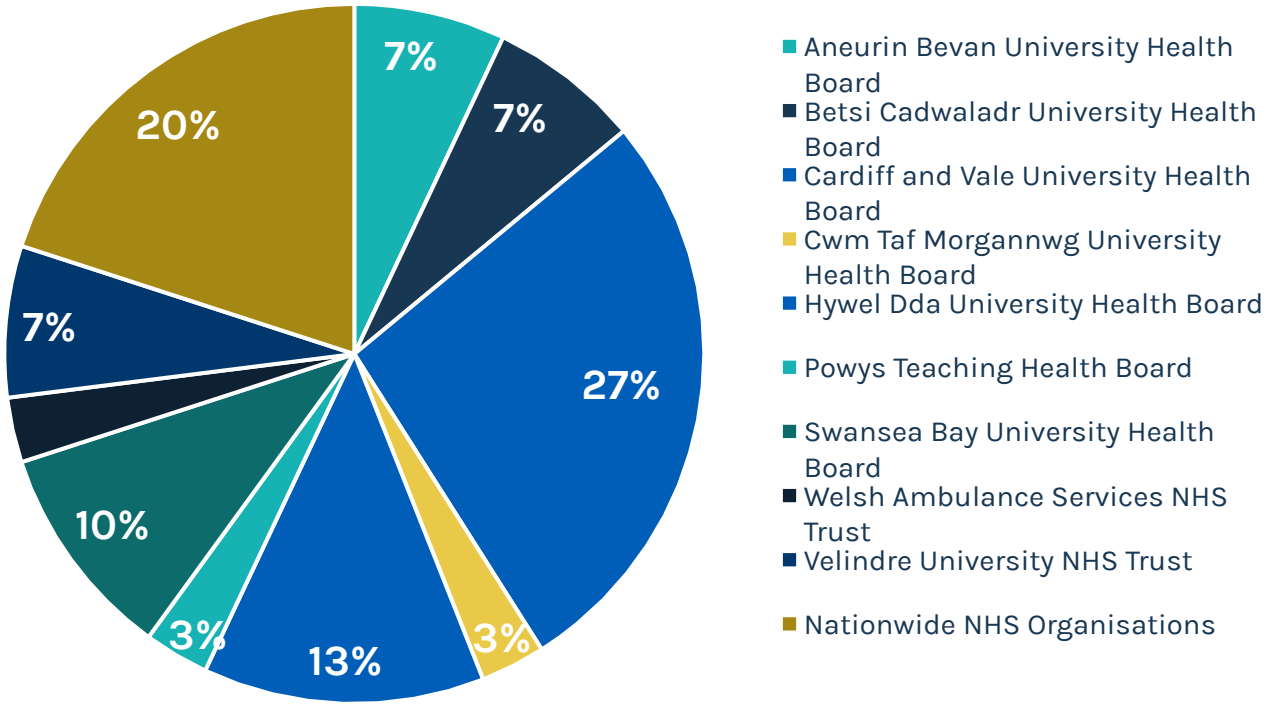
155
Topics proposed to HTW in 2022/23

463
Topics proposed to HTW 2017-23

Source of topic referrals in 2022/23



Breakdown of topics referred from the NHS in 2022/23



Technoleg Iechyd Cymru
Health Technology Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

GUIDANCE PUBLISHED IN 2022/23

- Transcranial magnetic stimulation
- Extreme hypofractionated radiotherapy
- Electronic blood management systems
- Video laryngoscopes
- Stereotactic ablative radiotherapy
- Outpatient laryngeal biopsy
- Left atrial appendage occlusion in patients with atrial fibrillation
- Continuous topical oxygen therapy
- Virtual reality distraction therapy
- Photobiomodulation

EXTREME HYPOFRACTIONATED RADIOTHERAPY

The evidence supports the routine adoption of extreme hypofractionated radiotherapy (EHFRT) to treat localised prostate cancer. EHFRT is associated with equivalent short- and medium-term cancer recurrence and survival outcomes compared with standard care (moderately or conventionally fractionated radiotherapy). **EHFRT reduces the number of visits required for treatment and is associated with a low incidence of adverse events. EHFRT is likely to be cost effective when compared with standard care.** Compared with moderately hypofractionated radiotherapy guided by fiducial markers, EHFRT (seven fractions) using fiducial markers is likely to be cost effective if it is delivered in treatment slots of 20 minutes or shorter. If EHFRT is delivered in five fractions, it is likely to be cost effective at all slot lengths up to 30 minutes.

HTW's guidance would have a 'major positive impact' leading to "less treatment sessions for patients, and increased radiotherapy machine capacity for the Cancer Centre" The experience has led SWWCC to make further referrals of topics for consideration by HTW.

Dr Russell Banner, Consultant Clinical Oncologist, Velindre Cancer Center

(HTW's appraisal) was extremely helpful as an independent appraisal to provide guidance and support to discussions regarding bringing the technique into routine NHS use.

Michael Stone, Costing and Service Improvement Accountant, Velindre University NHS Trust

Technoleg Iechyd Cymru
Health Technology Wales

Ariennir gan Lywodraeth Cymru
Funded by Welsh Government

STEREOTACTIC ABLATIVE THERAPY FOR PRIMARY KIDNEY CANCER

The evidence supports the routine adoption of stereotactic ablative radiotherapy (SABR) to treat people with primary kidney cancer who are not suitable for surgery or other ablative techniques. The use of SABR provides a treatment option that **may improve survival** in patients who would otherwise have no other treatment options available. Patient selection for SABR should be undertaken by a cancer multidisciplinary team. Economic modelling estimates **that the use of SABR is cost effective when compared with clinical surveillance**, with a cost per quality-adjusted life year (QALY) of £1,675.

Dr Tom Rackley, a consultant at the Velindre Cancer Centre who provided expert clinical input during the appraisal process, said he found the EAR report on SABR "extremely useful" and that HTW "presented the evidence in a succinct way". He went on to say that the EAR and guidance would have a "major positive impact" on the wider health and social care context in Wales

PATIENT AND PUBLIC INVOLVMENT (PPI) HIGHLIGHTS

Highlights of our PPI work in 2022/23 include:

- Working collaboratively with a number of patient organisations for contributions to our appraisals
- Continuing to provide input to national and international groups and forums, and share good practice in PPI methods
- Adapting and refining our processes to ensure PPI is an integral part of our work
- Increasing the PPI presence on our website

4 **Patient submissions received**

3 **Specific patient evidence literature reviews**

"The PPI Standing Group is proud of the breadth of patient and public involvement that has been embedded across HTW's programme since its inception. Reflecting on key achievements from the last year, we recognise the flexible and transformative approach to capture PPI and its impact, expanding its novel and adaptive approach to topics such as social care and digital tools. Ensuring PPI is included in reassessment topics at an earlier stage in the process and developing new website animations and tools to share best practice are key highlights from the last year. These achievements should be celebrated and held up as a model of best practice for organisations internationally to benefit from the robust mechanisms for PPI engagement that have been developed."

HTW PPI Standing Group

Potential impact of HTW Guidance

365,515
Total estimated people impacted (per year) by HTW Guidance published **2017-2022**

Guidance Impact

463
Topics proposed to HTW since 2017

56
Topics progressed to evidence appraisal

33
Pieces of Guidance published

OUR RECOMMENDATIONS

Our national guidance recommendations fall into three main categories:

Routine adoption:

The evidence supports the adoption of that technology for a general population.

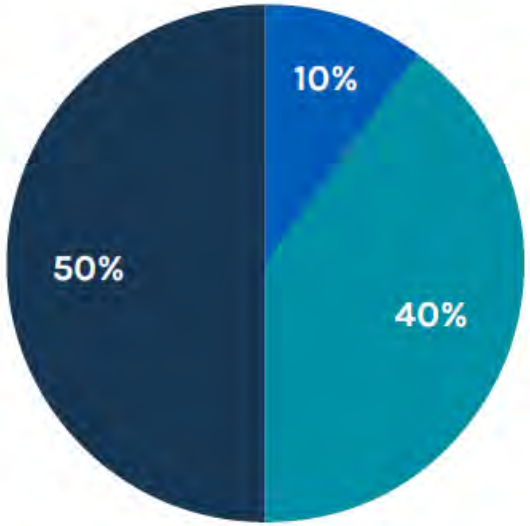
Selective adoption:

The evidence supports the adoption of that technology in a specific subset of the general population.

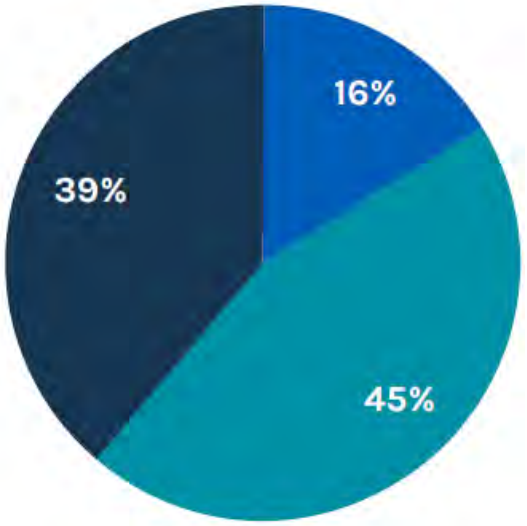
Insufficient evidence to support adoption:

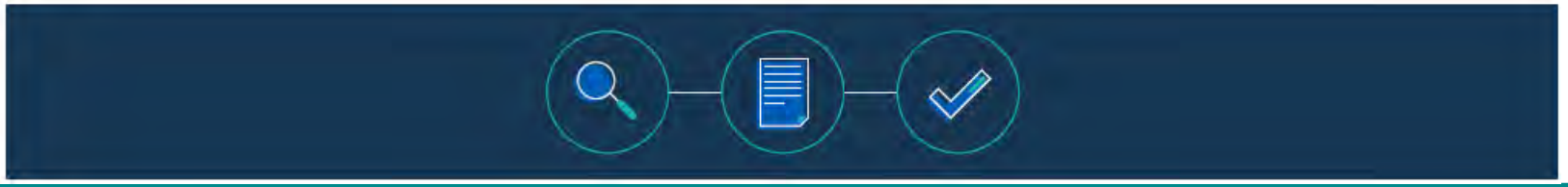
There is not enough evidence to support the adoption of that technology.

2022/23



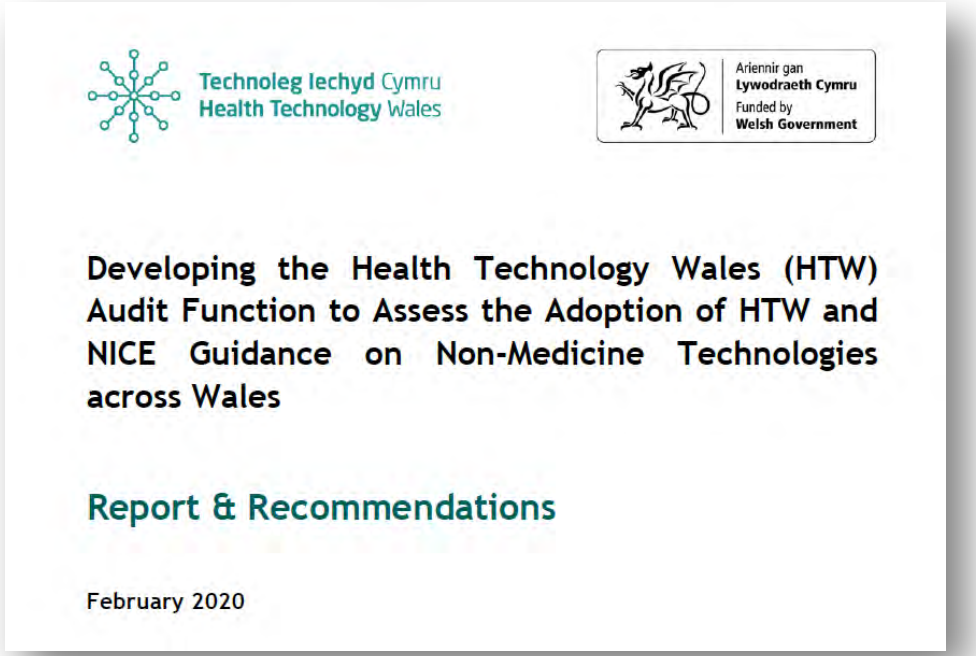
2017-2023





Adoption of HTW Guidance

- HTW guidance has an "**Adopt or Justify**" status
- Expectation from Welsh Government that guidance is considered and adopted or a justification is provided if not
- An Adoption Audit Task and Finish Group convened in 2019 to assess the optimal approach to monitoring adoption of non-medicine technologies in Wales
- Nine recommendations, including requirement for local health boards and other bodies to support the audit led by HTW



Adoption Audit 22/23 - Key Findings

Process

- 11 HTW & 3 NICE
- Process worked for NICE MTGs
- Response encouraging. Partial response from 6/7 LHBs & WHSSC
- Procurement provided all requested data
- Audit able differentiate levels of adoption & impact

Awareness, clarity & impact of guidance

- **Awareness** good **70%**
- **Clarity** very good **83%**
- **Impact** high **72%**
- Useful **feedback** on barriers & enablers

National and International Collaboration

- Collaborating partner in the Welsh COVID-19 Evidence Centre 2021
- Collaborating Partner in the Health and Care Research Wales (HCRW) Evidence Centre 2023
- International HTA Collaboration
  - NICE
  - Canada Agency for Drugs and Technologies in Health
  - Australia Government Department of Health and Aged care
  - Health Improvement Scotland
  - All-Wales Therapeutics and Toxicology Centre

FIVE-YEAR REVIEW HIGHLIGHTS

Key findings on notable developments since the Three-Year Review in 2020 included:

- Significant contribution to the COVID-19 response in Wales
- The development of a strong Strategic Plan
- Completion of a Pilot Adoption Audit
- Innovative work on evaluating social care technologies

Suggestions for future development:

- Further work to consolidate HTW's profile; including awareness of the complementary roles of HTW and NICE
- Aligning topic calls with Welsh system priorities
- Enhancing work on topic co-ordination with other HTA agencies
- Opportunities arising from the Innovation Strategy for Wales

"Health Technology Wales is a distinct, trusted and valued part of the innovation landscape in Wales and has achieved bold and ambitious growth since being established in 2017. The challenges it faces are common to HTW agencies evaluating health technologies, but its Wales focus and closeness to health and care stakeholders are highly positive predictors of future success."

Mark Campbell, Independent HealthTech Consultant

"Over the past five years, Health Technology Wales has shown it can adapt quickly to the changing demands of the health and social care sectors. There are so many exciting opportunities ahead to identify and implement innovative health and care technologies in Wales, but it is important that we make the correct decisions in searching for the best quality and value for the people of Wales. I am confident that Health Technology Wales will continue to play a pivotal role in ensuring this."

Eluned Morgan, Minister for Health and Social Services

HTW's FUTURE

Adapting the core functions of HTW to align with the 6 Ministerial Priorities

- **Identification** – new approach to topic selection and work programme planning
- **Appraisal** – permissive approach to all evidence sources and signposting areas for new evaluation and evidence generation
- **Adoption** – strengthened collaboration with service providers to promote early adoption

Technoleg Iechyd Cymru
Health Technology Wales

Ariennir gan
Lywodraeth Cymru
Funded by
Welsh Government

Diolch | Thank you

Healthtechnology@wales.nhs.uk

Healthtechnology.wales

@HealthTechWales

Health Technology Wales: Report of 5 Year Progress Review

Mark Campbell, independent healthtech consultant
November 2022

Executive summary

- **This report reviews the progress of Health Technology Wales (HTW) after 5 years of operation, using a specification based on the 2014 Access to Medical Technologies in Wales report recommendations, and in follow-up to a similar report at the 3-year stage.**
- **Based on a rapid review, comprising documentary evidence, stakeholder feedback and direct observation, HTW strongly and demonstrably fulfil its core functions, and has made good progress on the improvement suggestions in the 3-year review. Stakeholders within and outside Wales who work with HTW recognise and value its expertise in the identification, appraisal and adoption of health technologies. Stakeholders also see HTW as a well-governed organisation.**
- **HTW has grown since 2020 and remains a high-functioning unit and has continued to publish an impressive range of high-quality HTA outputs. Notable developments since 2020 include a significant contribution to the COVID-19 response in Wales, the development of a strong strategic plan, completion of a pilot adoption audit and innovative work on evaluating social care technologies.**
- **The impact of HTA organisations, including their value for money, is challenging to measure because of a lack of benchmarking information. The topic identification and adoption functions of HTW are significant challenges for all HTA organisations because effective solutions, such as innovation policy to mandate uptake, or health system capacity for local adoption, are outside their control. However, HTW has worked hard to make its topic identification processes as efficient as possible, and the adoption audit findings are encouraging about the uptake of technologies recommended in its guidance.**
- **In summary, HTW is a distinct, trusted and valued part of the innovation landscape in Wales and its strategic plan provides an excellent foundation for future development. As in the 3-year progress review, this report includes suggestions for improvement for each of the review questions.**

Background

1. This report is in response to a specification (appendix 1) developed in September 2022 by the Director and Chair of Health Technology Wales (HTW). It describes the origins and functions of HTW and explains the background to the review. In summary, the review is designed to help critical reflection on the organisation's activities and future direction after 5 years of operation, and is in follow up to a similar 3-year review in 2020.. Table 1 below lists the review questions in the specification, cross-referenced to the 3-year review specification.

Table 1: questions in the HTW 3- and 5-year progress review specifications

Q	Review questions for 5-year progress review	Q number in 3-yr review# (or most closely-related question[s] if not also present in both specifications)
1	HTWs general progress against the recommendations underpinning its establishment in the 2014 Welsh Government inquiry into 'Access to Medical Technologies in Wales'.	1
2	HTW's progress against the objectives set out in the HTW Strategic Plan	New (1)
3a	Ongoing progress, building on HTW's 3-year independent review report, updating it to the 5-year period; focusing on years 3-5 and incorporating this into an overall summary of progress (years 0-5).	New (1)
3b	To assess HTW progress against the improvement suggestions outlined in the 3-year review.	New (NA)
4	The quality of HTWs appraisal function, its evidence review and Guidance outputs and their concordance with good practice in undertaking HTAs.	2
5	To assess progress in the development of the HTA adoption audit function, based on the pilot adoption audit report (draft).	New (1)
6	Assessment of HTWs contribution to the COVID-19 response in Wales.	New (6)
7	Consider key contributions that HTW can offer to support the Welsh Government Innovation Strategy for Wales.	New (6)
8	Assessment of the impact of HTWs contributions and the return on the investment and value for money of HTW	4 (3,5,7)
9	HTWs capacity and capability, both in terms of staffing and leadership, to respond effectively to future demands and the changing environment.	6
10	Suggested areas for development, based on a gap analysis against the Inquiry recommendations, to ensure that HTW remains at the forefront of HTA practice and maintains rigour and trust in its appraisals and guidance	8
#	Additional questions specified in the 3 year review, but not here, were: 3. The efficiency and productivity of HTWs rapid review model, benchmarked against national and international peer organisations (eg, other HTA bodies); 5 - The merit of building additional HTA capacity in Wales, through increased investment in HTW, compared with buying this capacity from external providers of analytical services (e.g. academic centres, consultants etc.); 7 - Balance between HTW's identification, appraisal and adoption functions and whether current funding levels and allocations reflect the balance of functions and priorities.	

Methods

2. The review took place in October and November 2022 with a total allocated working time of 7.5 days. A mixed methods approach was used drawing mainly on readily-available information which was collected in three ways:
    a. Documentary information comprising published information available from the HTW website or social media channels, and internal material supplied by the HTW team. An evidence collection plan was developed incorporating generic document descriptors for the type of information which was expected to be available and could inform commentary on the review questions. The descriptors were matched by the HTW team to available documentation. Further written evidence was gathered as issues emerged, supplemented by email clarifications and questions;
    b. Informal, semi-structured interview with staff and stakeholders chosen to reflect relevant perspectives on HTW's work: experience of direct working with the organisation; health and care system; life sciences industry; and partner health technology assessment (HTA) agencies. Question themes were designed to cover written evidence gaps and corroborate impressions gained from other evidence. Interviews were conducted in confidence, and on the basis that responses would not be attributed to individuals;
    c. Observing key HTW decision-making groups to assess process efficiency and quality, and methods of decision-making.
3. The initial planned report structure was to separately analyse and summarise the collected evidence for each of the 10 questions but this - because of overlap in the questions and in the evidence collected - would have resulted in repetition and a lack of clarity. Instead, the narrative is presented by grouping the 10 review questions in 4 themes, onto which the improvement suggestions from the 3-year review were mapped (Table 2).

Table 2. Theming and aggregation of review questions and suggestions for improvement from the 3-year progress review

Theme	Review Q(s)	5-year review questions and related improvement suggestions from the 3-year progress review report (with relevant paragraph number[s] from that report)
A Incremental and overall progress	1	HTW's general progress against the recommendations underpinning its establishment in the 2014 Welsh Government inquiry into 'Access to Medical Technologies in Wales'.
	2	HTW's progress against the objectives set out in the HTW Strategic Plan
	3a	Ongoing progress, building on HTW's 3-year independent review report, updating it to the 5-year period; focusing on years 3-5 and incorporating this into an overall summary of progress (years 0-5).
	5	To assess progress in the development of the HTA adoption audit function, based on the pilot adoption audit report (draft).
B. Quality of appraisal output	4	The quality of HTW's appraisal function, its evidence review and Guidance outputs and their concordance with good practice in undertaking HTAs. S1 Induction and away time for committees (paragraph 22) S2 Enhance the arrangements for QA of HTW's evidence assessment work (23) S3 Develop and publish processes and methods of guidance development (24)
C. Impact and return on investment	8	Assessment of the impact of HTW's contributions and the return on the investment and value for money of HTW S4 Monitor commitments in MoUs and HTA agency collaborations (33, 34) S6 Ensure balance between signposting and guidance development activities to allow future judgments on VFM (36) S7 Explore options for collaborative provision/commissioning of evidence assessment services (41) S10 Resource use analysis of technical time to ensure prioritization on core HTW guidance function (53) S11 Monitor and improve efficiency of topic identification and work-up processes including joint work with other HTA agencies (54) S12 Options to increase the throughput of guidance topics, including earlier decisions on whether and how to progress topics, adapting other guidance and limiting the number of resource-intensive multiple technology appraisals (55)
D. Capacity and capability	9	HTW's capacity and capability, both in terms of staffing and leadership, to respond effectively to future demands and the changing environment. S5 Ensure fair market price for Scientific Advice (35) S8 Develop leadership and management skills in senior staff and consider programme management role (46) S9 Sustain and further develop business planning and reporting framework, including risk monitoring (47)
	6	Assessment of HTW's contribution to the COVID-19 response in Wales.
	7	Consider key contributions that HTW can offer to support the Welsh Government Innovation Strategy for Wales.
#	3b	To assess HTW progress against the improvement suggestions outlined in the 3-year review.
#	10	Suggested areas for development, based on a gap analysis against the Inquiry recommendations, to ensure that HTW remains at the forefront of HTA practice and maintains rigour and trust in its appraisals and guidance
#	Included at the end of each theme section	

Evidence

Documentary

4. In total, over 130 pieces of documentary evidence were reviewed. The evidence collection plan and a summary listing of documents by review question is at appendix 2. Much of the documentary evidence was relevant to more than 1 question; each source is listed against the first question to which it applied.

Stakeholder interviews

5. Telephone interviews lasting up to 30 minutes were held with 6 members of staff, including the HTW Chair, and with 16 external stakeholders; a further 3 external stakeholders answered specific questions by email (appendix 3). Questions were based on the review specification, adapted for the interviewee's perspective. Four of the external stakeholders (2 from HTA agencies, 1 industry association lead and 1 from the Welsh health and care system) also provided input to the 3-year review.

Observation of key meetings

6. Three HTW meetings were observed:
    a. Appraisal Panel (AP) on 25 October at which guidance was developed on 1 topic;
    b. Assessment Group (AG) on 1 November which reviewed 1 Evidence Assessment Review (EAR) planned for presentation to the Appraisal Panel, and 1 EAR not progressing prior to publication;
    c. Assessment Group (15 November) which considered about 60 topics (the majority of which were identified between June and September 2022) of which 3 were presented for a decision to progress to guidance development. In addition, the need to update two existing guidance topics was discussed and agreed.

    Although not observed, recent examples of the agenda, papers and terms of reference for the Industry User Group, Patient and Public Involvement (PPI) Standing Group and Signposting Group were reviewed as part the provided evidence.

Theme A - Review question 1 – incremental and overall progress against the Access to Medical Technologies in Wales (AMTW) recommendations

7. This theme covers the following review questions, in the order shown.

Theme	Number	Review question
[A. Incremental and overall progress	1	HTW's general progress against the recommendations underpinning its establishment in the 2014 Welsh Government inquiry into 'Access to Medical Technologies in Wales'.
	3a	Ongoing progress, building on HTW's 3-year independent review report, updating it to the 5-year period; focusing on years 3-5 and incorporating this into an overall summary of progress (years 0-5).
	2	HTW's progress against the objectives set out in the HTW Strategic Plan
	5	To assess progress in the development of the HTA adoption audit function, based on the pilot adoption audit report (draft).

8. The Health and Care Committee made 13 recommendations all of which were accepted in principle by the Welsh Government. All recommendations have a bearing on the work of HTW, with numbers 3 and 5 being particularly relevant to its establishment:
    a. 3. That the Minister for Health and Social Services, within 12 months of the publication of this report, should develop options for an all-Wales medical technologies appraisal mechanism, to undertake a similar function in respect of medical technologies as the All Wales Medicines Strategy Group (AWMSG) does for medicines.
    b. 5. That the Minister for Health and Social Services should ensure that the uptake of recommended medical technologies across Wales, including those recommended by NICE, is measured as part of a formal audit process.

Main findings

9. After five years of operation, HTW convincingly fulfils recommendations 3 and 5, which is a significant achievement because of the multiple challenges of health technology assessment (HTA) of non-drug products, and because of the need to respond to, and return to business as usual after, the COVID-19 pandemic (see theme D for more information on HTW's contribution).
10. HTW has continued, as concluded in the 3-year review report, to be recognised as a respected centre of expertise for the identification, appraisal and audit of health technologies, drawing on international best practice and collaboration but with a strong Welsh perspective to its work. Notable achievements since the 3-year review include:
    a. Development of the 5-year strategic plan, through careful stakeholder engagement, to provide the foundation for annual business objectives, and to enable a longer-term vision to be articulated;
    b. Further engagement with key health and care system networks and the creation and maintenance of partnership agreements with other organisations in the innovation ecosystem. This was confirmed by

external stakeholders who, when asked for general impressions, consistently described HTW as collaborative;

c. Publication of the first of several planned pieces of social care guidance, following a structured and successful engagement programme;
d. Completion of the pilot adoption audit.

11. The Strategic Plan, published in July 2021, sets 4 goals for the period 2021-25 covering HTW's core functions of identification, appraisal and adoption, with a cross-cutting goal on engagement. The 2021 Annual Report clearly and comprehensively describes the extensive activities and outputs supporting each goal. The Strategic Plan goals are also used to set appropriate milestones, outputs and performance indicators, which are agreed with Welsh Government. Based on the Q4 report for 2021/22, HTW achieved or exceeded almost all targets and there is a clear commentary on variance and lessons learned.
12. HTW has sustained its early commitment to system engagement and the developmental work on the Stakeholder Forum, including the leadership activities of its chair, should result in an effective sounding board.
13. The 3-year review concluded that any judgements on Health and Care Committee recommendation 5 would be premature because - although excellent groundwork had been laid - the pandemic had delayed the planned adoption audit. The pilot audit report, published in October 2022, has been welcomed by Welsh Government and, notably, has been commended to the health and care system by the Director General for Health and NHS Wales Chief Executive. The report demonstrates that the methodology, which included the development of a bespoke data collection tool and practical and financial support for responders, is capable of eliciting meaningful responses. A literature review to determine whether any comparable work exists is outside the scope of this report but it is, by any standard, a significant achievement made possible by a carefully planned and sensitive approach, and the closeness of HTW to its target audiences.
14. The adoption audit findings are inevitably mixed, reflecting the challenges in adopting health technologies, but provide overall positive messages for the recognition of HTW's guidance and its impact on adoption decision-making. These are empiric judgements because of the rarity of similar work by HTA agencies in other health and care systems, which reflects the well-recognised challenges of measuring uptake of health technology adoption. Overall, the pilot report provides an excellent foundation for development including – as specified in Recommendation 5 of the Access to Medical Technologies in Wales inquiry - the planned inclusion of relevant NICE recommendations.

External stakeholder feedback

15. Feedback from external stakeholders who work with HTW strongly confirms the overall picture of an established HTA agency which is highly expert, well-governed, collaborative, and occupies a distinct and valued place in the Welsh innovation ecosystem. A theme recurrent from the 3-year review was the poor capacity and capability for innovation adoption at scale in a pressurised health

and care system, notwithstanding the quality and credibility of HTW's outputs. Several stakeholders noted the need to further develop national innovation policy, including building on learning from other health systems, such as the English Accelerated Access Collaborative. When asked how HTW's work could be more impactful, a recurring theme in stakeholder feedback was for further and more obvious alignment of its work programme to system priorities including COVID recovery.

16. There was a minority view among stakeholders over whether a separate HTA agency is needed for Wales. A much more prevalent view was support for a Welsh focus but improved clarity over the respective roles of HTW and NICE. Stakeholders reported confusion and a risk of duplication and would welcome more coordinated promotion and explanation of the respective outputs, enabling more evidence-proven technologies to be available to the health and care system.
17. Stakeholders with direct experience of HTW commented that it was characterised by strong and effective engagement including its work with the social care community. However, stakeholders also noted the challenge, as a disproportionately small part of the Welsh health and care system, of increasing HTW's profile among a wider population of heath and care professionals and managers. This challenge is also highlighted in HTW's recent stakeholder survey which, although it is not explained how the sample of 300 stakeholders was identified, showed that recognition and understanding among the 60 respondents was mixed. A majority of the respondents were already engaged with HTW so these results may even overestimate HTW's profile.
18. There was universal support from external stakeholders for the adoption audit work and for the approach used which had balanced the need to understand the impact from a quality improvement perspective with compliance with the 'adopt-or-justify' guidance status. In welcoming further development of the work to understand adoption in more detail, stakeholder views included:
    a. Support for the inclusion of relevant NICE guidance;
    b. The need to take into account local service availability, capacity, infrastructure and configuration in making judgements on adoption.

Suggestions for further improvement

19. There were no specific suggestions for improvement for this theme in the 3-year review, mainly because there are no progress reports or updates on 2014 inquiry which led to HTW's establishment.
20. Based on stakeholder feedback, and to further support its strategic goal on engagement:
    a. HTW should consider how to further increase its profile beyond its directly-engaged audience. The HTW team has already worked hard on outreach activities, and the input of professional external relations expertise, with direct experience of engaging front-line health and care staff, may be helpful in developing further options for this;

b. HTW should also consider how to improve the understanding of how its and NICE's outputs co-exist to further exploit the unique benefits of its Welsh focus with as wide a range of HTA guidance as possible (see Theme C for further consideration of joint working with other HTA agencies). The Welsh Health Health Network, in which HTW is effectively engaged, offers an existing forum to explore this.

21. Future adoption audit work should include NICE medical technology and diagnostic guidance recommendations and, where relevant, take account of NICE guideline updates where these have direct impact on innovative technologies. This would reflect NICE's transformation programmes which include the ambition for dynamic guidelines and where future incremental updates seem increasingly likely to reflect new evidence on health technologies. This will also achieve full compliance with recommendation 5 of the Health and Care Committee report.
22. In future audit work, HTW should also consider seeking feedback from companies whose products are appraised. HTW has good links to obtain purchase data from procurement organisations so the commercial sensitivities which prevent the sharing of sales data would be avoided but qualitative feedback from companies may help build a fuller picture of the guidance impact. HTW's Industry User Group would be well-placed to advise on this although wider company representation may be needed, depending on industry's interest in participating.
23. Based on stakeholder feedback, and to further support its strategic goal on identification, it would be worth considering a future topic call specifically themed on system priorities, particularly on COVID recovery. Topics with significant system impact can be elusive because wider pathway change, which may be enabled by technology, relies mainly on people and processes and is often driven by clinical guidelines such as those from NICE. However, HTW has shown in its previous topic calls, including the recent digital theme, an enviable ability to elicit a strong response from the health and care system. External stakeholders welcomed this idea and were supportive of it spanning all sectors, including secondary care elective recovery and primary and community care. Stakeholders also recommended using all available clinical networks including those for therapies and nursing, as well as medical groups with which HTW is already strongly connected. Stakeholders identified cancer and remote diagnosis and monitoring (which are already represented in HTW's work programme) as areas of particularly high interest.

THEME B. Quality of appraisal output

24. This theme covers the following review questions and improvement suggestions, in the order shown. For suggestions made about questions at the 3-year stage, but not included in the 5-year review specification, a brief account of progress is given.

Theme	Review Q	Review questions and relevant improvement suggestions S1 to S3 (and paragraph numbers) from the 3-year progress review report)
B. Quality of appraisal output	4	The quality of HTW's appraisal function, its evidence review and guidance outputs and their concordance with good practice in undertaking HTAs. S1 Induction and away time for committees (paragraph 22) S3 Develop and publish processes and methods of guidance development (24) S2 Enhance the arrangements for QA of HTW's evidence assessment work (23)

Main findings

25. At the 3-year review, HTW had published 18 pieces of guidance; the resumption of topics paused when capacity was diverted to COVID-19 work has resulted in a further 13 pieces of guidance including updates of 2 early topics (appendix 4) and the supporting topic exploration reports (TER) and evidence appraisal reports (EAR). Compared with the period 2018 to 2020, there was a higher proportion of positive recommendations in guidance published in 2021 and 2022 (appendix 5).
26. Guidance recommendations and considerations are presented concisely in a short, logically-structured document, and the Appraisal Panel's considerations during its decision-making are fully explained.
27. HTW has made, and continues to make, an important contribution to evidence assessments both in Wales, and through international collaborations, on technologies used in the management of COVID-19 (see Theme D for further consideration of this).
28. The recruitment, retention, supervision and professional development of appropriately skilled researchers is critical to maintaining the quality of HTA output, especially when new staff come into post as has been the case during HTW's expansion. The organisation has been successful, notwithstanding the relatively small pool of candidates in Wales, in both recruiting and retaining high-quality staff and there is a policy, based on the staff appraisal and development review process, for accessing relevant training and development. The HTW team recognises that further work is needed in supplementing the standard induction process for researchers (see theme D for further consideration of staff development). This should ensure that, for example, high-quality professional development and training in the core HTA skills of systematic reviewing and economic modelling are available to researchers. Such training, especially with direct relevance to health technologies, can be difficult to source so HTW should continue to work with organisations with similar needs.

Feedback from external stakeholders

29. Advisory group members described their experience as satisfying and worthwhile, promoted confidence in evidence-driven care, and that the

documentation and support from the HTW team was of high-quality. A large majority, including those who had prior experience of face-to-face meetings, also said that the virtual meeting arrangements worked well and did not inhibit the quality of the discussion. Some stakeholders said that they would not otherwise be able to commit the time to attend were there to be a return to in-person meetings. The appraisal process was judged as thorough but fair by all stakeholders, and that the team is open to discussion when concerns are expressed about the process or its outcomes.

Progress on suggestions for improvement in the 3-year review

30. S1 - A system of induction and ongoing development for decision-making groups has been introduced and, although the HTW team is keen to develop this further, there was positive feedback from members.
31. S3 – an appraisal manual is at a good stage of development supported by effective project management and although a draft was shared for this review, it is at too early a stage to form detailed conclusions about its completeness or usefulness. The following considerations may be helpful in its future development:
    a. Consider including a section dedicated to identifying the primary audience(s) for the manual and for the language and content to reflect that;
    b. Only high-level timescales and milestones for guidance development steps should be described to leave flexibility for future adaptation;
    c. Decide on the balance between describing processes (what steps are followed) and methods (how the evidence is assessed and appraised) and that the level of detail on methods is similar between determination of clinical effectiveness and economic impact;
    d. Consider including decision-making considerations on when a single or multiple technology appraisal will be carried out and, for the latter, what approach is taken when a procedure is appraised where multiple similar technologies are available to effect it;
    e. Consider including signposting of the need for new processes and methods in response to emerging best practice in HTA, and adaptions needed for different technology types such as social care interventions. It would be particularly timely to include methods for the structured quality assessment of real-world evidence, given the methodological developments in this area;
    f. Consider using the planned consultation period on the appraisal manual to seek targeted feedback from industry stakeholders.
32. S2 – the Assessment Group (AG) has been strengthened by the addition of 2 systematic reviewers and a second health economist. HTW is also currently tendering for external quality assurance services for its appraisal manual, evidence assessment work and the creation of a technical manual for

researchers. Taken together, these initiatives should provide appropriate quality assurance provided that:

a. The tender is successful;
b. The expectations of the external Assessment Group HTA experts are clear, their QA contributions are part of the AG workplan, and the workload is acceptable;
c. Subject to confirming that HTW's work is in scope, the overall quality assurance arrangements for economic modelling comply with the UK government's review of quality assurance of economic models (the Macpherson recommendations).

Further suggestions for improvement

33. The format of HTW guidance is largely unchanged since early topics and, although the adoption audit asked whether the recommendations were clear, it was not designed to test which sections of the guidance were most useful, or its readability. Input from a professional medical editor to review a sample of guidance output may provide a helpful analysis of directness, brevity, plain English and clarity, and may identify any accessibility issues with HTW's outputs. Future options may include promoting the use of existing resources such as a style guide and an updated guidance template. It may also be worth, perhaps as part of a future adoption audit, including questions designed to test the use of, and usefulness, of sections of the guidance and supporting documentation.
34. Observation of the advisory groups involved in guidance development confirmed the conclusions of the 3-year review that the appraisal process is supported by high-quality documentation, and the presentation of summary findings from the evidence identified is clear and comprehensive. HTW should also consider adding explicit considerations on the quality of the evidence, taking account of internal (using appropriate quality checklists for the technology and evidence types) and external (its generalisability to a UK/Welsh pathway) validity.
35. The 3-year review concluded that arrangements for PPI were notable, and this continues to be the case. However, neither the EAR or guidance documents have a dedicated section on equality and diversity considerations, including the impact of adopting the technology on groups with protected characteristics under the Equality Act 2010. The PPI Standing Group would be well placed to consider options for this, using the equity assessment done during the topic prioritisation process.
36. HTW monitors the attendance of advisory group members and there is a pre-defined quorum. To enable the best possible decision-making, it should also consider:

a. Setting a minimum expected attendance rate (eg, 75% of meetings in each 18-month membership term) for continued membership;
b. Further defining the mix of members required to fulfil a quorum, in addition to an arithmetic majority.

THEME C. Impact and return on investment

37. This theme covers the review questions and improvement suggestion below, in the order shown. For suggestions made about questions at the 3-year stage, but not included in the 5-year review specification, a brief account of progress is given.

Theme	Review question	Review questions and relevant improvement suggestions S5 to S7, S10-S12 (and paragraph numbers) from the 3-year progress review report)
C. Impact and return on investment	8	Assessment of the impact of HTWs contributions and the return on the investment and value for money of HTW S4 Monitor commitments in MoUs and HTA agency collaborations (33, 34) S10 Resource use analysis of technical time to ensure prioritization on core HTW guidance function (53) S11 Monitor and improve efficiency of topic identification and work-up processes including joint work with other HTA agencies (54) S6 Ensure balance between signposting and guidance development activities to allow future judgments on VFM (36) S12 Options to increase the throughput of guidance topics, including earlier decisions on whether and how to progress topics, adapting other guidance and limiting the number of resource-intensive multiple technology appraisals (55) S7 Explore options for collaborative provision/commissioning of evidence assessment services (41)

Main findings

38. The 3-year concluded that documentary evidence showed a strategic approach for HTW to measure its efficiency and productivity, including annual impact statements which now also cover COVID-19 outputs, continued use of the organisation evaluation framework, and cost impact analysis of its guidance. This area therefore remains a strength.
39. The 3-year review also concluded that there is insufficient information to make a definitive judgement on overall value for money. This remains the case and the limitations (a lack of benchmarking information and incomplete data on adoption impact) are outside HTW's direct control. Instead, this theme considers some areas where HTW is already increasing its impact and/or efficiency, and/or there are further potential opportunities.
40. HTW has worked hard to sustain and develop the national and international collaborations described in detail in the 3-year review report, both to refresh existing partnership agreements and to form new alliances. Meeting papers and notes show evidence of strong collaborations based on mutual trust and recognition. While it is justifiably proud of the quality and independence of its guidance and other outputs, there is notable work behind the scenes to share data and technical evidence assessments, particularly through the Celtic Alliance.

Feedback from external stakeholders

41. Stakeholders noted that topic handling had improved since 2020; those with experience of notifying topics gave positive feedback, would do so again and would encourage colleagues to do likewise. Stakeholders reported that positive guidance was helpful in building a business case for adoption and securing additional investment but noted that guidance from NICE may carry more weight.

42. There was warm feedback on the impact of HTW's collaborative work within the Welsh innovation ecosystem, including for its joint working with the Welsh Health Specialised Services Committee (WHSSC).
43. Stakeholders judged that most of the topics selected for appraisal by HTW are worthwhile in terms of their potential patient and system benefits. There was a minority view that topic progression decisions were too risk-averse and that topics with more uncertainty could be appraised, with the potential to make recommendations with prospective data collection to close the evidence gaps identified.
44. Stakeholders from all sectors noted the need for further work on topic coordination with other HTA agencies, particularly NICE, and this is recognised by the HTW team. There are established groups at strategic and operational level but there is universal agreement that more work is needed on a clearer framework for deciding which agency will appraise an identified topic, and on the reciprocal status of the resulting guidance. The current arrangements on topic coordination are judged to need further development to avoid the risk of work being duplicated on the same topic, with examples of this in recent HTW TER/SHTG IMTO/NICE MIB outputs, and in HTW and NICE IPG/MTG guidance. Stakeholders noted the challenge of resolving these issues and noted some key considerations, including:
    a. No HTA body should start a topic without telling the other agencies and that information should be centrally stored;
    b. If a lead agency is decided for any identified topic, whether the resulting appraisal will be mutually recognised and how any resulting guidance would be branded;
    c. Adaption is an attractive option to re-use existing appraisals to promote the adoption of a wider group of evidence-proven technologies, and thus have greater impact. However, care is needed to ensure that the decision problem used reflects the local pathway, and that any differences in the judgements reached on the same evidence assessment are fully justified.
45. These are challenging issues but stakeholders agreed that, HTW is strongly-placed as a focus for adoption of proven technologies in Wales, whatever the origin of the evaluation.

Progress on suggestions for improvement from 3-year review

46. Suggestions S4, S6, S10, S11 and S12 covered the potential for improving the efficiency of HTW's work in areas including topic identification and work-up, options for increasing the throughput of guidance topics, and on inter-agency collaborations. Since the 3-year report, there is clear evidence of enhanced workflow planning including troubleshooting of, and creative approaches to resolving, process 'bottlenecks'. For topic development, there are indicative timescales for each team member's involvement and although there have been efficiency gains from this, the team recognises that more work is needed,

especially to reduce the time taken at early topic stages, including TER development.

47. The 3-year review noted the need to monitor HTW's involvement in international collaborations such as INAHTA to ensure that HTW derives benefit from its contribution, and that the staff time committed does not impact on its core functions. Continued monitoring of this is needed despite the well-managed exit by HTW from involvement in the EUNetHTA collaboration, a consequence of the UK leaving the European Union.
48. Suggestion S12 included consideration of limiting the number of appraisals including multiple technologies, which are usually more resource-intensive. Since the start of 2021, 8 of the 13 guidance topics have included multiple technologies, usually where there are available alternatives to effect the procedure which is the focus of the appraisal. It is likely that this a simple reflection of topic areas identified by proposers, and which scored highly on HTW's progression criteria.
49. Suggestion S7 covered options for collaborative provision/commissioning of evidence assessment services. HTW continues to explore these options and is well-placed, including through its work as an evidence service provider for the Wales COVID-19 Evidence Centre, to exploit future opportunities.

Further suggestions for improvement

50. In its Strategic Plan goal on topic identification, HTW articulated the need to agree mechanisms between UK HTA bodies. Such mechanisms exist but agencies and stakeholders agree that a transformative change is needed, both to improve the efficiency of topic handling, and to resolve the issues described in paragraph 44. A full exploration and options appraisal for this and related issues, such as the reciprocal status of guidance, is outside the scope of this report but potential short-term solutions include:
    a. A move away from the current system of sharing topic workplan spreadsheets and ad hoc email exchanges. The Innovation Service could provide a platform for this and HTW is engaged at both strategic and operational levels of the service user community;
    b. The recent international collaboration between Australian, Canadian and UK HTA agencies offers the opportunity, under Priority 4, to test efficiency arrangements for joint assessment, including work-sharing. This has strong potential for a single technical evidence assessment to be translated into recommendations which take into account the local health system impact, for which HTW is ideally placed. HTW is also well-placed to take advantage of a collaborative assessment process because its discrete outputs – TER, EAR and guidance – provide a logical basis for any future work-sharing framework.
    c. An overlap analysis, conducted jointly with NICE and other agencies, would be helpful in quantifying the extent of the challenges in topic coordination;

d. A focus on topics which are particularly relevant for Wales and may not be prioritised by other agencies; HTW is also well-placed for this because of its strong engagement with programmes such as the Welsh Value in Health centre, which has previously publicised its topic calls.

51. To enhance further its working with innovation organisations in Wales, HTW should consider developing a partnership agreement with TriTech (and any other similar initiatives in Health Boards or elsewhere) with which, based on its 5-year strategic plan, there appear to be shared ambitions. As with other such agreements, this should clarify respective roles and identify opportunities for collaborative workstreams which have the potential to generate, or support, guidance topics.
52. To further reduce the time spent on topic processing which doesn't lead to guidance output, HTW should consider whether the Signposting Group's functions could be equally effectively handled by another organisation, such as the Life Sciences Hub (LSH). Stakeholders described the LSH as having a similar function to an AHSN in England, the innovation workstreams of which fulfil a similar signposting purpose.
53. To further increase its potential impact, HTW should consider exploiting its strong link with procurement organisations to explore stakeholder views and options for appraising disinvestment opportunities on health technologies.

THEME D. Capacity and capability

54. This theme covers the review questions and improvement suggestions below, in the following order. For suggestions made about questions at the 3-year stage, but not included in the 5-year review specification, a brief account of progress is given.

Theme	Review questions	Review questions and relevant improvement suggestions S8, S9 and S5 (and paragraph numbers) from the 3-year progress review report)
D. Capacity and capability	9	HTW's capacity and capability, both in terms of staffing and leadership, to respond effectively to future demands and the changing environment. S8 Develop leadership and management skills in senior staff and consider programme management role (46) S9 Sustain and further develop business planning and reporting framework, including risk monitoring (47) S5 Ensure fair market price for Scientific Advice (35)
	6	Assessment of HTW's contribution to the COVID-19 response in Wales.
	7	Consider key contributions that HTW can offer to support the Welsh Government Innovation Strategy for Wales.

Main findings

55. The 3-year review concluded that HTW was well-governed, with strong leadership and a positive organisational culture, and this continues to be the case. Since 2020, it is justifiably proud of a managed return to business as usual and, as noted earlier, this is particularly evident in the increase in guidance output, with 13 published since the start of 2021 compared with 18 from inception to the end of 2020.
56. The HTW team reports recruitment and retention as its biggest operational challenge but has nevertheless been successful in recruiting to new posts and has explored novel ways of developing new researchers with limited HTA experience.
57. HTW has repeatedly shown – particularly, but not exclusively in its work on COVID-19 – the ability to respond to new challenges, to work flexibility and effectively with a wide range of stakeholders.
58. Between July and September 2022, the Welsh Government consulted on its Innovation Wales strategy. HTW's response was shared as part of this review and demonstrates a perceptive understanding of the innovation landscape in general and of the challenges and needs for organisations, like it, whose responsibility is promoting the adoption of innovative technologies.

Feedback from external stakeholders

59. There was praise from external stakeholders for the speed and quality of HTW's COVID-19 work, and on the ease of working with HTW team. Several stakeholders commented that the COVID-19 work had helped HTW to broaden its reach. It is perceived as a strong partner in the Wales COVID-19 Evidence Centre network of organisations.
60. In the context of the Innovation Wales strategy, stakeholders identified HTW as the 'natural home' in Wales for assessment of clinical and cost effectiveness and reflected disappointment that there was insufficient capacity in the health and

care system to adopt its guidance. They also judged that future innovation policy should be based on learning from other parts of the UK, for example so that guidance was subject to accelerated or enhanced adoption initiatives to strengthen the current 'adopt or justify' status, which is not universally understood.

Progress on suggestions for improvement from the 3-year review

61. S8 - A senior programme manager has been in place since December 2021 and is highly effective in leading a programme office whose wide-ranging responsibilities include planning and reporting, project management and operational support functions. In addition to the existing dedicated project management expertise for topic and committee work, a business and operations manager is responsible for essential support functions including finance, procurement, human resources and organisational development.
62. S8 - The 3-year review also suggested that, as HTW expands, senior staff would need additional leadership and management development. This is part-complete and a wider management development scheme has been introduced for all line managers.
63. S9 – the development of the Strategic Plan, and the additional capacity in the programme office, has enabled a significantly enhanced annual business planning and reporting framework. This receives regular, effective scrutiny through the Executive Group of which HTW's Welsh Government sponsor and its host Chief Executive are members.
64. S5 – there have been fewer Scientific Advice projects than expected so it would be premature to judge progress on this suggestion. Further considerations on the service are in paragraph 68.

Further suggestions for improvement

65. As for any high-achieving organisation, and after five years of successful operation, HTW should ensure there is effective succession planning, particular for the Director and Chair; this need was reflected by several external stakeholders. It has begun this process through recruitment for a Deputy Chair for the Appraisal Panel which, although delayed, is complete and will begin in early 2023.
66. Priority should be given to developing, implementing and monitoring the action plan based on the recent staff survey, particularly but not exclusively in relation to: the transition to hybrid working; organisational culture and development; and the development of structured professional development in HTA skills for researchers.
67. After five years of operation, HTW should review the impact of and need for its evaluation framework and the associated software platform. Although these provided a valuable guide in its formative years, HTW should ensure that it is not constraining its work or reducing its agility. The evaluation framework has also informed the development of annual reports which have hitherto been comprehensive and professionally produced. It may now be possible to re-use

content from routine business plan monitoring reports to compile a shorter, simpler, annual report without reducing its value to target audiences.

68. The Innovation Wales strategy recognises HTW's core evaluation function as part of the life sciences product lifecycle. There are opportunities for HTW at other stages of the lifecycle and it should be selective in targeting these. Its Scientific Advice Service (SAS) already supports value proposition building and primary evidence design and development and there is support from stakeholders for it to be expanded. In the context of the strategy, HTW would be well-placed to increase the provision of such expertise to product developers. This includes projects seeking translational research funding from Health and Care Research Wales and other grant funders, where – for example - early economic modelling is often needed but absent. Expanding Scientific Advice in this way would involve operating commercially as a notionally separate activity from guidance development, but would have the dual advantages of recovering costs expended, and should increase the number of technologies coming forward with a well-designed evidence base.

Acknowledgements

I thank the Health Technology Wales team for dedicated and committed support for the review which they did in a friendly and highly efficient way. I also thank them for their openness in the various discussions. I am also grateful to external stakeholders who gave their views freely and enthusiastically.

The views expressed in the report are mine alone. This was a high-level review with wide-ranging objectives and where there was a large amount of documentary evidence on which to draw. A rapid review of the evidence informed the commentary and recommendations in the report but a detailed summary of all of the evidence gathered was outside the scope of the review. Any resulting errors or omissions as a result are my responsibility.

Declaration of interests

I provide paid consultancy services to health technology companies but have no current projects on technologies under active consideration by HTW. In a previous role as a NICE senior manager, I took part in early stakeholder discussions with Welsh Government representatives on the options appraisal arising from the Access to Medical Technologies in Wales report.

Mark Campbell, independent healthtech consultant
November 2022

Appendix 1: HTW 5 year progress review specification

20220825__HTW 5 Year Review_Specifica

Appendix 2: Summary of evidence retrieved and reviewed

(Note: much of the evidence informed the report in more than 1 review question; each item is listed in the first question to which it is relevant)

	Review question	Summary description of evidence reviewed
1	HTWs general progress against the recommendations underpinning its establishment in the 2014 Welsh Government inquiry into 'Access to Medical Technologies in Wales'.	**Publicy-available** Annual reports Impact reports **Provided** Report to key Welsh peer groups e.g. Chief Executives Examples of recent minutes (where available) of: Executive Group; Industry User Group; Signposting Group; PPI Standing Group; Stakeholder Forum Group; Appraisal Panel Assessment Group HTW-Social Care Wales-Workshop-Report June 21 HTW Social Care Action Plan January 2022
2	HTW's progress against the objectives set out in the HTW Strategic Plan Strategic Plan	**Publicly available** Strategic Plan **Provided** Business Plan 2022/23
3a	Ongoing progress, building on HTW's 3-year independent review report, updating it to the 5 year period; focusing on years 3-5 and incorporating this into an overall summary of progress (years 0-5).	**Publicly available** **Provided** Director's Reports/Quarterly Reports to Welsh Government 2022 Stakeholder Survey Report
3b	To assess HTW progress against the improvement suggestions outlined in the 3-year review.	**Publicly available** Health Technology Wales: Report of 3 Year Progress Review, November 2020
4	The quality of HTWs appraisal function, its evidence review and Guidance outputs and their concordance with good practice in undertaking HTAs.	**Publicly available** Guidance documents Evidence Assessment Reports Topic Exploration Reports **Provided** Assessment group (AG) papers Appraisal Panel (AP) papers

	Review question	Summary description of evidence reviewed
		Induction arrangements and awayday programmes for AG/AP members Draft Appraisal Manual Specification for External Quality Assurance
5	To assess progress in the development of the HTA adoption audit function, based on the pilot adoption audit report (draft).	**Publicly available** Developing the HTW Audit Function to assess the adoption of HTW and NICE guidance on non-medicine technologies across Wales: Report & Recommendations 2020 Health Technology Wales Adoption Audit Pilot Report 2021/2022
6	Assessment of HTWs contribution to the COVID-19 response in Wales.	**Publicly available** COVID-related outputs from HTW website including 2020 Impact Statement
7	Consider key contributions that HTW can offer to support the Welsh Government Innovation Strategy for Wales.	**Publicly available** Innovation Wales consultation document July 2022 Digital Strategy for Wales 2021 TriTech Institute Business Plan **Provided** HTW consultation response to Innovation Strategy
8	Assessment of the impact of HTWs contributions and the return on the investment and value for money of HTW	**Publicly available** Impact Statements **Provided** Impact strategy Stakeholder survey Memorandum of agreement and meetings notes with other agencies
9*	HTWs capacity and capability, both in terms of staffing and leadership, to respond effectively to future demands and the changing environment.	**Provided** Standard Operating Procedures HTWs work programme tracker, detailing volume of requests and outputs Organogram Vacancy and staff turnover information HTW Business plan
10	Suggested areas for development, based on a gap analysis against the Inquiry recommendations, to ensure that HTW remains at the forefront of HTA practice and maintains rigour and trust in its appraisals and guidance	NA
*	carried over or adapted from 3-year progress review areas	

Appendix 3: telephone interviewees

Name	Position	Perspective
Staff		
Susan Myles	HTW Director	
Peter Groves	HTW Chair	
June Price	Business Manager	
Katie McDermott	Project Manager	
Lisa King	Senior Programme Manager	
Matthew Prettyjohns	Principal Researcher	
David Jarrom	Principal Researcher	
External stakeholders		
Luella Trickett*	Director Value and Access, ABHI *unavailable during interview period, responded to questions by email	Industry Appraisal panel member
Alex Zervakis	General Manager – Health Economics & Market Access, Olympus UK	Industry
Ifan Evans	Executive Director - Digital Strategy, Digital Health & Care Wales	National strategy and policy
Tom James	Head of Innovation, Welsh Government	National strategy and policy Welsh Government sponsor
Rhodri Huw Davies	Consultant Cardiologist, C&VUHB	Clinician Appraisal panel member
Andrew Champion	Assistant Director, Evidence Evaluation and Effectiveness, WHSSC	Health and care system Appraisal panel member
Melanie Wilkie	Head of Outcomes Based Commissioning, C&VUHB	Health and care system Appraisal panel member
Sarah McCarty	Director of Improvement and Development, Social Care Wales	Health and care system Stakeholder Forum Chair
Raj Krishnan	Associate Medical Director/ Consultant Paediatric Nephrologist, C&VUHB	Health and care system Stakeholder Forum member
Thomas Rackley	Consultant Oncologist, Velindre UHB	Clinician

Name	Position	Perspective
		Topic expert adviser
Lisa Davies	Head of Effective Clinical Practice and Quality Improvement, Hywel Dda HB	Health and care system
Andrew Smallwood	Assistant Director of Procurement (Transformation), NHS Wales Shared Services Partnership	National strategy and policy Appraisal panel member
Mark Briggs	Assistant Director of Innovation and Implementation Cardiff and Vale UHB	Health and care system Assessment group member
Ed Clifton	Head of Scottish Health Technologies Group	HTA
Adrian Edwards	Director of COVID-19 Evidence Centre and Professor of General Practice	Health and care system
Rhys Morris	Director of CEDAR Health Technology Research Centre, Cardiff	HTA Assessment group member
Mark Chapman	Interim director of medical technology and digital evaluation, NICE	HTA
Zoe Garrett	Senior Technical Adviser – Scientific Affairs, NICE	HTA
Paul Dimmock/Liz Islam*	Senior Technical Adviser/Project Manager, NICE *responded to specific questions by email	HTA

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

PRESENT	
Professor Donna Mead OBE	Chair
Stephen Harries	Vice Chair
Steve Ham	Chief Executive
Professor Andrew Westwell	Independent Member
Gareth Jones	Independent Member
Martin Veale	Independent Member
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director
Sarah Morley	Executive Director of Organisational Development and Workforce
Carl James	Executive Director of Strategic Transformation, Planning & Digital
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science
ATTENDEES	
Lauren Fear	Director of Corporate Governance and Chief of Staff
Cath O'Brien MBE	Chief Operating Officer *(for part)*
Emma Stephens	Head of Corporate Governance
Kyle Page	Business Support Manager, Secretariat

1.0.0	STANDARD BUSINESS	ACTION LEAD
	The Chair opened the meeting and welcomed everyone in attendance.	
1.1.0	**Apologies noted:** • Hilary Jones, Independent Member • Vicky Morris, Independent Member • Katrina Febry, Audit Lead, Audit Wales • Emma Rees, Deputy Head of Internal Audit, NHS Wales Shared Services Partnership • David Cogan, Patient Representative	
1.2.0	**In Attendance** The Chair extended a warm welcome to the following attendees in support of specific agenda items: • Carl Taylor, Chief Digital Officer (for item 4.3.0) • Gareth Cooke, Engagement & Digital Transformation Services, Digital Health & Care Wales (in support of item 4.3.0)	

	• Dr Sian Phillips, Consultant Radiologist (CTMUHB) and Clinical Lead for RISP programme (in support of item 4.3.0) • Amy English, Deputy Regional Director, Llais Cymru	
1.3.0	**Declarations of Interest** There were no declarations of interest to **NOTE** in respect of today's agenda.	
1.4.0	**Minutes from the Public Trust Board meeting held on 30.03.2023** The following amendments to the minutes of the Public Trust Board meeting held on 30th March 2023 were noted: • *Item 3.4.0 (Financial Report)* – Matthew Bunce advised that both bullet points within the 'Trust Board NOTED' section should be amended to read January 2023 instead of November 2022. • *Item 4.1.0 (Audit Wales 2022 Structured Assessment and 2022 Audit Annual Report)* – "*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."* – Although it was advised that the reason for the above statement had been recorded on page 2 of the April 2023 Public Audit Highlight Report, Stephen Harries requested inclusion of this in the March 2023 minutes. Subject to the amendments noted above, the Trust Board **APPROVED** the minutes as an accurate and true reflection of proceedings.	
1.5.0	**Action Log** Board members confirmed there was sufficient information contained in the log to provide assurance that the actions identified as complete could be **CLOSED**. Action 3.3.0 from meeting held 30/03/2023 was discussed **(Ensure clear narrative in the Performance Management Framework in relation to the potential impact of the implementation of the new COSC targets on perceived performance).** It was advised that the Performance Management Framework would be addressed on today's agenda and that the new targets would be reviewed in detail at the June 2023 Board Development Session. The Chair will seek to close the above action at the July 2023 meeting, following discussions as detailed above.	**COB**
1.6.0	**Matters Arising** There were no matters arising which were not included on the action log or meeting agenda.	

2.0.0	**KEY REPORTS**	
2.1.0	**Chair's Update (including Armed Forces and Veterans Board Champion Annual Report)** In addition to the items included in the Chair's Update, the Chair advised the Board of the following: • Her attendance at the first Welsh Blood Service Awards in three years (held on May 23rd & 24th 2023 in Llandrindod Wells), alongside the Welsh Blood Engagement Team. Approximately 80 attendees (including a blood donor awarded for donating 100 units of blood and bone marrow donor) had been present at what were truly inspirational events. Further detail of the event will be included in the Chair's update to the July 2023 Trust Board. • As World Blood Cancer Day approaches (May 28th 2023), the Welsh Blood Service team had engaged with Velindre Patron and comedian Rhod Gilbert, the purpose of which is to encourage those aged 17-30 to join the Welsh Bone Marrow Donor Registry. The Trust Board **NOTED** the content of the Update Report. **Armed Forces and Veterans Board Champion Annual Report** As Armed Forces & Veterans Board Champion, the Chair presented the Annual report, acknowledging a number of significant achievements over the period; most notably, the Trust has been shortlisted for the **Gold Defence Employer Award**, the outcome of which is anticipated in early July 2023. The report outlined the importance of identifying patients and staff who are veterans being key to ascertaining their needs and enabling appropriate provision of services. Martin Veale queried whether further measures could be taken by the Trust to facilitate this should patients not be identified as such when first registering with Primary Care. The Chair advised that Health Boards are now encouraged to record such information in patients' electronic health records as this has not been routinely done to date. Additionally, the Trust is currently working with Health Boards to review the process for the capture of this information to enable the Trust to accommodate the needs of such patients appropriately. Stephen Harries queried whether veterans from outside the British Armed Forces residing in the UK would be included in the Covenant. The Chair did not believe such veterans were included, however acknowledged that a similar approach should be taken regarding their treatment. The Chair agreed to investigate further to ensure the needs of all veterans are met. Carl James suggested a future discussion around the potential implementation of measures to widen access to a range of other needs (for example those of the homeless), in addition to those of veterans.	**Chair**

	The Trust Board **NOTED** the content of the Report. The Chair expressed the intention for a Champion report to be presented at each Trust Board meeting going forward, ensuring coverage of all Champions during each Annual cycle.	
2.2.0	**Chief Executive's Update** The Chief Executive was delighted to be in attendance following a period of absence and thanked the Executive Team and board for their support. The Chief Executive highlighted the following: • ***Pay negotiations / industrial action*** – Following a period of negotiation and discussion with Partnership Boards, the 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 (due to be received from June 2023). However, due to the rejection of this offer by individual unions, the Trust continues to plan for RCN strikes via the Industrial Action Cell. It is also the intention to resume Gold Command meetings from week commencing 29th May 2023, to manage planned industrial action during early June and mid-July. • The **Joint Executive Team (JET) meeting** with Welsh Government had taken place on 19th May 2023. Positive feedback had been received, recognising the Trust's achievements and progress. Formal written acknowledgement of this will follow, which will be circulated and sighted at Trust Board in due course. The Chair informed the Trust Board that the Powerpoint Slide deck submitted to the JET meeting would be circulated to Independent Members following the meeting. The Trust Board **NOTED** the content of the update Report.	**Secretariat**
3.0.0	**QUALITY, SAFETY & PERFORMANCE**	
3.1.0	**Velindre University NHS Trust Risk Register** The report informed the Board of the status of reportable risks in line with Risk Appetite. Lauren Fear highlighted the following: • Evidence of positive progress in relation to **Level 1** mandatory training for all staff, which is now live in individual ESR matrices (to be completed within 6 months). To date, 37% of staff across the Trust have completed Introduction to Risk Training, ongoing management of which will be via the Trust's weekly Risk meeting (and subsequently reported to Executive Management Board). • Discussions during the May 2023 meeting of the Quality, Safety & Performance Committee suggested that it would be of benefit to undertake an in-depth review of two risks prior to each meeting to initiate more detailed discussion at the Committee. Questions on the overall approach were invited.	

	Gareth Jones queried how the remaining 63% of staff yet to complete the mandatory risk training would be monitored. It was advised that staff would be prompted via the new mandatory training module within ESR and monitored by routine tracking of training compliance, via the personal appraisal process and provision of staff compliance data to Managers. It was also noted that Independent Members are obliged to complete this module and that support would be available via Workforce should this be required. The Chair agreed to ensure that Independent Members are sighted on requirements. Lauren Fear emphasised that the 37% compliance was achieved within the first **5** weeks of roll out.	**LF**
	Martin Veale queried how it was intended to progress from the current assurance rating of 1 (of 7) to a higher level of assurance. Lauren Fear advised that training is currently in progress for staff authoring papers. It is anticipated that the new template will be rolled out to all areas once details have been worked through and clarified.	
	It had been noted at the May 2023 Quality, Safety & Performance Committee that a number of risks have remained in the system for a significant period, with little change in trends. The Chair requested a review of these particular risks and it was agreed that the potential impact of external influences should also be reflected in the narrative.	**SH/LF**
	Martin Veale raised the following: • **Risk 2714** (**interest rates**) – Target rating should be shown as amber due to a score of 12. • Use of abbreviations within a public document should be avoided or referenced in full. • Whether **risk 2465 (risk to patient safety due to critical emails being missed)** had arisen due to a specific incident or is a symptom of overwhelmed staff – The Chair advised that extensive discussion at the Quality, Safety & Performance Committee had identified that this is multi-factorial and would be analysed via a detailed audit of emails to identify and act upon issues. Prompt resolution is not anticipated; however this has been prioritised with expected completion of the audit by September 2023 and Nicola Williams agreed to request that the controls within the risk are amended to reflect this.	**NW**
	Gareth Jones noted duplication of the controls and action plan within **risk 3011 (safety)** and Nicola Williams agreed to address this.	
	Stephen Harries queried **risk 3065 (to compliance resulting from the permanent deletion of staff mailboxes upon leaving the Trust since September 2021**). While it was acknowledged that deletion of the majority of emails would not pose a risk, a small percentage of emails may be of critical importance to future investigations or may have influenced past clinical decisions. It was questioned whether the use of emails as an element of the decision-making process is reflected within patient medical records.	**NW** **COB**

	Nicola Williams emphasised that clinical decisions should under no circumstances be recorded via email or be used to substitute the clinical record; this will be fully addressed by the principles developed. Clinicians are clear regarding the process for documenting clinical decisions, utilising medical secretaries appropriately alongside additional escalation mechanisms and it was advised that there is also a mechanism to cut and paste any clinically relevant email exchanges into the clinical record. It was recognised that structured data is required for future use going forward. Carl James advised that a technical issue had resulted in the deletion of staff email inboxes as opposed to the archive of these for a designated time period. This issue has now been resolved and emails are retrievable should this be required. Dr Jacinta Abraham agreed to confirm timescales for the development of principles. 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 this paper. • the ongoing developments of the Trust's risk framework.	**JA**
3.2.0	**Brachytherapy Review and Action Plan** In presenting the Velindre Cancer Service Brachytherapy Peer Review and Action Plan, Nicola Williams highlighted the following: • Following three (pre-2021) National Reportable Incidents relating to Brachytherapy within the organisation, the Brachytherapy Project Board was established to undertake a professional peer review of the service during May / June 2022. This was undertaken by the Clatterbridge Cancer Centre, resulting in an ongoing positive reciprocal arrangement between the Clatterbridge and the Trust. • Of the **134** recommendations noted in the peer review report, **77** have been closed to date. Of the **7** recommendations strongly needing to be implemented, **5** are closed, **1** is expected to close imminently with the remaining currently under discussion with Health Education and Improvement Wales (HEIW). • The plan will continue to be monitored via the Brachytherapy Project Board, to conclude in Autumn 2023, before progressing through the Brachytherapy Delivery Group, Senior Leadership Team and Executive Management Board. The Chair commended the team for commissioning an independent peer review, the mutual learning resulting from areas of good practice identified and development of the action plan. Martin Veale queried whether the Trust had achieved the anticipated position in addressing all recommendations and whether all **134** would be delivered. It was advised that all urgent matters and those	

	relating to safety had already been addressed; however it was also noted that the recommendations contained a number of duplicates. It was recognised that the significant changes required would involve additional time due to the fragility of the service, volume of activity and workforce constraints. However, the service remains committed to progressing the action plan as soon as possible and resilience / training opportunities are being implemented where possible. Andrew Westwell noted a number of actions relate to the infrastructure of the existing Cancer Centre site (security, size, access to controlled drugs) and requested assurance that the new Velindre Cancer Centre (nVCC) could accommodate these. Nicola Williams advised that security of access had been addressed and that the Team had fully engaged with the nVCC Design Team to ensure inclusion of all recommendations in the new build. The Trust Board **NOTED**: • the Brachytherapy Peer Review report and Improvement Plan; • the Quality, Safety & Performance Committee, through its redeveloped Quality, Safety & Assurance Tracker, monitor all outstanding actions through to completion (to be reported by exception).	
3.3.0	**Performance Management Framework (PMF) (March 2023)** *This item followed item 3.4.0 (Cath O'Brien joined the meeting at 11:30am)* Cath O'Brien MBE expressed thanks to staff for the continued strong performance despite competing priorities within the organisation and complexity of care. The following key points for the Velindre Cancer Service (VCS) and the Welsh Blood Service (WBS) March 2023 Performance Report were highlighted: ***Velindre Cancer Service:*** • Achievement of performance targets across a broad range of metrics (including pressure ulcers, falls, Sepsis, Healthcare Associated Infection and Systemic Anti-Cancer Therapy (SACT) waiting times). • Targets were not met in a small number of areas (including Radiotherapy and Therapies waiting times, Hospital Acquired Thrombosis and Delayed Transfers of Care); this is, however, not a continuing trend. ***Radiotherapy performance*:** Performance was reported against new the new national Welsh targets. The new targets have imposed a reduction in Radiotherapy time to treatment (RRTT), while also defining new categories for Radiotherapy. It was recognised that the targets and their implementation pose a major change for the Service, exacerbated by the implementation of the Digital Health and Care Record (DHCR). Compliance against the new targets is expected to improve over the	

	coming months, achieved via implementation of the new Integrated Radiotherapy System (IRS) and new equipment which will allow streamlining of patient pathways. Additionally, the establishment of a Radiotherapy Capacity Management Group will enable the development of an action plan to address ongoing requirements. Although it is unlikely that the new targets will be fully met until new systems and equipment are fully embedded, this does not signal a drop in current performance and a full Board Development Session (June 2023) will be devoted to reviewing and understanding the new the targets in detail in addition to accurate reflection of performance. It was acknowledged that the Performance Management Framework would continue to develop with the addition / removal of further quality measures, priorities and analytics, aided by current work aligning with the Duty of Quality. This will ensure appropriate measuring mechanisms, reporting and levels of assurance. Stephen Harries acknowledged that sufficient assurance in relation to safeguarding patient care in relation to Radiotherapy performance had been received via conversations outside of Trust Board and no further questions were raised in relation to the performance of the Velindre Cancer Service. ***Welsh Blood Service:*** Cath O'Brien advised that the service has continued to perform well in the main, despite another challenging year. All clinical demand had been met during March 2023 and quality incident investigations and donor satisfaction continue to exceed target. The following areas were highlighted: • Recruitment of additional staff to the Red Cell Immunohaematology Laboratory to accommodate increased activity, with prioritisation of time critical testing. No patient impact was reported despite Reference Serology and Antenatal anti-D quantitation reporting below target. • Platelet wastage continues to remain above target due to stock level planning, short shelf life and unpredictable demand. The Platelet Strategy Project will continue to work with hospitals to resolve this. This has also been escalated at a European level. No questions were raised in relation to the performance of the Welsh Blood Service. ***Workforce:*** Sarah Morley highlighted the following key points for the Workforce element of the report: • Evidence of improvement in sickness absence levels (6.09% in the year to April 2023). Short-term absence currently stands at 1.99%, with long-term sickness at 4.1%.	

	• A range of wellbeing interventions will continue, in addition to work in relation to reducing avoidable employee harm; this will seek to identify systemic reasons for periods of sickness absence. A national assessment of the impact of workforce policies and employee relations cases on staff is currently in progress and it was noted that resolution of standard employee relations cases has reduced from 96 days to 27 during the first three months of 2023. • A national piece of work as a result of the Anti-Racist Wales action plan will review all national workforce policies from the perspective of anti-racist principles. An audit report and associated recommendations will follow during July 2023. Stephen Harries noted that the 3.54% sickness target is set by Welsh Government is not realistically achievable and questioned whether further engagement is required with Welsh Government, or whether it would be appropriate for the Trust to set a realistic local target. The Board sought assurance that measures in place to manage sickness levels are effective, as this is of equal importance to the target. Sarah Morley advised that Welsh Government acknowledged that while the target requires review, other areas such as Industrial Action had been prioritised. Sarah also agreed that it would be appropriate for the Trust to measure progress in a more nuanced way, based on the nature of the organisation. This could be achieved via conversations with staff and via the Healthy & Engaged Steering Group. It is important to understand and proactively manage the drivers of ill health and absence, such as age of workforce, demographics, distance from home to work and any other significant changes outside of the COVID-19 pandemic. Sarah Morley agreed to explore how this is assessed going forward and a proposal will be brought to a future Board meeting. The Chair shared an email from a senior NHS employee currently receiving Radiotherapy at the Cancer Centre, commending the kindness, courtesy, compassion and exceptional management of patients' and families' individual needs by staff. The Trust Board: • **APPROVED** the content of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 3.	**SfM**
3.4.0	**Financial Report (March 2023)** *This item followed item 3.2.0*. In presenting the report outlining the financial position for year-end (2022-2023), Matthew Bunce highlighted the following: • NHS Wales Shared Services Partnership's revenue position is not reflected within the report, as this is reported directly to Welsh Government.	

	• Revenue – subject to audit, the overall revenue position for 2022-2023 indicates an underspend of £0.064m based on draft accounts. • Capital spend remained within the Capital Resource Limit. • The Public Sector Payment Performance Target was met, at 95%. • Due to receipt of extraordinary non-recurrent income during the period, in addition to late notification of Welsh Government funding, recurrent reserves were retained to fund inflated energy costs. The Board had previously approved that the recharge to the Charity would be reduced by £1.5m during the period to offset this. • The £7.1m returned to Welsh Government as a result of slippage on the nVCC Enabling Works during 2022-2023 will be re-provided for the next financial year. The Trust Board **NOTED**: • the content of the March 2023 financial report and, in particular, the year-end financial performance which reported a £0.064m underspend; • compliance with all statutory duties; • the TCS Programme financial report 2022-2023 and in particular, the reported breakeven position and the reported £0.131m underspend on the revenue budget. The Chair and Board members extended their thanks to the Finance Team for their excellent efforts in concluding the year end work.	
4.0.0	**PLANNING AND STRATEGIC DEVELOPMENT**	
4.1.0	**Nursing Strategy** Nicola Williams provided the Nursing Strategy to the Trust Board for approval, following endorsement at the May 2023 Strategic Development Committee. Prior to discussion, the Nursing Strategy was presented by Nursing Staff via a video, outlining the desired direction of nursing for the Trust over the next three years and how this could be achieved. In presenting the Nursing Strategy, Nicola Williams highlighted the following: • The Strategy had been developed over the last 12 months in alignment with the Chief Nursing Officer Priorities, via proactive engagement and consultation with Trust staff, facilitated by the Trust's Professional Nursing Forum. This was formally launched at the May 12th 2023 inaugural Trust Nursing Conference. • A breakout session had been held at the Nursing Conference, encouraging staff to translate the three aims of the Strategy into deliverable actions, with a view for the Professional Nursing Forum to develop a delivery plan on this basis. • Plans are underway to develop a similar Strategy for other professional groups within the organisation.	

	The approach to the development of the Strategy was commended and it was agreed that involvement of the workforce in such an approach could be adopted more broadly across the organisation. The Board echoed this sentiment and suggested that this may be shared with patients, carers, donors and their families. This will be discussed at Professional Nursing Forum. Nicola Williams thanked Tina Jenkins, Interim Deputy Director of Nursing, for leading on this work. The Chair commended how the Nursing Conference was led and wished to invite the Conference Team to a future Trust Board Lunch. It was noted that in addition to over 100 nurses, 6 Board members had attended in support of the team. The Chair also extended appreciation to staff who had remained on site to ensure safe delivery of services on the day. The Chair acknowledged the development of Assistant Practitioner roles, expressing concern that this may result in 'dilution' of the registered nursing workforce. Therefore, it was requested that an analysis of the relationship between the Assistant Practitioner and registered workforce is included in future Nurse Staffing Act Annual reports. The Trust Board **APPROVED** the Velindre University NHS Trust 2023-2026 Nursing Strategy.	
4.2.0	**Integrated Medium Term Plan** *This item followed item 4.3.0* In presenting the Quarter 4 (January to March 2023) progress against the quarterly actions identified in the Integrated Medium Term Plan (IMTP) 2022-2025, Carl James highlighted the following: • Positive progress in terms of the quality of services provided and infrastructure projects and models. Overall quality of service continues to be sustained. • Alignment of the plan with strategic goals / objectives and associated tracking. • Key deliverables not achieved during 2022-2023 will form the basis of the 2023-2024 workplan, with a view to further improve the 'cause and effect' relationship between the plan, outputs and outcomes going forward. Martin Veale queried the category within the report relating to outstanding actions (issues with delivery identified), noting completion of these will now not be feasible by year end. It was also queried whether the Trust had achieved the desired position, what had progressed well and whether any lessons learned had been identified. Carl James agreed that the key could be simplified. Notwithstanding, all material matters had been either included in the plan for 2023-2024 or recorded as risk.	

	The Trust Board **NOTED** the year end position in delivering against the key Trust actions included within the approved Integrated Medium Term Plan for 2022-2025.	
4.3.0	**Full Business Case for Radiology Informatics Systems Programme (RISP)** *This item followed item 3.3.0.* In presenting the Business Case for Board approval, Carl Taylor highlighted the following: • This national clinical programme will seek to replace the current 3 digital infrastructure components and modernise delivery of Radiology services across Wales. This will be applicable to all Health Boards across Wales (with anticipated implementation during March 2025 for Velindre University NHS Trust): o Picture Archiving and Communication System (PACS) – for the storage of scan and x-ray images; o Radiology Information System (RIS) – for the capture of patient demographic details and managing the appointment process; o Patient Dose Monitoring System (PDMS) – in place to assist health boards in monitoring and managing patient radiation doses. • Key benefits expected include improved patient safety, earlier diagnosis aided by modernised digital technology, improved workforce experience and productivity gains. • It was recognised that the programme must be prioritised by all Health Boards in order for timescales to be met. The programme has been approved by three Health Boards to date. Gareth Jones suggested retaining a local version of this until completion of the new Velindre Cancer Centre (nVCC). However, Carl Taylor indicated that it would be of more benefit to introduce the new system as soon as possible to ensure it is fit for purpose prior to moving to the nVCC. Use of the new system at the nVCC has also been addressed by the Supplier and Contractors. The Trust Board **APPROVED** the Business justification case, to include the key risks and matters for escalation outlined. It was agreed that commercial elements would be discussed during the private session.	
4.4.0	**Public Audit Committee Highlight Report (25/04/2023)** The report was removed from the consent section of the agenda due to items for escalation to the Board. In presenting the highlight report, Martin Veale advised the following: • Internal Audit had informed the Audit Committee that despite positive engagement by management during planning and fieldwork, further improvements were required in relation to the management of draft reports and associated 15 working day	

	deadline (management response currently reported at 47%). It was agreed that further engagement is required with Audit Committee to resolve this effectively. • A lack of update provided for a number of outstanding audit recommendations has since been addressed by Audit Committee. Nicola Williams noted that it had been identified that older actions currently tracked via Excel require implementation of a more streamlined automated tracker system, which will allow access by all required individuals to update on a live basis. Two options are currently being explored (document management / quality management electronic system) to facilitate enhanced management of this and the Business Intelligence Team are currently exploring Office 365 and power BI apps. Matthew Bunce advised that closing of older actions on the tracker had much improved and extended thanks to the Operational Team. It was agreed that this will continue to be monitored via the Audit Committee for Trust Board purposes. The Trust Board **NOTED** the content of the report.	
5.0.0	**CONSENT ITEMS**	
5.1.0	**CONSENT FOR APPROVAL**	
5.1.1	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chair's Urgent actions taken between the **30/03/2023** and **16/05/2023** outlined in Appendix 1 of the report.	
5.1.2	**Commitment of Expenditure Exceeding Chief Executive's Limit** During the meeting, Gareth Jones requested the removal of this item from the consent section of the agenda to allow for further discussion of **Appendix 5 – (Welsh Blood Service Project Management Office Software Tool).** This relates to the continued provision of a project management software solution (**VERTO**), currently used by the Welsh Blood Service to support management of projects and programmes across NHS Wales. The Welsh Blood Service entered a direct call-off contract in March 2020 (permitting a period of 2 years with the option to extend for a further 12 months (2+1)) due to expire on the 29th March 2023. This has since been extended until July 2023. As the anticipated Tool has not been implemented and currently has no agreed implementation date, the Welsh Blood Service wishes to renew the call-off contract for a further 2 years (plus further 1 year extension option). Gareth queried whether the Trust was permitted to enter into consecutive call-off contracts under the same framework agreement, or whether any constraints within the agreement may prevent the Trust from doing so.	

	Matthew Bunce advised that each commitment of expenditure is subject to NHS Wales Shared Services Partnership checks to ensure it is procurement compliant. However, formal clarification is awaited. The Chair advised that timely implementation of the solution would not invoke an extension to the contract. The Trust Board **AUTHORISED** the Chief Executive to **APPROVE** the award of contracts summarised within the report and supporting appendices and **AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement, **with the exception of Appendix 5. Approval for this will be subject to a satisfactory response in relation to whether the Trust is permitted to enter into consecutive contracts under the framework agreement and whether a potential new contract could be terminated on an annual basis under the new regulations.**	
5.1.3	**Amendments to Trust Standing Orders – Schedule 3** The Trust Board **APPROVED** the amendments to the Trust Standing Orders – Schedule 3, as outlined in section 3 of the report and Appendices 1-7. Following this approval, they will be adopted into the Trust Standing Orders and published on the Trust website.	
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** The Trust Board **AUTHORISED** the Chief Executive to sign the Memorandum of Understanding as detailed above.	
5.2.0	**CONSENT FOR NOTING**	
5.2.1	**Trust-wide Policies** The Trust Board **NOTED** the policies that have been approved during the period April 2023 to May 2023.	
5.2.2	**NHS Wales Shared Services Partnership Committee (NWSSP) – Assurance Report (23/03/2023)** The Trust Board **NOTED** the summary of key matters, including achievements and progress considered by the Shared Services Partnership Committee and any related decisions made.	
5.2.3	**Trust Seal Report** The Trust Board **NOTED** the content of the Trust Board Seal Register, included in appendix 1 of the report.	
5.2.4	**Nurse Staffing Levels (Wales) Act 2016** The Trust Board **NOTED** the Annual Nurse Staffing Levels report for 2022-2023 as assurance that the necessary processes and reviews	

	and have taken place for Velindre NHS Trust to remain compliant with its duties under the Nurse Staffing Levels (Wales) Act 2016.	
5.2.5	**Public Quality, Safety & Performance Committee Highlight Report (16/05/2023)** The Trust Board **NOTED** the content of the report.	
5.2.6	**Public Strategic Development Committee Highlight Report (04/05/2023)** The Trust Board **NOTED** the content of the report.	
5.2.7	**Public Charitable Funds Committee Highlight Report (21/03/2023)** The Chair acknowledged the late addition of the report and the Trust Board **NOTED** its content.	
8.0.0	**ANY OTHER BUSINESS** No further items of business were raised.	
9.0.0	**DATE and TIME OF THE NEXT MEETING** The next meeting of the Public Trust Board will take place on Thursday 27th July 2023.	
10.0.0	**CLOSE**	

ACTIONS ARISING FROM 30/03/2023					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / 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 (revised to 27/07/2023)**	**Update 19/07/2023** – Presentation delivered at June's Board Development Session. The required narrative is now included in the Performance Management Framework. Update 16/05/2023 – This will be addressed within the July 2023 PMF report. The June 2023 Board Development Session will also review this in detail.	**CLOSED**
ACTIONS ARISING FROM 25/05/2023					
2.1.0	Confirm whether Veterans from outside the British Armed Forces are included in the Armed Forces Covenant.	VUNHST Chair	**25/07/2023**	**Update 18/07/2023** – Confirmation received from Welsh Government of the following: *The Covenant applies to Serving personnel (regular and reservists) in the:* • *Royal Navy* • *Royal Marines* • *Army* • *Royal Air Force.* *It also applies to veterans in these services but also includes Navy Seafarers and Fishermen who served in a vessel at a time it was operated to facilitate military operation by HM Armed Forces.* *Locally Employed Staff (such as Afghani interpreters), whilst they may have worked alongside UK forces, they are not serving members of HM armed forces. Therefore, they do not qualify for UK veteran status. Neither are Civil Servants or civilian contractors who may have also served on operations.*	**CLOSED**
2.2.0	Powerpoint Slide Deck of JET slides to be circulated to all Independent Members following Trust Board.	Secretariat	**25/07/2023**	**Update 25/05/2023** – Slides circulated.	**CLOSED**

3.1.0a	Ensure that Independent Members are sighted on requirements for statutory and mandatory risk training.	Director of Corporate Governance & Chief of Staff	**25/07/2023**	**Update 12/07/2023** – Individual summaries of compliance sent to all Independent Members (30/05/2023), followed by a request for an update (12/07/2023).	**CLOSED**
3.1.0b	Chief Executive and Director of Corporate Governance to review risks where external influences may impact the narrative.	Chief Executive/Director of Corporate Governance & Chief of Staff	**25/07/2023**	**Update 11/07/2023 –** Addressed in cover paper.	**CLOSED**
3.1.0c	Request that controls within risk 2465 on the Trust Risk Register accurately reflects the situation (no rapid resolution).	Executive Director of Nursing, AHPs and Health Science	**25/07/2023**	**Update 25/05/2023** – Email sent to relevant risk owners by Executive Director of Nursing.	**CLOSED**
3.1.0d	Ensure that the Trust Board cover paper for the Risk Register would include more detailed narrative to that already provided related to discussions undertaken at Quality, Safety & Performance Committee to avoid duplicate discussions at Trust Board.	Director of Corporate Governance & Chief of Staff	**25/07/2023**	**Update 11/07/2023 –** Addressed in cover paper.	**CLOSED**
3.1.0e	Confirm timescales for review of email in clinical decision-making.	Chief Operating Officer	**25/07/2023**	**Update 11/07/2023** - The Trust Head of IG will undertake an Audit of the use of email in Clinical Decision-Making week commencing 17th July 2023. Whilst the full scope of the Audit remains flexible, the estimated completion date is 28th July 2023. The estimated completion date of the report is 4th August 2023.	**CLOSED**

3.3.0	Explore an appropriate internal Trust target for sickness absence levels and provide a proposal to a future Trust Board.	Executive Director of Organisational Development and Workforce	**28/09/2023**	**NOT YET DUE**	**OPEN**

TRUST BOARD

ACCOUNTABILITY REPORT & ANNUAL ACCOUNTS 2022-23

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	• Emma Stephens, Head of Corporate Governance • Tracy Hughes, Head of Financial Operations • Sue Thomas, Deputy Director of OD & Workforce
PRESENTED BY	• Lauren Fear, Director of Corporate Governance & Chief of Staff • Matthew Bunce, Executive Director of Finance
APPROVED BY	• Lauren Fear, Director of Corporate Governance & Chief of Staff • Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes: • The Performance Report, which must include: o An overview o *Delivery and Performance analysis*

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

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

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Board (*Board Development Session)*	(18/04/2023)
Trust Audit Committee	(26/07/2023)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
In developing the Accountability Report this has also been discussed at various stages with Trust Officers, and presented at the April 2023 Trust Board Development Session, colleagues from NHS Wales Shared Services Internal Audit were also in attendance. It has also been shared with Audit Wales and Welsh Government with any feedback incorporated as appropriate. The Trust has also continued to receive regular updates on the Monthly Financial Reporting Position throughout the year, at each meeting of the Executive Management Board, Quality, Safety & Performance Committee and Trust Board, forming the basis of the Trust Accounts for the reporting period. The Accountability Report & Annual Accounts for the 2022-23 reporting period is due to be presented to the Trust Audit Committee on the **26th July 2023** for **ENDORSEMENT FOR BOARD APPROVAL;** the outcome of which is currently pending at the time of preparing this report.

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

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

1. SITUATION

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

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

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

The Accountability Report and Audited Annual Accounts 2022-23 is presented to the Trust Board **FOR APPROVAL.**

2. BACKGROUND

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

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

3. ASSESSMENT

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

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

3.3 Key aspects to highlight within the Governance Statement include:

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

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

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

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

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to:

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

APPROVE the Accountability Report and Annual Accounts for 2022-23.

5. IMPACT ASSESSMENT

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

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

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

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Velindre University NHS Trust Accountability Report 2022-2023

CONTENT

VELINDRE UNIVERSITY NHS TRUST
SCOPE OF RESPONSIBILITY

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

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

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

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

NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

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

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

HEALTH TECHNOLOGY WALES (HTW)

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

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

VELINDRE UNIVERSITY NHS TRUST SCOPE OF ACCOUNTABILITY

(*inc* HOSTED ORGANISATIONS)

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

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

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

SCOPE OF THE ACCOUNTABILITY REPORT

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

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

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

I. Corporate Governance Report

II. Financial Accountability Report

III. Remuneration and Staff Report

IV. Parliamentary Accountability and Audit Report

CORPORATE GOVERNANCE REPORT

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

The Corporate Governance Report includes the following sub sections:

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

DIRECTORS' REPORT

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

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

CHAIR & INDEPENDENT MEMBERS OF THE TRUST 2022-2023

Professor Donna Mead, OBE, Chair

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

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

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

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

Professor Mead is supported by six other Independent Members.

Mr. Stephen Harries, Vice Chair and Independent Member

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

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

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

Champion Role:
Trust Champion for Digital and Mental Health.

Mr. Gareth Jones, Independent Member

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

Area of Expertise:
Legal.

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

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

Mrs. Hilary Jones, Independent Member

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

Area of Expertise:
Estates & Planning.

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

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

Mrs. Vicky Morris, Independent Member

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

Area of Expertise:
Quality & Safety.

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

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

Mr. Martin Veale, JP, Independent Member

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

Area of Expertise:
Finance, Audit & Governance.

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

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

Professor Andrew Westwell,
Independent Member

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

Area of Expertise:
University Representative.

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

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

EXECUTIVE DIRECTORS (BOARD MEMBERS)

Mr. Steve Ham, Chief Executive Accountable Officer

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

Dr. Jacinta Abraham, Executive Medical Director

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

Lead Function: Medical Director and Research

Mr. Matthew Bunce, Executive Director of Finance

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

Lead Function: Finance and Charitable Funds.

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

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

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

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

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

Lead Function: Organisational Development & Workforce

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

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

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

EXECUTIVE TEAM MEMBERS (NON-BOARD MEMBERS)

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

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

Mrs. Cath O'Brien, Chief Operating Officer

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

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

Mr. Alan Prosser, Director – Welsh Blood Service

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

Mr. Paul Wilkins, Director – Velindre Cancer Service

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

Further information in respect of the Trust Board, a Review of its Effectiveness, Committee Activity, the System of Internal Control and the Trust Assurance Framework are captured in the Governance Statement section of this report, which starts on page 26 and ***Appendix 1*** on page 64.

PUBLIC INTEREST DECLARATION

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

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

DISCLOSURE STATEMENTS

Information Governance:

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

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

- **Information Governance Roles and Responsibilities:**

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

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

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

- **Information Governance Overall Risk:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There was a 92 working day delay in response

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

The document provided was undated and unsigned

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

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

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

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

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

An insight in to the 92 working day delay was requested

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

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

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

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

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

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

Medical Records

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

Non-clinical

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

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

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

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

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

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

and compliance with the Surveillance Camera Code of Practice 2021
- Use of social media platforms for fundraising purposes, especially assessing the consideration of Legitimate Interest as a lawful basis of processing
- The regulators position on the use of the Freedom of Information Act by companies seeking contract work in Public Bodies
- The regulators position on the frequency of requests by the same requestor made to the Trust under the Freedom of Information Act
- Monitoring of employees in the workplace and privacy considerations

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

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

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

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

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

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

The Information Commissioner made clear recommendations, these being:

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

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

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

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

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

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

Corporate Governance Code for Central Government Departments:

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

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

Governance Code during the year.

Sustainability:

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

The Trust recognises that its day-to-day operational activities have a direct impact upon the environment and is committed to meeting the legislative drivers set out by Welsh Government to address this when possible. Welsh Government have an ambition for the public sector to be carbon neutral by 2030. This ambition sits alongside the Environment (Wales) Act 2016 and Well-being of Future Generations (Wales) Act 2015 as legislative drivers for decarbonisation and embracing the Sustainable Development Principle within the public sector in Wales. The Trust will continue its work on carbon footprint monitoring in line with the NHS Wales Decarbonisation Strategy, to realise this ambition, the Trust has created tangible actions in a detailed Decarbonisation Action Plan. The Trust is taking ambitious action, both strategically through the Trust Sustainability Strategy and operationally to adapt to climate change and respond to climate risk through the development of new Velindre Cancer Centre Radiotherapy Satellite Centre and the Talbot Green Infrastructure upgrade project. Capital schemes are designed using projected climate data to ensure the design caters for global warming assessed within the lifetime of the build. This approach ensures as far as is reasonably practicable that fabric and systems used to control internal comfort remain fit for purpose. Alongside these major capital schemes, the Trust is actively educating our staff to instigate meaningful behavioral change, through events and raising awareness. The Trust Annual Sustainability Report for 2022/2023 received at the July Quality, Safety and Performance Committee, further outlines how the Trust is driven by its Sustainability Strategy and has continued to be ambitious with its strategic aims in this context and will continue to work to ensure that it is compliant with the Climate Change Act and the Adaptation reporting requirements. Progress against which will be reported using a risk-based approach via the Quality, Safety and Performance Committee.

NHS Pension Scheme:

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

MINISTERIAL DIRECTIONS

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

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

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

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

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

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

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

Signed by:

Mr. Steve Ham
Chief Executive

Dated: XX/XX/2023

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

In preparing those accounts, the directors are required to:

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

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

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

By Order of the Board
Signed:

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

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

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

GOVERNANCE STATEMENT

GOVERNANCE AND ACCOUNTABILITY FRAMEWORK

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

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

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

DISCHARGING RESPONSIBILITIES

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

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

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

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

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

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

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

The dates the Trust Board and Committees met during the period 2022-2023 are captured in ***Appendix 1*** on page 64.

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

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

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

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

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

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

COMMITTEE ACTIVITY

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

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

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

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

Key highlights and issues considered by the Trust Board and its Committees during 2022-2023 are included in ***Appendix 1*** of the Governance Statement on **page 64.**

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

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

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

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

BOARD ASSURANCE FRAMEWORK

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

ENGAGEMENT WITH THE LOCAL PARTNERSHIP FORUM

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

Examples of engagement with the Local Partnership Forum during 2022-2023 are outlined in ***Appendix 1*** on page 64.

TRUST BOARD DEVELOPMENT AND EFFECTIVENESS

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

April 2022

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

June 2022

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

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

October 2022

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

November 2022

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

December 2022

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

February 2023

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

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

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

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

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

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

STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

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

- **January 2023 –** Amendments to Trust Standing Orders Schedule 3.0, resulting from the Annual review of the Terms of Reference and Operating Arrangements in respect of the Quality, Safety & Performance Committee.

- **February 2023 –** Amendment to the Trust Standing Orders (via Chairs Urgent Action) the revised membership of the Trust Board in line with The Health and Social Care (Quality and Engagement) (Wales) Act to comprise of one additional Executive Director.

TRUST BOARD APPOINTMENTS DURING 2022-2023

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

Independent Members

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

Executive Team Members

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

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

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

PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

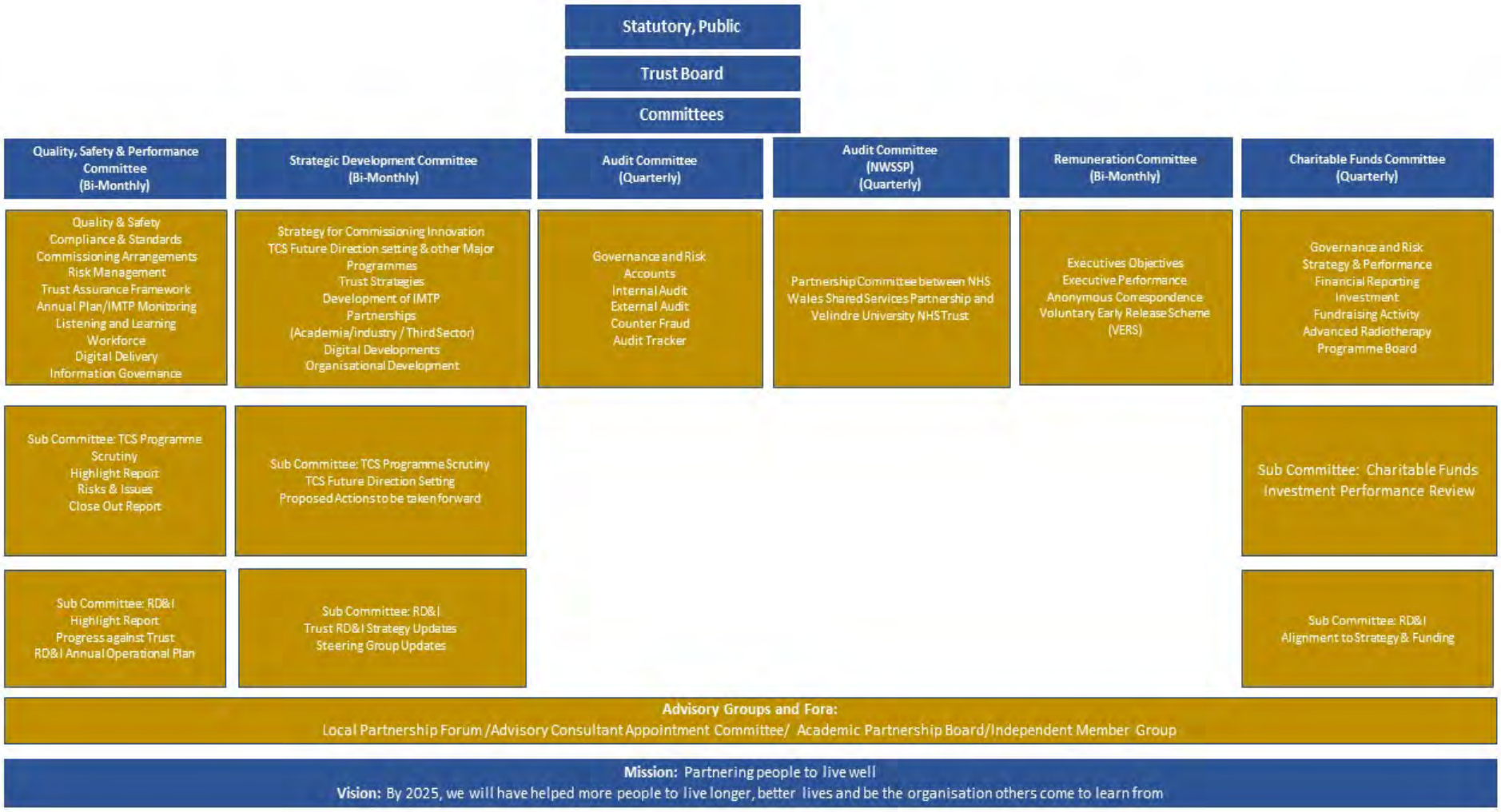
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risks, it can therefore only provide reasonable and not absolute assurances of effectiveness.

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

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

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

Trust's Governance and Accountability Framework



GOVERNANCE OF THE CHARITABLE FUNDS

The Velindre University NHS Trust Board was appointed as Corporate Trustee of the Charitable Funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and the Trust Board serves as its agent in the administration of the Charitable Funds held by the Trust.

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

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

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

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

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

HOSTED ORGANISATIONS SYSTEMS OF INTERNAL CONTROL AND ASSURANCE

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

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

NWSSP has an 'NHS Wales Shared Services Partnership Committee' which was established in 2012 to comply with the Velindre University NHS Trust Shared Services (Wales) Regulations 2012 (2012/1261 (W.156)). Velindre University NHS Trust (Velindre) must agree Standing Orders (SOs) for the regulation of the Shared Services Partnership Committee's (the SSPC) proceedings and business. These SSPC SOs form an Annex to Velindre's own SOs and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Velindre University NHS Trust Shared Services (Wales) Regulations 2012 (2012/1261 (W.156)) and Velindre's Standing Order 3 into day to day operating practice. The NWSSP Committee has membership from each statutory body in NHS Wales and is chaired by an Independent Chair. The NWSSP Committee reports to Velindre University NHS Trust Board and all other health body Boards in Wales via their representative member on the Committee. NWSSP have their own Standing Orders which are appended to the Velindre University NHS Trust Standing Orders.

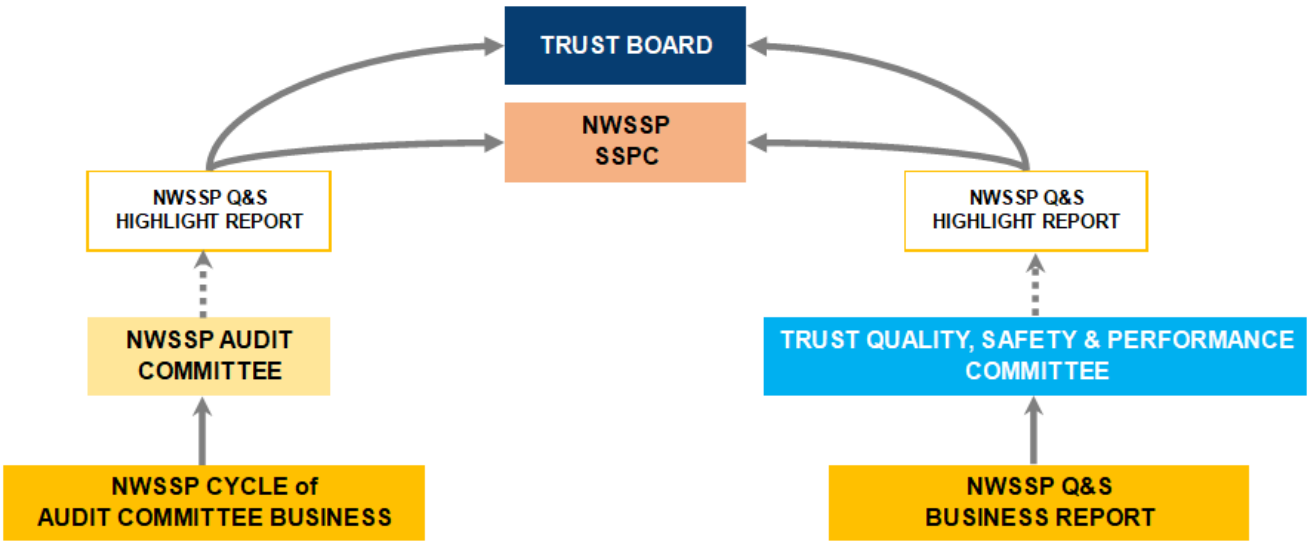
Currently, organisations hosted by Velindre University NHS Trust are able to link with Trust Board Committees and Management Groups where appropriate to ensure assurance is provided for the governance arrangements, including statutory compliance for the areas remaining within the Trust's area of responsibility.

In May 2021, a review was undertaken by Velindre University NHS Trust in partnership with NWSSP to consider arrangements for Quality & Safety governance in respect of the Shared Services Partnership Committee. This included consideration of the culture and approach adopted by the Velindre Board following the creation of the Quality, Safety & Performance Committee in November 2020. In addition, it also considered the approaches with other hosted organisations to support in

considering different models and what may work best to fulfill the purpose agreed by the Shared Services Partnership Committee – to "advise and assure the Shared Services Partnership Committee and Accountable Officer on whether effective arrangements are in place for quality and safety" (in line with the approved NWSSP Standing Orders). This was coupled with ensuring that Velindre University NHS Trust Board, as the host organisation and statutory body, also having appropriate assurance to fulfill its accountabilities in this respect. The review recommended that an additional section be added to the start of each Trust Quality, Safety & Performance Committee to cover NWSSP Quality and Safety business. This approach was considered sufficient for the volume of business at this time, and in quarter 4 of FY 2022-23 has been subject to further review as the NWSSP business model continues to develop. This has been reflected in the Trust Quality, Safety & Performance Committee Cycle of Business, and reported in the March 2023 meeting of the Committee.

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

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



A review of the existing governance reporting arrangements in place for Health Technology Wales

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

CAPACITY TO HANDLE RISK

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

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

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

RISK MANAGEMENT

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

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

"The primary objective of the Policy is to support staff across the Trust to identify and manage the risks that may prevent the achievement of the Trust's objectives. This includes assessing risks to patient and donor safety, compliance across our legal and regulatory frameworks and risks attached to our key dependencies, core processes, and stakeholder expectations and in so doing, the achievement of Trust Strategy. It is also important to emphasise that the Trust's commitment to quality and safety is the 'golden thread' throughout the organisation and recognise the key role that a strong risk management culture has in that. As with everything the Trust does, this is achieved by putting our patients and donors at the centre of everything we do, working towards optimum quality, safety and experience and continual learning and improving.

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

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

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

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

The Quality, Safety & Performance Committee has a remit to review risks, however, during 2022-23 the committee's focus has been more so on ensuring that the information in the risk register is accurate and providing the appropriate details to enable effective assurance. During 2023-24 the committee's

focus will be on scrutinising risks in the register. The committee provides: assurance to the Trust Board that the risk register appropriately reflects the most significant risks facing the organisation, through a Quality and Safety lens; that the control framework in place is appropriate both in design and operating effectiveness; and that actions to manage risk are appropriately progressing to reach the target risk score.

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

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

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

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

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

In summary, the Trust's risk management framework:

- promotes consistency and transparency by articulating an overarching framework for managing risk and establishing a common risk language across Trust;
- explains how the three lines of defence operates;
- explains how risk management is aligned to the governance structures across the

organisation;

- defines risk management roles and responsibilities for individuals and teams within VUNHST;
- ensures that risk management processes support and align with the overarching strategy for the Trust, in which the golden thread is our commitment to quality and safety, ensuring that we put our patients and donors at the centre of everything we do;
- recognises that timely and accurate monitoring, review, communication and reporting of risk are critical to providing:

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

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

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

TRUST RISK REGISTERS

The organisation's risk profile is visible through the Trust Risk Registers. Risks are identified at the commencement of new or amended activities and through the ongoing review of existing risks. Risk assessments are undertaken to assess the impact upon the service and other stakeholders. Public Stakeholders are involved in the assessment of risk through public consultations, Patient Liaison

Group representation and Community Health Council at Trust Board and Committee meetings, feedback received in respect of Patient Experience surveys and Donor Forums and learning from Concerns received from patients, donors, relatives and/or carers.

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

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

The Trust has three levels of risk training:

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

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

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

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

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

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

RISK APPETITE STATEMENT

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

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

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

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

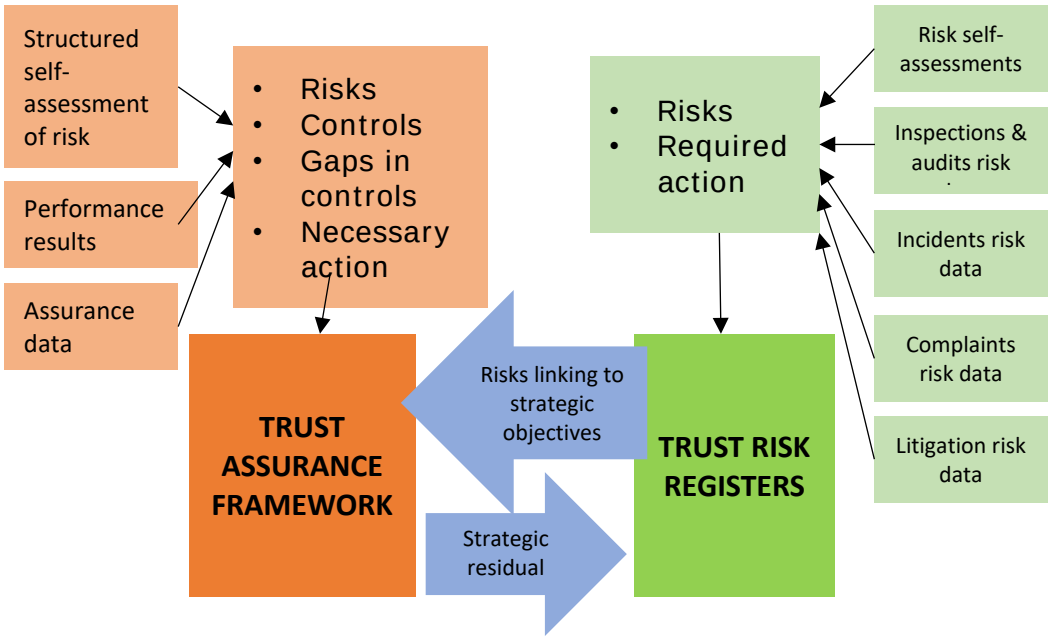
TRUST ASSURANCE FRAMEWORK (TAF)

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

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

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

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



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

The focus of the management of the TAF is twofold:

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

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

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

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

HEALTH & CARE STANDARDS FOR WALES

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

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

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

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

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

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

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

GOVERNANCE & ACCOUNTABILITY ASSESSMENT / TRUST BOARD EFFECTIVENESS

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

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

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

REVIEW OF EFFECTIVENESS
(ADDITIONAL SOURCES OF ASSURANCE)

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

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

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

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

INTERNAL AUDIT OPINION & SCORES FOR 2022–2023

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

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

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

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

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

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

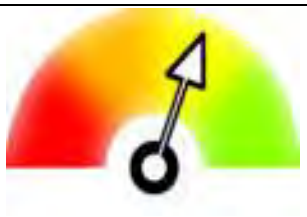
The Trust has received two high priority recommendations during the reporting period and these are detailed in the Head of Internal Audit Opinion for 2022-2023.

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

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

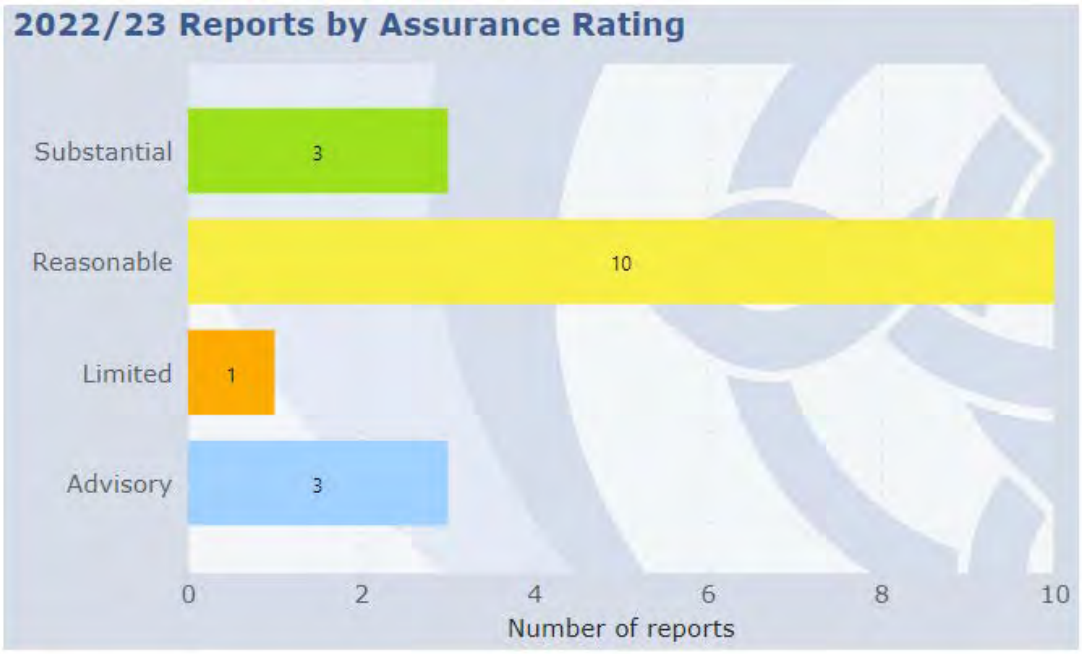
The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement.

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

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

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

Summary of audit ratings



AUDIT WALES STRUCTURED ASSESSMENT 2022 - 2023

The Trust's External Auditors, Audit Wales, Structured Assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness of their use of resources under section 61 of the Public Audit (Wales) Act 2004.

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

The key focus of the work has been on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements, strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets.

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

- Overall, the Trust is generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance, and effective arrangements for managing its finances and other resources.
- The Trust's Board and its committees continue to operate effectively and are actively using learning to drive improvement. Opportunities remain to improve the public availability of key papers and documents on the Trust's website.
    - In the Trust management response, it has set out / advised Audit Wales that it has implemented tracking to ensure the completeness and timely publication of committee agenda bundles and other key governance papers in this regard.
- The Trust continues to have a stable Executive Team and organisational structure. It has reviewed and strengthened its systems of assurance which should enable the Board and its committees to assess and improve organisational performance and effectiveness once fully operational. It would benefit from reinstating the log for tracking recommendations relating to the quality and safety of services made by external inspection and regulatory bodies.
    - In the Trust management response, it has set out / advised Audit Wales that the Quality & Safety Improvement Tracker will be received at each meeting of the Quality, Safety & Performance Committee from May 2023 onwards, together with the associated Improvement Plan using the 7 levels of assurance template. The Trust management

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

- The Trust has good planning and stakeholder engagement arrangements. It has a clear strategic vision, supported by goals and objectives, which the Trust articulates in its new ten-year strategy (Destination 2032), enabling strategies, and Welsh Government approved 2022-25 Integrated Medium-Term Plan (2022-25 IMTP). However, whilst the Trust's strategic priorities as set out in the 2022-25 IMTP, are specific, measurable and time bound, they do not set out the intended outcome. In the Trust management response, it has set out / advised Audit Wales that further work will be undertaken to:

  (i.) improve the SMART elements of the objectives

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

- Whilst reporting on delivery of the 2022-25 IMTP is good, opportunities exist to strengthen reports to provide greater detail on whether the intended outcome has been achieved.
  - In the Trust management response, it has set out / advised Audit Wales that its IMTP for 2023-2026 will outline the impact / benefits of actions being taken and the process for developing the IMTP has included an assessment of actions which should be rolled forward to 2023 – 2026 reported through the Trust governance structure.
- The Trust has effective arrangements for managing its financial resources and continues to meet its financial duties. However, the Trust is aware that it faces risks to maintaining financial sustainability in the medium- to long-term. Financial controls are effective, and the Trust continues to produce clear and accessible financial reports to support effective monitoring and scrutiny.
- Staff well-being continues to be a priority for the Trust. But its arrangements for measuring and reporting on the effectiveness of well-being interventions require strengthening.
  - In the Trust management response, it has set out / advised Audit Wales this will be addressed in the Workforce and OD report received at the May 2023 Trust Board onwards and also as appropriate via the Trust Quality, Safety & Performance Committee Cycle of Business.
- The Trust has ambitious plans in place to harness the potential of digital to transform service delivery, but some plans remain un-costed. Furthermore, arrangements for monitoring and reporting on the benefits of digital require strengthening.
  - In the Trust management response, it has set out / advised Audit Wales that further development of digital benefits will be undertaken in several ways:

    (i). a range of key performance indicators that are reported to the Executive Management Board

(ii). improving the clarity of benefits in projects/business cases on a case-by-case basis

(iii). implementing the measures set out within the digital strategy and key service plans (e.g., quality metrics) which will demonstrate the impact of digital services on service quality and outcomes and including an overall % spent on digital technology

- The Trust has a clear vision for its estates and environmental sustainability and has good arrangements in place for ensuring Board-level oversight and scrutiny of key estates related risks and matters.

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

BUSINESS CONTINUITY AND EMERGENCY PREPAREDNESS

Business Continuity & Emergency Preparedness:

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

Co-operation and Information Sharing:

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

Training and Exercising:

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

Work Programme 2023/2024:

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

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

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

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

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

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

Destination 2032: Our View of the Future

Our Purpose: To Improve Lives

Our Vision: Excellent Care, Inspirational Learning, Healthier People

Our Strategic Goals

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

EQUALITY & DIVERSITY

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

The control measures include:

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

CONCLUSION

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

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

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

Signed by:

Mr. Steve Ham
Chief Executive

Date: xx/xx/2023

APPENDIX 1 – GOVERNANCE STATEMENT – TRUST BOARD, COMMITTEE, ADVISORY GROUP AND FORA ACTIVITY 2022-2023

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

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

Meeting:	Meeting Dates:	Activity:
		• Wales Infected Blood Support Service (WIBSS) Annual Report • Integrated Radiotherapy Solution Full Business Case • Radiotherapy Satellite Centre Full Business Case
Advisory Consultant Appointments Committee	Panels were held: • 14/06/22 • 20/07/22 • 23/02/23	As and when required the Advisory Consultant Appointment Committee meet to manage the arrangements for appointments to NHS Consultant posts within the Trust.
NHS Wales Shared Services Partnership Audit Committee (NWSSP) Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 05.04.2022 • 29.06.2022 • 13.07.2022 • 11.10.2022 • 24.01.2023 All meetings were quorate.	The NWSSP Audit Committee Annual Review was received at its July 2022 meeting and is available here.
Trust Audit Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here: https://velindre.nhs.wales/about-us/audit-committee/	• 03.05.2022 • 13.06.2022 • 19.07.2022 • 04.10.2022 • 12.01.2023 • 25.04.2023 All meetings were quorate.	The purpose of the Audit Committee is to: Advise and assure the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's system of assurance - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales. Where appropriate, the Committee will advise the Board and the Accountable Officer on where and how its system of assurance may be strengthened and developed further. The Audit Committee Annual Report which outlines the activity of the Committee for the year ending 31 December 2022 was approved by the Audit Committee on 12 January 2023 and is available on the Trust Internet site here:

Meeting:	Meeting Dates:	Activity:
Charitable Funds Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 17.05.2022 • 20.09.2022 • 19.01.2022 • 21.03.2023 All meetings were quorate.	The Velindre University NHS Trust Board was appointed as Corporate Trustee of the Charitable Funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993 and that its Board serves as its agent in the administration of the Charitable Funds held by the Trust. The purpose of the Committee "is to make and monitor arrangements for the control and management of the Trust's Charitable Funds". The Charitable Funds Committee Annual Report for 2022/23, which outlines the activity of the Committee for the year ending 31 March 2023, will be received by the Committee for approval in June 2023. The Charitable Funds Committee also receives a Highlight Report from the Charitable Funds Investment Performance Review Sub-Committee.
Local Partnership Forum (LPF)	• 05/05/2022 • 05/07/2022 • 06/09/2022 • 08/11/2022 • 07/03/2023 All meetings were quorate.	The purpose of the Local Partnership Forum (LPF) is: To provide a formal mechanism where the Trust, as employer and trade unions / professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the Trust's workforce. It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around

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

Meeting:	Meeting Dates:	Activity:
Strategic Development Committee Meeting Agendas, Minutes and Papers are available on the Trust Internet site here:	• 16.05.2022 • 07.07.2022 • 13.10.2022 • 08.12.2022 • 07.02.2023 • 24.03.2023 All meetings were quorate.	The purpose of the Strategic Development Committee is to provide: Evidence based and timely advice to the Board to assist it in discharging its functions and responsibilities with regard to the: • strategic direction • strategic planning and related matters • organisational development • digital services, estates and other enabler services • sustainable development and the implementation of strategy through the spirit and intention of the Well Being of Future Generations Act • investment in accordance with Value-based healthcare Assurance to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives. Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further. The Strategic Development Committee Annual Report which outlines the activity of the Committee for the year ending 31 March 2022 will be approved at its July 2023 Committee.
Remuneration Committee	• 28/04/2022 • 22/09/2022 • 25/10/2022 • 09/02/2023	The purpose of the Remuneration Committee is to provide: • ***advice*** to the Board on remuneration and terms of service for the Chief

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

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

Meeting:	Meeting Dates:	Activity:
		Board and the Accountable Officer on where, and how, its system of assurance in relation to the TCS Programme may be strengthened and developed further.

APPENDIX 2–Board Member Attendance

Trust Board, Committee, Advisory Group and Fora Meetings 2022- 2023

NAME	POSITION & AREA OF REPRESENTATION	BOARD, COMMITTEE, ADVISORY GROUP AND FORA MEMBERSHIP & RECORD OF ATTENDANCE	CHAMPION ROLE	AREAS OF EXPERTISE
Professor Donna Mead, OBE	Trust Chair	• Trust Board **(Chair) 7/7** • Charitable Funds Committee **(Chair) 4/4** • Remuneration Committee **(Chair) 4/4** • Quality, Safety & Performance Committee **5/6** • Strategic Development Committee **4/6** • Research, Development & Innovation Sub-Committee **4/4** • TCS Programme Scrutiny Sub-Committee **8/9**	Trust Champion for Armed Forces and Veterans, University Trust	Higher Education, Research, the NHS and Education, Partnerships and Collaboration.
Stephen Harries	Vice-Chair	• Trust Board **6/7** • Strategic Development Committee **(Chair) 5/6** • TCS Programme Scrutiny Sub-Committee **(Chair) 7/10** • Quality, Safety & Performance Committee **5/6** • Remuneration Committee **4/4**	Digital and Mental Health	Information Governance, Information Management and Technology.
Gareth Jones	Independent Member	• Trust Board **6/7** • Strategic Development Committee **5/6** • Audit Committee **5/5** • NWSSP Audit Committee **4/4** • TCS Programme Scrutiny Sub-Committee **7/10**	Patient Information and Welsh Language.	Legal

NAME	POSITION & AREA OF REPRESENTATION	BOARD, COMMITTEE, ADVISORY GROUP AND FORA MEMBERSHIP & RECORD OF ATTENDANCE	CHAMPION ROLE	AREAS OF EXPERTISE
Hilary Jones	Independent Member	• Trust Board **6/7** • Quality, Safety & Performance Committee **4/6** • Charitable Funds Committee **4/4** • Charitable Funds Investment Performance Review Sub-Committee **2/2** • TCS Programme Scrutiny Sub-Committee **9/10**	Patient Engagement & Experience, Sustainable Development and Design.	Estates and Planning
Vicky Morris	Independent Member	• Trust Board **5/7** • Quality, Safety & Performance Committee **(Chair) 5/6** • Audit Committee **5/5** • NWSSP Audit Committee **4/4** • Research, Development & Innovation Sub-Committee **4/4**	Infection Prevention, Vulnerability and Violence & Aggression.	Quality and Safety
Martin Veale	Independent Member	• Trust Board **5/7** • Charitable Funds Committee **4/4** • Charitable Funds Investment Performance Review Sub-Committee **(Chair) 2/2** • Audit Committee **4/5** • Remuneration Committee **3/4** • NWSSP Audit Committee **(Chair) 4/4**	Hosted Organisations and Performance Framework.	Finance, Audit and Governance
Professor Andrew Westwell	Independent Member	• Trust Board **7/7** • Research, Development & Innovation Sub-Committee **(Chair) 4/4** • Strategic Development Committee **5/6**	Research, Development & Innovation.	University Representative

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

NAME	POSITION & AREA OF REPRESENTATION	BOARD & COMMITTEE MEMBERSHIP & RECORD OF ATTENDANCE	LEAD FUNCTION
Matthew Bunce	Executive Director of Finance	• Trust Board **7/7** • Audit Committee **5/5** • NWSSP Audit Committee **4/4** • Quality, Safety & Performance Committee **5/6** • Strategic Development Committee **6/6** • Charitable Funds Committee **4/4** • TCS Programme Scrutiny Sub-Committee **7/10** • Charitable Funds Investment Performance Review Sub-Committee **2/2** • Research, Development & Innovation Sub-Committee **3/4** • Local Partnership Forum **2/5**	Finance and Charitable Funds
Sarah Morley	Executive Director of Organisational Development & Workforce	• Trust Board **6/7** • Quality, Safety & Performance Committee **4/6** • Strategic Development Committee **5/6** • Remuneration Committee **4/4** • Local Partnership Forum **(Chair) 5/5**	Organisational Development and Workforce
Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Science	• Trust Board **5/7** • Quality, Safety & Performance Committee **4/6** • Strategic Development Committee **4/6** • TCS Programme Scrutiny Sub-Committee **2/10** • Research, Development & Innovation Sub-Committee **3/4** • Local Partnership Forum **1/5**	Quality & Safety, Safeguarding, Infection Prevention & Control, professional lead for nursing, Allied Health Professionals and Healthcare Scientists.

APPENDIX 3 – Ministerial Directions and Welsh Health Circulars

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

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

FINANCIAL ACCOUNTABILITY REPORT

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

During 2022/23 the Trust Services incurred additional spend to establish additional capacity, support mass vaccination, provide PPE, undertake enhanced cleaning etc in its response to the pandemic. Welsh Government and Commissioners through protected LTA activity growth income provided the Trust with funding to cover these COVID-19 related issues which ensured they did not impact on the Trust meeting the key target of its revenue expenditure not exceeding income.

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

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

FINANCIAL TARGETS

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

- Breakeven duty - The Trust achieved a revenue surplus of £0.076m in 2022/2023 (2021/2022: surplus of £0.041m; 2020/2021 surplus of £0.038m), resulting in a surplus of £0.155m over a three year period. The Trust has therefore achieved its statutory financial duty to achieve financial breakeven over a rolling three year period.
- Duty to prepare a 3 year integrated plan –The Trust submitted a 2022-2025 integrated plan in

accordance with the planning framework and has therefore met its statutory duty to have an approved financial plan.

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

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

FEES & CHARGES - AUDITOR REMUNERATION

Fees paid to Audit Wales for their statutory audit and performance audit work relating to 2021 - 2022 was £260,000 in total by the Trust, this included the £17,000 for the audit of the Trust's Charity.

MATERIAL REMOTE CONTINGENT LIABILITIES

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

LONG TERM EXPENDITURE TRENDS

	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
	£000	£000	£000	£000	£000
Total Revenue	**525,607**	**572,642**	**848,405**	**1,044,074**	**961,179**
Pay	160,551	182,684	242,072	294,020	404,977
Non Pay	352,075	373,015	587,320	738,544	551,840
Depreciation	16,466	17,186	17,554	10,222	11,860
Total Expenditure	**529,092**	**572,885**	**846,946**	**1,042,786**	**968,677**
Non-operating revenue and costs	**3,295**	**440**	**(207)**	**(953)**	**10,324**
Total consolidated surplus / (deficit)	**(190)**	**197**	**1,252**	**335**	**2,826**

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

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

Notes

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

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

MODERN SLAVERY ACT 2015
TRANSPARENCY IN SUPPLYCHAINS STATEMENT 2022/2023

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

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

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

The Trust will not undertake any employment practices that;

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

Current Policies and Initiatives

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

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

People

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

Procurement and our Supply Chain

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

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

Training

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

Policies and Initiatives 2022 /2023

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

REMUNERATION & STAFF REPORT

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

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

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

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

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

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

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

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

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

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

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

STAFF COMPOSITION BY SEX

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

*FTE – Full-time Equivalent

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

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

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

STAFF COMPOSITION BY STAFF GROUP

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

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

SICKNESS ABSENCE DATA 2022/23

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

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

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

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

STAFF POLICIES

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

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

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

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

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

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

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

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

Notes:

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

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

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

SALARY AND PENSION DISCLOSURE

CASH EQUIVALENT TRANSFER VALUES

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

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

REAL INCREASE IN CETV

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

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

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

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

Notes:

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

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

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

REPORTING OF OTHER COMPENSATION SCHEMES – EXIT PACKAGES

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

REMUNERATION RELATIONSHIP

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

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

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

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

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

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

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

EXPENDITURE ON CONSULTANCY

During 2022/2023 the Trust spent £3.950m of its revenue funding on external consultancy fees (£1.588m related to the NHS Wales Shared Services Partnership); and £0.827m of its capital funding on external consultancy fees, including £0.773m related to the new hospital project (and £0.048m related to the NHS Wales Shared Services Partnership).

Examples include:

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

TAX ASSURANCE FOR OFF-PAYROLL ENGAGEMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AUDIT CERTIFICATE AND AUDITOR GENERAL FOR WALES REPORT

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion on financial statements

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

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

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

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

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

Opinion on regularity

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

Basis for opinions

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

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

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

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

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

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

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

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

I have nothing to report in this regard.

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

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

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

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

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

I have nothing to report in respect of the following matters, which I report to you, if, in my opinion:
I have not received all the information and explanations I require for my audit

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

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

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

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

My objectives are to obtain reasonable assurance about whether the financial

statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion.

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

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

My procedures included the following:

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

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

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

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

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

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

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

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

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

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

Adrian Crompton
Auditor General for Wales
31 July 2023

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Velindre University NHS Trust

Finance Report

2022-2023

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

Canolfan Ganser Felindre
Velindre Cancer Centre

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Velindre University NHS Trust

Foreword

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

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

Statutory background

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

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

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

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

Performance Management and Financial Results

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

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

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

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2023

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

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

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2023

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

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

Steve Ham, Chief Executive and Accountable Officer

Date: 27 July 2023

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

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

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

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

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

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

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2023

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

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

Notes to the Accounts

1. Accounting policies

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

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

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Revenue

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

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

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

Only non-NHS income may be deferred.

1.4 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

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

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

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

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

NEST Pension Scheme

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

1.5 Other expenses

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

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

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

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

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

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

managerial control; or

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

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

Valuation

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

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

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

● Specialised buildings – depreciated replacement cost

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

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

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

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

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

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

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

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

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

Subsequent expenditure

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

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

1.7 Intangible assets

Recognition

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

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

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

● the intention to complete the intangible asset and use it

● the ability to use the intangible asset

● how the intangible asset will generate probable future economic benefits

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

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

Measurement

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

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

1.8 Depreciation, amortisation and impairments

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

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

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

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

1.9 Research and Development

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

1.10 Non-current assets held for sale

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

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

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

1.11 Leases

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

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

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

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

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

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

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

These include:

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

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

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

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

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

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

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

1.11.1 The Trust as lessee

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

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

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

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

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

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

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

1.11.2 The Trust as lessor (where relevant)

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

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

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

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

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

1.12 Inventories

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

1.13 Cash and cash equivalents

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

1.14 Provisions

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

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

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

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

1.14.1 Clinical negligence and personal injury costs

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

1.14.2 Future Liability Scheme (FLS)

General Medical Practice Indemnity (GMPI)

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

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

1.15 Financial Instruments

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

1.16 Financial assets

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

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

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

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

1.16.1 Financial assets are initially recognised at fair value

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

1.16.2 Financial assets at fair value through SoCI

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

1.16.3 Held to maturity investments

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

1.16.4 Available for sale financial assets

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

1.16.5 Loans and receivables

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

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

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

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

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

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

1.16.6 Other financial assets

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

1.17 Financial liabilities

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

1.17.1 Financial liabilities are initially recognised at fair value through SoCI

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

1.17.2 Financial liabilities at fair value through the SoCI

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

1.17.3 Other financial liabilities

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

1.18 Value Added Tax (VAT)

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

1.19 Foreign currencies

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

1.20 Third party assets

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

1.21 Losses and Special Payments

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

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

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

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

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

1.22 Pooled budget

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

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

1.23 Critical Accounting Judgements and key sources of estimation uncertainty

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

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

1.24 Key sources of estimation uncertainty

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

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

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

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

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

Probable & Certain Cases – Accounting Treatment

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

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

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

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

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

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

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

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

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

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

PPO Provisions

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

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

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

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

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

1.26 Discount Rates

Where discount is applied, a disclosure detailing the impact of the discounting on liabilities will be included for the relevant notes. The disclosure should include where possible undiscounted values to demonstrate the impact. An explanation of the source of the discount rate or how the discount rate has been determined will be included.

1.27 Private Finance Initiative (PFI) transactions

The Trust has no PFI arrangements.

1.28 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS Wales organisation. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Remote contingent liabilities are those that are disclosed under Parliamentary reporting requirements and not under IAS 37 and, where practical, an estimate of their financial effect is required.

1.29 Absorption accounting

Transfers of function are accounted for as either by merger or by absorption accounting, dependent upon the treatment prescribed in the FReM. Absorption accounting requires that entities account for their transactions in the period in which they took place with no restatement of performance required.

For transfers of functions involving NHS Wales Trusts in receipt of PDC the double entry for the fixed asset NBV value and the net movement in assets is PDC.

1.30 Accounting standards that have been issued but not yet been adopted

The following accounting standards have been issued and or amended by the IASB and IFRIC but have not been adopted because they are not yet required to be adopted by the FReM:

IFRS14 Regulatory Deferral Accounts - Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable.

IFRS 17 Insurance Contracts, Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.31 Accounting standards issued that have been adopted early

During 2022-2023 there have been no accounting standards that have been adopted early. All early adoption of accounting standards will be led by HM Treasury.

1.32 Charities

Following Treasury's agreement to apply IAS 27 to NHS Charities from 1 April 2013, the Trust has established that as it is the corporate trustee of the Velindre University NHS Trust Charitable Fund it is therefore considered for accounting standards compliance to have control of Velindre University NHS Trust Charitable Fund as a subsidiary, and with the agreement of Welsh Government has made the decision to consolidate the Velindre University NHS Trust Charitable Fund within the statutory accounts of the Trust.

The determination of control is an accounting standard test of control and there has been no change to the operation of the Velindre University NHS Trust Charitable Fund or its independence in its management of charitable funds.

Welsh Government as the ultimate parent of the NHS Wales organisations will disclose the Charitable Accounts in the Welsh Government Consolidated Accounts. Details of the transactions with the charity are included in the related parties notes.

1.33 Subsidiaries

Material entities over which the NHS Wales organisation has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS Wales organisation or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Borrowing costs

Borrowing costs are recognised as expenses as they are incurred.

1.35 Public Dividend Capital (PDC) and PDC dividend

PDC represents taxpayers' equity in the NHS Wales organisation. At any time the Minister for Health and Social Services with the approval of HM Treasury can issue new PDC to, and require repayments of, PDC from the NHS wales organisation. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

From 1 April 2010 the requirement to pay a public dividend over to the Welsh Government ceased.

2. Financial Performance

2.1 STATUTORY FINANCIAL DUTIES

Under the National Health Services (Wales) Act 2006 the financial obligations of the NHS Trust are contained within Schedules 4 2(1) and 4(2).

The Trust is required to achieve financial breakeven over a rolling 3 year period.

Welsh Health Circular WHC/2016/054 replaced WHC/2015/014 'Statutory and Financial Duties of Local Health Boards and NHS Trusts' and further clarifies the statutory financial duties of NHS Wales bodies.

2.1.1 Financial Duty

	Annual financial performance			**2020-21 to 2022-23**
	2020-21 £000	2021-22 £000	2022-23 £000	**Financial duty £000**
Retained surplus / (deficit)	1,222	(203)	76	**1,095**
Less Donated asset / grant funded revenue adjustment	(1,184)	244	0	**(940)**
Adjusted surplus/ (Deficit)	38	41	76	**155**

The Trust has met its financial duty to break even over the 3 years 2020-2021 to 2022-2023.

2.1.2 Integrated Medium Term Plan (IMTP)

The NHS Wales Planning Framework for the period 2022-2025 issued to Trusts placed a requirement upon them to prepare and submit Integrated Medium Term Plans to the Welsh Government.

The Trust submitted an Integrated Medium Term Plan for the period 2022-2025 in accordance with NHS Wales Planning Framework.

Status	**Approved**
Date	13/07/2022

The Trust has therefore met its statutory duty to have an approved financial plan.

2. Financial Performance (cont)

2.2 ADMINISTRATIVE REQUIREMENTS

2.2.1. External financing

The EFL target has been suspended in 2022-23.

2.3. Creditor payment

The Trust is required to pay 95% of the number of non-NHS bills within 30 days of receipt of goods or a valid invoice (whichever is the later). The Trust has achieved the following results:

	2022-23	2021-22
Total number of non-NHS bills paid	**81,328**	72,627
Total number of non-NHS bills paid within target	**77,780**	69,488
Percentage of non-NHS bills paid within target	**95.6%**	95.7%

The Trust has met the target.

3. Revenue from patient care activities	2022-23	2021-22	2022-23	2021-22
	NHS Trust		Consolidated	
	£000	£000	£000	£000
Local health boards	95,698	88,569	95,698	88,569
Welsh Health Specialised & Emergency Ambulance Services Committees (WHSSC & EASC)	52,959	49,172	52,959	49,172
Welsh NHS Trusts	1,494	1,512	1,494	1,512
Welsh Special Health Authorities	2,159	1,465	2,159	1,465
Foundation Trusts	0	0	0	0
Other NHS England bodies	107	107	107	107
Other NHS Bodies	9	1	9	1
Local Authorities	0	0	0	0
Welsh Government	16,250	13,533	16,250	13,533
Welsh Government Welsh Risk Pool Reimbursements			0	
NHS Wales Secondary Health Sector	199,763	424,563	199,763	424,563
NHS Wales Primary Sector Future Liability Scheme Reimbursement	144	93	144	93
NHS Wales Redress	1,503	1,679	1,503	1,679
Other	0	0	0	0
Welsh Government - Hosted Bodies	168,350	153,833	168,350	153,833
Non NHS:				
Private patient income	2,032	2,017	2,032	2,017
Overseas patients (non-reciprocal)	0	0	0	0
Injury Costs Recovery (ICR) Scheme	0	0	0	0
Other revenue from activities	28	164	28	164
Total	540,496	736,708	540,496	736,708

Injury Cost Recovery (ICR) Scheme income:

	2022-23	2021-22
	%	%
To reflect expected rates of collection ICR income is subject to a provision for impairment of:	23.76	23.76

4. Other operating revenue	2022-23	2021-22	2022-23	2021-22
	£000	£000	£000	£000
	NHS Trust		Consolidated	
Income generation	549	842	549	842
Patient transport services	0	0	0	0
Education, training and research	3,877	5,431	3,877	5,431
Charitable and other contributions to expenditure	1,858	3,105	515	314
Incoming FHoT Revenue				
Unrestricted - donations and legacies			4,781	3,066
Restricted - donations and legacies			0	0
Receipt of Covid Items free of charge from other NHS Wales Organisations	0	0	0	0
Receipt of Covid Items free of charge from other organisations	0	0	0	0
Receipt of donations for capital acquisitions	0	0	0	0
Receipt of government grants for capital acquisitions	0	0	0	0
Right of Use Grant (Peppercorn Lease)	0		0	
Non-patient care services to other bodies	931	936	931	936
Right of Use Asset Sub-leasing rental income	0		0	
Rental revenue from finance leases	10	0	10	0
Rental revenue from operating leases	100	133	100	133
Other revenue:				
Provision of pathology/microbiology services	0	0	0	0
Accommodation and catering charges	211	180	211	180
Mortuary fees	0	0	0	0
Staff payments for use of cars	157	103	157	103
Business unit	0	0	0	0
Scheme Pays Reimbursement Notional	(169)	339	(169)	339
Other	409,721	296,022	409,721	296,022
Total	417,245	307,091	420,683	307,366
Total Patient Care and Operating Revenue	957,741	1,043,799	961,179	1,044,074

Other revenue comprises:

NHS Wales Shared Services Partnership	406,288	291,705	406,288	291,705
Other	3,433	4,317	3,433	4,317
Total	409,721	296,022	409,721	296,022

On 1st April 2019 employer pension contributions increased by 6.3%. Welsh Government funded this by making payment directly to the NHS Business Services Agency on the Trust's behalf. The notional income of £14.659m (2021/2022 £11.406m) is reported within the above notes, with further details provided in note 37.1.

5. Operating expenses	2022-23	2021-22	2022-23	2021-22
5.1 Operating expenses	£000	£000	£000	£000
	NHS Trust		Consolidated	
Local Health Boards	**14,484**	11,464	**14,484**	11,464
Welsh NHS Trusts	**18**	23	**18**	23
Welsh Special Health Authorities	**2,021**	1,170	**2,021**	1,170
Goods and services from other non Welsh NHS bodies	**0**	0	**0**	0
WHSSC/EASC	**0**	0	**0**	0
Local Authorities	**3**	0	**3**	0
Purchase of healthcare from non-NHS bodies	**0**	0	**0**	0
Welsh Government	**0**	0	**0**	0
Other NHS Trusts	**508**	514	**508**	514
Directors' costs	**1,420**	1,392	**1,420**	1,392
Operational Staff costs	**171,346**	153,982	**171,346**	153,982
Non operational trainee staff costs	**229,121**	137,379	**229,121**	137,379
Non operational collaborative bank staff costs	**347**	234	**347**	234
Single lead employer Staff Trainee Cost	**2,743**	1,033	**2,743**	1,033
Collaborative Bank Staff Cost	**0**	0	**0**	0
Supplies and services - clinical	**144,992**	136,174	**144,992**	136,174
Supplies and services - general	**83,340**	78,047	**83,340**	78,047
Consultancy Services	**3,950**	4,224	**3,950**	4,224
Establishment	**13,206**	12,383	**13,206**	12,383
Transport	**3,483**	3,160	**3,483**	3,160
Premises	**29,863**	24,771	**29,863**	24,771
FHoT Resources expended				
Costs of generating funds			**654**	157
Charitable activites			**178**	(306)
Governance Costs			**(17)**	(15)
Impairments and Reversals of Receivables	**0**	0	**0**	0
Depreciation	**8,826**	9,110	**8,826**	9,110
Depreciation (RoU Asset)	**1,676**		**1,676**	
Amortisation	**1,358**	1,112	**1,358**	1,112
Impairments and reversals of property, plant and equipment	**1,121**	0	**1,121**	0
Fixed asset impairments and reversals (RoU Assets)	**1,894**		**1,894**	
Impairments and reversals of intangible assets	**348**	0	**348**	0
Impairments and reversals of financial assets	**0**	0	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0	**0**	0
Audit fees	**243**	224	**260**	239
Other auditors' remuneration	**0**	0	**0**	0
Losses, special payments and irrecoverable debts	**227,983**	447,889	**227,983**	447,889
Research and development	**0**	0	**0**	0
NWSSP centrally purchased and donated Covid assets issued free of charge to NHS Wales organisations	**0**	0	**0**	0
NWSSP centrally purchased Covid assets issued free of charge to other organisations	**0**	0	**0**	0
Expense related to short-term leases	**369**		**369**	
Expense related to low-value asset leases (excluding short-term leases)	**60**		**60**	
Other operating expenses	**23,122**	18,650	**23,122**	18,650
Total	**967,845**	1,042,935	**968,677**	1,042,786

On 1st April 2019 employer pension contributions increased by 6.3%. Welsh Government funded this by making payment directly to the NHS Pensions Agency on the Trust's behalf. The notional expenditure of £14.659m (£11.406m 2021/2022) is reported above under the various staff cost headings. Further detail is provided in note 37.1.

Staff costs are split over a number of different headings. Operational staff costs are those staff employed by the Trust and deemed operational within it. Non-operational trainee staff costs are those trainees employed by NWSSP under the All Wales Single Lead Employer Scheme (SLE) on behalf of other NHS Wales organisations, and who are operational within those organisations rather than the Trust. Where NWSSP employ staff under the SLE scheme on behalf of the Trust, these costs are reported as Single Lead Employer Staff Trainee costs. Staff employed under another NWSSP scheme, which commenced in 2020/2021, the All Wales Collaborative Bank, are also identified separately and split between those operational within the Trust and those operational in other NHS Wales organisations. Further analysis of these costs is shown in notes 10.1 and 10.7, with details of average numbers of employees shown in notes 10.2 and 10.8.

Following WG guidance £39,947,860 relating to pharnacy rebates with the other Heath Boards has been restated last year from supplies services - general to supplies and services - clinical to ensure consistency with this years treatment.

5. Operating expenses (continued)

5.2 Losses, special payments and irrecoverable debts:

Charges to operating expenses **Increase/(decrease) in provision for future payments:**	**2022-23** **£000**	2021-22 £000	**2022-23** **£000**	2021-22 £000
	NHS Trust		**Consolidated**	
Clinical negligence;-				
Secondary care	**212,515**	299,158	**212,515**	299,158
Primary care	**567**	92	**567**	92
Redress Secondary Care	**2,365**	951	**2,365**	951
Redress Primary Care	**0**	0	**0**	0
Personal injury	**2,127**	(1,777)	**2,127**	(1,777)
All other losses and special payments	**16,839**	23,441	**16,839**	23,441
Defence legal fees and other administrative costs	**2,744**	2,057	**2,744**	2,057
Structured Settlements Welsh Risk Pool	**(9,174)**	123,967	**(9,174)**	123,967
Gross increase/(decrease) in provision for future payments	**227,983**	447,889	**227,983**	447,889
Contribution to Welsh Risk Pool	**0**	0	**0**	0
Premium for other insurance arrangements	**0**	0	**0**	0
Irrecoverable debts	**0**	0	**0**	0
Less: income received/ due from Welsh Risk Pool	**0**	0	**0**	0
Total charge	**227,983**	447,889	**227,983**	447,889

The Clinical Negligence figure includes £2,149,439 (2021/2022 £1,908,747) in respect of payments made under Redress during 2022/2023. The Redress creditor reduced by £646,000 in 2022/23 compared to a reduction in the creditor movement of £229,000 in 2021/22.

Other losses include stock revaluations of £12.9m and stock losses of £3.6m.

	2022-23 **£**	2021-22 £
Permanent injury included within personal injury:	**0**	0

6. Investment revenue	2022-23	2021-22	2022-23	2021-22
Rental revenue :	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
PFI finance lease revenue:				
Planned	**0**	0	**0**	0
Contingent	**0**	0	**0**	0
Other finance lease revenue	**0**	0	**0**	0
Interest revenue:				
Bank accounts	**1,257**	23	**1,257**	23
Other loans and receivables	**0**	0	**0**	0
Impaired financial assets	**0**	0	**0**	0
Other financial assets	**0**	0	**144**	114
Total	**1,257**	23	**1,401**	137

Interest received in 2022/2023 relates to the Trust's main bank account and an Escrow account established in relation to the build of the new cancer centre.

On 19th March 2020, the interest rate on the Trust's bank accounts was reduced to nil and remained at that rate until 16th December 2021. Interest received in 2021/2022 therefore related to the period 16th December 2021 to 31st March 2022. During 2022/2023 the interest rate remained above nil and therefore interest was received each month at the appropriate rate.

7. Other gains and losses	2022-23	2021-22	2022-23	2021-22
	£000	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Gain/(loss) on disposal of property, plant and equipment	**3**	3	**3**	3
Gain/(loss) on disposal of intangible assets	**0**	0	**0**	0
Gain/(loss) on disposal of assets held for sale	**0**	0	**0**	0
Gain/(loss) on disposal of financial assets	**0**	0	**0**	0
Gains/(loss) on foreign exchange	**0**	0	**0**	0
Change in fair value of financial assets at fair value through income statement	**0**	0	**0**	0
Change in fair value of financial liabilities at fair value through income statement	**0**	0	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0	**0**	0
Total	**3**	3	**3**	3

8. Finance costs	2022-23	2021-22	2022-23	2021-22
	£000	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Interest on loans and overdrafts	**0**	0	**0**	0
Interest on obligations under finance leases	**0**	0	**0**	0
Interest on obligations under Right of Use Leases	**40**		**40**	
Interest on obligations under PFI contracts:				
Main finance cost	**0**	0	**0**	0
Contingent finance cost	**0**	0	**0**	0
Interest on late payment of commercial debt	**0**	0	**0**	0
Other interest expense	**0**	0	**0**	0
Total interest expense	**40**	0	**40**	0
Provisions unwinding of discount	**(4,637)**	(50)	**(4,637)**	(50)
Periodical Payment Order unwinding of discount	**(4,323)**	1,143	**(4,323)**	1,143
Other finance costs	**0**	0	**0**	0
Total	**(8,920)**	**1,093**	**(8,920)**	**1,093**

9. Future change to SoCI/Operating Leases

9.1 Trust as lessee

Operating lease payments represent rentals payable by the Trust for properties and equipment.

	Post Implementation of IFRS 16		Pre implementation of IFRS 16	Post Implementation of IFRS 16		Pre implementation of IFRS 16
	Low Value & Short Term	Other		Low Value & Short Term	Other	
Payments recognised as an expense	**2022-23**	**2022-23**	2021-22	**2022-23**	**2022-23**	2021-22
	£000	**£000**	£000	**£000**	**£000**	£000
		NHS Trust			**Consolidated**	
Minimum lease payments	**429**	**0**	2,276	**429**	**0**	2,276
Contingent rents	**0**	**0**	0	**0**	**0**	0
Sub-lease payments	**0**	**0**	0	**0**	**0**	0
Total	**429**	**0**	2,276	**429**	**0**	2,276

Total future minimum lease payments	**2022-23**	**2022-23**	2021-22	**2022-23**	**2022-23**	2021-22
Payable:	**£000**	**£000**	£000	**£000**	**£000**	£000
		NHS Trust			**Consolidated**	
Not later than one year	**79**	**0**	1,762	**79**	**0**	1,762
Between one and five years	**101**	**0**	2,843	**101**	**0**	2,843
After 5 years	**0**	**0**	570	**0**	**0**	570
Total	**180**	**0**	5,175	**180**	**0**	5,175
Total future sublease payments expected to be received	**0**	**0**	0	**0**	**0**	0

As a result of the implementation of IFRS 16 the current year operating lease figures relate to low value and short term leases only. Previously reported expenditure of £nil and minimum lease payments of £4.8m transitioned to the balance sheet as right of use assets.

9. Future change to SoCI/Operating Leases (continued)

9.2 Trust as lessor

NWSSP continues to lease two areas of Matrix House to commercial entities. It also continues to lease areas of Matrix House to the Welsh Ambulance Services NHS Trust and Public Health Wales NHS Trust for zero consideration.

NWSSP also continues to lease a laboratory area of the IP5 warehouse to Public Health Wales for zero consideration. It also leased an area of the IP5 warehouse to DHSC for the Lighthouse Laboratory, but this arrangement ended during 2022/23.

Velindre Cancer Centre has an ongoing agreement with Cancer Research Wales to lease space in the research block building of Velindre Cancer Centre. Rental income is also received in respect of the staff residence in Whitchurch, Cardiff.

Rental Revenue

	Post Implementation of IFRS 16	Pre implementation of IFRS 16	**Post Implementation of IFRS 16**	Pre implementation of IFRS 16
Receipts recognised as income	**2022-23**	2021-22	**2022-23**	2021-22
	£000	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Rent	**100**	133	**100**	133
Contingent rent	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total rental revenue	**100**	133	**100**	133

Total future minimum lease payments	**2022-23**	2021-22	**2022-23**	2021-22
Receivable:	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Not later than one year	**71**	266	**71**	266
Between one and five years	**97**	691	**97**	691
After 5 years	**0**	414	**0**	414
Total	**168**	1,371	**168**	1,371

10. Employee costs and numbers

10.1 Employee costs Operational Staff	Permanently employed staff	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2022-23 £000	2021-22 £000
	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	**129,105**	**754**	**2,273**	**2,208**	**5,188**	**139,528**	121,600
Social security costs	**12,939**	**0**	**0**	**269**	**223**	**13,431**	12,901
Employer contributions to NHS Pensions Scheme	**23,425**	**0**	**0**	**266**	**343**	**24,034**	23,247
Other pension costs	**48**	**0**	**0**	**0**	**0**	**48**	42
Other post-employment benefits	**0**	**0**	**0**	**0**	**7**	**7**	5
Termination benefits	**83**	**0**	**0**	**0**	**0**	**83**	102
Total	**165,600**	**754**	**2,273**	**2,743**	**5,761**	**177,131**	157,897

Of the total above:		
Charged to capital	**2,231**	1,633
Charged to revenue	**174,900**	156,264
Total	**177,131**	157,897

Net movement in accrued employee benefits (untaken staff leave)	**(25)**	35
Covid 19 - Net movement in accrued employee benefits (untaken staff leave)		538
Non Covid 19 - Net movement in accrued employee benefits (untaken staff leave)		(503)

The majority of staff reported as "other" are individuals working under NWSSP bank arrangements.

10.2 Average number of employees	Permanently Employed	Staff on Inward Secondment	Agency Staff	Specialist Trainee (SLE)	Other Staff	2022-23 Total	2021-22 Total
	Number	Number	Number	Number	Number	Number	Number
Administrative, clerical and board members	**2,029**	**12**	**18**	**0**	**62**	**2,121**	2,029
Medical and dental	**84**	**1**	**0**	**30**	**6**	**121**	117
Nursing, midwifery registered	**208**	**0**	**0**	**0**	**5**	**213**	204
Professional, scientific and technical staff	**77**	**0**	**1**	**0**	**0**	**78**	73
Additional Clinical Services	**232**	**0**	**1**	**0**	**10**	**243**	247
Allied Health Professions	**140**	**0**	**7**	**0**	**0**	**147**	139
Healthcare scientists	**157**	**0**	**1**	**0**	**7**	**165**	153
Estates and Ancillary	**524**	**0**	**36**	**0**	**65**	**625**	641
Students	**3**	**0**	**0**	**0**	**2**	**5**	3
Total	**3,454**	**13**	**64**	**30**	**157**	**3,718**	3,606

The average number is calculated using the full time equivalent (FTE) of employees.

10.3. Retirements due to ill-health	2022-23	2021-22
Number		
Estimated additional pension costs £		

Please see note 10.9 for information relating to both operational and non operational staff. The information is supplied by the NHS Pensions Agency and is not split at source.

10.4 Employee benefits

The Trust operates four salary sacrifice schemes (childcare vouchers, cycle to work, home electronics and lease cars) for the financial benefit of its employees. In addition, staff have access to a non contributory Employee Assistance Programme which provides financial wellbeing support; a financial wellbeing scheme to provide staff with access to simple financial education; salary deducted loans, and a range of savings and investment products. In 2022-2023 the Trust launched a health cash plan where staff can claim money back on everyday healthcare costs. It also provided a summer childcare subsidy scheme in 2022-2023 and a purchase of annual leave scheme.

10.5 Reporting of other compensation schemes - exit packages

Exit packages cost band (including any special payment element)	2022-23 Number of compulsory redundancies Whole numbers only	2022-23 Number of other departures Whole numbers only	2022-23 Total number of exit packages Whole numbers only	2022-23 Number of departures where special payments have been made Whole numbers only	2021-22 Total number of exit packages Whole numbers only
less than £10,000	0	1	**1**	1	0
£10,000 to £25,000	1	0	**1**	0	0
£25,000 to £50,000	0	2	**2**	2	1
£50,000 to £100,000	0	0	**0**	0	1
£100,000 to £150,000	0	0	**0**	0	0
£150,000 to £200,000	0	0	**0**	0	0
more than £200,000	0	0	**0**	0	0
Total	**1**	**3**	**4**	**3**	**2**

Exit packages cost band (including any special payment element)	2022-23 Cost of compulsory redundancies £	2022-23 Cost of other departures £	2022-23 Total cost of exit packages £	2022-23 Cost of special element included in exit packages £	2021-22 Total cost of exit packages £
less than £10,000	0	3,178	**3,178**	3,178	0
£10,000 to £25,000	21,567	0	**21,567**	0	0
£25,000 to £50,000	0	58,284	**58,284**	58,284	25,899
£50,000 to £100,000	0	0	**0**	0	75,874
£100,000 to £150,000	0	0	**0**	0	0
£150,000 to £200,000	0	0	**0**	0	0
more than £200,000	0	0	**0**	0	0
Total	**21,567**	**61,462**	**83,029**	**61,462**	**101,773**

Exit costs paid in year of departure	Total paid in year 2022-23 £	Total paid in year 2021-22 £
Exit costs paid in year	**158,903**	25,899
Total	**158,903**	**25,899**

Redundancy and other departure costs have been paid in accordance with the provisions of the relevant schemes or legislation. Where the Trust has agreed early retirements or compulsory redundancies, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table (see notes 10.3 & 10.9 for details of ill health retirement costs).

The disclosure reports the number and value of exit packages agreed in the year in line with the Welsh Government manual for accounts. The values payable to the individuals are shown. Any on costs are excluded as they do not form part of the payment to the individual.

There were 3 special payments agreed in 2022/2023 (2021/2022 nil).

The maximum payment made during 2022/23 was £30,081, the lowest payment made during 2022/23 was £3,178, with the median payment being £24,885

10.6 Fair Pay disclosures

10.6.1 Remuneration Relationship

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

Total pay and benefits	2022-23 £000 Chief Executive	2022-23 £000 Employee	2022-23 Ratio	2021-22 £000 Chief Executive	2021-22 £000 Employee	2021-22 Ratio
25th percentile pay ratio	**152.0**	**24.0**	**6.3**	147.5	22.0	6.7
Median pay	**152.0**	**29.0**	**5.2**	147.5	26.4	5.6
75th percentile pay ratio	**152.0**	**44.0**	**3.5**	147.5	40.3	3.7
Salary component of total pay and benefits						
25th percentile pay ratio	**152.0**	**24.0**		147.5	21.8	
Median pay	**152.0**	**27.0**		147.5	24.9	
75th percentile pay ratio	**152.0**	**42.0**		147.5	40.1	

In 2022-23, 11 (2021-2022, 8) employees received remuneration in excess of the highest-paid Chief Executive.

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

The all staff range includes directors (including the highest paid director) and excludes pension benefits of all employees. As the Highest Paid Director has no control over the performance of the Trust, the information in the lower half of the table has not been included.

Financial year summary

The current financial year's pay ratios are not dissimilar to the previous year. The decrease in the median pay ratio is generally attributable to an increase in the banding of the remuneration of the Chief Executive.

10.6.2 Percentage Changes	2021-22 to 2022-23	2020-21 to 2021-22
% Change from previous financial year in respect of Chief Executive	**%**	%
Salary and allowances	**3.4**	3.5
Performance pay and bonuses	**0**	0
% Change from previous financial year in respect of highest paid director		
Salary and allowances		
Performance pay and bonuses		
Average % Change from previous financial year in respect of employees taken as a whole		
Salary and allowances	**9.1**	-5.6
Performance pay and bonuses	**0**	0

The average % change from the previous financial year in respect of employees taken as a whole has increased primarily due to an increase in the sum of allowances paid.

The employees of the Trust do not receive any performance pay or bonuses.

10.7 Operational and Non Operational Employee costs

	Operational Staff Total	Non operational staff: SLE Trainee Staff	Non operational staff: Collaborative Bank Staff	Total 2022-23	2021-22
	£000	£000	£000	**£000**	£000
Salaries and wages	139,528	183,298	298	**323,124**	231,027
Social security costs	13,431	22,249	19	**35,699**	25,622
Employer contributions to NHS Pension Scheme	24,034	24,054	30	**48,118**	38,712
Other pension costs	48	0	0	**48**	42
Other employment benefits	7	0	0	**7**	5
Termination benefits	83	0	0	**83**	102
Total	177,131	229,601	347	**407,079**	295,510
Charged to capital	2,231	0	0	**2,231**	1,633
Charged to revenue	174,900	229,601	347	**404,848**	293,877
	177,131	229,601	347	**407,079**	**295,510**
Net movement in accrued employee benefits (untaken staff leave)	**(25)**	**0**	**0**	**(25)**	35
Covid 19 - Net movement in accrued employee benefits (untaken staff leave)					538
Non Covid 19 - Net movement in accrued employee benefits (untaken staff leave)					(503)

10.8 Average number of operational and non operational employees

	Operational Staff Total Number	Non operational staff: SLE Trainee Staff Number	Non operational staff: Collaborative Bank Staff Number	Total 2022-23 Number	2021-22 Number
Administrative, clerical and board members	2,121	0	0	**2,121**	2,029
Medical and dental	121	2,979	0	**3,100**	2,131
Nursing, midwifery registered	213	0	6	**219**	209
Professional, Scientific, and technical staff	78	0	0	**78**	73
Additional Clinical Services	243	113	0	**356**	368
Allied Health Professions	147	0	0	**147**	139
Healthcare Scientists	165	0	0	**165**	153
Estates and Ancillary	625	0	0	**625**	641
Students	5	0	0	**5**	3
Total	**3,718**	3,092	6	**6,816**	**5,746**

10.9. Retirements due to ill-health

	2022-23	2021-22
Number	3	5
Estimated additional pension costs £	189,690	310,700

Information received from the NHS Pensions Agency does not provide detail on whether the retirements related to operational or non operational staff.

10.10 Employee benefits

The Single Lead Employer Trainees are entitled to the same employee benefits as the Velindre operational staff.

10.11 Reporting of other compensation schemes - exit packages

There have been no exit package payments for the Single Lead Employer Trainee staff, therefore the figures reported in Note 10.5 remain unchanged.

11. Pensions

PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

c) National Employment Savings Trust (NEST)

NEST is a workplace pension scheme, which was set up by legislation and is treated as a trust-based scheme. The Trustee responsible for running the scheme is NEST Corporation. It's a non-departmental public body (NDPB) that operates at arm's length from government and is accountable to Parliament through the Department for Work and Pensions (DWP).

NEST Corporation has agreed a loan with the Department for Work and Pensions (DWP). This has paid for the scheme to be set up and will cover expected shortfalls in scheme costs during the earlier years while membership is growing.

NEST Corporation aims for the scheme to become self-financing while providing consistently low charges to members.

Using qualifying earnings to calculate contributions, currently the legal minimum level of contributions is 8% of a jobholder's qualifying earnings, for employers whose legal duties have started. The employer must pay at least 3% of this.

The earnings band used to calculate minimum contributions under existing legislation is called qualifying earnings. Qualifying earnings are currently those between £6,240 and £50,270 for the 2022-2023 tax year (2021-2022 £6,240 and £50,000).

Restrictions on the annual contribution limits were removed on 1st April 2017.

12. Public Sector Payment Policy

12.1 Prompt payment code - measure of compliance

The Welsh Government requires that trusts pay all their trade creditors in accordance with the CBI prompt payment code and Government Accounting rules. The Welsh Government has set as part of the trust financial targets a requirement to pay 95% of the number of non-NHS creditors within 30 days of delivery or receipt of a valid invoice, whichever is the later.

	2022-23 Number	**2022-23 £000**	2021-22 Number	2021-22 £000
NHS				
Total bills paid in year	**2,622**	**109,896**	2,635	90,939
Total bills paid within target	**2,272**	**104,135**	2,388	81,381
Percentage of bills paid within target	**86.7%**	**94.8%**	90.6%	89.5%
Non-NHS				
Total bills paid in year	**81,328**	**365,417**	72,627	279,961
Total bills paid within target	**77,780**	**343,678**	69,488	270,196
Percentage of bills paid within target	**95.6%**	**94.1%**	95.7%	96.5%
Total				
Total bills paid in year	**83,950**	**475,313**	75,262	370,900
Total bills paid within target	**80,052**	**447,813**	71,876	351,577
Percentage of bills paid within target	**95.4%**	**94.2%**	95.5%	94.8%

12.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2022-23 £	2021-22 £
Amounts included within finance costs from claims made under legislation	**0**	0
Compensation paid to cover debt recovery costs under legislation	**0**	0
Total	**0**	0

13. Property, plant and equipment :

2022-23	Land	Buildings, excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport Equipment	Information Technology	Furniture and fittings	Total	FHoT	Consolidated Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost at 31 March bf	17,756	84,488	283	29,664	43,408	7,910	21,208	1,866	206,583	0	206,583
NHS Wales Transfers	0	0	0	0	0	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset N	0	(12,133)	0	0	0	0	0	0	(12,133)	0	(12,133)
At 1 April 2022	17,756	72,355	283	29,664	43,408	7,910	21,208	1,866	194,450	0	194,450
Indexation	(327)	3,696	12	0	0	0	0	0	3,381	0	3,381
Additions - purchased	0	3,056	0	17,823	4,983	686	1,915	293	28,756	0	28,756
Additions - donated	0	0	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0	0	0
Reclassifications	1,400	(1,400)	0	0	113	0	0	0	113	0	113
Revaluation	2,629	(10,314)	(23)	0	0	0	0	0	(7,708)	0	(7,708)
Reversal of impairments	0	0	0	0	0	0	0	0	0	0	0
Impairments	0	(1,121)	0	0	0	0	0	0	(1,121)	0	(1,121)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,729)	(92)	(1,685)	0	(3,506)	0	(3,506)
At 31 March 2023	21,458	66,272	272	47,487	46,775	8,504	21,438	2,159	214,365	0	214,365
Depreciation											
Depreciation at 31 March bf	0	14,970	46	0	28,863	3,960	14,542	1,066	63,447	0	63,447
NHS Wales Transfers	0	0	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset N	0	(910)	0	0	0	0	0	0	(910)	0	(910)
At 1 April 2022	0	14,060	46	0	28,863	3,960	14,542	1,066	62,537	0	62,537
Indexation	0	508	0	0	0	0	0	0	508	0	508
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	45	0	0	0	45	0	45
Revaluation	0	(9,615)	(46)	0	0	0	0	0	(9,661)	0	(9,661)
Reversal of impairments	0	0	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,729)	(92)	(1,684)	0	(3,505)	0	(3,505)
Charged during the year	0	2,829	10	0	2,951	895	1,994	147	8,826	0	8,826
At 31 March 2023	0	7,782	10	0	30,130	4,763	14,852	1,213	58,750	0	58,750
Net book value											
At 1 April 2022	17,756	58,295	237	29,664	14,545	3,950	6,666	800	131,913	0	131,913
Net book value											
At 31 March 2023	21,458	58,490	262	47,487	16,645	3,741	6,586	946	155,615	0	155,615
Net book value at 31 March 2023 comprises :											
Purchased	21,458	53,473	262	47,487	16,615	3,741	6,583	946	150,565	0	150,565
Donated	0	5,017	0	0	30	0	3	0	5,050	0	5,050
Government Granted	0	0	0	0	0	0	0	0	0	0	0
At 31 March 2023	21,458	58,490	262	47,487	16,645	3,741	6,586	946	155,615	0	155,615
Asset Financing:											
Owned	21,458	58,490	262	47,487	16,645	3,741	6,586	946	155,615	0	155,615
Held on finance lease	0	0	0	0	0	0	0	0	0	0	0
On-SoFP PFI contract	0	0	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0	0	0
At 31 March 2023	21,458	58,490	262	47,487	16,645	3,741	6,586	946	155,615	0	155,615

The net book value of land, buildings and dwellings at 31 March 2023 comprises :

	£000	£000	£000
Freehold	67,948	0	67,948
Long Leasehold	12,165	0	12,165
Short Leasehold	0	0	0
Total	80,113	0	80,113

Valuers 'material uncertainty', in valuation.	0	0	**0**

The disclosure relates to the materiality in the valuation report not that of the underlying account.

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. Trusts are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

13. Property, plant and equipment :

2021-22	Land	Buildings, excluding dwellings	Dwellings	Assets under construtction and payments on account	Plant & machinery	Transport Equipment	Information Technology	Furniture and fittings	Total	FHoT	Consolidated Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost at 31 March bf	17,463	72,876	270	23,315	36,743	6,409	42,072	1864	201,012	0	201,012
NHS Wales Transfers	0	(1,428)	0	(29)	(172)	(9)	(23,047)	-5	(24,690)	0	(24,690)
Prepayments	0	0	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note											
At 1 April 2021	17,463	71,448	270	23,286	36,571	6,400	19,025	1,859	176,322	0	176,322
Indexation	214	3,333	13	0	0	0	0	0	3,560	0	3,560
Additions - purchased	0	8,628	0	8,459	2,500	1,502	2,171	7	23,267	0	23,267
Additions - donated	0	0	0	0	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	79	1,077	0	0	5,933	70	31	0	7,190	0	7,190
Reclassifications	0	2	0	(2,081)	0	0	0	0	(2,079)	0	(2,079)
Revaluation	0	0	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,596)	(62)	(19)	0	(1,677)	0	(1,677)
At 31 March 2022	17,756	84,488	283	29,664	43,408	7,910	21,208	1,866	206,583	0	206,583
Depreciation											
At 1 April 2021	0	10,950	36	0	23,936	3,288	12,562	889	51,661	0	51,661
Indexation	0	485	1	0	0	0	0	0	486	0	486
Transfers from/(into) other NHS bodies	0	415	0	0	3,322	70	29	0	3,836	0	3,836
Reclassifications	0	0	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(1,565)	(62)	(19)	0	(1,646)	0	(1,646)
Charged during the year	0	3,120	9	0	3,170	664	1,970	177	9,110	0	9,110
At 31 March 2022	0	14,970	46	0	28,863	3,960	14,542	1,066	63,447	0	63,447
Net book value											
At 1 April 2021	17,463	60,498	234	23,286	12,635	3,112	6,463	970	124,661	0	124,661
Net book value											
At 31 March 2022	17,756	69,518	237	29,664	14,545	3,950	6,666	800	143,136	0	143,136
Net book value at 31 March 2022 comprises :											
Purchased	17,756	65,002	237	29,664	14,496	3,950	6,660	800	138,565	0	138,565
Donated	0	4,516	0	0	49	0	6	0	4,571	0	4,571
Government Granted	0	0	0	0	0	0	0	0	0	0	0
At 31 March 2022	17,756	69,518	237	29,664	14,545	3,950	6,666	800	143,136	0	143,136
Asset Financing:											
Owned	17,756	69,518	237	29,664	14,545	3,950	6,666	800	143,136	0	143,136
Held on finance lease	0	0	0	0	0	0	0	0	0	0	0
On-SoFP PFI contract	0	0	0	0	0	0	0	0	0	0	0
PFI residual interest	0	0	0	0	0	0	0	0	0	0	0
At 31 March 2022	17,756	69,518	237	29,664	14,545	3,950	6,666	800	143,136	0	143,136

The net book value of land, buildings and dwellings at 31 March 2022 comprises :

	£000	£000	£000
Freehold	66,047	0	66,047
Long Leasehold	21,464	0	21,464
Short Leasehold	0	0	0
Total	87,511	0	87,511
Valuers 'material uncertainty', in valuation.	0	0	0

The disclosure relates to the materiality in the valuation report not that of the underlying account.

The land and buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2017. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards. LHB s are required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in occupation.

13. Property, plant and equipment :

Disclosures:

i) Donated Assets
The Trust received no donated assets during the financial year 2022-23.

ii) Valuations
The Trust's land and Buildings were revalued by the Valuation Office Agency with an effective date of 1st April 2022. The valuation has been prepared in accordance with the terms of the latest version of the Royal Institute of Chartered Surveyors' Valuation Standards.

The Trust is required to apply the revaluation model set out in IAS 16 and value its capital assets to fair value. Fair value is defined by IAS 16 as the amount for which an asset could be exchanged between knowledgeable, willing parties in an arms length transaction. This has been undertaken on the assumption that the property is sold as part of the continuing enterprise in operation.

The next District Valuation is due to take place during 2027-2028.

iii) Asset Lives
Depreciated as follows:
- Land is not depreciated.
- Buildings as determined by the Valuation Office Agency.
- Equipment 5-15 years.

iv) Compensation
There has been no compensation received from third parties for assets impaired, lost or given up, that is included in the income statement.

v) Write Downs
Impairments and revaluations are shown in the body of note 13.

vi) The Trust does not hold any property where the value is materially different from its open market value.

vii) Assets Held for Sale or Sold in the Period
The Trust does not hold any assets for sale at the end of the financial year.

vii) Consultancy Services
The Trust capitalised a total of £827k of consultancy services during the financial year (including £773k related to the new hospital project and £48k to NWSSP).

Gain/(Loss) on Sale

Asset description	Reason for sale	Gain/(Loss) on sale £000
Van	Insurance write-off	**3**
		3

13.2 Non-current assets held for sale

	Land	Buildings, including dwellings	Other property plant and equipment	Intangible assets	Other assets	Total	FHoT assets	Consolidated Total
	£000	£000	£000	£000	£000	£000	£000	£000
Balance b/f 1 April 2022	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Plus assets classified as held for sale in year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less assets sold in year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Plus reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less impairment for assets held for sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Less assets no longer classified as held for sale for reasons other than disposal by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance c/f 31 March 2023	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance b/f 1 April 2021	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in year	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0
Less assets sold in year	0	0	0	0	0	0	0	0
Plus reversal of impairments	0	0	0	0	0	0	0	0
Less impairment for assets held for sale	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale for reasons other than disposal by sale	0	0	0	0	0	0	0	0
Balance c/f 31 March 2022	0	0	0	0	0	0	0	0

13.3 Right of Use Assets

The organisation's right of use asset leases are disclosed across the relevant headings below. Most are individually insignificant, however, the following are significant in their own right, all included in Land & Buildings:

	NBV at 31/03/2023
NWSSP Unit IP5 Imperial Park, Newport	£8,162,000
NWSSP Greenvale Laundry, Llanfrechfa	£2,460,000
NWSSP Alder House, St Asaph,	£1,176,000
NWSSP Bridgend Stores, Bridgend	£507,000
NWSSP Surgical Materials Testing Laboratory, Bridgend	£562,000
NWSSP Companies House, 4th floor	£275,000
NWSSP Unit 25 Samlet Road, Swansea	£245,000
NWSSP Glan Clwyd Laundry, Rhyl	£234,000

2022-23	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000	FHoT Assets £000	Consolidated Total £000
Cost or valuation at 31 March	0	0	0	0	0	0	0	0	**0**	0	**0**
Lease prepayments in relation to RoU Assets	0	0	0	0	0	0	0	0	**0**	0	**0**
Transfer of Finance Leases from PPE Note	0	12,133	0	0	0	0	0	0	**12,133**	0	**12,133**
Operating Leases Transitioning	0	7,439	0	0	595	24	0	0	**8,058**	0	**8,058**
Cost or valuation at 1 April	**0**	**19,572**	**0**	**0**	**595**	**24**	**0**	**0**	20,191	**0**	20,191
Additions	0	98	0	0	8	0	0	0	**106**	0	**106**
Transfer from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**	0	**0**
Impairments	0	-3,816	0	0	0	0	0	0	**-3,816**	0	**-3,816**
De-recognition	0	0	0	0	0	0	0	0	**0**	0	**0**
At 31 March	**0**	**15,854**	**0**	**0**	**603**	**24**	**0**	**0**	16,481	**0**	16,481
Depreciation at 31 March	0	0	0	0	0	0	0	0	**0**	0	**0**
Transfer of Finance Leases from PPE Note	0	910	0	0	0	0	0	0	**910**	0	**910**
Operating Leases Transitioning	0	0	0	0	0	0	0	0	**0**	0	**0**
Depreciation at 1 April	**0**	**910**	**0**	**0**	**0**	**0**	**0**	**0**	910	**0**	910
Recognition	0	0	0	0	0	0	0	0	**0**	0	**0**
Transfers from/into other NHS bodies	0	0	0	0	0	0	0	0	**0**	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**	0	**0**
Revaluations	0	0	0	0	0	0	0	0	**0**	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**	0	**0**
Impairments	0	-910	0	0	0	0	0	0	**-910**	0	**-910**
De-recognition	0	0	0	0	0	0	0	0	**0**	0	**0**
Provided during the year	0	1,497	0	0	169	12	0	0	**1,678**	0	**1,678**
At 31 March	**0**	**1,497**	**0**	**0**	**169**	**12**	**0**	**0**	1,678	**0**	1,678
Net book value at 1 April	**0**	**18,662**	**0**	**0**	**595**	**24**	**0**	**0**	19,281	**0**	19,281
Net book value at 31 March	**0**	**14,357**	**0**	**0**	**434**	**12**	**0**	**0**	14,803	**0**	14,803

	Land £000	Land & buildings £000	Buildings £000	Dwellings £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000	FHoT Assets £000	Consolidated Total £000
RoU Asset Total Value Split by Lessor											
NHS Wales Peppercorn Leases	0	3,281	0	0	0	0	0	0	**3,281**	0	**3,281**
NHS Wales Market Value Leases	0	482	0	0	0	0	0	0	**482**	0	**482**
Other Public Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**	0	**0**
Other Public Sector Market Value Leases	0	440	0	0	0	0	0	0	**440**	0	**440**
Private Sector Peppercorn Leases	0	0	0	0	0	0	0	0	**0**	0	**0**
Private Sector Market Value Leases	0	10,154	0	0	434	12	0	0	**10,600**	0	**10,600**
Total	**0**	**14,357**	**0**	**0**	**434**	**12**	**0**	**0**	14,803	**0**	14,803

13.3 Right of Use Assets

Quantitative disclosures

Maturity analysis **Contractual undiscounted cash flows relating to lease liabilities**	**£000**
Less than 1 year	1,148
2-5 years	1,819
> 5 years	687
Total	**3,654**

Lease Liabilities (net of irrecoverable VAT)	**£000**
Current	1,123
Non-Current	2,420
Total	**3,543**

Amounts Recognised in Statement of Comprehensive Net Expenditure	**£000**
Depreciation	1,676
Impairment	1,894
Variable lease payments not included in lease liabilities - Interest expense	40
Sub-leasing income	0
Expense related to short-term leases	369
Expense related to low-value asset leases (excluding short-term leases)	60

Amounts Recognised in Statement of Cashflows (net of irrecoverable VAT)	**£000**
Interest expense	40
Repayments of principal on leases	1,366
Total	**1,406**

14. Intangible assets

	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Assets under Construction	Total	FHoT	Consolidated Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 31 March bf	7,907	4,321	1,342	0	0	0	13,570	0	13,570
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
At 1 April 2022	7,907	4,321	1,342	0	0	0	13,570	0	13,570
Revaluation		0			0	0	0	0	0
Reclassifications	(113)	0	0	0	0	0	(113)	0	(113)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	(348)	0	0	0	0	0	(348)	0	(348)
Additions									
- purchased	1,934	581	1,786	0	0	0	4,301	0	4,301
- internally generated	0	0	0	0	0	0	0	0	0
- donated	0	0	0	0	0	0	0	0	0
- government granted	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	(354)	0	(196)	0	0	0	(550)	0	(550)
At 31 March 2023	9,026	4,902	2,932	0	0	0	16,860	0	16,860
Amortisation									
Amortisation at 31 March bf	3,304	343	1,256	0	0	0	4,903	0	4,903
NHS Wales Transfers	0	0	0	0	0	0	0	0	0
Transfer of Finance Leases to ROU Asset N	0	0	0	0	0	0	0	0	0
At 1 April 2022	3,304	343	1,256	0	0	0	4,903	0	4,903
Revaluation		0			0	0	0	0	0
Reclassifications	(45)	0	0	0	0	0	(45)	0	(45)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Charged during the year	1,043	249	66	0	0	0	1,358	0	1,358
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	0
Disposals other than by sale	(354)	0	(196)	0	0	0	(550)	0	(550)
Accumulated amortisation at 31 March 2023	3,948	592	1,126	0	0	0	5,666	0	5,666
Net book value At 1 April 2022	4,603	3,978	86	0	0	0	8,667	0	8,667
Net book value At 31 March 2023	5,078	4,310	1,806	0	0	0	11,194	0	11,194
Net book value									
Purchased	5,076	4,310	1,806	0	0	0	11,192	0	11,192
Donated	2	0	0	0	0	0	2	0	2
Government granted	0	0	0	0	0	0	0	0	0
Internally Generated	0	0	0	0	0	0	0	0	0
At 31 March 2023	5,078	4,310	1,806	0	0	0	11,194	0	11,194

14. Intangible assets

	Computer software purchased	Computer software internally developed	Licenses and trade-marks	Patents	Development expenditure internally generated	Assets under Construction	Total	FHoT	Consolidated Total
Cost or valuation	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 31 March bf	42,122	6,710	4,658	0	0	0	53,490	0	53,490
NHS Wales Transfers	(37,352)	(4,183)	(3,319)	0	0	0	(44,854)	0	(44,854)
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	0
At 1 April 2021	**4,770**	**2,527**	**1,339**	**0**	**0**	**0**	**8,636**	**0**	**8,636**
Revaluation		0			0	0	0	0	**0**
Reclassifications	1,340	739	0	0	0	0	2,079	0	**2,079**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Additions									
- purchased	1,797	1,055	3	0	0	0	2,855	0	**2,855**
- internally generated	0	0	0	0	0	0	0	0	**0**
- donated	0	0	0	0	0	0	0	0	**0**
- government granted	0	0	0	0	0	0	0	0	**0**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
At 31 March 2022	7,907	4,321	1,342	0	0	0	13,570	0	**13,570**
Amortisation									
Amortisation at 31 March bf	26,793	1,759	4,117	0	0	0	32,669	0	**32,669**
NHS Wales Transfers	(24,344)	(1,528)	(3,006)	0	0	0	(28,878)	0	**(28,878)**
Transfer of Finance Leases to ROU Asset Note	0	0	0	0	0	0	0	0	**0**
At 1 April 2021	**2,449**	**231**	**1,111**	**0**	**0**	**0**	**3,791**	**0**	**3,791**
Revaluation		0			0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	0	0	0	**0**
Charged during the year	855	112	145	0	0	0	1,112	0	**1,112**
Reclassified as held for sale	0	0	0	0	0	0	0	0	**0**
Transfers from/(into) other NHS bodies	0	0	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	0	0	**0**
Accumulated amortisation at 31 March 2022	**3,304**	**343**	**1,256**	**0**	**0**	**0**	**4,903**	**0**	**4,903**
Net book value At 1 April 2021	**2,321**	**2,296**	**228**	**0**	**0**	**0**	**4,845**	**0**	**4,845**
Net book value At 31 March 2022	**4,603**	**3,978**	**86**	**0**	**0**	**0**	**8,667**	**0**	**8,667**
Net book value									
Purchased	4,599	3,978	86	0	0	0	8,663	0	**8,663**
Donated	4	0	0	0	0	0	4	0	**4**
Government granted	0	0	0	0	0	0	0	0	**0**
Internally Generated	0	0	0	0	0	0	0	0	**0**
At 31 March 2022	**4,603**	**3,978**	**86**	**0**	**0**	**0**	**8,667**	**0**	**8,667**

14. Intangible assets

Disclosures:

i) Donated Assets
There were no intangible assets donated or received by Government Grant this financial year.

ii) Recognition
Intangible assets comprise of licences for use of purchased IT software such as financial systems, internally generated IT software and various licences and trade marks.

An assessment is performed on an annual basis to determine that the assets are still available for use and that there is a continued market for their use. The fair values are based on the original cost and amortised based upon finite lives detailed below, and are as detailed in the notes to the accounts.

Intangible assets acquired separately are initially recognised at fair value. The amount recognised for internally-generated intangible assets is the sum of the expenditure incurred to date when the criteria for recognising internally generated assets has been met (see accounting policy 1.7 for criteria).

iii) Asset Lives
The useful economic life (UEL) of intangible non-current assets are assigned on an individual asset basis. Software is generally assigned a 5 year UEL and the UEL of internally generated software is based on the professional judgement of Trust professionals and Finance staff. No intangible assets are assessed as having indefinite useful lives.

iv) Additions During the Period
Intangible additions were acquired from All Wales & Discretionary funding during the year, and have been analysed into the relevant categories.

v) Disposals During the Period
The Trust disposed of some software and licences during the year, all of which had net book values of nil.

15. Impairments

Impairments in the period arose from:	2022-23 Property, plant & equipment £000	2022-23 Right of Use Assets £000	2022-23 Intangible assets £000	2021-22 Property, plant & equipment £000	2021-22 Right of Use Assets £000	2021-22 Intangible assets £000
Loss or damage from normal operations	**0**	**0**	**0**	0		0
Abandonment of assets in the course of construction	**996**	**0**	**348**	0		0
Over specification of assets (Gold Plating)	**0**	**0**	**0**	0		0
Loss as a result of a catastrophe	**0**	**0**	**0**	0		0
Unforeseen obsolescence	**0**	**0**	**0**	0		0
Changes in market price	**125**	**1,894**	**0**	0		0
Other	**0**	**0**	**0**	0		0
Reversal of impairment	**0**	**0**	**0**	0		0
Impairments charged to operating expenses	**1,121**	**1,894**	**348**	0		0
FHoT Impairments charged to operating expenses	**0**	**0**	**0**	0		0
Consolidated impairment charged to operating expenses	**1,121**	**1,894**	**348**	**0**		**0**
Analysis of impairments :						
Operating expenses in Statement of Comprehensive Income	**1,121**	**1,894**	**348**	0		0
Revaluation reserve	**0**	**1,010**	**0**	0		0
Total	**1,121**	**2,904**	**348**	0		0
FHoT Operating expenses in SoCNI	**0**	**0**	**0**	0		0
FHoT reserves	**0**	**0**	**0**	0		0
NHS Consolidated Total	**1,121**	**2,904**	**348**	0		0

£0.995m relates to exploratory costs for the All Wales Laundry capital scheme to reach OBC stage, which has now been abandoned following Welsh Government confirmation that there is insufficient capital funding for the programme to proceed as planned. £0.348m relates to the abandonment of a capital project due to a supplier issue which is progressing to legal proceedings. £1.894m is in respect of the impairment of the IP5 warehouse to the value in the District Valuer quinquennial report following the transfer to a Right of Use Asset under IFRS16 and £0.125m impairment is reported for Matrix House as a result of the District Valuer quinquennial valuation.

16. Inventories

16.1 Inventories

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Drugs	**3,384**	2,217	**3,384**	2,217
Consumables	**24,962**	57,422	**24,962**	57,422
Energy	**0**	0	**0**	0
Work in progress	**0**	0	**0**	0
Other	**5,724**	5,568	**5,724**	5,568
Total	**34,070**	65,207	**34,070**	65,207
Of which held at net realisable value:	**13,011**	2,290	**13,011**	2,290

DH Assets within other covered under	31 March 2023 Capital £000	31 March 2023 Revenue £000	31 March 2022 Capital £000	31 March 2022 Revenue £000
Memorandum of Understanding 1	**0**	**0**	227	0
Memorandum of Understanding 2	**0**	**0**	0	0
Memorandum of Understanding 3	**0**	**0**	0	0
	0	**0**	227	0

Department of Health and Social Care and National Health Commissioning Board Donated Assets

	31 March 2023 Capital £000	31 March 2023 Revenue £000	31 March 2022 Capital £000	31 March 2022 Revenue £000
At 1 April	**227**	**0**	561	544
Transferred under Memorandum of Understanding 1	**0**	**0**	0	0
Transferred under Memorandum of Understanding 2	**0**	**0**	730	86
Transferred under Memorandum of Understanding 3	**0**	**0**	1,491	0
Issued to NHS Wales bodies	**0**	**0**	(2,234)	(317)
Other Issues	**0**	**0**	(321)	(313)
AME Impairment	**0**	**0**	0	0
Returned to DH	**0**	**0**	0	0
Replacement from DH	**0**	**0**	0	0
As at 31 March	**227**	**0**	227	0

16.2 Inventories recognised in expenses

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Inventories recognised as an expense in the period	**128,716**	173,686	**128,716**	173,686
Write-down of inventories (including losses)	**19,091**	13,066	**19,091**	13,066
Reversal of write-downs that reduced the expense	**0**	0	**0**	0
Total	**147,807**	186,752	**147,807**	186,752

Of the stock balance at 31st March 2023, £13.672m relates to Covid PPE and Testing stock with the continued Welsh Government request to hold 16 weeks of PPE to provide resilience in the event of any additional Covid waves.

Due to the expansion of the NWSSP Medicines Unit during 2022/23, the stock balance now includes £1.070m of drugs stock at 31st March 2023.

£0.283m of Covid equipment stock is held at 31st March 2023, of which £0.227m was donated from DHSC in 2020/21.

The continued high value of inventories recognised as an expense in the period is reported due to (a) the quantities of PPE that have been issued from NWSSP stores during 2022/23, however this is a reduction on the 2021/22 values and (b) NICE and high cost drug purchases made by VCS in 2022/2023.

Included in the write down of inventories is a loss of £12.858m in respect of the revaluation of PPE stocks to net realisable value, in addition to the write off of £3.604m of either faulty stock or stock of no value to NHS Wales which is held for a potential donation to Africa, and £2.396m of provisions for the potential write off of items nearing their expiry date that are unlikely to be utilised given the current stock issue rates.

17. Trade and other receivables

17.1 Trade and other receivables

Current	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Welsh Government	**525,653**	457,058	**525,653**	457,058
WHSSC & EASC	**(1,754)**	81	**(1,754)**	81
Welsh Health Boards	**14,735**	15,859	**14,735**	15,859
Welsh NHS Trusts	**1,839**	710	**1,839**	710
Welsh Special Health Authorities	**2,626**	2,911	**2,626**	2,911
Non - Welsh Trusts	**118**	160	**118**	160
Other NHS	**219**	141	**219**	141
2019-20 Scheme Pays - Welsh Government Reimbursement	**170**	339	**170**	339
Welsh Risk Pool Claim reimbursement:-				
NHS Wales Secondary Health Sector	**68**	9	**68**	9
NHS Wales Primary Sector FLS Reimbursement	**0**	0	**0**	0
NHS Wales Redress	**0**	0	**0**	0
Other	**0**	0	**0**	0
Local Authorities	**26**	0	**26**	0
Capital debtors- Tangible	**0**	0	**0**	0
Capital debtors- Intangible	**0**	0	**0**	0
Other debtors	**12,866**	16,934	**12,811**	15,849
FHoT debtor			**65**	4
Provision for impairment of trade receivables	**(5,448)**	(5,276)	**(5,448)**	(5,276)
Pension Prepayments				
NHS Pensions Agency	**0**	0	**0**	0
NEST	**0**	0	**0**	0
Other prepayments	**9,831**	5,103	**9,831**	5,103
Accrued income	**4,793**	4,449	**4,793**	4,449
Sub-total	**565,742**	498,478	**565,752**	497,397
Non-current				
Welsh Government	**1,106,800**	1,091,598	**1,106,800**	1,091,598
WHSSC & EASC	**0**	0	**0**	0
Welsh Health Boards	**0**	0	**0**	0
Welsh NHS Trusts	**0**	0	**0**	0
Welsh Special Health Authorities	**0**	0	**0**	0
Non - Welsh Trusts	**0**	0	**0**	0
Other NHS	**1**	23	**1**	23
2019-20 Scheme Pays - Welsh Government Reimbursement	**0**	0	**0**	0
Welsh Risk Pool Claim reimbursement				
NHS Wales Secondary Health Sector	**0**	0	**0**	0
NHS Wales Primary Sector FLS Reimbursement	**0**	0	**0**	0
NHS Wales Redress	**0**	0	**0**	0
Other	**0**	0	**0**	0
Local Authorities	**128**	128	**128**	128
Capital debtors- Tangible	**0**	0	**0**	0
Capital debtors- Intangible	**0**	0	**0**	0
Other debtors	**0**	0	**0**	0
FHoT debtor			**0**	0
Provision for impairment of trade receivables	**0**	0	**0**	0
Pension Prepayments				
NHS Pensions Agency	**0**	0	**0**	0
NEST	**0**	0	**0**	0
Other prepayments	**118**	259	**118**	259
Accrued income	**0**	0	**0**	0
Sub-total	**1,107,047**	1,092,008	**1,107,047**	1,092,008
Total trade and other receivables	**1,672,789**	1,590,486	**1,672,799**	1,589,405

The great majority of trade is with other NHS bodies. As NHS bodies are funded by Welsh Government, no credit scoring of them is considered necessary.

The value of trade receivables that are past their payment date but not impaired is £9,366,000 (£3,935,000 in 2021-22).

The Welsh Government figure for 2021-22 has been restated from £498,807 to £457,058 to ensure consistent reporting with WG. WG Payables note has also been been restated from £51,216 to £9,467.

17.2 Receivables past their due date but not impaired

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
By up to 3 months	**3,827**	2,236	**3,827**	2,236
By 3 to 6 months	**907**	1,040	**907**	1,040
By more than 6 months	**4,632**	659	**4,632**	659
Balance at end of financial year	**9,366**	3,935	**9,366**	3,935

The increase in those debts aged more than 6 months old largely relates to monies due to NWSSP for an unfulfilled PPE contract.

17.3 Expected Credit Losses (ECL) Allowance for bad and doubtful debts

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Balance at 1 April	**(5,276)**	(2,411)	**(5,276)**	(2,411)
Transfer to other NHS Wales body	**0**	0	**0**	0
Provision utilised (Amount written off during the year)	**40**	100	**40**	100
Provision written back during the year no longer required	**0**	0	**0**	0
(Increase)/Decrease in provision during year	**(291)**	(3,567)	**(291)**	(3,567)
ECL/Bad debts recovered during year	**79**	602	**79**	602
Balance at end of financial year	**(5,448)**	(5,276)	**(5,448)**	(5,276)

The value of the provision remains high as an NWSSP doubtful debt raised in March 2022 of £3.248m remains unpaid.

17.4 Receivables VAT

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Trade receivables	233	252	233	252
Other	0	0	0	0
Total	**233**	**252**	**233**	**252**

18. Other financial assets

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Current				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCI	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	0		0	
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCI	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**0**	**0**	**0**
Non-Current				
Shares and equity type investments				
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCI	**0**	0	**0**	0
Available for sale at FV	**0**	0	**0**	0
Deposits	**0**	0	**0**	0
Loans	**0**	0	**0**	0
Derivatives	**0**	0	**0**	0
Other (Specify)				
Right of Use Asset Finance Sublease	**0**		**0**	
Held to maturity investments at amortised costs	**0**	0	**0**	0
At fair value through SOCI	**0**	0	**5,572**	5,826
Available for sale at FV	**0**	0	**0**	0
Total	**0**	**0**	**5,572**	**5,826**

19. Cash and cash equivalents

	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Opening Balance	**30,404**	43,263	**33,116**	44,811
Net change in year	**732**	(12,859)	**619**	(11,695)
Closing Balance	**31,136**	30,404	**33,735**	33,116
Made up of:				
Cash with Government Banking Service (GBS)	**31,112**	30,385	**31,112**	30,385
Cash with Commercial banks	**0**	0	**0**	2,712
Cash in hand	**24**	19	**24**	19
Total cash	**31,136**	30,404	**31,136**	33,116
Current investments	**0**	0	**2,599**	0
Cash and cash equivalents as in SoFP	**31,136**	30,404	**33,735**	33,116
Bank overdraft - GBS	**0**	0	**0**	0
Bank overdraft - Commercial banks	**0**	0	**0**	0
Cash & cash equivalents as in Statement of Cash Flows	**31,136**	30,404	**33,735**	33,116

Current investments for the FHoT previously reported as 'cash with commercial banks' is reported in 2022/2023 as 'current investments'.

In response to the IAS 7 requirement for additional disclosure, the changes in liabilities arising for financing activities are:

Lease Liabilities £nil
PFI liabilities £nil

The movement relates to cash, no comparative information is required by IAS 7 in 2022-23.

20. Trade and other payables at the SoFP Date	31 March 2023	31 March 2022	31 March 2023	31 March 2022
Current	£000	£000	£000	£000
	NHS Trust		Consolidated	
Welsh Government	**6,312**	9,467	**6,312**	9,467
WHSSC & EASC	**0**	877	**0**	877
Welsh Health Boards	**144,437**	163,061	**144,437**	163,061
Welsh NHS Trusts	**3,335**	3,363	**3,335**	3,363
Welsh Special Health Authorities	**1,937**	62	**1,937**	62
Other NHS	**2,553**	2,418	**2,553**	2,418
Taxation and social security payable / refunds:				
Refunds of taxation by HMRC	**0**	0	**0**	0
VAT payable to HMRC	**0**	0	**0**	0
Other taxes payable to HMRC	**4,920**	26	**4,920**	26
National Insurance contributions payable to HMRC	**5,157**	155	**5,157**	155
Non-NHS trade payables - revenue	**18,271**	22,305	**18,271**	22,305
Local Authorities	**84**	91	**84**	91
Capital payables-Tangible	**7,860**	8,097	**7,860**	8,097
Capital payables- Intangible	**1,735**	537	**1,735**	537
Overdraft	**0**	0	**0**	0
FHoT payables			**(1,476)**	48
Rentals due under operating leases	**0**	0	**0**	0
Obligations due under finance leases and HP contracts	**0**	0		0
Imputed finance lease element of on SoFP PFI contracts	**0**	0	**0**	0
Pensions: staff	**4,703**	3,918	**4,703**	3,918
Non NHS Accruals	**22,952**	20,307	**22,952**	20,307
Deferred Income:				
Deferred income brought forward	**1,167**	1,210	**1,167**	1,210
Deferred income additions	**1,458**	753	**1,458**	753
Transfer to/from current/non current deferred income	**(6)**	0	**(6)**	0
Released to the Income Statement	**(621)**	(795)	**(621)**	(795)
Other liabilities - all other payables	**0**	0	**0**	0
PFI assets – deferred credits	**0**	0	**0**	0
PFI - Payments on account	**0**	0	**0**	0
Sub-total	**226,254**	235,852	**224,778**	235,900

The Trust aims to pay all invoices within the 30 day period directed by the Welsh Government.

The Welsh Government figure for 2021-22 has been restated from £51,216 to £9,467 to ensure consistent reporting with WG. WG Trade Receivables has been restated from £498,807 to £457,058

20. Trade and other payables at the SoFP Date (cont)

Non-current	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Welsh Government	**2,500**	7,000	**2,500**	7,000
WHSSC & EASC	**0**	0	**0**	0
Welsh Health Boards	**0**	0	**0**	0
Welsh NHS Trusts	**0**	0	**0**	0
Welsh Special Health Authorities	**0**	0	**0**	0
Other NHS	**0**	0	**0**	0
Taxation and social security payable / refunds:				
Refunds of taxation by HMRC	**0**	0	**0**	0
VAT payable to HMRC	**0**	0	**0**	0
Other taxes payable to HMRC	**0**	0	**0**	0
National Insurance contributions payable to HMRC	**0**	0	**0**	0
Non-NHS trade payables - revenue	**0**	0	**0**	0
Local Authorities	**0**	0	**0**	0
Capital payables- Tangible	**0**	0	**0**	0
Capital payables- Intangible	**0**	0	**0**	0
Overdraft	**0**	0	**0**	0
FHoT payables			**0**	0
Rentals due under operating leases	**0**	0	**0**	0
Obligations due under finance leases and HP contracts	**0**	0		0
Imputed finance lease element of on SoFP PFI contracts	**0**	0	**0**	0
Pensions: staff	**0**	0	**0**	0
Non NHS Accruals	**0**	0	**0**	0
Deferred Income:				
Deferred income brought forward	**336**	301	**336**	301
Deferred income additions	**250**	35	**250**	35
Transfer to/from current/non current deferred income	**6**	0	6	0
Released to the Income Statement	**0**	0	0	0
Other liabilities - all other payables	**0**	0	0	0
PFI assets –deferred credits	**0**	0	0	0
Payments on account	**0**	0	0	0
Sub-total	**3,092**	**7,336**	**3,092**	**7,336**
Total	**229,346**	243,188	**227,870**	243,236

The WG non current creditor arose as a result of a requirement to hold additional stocks as a result of Brexit. The value has reduced in year as £4.5m stock for NWSSP was released and WG reimbursed. The remaining value relates to additional stocks still held by the Welsh Blood Service.

21. Borrowings	31 March 2023	31 March 2022	31 March 2023	31 March 2022
Current	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Bank overdraft - Government Banking Service (GBS)	**0**	0	**0**	0
Bank overdraft - Commercial bank	**0**	0	**0**	0
Loans from:				
Welsh Government	**0**	0	**0**	0
Other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0		0
RoU Lease Liability	**1,123**		**1,123**	
Other	**0**	0	**0**	0
Total	**1,123**	0	**1,123**	0
Non-current				
Bank overdraft - GBS	**0**	0	**0**	0
Bank overdraft - Commercial bank	**0**	0	**0**	0
Loans from:				
Welsh Government	**0**	0	**0**	0
Other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0		0
RoU Lease Liability	**2,421**		**2,421**	
Other	**0**	0	**0**	0
Total	**2,421**	0	**2,421**	0

RoU Lease Liability Transitioning & Transferring	**£000**
RoU liability as at 31 March 2022	**0**
Transfer of Finance Leases from PPE Note	**0**
Operating Leases Transitioning	**4,798**
RoU Lease liability as at 1 April 2022	**4,798**

The opening liability as at 1 April 2022 was £4.798m: consisting of £4.330m for NWSSP and £0.468m for the Trust core services.

21.2 Loan advance/strategic assistance funding

	31 March 2023	31 March 2022	31 March 2023	31 March 2022
Amounts falling due:	**£000**	£000	**£000**	£000
In one year or less	**0**	0	**0**	0
Between one and two years	**0**	0	**0**	0
Between two and five years	**0**	0	**0**	0
In five years or more	**0**	0	**0**	0
Sub-total	**0**	0	**0**	0
Wholly repayable within five years	**0**	0	**0**	0
Wholly repayable after five years, not by instalments	**0**	0	**0**	0
Wholly or partially repayable after five years by instalments	**0**	0	**0**	0
Sub-total	**0**	0	**0**	0
Total repayable after five years by instalments	**0**	0	**0**	0

The Trust has not received a loan advance or strategic funding from the Welsh Government.

22. Other financial liabilities

Current	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Financial Guarantees				
At amortised cost	**0**	0	**0**	0
At fair value through SoCI	**0**	0	**0**	0
Derivatives at fair value through SoCI	**0**	0	**0**	0
Other				
At amortised cost	**0**	0	**0**	0
At fair value through SoCI	**0**	0	**0**	0
Total	**0**	0	**0**	0

Non-current	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
	NHS Trust		Consolidated	
Financial Guarantees				
At amortised cost	**0**	0	**0**	0
At fair value through SoCI	**0**	0	**0**	0
Derivatives at fair value through SoCI	**0**	0	**0**	0
Other				
At amortised cost	**0**	0	**0**	0
At fair value through SoCI	**0**	0	**0**	0
Total	**0**	0	**0**	0

23. Provisions

2022-23

	At 1 April 2022	Structured settlement cases transferr-ed to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
Current										
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	308,483	(40,291)	(33,716)	48,409	0	227,939	(61,159)	(88,156)	(4,637)	356,872
Primary Care	133	0	0	0	0	639	(69)	(72)	0	631
Redress Secondary Care	2,300	0	(366)	8	0	3,638	(1,183)	(1,276)	0	3,121
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	3,803	0	(8)	(197)	0	4,196	(1,821)	(2,333)	0	3,640
All other losses and special payments	0	0	0	0	0	16,839	(16,839)	0	0	0
Defence legal fees and other administration	5,404	0	0	363	0	4,315	(1,791)	(2,563)	0	5,728
Structured Settlements - WRPS	18,070	1,247	0	0	0	24,219	(19,116)	(679)	(4,323)	19,418
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	15		(5)	20	0	0	(17)	0	0	13
2019-20 Scheme Pays - Reimbursement	2		0	0	0	1	0	(2)	0	1
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	2,913		0	569	0	3,244	0	(3,625)		3,101
Total	341,123	(39,044)	(34,095)	49,172	0	285,030	(101,995)	(98,706)	(8,960)	392,525
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	341,123	(39,044)	(34,095)	49,172	0	285,030	(101,995)	(98,706)	(8,960)	392,525
Non Current										
Clinical negligence:-										
Secondary Care	472,825	0	(400)	(48,687)	0	100,677	(15,318)	(27,945)	0	481,152
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	12	0	0	(12)	0	3	0	0	0	3
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	0	0	0	195	0	403	(247)	(139)	0	212
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	3,656	0	0	(79)	0	1,591	(292)	(599)	0	4,277
Structured Settlements - WRPS	615,107	39,044	0	0	0	13,489	0	(46,483)	0	621,157
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	53		0	(20)	0	9	0	0	0	42
2019-20 Scheme Pays - Reimbursement	337		0	0	0	169	0	(337)	0	169
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	2,216		0	(569)	0	780	0	(520)		1,907
Total	1,094,206	39,044	(400)	(49,172)	0	117,121	(15,857)	(76,023)	0	1,108,919
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,094,206	39,044	(400)	(49,172)	0	117,121	(15,857)	(76,023)	0	1,108,919
TOTAL										
Clinical negligence:-										
Secondary Care	781,308	(40,291)	(34,116)	(278)	0	328,616	(76,477)	(116,101)	(4,637)	838,024
Primary Care	133	0	0	0	0	639	(69)	(72)	0	631
Redress Secondary Care	2,312	0	(366)	(4)	0	3,641	(1,183)	(1,276)	0	3,124
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	3,803	0	(8)	(2)	0	4,599	(2,068)	(2,472)	0	3,852
All other losses and special payments	0	0	0	0	0	16,839	(16,839)	0	0	0
Defence legal fees and other administration	9,060	0	0	284	0	5,906	(2,083)	(3,162)	0	10,005
Structured Settlements - WRPS	633,177	40,291	0	0	0	37,708	(19,116)	(47,162)	(4,323)	640,575
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	68		(5)	0	0	9	(17)	0	0	55
2019-20 Scheme Pays - Reimbursement	339		0	0	0	170	0	(339)	0	170
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	5,129		0	0	0	4,024	0	(4,145)		5,008
Total	1,435,329	0	(34,495)	0	0	402,151	(117,852)	(174,729)	(8,960)	1,501,444
FH0T	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,435,329	0	(34,495)	0	0	402,151	(117,852)	(174,729)	(8,960)	1,501,444

Expected timing of cash flows:

	In year to 31 March 2024	Between 01-Apr-24 to 31 March 2028	Thereafter	Totals
	£000	£000	£000	£000
Clinical negligence:-				
Secondary Care	356,872	363,883	117,269	838,024
Primary Care	631	0	0	631
Redress Secondary Care	3,121	3	0	3,124
Redress Primary Care	0	0	0	0
Personal injury	3,640	212	0	3,852
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	5,728	4,277	0	10,005
Structured Settlements - WRPS	19,418	83,967	537,190	640,575
Pensions - former directors	0	0	0	0
Pensions - other staff	13	42	0	55
2019-20 Scheme Pays - Reimbursement	1	2	167	170
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Other	3,101	1,461	446	5,008
Total	392,525	453,847	655,072	1,501,444
FHoT	0	0	0	0
Consolidated Total	392,525	453,847	655,072	1,501,444

23. Provisions NHS Trust
2022-23

	At 1 April 2022	Structured settlement cases transferr-ed to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
Current										
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	90	0	0	0	0	1,723	0	(90)	0	1,723
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	26	0	0	0	0	19	0	(22)	0	23
All other losses and special payments	0	0	0	0	0	16,839	(16,839)	0	0	0
Defence legal fees and other administration	89	0	0	0	0	197	0	(92)	0	194
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	15		(5)	21	0	0	(17)	0	0	14
2019-20 Scheme Pays - Reimbursement	2		0	0	0	1	0	(2)	0	1
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	2,914		0	569	0	3,245	0	(3,624)		3,104
Total	3,136	0	(5)	590	0	22,024	(16,856)	(3,830)	0	5,059
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	3,136	0	(5)	590	0	22,024	(16,856)	(3,830)	0	5,059
Non Current										
Clinical negligence:-										
Secondary Care	0	0	0	0	0	0	0	0	0	0
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	0	0	0	0	0	0	0	0	0	0
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	0	0	0	0	0	0	0	0	0	0
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	53		0	(20)	0	9	0	0	0	42
2019-20 Scheme Pays - Reimbursement	337		0	0	0	169	0	(337)	0	169
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	2,216		0	(569)	0	780	0	(520)		1,907
Total	2,606	0	0	(589)	0	958	0	(857)	0	2,118
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	2,606	0	0	(589)	0	958	0	(857)	0	2,118
TOTAL										
Clinical negligence:-										
Secondary Care	90	0	0	0	0	1,723	0	(90)	0	1,723
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	0	0	0	0	0	0	0	0	0	0
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	26	0	0	0	0	19	0	(22)	0	23
All other losses and special payments	0	0	0	0	0	16,839	(16,839)	0	0	0
Defence legal fees and other administration	89	0	0	0	0	197	0	(92)	0	194
Structured Settlements - WRPS	0	0	0	0	0	0	0	0	0	0
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	68		(5)	1	0	9	(17)	0	0	56
2019-20 Scheme Pays - Reimbursement	339		0	0	0	170	0	(339)	0	170
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	5,130		0	0	0	4,025	0	(4,144)		5,011
Total	5,742	0	(5)	1	0	22,982	(16,856)	(4,687)	0	7,177
FH0T	0	0	0	0	0	0	0	0	0	0
Consolidated Total	5,742	0	(5)	1	0	22,982	(16,856)	(4,687)	0	7,177

Expected timing of cash flows:

	In year to 31 March 2024	Between 01-Apr-24 to 31 March 2028	Thereafter	Totals
	£000	£000	£000	£000
Clinical negligence:-				
Secondary Care	1,723	0	0	1,723
Primary Care	0	0	0	0
Redress Secondary Care	0	0	0	0
Redress Primary Care	0	0	0	0
Personal injury	23	0	0	23
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	194	0	0	194
Structured Settlements - WRPS	0	0	0	0
Pensions - former directors	0	0	0	0
Pensions - other staff	14	42	0	56
2019-20 Scheme Pays - Reimbursement	1	2	167	170
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	0
Other Capital Provisions	0	0	0	0
Other	3,104	1,461	446	5,011
Total	5,059	1,505	613	7,177
FHoT	0	0	0	0
Consolidated Total	5,059	1,505	613	7,177

23. Provisions WRP
2022-23

Current	At 1 April 2022	Structured settlement cases transferr-ed to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2023
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	308,391	(40,291)	(33,716)	48,409	0	226,216	(61,159)	(88,066)	(4,637)	355,147
Primary Care	133	0	0	0	0	639	(69)	(72)	0	631
Redress Secondary Care	2,301	0	(366)	8	0	3,638	(1,183)	(1,276)	0	3,122
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	3,777	0	(8)	(197)	0	4,177	(1,821)	(2,311)	0	3,617
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	5,316	0	0	363	0	4,118	(1,791)	(2,471)	0	5,535
Structured Settlements - WRPS	18,070	1,247	0	0	0	24,219	(19,116)	(679)	(4,323)	19,418
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	0		0	0	0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	337,988	(39,044)	(34,090)	48,583	0	263,007	(85,139)	(94,875)	(8,960)	387,470
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	337,988	(39,044)	(34,090)	48,583	0	263,007	(85,139)	(94,875)	(8,960)	387,470
Non Current										
Clinical negligence:-										
Secondary Care	472,825	0	(400)	(48,687)	0	100,677	(15,318)	(27,945)	0	481,152
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	12	0	0	(12)	0	3	0	0	0	3
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	0	0	0	195	0	403	(247)	(139)	0	212
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	3,655	0	0	(79)	0	1,590	(292)	(599)	0	4,275
Structured Settlements - WRPS	615,107	39,045	0	0	0	13,489	0	(46,483)	0	621,158
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	0		0	0	0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	1,091,599	39,045	(400)	(48,583)	0	116,162	(15,857)	(75,166)	0	1,106,800
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,091,599	39,045	(400)	(48,583)	0	116,162	(15,857)	(75,166)	0	1,106,800
TOTAL										
Clinical negligence:-										
Secondary Care	781,216	(40,291)	(34,116)	(278)	0	326,893	(76,477)	(116,011)	(4,637)	836,299
Primary Care	133	0	0	0	0	639	(69)	(72)	0	631
Redress Secondary Care	2,313	0	(366)	(4)	0	3,641	(1,183)	(1,276)	0	3,125
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	3,777	0	(8)	(2)	0	4,580	(2,068)	(2,450)	0	3,829
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	8,971	0	0	284	0	5,708	(2,083)	(3,070)	0	9,810
Structured Settlements - WRPS	633,177	40,292	0	0	0	37,708	(19,116)	(47,162)	(4,323)	640,576
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	0		0	0	0	0	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0		0	0	0	0	0	0	0	0
Restructurings	0		0	0	0	0	0	0		0
RoU Asset Dilapidations CAME	0		0	0	0	0	0	0		0
Other Capital Provisions	0		0	0	0	0	0	0		0
Other	0		0	0	0	0	0	0		0
Total	1,429,587	1	(34,490)	0	0	379,169	(100,996)	(170,041)	(8,960)	1,494,270
FH0T	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,429,587	1	(34,490)	0	0	379,169	(100,996)	(170,041)	(8,960)	1,494,270

Expected timing of cash flows:

	In year to 31 March 2024 £000	Between 01-Apr-24 to 31 March 2028 £000	Thereafter £000	Totals £000
Clinical negligence:-				
Secondary Care	355,147	363,885	117,269	836,301
Primary Care	631	0	0	631
Redress Secondary Care	3,122	3	0	3,125
Redress Primary Care	0	0	0	0
Personal injury	3,617	211	0	3,828
All other losses and special payments	0	0	0	0
Defence legal fees and other administration	5,535	4,274	0	9,809
Structured Settlements - WRPS	19,418	83,967	537,191	640,576
Pensions - former directors	0	0	0	0
Pensions - other staff	0	0	0	0
2019-20 Scheme Pays - Reimbursement	0	0	0	0
Restructuring	0	0	0	0
RoU Asset Dilapidations CAME	0	0	0	
Other Capital Provisions	0	0	0	
Other	0	0	0	0
Total	387,470	452,340	654,460	1,494,270
FHoT	0	0	0	0
Consolidated Total	387,470	452,340	654,460	1,494,270

The provisions relate to amounts over £25,000 in respect of ongoing claims against the NHS in Wales, the outcome of which will not be determined until the case has been finalised.

Timings of cashflow have been profiled to match total current liabilities. However, the total will include cases which may settle with a structured settlement, so the underlying cashflows will be over a number of years. Also, there can be delays in settlement dates anticipated for next year which will further impact the cashflow timings.

23. Provisions (continued)

2021-22

NHS Trust and Welsh Risk Pool

	At 1 April 2021	Structured settlement cases transferred to Risk Pool	Transfers to creditors	Transfers between current and non current	Transfers (to)/from other NHS body	Arising during the year	Utilised during the year	Reversed unused	Unwinding of discount	At 31 March 2022
Current										
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Clinical negligence:-										
Secondary Care	286,428	(56,929)	(8,495)	(9,360)	0	285,210	(94,727)	(93,594)	(50)	308,483
Primary Care	122	0	0	0	0	134	(81)	(42)	0	133
Redress Secondary Care	2,843	0	227	(10)	0	3,176	(1,712)	(2,224)	0	2,300
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	6,428	0	(229)	1,292	0	5,932	(1,911)	(7,709)	0	3,803
All other losses and special payments	0	0	0	0	0	23,441	(23,441)	0	0	0
Defence legal fees and other administration	5,590	0	0	420	0	3,725	(1,930)	(2,401)	0	5,404
Structured Settlements - WRPS	15,111	1,700	0	0	0	18,568	(16,645)	(1,807)	1,143	18,070
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	18		(6)	22	0	0	(19)	0	0	15
2019-20 Scheme Pays - Reimbursement	0		0	0	0	2	0	0	0	2
Restructurings	0		0	0	0	0	0	0		0
Other	419		0	0	0	3,311	0	(817)		2,913
Total	316,959	(55,229)	(8,503)	(7,636)	0	343,499	(140,466)	(108,594)	1,093	341,123
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	316,959	(55,229)	(8,503)	(7,636)	0	343,499	(140,466)	(108,594)	1,093	341,123
Non Current										
Clinical negligence:-										
Secondary Care	359,188	0	0	9,195	0	130,985	(3,100)	(23,443)	0	472,825
Primary Care	0	0	0	0	0	0	0	0	0	0
Redress Secondary Care	6	0	0	9	0	10	(2)	(11)	0	12
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	1,292	0	0	(1,292)	0	0	0	0	0	0
All other losses and special payments	0	0	0	0	0	0	0	0	0	0
Defence legal fees and other administration	3,289	0	0	(254)	0	1,026	(112)	(293)	0	3,656
Structured Settlements - WRPS	452,672	55,229	0	0	0	108,342	0	(1,136)	0	615,107
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	71		0	(22)	0	4	0	0	0	53
2019-20 Scheme Pays - Reimbursement	0		0	0	0	337	0	0	0	337
Restructurings	0		0	0	0	0	0	0		0
Other	2,264		0	0	0	642	0	(690)		2,216
Total	818,782	55,229	0	7,636	0	241,346	(3,214)	(25,573)	0	1,094,206
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	818,782	55,229	0	7,636	0	241,346	(3,214)	(25,573)	0	1,094,206
TOTAL										
Clinical negligence:-										
Secondary Care	645,616	(56,929)	(8,495)	(165)	0	416,195	(97,827)	(117,037)	(50)	781,308
Primary Care	122	0	0	0	0	134	(81)	(42)	0	133
Redress Secondary Care	2,849	0	227	(1)	0	3,186	(1,714)	(2,235)	0	2,312
Redress Primary Care	0	0	0	0	0	0	0	0	0	0
Personal injury	7,720	0	(229)	0	0	5,932	(1,911)	(7,709)	0	3,803
All other losses and special payments	0	0	0	0	0	23,441	(23,441)	0	0	0
Defence legal fees and other administration	8,879	0	0	166	0	4,751	(2,042)	(2,694)	0	9,060
Structured Settlements - WRPS	467,783	56,929	0	0	0	126,910	(16,645)	(2,943)	1,143	633,177
Pensions relating to: former directors	0		0	0	0	0	0	0	0	0
Pensions relating to: other staff	89		(6)	0	0	4	(19)	0	0	68
2019-20 Scheme Pays - Reimbursement	0		0	0	0	339	0	0	0	339
Restructurings	0		0	0	0	0	0	0		0
Other	2,683		0	0	0	3,953	0	(1,507)		5,129
Total	1,135,741	0	(8,503)	0	0	584,845	(143,680)	(134,167)	1,093	1,435,329
FHoT	0	0	0	0	0	0	0	0	0	0
Consolidated Total	1,135,741	0	(8,503)	0	0	584,845	(143,680)	(134,167)	1,093	1,435,329

24 Contingencies

24.1 Contingent liabilities

Provision has not been made in these accounts for the following amounts:	**31 March 2023 £000**	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
	NHS Trust		**Consolidated**	
Legal claims for alleged medical or employer negligence;				
Secondary care	**1,172,097**	1,252,357	**1,172,097**	1,252,357
Primary Care	**6,351**	1,790	**6,351**	1,790
Secondary care - Redress	**1,539**	712	**1,539**	712
Primary Care - Redress	**0**	0	**0**	0
Doubtful debts	**0**	0	**0**	0
Equal pay cases	**0**	0	**0**	0
Defence costs	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total value of disputed claims	**1,179,987**	1,254,859	**1,179,987**	1,254,859
Amount recovered under insurance arrangements in the event of these claims being successful	**(1,179,711)**	(1,254,460)	**(1,179,711)**	(1,254,460)
Net contingent liability	**276**	399	**276**	399

Other litigation claims could arise in the future due to known incidents. The expenditure which may arise from such claims cannot be determined and no provision has been made for them.

Liability for Permanent Injury Benefit under the NHS Injury Benefit Scheme lies with the employer. Individual claims to the NHS Pensions Agency could arise due to known incidents.

Contingent liabilities includes claims relating to alleged clinical negligence, personal injury and permanent injury benefits under the NHS Injury Benefits Scheme. The above figures include contingent liabilities for all Health Bodies in Wales.

24.2. Remote contingent liabilities

	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
	NHS Trust		**Consolidated**	
Guarantees	**0**	0	0	0
Indemnities	**102,503**	60,204	**102,503**	60,204
Letters of comfort	**0**	0	0	0
Total	**102,503**	60,204	**102,503**	60,204

24.3 Contingent assets

	31 March 2023 £000	31 March 2022 £000	**31 March 2023 £000**	31 March 2022 £000
	NHS Trust		**Consolidated**	
	0	0	**0**	0
	0	0	**0**	0
	0	0	**0**	0
	0	**0**	**0**	**0**

The Trust has no contingent assets.

25. Capital commitments

Commitments under capital expenditure contracts at the statement of financial position sheet date:
The disclosure of future capital commitments not already disclosed as liabilities in the accounts.

	31 March 2023	31 March 2022	**31 March 2023**	31 March 2022
	NHS Trust		**Consolidated**	
	£000	£000	**£000**	£000
Property, plant and equipment	**38,598**	19,553	**38,598**	19,553
Right of Use Assets	**0**		**0**	
Intangible assets	**6,068**	83	**6,068**	83
Total	**44,666**	19,636	**44,666**	19,636

The Capital commitments include contract obligations of £32m in respect of the Integrated Radiotherapy Solution project and £11m for the enabling works at the new hospital site development.

26. Losses and special payments

Losses and special payments are charged to the Income statement in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during year to 31 March 2023	
	Number	£
Clinical negligence	402	129,272,440
Personal injury	68	2,466,371
All other losses and special payments	338	20,023,038
Structured Settlements managed by WRP	264	19,483,889
Total	**1,072**	**171,245,738**
FHoT losses and special payments	**0**	**0**
Consolidated Total	**1,072**	**171,245,738**

Analysis of cases in excess of £300,000

	Case Type	In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
		Number	£	Number	£
Cases in excess of £300,000:					
Velindre University NHS Trust	Losses & Special Payments; Clinical Negligence	5	16,733,415	6	17,037,361
WRP - Secondary Care:					
Secondary Care					
Aneurin Bevan UHB	Clinical Negligence	8	16,766,241	8	16,766,241
Betsi Cadwaladr UHB	Clinical Negligence	16	27,038,030	16	27,396,834
Cardiff and Vale UHB	Clinical Negligence; Personal Injury	14	19,978,044	14	19,978,044
Cwm Taf Morgannwg UHB	Clinical	14	21,872,901	14	31,708,369
Hywel Dda UHB	Clinical Negligence	10	11,703,490	10	13,113,726
Swansea Bay UHB	Clinical Negligence	10	8,684,908	10	12,217,878
Welsh Ambulance Service NHS Trust	Clinical Negligence	2	1,150,953	2	1,150,953
Sub-total		**79**	**123,927,982**	**80**	**139,369,406**
All other cases		986	44,857,336	986	119,254,282
Structured Settlements managed by WRP		7	2,460,420	7	16,870,060
Total cases		**1,072**	**171,245,738**	**1,073**	**275,493,748**

The Welsh Risk Pool (WRP) reimburses Trusts, Local Health Boards and Special Health Authorities for payments made in year. The WRP also manages annual payments directly to WRP claimants. They arise when a case settles with a Structured Settlement arrangement. The comparative figure of annual payments for 2021/22 is **£16,644,570** for **235** transactions**.** Structured settlements relate to cases which have settled with a lower lump sum element within the total settlement value, plus annual payments over the lifetime of the claimant (the Periodical Payment Order). They typically relate to high value cases over £1M and are primarily used to meet the future care costs of the claimant as they fall due.

26.2 Velindre NHS Trust excluding WRP Losses and special payments

Losses and special payments are charged to the Income statement in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during year to 31 March 2023	
	Number	**£**
Clinical negligence	4	157,022
Personal injury	2	1,367
All other losses and special payments	9	16,879,531
Structured Settlements managed by WRP	0	0
Total	**15**	**17,037,920**
FHoT losses and special payments	**0**	**0**
Consolidated Total	**15**	**17,037,920**

Analysis of cases in excess of £300,000

	In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
	Number	**£**	**Number**	**£**
Cases in excess of £300,000:				
Clinical Negligence	0	0	1	303,946
Other Losses	5	16,733,415	5	16,733,415
Sub-total	**5**	**16,733,415**	**6**	**17,037,361**
All other cases	10	304,505	9	702,122
Total cases	**15**	**17,037,920**	**15**	**17,739,483**

Other losses include stock revaluations of £12.9m and stock losses of £3.6m

26. 3 WRP Losses and special payments

Losses and special payments are charged to the Income statement in accordance with IFRS but are recorded in the losses and special payments register when payment is made. Therefore this note is prepared on a cash basis.

Gross loss to the Exchequer

Number of cases and associated amounts paid out during the financial year

	Amounts paid out during year to 31 March 2023	
	Number	**£**
Clinical negligence	398	129,115,418
Personal injury	66	2,465,004
All other losses and special payments	329	3,143,507
Structured Settlements managed by WRP	264	19,483,889
Total	**1,057**	**154,207,818**
FHoT losses and special payments	**0**	**0**
Consolidated Total	**1,057**	**154,207,818**

Analysis of cases in excess of £300,000

		In year claims in excess of £300,000		Cumulative claims in excess of £300,000	
		Number	**£**	**Number**	**£**
Cases in excess of £300,000:					
Secondary Care					
Aneurin Bevan UHB	Clinical Negligence	8	16,766,241	8	16,766,241
Betsi Cadwaladr UHB	Clinical Negligence	16	27,038,030	16	27,396,834
Cardiff and Vale UHB	Clinical Negligence; Personal Injury	14	19,978,044	14	19,978,044
Cwm Taf Morgannwg UHB	Clinical Negligence	14	21,872,901	14	31,708,369
Hywel Dda UHB	Clinical Negligence	10	11,703,490	10	13,113,726
Swansea Bay UHB	Clinical Negligence	10	8,684,908	10	12,217,878
Welsh Ambulance Service NHS Trust	Clinical Negligence	2	1,150,953	2	1,150,953
Primary Care		0	0	0	0
Sub-total		**74**	**107,194,567**	**74**	**122,332,045**
WRP Managed Structured Settlements		7	2,460,420	7	16,870,060
All other cases		976	**44,552,831**	**976**	118,552,160
Total cases		**1,057**	**154,207,818**	**1,057**	**257,754,265**

The Welsh Risk Pool (WRP) reimburses Trusts, Local Health Boards and Special Health Authorities for payments made in year. The WRP also manages annual payments directly to WRP claimants. They arise when a case settles with a Structured Settlement arrangement. The comparative figure of annual payments for 2021/22 is **£16,644,570** for **235** transactions**.** Structured settlements relate to cases which have settled with a lower lump sum element within the total settlement value, plus annual payments over the lifetime of the claimant (the Periodical Payment Order). They typically relate to high value cases over £1M and are primarily used to meet the future care costs of the claimant as they fall due.

27. Right of Use / Finance leases obligations

27.1 Obligations (as lessee)

The Trust currently has finance lease obligations in respect of Buildings and Non-Property.

Amounts payable under right of use asset / finance leases:

LAND		Post Implementation of IFRS 16 (RoU) 31 March 2023 £000	Pre implementation of IFRS 16 (FL) 31 March 2022 £000	Post Implementation of IFRS 16 (RoU) 31 March 2023 £000	Pre implementation of IFRS 16 (FL) 31 March 2022 £000
		NHS Trust		Consolidated	
Minimum lease payments					
Within one year		**0**	0	**0**	0
Between one and five years		**0**	0	**0**	0
After five years		**0**	0	**0**	0
Less finance charges allocated to future periods		**0**	0	**0**	0
Minimum lease payments		**0**	0	**0**	0
Included in:	Current borrowings	**0**	0	**0**	0
	Non-current borrowings	**0**	0	**0**	0
Total		**0**	0	**0**	0
Present value of minimum lease payments					
Within one year		**0**	0	**0**	0
Between one and five years		**0**	0	**0**	0
After five years		**0**	0	**0**	0
Total present value of minimum lease payments		**0**	0	**0**	0
Included in:	Current borrowings	**0**	0	**0**	0
	Non-current borrowings	**0**	0	**0**	0
Total		**0**	0	**0**	0

27.1 Finance leases obligations (as lessee) continued

Amounts payable under right of use asset / finance leases: BUILDINGS	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022
Minimum lease payments	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Within one year	**963**	0	**963**	0
Between one and five years	**1,540**	0	**1,540**	0
After five years	**687**	0	**687**	0
Less finance charges allocated to future periods	**(105)**	0	**(105)**	0
Minimum lease payments	**3,085**	0	**3,085**	0
Included in: Current borrowings	**941**	0	**941**	0
Non-current borrowings	**2,144**	0	**2,144**	0
Total	**3,085**	0	**3,085**	0
Present value of minimum lease payments				
Within one year	**941**	0	**941**	0
Between one and five years	**1,491**	0	**1,491**	0
After five years	**653**	0	**653**	0
Total present value of minimum lease payments	**3,085**	0	**3,085**	0
Included in: Current borrowings	**941**	0	**941**	0
Non-current borrowings	**2,144**	0	**2,144**	0
Total	**3,085**	0	**3,085**	0

Amounts payable under right of use asset / finance leases: OTHER - Non Property	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022	Post Implementation of IFRS 16 (RoU) 31 March 2023	Pre implementation of IFRS 16 (FL) 31 March 2022
Minimum lease payments	**£000**	£000	**£000**	£000
	NHS Trust		**Consolidated**	
Within one year	**185**	0	**185**	0
Between one and five years	**279**	0	**279**	0
After five years	**0**	0	**0**	0
Less finance charges allocated to future periods	**(6)**	0	**(6)**	0
Minimum lease payments	**458**	0	**458**	0
Included in: Current borrowings	**182**	0	**182**	0
Non-current borrowings	**276**	0	**276**	0
Total	**458**	0	**458**	0
Present value of minimum lease payments				
Within one year	**182**	0	**182**	0
Between one and five years	**276**	0	**276**	0
After five years	**0**	0	**0**	0
Total present value of minimum lease payments	**458**	0	**458**	0
Included in: Current borrowings	**182**	0	**182**	0
Non-current borrowings	**276**	0	**276**	0
Total	**458**	0	**458**	0

27.2 Right of Use Assets / Finance lease receivables (as lessor)

Amounts receivable under right of use assets / finance leases:

The Trust has no finance lease receivables.

Amounts receivable under right of use assets / finance leases:		Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)	Post Implementation of IFRS 16 (RoU)	Pre implementation of IFRS 16 (FL)
		31 March	31 March	**31 March**	31 March
		2023	2022	**2023**	2022
Gross investment in leases		**£000**	£000	**£000**	£000
		NHS Trust		**Consolidated**	
Within one year		**0**	0	**0**	0
Between one and five years		**0**	0	**0**	0
After five years		**0**	0	**0**	0
Less finance charges allocated to future periods		**0**	0	**0**	0
Present value of minimum lease payments		**0**	0	**0**	0
Included in:	Current borrowings	**0**	0	**0**	0
	Non-current borrowings	**0**	0	**0**	0
Total		**0**	0	**0**	0
Present value of minimum lease payments					
Within one year		**0**	0	**0**	0
Between one and five years		**0**	0	**0**	0
After five years		**0**	0	**0**	0
Less finance charges allocated to future periods		**0**	0	**0**	0
Total present value of minimum lease payments		**0**	0	**0**	0
Included in:	Current borrowings	**0**	0	**0**	0
	Non-current borrowings	**0**	0	**0**	0
Total		**0**	0	**0**	0

27.3 Finance Lease Commitment

The Trust does not have any commitments becoming operational in a future period.

28. Private finance transactions

Private Finance Initiatives (PFI) / Public Private Partnerships (PPP)

The Trust has no PFI or PPP Schemes.

29. Financial Risk Management

IFRS 7, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

NHS Trusts are not exposed to the degree of financial risk faced by business entities. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. NHS Trusts have limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day to day operational activities rather than being held to change the risks facing NHS Trusts in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk
The Trust's net operating costs are incurred under annual service agreements with various Health bodies, which are financed from resources voted annually by parliament. NHS Trusts also largely finance their capital expenditure from funds made available from the Welsh Government under agreed borrowing limits. NHS Trusts are not, therefore, exposed to significant liquidity risks.

Interest-rate risks
The great majority of NHS Trusts' financial assets and financial liabilities carry nil or fixed rates of interest. NHS Trusts are not, therefore, exposed to significant interest-rate risk.

Foreign currency risk
NHS Trusts have no significant foreign currency income or expenditure and any such risk for Velindre University NHS Trust is underwritten by Welsh Government.

Credit Risk
Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures are in receivables from customers as disclosed in the trade and other receivables note.

General
The powers of the Trust to invest and borrow are limited. The Board has determined that in order to maximise income from cash balances held, any balance of cash which is not required will be invested. The Trust does not borrow from the private sector. All other financial instruments are held for the sole purpose of managing the cash flow of the Trust on a day to day basis or arise from the operating activities of the Trust. The management of risks around these financial instruments therefore relates primarily to the Trust's overall arrangements for managing risks to their financial position, rather than the Trust's treasury management procedures.

30. Movements in working capital

	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
Movements in working capital	NHS Trust		Consolidated	
(Increase) / decrease in inventories	**31,137**	30,357	**31,137**	30,357
(Increase) / decrease in trade and other receivables - non-current	**(15,039)**	(274,866)	**(15,039)**	(274,866)
(Increase) / decrease in trade and other receivables - current	**(67,264)**	8,609	**(68,355)**	9,383
Increase / (decrease) in trade and other payables - non-current	**(4,244)**	35	**(4,244)**	35
Increase / (decrease) in trade and other payables - current	**(9,598)**	(75,535)	**(11,122)**	(75,594)
Total	**(65,008)**	(311,400)	**(67,623)**	(310,685)
Adjustment for accrual movements in fixed assets - creditors	**(961)**	(2,415)	**(961)**	(2,415)
Adjustment for accrual movements in fixed assets - debtors	**0**	(187)	**0**	(187)
Other adjustments	**9,241**	(1,093)	**9,368**	(1,077)
Total	**(56,728)**	(315,095)	**(59,216)**	(314,364)

31. Other cash flow adjustments

	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	NHS Trust		Consolidated	
Other cash flow adjustments	£000	£000	£000	£000
Depreciation	**10,504**	9,110	**10,504**	9,110
Amortisation	**1,358**	1,112	**1,358**	1,112
(Gains)/Loss on Disposal	**(3)**	0	**(3)**	0
Impairments and reversals	**3,363**	0	**3,363**	0
Release of PFI deferred credits	**0**	0	**0**	0
NWSSP Covid assets issued debited to expenditure but non-cash	**0**	0	**0**	0
NWSSP Covid assets received credited to revenue but non-cash	**0**	0	**0**	0
Donated assets received credited to revenue but non-cash	**0**	0	**0**	0
Government Grant assets received credited to revenue but non-cash	**0**	0	**0**	0
Right of Use Grant (Peppercorn Lease) credited to revenue but non ca	**0**		**0**	
Non-cash movements in provisions	**183,967**	443,268	**183,967**	443,268
Total	**199,189**	453,490	199,189	453,490

32. Events after reporting period

NHS Wales bodies were notified in a pay circular letter issued on 25th May 2023 by the Welsh Government, of the additional pay arrangements for employees covered by the Agenda for Change terms and conditions in Wales for 2022-23, which will be funded by the Welsh Government.
NHS Wales bodies will make a one off non-consolidated, prorated “recovery payment” for staff employed on the Agenda for Change terms and conditions (this includes most NHS staff including nursing staff but excludes medical staff).
These costs have not been recognised in the 2022-23 financial statements because the obligating event was the publication of the offer agreed with the Minister on 20 April 2023 and therefore post 31st March 2023. The costs will be accounted for in the 2023-24 Annual Accounts of NHS Wales bodies.
The estimated cost is £3.419m.

The detailed extent and condition of the NHS Wales organisations' buildings identified as having Reinforced Autoclaved Aerated Concrete (RAAC), has yet to be completed. Thus to make an informed assessment to determine the remaining life assessment of the buildings further work is required. This work is being undertaken at present across all of the NHS Estate (which will hopefully be completed by late summer 2023) which will enable such an assessment to be made for the 23-24 financial year.

During the financial year, it was identified that in order to progress with the building of the new Velindre Cancer Centre, a European Protected Species Licence is required to allow clearance of the site in early 2023/2024. To secure this licence, a portion of the neighbouring Cardiff and Vale UHB site is required to create around 1.6 hectares of new habitat. The Trust Board agreed on 28 April 2023 that the Trust should express an interest in the acquisition of the site.

These financial statements were authorised for issue by the Chief Executive and Accountable Officer on 01 Aug 2023; post the date the financial statements were certified by the Auditor General for Wales.

33. Related Party transactions

The Trust is a body corporate established by order of the Welsh Minister for Health and Social Services.

The Welsh Government is regarded as a related party. During the year, the Trust has had a significant number of material transactions with the Welsh Government and with other entities for which the Welsh Government is regarded as the parent body, namely:

Related Party	Expenditure to related party £000	Income from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Welsh Government	34,670	302,408	8,812	1,632,351
WHSSC	600	53,062	164	(1,754)
Aneurin Bevan UHB	29,264	78,852	33,156	3,043
Betsi Cadwaladr UHB	39,389	53,808	30,160	3,494
Cardiff and Vale UHB	27,782	95,552	21,306	3,814
Cwm Taf Morgannwg UHB	36,166	63,239	16,445	(669)
Hywel Dda UHB	18,614	28,612	20,642	2,213
Powys THB	1,300	3,334	1,300	399
Swansea Bay UHB	20,093	51,982	21,270	2,440
Public Health Wales NHS Trust	446	8,686	944	1,150
Welsh Ambulance Service NHS Trust	3,061	2,275	2,334	689
Health Education & Improvement Wales	14	56,494	6	2,175
Digital Health & Care Wales	4,874	1,520	1,930	449
Welsh Risk Pool	0	45	0	57
Welsh Local Authorities (*excluding those listed below where declarations of interest have been received*):	1,388	26	87	26

Parties where specific interests have been declared	Name of individual declaring interest	Nature of the relationship				
Pembrokeshire County Council	Martin Veale, Independent Member	Lay Member of Audit Committee	(1)	0	8	0
Capita	Donna Mead, Chair	Party employs son	3	0	23	0
City Hospice	Stephen Harries, Vice Chair	Member	(3)	295	3	101
CTX-Cyf	Chief Operating Officer - Cath C	Partner is Company Director	(1)	0	0	0
Healthcare People Management Association	Sarah Morley, Executive Director of Organisational Development & Workforce	Joint President & Trustee	11	0	1	0
John Sisk	Gareth Jones, Independent Member	Senior Counsel	9	0	14	0
Life Sciences Hub	Cath O'Brien, Chief Operating Officer Neil Frow, NWSSP Accountable Officer	COB: Director NF: Observer at Board	0	0	4	0
			217,679	**800,190**	**158,609**	**1,649,978**

In addition, the Trust has had a number of material transactions with other Government departments and other central and local Government bodies. The majority of these transactions have been with universities; and other transactions include payments to English, Scottish and Irish NHS organisations amounting to £13,594,000 (2021/2022 £10,053,000); of this total £2,208,000 (2021/2022 £1,610,550) related to an English Trust that provides a lease car salary sacrifice scheme to Trust employees.

The Trust Board is the corporate trustee of Velindre University NHS Trust Charitable Funds. During the year the Trust received £1,343,000 (2021/2022 £2,791,000) from Velindre University NHS Trust Charitable Funds.

Welsh Government expenditure excludes £18,479,000 that relates to Public Dividend Capital (PDC) received during 2022/2023 (2021/2022 £9,486,000 was received).

Transactions with Capita, City Hospice, CTX-Cyf, Healthcare People Management Association, Life Sciences Hub and John Sisk have been disclosed due to senior Trust managers declaring an interest in these parties and as the transactions could be of material value to these companies.

34. Third party assets

The Trust held £nil cash at bank and in hand at 31 March 2023 (31 March 2022, £nil) which relates to monies held by the Trust on behalf of patients. Cash held in Patient's Investment Accounts amounted to £nil at 31 March 2023 (31 March 2022, £nil).

35. Pooled budgets

Velindre University NHS Trust has no pooled budgets.

36. Operating Segments
IFRS 8 requires organisations to report information about each of its operating segments.

36. Operating Segments	VELINDRE		NWSSP		WRP		TOTAL		FHOT		ELIMINATIONS		CONSOLIDATED	
	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22	2022-23	2021-22
Operating Revenue	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Segmental Income	183,449	171,601	572,881	444,770	201,411	427,428	957,741	1,043,799	4,781	3,066	(1,343)	(2,791)	961,179	1,044,074
	183,449	**171,601**	**572,881**	**444,770**	**201,411**	**427,428**	**957,741**	**1,043,799**	**4,781**	**3,066**	**(1,343)**	**(2,791)**	**961,179**	**1,044,074**
Operating Expenses	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Local Health Boards	243	250	14,241	11,214	0	0	14,484	11,464	0	0	0	0	14,484	11,464
Welsh NHS Trusts	0	0	18	23	0	0	18	23	0	0	0	0	18	23
Welsh Special Health Authorities	451	10	1,570	1,160	0	0	2,021	1,170	0	0	0	0	2,021	1,170
Goods and services from other NHS bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WHSSC & EASC	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Local Authorities	3	0	0	0	0	0	3	0	0	0	0	0	3	0
Purchase of healthcare from non-NHS bodies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Welsh Government	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other NHS Trusts	0	0	508	514	0	0	508	514	0	0	0	0	508	514
Directors' costs	1,420	1,392	0	0	0	0	1,420	1,392	0	0	0	0	1,420	1,392
Operational staff costs	80,121	72,919	91,225	81,063	0	0	171,346	153,982	0	0	0	0	171,346	153,982
Non operational trainee staff costs	0	0	229,121	137,379	0	0	229,121	137,379	0	0	0	0	229,121	137,379
Non operational collaborative bank staff costs	0	0	347	234	0	0	347	234	0	0	0	0	347	234
Single lead employer staff trainee costs	2,743	1,033	0	0	0	0	2,743	1,033	0	0	0	0	2,743	1,033
Collaborative bank staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Supplies and services - clinical	80,909	77,334	64,083	58,840	0	0	144,992	136,174	0	0	0	0	144,992	136,174
Supplies and services - general	657	292	82,683	77,755	0	0	83,340	78,047	0	0	0	0	83,340	78,047
Consultancy Services	2,403	841	1,547	3,383	0	0	3,950	4,224	0	0	0	0	3,950	4,224
Establishment	2,777	3,053	10,429	9,330	0	0	13,206	12,383	0	0	0	0	13,206	12,383
Transport	953	811	2,530	2,349	0	0	3,483	3,160	0	0	0	0	3,483	3,160
Premises	5,908	5,891	23,954	18,880	0	0	29,862	24,771	0	0	0	0	29,862	24,771
FHOT Resources expended:														
Costs of generating funds	0	0	0	0	0	0	0	0	965	362	(311)	(205)	654	157
Charitable activites	0	0	0	0	0	0	0	0	1,110	2,206	(932)	(2,512)	178	(306)
Governance Costs	0	0	0	0	0	0	0	0	83	59	(100)	(74)	(17)	(15)
Impairments and Reversals of Receivables	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Depreciation	5,469	5,987	3,357	3,123	0	0	8,826	9,110	0	0	0	0	8,826	9,110
Depreciation (RoU Asset)	148		1,529		0		1,677		0		0		1,677	
Amortisation	787	680	571	432	0	0	1,358	1,112	0	0	0	0	1,358	1,112
Impairments and reversals of property, plant and equipment	0	0	1,121	0	0	0	1,121	0	0	0	0	0	1,121	0
Fixed asset impairments and reversals (RoU Assets)	0		1,894		0		1,894		0		0		1,894	
Impairments and reversals of intangible assets	0	0	348	0	0	0	348	0	0	0	0	0	348	0
Impairments and reversals of financial assets	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Impairments and reversals of non current assets held for sale	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Audit fees	236	224	7	0	0	0	243	224	17	15	0	0	260	239
Other auditors' remuneration	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Losses, special payments and irrecoverable debts	(1,084)	472	19,659	21,082	209,408	426,335	227,983	447,889	0	0	0	0	227,983	447,889
Research and development	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NWSSP centrally purchased and donated COVID items issued free of charge to NHS Wales organisations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
NWSSP centrally purchased COVID items issued free of charge to other organisations	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Expense related to short-term leases	197		172		0		369		0		0		369	
Expense related to low-value asset leases (excluding short-term leases)	40		20		0		60		0		0		60	
Other operating expenses	256	408	21,903	18,242	963	0	23,122	18,650	0	0	0	0	23,122	18,650
Total	**184,637**	**171,597**	**572,837**	**445,003**	**210,371**	**426,335**	**967,845**	**1,042,935**	**2,175**	**2,642**	**(1,343)**	**(2,791)**	**968,677**	**1,042,786**
Investment Revenue	1,257	23	0	0	0	0	1,257	23	144	114	0	0	1,401	137
Other Gains and Losses	0	3	3	0	0	0	3	3	0	0	0	0	3	3
Finance Costs	(4)	0	(36)	0	8,960	(1,093)	8,920	(1,093)	0	0	0	0	8,920	(1,093)
SURPLUS / (DEFICIT)	**65**	**30**	**11**	**(233)**	**0**	**0**	**76**	**(203)**	**2,750**	**538**	**0**	**0**	**2,826**	**335**
(excluding donated assets received or issued)														

37. Other Information

37.1. 6.3% Staff Employer Pension Contributions - Notional Element

The value of notional transactions is based on estimated costs for the twelve month period 1 April 2022 to 31 March 2023. This has been calculated from actual Welsh Government expenditure for the 6.3% staff employer pension contributions between April 2022 and February 2023 alongside Trust data for March 2023.

Transactions include notional expenditure in relation to the 6.3% paid to NHS BSA by Welsh Government and notional funding to cover that expenditure as follows:

	2022-23	2021-22
STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2023	**£000**	**£000**
Revenue from patient care activities	14,659	11,406
Operating expenses	14,659	11,406
3. Analysis of gross operating costs		
3. Revenue from patient care activities		
Welsh Government	3,373	3,160
Welsh Government - Hosted Bodies	3,868	3,535
4. Other Operating Revenue		
Other	7,418	4,711
5.1 Operating expenses		
Directors' costs	59	58
Operational staff costs	7,182	6,604
Non operational trainee staff costs	7,328	4,704
Non operational collaborative bank staff costs	9	7
Single lead employer staff trainee cost	81	33
Collaborative bank staff cost	0	0

Notional income reported as 'other operating revenue' is from Local Health Boards, Welsh NHS Trusts and Welsh Special Health Authorities in respect of the Single Lead Employer (SLE) trainees employed via NWSSP and operational within the respective organisation.

37. Other Information (continued)

37.2 Other (continued)

Welsh Government Covid 19 Funding

Details of Covid 19 Pandemic Welsh Government funding amounts provided to the Trust:

	NWSSP 2022-23 £000	Velindre 2022-23 £000	Total 2022-23 £000	Total 2021-22 £000
Capital				
Capital Funding Field Hospitals				0
Capital Funding Equipment & Works				675
Capital Funding other (Specify)				0
Welsh Government Covid 19 Capital Funding	**-**	**-**	**-**	**675**
Revenue				
Stability Funding	4,580	575	**5,155**	**7,406**
Covid Recovery	0	0	**0**	3,479
Cleaning Standards	0	0	**0**	769
PPE (including All Wales Equipment via NWSSP)	25,850	70	**25,920**	47,180
Testing / TTP- Testing & Sampling - Pay & Non Pay	0	0	**0**	3,941
Tracing / TTP - NHS & LA Tracing - Pay & Non Pay	0	0	**0**	0
Extended Flu Vaccination / Vaccination - Extended Flu Programme	0	0	**0**	0
Mass Covid-19 Vaccination / Vaccination - COVID-19	1,337	224	**1,561**	1,853
Annual Leave Accrual - Increase due to Covid				0
Urgent & Emergency Care				77
Private Providers Adult Care / Support for Adult Social Care Providers				0
Hospices				4,500
Other Mental Health / Mental Health				0
Other Primary Care	0	0	**0**	0
Social Care				0
Dental Patient charges				0
Nosocomial C19 Funding	0	4	**4**	0
Other	0	0	**0**	0
Welsh Government Covid 19 Revenue Funding	**31,767**	**873**	**32,640**	**69,205**

THE NATIONAL HEALTH SERVICE IN WALES ACCOUNTS DIRECTION GIVEN BY WELSH MINISTERS IN ACCORDANCE WITH SCHEDULE 9 SECTION 178 PARA 3(1) OF THE NATIONAL HEALTH SERVICE (WALES) ACT 2006 (C.42) AND WITH THE APPROVAL OF TREASURY

NHS TRUSTS

1. Welsh Ministers direct that an account shall be prepared for the financial year ended 31 March 2010 and subsequent financial years in respect of the NHS Wales Trusts in the form specified in paragraphs [2] to [7] below.

BASIS OF PREPARATION

2. The account of the NHS Wales Trusts shall comply with:

(a) the accounting guidance of the Government Financial Reporting Manual (FReM), which is in force for the financial year for which the accounts are being prepared, as detailed in the NHS Wales Trust Manual for Accounts;

(b) any other specific guidance or disclosures required by the Welsh Government.

FORM AND CONTENT

3. The account of the Trust for the year ended 31 March 2010 and subsequent years shall comprise a foreword, an income statement, a statement of financial position, a statement of cash flows and a statement of changes in taxpayers' equity as long as these statements are required by the FReM and applied to the NHS Wales Manual for Accounts, including such notes as are necessary to ensure a proper understanding of the accounts.

4. For the financial year ended 31 March 2010 and subsequent years, the account of the Trust shall give a true and fair view of the state of affairs as at the end of the financial year and the operating costs, changes in taxpayers' equity and cash flows during the year.

5. The account shall be signed and dated by the Chief Executive.

MISCELLANEOUS

6. The direction shall be reproduced as an appendix to the published accounts.

7. The notes to the accounts shall, inter alia, include details of the accounting policies adopted.

Signed by the authority of Welsh Ministers

Signed : Chris Hurst Dated : 17.06.2010

1 Please see regulation 3 of the 2009 No 1558(W.153); NATIONAL HEALTH SERVICE, WALES; The National Health Service Trusts (Transfer of Staff, Property Rights and Liabilities)

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CF15 7QZ

Ffôn/Phone : (029) 20196161
https://velindre.nhs.wales

Final Letter of Representation

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

27 July 2023

Representations regarding the 2022-23 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Velindre University NHS Trust for the year ended 31st March 2023 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- Preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers/HM Treasury, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Velindre University NHS Trust will continue in operation.

- Ensuring the regularity of any expenditure and other transactions incurred.

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

Gwasanaeth Gwaed Cymru Welsh Blood Service

Canolfan Ganser Felindre Velindre Cancer Centre

Pencadlys Ymddiriedolaeth GIG Prifysgol Felindre
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- The design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
- unrestricted access to staff from whom you determined it necessary to obtain audit evidence.

- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

- Our knowledge of fraud or suspected fraud that we are aware of and that affects Velindre University NHS Trust and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.
- Our knowledge of all possible and actual instances of irregular transactions.

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Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by the Board of Velindre University NHS Trust

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Board on 27th July 2023.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by: Chief Executive	Signed by: Chair of the Trust
Date:	Date:

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16 March 2023

Dear Matt,

Audit enquiries to those charged with governance and management

The Auditor General's Statement of Responsibilities sets out that he is responsible for obtaining reasonable assurance that the financial statements taken as a whole are free from material misstatement, whether caused by fraud or error. It also sets out the respective responsibilities of auditors, management and those charged with governance.

This letter formally seeks documented consideration and understanding on a number of governance areas that impact on our audit of your financial statements. These considerations are relevant to both the management of Velindre University NHS Trust (the Trust) and 'those charged with governance' (the Board).

I have set out below the areas of governance on which I am seeking your views:

1. Matters in relation to fraud
2. Matters in relation to laws and regulations
3. Matters in relation to related parties

The information you provide will inform our understanding of the Trust and its business processes and support our work in providing an audit opinion on your 2022-23 financial statements.

I would be grateful if you could update the attached table in Appendix 1 to Appendix 3 for 2022-23.

The completed Appendix 1 to Appendix 3 should be formally considered and communicated to us on behalf of both management and those charged with governance by **5 May 2023**. In the meantime, if you have queries, please contact me (02920 320664 or at steve.wyndham@audit.wales).

Yours sincerely

Steve Wyndham

Audit Manager

Cc

Richard Harries, Audit Wales Engagement Lead

Clare Bowden, Head of Financial Operations

Audit enquiries to those charges with governance and management. Please contact us in Welsh or English / cysylltwch â ni'n Gymraeg neu'n Saesneg.

Appendix 1

Matters in relation to fraud

International Standard for Auditing (UK) 240 covers auditors' responsibilities relating to fraud in an audit of financial statements. This standard has been revised for 2022-23 audits.

The primary responsibility to prevent and detect fraud rests with both management and 'those charged with governance', which for Velindre University NHS Trust (the Trust) is the Board. Management, with the oversight of those charged with governance, should ensure there is a strong emphasis on fraud prevention and deterrence and create a culture of honest and ethical behaviour, reinforced by active oversight by those charged with governance.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error. We are required to maintain professional scepticism throughout the audit, considering the potential for management override of controls.

What are we required to do?

As part of our risk assessment procedures we are required to consider the risks of material misstatement due to fraud. This includes understanding the arrangements management has put in place in respect of fraud risks. The ISA views fraud as either:

- The intentional misappropriation of assets (cash, property, etc); or
- The intentional manipulation or misstatement of the financial statements.

We also need to understand how those charged with governance exercises oversight of management's processes. We are also required to make enquiries of both management and those charged with governance as to their knowledge of any actual, suspected or alleged fraud, management's process for identifying and responding to the risks and the internal controls established to mitigate them.

Enquiries of management – in relation to fraud

Question	2022-23 Response
1. What is management's assessment of the risk that the financial statements may be materially misstated due to fraud? What is the nature, extent and frequency of management's assessment?	The Trust's Standing Financial Instructions are designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business: they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders, a Schedule of decisions reserved to the Board and a Scheme of delegation to officers and others, they provide the regulatory framework for the business conduct of the Trust. This regulatory framework, together with detailed and regular financial reporting throughout the year significantly mitigates the risk of the financial statements being materially misstated due to fraud. This risk is further mitigated by issuing clear guidance and instructions to management and budgetary holders regarding their financial management responsibilities. Management's assessment of this risk is therefore that it is currently rated as low.
2. Do you have knowledge of any actual, suspected or alleged fraud affecting the audited body?	Yes - as part of their meetings, the Audit Committee receives a Counter Fraud Progress Report which includes relevant reference to any new cases, significant changes with ongoing investigations, together with outcomes from cases that are already in the public domain. Management representatives attend the Audit Committee and so have access to this information.

Enquiries of management – in relation to fraud

Question	2022-23 Response
3. What is management's process for identifying and responding to the risks of fraud in the audited body, including any specific risks of fraud that management has identified or that have been brought to its attention?	The risks around fraud are mitigated by a robust and well-resourced counter fraud programme. This programme is led and resourced by a dedicated local Counter Fraud Team. The Cabinet Office NHS requirement gov13 requires that the counter fraud risk assessment is carried out by the Counter Fraud Team. All informed Fraud Risk is subject to assessment and review by the counter fraud team. This can be informed internally via management, post-investigation, thematic exercise or central NHS trends. Thorough assessment is conducted and recommendations made which are reported to Directorate, Executive Director with responsibility for the risk domain, Executive Director of Finance and Audit committee. The aim of the assessment is to fraud proof areas, address any identified weakness and with the goal of reducing the opportunity of fraud to an absolute minimum. All fraud risks remain live on a living document within the Counter Fraud department and are subject to regular review. All fraud risk is recorded and reported to the NHS CFA via the CLUE case management system. All fraud risk work carried out is compliant with the organisations over riding Risk Management Policy and the requirements of Compliance set by the NHS CFA. The Trust has in place a Counter Fraud Policy which is intended to provide direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and

Enquiries of management – in relation to fraud

Question	2022-23 Response
	information on various aspects and implications of an investigation. The Policy was reviewed & updated earlier this year. The fundamental financial systems are robustly reviewed by internal audit on a cyclical basis to test that they are being used appropriately and that adequate controls are in place. The Trust has other policies and resources that would support it in identifying and reporting risks, such as: • various incident reporting routes • Incident Reporting Policy • Raising Concerns (Whistle blowing Policy) In addition, a series of Counter Fraud awareness events are held by the Local Counter Fraud Team, on behalf of the Trust, which staff are encouraged to attend. A short summary of the Counter Fraud strategy and contact details are also available on the Trust intranet pages, that signposts to a comprehensive dedicated Counter Fraud Intranet site which contains a high volume of support material. A bi-monthly newsletter from the Counter Fraud team is shared periodically with Trust staff.
4. What classes of transactions, account balances and disclosures have you identified as most at risk of fraud?	Payments to staff & suppliers: particularly those that are marked 'urgent' or are made to bank accounts that have not previously received payments from the Trust.

Enquiries of management – in relation to fraud

Question	2022-23 Response
5. Are you aware of any whistleblowing or complaints by potential whistle blowers? If so, what has been the audited body's response?	All complaints made in relation to fraud are directed to the local Counter Fraud team via the reporting routes available. These can be anonymous or named. There have been a number of complaints/referrals this year and the response is always consistent. Whistleblowers are treated in accordance with policy and identity is protected where appropriate. All reports of fraud are robustly investigated and each is dealt with on its own merits once the investigation is complete. Should there be the need for follow up with regard to identified risk then this is carried out accordingly.
6. What is management's communication, if any, to those charged with governance regarding their processes for identifying and responding to risks of fraud?	The Trust's Counter Fraud Policy as described in question (3) above provides direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and information on various aspects and implications of an investigation. The Trust's Standards of Behaviour Framework Policy outlines how the Trust is committed to ensuring that its employees and Independent Members practice the highest standards of conduct and behaviour. This policy sets out those expectations and provides supporting guidance so that all employees and Independent Members are supported in delivering those requirements.

Enquiries of management – in relation to fraud

Question	2022-23 Response
	There is also a dedicated webpage supporting this policy including Frequently Asked Questions, guidance documents, and contact details for support on the Trust's intranet pages. It is a requirement that annual declaration of interests are obtained from specific groups of employees and Independent Members, and this is completed in March each year. All fraud risks that are identified are duly reported to the risk owning domain and for assurance purposes and monitoring via the Audit Committee.
7. What is management's communication, if any, to employees regarding their views on business practices and ethical behaviour?	The response to question (6) above is equally relevant here. In addition, regular Annual Performance Appraisals and Development Reviews undertaken support and reinforce the code of conduct and performance expected from Trust employees.
8. For service organisations, have you reported any fraud to the user entity?	No fraud reported to a user entity. Should matters arise that concerns other agencies or partners then a close working protocol is adopted in order that all fraud identified is appropriately dealt with. Eg: Overseas Patients and Immigration Services; Taxi Contracts; Universities; nursing agencies. Should fraud occur in a partner organisation and the Trust is not the victim then assistance is provided to the investigating body.

Enquiries of those charged with governance – in relation to fraud

Question	2022-23 Response
1. Do you have any knowledge of actual, suspected or alleged fraud affecting the audited body?	Yes - as part of their meetings, the Audit Committee receives a Counter Fraud Progress Report which includes relevant reference to any new cases, significant changes with ongoing investigations, together with outcomes from cases that are already in the public domain.
2. What is your assessment of the risk of fraud within the audited body, including those risks that are specific to the audited body's business sector?	The risk of fraud occurring within the organisation is always present. However, a robust and planned Fraud Risk Assessment programme is undertaken by the Counter Fraud Team and the aim of this is to reduce the risk of fraud to an absolute minimum. The fraud risk management programme is fully compliant with the local Risk Management Policy and the Cabinet Office Gov 13 NHS Requirements in relation to risk management. All fraud risk work is reported through audit committee and to the Counter Fraud Authority quality and compliance team via an end of year functional standard return. Inherent risks are identified and assessed and any newly identified risks are added to this living document.

Enquiries of those charged with governance – in relation to fraud

Question	2022-23 Response
3. How do you exercise oversight of: • management's processes for identifying and responding to the risk of fraud in the audited body, and • the controls that management has established to mitigate these risks?	Audit reports provide the Audit Committee with assurance as to whether appropriate control measures are in place and whether the Trust is compliant with current standard practice. The Audit Committee provide a highlight report to each Trust Board meeting to provide assurance and inform them of any issues. All fraud risks are recorded on the clue case management system by the counter fraud manager. They are retained as a live document and are subject to review on a timed basis. Recommendations made as a result of risk assessment is subject to onward testing by way of Local Proactive Exercise.

Appendix 2

Matters in relation to laws and regulations

International Standard for Auditing (UK and Ireland) 250 covers auditors' responsibilities to consider the impact of laws and regulations in an audit of financial statements.

Management, with the oversight of those charged with governance, is responsible for ensuring that the Trust's operations are conducted in accordance with laws and regulations, including compliance with those that determine the reported amounts and disclosures in the financial statements.

As external auditors, we are responsible for obtaining reasonable assurance that the financial statements are free from material misstatement due to fraud or error, taking into account the appropriate legal and regulatory framework. The ISA distinguishes two different categories of laws and regulations:

- laws and regulations that have a direct effect on determining material amounts and disclosures in the financial statements;
- other laws and regulations where compliance may be fundamental to the continuance of operations, or to avoid material penalties.

What are we required to do?

As part of our risk assessment procedures we are required to make enquiries of management and those charged with governance as to whether the Trust is in compliance with relevant laws and regulations. Where we become aware of information of non-compliance or suspected non-compliance we need to gain an understanding of the non-compliance and the possible effect on the financial statements.

Enquiries of management – in relation to laws and regulations

Question	2022-23 Response
1. Is the audited body in compliance with relevant laws and regulations? How have you gained assurance that all relevant laws and regulations have been complied with? Are there any policies or procedures in place?	The Trust is compliant with relevant laws and regulations. Employees and Senior Officers within the Finance and Information Governance Function are professionally qualified and experienced and are required as part of their role within the Trust to ensure that they remain aware of any legislative or regulatory changes. All Wales groups such as the Directors of Finance Forum, Deputy Directors of Finance Forum, and the All Wales Technical Accounting Group help facilitate this shared learning. Cyclical audits on systems and processes applied in the Trust are reviewed in light of expected current practice and would highlight any breaches or compliance issues in respect of current legislation and/or regulation. Also, the Trust compiles a Legislative & Regulatory Compliance Register which is presented to the Audit Committee on a regular basis. The purpose of the register is to ensure the Trust has a comprehensive and up-to-date list of the legislation that applies to it. It is also a mechanism which demonstrates that the Trust can ensure that by regular updating and monitoring of the register there is a process in place that ensures compliance with legislation is being managed effectively.
2. Have there been any instances of non-compliance or suspected non-compliance with relevant laws and regulations in the financial year, or earlier with an	During the final quarter of 2020/2021, liaison with VAT advisors identified potential non-compliance in one area. A provision was made within the 2020/21 financial statements which has been

Enquiries of management – in relation to laws and regulations

Question	2022-23 Response
ongoing impact on this year's audited financial statements?	reviewed, updated, and is reflected in the 2022/2023 financial statements.
3. Are there any potential litigations or claims that would affect the financial statements?	The Director of Finance and the Head of Financial Operations monitor and are not aware of any litigation claims against the Trust which could impact the financial statements. Losses and Redress reports detailing claims are received at relevant Trust Committees. In respect of civil litigation claims against the Trust, quantum values of each case are provided and based on the probability of success, the Trust accrues the relevant cost against each case as appropriate. This ensures that the quantum value assigned to each case is monitored and reported within the financial accounts.
4. Have there been any reports from other regulatory bodies, such as HM Revenues and Customs which indicate non-compliance?	There have not been any reports from regulatory bodies indicating non compliance. To note, a HMRC review of the Trust's treatment of VAT and employment taxes which commenced in 2017/2018 concluded in 2022/2023 with no further issues of non compliance noted.
5. Are you aware of any non-compliance with laws and regulations within service organisations since 1 April of the	A Data Processor under contract to the Trust did not comply with UK GDPR Article 28(2) and (3)(a) in that it failed to:

Enquiries of management – in relation to laws and regulations

Question	2022-23 Response
financial year? This would include the NHS Wales Shared Services Partnership.	1. Comply with Article 28(3)(a) UK GDPR in that it processed personal data against the express instructions of the Controller by 2. Appointing a sub-processor without the express permission of the controller which contravened Article 28(2) UK GDPR and that the Processor directed the Sub-Processor to destroy Trust records against the express instructions of the controller The Information Commissioner was informed, a full investigation was carried out and the Trust found to have acted appropriately. Full details are in the 2022/23 IG Disclosure Statement with findings.

Enquiries of those charged with governance – in relation to laws and regulations

Question	2022-23 Response
1. Are you aware of any non-compliance with laws and regulations that may be expected to have a fundamental effect on the operations of the entity?	The Board is not aware of any non-compliance issues in relation to relevant laws and regulations that have had a fundamental effect on the operations of the entity. Any such incidents would be reported to the Board via the Audit Committee if they occurred as happens in instances of non-compliance with for example, Standing Orders (SOs) or Standing Financial Instructions (SFIs). However, Internal Audit recommendations in their audit of nVCC MIM Contract Management identified non-compliances with the SOs & SFIs regarding the procurement of advisors and the approval of contract value increases for the new Velindre Cancer Centre (nVCC): • Undertaking a lessons-learned exercise on contract management practices applied to date for nVCC; • Developing a governance framework for effective and compliant management of advisor and construction contracts at the nVCC and Enabling Works projects; and • Delegation to a suitable level (e.g., Chief Executive) of a contingency allowance (accommodated within the project budget) for the management of compensating events where NEC contracts are applied. The Trust is in the process of implementing the agreed management actions in response to the recommendations.

Enquiries of those charged with governance – in relation to laws and regulations	
Question	**2022-23 Response**
2. How does the Board, in your role as those charged with governance, obtain assurance that all relevant laws and regulations have been complied with?	Audit reports provide the Audit Committee with assurance as to whether appropriate control measures are in place and whether the Trust is compliant with current standard practice. The Audit Committee provide a highlight report to each Trust Board meeting to provide assurance and inform them of any issues.

Appendix 3

Matters in relation to related parties

International Standard for Auditing (UK) 550 covers auditors' responsibilities relating to related party relationships and transactions.

The nature of related party relationships and transactions may, in some circumstances, give rise to higher risks of material misstatement of the financial statements than transactions with unrelated parties.

Because related parties are not independent of each other, many financial reporting frameworks establish specific accounting and disclosure requirements for related party relationships, transactions and balances to enable users of the financial statements to understand their nature and actual or potential effects on the financial statements. An understanding of the entity's related party relationships and transactions is relevant to the auditor's evaluation of whether one or more fraud risk factors are present as required by ISA (UK and Ireland) 240, because fraud may be more easily committed through related parties.

What are we required to do?

As part of our risk assessment procedures, we are required to perform audit procedures to identify, assess and respond to the risks of material misstatement arising from the entity's failure to appropriately account for or disclose related party relationships, transactions or balances in accordance with the requirements of the framework.

Enquiries of management – in relation to related parties

Question	2022-23 Response
1. Have there been any changes to related parties from the prior year? If so, what is the identity of the related parties and the nature of those relationships? Confirm these have been disclosed to the auditor.	Annual declaration of interests are obtained from specific groups of Employees and Independent Members to confirm if there are any changes required to related parties from the prior year. The annual updated declarations of interest for the reporting period have been provided to the Trust Finance Team for their review and action as appropriate and reporting in regards to any matters pertinent to the Trust Annual Accounts for the respective reporting period.
2. What transactions have been entered into with related parties during the period? What is the purpose of these transactions? Confirm these have been disclosed to the auditor.	The total value of any transactions with related parties are calculated and reported in the related party note (number 33) in the Trust's accounts. Details of these transactions will be available to the Audit team during the audit of the accounts.

Enquiries of management – in relation to related parties

Question	2022-23 Response
3. What controls are in place to identify, account for and disclose related party transactions and relationships?	Statements are included in the Statement of Accounts acknowledging the relationships. These statements are produced by experienced and qualified officers with an in-depth knowledge of Trust operations. Audit reviews are undertaken to ensure appropriate control measures are in place. Annual declaration of interests are obtained from specific groups of Employees and Independent Members. Access is provided to the Trust to examine Welsh Ministers interest delegations.
4. What controls are in place to authorise and approve significant transactions and arrangements: • with related parties, and • outside the normal course of business?	The NWSSP Procurement team manage all such arrangements in line with the Trust Standing Financial Instructions, NWSSP Procurement manual and detailed policies and procedures. Any non compliance or matters of note are reported to the Audit Committee.

Enquiries of those charged with governance – in relation to related parties

Question	2022-23 Response
1. How does the Board, in its role as those charged with governance, exercise oversight of management's processes to identify, authorise, approve, account for and disclose related party transactions and relationships?	The Audit Committee receives the Statement of Accounts and receives assurance from Senior Officers and through audit mechanisms that they are accurate. The Audit Committee are able to scrutinise, challenge and query any aspect of the accounts and request further supporting information or initiate any additional work to assure themselves this area is addressed. Any relevant issues are subsequently reported to the Board.

TRUST BOARD

TRUST ANNUAL PERFORMANCE REPORT - 2022-23

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	• Peter Gorin – Head of Strategic Planning and Performance (VUNHST) • Phil Hodson, Deputy Director of Planning and Performance (VUNHST)
PRESENTED BY	• Carl James - Director of Strategic Transformation, Planning and Digital (VUNHST) • Cath O'Brien – Chief Operating Officer (VUNHST)
APPROVED BY	• Carl James - Director of Strategic Transformation, Planning and Digital (VUNHST)
EXECUTIVE SUMMARY	NHS bodies are required to publish, as a single document, a three-part Annual Report and Accounts which includes: • The Trust Annual Performance Report (2022/2023), which must include: o An overview

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

RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **APPROVE** the Trust Annual Performance Report (***Appendix A***) for 2022-23.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	2nd May 2023
Quality, Safety and Performance Committee	16th May 2023
Executive Management Board	29th June 2023
Quality, Safety and Performance Committee	13th July 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Trust Annual Performance Report was **ENDORSED FOR BOARD APPROVAL** by the Quality, Safety & Performance Committee on the 13th July 2022.	

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

APPENDICES	
Appendix 1	Trust Annual Performance Report – 2022/2023

1. SITUATION

The Trust Annual Performance Report (2022-2023) is to be submitted by Audit Wales to the Finance Health and Social Service Group (HSSG), on the 31st July 2023.

The Trust Annual Performance Report 2022-232 will be presented at the Trust's Annual General Meeting on the 29th September 2023.

The Trust Annual Performance Report is presented to the Trust Board for **APPROVAL.**

2. BACKGROUND

The Trust Draft Annual Performance Report was submitted to the HSSG Finance and Audit Wales on the 12th May 2023.

During the reporting period the Trust has continued to work in close collaboration with the Deputy Board Secretaries Group in partnership with Welsh Government to review the content, structure and reporting requirements of the Report.

3. ASSESSMENT

3.1 The purpose of the Trust Annual Performance Report, which sits within the suite of Annual Report documents, is to report to the Senedd Cymru/ Welsh Parliament in respect of the Trust key accountability requirements. These have been reviewed in draft form at various stages by the Trust, Audit Wales and Welsh Government

during April - July 2023. Any comments from these reviews have been incorporated as appropriate.

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

3.3 SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to:

- Approve the Trust Annual Performance Report for 2022/2023.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	01 - Demand and Capacity Choose an item

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required *There are no socio-economic impacts linked directly to the activity outlined in this report.*

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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Velindre University NHS Trust Performance Report 2022-2023

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

Canolfan Ganser Felindre
Velindre Cancer Centre

Gwasanaeth Gwaed Cymru
Welsh Blood Service

INTRODUCTION AND CEO STATEMENT

This Annual Performance Report, describes how we delivered services from 1st April 2022 to 31st March 2023. It also outlines how we ensured patient, donor and staff safety and demonstrates our total commitment to Quality, Care and Excellence.

During 2022/2023 I am proud that our patients, donors and families have continued to benefit from the highest standards of care, innovation and professionalism across the range of services we deliver. We successfully maintained the delivery of transplant services and the supply of blood and blood products to the whole of NHS Wales whilst also delivering essential tertiary cancer services to the South East Wales population. We believe the strong foundations and clinical operating models that we have established will stand us in good stead, as we enter 2023/2024.

The NHS Wales Annual Planning Framework Guidance required the production of a three year Integrated Medium Term Plan (IMTP), covering the period 2023/24 – 2025/26. In line with this guidance we submitted our plan to the Welsh Government on 31st March 2023. Our plan builds upon the excellent work undertaken by teams from across the Trust, working with our many partners, to develop a set of ambitious organisational priorities, which build on our strengths and which will result in people who use our services receiving excellent care, service and support. Our plans are outlined in four distinct areas.

Firstly, the plan sets out our commitment to ensuring that we have firm foundations to support the delivery of high quality, safe and effective services which provide an excellent experience to all of our service users. This will include the establishment of our Quality Management System, supported by enhanced Business Intelligence capacity and expertise.

The second area signals the continued strategic development of the Trust. This will see us explore opportunities across the health and social care system to identify areas where we can further support our partners in achieving outcomes and benefits for the population we serve. It outlines our key strategic priorities and objectives and describes the programmes of work we have established to ensure that these will be delivered.

Thirdly, the plan identifies our priorities related to the implementation of enhanced models of care and services for blood and cancer services. This will see donors and patients being able to access services as close to home as possible, being able to receive a wider range of information services digitally, and having access to trials and other services provided by our partners which may add value for them.

Finally, our plan describes our ambition to significantly develop our buildings and upgrade our equipment by 2026. These infrastructure improvements, together with our clinical and sustainability plans, will provide us with the opportunity to deliver a carbon net-zero organisation and a range of wider benefits to support the development of thriving and resilient communities across Wales.

The Trust has developed this plan to take account of its commitment to Diversity and Inclusion in the way in which services are delivered and also the way in which staff are recognised and engaged with across the organisation. The Trust embraces an anti-discriminatory approach and this is central to our programme of listening and to enhancing the positive culture of the Trust.

The plan we have set out demonstrates the challenging, but exciting times, ahead for the Trust. We look forward to working with our commissioners, staff, patients, donors and partners to deliver the changes set out within the plan and to continue our transformation into the future.

Mr Steve Ham, Chief Executive

Note: The Chief Executive Introduction and Statement will be reviewed following feedback received through the Trust internal approval process.

CONTENTS

ANNUAL PLANNING FRAMEWORK AND DELIVERY FRAMEWORK CONTEXT 2022-2023

Our Integrated Medium Term Pan (IMTP) for 2023/24- 2025/26 was approved by the Trust Board, on 30th March 2023, as part of the Trusts' statutory duty under the Finance (Wales) Act 2014. Our IMTP was developed in line with the requirements of the Welsh Government NHS Wales Planning Framework for 2023/24 – 2025/26.

Our plan builds upon our approved plan for 2022/23 – 2024/25 and is and output of the excellent work undertaken by teams from across the Trust and strong engagement with our many stakeholders. We have set ourselves a set of ambitious priorities, which build upon our strengths, and which will result in the people who use our services receiving excellent and person-centred care.

Our plan is framed within the Trusts' ambition for the future, following the Boards' approval of the Trust strategy '*Destination 2032*' and brings together the immediate, medium and long-term ambitions of the organisation. The core principle in developing our plan has been our commitment to quality and safety. Our plan will ensure that we put our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving. This is the '*golden thread*' throughout our organisation.

Our strategic goals will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve. These priorities, as set out within our IMTP, have been discussed and agreed with our commissioners and reflects their service needs.

Our IMTP for 2023/24 – 2025/26 will be subject to internal performance management arrangements and will be reported to various external stakeholders, including the Welsh Government.

DUTY OF QUALITY

The Duty of Quality comes into legal force in April 2023, in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The new reporting requirements will therefore be captured in processes in place for 2023/24. In the interim it is anticipated that there will be a non-statutory implementation of the duty of quality in autumn 2022.

This will allow for testing the quality reporting indicators, measures and narrative framework concepts being developed during the duty of quality implementation phase as a hybrid reporting process for 2022/23.

2021-22	Quality reporting requirements embedded in the Annual Report and Accounts process.
2022-23	Non-statutory implementation of the duty of quality in autumn 2022. Hybrid reporting process to test indicators, measures and narrative framework being developed during the duty of quality preparation phase.
2023-24	Duty of quality comes into force April 2023. New reporting requirements will subsequently be in place.

Clinical Safety for our Patients and Donors:

Quality is the ‘golden thread’ running through the planning and provision of services to improve the quality of care provided, leading to improved patient and donor outcomes and promote good practice and innovation.

During 2022/23 we have put in place a number of initiatives, ensuring that ‘quality is at the heart of what we do’ to deliver and improve the quality of services we provide and to drive further improvements in care.

- Trust Quality & Safety Framework approved – Quality, Safety, Outcomes is everyone's business
- Readiness for Duty of Quality & Duty of candour requirements focus
- Integrated Quality & Safety Group operational – to enhance triangulation & assurance
- Quality governance assurance mechanisms implemented with training for all department, divisional, executive and Board leaders

The Trust continually drives hard on quality, safety, experience and value in delivering our primary focus on cancer services and blood products. We are currently developing further quality and safety initiatives, as below:

- The Quality and Safety Team are in the process of developing a Trust wide repository where learning and outcomes from patient and donor experiences can be shared and saved.
- The Trust will also establish “Always on” reporting metrics to aid continual improvement opportunities and real time investigation of concerns that are raised.
- The Trust is developing Quality Hubs operating quality management systems in both VCS and WBS divisions (WBS now operational)

OUR APPROACH TO THE PLANNING AND DELIVERY OF SAFE, EFFECTIVE AND QUALITY SERVICES

Velindre Cancer Service (VCS):

Our work in 2022/2023 has been based on:

The sustained delivery of our services, with sufficient capacity in the context of COVID-19, and the recovery phase was our primary focus during 2022/23. Our overarching aim has been to safely maintain the delivery of non-surgical cancer services for the population of South East Wales during continued growth in cancer treatments, while ensuring that staff and patients continued to be safe when attending our treatment locations and to minimise the risk of COVID-19 transmission.

The Transforming Cancer Services programme, leading to the opening of the new cancer centre in 2025/26, will continue to be a core area of work for us and we continue to work in partnership with South-East Wales Local Health Boards and the Collaborative Cancer Leadership Group (CCLG). Existing regional projects such as the Acute Oncology Service Project also continue to be key strategic priorities for us and our LHB partners.

In taking account of the above determining factors, the Velindre Cancer Service pursued the following priorities during 2022/23.

Our Priorities in 2022/23:

Priority 1: Ensuring that Staff and Patients are Safe at our Treatment Locations – we minimised the Risk of COVID-19 transmission through maintaining enhanced infection control measures, revised patient and care delivery pathways during 2022/23 with most preventative measures being lifted in quarter 4.

Priority 2: Delivery of appropriate capacity to meet patient demand – despite the pressures caused by the pandemic and subsequent recovery challenges, we continued to deliver all of our services by adapting our clinical model and seeking capacity delivery solutions.

Priority 3: Delivery of business critical initiatives – we continued to deliver a number of business critical and strategic initiatives. These included:

- Engagement processes with Heath Boards commenced to support the operational planning for the clinical models for the new Velindre Cancer Centre and outreach services.
- Support and input into the Outline Business Case for the construction of a cancer centre in Neville Hall Hospital in partnership with Aneurin Bevan University Health Board.
- Implementation of the Digital Health and Care Record (DHCR) replacing the CANISC system.

- Implementation of a rolling Linac replacement programme as part of the implementation of an integrated radiotherapy system (IRS).

Priority 4: Engagement with Health Boards and Regional Service Planning – we have continued to lead and support regional service developments, including:

- The Radiotherapy Satellite Centre implementation ion Neville Hall Hospital.
- The development of a South-east Wales Acute Oncology Service.
- The development of a research and development facility in partnership with Cardiff and Vale University Health Board and Cardiff University.

Priority 5: Patient Experience and Engagement (recognising and responding to the impact of COVID-19) - Our patient engagement strategy has been developed in collaboration with our staff, our patients and donors and with other key stakeholders. It outlines how we will engage with our patients, donors and their families and carers in the future to ensure that their voices are at the heart of how we plan and deliver our services.

Performance Analysis:

We have developed a wide range of measures which are routinely used to monitor the quality and performance of our core services. The VCS performance against a range of quality measures and targets are explored further in the following Performance Analysis Section. The Trust's detailed performance reports received by the Trust Board are available on the Trusts internet site via the following link **(insert link).**

Challenges faced during 2022/23:

VCS continues to operate against the background of the challenges for tertiary cancer services in addition to those that resulted from the pandemic, including increasing cancer rates and health inequalities, a growing gap in the forecast demand between supply and demand, increasingly complicated and personalised treatments and supporting people to live with and beyond cancer.

The year 2022/23 provided significant challenges for VCS in responding to the COVID-19 pandemic recovery phase and move into business as usual. Ensuring effective and safe utilisation of the site to accommodate services remained a challenge in year with a number of PPE restrictions only relaxed in the last quarter.

Quarter 1 2022/23 saw an increase in demand for Services within VCS as Health Board implemented a range of measures to address their backlog of activity that had resulted from the COVID pandemic. SACT services faced significant pressure and a formal recovery project was established in response to managing the demand. This work focused on identifying opportunities for increasing short terms and sustainable longer term capacity. Implementation of the recovery plan, resulted in a return to balance in Quarter 3, which has continued to be maintained throughout Quarter 4. At all times, the treatment of patients was managed in keeping with accepted national guidelines. A further focus of the recovery plan was the repatriation back to Health Board sites of pre-pandemic SACT outreach facilities, working in partnership with ABUHB and CTM UHB.

An increase in referrals for breast cancer provided a level of challenge for Radiotherapy performance. This was effectively managed within the operational service through reconfiguration of systems, workforce and processes. Management of this cohort of patients was further exacerbated as the planned replacement of the LINACs commenced towards the end of Quarter 3. Clinical prioritisation of patients in line with national guidelines was maintained

At the start of Quarter 4, the new Radiotherapy performance metrics (Radiotherapy Quality Indicators) were introduced across Wales, replacing the previous JCCO performance targets. All patients are now having their treatment planned with an aim to meet those targets. Optimum pathways to support delivery of this new reporting metrics were developed, which require changes to processes and workflows, some of which will be dependent on elements of the new radiotherapy technology replacement programme. Implementation of the new pathways continues as we move into 2023/24.

A major change to 'ways of working' at the VCS was successfully implemented in Quarter 3 as the existing CANISC system was replaced with a new Digital Health Care Record (DHCR) Welsh Patient Administration system (WPAS). This is the first phase of a larger programme of work across Wales to bring all Health Boards and Trust onto the same WPAS platform. Work to embed the system and new 'ways of working' continued through Quarter 4 and is continuing into 2023/24.

The wellbeing of our staff continued to be a key priority during 2022/23, and the professional and personal impact of the pandemic and the way in which we work will continue to be a key area of focus. The recruitment of additional staff with specialist skills that we require and the most effective use of our staff skill sets and skill mix has been and remains to be critical to our demand response. This has required us to develop different ways of working and delivering our services.

Velindre Futures:

The Velindre Futures programme was established in 2020, and is the vehicle through which we are delivering the transformation needed to meet the aspirations of the South East Wales Transforming Cancer Services programme, the further regional opportunities which we have identified and the existing ambitious plans for service modernisation.

Over the past year, a number of the transformation programmes have made good progress despite the impact of the COVID pandemic – these have included progress on the Unscheduled and Acute Oncology pathways with our local Health Board partners, the development of a Research and Development Hub at the University of Wales Hospital, the Radiotherapy service change programme and the development of a formal engagement strategy for the Trust.

The outpatient transformation programme (linked with Values Based Health Care), and the replacement of the CANISC system through the delivery of the Digital Health and Care Record system are continuing.

In the autumn the Integrated Radiotherapy Solution procurement was completed and the implementation phase started with the first LINAC delivered in January. Work has also commenced on the establishment of the Radiotherapy Satellite Centre. We will continue to drive the transformation agenda at the Cancer Centre via the Velindre Futures Major Programme Board. Core to these ongoing service changes is ensuring that the voice of the patient, their carer's, families and the public are involved in shaping what we do.

New Velindre Cancer Centre:

Since Welsh Government's approval in March 2021 for the outline business case for the new Velindre Cancer Centre the Trust has successfully continued to take forward the plans to the next stage. The Trust has been working with two consortia as part of the competitive dialogue process to design, build and operate the new VCS. This work includes working with our patients and staff to develop a hospital design that will deliver our ambition of a world-class facility that will deliver unrivalled care for cancer patients across South-East Wales, be an inspiring workplace for our dedicated staff to thrive and be a focal point for international research. In addition, the Trust and consortia have been actively seeking to ensure the new hospital is a place that benefits the local community.

The Trust has successfully started the enabling works on the new site, which is a key dependency for the opening of the new centre, which is programmed to open in 2025.

We are all continuing to work to develop the new Velindre Cancer Centre to be one we can all be proud of for generations to come.

Welsh Blood Service (WBS):

The Welsh Blood Service has met all clinical demand in 2022/23, despite being another challenging year. Whilst it has had to rely on support from other UK blood services on occasions, it has also supported those services with mutual aid at other times during the year. WBS has continued to adapt its blood collection and processing service model and its transplant support services in response to changing public health and IPC guidance in relation to COVID throughout the year.

The pattern of change in demand for our services is clearly aligned to that of Local Health Board services and we have continued to work closely with NHS colleagues through the National Oversight Group for Blood Health and blood bank managers to respond as required.

In 2022/23, work began on establishing the WBS Future initiative which will be the vehicle to deliver the aspirations and shape future services for WBS.

The Welsh Blood Service Strategy has been developed and will be launched in Quarter 1 2023/24. It sets out our vison for blood and transplant services in Wales for the next five years, outlining where we are now, where we want to be in 2028 and the steps we will take to get there. In 2022/23, work began on establishing the WBS Future initiative which will be the vehicle to deliver the aspirations outlined in our strategy and shape future services for WBS.

Our Priorities Delivered in 2022/23:

Provide an efficient and effective collection service, facilitating the best experience for the donor, and ensuring blood products and bone marrow donations are safe and high quality – The donor strategies, for both whole blood and bone marrow donors, began development in 2022/23 and will be finalised in 2023/24.

Monthly donor satisfaction surveys have continued to be a source of feedback that promotes donor led improvements in service delivery. These have included the re-introduction of Mobile Donation Clinics and smaller community based whole blood clinics that had been removed due to COVID related IPC constraints, enhanced pre clinic screening to reduce incidents of donors being unable to donate blood having attended their appointment, a revised approach to children on clinic and improved donor adverse event recording.

A number of national campaigns have been undertaken during 2022/23 including Blood Sweat and Cheers, Giving Runs in Your Blood, #BestGift, our sixth form, college and university donation programme (#YoungBlood) and #ChilledOutLifesaver which re-launched in November featuring a donor Tom and his recipient, Rob – both from Wales who met for the first time after Rob received a lifesaving bone marrow donation from Tom – you can watch the video when they met here www.wbs.wales/col. Further campaigns are anchored around key dates across the year including World Cancer Day, World Blood Cancer Day, National Blood Donor Week, World Blood Donor Day, World Marrow Donor Day and Christmas/New Year.

Meet the patient demand for blood and blood products through facilitating the most appropriate use across Health organisations - WBS has sustained supply of blood and blood products for Wales in difficult circumstances and whist it has had to rely on support from other UK blood services on occasion, WBS has also found itself supporting those services at other times during the year. A collaborative working group continues to match supply to demand through the extensive use of data, flexing the collection of whole blood and platelets on a seasonal basis.

The Blood Health team continue to work with hospitals across Wales, providing training and support to ensure that blood products are used appropriately.

Provide safe, high quality and the most advanced manufacturing, distribution and testing laboratory services – In the last year, Welsh Blood has procured new Blood Group Analysers for whole blood, and a new Bacteriological monitoring and alerting system for platelets. New processes have been developed to support the screening of donors for occult Hepatitis B infections. Screening of platelet donors for HNA antigens has been introduced.

Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services – Welsh Blood has implemented state of the art Next Generation Sequencing in the Histo-compatibility and Immuno-genetics laboratories and has implemented changes to cross-matching tests used to assess compatibility in solid organ transplantation. During 2022/2023 WBS will introduce a Consultant Clinical Scientist on-call service to support organ transplantation.

We have also been working closely and collaboratively with our international colleagues through the Association of Donor Relations Professional (ADRP) and the European Blood Alliance (EBA) to share best practice, information and knowledge and to benchmark our systems and processes to help identify opportunities to improve our service delivery.

Provide, services that are environmentally sustainable and benefit our local communities and Wales – A programme of work is underway to develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. Other projects are working to reduce the use of non-recyclable materials such as water bottles and bio degradable cups in donation clinics, and to reduce the use of printed documents across the service. The first electric vehicle was introduced to the Logistics department where it is deployed on the delivery of blood components to hospitals across the south east region of Wales.

Be a great organisation with great people dedicated to improving outcomes for patients and donors – Welsh Blood continues to offer a variety of career development pathways for its people. It has maintained support for higher education and vocational training for scientists and health professionals. This includes the national Higher Specialist Scientific Training programme for consultant clinical scientists as well as management and leadership development. Trade union engagement continues to be positive with close collaboration as we seek to align terms and conditions across our collection teams. Work is ongoing to design an agile model of working where lessons from the pandemic can be applied to allow our people flexibility in where they work.

Performance Analysis:

We have developed a wide range of measures which are routinely used to monitor the quality and performance of our core services. The WBS performance against a range of quality measures and targets are explored further in the following Performance Analysis Section. The Trust's detailed performance reports received by the Trust Board are available on the Trusts internet site via the following link (insert link).

Challenges faced during 2022/23:

Whilst we always plan to collect enough blood to meet the forecast issuing requirements of hospitals across NHS Wales, 2022/23 has continued to present unique challenges as a result of the pandemic and industrial action, as outlined below:

Collection of Blood and blood products, processing and distribution:

- Fewer fixed donation sites, incorporating social distancing and infection prevention control measures.
- Competition for donation sites from vaccination clinics.
- Continuation of IPC measures for COVID positive staff and contacts.
- The need to increase stocks of Fresh Frozen Plasma to support stock replacement as part of the occult Hepatitis B screening programme.
- Access to timely, up to date demand information to support forward planning.
- Industrial Action derogation negotiations.

Wholesale Distribution of Commercial Blood Products:

- Ongoing monitoring of availability of stock and contingency planning.
- Pressure to increase and maintain critical stocks in response to forecast global shortages of donated plasma from which these products are made.

Blood and stem cell donor selection regulations:

- Continuing to meet stringent and changing donor selection guidelines and regulations for blood and stem cells including the introduction of screening for occult Hepatitis B Infections and the need to review historical donations from donors who test positive.
- Continuing to meet COVID-19 requirements for facilitation of export and import of stem cell products such as transport from restricted countries and COVID-19 testing of couriers.

Maintaining an engaged healthy donor panel:

- Focus on ‘targeting’ to meet specific and fluctuating requirements for specific groups.
- Strategy for bone marrow donor recruitment, where age group differs to whole blood donors.

A healthy and sustainable workforce:

- Specialist staff shortages.
- Recruitment and retention.

Work is ongoing through the Blood Health Team and Collections Team to align the collection profile with demand for specific blood groups, but this remains difficult to determine. Furthermore, there is a requirement to ensure the supply of blood by blood group meets the demand, which adds to the risk of supply and issuing alignment being achieved. Unpredictability within the platelet demand, alongside the short life span of this component has led to particular difficulties in matching supply to demand and controlling expiry of unused units.

We continue to use our donor recruitment plans to flex to meet demand and our donors are responsive. However, in the event of shortage, we will draw on our mutual aid agreement with the UK Blood Services or in extreme circumstances initiate the National Blood Shortage Plan to actively manage stocks with hospitals.

PERFORMANCE ANALYSIS

During 2022/23 our Performance Management framework (PMF) has evolved with an enhanced range of measures which are routinely used to monitor the quality and performance of our core services. The core measures for Velindre Cancer Centre and the Welsh Blood Service are included in the tables below.

The performance summaries are explored further with supporting narrative in the Trusts performance reports received by the Trust Board. These papers are available on the Trust's internet site via the following **link:**

Our Performance Management Framework

This Annual Report provides an overview of the performance our Trust for the financial year 2022/23, in our new PMF format, 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 and sustainability.

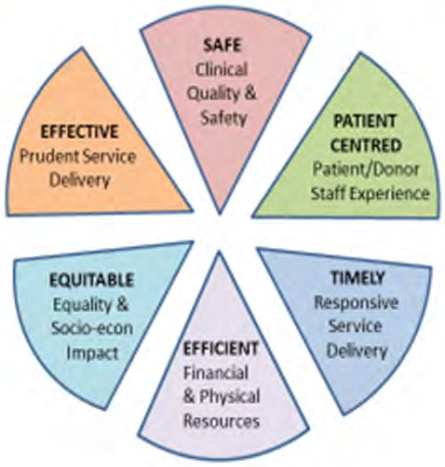
The new performance report format adopts a 'balanced scorecard' approach which seeks to 'triangulate' the interplay between operational delivery, service quality and safety, our people and physical/finance resources, and is based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.

Each Key Performance Indicator (KPI) is supported by analysis that explains the current performance, using wherever possible Statistical Process Control (SPC) Charts, to enable the distinction to be made between 'natural variations' in activity, and trends or performance requiring investigation.

The process of developing the new PMF performance reporting style has involved extensive engagement and discussion with Independent Members, Executive Directors, Community Health Council Representatives plus detailed work with Directorate Leads and key staff responsible for gathering, collating and reporting performance.

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework



Welsh Blood Service

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2022/23		
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	85%	85%	86%
	Number of VCS Inpatient (avoidable) falls	National	Monthly	1	0	1
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	1
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	1
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	0	0	0
	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	3	0	1
	Carbon Emissions – carbon parts per million by volume 16% reduction by 2025 against 2018/19 baseline	National	Annually	0%	-3%	-3%

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2022/23		
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	0	0	0
	% Demand for Red Blood Cells Met	Best practice	Monthly	102%	100%	105%
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.08%	Max 1%	0.12%
	% Time Expired Platelets (adult)	Local	Monthly	16%	Max 10%	18%
	Number of Stem Cell Collections per month	Local	Monthly	1	7	4
	% Rolling average Staff sickness levels	National	Monthly	6.31%	3.54%	6.12%
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	69%	85%	72%
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCS as very good or excellent	Prof. Std.	Monthly	85%	85%	92%
	% Donor Satisfaction	Local	Monthly	96%	95%	96%
	% of 'formal' VCS concerns responded within 30 working days	Local	Monthly	100%	85%	100
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	100%
Timeliness	% Patients Beginning Radical Radiotherapy Within 28 days (JCCO)	National	Monthly	87%	98%	89%
	% Patients Beginning Palliative Radiotherapy Within 14 days (JCCO)	National	Monthly	79%	98%	84%
	% Patients Beginning Emergency Radiotherapy Within 2 days (JCCO)	National	Monthly	84%	98%	96%
	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC) – Feb and March data only	National	Monthly	N/A	80% 100%	29% 47%
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC) – Feb and March data only	National	Monthly	N/A	80% 100%	6% 50%
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC) – Feb and March data only	National	Monthly	N/A	100%	94%
	Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC) – Feb and March data only	National	Monthly	N/A	80% 100%	27% 32%
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	69%	98%	88%
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	96%
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	96%
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	97%	90%	94%

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2022/23		
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.064m) outturn
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£27,760 M	£27,758M outturn
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.128m	£0.140m outturn
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.300m	£1.300m outturn
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	96%
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	N/A	N/A	63%
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	N/A	N/A	12%
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	N/A	N/A	4%
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	N/A	N/A	4%

VELINDRE CANCER CENTRE (VCS)

Performance during 2022/23 was of a high standard and reflected our on-going ambition to deliver the best possible services. Areas not meeting set levels have been and are subject to continued scrutiny and actions are being taken forward to improve. Below, we examine our performance in 2022/23 in more detail.

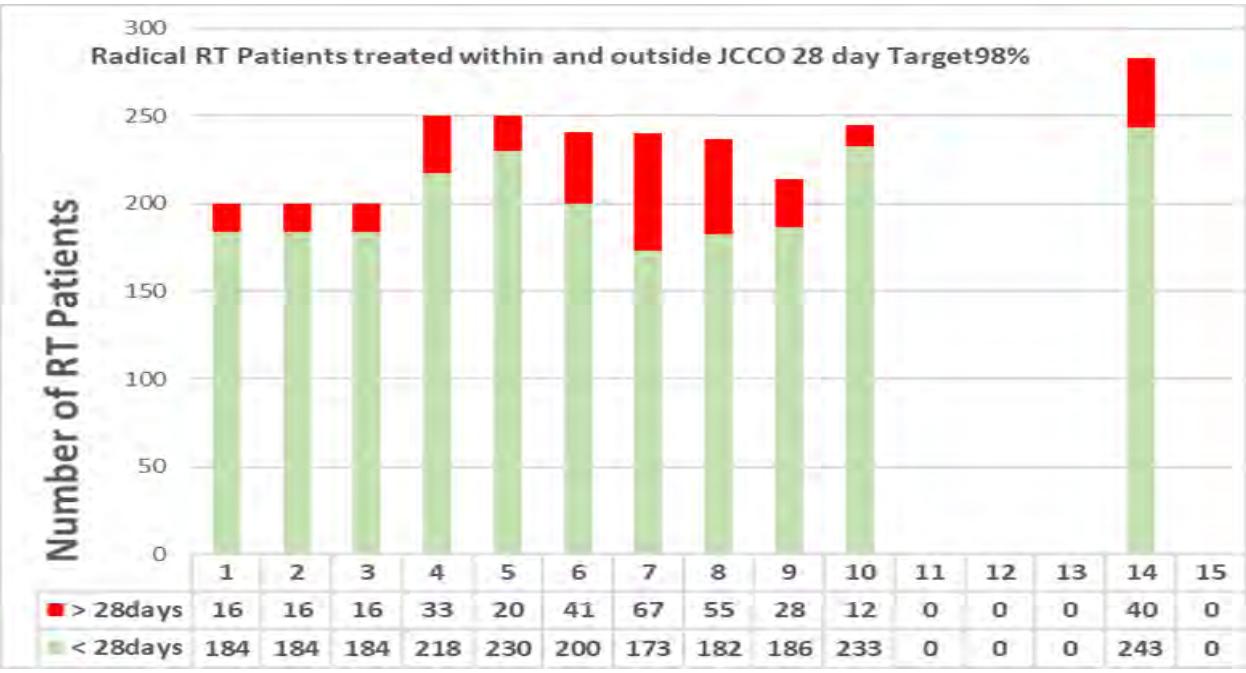
WAITING TIMES AND ACCESS TO SERVICES

During the year we saw high demand for the radiotherapy and chemotherapy services provided at the Velindre Cancer Centre. Our staff worked hard to meet this demand and we continue to explore new ways of working which will reduce waiting times and improve patient access to our services.

PROGRESS AGAINST: RADIOTHERAPY

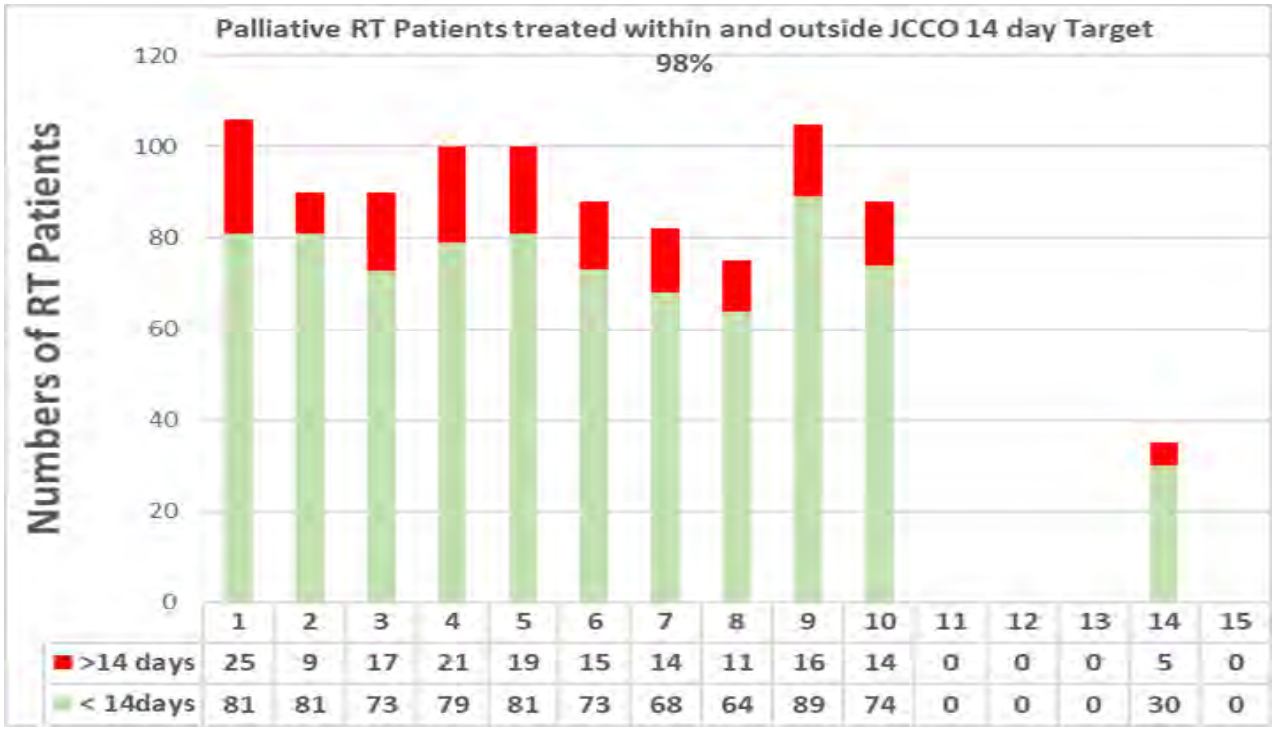
In 2022/23, we observed an 8% increase in demand for radiotherapy services. We implemented a balanced capacity plan to ensure sufficient capacity was in place to meet demand increases. Our performance between April and October 2022 was 85% against the Radical 28 day target, 83% against the Palliative 14 day target and 93% against the Emergency 2 day target.

The new categorisation of treatment times new Radiotherapy Time to Treatment targets (RRTT) (previously known as COSC), are a major change implemented from January 2023, that is being adopted across Wales and work is ongoing to fully embed the changes. 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 data, waiting times reports were unavailable for the period November 2022 to January 2023. Work is also taking place at a national level to more clearly define the new categories, reporting criteria and how pathways can be changed to ensure the delivery of the new measures. Our performance between April and October 2022 was 85% against the Radical 28 day target, 83% against the Palliative 14 day target and 93% against the Emergency 2 day target.

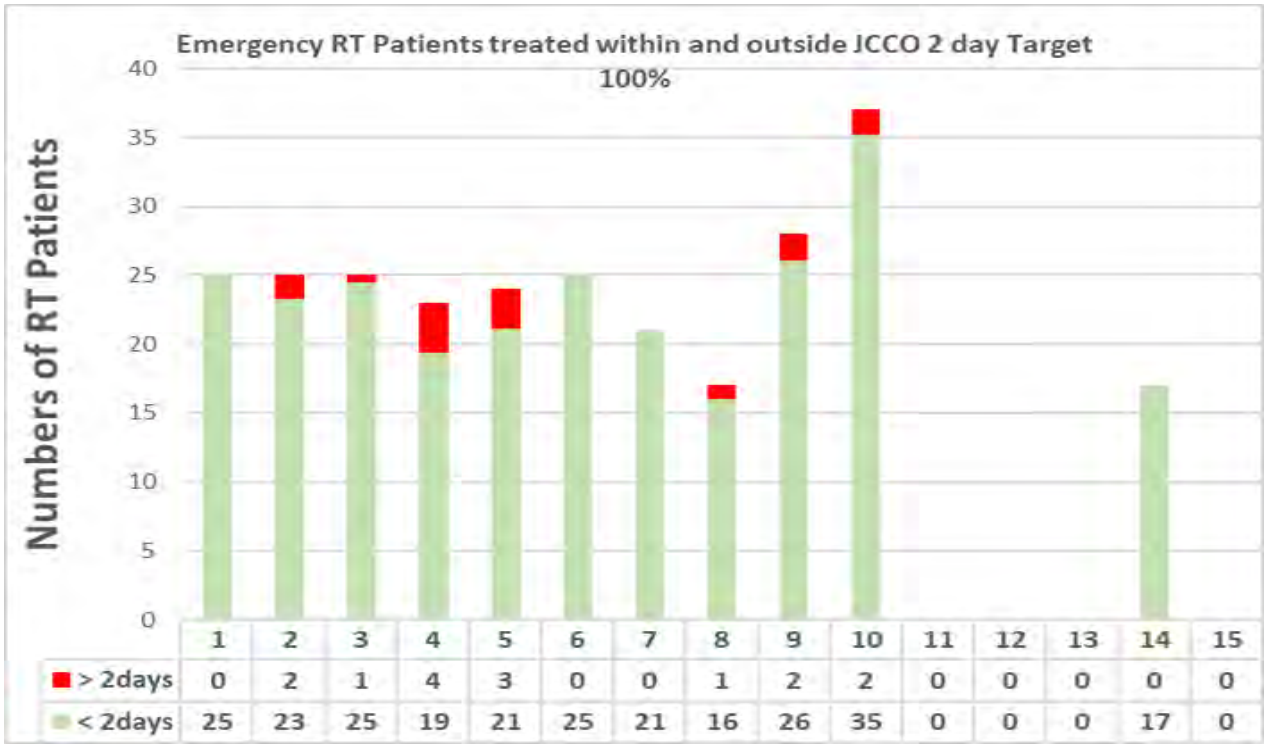


	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
> 28days	16	16	16	33	20	41	67	55	28	12	0	0	0	40	0
< 28days	184	184	184	218	230	200	173	182	186	233	0	0	0	243	0

Months 1 to 15 Jan 2022 to March 2023



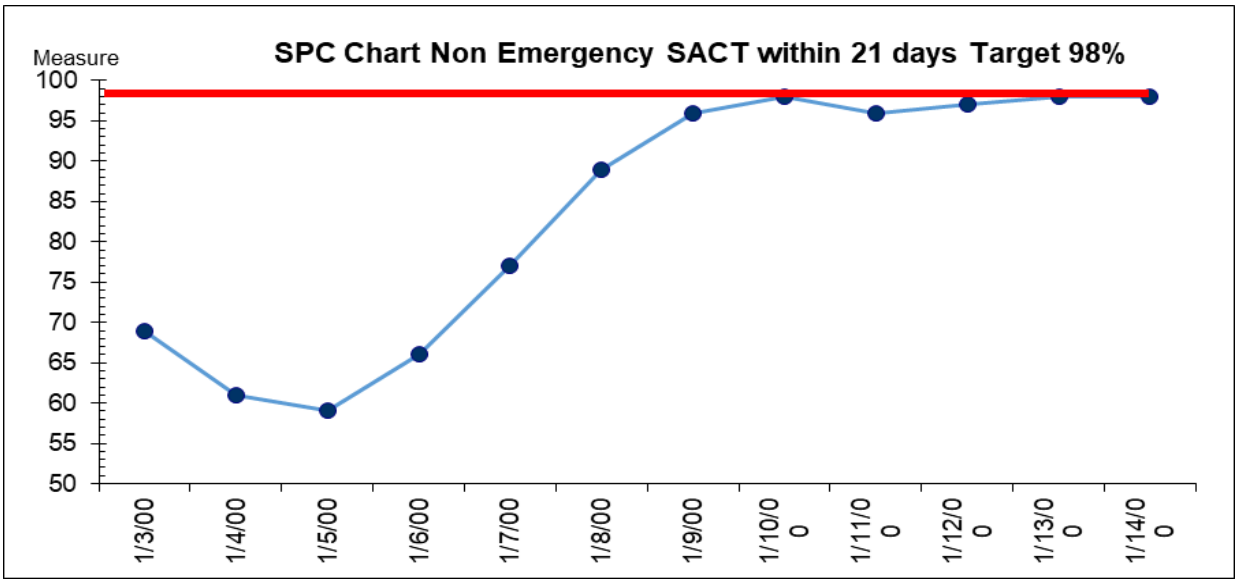
Months 1 to 15 Jan 2022 to March 2023

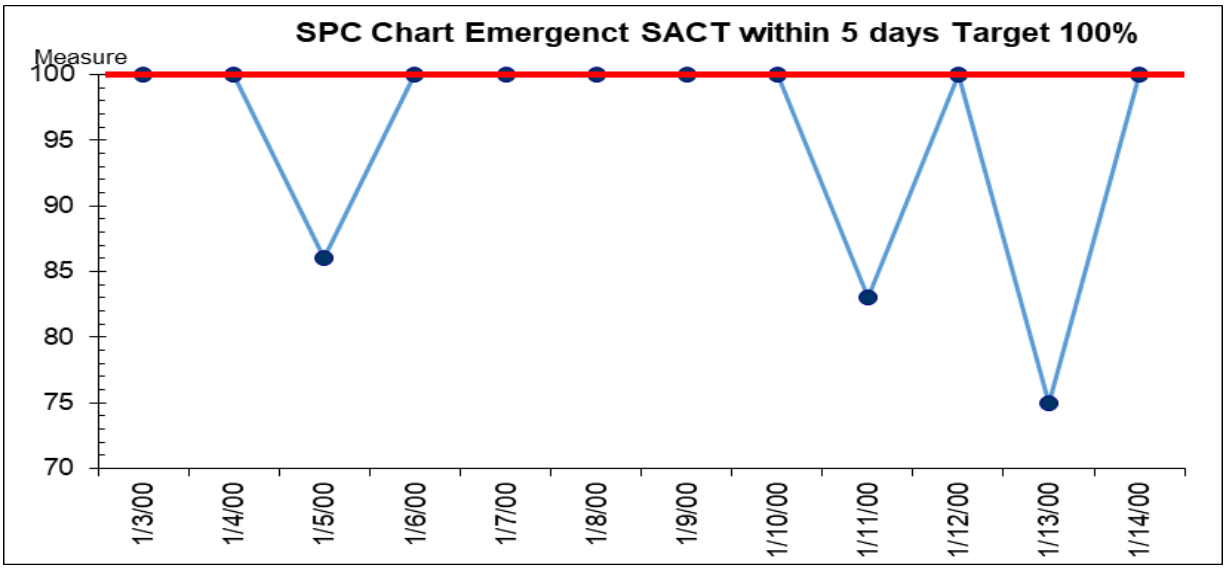


Months 1 to 15 Jan 2022 to March 2023

PROGRESS AGAINST: CHEMOTHERAPY

Following a significant increase in SACT referrals of 8% in 2021/22 we saw a further increase of 12% in 22/23. This resulted in a significant challenge to produce capacity to match the demand as all outreach provision for ABUHB and 50% for CTMUHB had been repatriated and delivered at VCS. As a result we saw deterioration in performance between January and June 2022. We implemented a delivery plan which included additional resources alongside a return to full capacity at CTMUHB and internal productivity and service improvement changes. This saw us recover between July and November 2022 to return to delivery of our waiting times targets. We feel that this reflects the hard work and dedication of our team and our ongoing commitment to improve our services.





PROGRESS AGAINST: ACCESS TO THERAPY SERVICES

Performance throughout 2022/2023 was excellent overall, but we recognise that the small number of therapies staff means that staff absence can have a disproportionate effect on overall performance. Every effort is made to manage such situations effectively.

VCS	Apr22	My 22	Jun22	Jul 22	Aug22	Sep22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar23
Dietetics	100	100	100	100	96	95	100	100	100	100	100	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	100	100	100	100
SLT	67	100	100	100	100	100	100	100	100	100	100	100
Dietetics	100	100	100	100	100	100	100	98	100	91	100	98
Physio	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	67	100	100	100
SLT	100	100	100	100	100	50	100	100	100	100	100	100
Dietetics	100	100	100	100	100	100	100	100	100	100	100	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	97	100	78	100	100	96	100	96
SLT	100	100	100	100	96	100	100	100	100	100	100	100

PROGRESS AGAINST: SAFE AND RELIABLE SERVICES TARGET

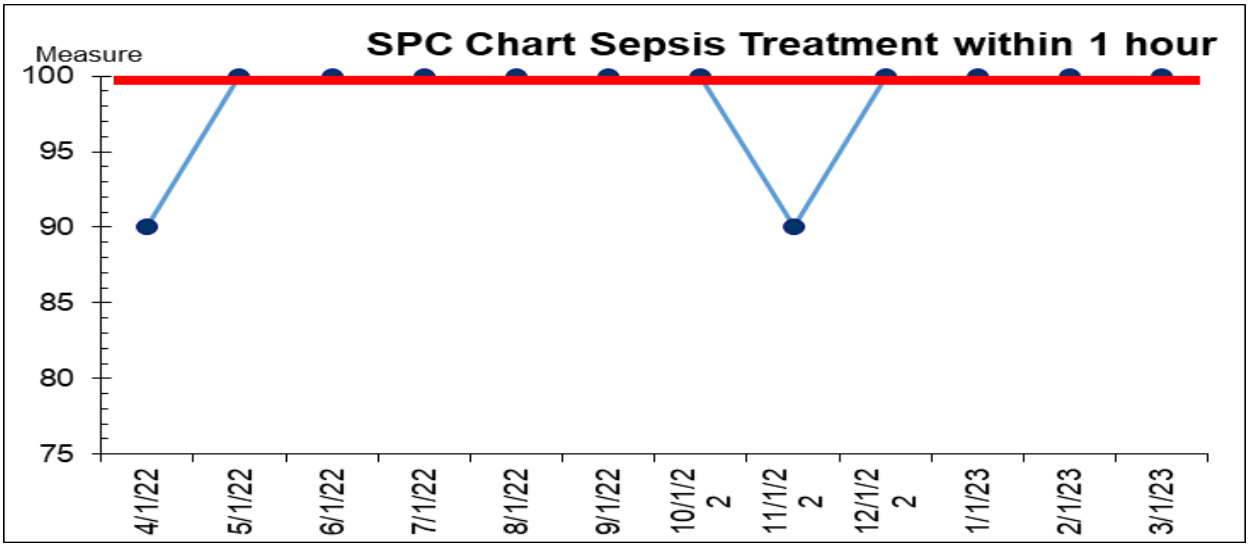
Hospital Acquired Infections: We have continued to maintain our low rates of hospital acquired infections. We have zero tolerance with respect to hospital acquired infections, such as MRSA. This means that our aim is to see no such infections in our inpatients over the course of any year. However, we also recognise that our inpatients can be particularly susceptible to infection because of the nature of the treatments that they undergo and their physical condition. There was a peak in December 2022 and January 2023 which reflected a national rise in infection rates.

VCS	Apr22	My 22	Jun22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
C.diff	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
MSSA	0	0	0	0	0	0	0	0	1	0	0	0
E.coli	0	0	0	1	0	0	0	0	1	3	1	0
Klebsiella	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
Gram Neg	0	0	0	0	0	0	0	0	1	4	1	0

Pressure Ulcers: We also have zero tolerance with respect to tissue damage and pressure ulcers. Again, our inpatients can be particularly susceptible to this sort of damage. Compliance with our Skin Care bundle, which has been developed to reduce the risk of skin and tissue damage for our inpatients, showed full compliance with the aviodable pressure ulcer target all year.

VCS	Apr22	My 22	Jun 22	Jul 22	Aug22	Sep 22	Oct22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual Number	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
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0

National Early Warning Score (NEWS): NEWS was originally developed by the Royal College of Physicians and is intended to help reduce the number of patients whose conditions deteriorate whilst they are in hospital. When a patient is assessed using NEWS, a score equal to, or greater than 3, indicates that they may be at an increased risk of developing complications. At VCS, we use NEWS to determine whether our patients are at an increased risk of complications related to neutropenic sepsis. Those patients that are deemed to be at greater risk have the 'Sepsis Six' bundle (a combination of 3 different treatments and 3 tests) administered to them within a set time. The graph below shows that we performed well against our target (that all patients be administered with the 'Sepsis Six' bundle within the set timeframe) in 2022/23, with full compliance in 10 of 12 months.



PROGRESS AGAINST: FIRST CLASS PATIENT EXPERIENCE TARGET

Our patient feedback is largely positive. The Trust has worked to improve the way it collects and receives feedback from those who use our services. Work to understand how best to collate feedback, identify themes and to use this information to aid improvement is crucial. There are 2 surveys used in VCS – 'Would you recommend us?' and 'Your Velindre Experience' The Your Velindre experience uses 0-10 in the question about rating VCS, whereas 'Would you recommend us?' used Very good, good etc. The majority of surveys completed in VCS is the 'Would you recommend us?' one.

Patients at Velindre Cancer Centre consistently rated their own experience as being very good, scoring an average in the 90 %s for 'would you recommend us?' to an 85% average for 'your Velindre experience'. The importance of learning from patient feedback remains paramount in the development of our services.

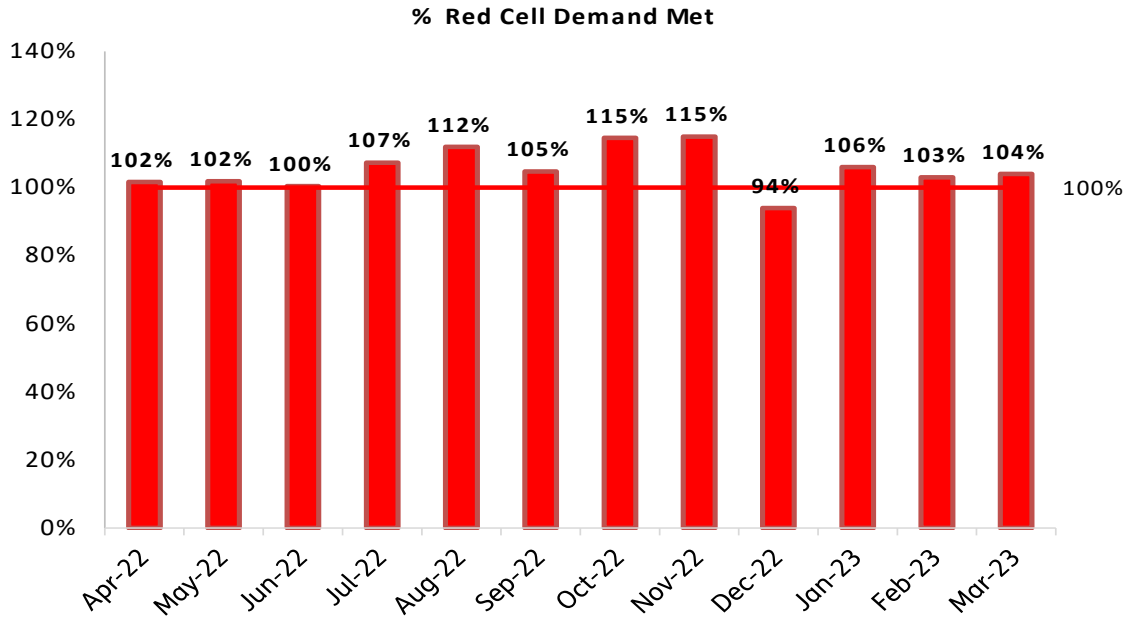
VCS	Apr22	My 22	Jun22	Jul l22	Aug22	Sep22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Would you recommend us? %					89	89	88	nda	nda	93	96	95
Your Velindre Experience? %								nda	nda	84	86	82
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95

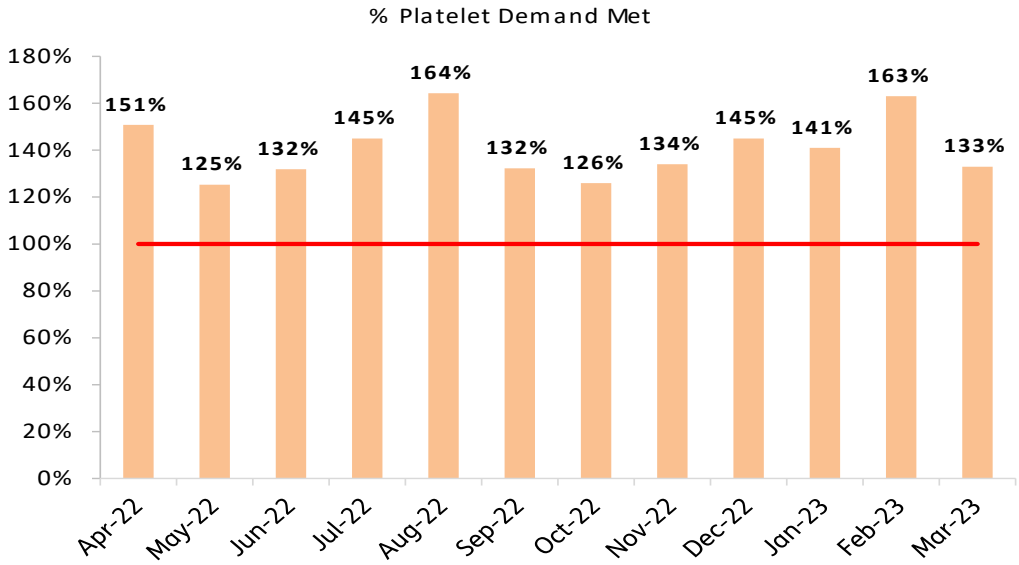
WELSH BLOOD AND TRANSPLANT SERVICE (WBS)

Performance metric	2020/21		2021/22		2022/23	
	Target	Actual	Target	Actual	Target	Actual
Number of new Bone Marrow Volunteer (BMV) registrations aged 17-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	2,964	4,000	2,199	4,000	2,175
≥80% deceased donor typing / cross matching reported within 4 hours (turnaround times target reduced from 6 to 4 hours in 2017/18)	80%	89%	80%	88%	80%	86%
≥90% Anti-D & -c Quantitation results provided to customer hospitals within 5 working days	90%	99%	90%	97%	90%	93%
≥90% routine antenatal patient results provided to customer hospitals within 3 working days	90%	98%	90%	97%	90%	96%
≥80% samples referred for red cell reference serology work up provided to customer hospitals within 2 working days	80%	84%	80%	81%	80%	69%
Number of reportable SABRE events	5	5	5	9	0	9
Quality incident Records closed within 30 days (rolling three month period)	90%	100%	90%	100%	90%	96%
≥71% of blood donors scoring 5 or 6 out of 6 for satisfaction with overall service	95%	92%	95%	95%	95%	96%
≥100 % of concerns answered within 30 days	100%	99%	100%	100%	100%	100%
<10% time expired platelets	10%	14.6%	10%	13.4%	10%	21%
<1% volume of waste (<0.5% until March 2017)	1%	0.6%	1%	2.5%	1%	0.12%
% Part Bags	3%	3.1%	3%	2.7%	3%	2.4%
% Failed Venipuncture	2%	1.6%	2%	1.4%	2%	1.4%

PROGRESS AGAINST: MEETING CLINICAL DEMAND FOR RED BLOOD CELLS AND PLATELETS

Throughout 2022/23, the Welsh Blood Service successfully met all clinical demand for Red Blood Cells (RBC) and Platelets for our customer hospitals across NHS Wales. This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs and working closely with our customer hospitals. Whilst it has had to rely on support from other UK blood services on occasions, it has also supported those services with mutual aid at other times during the year.

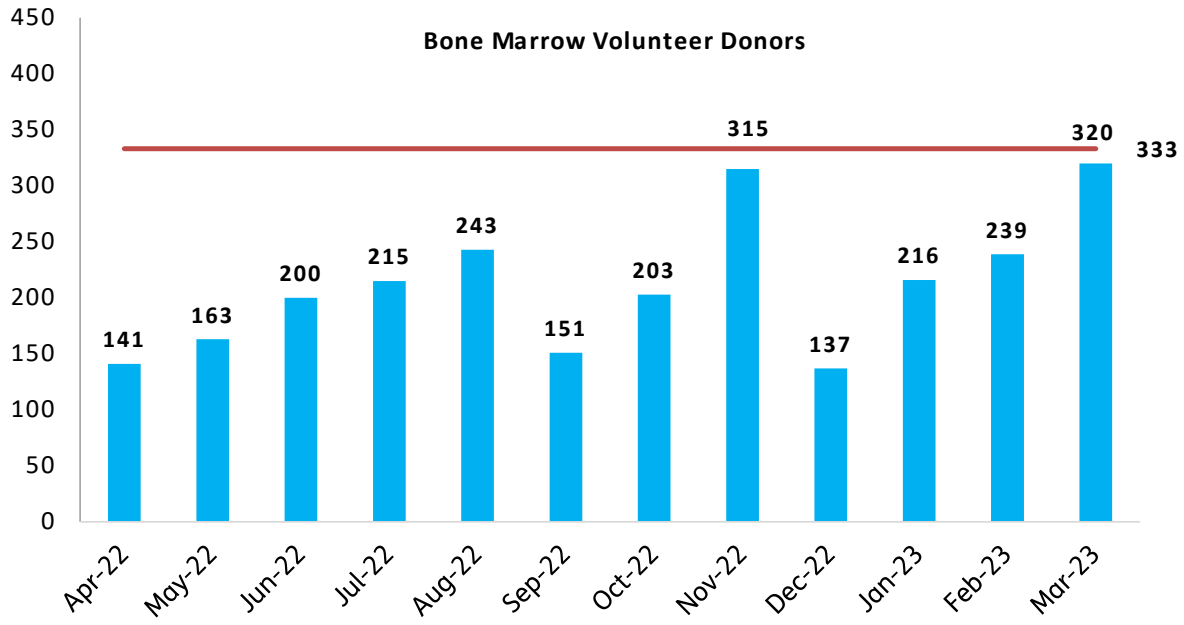




PROGRESS AGAINST: GROWING OUR BONE MARROW REGISTRY

The Welsh Bone Marrow Donor Registry (WBMDR) provides a panel of volunteer donors recruited from the blood donor panel willing to donate stem cells for use as cellular therapy. A donor attends a blood donor session and if aged between 17 and 30 is asked if they would like to join the panel. Donors stay on the panel until their 61st birthday.

Our registry currently includes more than 71,000 volunteers who were recruited via a blood donor session. However, the WBMDR donors represent only 3% of the UK donor panel and the target recruitment is 4,000 per annum (5.6% of the panel) which was not met in 2022/2023. However, a recruitment recovery plan has been put in place to address this shortfall. The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, began development in 2022/23.



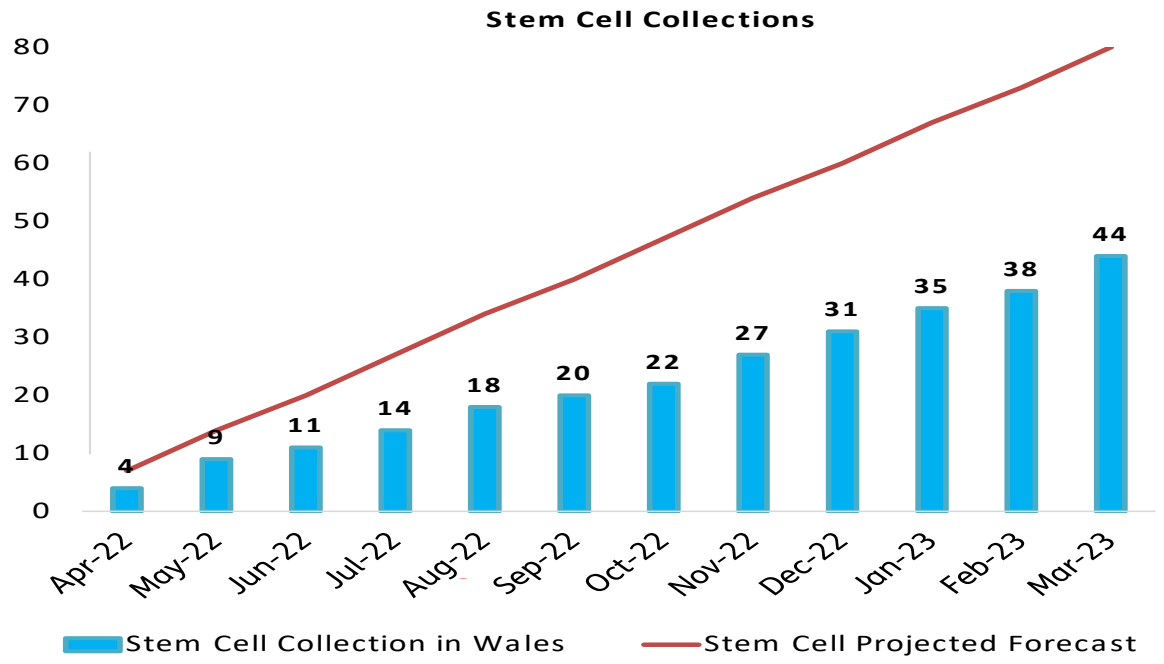
Current Bone Marrow Volunteer (BMV) recruitment involves a combination of recruitment of blood donors aged 17-30 at blood donor sessions and the recruitment of non-blood donors using buccal swabs. This age group is preferred as young donors have longevity as a potential donor and because they provide a more clinically effective transplant. Recruitment via blood donor sessions is becoming increasingly difficult to sustain as the strategy of aligning blood supply to demand going forward, will require increased focus on returning blood donors whose demographic is not necessarily aligned to the target BMV age group. This has resulted in the requirement to increase our focus on recruitment of bone marrow volunteers via buccal swabs

There are 114 registries in the global network and in total there are nearly 41 million donors on the global panel. The panel grows at ~7% each year. In the UK, there are 4 registries with a total of 2.1 million donors. The Welsh Bone Marrow Donor Registry represents 3% of the total donors in the UK. The WBMDR has the highest collection index of the 4 UK registries and consistently scores high in international collection and efficiency indexes and trend reports such as the WMDA Global Trends Report and the National Marrow Donor Program (NMDP-USA) Global Registry Report. The WBMDR has recently passed inspection by the Human Tissue Authority (HTA) and the World Marrow Donor Program (WMDA) and maintains its status as a donor centre for the NMDP.

PROGRESS AGAINST: MEETING TRANSPLANT SERVICES REQUESTS

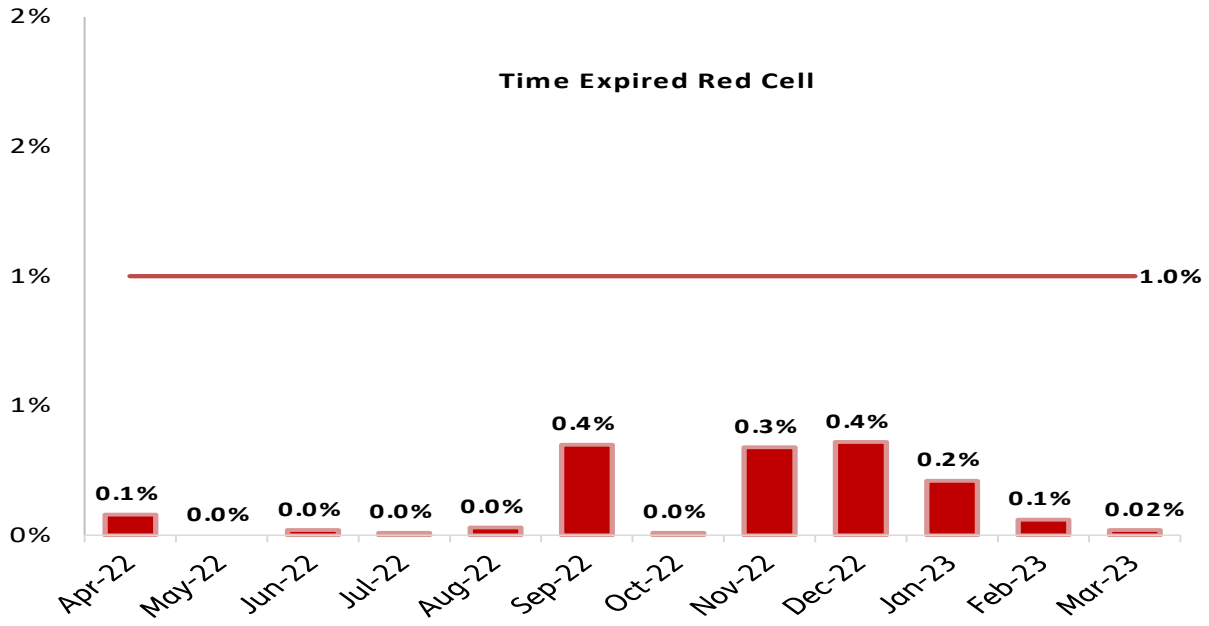
Our annual target for the number of stem cell collections that we would anticipate in any 12-month period is set at the beginning of the year.

There are a high number of variable factors that influence the number of stem cell collections that are undertaken in any one calendar month. There is an initial confirmatory test, which is, then sent back to the requesting transplant centre who then make a decision on which donor will be taken forward for their particular patient. From the basic genetic match of our donors, availability and willingness of our donors to participate and donate, the wellbeing of the recipient patient, and their treatment pathway, all contribute to the final number of collections that will be undertaken in any one calendar month. In 2022/23, the Welsh Bone Marrow Donor Registry fell shy of its annual target. However, during the pandemic stem cell collections had fallen mainly due to a reduction in transplant centre stem cell collection requests and the high cancellation rate due to patient factors during this period. The WBMDR has recently (November 2022) implemented a new piece of software that provides external registries with a more modern donor selection algorithm and we are already experiencing an increased number of sample requests, which have a direct relationship to product requests.



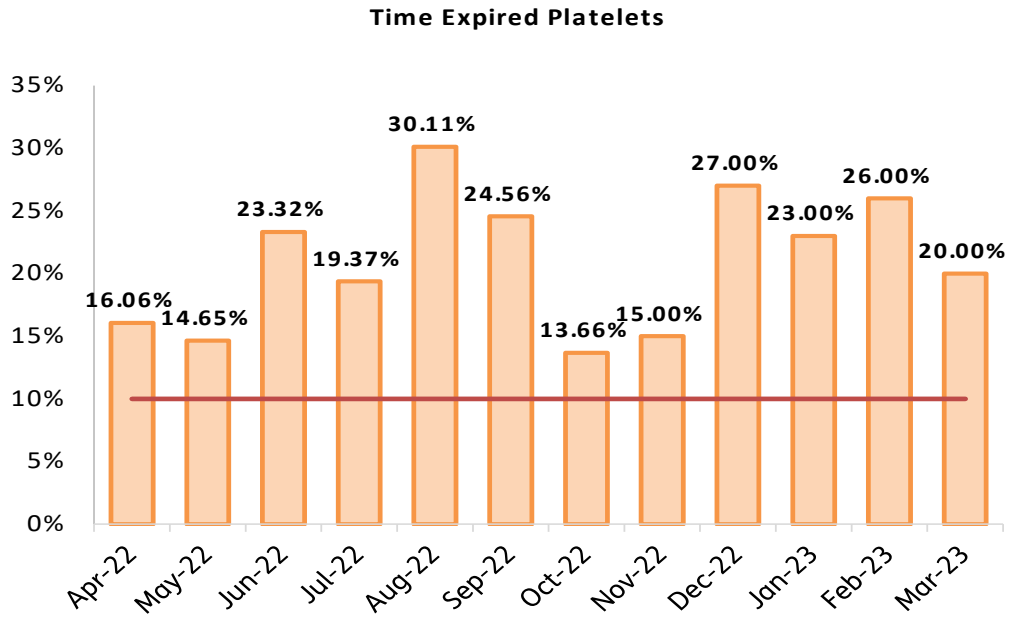
PROGRESS AGAINST: MINIMISING WASTE TIME EXPIRED RED CELLS AND PLATELETS

Aligning the supply of blood components, which have limited shelf life, to the varying demand of hospitals is highly complex and multifaceted. Currently, the WBS has set itself a target of no more than 1% of Red Blood Cells (RBC) time expiring each month where they exceed their 35-day 'shelf-life' and a 10% target for platelets (7 days shelf life).



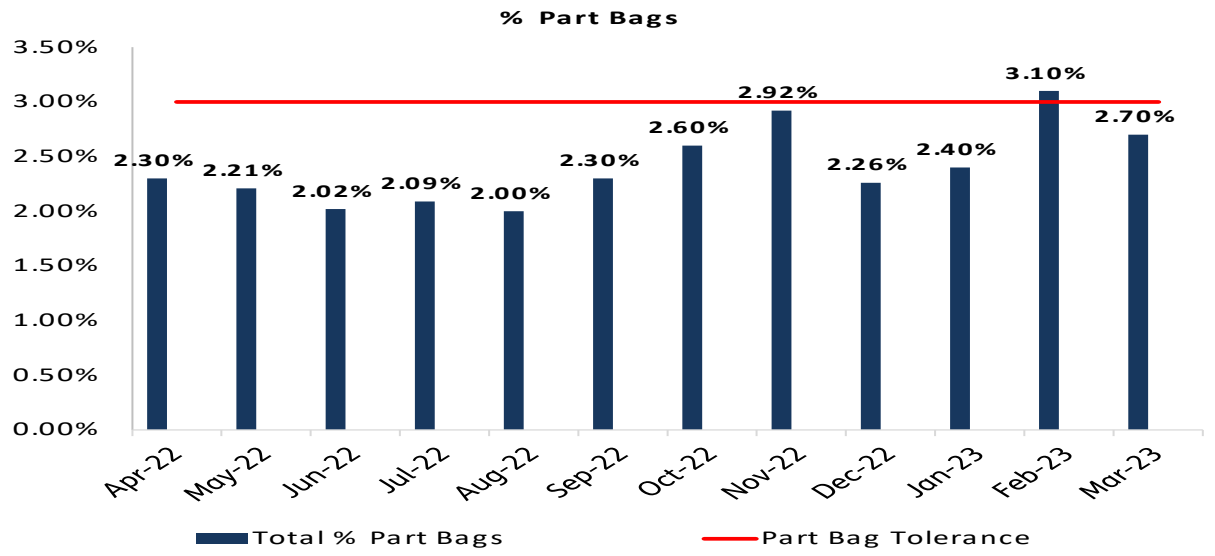
During 2022/23, the levels of time expired red cells remained consistently below the 1% target, this was attributed to the active and agile management of the supply chain.

Time expiry of platelets was above the target tolerance threshold on a number of occasions during 2022/23. This was largely due to a strong stock position against a reduction in demand. Operational focus directed towards provision of platelets as opposed to reduction in waste in the short-term. A longer-term review of the platelet production strategy is underway to minimise the potential for waste in the supply chain. This is in addition to work initiated during the year to develop an improved understanding of how the operational factors, which effect supply could continue to improve.



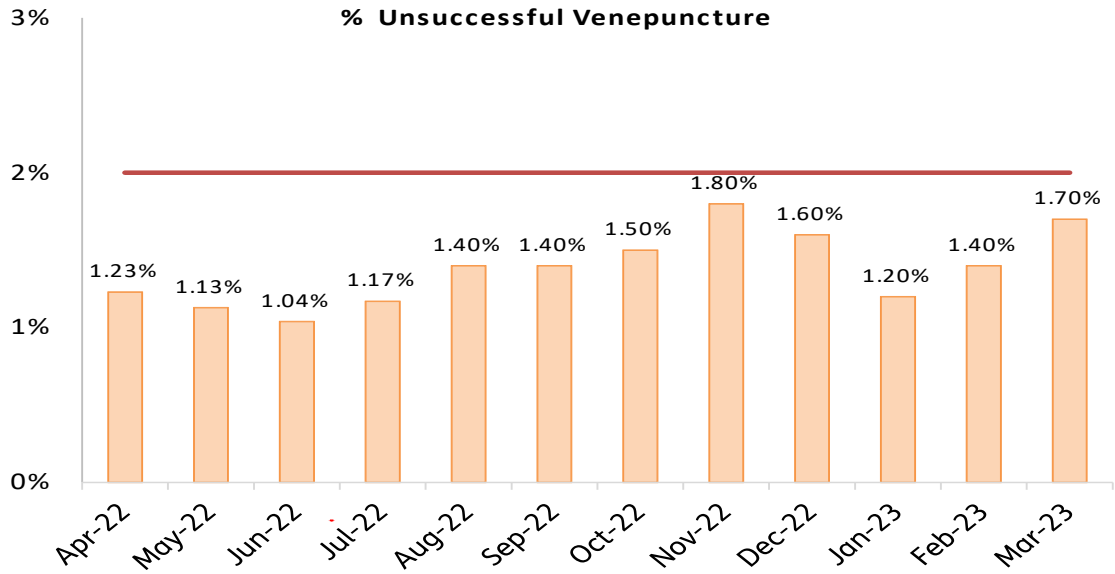
PROGRESS AGAINST: COMPLETE WHOLE BLOOD DONATIONS

Part bag is the term we use to describe a whole blood donation of less than 420ml of blood and which is therefore not viable for clinical use and disregarded. There are various reasons why a donation may need to be stopped before the required volume of blood has been collected. These reasons include venepuncture technique, donors feeling unwell or equipment failure. Our current target is to ensure that we collect less than a maximum of 3% part bag blood donations and during 2022/23, we consistently this target for 11 out of 12 months. Despite strong performance in this area, the WBS will continue to modernise our service and strive to reduce the numbers of part bags wherever possible.



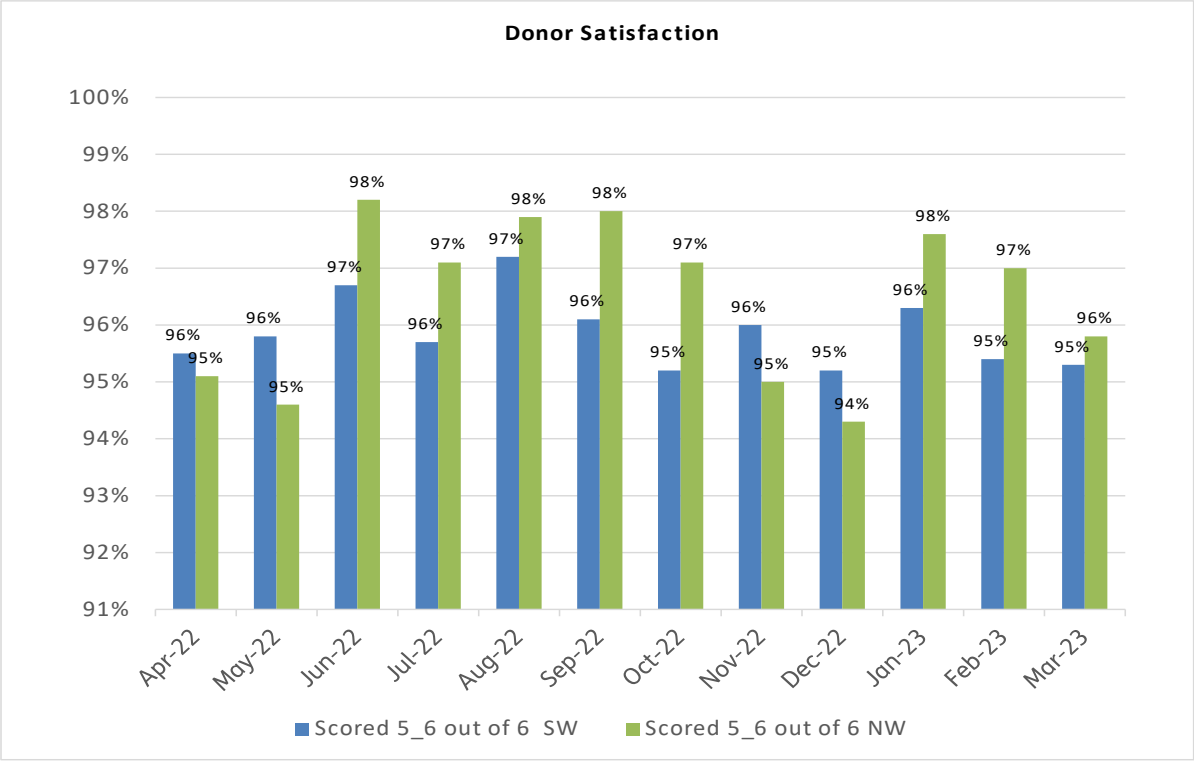
PROGRESS AGAINST: UNSUCCESSFUL VENEPUNCTURE

Unsuccessful venepuncture refers to donors who have reached the donation chair but despite an attempt to venepuncture the donor, no blood enters the bag. There are various reasons why this can happen, typically this might be a result of inaccessible donor veins, poor venepuncture technique or equipment failure. Our current tolerance threshold is no more than 2% of all donors where a blood donation is initiated to result in a failed venepuncture attempt. Performance during 2022/23 was consistently within target tolerance levels. Despite strong performance in this area the WBS will continue to modernise our service and strive to reduce the number of unsuccessful venepunctures wherever possible.



PROGRESS AGAINST: FIRST CLASS DONOR EXPERIENCE TARGET

The importance of learning from donor feedback remains paramount in the ongoing development of our services. During 2022/23, the Welsh Blood Service has worked hard to improve systems and processes relating to concerns management to ensure that donor and service user feedback is consistently managed in a timely and effective manner, whilst ensuring lessons are learnt and identified service improvements are introduced.



RISKS AND CHALLENGES

VELINDRE CANCER CENTRE – RISKS AND CHALLENGES

Velindre Cancer Centre, currently, faces a number of key challenges. Additional detail on how we will address these can be found in our three year plan, but it is important to recognise that these issues effect the design of our services and our performance.

CANCER INCIDENCE IS INCREASING

The incidence of cancer in Wales is forecast to increase by 2% per annum to 2031. This is expected to result in an estimated 12,677 new cases per year in the VCS catchment population by 2031, representing an increase of 35% since 2013.

THERE CONTINUES TO BE VARIATION IN OUTCOMES THROUGHOUT WALES

While survival rates have improved, there continues to be significant variation in survival rates between the least and most deprived in south-east Wales. We need to work with our partners to reduce inequalities, improve prevention, improve the rates of earlier detection and diagnosis and patient access and take up of treatment. The advent of the Single Cancer Pathway (SCP) will have important ramifications for the delivery of cancer services across Wales.

THERE IS A GAP BETWEEN FORECAST DEMAND AND SUPPLY WHICH WE NEED TO CLOSE

The increasing incidence of cancer, increasing survival rates of people with cancer and the increasing complexity in treatments will create a significant pressure on our ability to deliver the required level of services in the future. It is crucial that the healthcare system responds to this increasing and changing demand if it is to continue to deliver services and maintain current performance.

TREATMENTS ARE BECOMING MORE COMPLEX

The pace of innovation, clinical and technological change in cancer services is rapid. We know that on the immediate horizon are new advances in radiotherapy along with personalised medicine. Similarly, within SACT services, there is a growing list of cancer types for which immunotherapy has shown promising results and, consequently, we are introducing ever more immunotherapy treatments. These treatments are often used in addition to existing therapies or, in some cases, are providing entirely new options for patients. This is an exciting and dynamic area. We recognise that the use of these novel treatments introduce new levels of complexity and are sometimes delivered over extended periods. We must ensure that the appropriate support and infrastructure is in place to allow us to continue to offer these treatments in a timely, safe fashion in order to optimise outcomes for our patients.

MORE PEOPLE ARE LIVING WITH AND BEYOND CANCER

As treatments have improved survival in the UK has doubled over the last 40 years. A new approach to longer term care is therefore required to support individuals with ongoing treatment and rehabilitation, and to ensure patients are able to maximise their potential and enjoy the highest quality of life.

There is a need to develop a broader range of services which support individuals and helps them engage fully in society, including employment, following their recovery. We need to ensure that we can continue to offer robust, high quality Therapies and Clinical Psychology services. This will require a change in relationship between patient and clinician, with patients taking an equal role in designing and co-producing care.

SUPPLY OF WORKFORCE

Survival in the UK has doubled over the last 40 years. A new approach to longer term care is therefore required to support individuals with ongoing treatment and rehabilitation and to ensure patients are able to maximise their potential and enjoy the highest quality of life. There is a need to develop a broader range of services which support individuals to engage fully in society, including employment, following their recovery. We need to ensure that we can continue to offer robust Therapies and Clinical Psychology services. This will require a change in relationship between patient and clinician, with patients taking an equal role in designing and co-producing care.

VELINDRE CANCER CENTRE
HOW WE WILL MEET OUR CHALLENGES

The Challenge...	We will meet this by...
Cancer Incidence is Increasing	✓ Expanding our role in the early diagnosis of cancer ✓ Promoting effective public health messages– making every contact count
There Continues to be Variation in Outcomes Throughout Wales	✓ Delivering more services of consistent quality in outreach settings closer to patients' homes ✓ Delivering a Radiotherapy satellite centre, in collaboration with Aneurin Bevan University Health Board ✓ Leading on the standardisation of Acute Oncology Services across and the development of a Cancer of the Unknown Primary service across SE Wales
There is a Gap Between Forecast Demand and Supply Which We Need to Close	✓ Continuing to implement techniques which are resource neutral or that deliver efficiencies elsewhere in the process ✓ Developing a robust, flexible, highly skilled and responsive workforce ✓ Rationalising treatment pathways and identifying efficiencies
Treatments are Becoming More Complex and New Advances are Continuously Emerging	✓ Ensuring, in collaboration with health board partners, that sufficient linear accelerator capacity is available to accommodate new techniques ✓ Effective horizon scanning
More People are Living With and Beyond Cancer	✓ Ensuring timely access to robust, high quality Clinical Psychology and Therapies services

Maintaining an engaged healthy donor panel:
The challenge of ensuring we have enough donors of the right group to meet our demand is one that is being experienced by blood services globally with an aging population, increased travel to countries where donors may be susceptible to blood donor disease and people having busy lives.

Meeting demand and service development:
Aligning varying hospital demand to the supply of blood components, especially those with limited shelf life, is a challenge. National data on blood component usage required to make demand predictions more accurate and effective; all Wales LIMS project will be a major enabler for this.

Increasing use of immunotherapy and improved compliance with national guidelines increase the demand for highly specialised reference blood testing provided by WBS Red Cell Immunohaematology (RCI) laboratory. This service need continues to grow and is not sustainable under the current commissioning arrangement which needs to be revised.

Demand for stem cell donation and transplant immunology services is also expected to increase through presumed consent legislation across the UK and increased use of stem cell treatments. The Welsh Blood Service is also exploring the opportunity for expansion of its stem cell collection services for partner organisations.

Continuing to meet stringent blood selection guidelines and regulatory requirements:
Changes in science, technology and ways of working provide a continually evolving service and developing regulatory requirements for blood services. The In-vitro-diagnostic Device (IVDD) Regulations, changes to the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) guidance on plasma and platelets and monitoring the impact of Brexit on UK regulatory policy all provide an immediate work programme for WBS. These are in addition to the regular changes in Donor Selection Guidelines (DSGs) and the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) guidelines for the Blood Transfusion Services in the United Kingdom (Red Book).

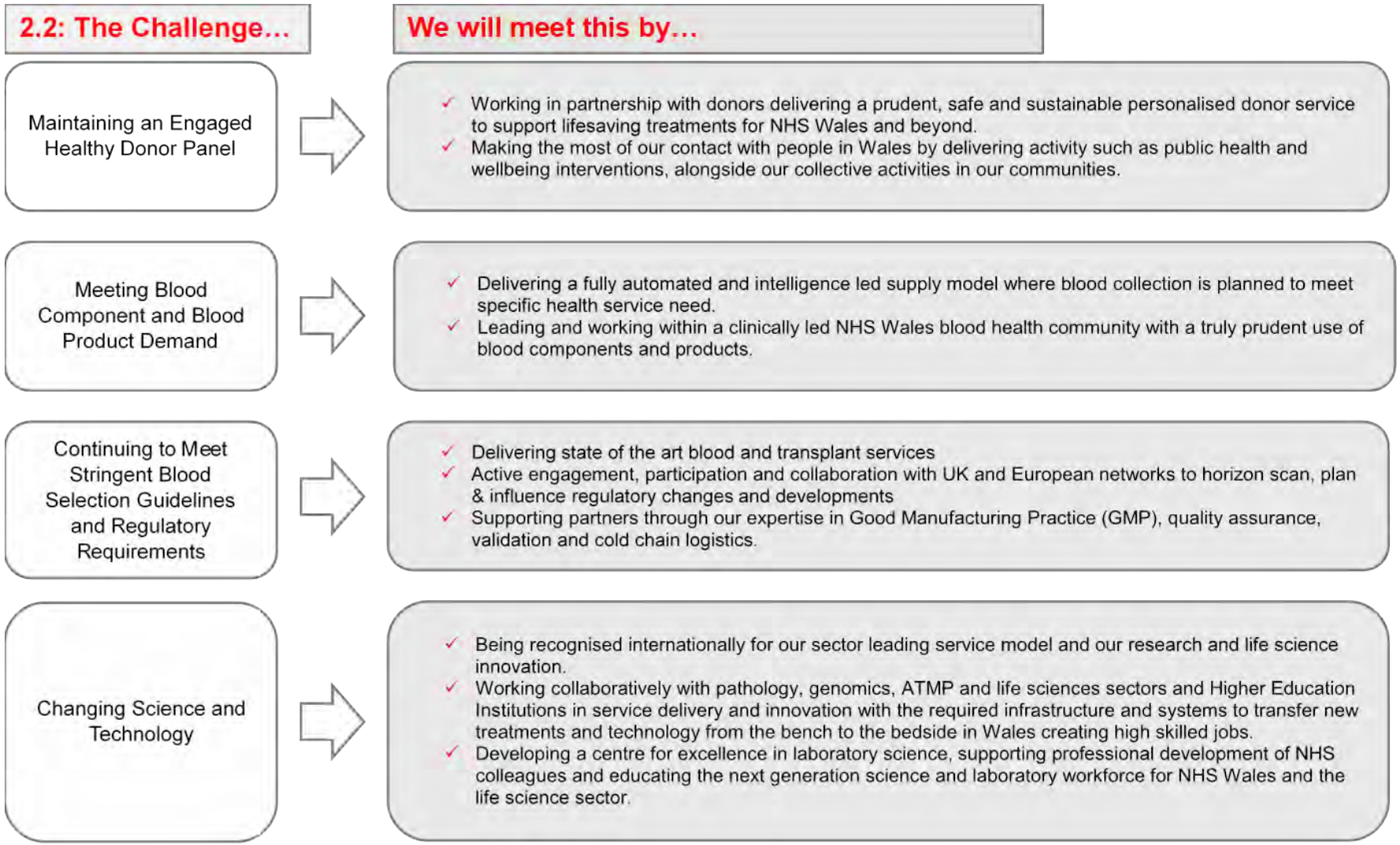
Changing science and technology:
Advances in both scientific and medical understanding of the origin and management of disease, as well as broader supporting technological developments, provide opportunities for step changes in operational workflows, efficiencies and services provided by WBS. This includes Next Generation Sequencing (NGS) and Advanced Therapy Medicinal Products (ATMPs).

During 2022/23, WBS continued to 'horizon scan' and support the Welsh Government and NHS Wales on developing strategies to facilitate the adoption of these new ATMP therapies. Through Advanced Therapies Wales, WBS worked closely with NHS Wales organisations, private and third sector to make recommendations on prioritised activities required for such a roll out.

Automated technology is rapidly evolving within the field of blood component manufacturing and testing and WBS are exploring the potential of these technologies including red cell genotyping.

Advances, such as artificial intelligence driven data analysis and implementation of augmented reality enhanced routine procedures, that increase throughput and quality, eliminate errors and identify issues earlier in a cost-effective manner are emerging. Adoption of these techniques will enable further developments in efficiency and quality of our services.

Workforce:
WBS has to respond to these advances in terms of its own workforce but also in the role it plays in the training of the current and future scientific workforce for NHS Wales through its support for undergraduate provision and its informal and formal outreach to support NHS colleagues. Consideration also needs to be given to the throughput of entry level scientific staff and their career progression within the NHS which already creates some pressure within WBS. In addition, competition for scientists with the commercial sector will increase the current difficulties in recruitment / retention, meaning that we will have to develop and maintain attractive roles and opportunities. Education strategies that support succession planning and develop a work force that is flexible and responsive to the transformation are being developed as well as those which support the new and emerging skills requirements.


2.2: The Challenge…
We will meet this by…
Maintaining an Engaged Healthy Donor Panel
✓ Working in partnership with donors delivering a prudent, safe and sustainable personalised donor service to support lifesaving treatments for NHS Wales and beyond.
✓ Making the most of our contact with people in Wales by delivering activity such as public health and wellbeing interventions, alongside our collective activities in our communities.
Meeting Blood Component and Blood Product Demand
✓ Delivering a fully automated and intelligence led supply model where blood collection is planned to meet specific health service need.
✓ Leading and working within a clinically led NHS Wales blood health community with a truly prudent use of blood components and products.
Continuing to Meet Stringent Blood Selection Guidelines and Regulatory Requirements
✓ Delivering state of the art blood and transplant services
✓ Active engagement, participation and collaboration with UK and European networks to horizon scan, plan & influence regulatory changes and developments
✓ Supporting partners through our expertise in Good Manufacturing Practice (GMP), quality assurance, validation and cold chain logistics.
Changing Science and Technology
✓ Being recognised internationally for our sector leading service model and our research and life science innovation.
✓ Working collaboratively with pathology, genomics, ATMP and life sciences sectors and Higher Education Institutions in service delivery and innovation with the required infrastructure and systems to transfer new treatments and technology from the bench to the bedside in Wales creating high skilled jobs.
✓ Developing a centre for excellence in laboratory science, supporting professional development of NHS colleagues and educating the next generation science and laboratory workforce for NHS Wales and the life science sector.

PUTTNG THINGS RIGHT

We are committed to managing, and learning from concerns in accordance with the Putting Things Right process, or NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

During 2022/23, we received a total of 155 concerns. This was a considerable reduction (-36) in the volume of concerns raised during 2021 – 2022. 55% of the concerns were raised to the Trust via email, 33% received verbally by telephone, 6% verbally in person, 5% via letter and 1% via social media.

The Trust has continued to respond to the complainant within 30 days of receipt of their concern. The compliance breakdown per quarter is listed below and demonstrates continuous compliance over the year:

Quarters Q1 – 100% Q2 – 100%, Q3 – *45%, Q4 – 100%
**Due to a validation of the PTR closure within 30-day return figures by the Welsh Risk Pool, an anomaly was found where the day on which a PTR concern was received being classed by the Trust as "day zero", when this should have been classed as "day one". The outcome has meant that for quarter 3, only 4 of the 9 PTR concerns have been completed within 30 days. However, all 9 PTR concerns were completed within 31 working days of receipt. This issue has been addressed and all future PTR concerns will be classed as "day one" on the date of receipt.*

Over 96% of the concerns raised were graded 1 and 2, and 70% were successfully resolved via the 'early resolution' process which is a 11% increase in comparison to 2021/22. The Trust has continued to have a low number of re-opened complaints of less than 6% for the year.

8 complaints have been referred to and upheld by the Ombudsman during the year. 3 Ombudsman cases remain open at the end of quarter 4 2022/23 and the Trust await further communication from the Ombudsman.

Covid related concerns have remained consistent throughout 2022/23 with 13 concerns being reported in comparison to 12 during 2021/22. The Covid related concerns have related to the impact on cancer patients due to delays in referral and treatment and in relation to Welsh Blood Service, the reduced number of venues available to donate following some venues having to close during the pandemic and not reopening.

The main themes for concerns raised throughout the year related to; delays in Cancer Service patient appointments and the attitude and behaviour of medical staff to patients in relation to the lack of communication and information regarding treatment options. There was also a theme identified relating to patient assessments through the treatment helpline, of which a full scale review, action plan and improvement project has been implemented. The Welsh Blood Service continue to receive concerns raised with donors experiencing issues with planning appointments or being turned away from scheduled appointments due to arriving late to donate. Donors also raised concerns in relation to the practicalities of giving blood which has resulted in identifying staff training needs and the review of related policies and procedures.

We remain committed to encouraging patient / carer feedback so that we can learn from and improve our services. We have continued to refine our complaints management processes and concerns investigation through to formal response to the service user, ensuring that any actions required are taken promptly and that learning from complaints is fully embedded.

VELINDRE UNIVERSITY NHS TRUST QUARTERLY INDICATORS 2022/23					
Quarters	**Q1**	**Q2**	**Q3**	**Q4**	**YTD Total**
CONCERNS					
Trust Early Resolution (ER) (resolved within 48 hours**)**					
ER opened	***40***	***20***	***24***	***24***	***108***
Trust Putting Things Right (PTR) (formal**)**					
Trust wide PTR opened	***13***	***12***	***9***	***11***	***45***
Acknowledged within 48 hours	**13**	**12**	**9**	**11**	**45** **4**
PTR closed within 30 days	**13**	**12**	**4**	**11**	**40**
PTR closed after 30 days	**0**	**0**	**5**	**0**	**5**
Concerns raised through Welsh language communication	**1**	**0**	**0**	**1**	**2**
Total number of concerns (PTR/ER) received per quarter	***53***	***32***	***33***	***35***	**-**
OMBUDSMAN (OMBS)					
OMBS cases opened	**0**	**3**	**0**	**1**	**4**
Open OMBS cases	**3**	**6**	**3**	**3**	**-**
OMBS cases closed	**0**	**0**	**3**	**1**	**4**
Total number of Ombudsman cases received	**0**	**3**	**0**	**1**	**-**
REDRESS					
Redress cases opened	**1**	**0**	**1**	**2**	**4**
Open redress cases	**3**	**4**	**3**	**4**	**2**

Redress cases closed	**0**	**0**	**1**	**0**	**1**
Total opened during quarter	**1**	**0**	**1**	**2**	**-**
CLAIMS					
Claims opened	**0**	**0**	**0**	**1**	**1**
Open claims	**8**	**7**	**6**	**5**	**3**
Closed claims	**0**	**1**	**1**	**2**	**4**
Total opened during quarter	**0**	**0**	**0**	**1**	**-**

Redress

During the reporting period, 7 Redress cases were investigated under the Putting Things Right Regulations (PTR):

- 1 case was closed following a determination of qualifying liability. Financial compensation was accepted and the case closed in December 2022, following approval of reimbursement by the Welsh Risk Pool.
- 1 case has not identified a qualifying liability and remains open pending settlement of financial matters.
- 1 case remains open following the determination of a qualifying liability. Financial compensation has been offered and is awaiting acceptance.
- 4 new Redress matters were opened during the reporting period and remain under investigation.

Claims

Throughout the reporting period, the Trust's role is to handle claims to achieve a fair resolution for all parties. Where claims are valid, the Trust looks to settle these or defend where there is sufficient merit to do so.
During the reporting period between 1st April 2022 and 31st May 2023, the Trust dealt with 9 claims in total, consisting of Clinical Negligence and Personal Injury. During the reporting period:

- 1 new clinical negligence claim was received.
- 4 claims were closed following out of court settlements (PI and CN).
- 5 claims remain under investigation

The number of new claims against the Trust has decreased during the reporting period. The Trust, however, continues to drive down litigation and the costs associated with it.

The reduction in litigation has not, however, been at the expense of a less rigorous approach to investigations, as the Trust continues to respond to the responsibilities and challenges in relation to claims and legal change. This has allowed flexibly to respond to new priorities without significantly affecting progress towards the Trust's strategic aims to ensure continued relevance. Negligence claims form a very small proportion of both the number of incidents and complaints reported in comparison to the many individual episodes of care that are delivered by the Trust on a daily basis. There are many factors influencing the reasons why individuals bring a claim, including factors in the legal market. There is also a significant time lag between an incident occurring and a claim being received (on average 3.1 years). It may also take several years to settle a claim, particularly those involving high-value claims and payments made in relation to these claims may take many years into the future. Taken together, this means that the claims that are progressed against the Trust is a very partial indicator of service user safety in past years, and also what we can expect to pay out in settlement of those claims in the future.

Decisions taken to settle claims against the Trust are often made as a consequence of lack of evidence. The ability to defend claims relies heavily on the quality of the Trust's documentation, its records and the decisions taken, or not taken, at the time.

Where learning is identified from these claims, the Trust continues to play its part in reducing the cost of claims through the actions it takes to improve the standard of care. As part of learning assurance, the Trust is required to submit a Learning from Events Report (LfER) to the Welsh Risk Pool that demonstrates what lessons are learnt. When a breach of duty has been identified or admissions are made, the Quality and Safety team continue to work with directorates and services to identify the learning and actions that are required to satisfy the Welsh Risk Pool criteria and the way in which learning can be implemented to reduce the risk of reoccurrence and future impact. These actions ultimately drive down cost in litigation and continues to promote and encourage a culture of learning that benefits both patient, service user and staff.

As part of the Welsh Risk Pool requirements, the Trust is required to pay the first £25,000 of any claim. A reimbursement is sought from the WRP
During the reporting period, 1 Learning from Events Report was submitted to the Welsh Risk Pool for approval and received approval following an amber deferral and request for further evidence in support of learning.

As part of learning from claims, Learning Briefs are presented periodically to the Quality and Safety Performance Committee. The briefing captures:-

a) The summary of the incident
b) The root cause
c) The key learning
d) Supplemental learning
e) Actions taken

f) Actions outstanding
g) Review and ongoing assurance

These Learning Briefings are designed to reinforce the learning and sharing across the organisation and provide enhanced assurance of the actions undertaken to improve quality and safety care.

Learning Briefs were presented to the Quality and Safety Performance Committee during the reporting period, demonstrating the Trust's ongoing commitment of improving standards in the services and care provided to prevent repeat occurrences.

The following figures are estimations provided by NHS Wales Shared Services Partnership (NWSP) Legal and Risk Services in the event a claim is successful. The estimated financial liability as at the 31st March 2023 was:-

- £924,576
- Anticipated Trust Liability: £119,224

Inquests

An inquest is an inquiry into the circumstances surrounding a person's death. The purpose of the inquest is to find out who the deceased person was and how, when and where they died for the death to be registered. To assist staff, guidance has been developed during the reporting period and includes:-

- An overview of inquest proceedings and what to expect as a witness
- Advice on how to write a statement for the Coroner and
- A revised template statement for witnesses to follow.

During the reporting period, 7 inquests were managed by the Trust comprising of;

- 3 new inquest notifications. Witness statements from treating clinicians have been submitted during this period, together with relevant copy medical records.
- 1 inquest hearing took place during the reporting period, where learning has been identified that can help improve communication with health care providers. The case remains open and is subject to an after action review.
- No inquest was subject to a Regulation 28, Prevention of Deaths Report during the reporting period.
- 2 inquests were closed during the reporting period.
- 5 inquests remain open at the end of the reporting period.

DELIVERING IN PARTNERSHIP

The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector. Our primary health partners are set out below:

Organisation	Relationship
Aneurin Bevan University Health Board	Commissioner
Betsi Cadwaladr University Health Board	Commissioner
Cardiff and Vale University Health Board	Commissioner
Cwm Taf Morgannwg University Health Board	Commissioner
Hywel Dda University Health Board	Commissioner
Powys University Health Board	Commissioner
Swansea Bay University Health Board	Commissioner
Welsh Ambulance Service NHS Trust	Provider
Public Health Wales NHS Trust	Provider
Health Education and Improvement Wales	Provider
NHS Wales Shared Services Partnership	Provider of services
Digital Healthcare Wales (DHCW)	Provider of services
Welsh Health Specialist Services Committee	Specialist Commissioner

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our Local Health Board partners to ensure that our key strategies are aligned, that there are a clear set of shared priorities and to ensure that we can provide sufficient capacity and capability to deliver commissioned services of the highest quality.

Engagement with people who use our services to design them in partnership

Effective and ongoing engagement is vital in the development of our services and we strive to make it as easy as possible for patients and donors to share feedback following their care.

There are a number of ways used to listen, discuss and learn about our services.

Velindre Cancer Services

Our service plans respond to feedback from patients and donors, their families and carers, Velindre staff, Health Boards, third sector and other partners. A range of engagement events and workshops have been undertaken with key stakeholders over the last three years.

Social Media continues to offer a productive two-way conversation tool with our online cancer community. This helps us to listen and respond to compliments, queries and concerns. Our Patient Advice and Liaison Service is able to respond

Blood and Transplant Services

The Blood Service also has daily interactions with members of its community of donors. We are committed to listening to our donors and we do this by circulating a comprehensive survey to every donor that enters a donation session each month.

The service operates a dedicated donor contact centre which exists to inform, educate and assist donors in contributing to the health of the nation by donating their blood, platelets or bone marrow. The service also engages existing and prospective donors through its donor engagement team. This team uses social media, the press, the website and face-to-face interactions to promote blood, platelet and bone marrow donations in Wales.

The engagement department is present in the communities of Wales, building close links and partnerships with community groups, sports teams, businesses, education providers and other socially engaged groups that have an influence in their localities. The engagement team is also committed to having a presence at the high profile national events that occur each year across Wales, such as the National Eisteddfod.

WORKFORCE AND WELLBEING

Our overall workforce aims for our people, articulated in our People Strategy, are:

- To develop a **Skilled and Developed Workforce**, given clear career pathways, provide them with leadership, skills and knowledge they need to deliver the care our patients and donors need now and in the future.
- To support a **Healthy and Engaged Workforce** where wellbeing is key, recognizing and valuing their diversity in a bi-lingual culture.
- To have a **Planned and Sustained Workforce** having the right people with the right values, behaviors, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing.

Over the past 12 months, key deliverables include:

Skilled and Developed Workforce:

- Worked with HEIW, maintaining provision of the Trust Inspire Management Programme.
- Further developed follow-on activities that are flexible and support 'just for me, just in time' development
- Working with colleagues to develop the School of Oncology and Centre for Learning
- 85% compliance with Statutory and Mandatory training

Healthy and Engaged Workforce

- Embarked on a 12 month project refreshing and embedding a positive and relevant code of values for the Trust.
- Agreed an Equality, Diversity and Inclusion plan and a Welsh Language Plan for 2022-23. Developed metrics to track progress of plans.
- Developed a plan to ensure compliance with Welsh Government Race Equality Action and LGBTQ+ Action Plans
- Health and Wellbeing infrastructure in place to support staff physical, mental and financial wellbeing

Planned and Sustained Workforce

- Further embedded our workforce planning process and toolkit
- Reviewed hard to fill roles ensuring robust recruitment and retention plans
- MDT training pathways mapped to maximise opportunities for transformation
- Ongoing management and development of Apprenticeships, Graduate trainees

Looking forward to 2023/24

Moving forward, focusing on looking after our staff will be key including ongoing engagement and wellbeing provisions. Working with partners regionally will be key to address recruitment issues and locally to develop and promote the opportunities working for a specialist Trust can provide – all focusing on meeting the vision of an Employer of Choice.

DIGITAL TRANSFORMATION

The Trust has developed a new Digital Strategy – 'Digital Excellence | 2023 to 2033' – to complement the new Trust strategy, 'Destination 2033'. It describes our vision for how digital services will be used to enhance patient and donor services, enable wider access through work on digital inclusion, secure and protect our data and how we will use data collected from all over NHS Wales to inform decision making and plan our services for the future. The new strategy is due to be published in May 2023

Over the past 12 months, the primary focus of activity within the Velindre Cancer Centre has been the delivery of the Digital Health & Care Record – a programme to replace the existing 'CANISC' IT system with the national Welsh Patient Administration System (WPAS) and an enhanced version of the Welsh Clinical Portal (WCP). The new platform was successfully deployed into the VCS in November 2022. Both WCP and WPAS are due to be further upgraded through 2023/24, to better support the clinical and operational workflows across the VCS and to further improve the mobility and visibility of patient data across organisational boundaries.

The major digital change introduced into the Welsh Blood Service saw the delivery of a new communications platform – 'Prometheus' – into the Welsh Bone Marrow Donor Registry (WBMDR), which also went live in November 2022. This service is expected to help enable a higher throughput of activity through the WBMDR, ultimately delivering an increase in the number of stem cell transplantations for patients across Wales and internationally.

Other digital activity over the past 12 months include:

- The Digital Service Desk – established in March 2021 – continues to effectively manage calls for IT support. Over 20,000 calls were resolved by the team in the 2022/23 financial year; of those, over 33% were fixed immediately by the 1st Line Support Team on the helpdesk. Over the coming year, the support team will be focused on improving the responsiveness of the Digital Service Desk, to include an element of automation for resolving common issues – this will further improve the turnaround times for calls raised with the team.

- Upgrades to some of the key operational and clinical applications across the Trust, including the WBS Blood Establishment Computer System (BECS) and the Welsh Nursing Care Record (WNCR), Welsh Clinical Portal and ChemoCare systems used in the Velindre Cancer Centre.

- The Digital Services team delivered a new system for the Welsh Infected Blood Support Scheme (WIBSS), to improve the support for beneficiaries of the scheme.

- The Digital Services team continue to play a central role in the design of the new Velindre Cancer Centre (nVCS) – due to open in 2025 – and the Radiotherapy Satellite Centre in Nevill Hall, Abergavenny – due to open in 2024. Digital is at the forefront of the design for the nVCS, with the intention to use a variety of new and innovative digital solutions to enhance the patient experience and improve the working conditions of staff who work in the new hospital.

- Delivered the IT infrastructure services and equipment to support the first phases of the Integrated Radiotherapy Solution (IRS) programme – the refurbishment of the 'LA6' radiotherapy suite at VCS. Further works are planned through 2023/24 to enhance radiotherapy services and ready the organisation for the establishment of the new, enhanced radiotherapy services at the new Velindre Cancer Centre, which is currently scheduled to open in 2025, and Radiotherapy Satellite Centre in Nevill Hall, which is due to open in 2024.

- Lastly, we continue to develop our local cyber security systems and procedures, and participate in national approaches to help secure patient and donor data and protect critical Trust IT services. A recent audit of the Trust's cyber security posture, undertaken by NHS Wales Shared Services Partnership, reported that the Trust had been able to provide **'substantial assurance'** in respect our cyber security strategic plan and internal procedures for reporting and managing cyber security performance.

To support the delivery and support for an ever-increasing portfolio of digital services, we are growing the Digital Services team, to include the introduction of new roles that we'll need to address the future challenges of cloud adoption, automation and the adoption of Microsoft 365 services.

Looking forward to 2023/24 the Trust will be establishing a Digital Programme, to oversee delivery of the digital transformation agenda across the Trust. In support of our digital aspirations, we are working with the Centre for Digital Public Services (CDPS) and Digital Communities Wales (DCW), to improve our approach to the design of digital services for our patients, donors and staff. Digital inclusion is a central theme within the Digital Strategy and will be a key focus for all our digital projects and programmes over the coming years.

SUSTAINABILITY STRATEGY 2022/2023

WELLBEING OF FUTURE GENERATIONS ACT / CREATING A SUSTAINABLE ORGANISATION

Our Approach to the Well-Being of Future Generations Act:

We have a commitment to transform the Trust and to create a sustainable organisation. The Trust Strategy together with those for specialist Cancer and Blood and Transplantation Services for 2022 – 2032 has been approved, and has sustainability at its core. These have set out what good look like in five years' time and the actions we will take over the coming years to achieve the excellence we are committed to.

These strategies have been developed within the context of the Well-Being of Future Generations Act (*the Act*) as we seek to implement the principles of the Act within the Trust to ensure that they become the central organising principle of each and every action that our staff take on a daily basis. This will take time but we are committed to ensuring we translate the intentions and spirit of the Act into tangible and sustainable benefits for the people of our region.

The Act requires public-sector organisations in Wales to focus on delivering long-term well-being goals in a sustainable manner. Whilst we have made progress in embedding the Act across the organisation we know that we have much more to do. The pioneering Act and the 2016 Environment (Wales) Act 2016 provides Wales with an exciting opportunity to lead the way internationally and outlines our sustainability aims and enables real action to create positive and significant change.

Therefore, we are really excited to be able to set out our journey to sustainability and the benefits it will realise over the coming years. As an anchor organisation in Wales, we are committed to embedding sustainability within our own organisation and become an exemplar for others to come and learn with, and from. We are committed to placing sustainability at the heart of everything we do and to maximise the benefits we can provide for people across Wales.

This Sustainability Strategy has created a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patients and carers. This will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

This will require an increased focus on sustainability and well-being over the next three years as we attempt to embed the Sustainable Development (SD) principle still further to make it a 'normal' part of everything that we do. The journey we are on will see us

implement a new approach to planning and delivery across the Trust and the development of a different organisation that is more involved across the breadth of health, social care and public services. This collaborative way of working will see us working across the region with a range of partners to ensure the five ways of working are embedded within everything we collectively do and that we are actively contributing to the seven well-being goals.

Leadership will be fundamental to effective change. Our Chair is committed to leading the Trust to function as an exemplar Public Sector body in relation to the five ways of working and the embedding of the sustainability principle in all we do as an organisation. We have worked with our Health Board partners to facilitate the establishment of the South East Wales Collaborative Cancer Leadership Group (and this regional collaborative work also embraces the Act as a central principle).

During the next five years we recognise that there are opportunities for us to do more to advance our and the wider community's, well-being and sustainable development agenda. Within our major capital schemes in the new Velindre Cancer Centre and Talbot Green Infrastructure Upgrade Project, are developing ambitious and inclusive community benefits. We will seek to evolve existing partnerships to a much greater extent, and also to develop new relationships within the health sector and beyond in order to maximise our contribution and to support others in doing the same.

Our Well-Being Objectives:

The Trust, recognised under the Act as a national body, was required to develop and publish a set of its own well-being objectives.

These objectives were developed following extensive engagement and were designed to focus the Trust's contribution to the realisation of the national well-being goals.

Delivery Arrangements:

Our approach is built upon the personal support and leadership from the Chair and our Board. At Executive level, the Director of Transformation, Strategy and Digital holds the responsibility for sustainability within their portfolio and discharges this through a range of Offices which are co-ordinated and led by the Director of Commercial and Strategic Partnerships. The Trust has established a Sustainability Community Group to facilitate and support work across the Trust and the Sustainability Manager plays a key role in this process.

However, it is important to emphasise that our approach is to expect all of our workforce, suppliers and service providers to contribute to the well-being goals and to

embody the five ways of working in their day-to-day actions and behaviours. The Act is viewed as adopting a 'way of being' rather than simply demonstrating compliance to standards. In this regard, at its heart, it is viewed as whole system organisational development and emphasis is being placed on induction, education and training, relationship management, communication and workforce health and well-being.

The workforce, and the processes they utilise to function, will be supported and enhanced respectively so that they: clearly reflect what 'long-term' means, identify the root causes of problems through system wide perspectives, support work across organisational boundaries to maximise value, establish shared processes and ways of working. Importantly, our actions will be framed and facilitated by our strategic approach.

Progress against Delivery:

There are a number of actions that we are progressing:

Doing things differently to deliver change: • The Trust is considering the Sustainability Development (SD) principle when developing its main strategic programmes, in new Velindre Cancer Centre and the Talbot Green Infrastructure Upgrade Project and the Radiotherapy Satellite Centre • The Trust is considering how it can evolve existing partnerships to a greater extent, and develop new relationships within the health sector and beyond, to maximise its contribution to A Healthier Wales and to support others in doing the same.
Developing core arrangements and processes: • The Trust has developed an ambitious Sustainability Strategy and plans to use it to embed the Sustainable Development principle and utilises the Well-being Goals at its core. • Responsibility for delivering the Act and embedding the Sustainable Development principle sits within the Strategic Transformation, Planning and Digital Division. The Trust is developing current capacity within the team to deliver the requirements of the Act. • The Trust is considering the merging or better alignment of its well-being objectives and strategic goals, ensuring we meaningfully contribute to our set objectives. • The Trust has developed a strategic planning framework, which aims to ensure that the Act genuinely underpins all service development work and the Trust's Integrated Medium Term Plan. All planning activity throughout the Trust will utilise this framework in order to ensure that the Sustainable Development Principle is fully embedded across the organisation. The Trust intends for all investment proposals to demonstrate how they align to the Act. • The Trust is currently undertaking work to create a more systematic approach to tracking and monitoring progress.
Involving citizens and stakeholders: • The Trust is actively identifying ways to improve how it engages with citizens,

stakeholders, patients and donors when developing its services.

- The Trust is exploring possibilities for collaborating with other health bodies to develop a wider regional 'whole system' Cancer Community and a public health promotion agenda.

Whilst recognising we have much more to do, it is important to acknowledge the achievements of the organisation to date and the strengths it can draw on as we grow together as a sustainable community.

The Welsh Blood Service is currently developing ambitious Business Case to reduce the carbon footprint of the Talbot Green site. A key and ambitious objective of this Programme is to transition to a carbon neutral footprint for the building. This will be achieved through an increased focus on the use of renewable technologies, solar photovoltaic arrays, ground source and air source heat pumps and bio- mass boilers.

We have also focused considerable efforts on ensuring that the TCS Programme has embedded the requirements of the Act. The new Velindre Cancer Centre project is championing sustainable developments, such as integrating sustainable transport into the design of the new VCS, and encouraging the use of sustainable travel. We have identified several proposals for community benefits in the design of the new VCS. In this regard, a number of fundamental deliverables can be evidenced. The project aims to the

We have applied, and continue to apply, the Sustainable Development Principle when designing and developing the TCS Programme clinical service model and supporting infrastructure. The new TCS Programme clinical service model has a clear preventative focus and there are opportunities to educate patients and the wider community on healthier lifestyles to help prevent cancer. The TCS Programme clinical service model and supporting infrastructure also has a strong long-term focus based on a sophisticated understanding of current and future needs.

We have worked in an integrated way to design and develop the TCS Programme and supporting infrastructure and have considered how it can deliver wider benefits as the programme progresses to ensure it has a positive impact on social, economic, environmental and cultural well-being. We are also collaborating with partner organisations across South East Wales to develop and improve cancer services.

In addition, we have a range of strategic and operational examples of good practice in implementing the Act. A number of these are shared below.

TRUST SUSTAINABILITY STRATEGY

The approved Sustainability Strategy seeks to ensure we contribute to a better world for future generations in our community and across the globe, acting today, for a more sustainable tomorrow.To achieve this vision, we set out what we want to achieve together with ten themes which we will focus on to deliver our ambitions. These are driven by the United Nations Sustainable Development Goals and the Well-Being of

Future Generations Act, which together ensure we achieve the Trust Well-being Objectives. The Trust's net zero reporting will be available on the Trust internet.

INTERACTIVE ACTIVE TRAVEL AND SUSTAINABILITY MAPS

An interactive Active Travel & Sustainability Map has been developed for ease of access to active and sustainable transport options for staff. This includes signposting to: the OVO Bikes cycle hires; cycling storage; local bus routes; local train stations; and disabled parking. Pop-ups on the map provide additional information to staff, including how to access the Active Travel Hub and OVO Bike availability. Specifically for VCS, the map will include information about staff and patient support sessions, including Ray of Light and Noddfa Staff Well-Being Gardens. At Talbot Green, it highlights the nature walk and the location of the beehives. It provides an engagement tool to staff to highlight upgrades, for example the installation of bike repair unit in the Active Travel hub is signposted.

BIODIVERSITY ENHANCEMENTS

As part of our obligations to enhance biodiversity under the Environment Wales Act, the Trust is actively increasing local flora and fauna on all sites, and encouraging and educating staff to do the same in their gardens. This has included 'No Mow May' and 'Let it Bloom June' communication campaigns and at all sites we have reduced mowing. At VCS, we planted seasonal shrubberies and flowers and over 50 different species of daffodils were planted, and wildflower seeds were sewn. At our Talbot Green site, we have removed invasive species to allow local flora to thrive.

ISO14001:2015 EXTERNAL AUDIT

Welsh Government sets a requirement for all NHS bodies to be accredited by the ISO14001:2015 standard, an environmental management system. Following the successful recertification, with no non-conformities in November 2021, the Trust passed the revalidation external audit in September 2022 with no non-conformities raised.

GREEN SOCIAL PRESCRIBING

The Trust continues to partner with Ray of Light Cancer Support, who deliver a safe and non-judgemental support group for patients, carers and families affected by a cancer diagnosis, based at Velindre Cancer Centre. Ray of Light centre their sessions on the well-being benefits of nature, with many activities to choose from, including painting, whittling, forest bathing and many more. The Trust has converted a shipping container in the Noddfa gardens which has been painted by a local artist, allowing the

sessions regardless of the weather. The Trust has continued to work with Down to Earth to deliver green woodworking skills workshops. Volunteers comprising of Velindre patients, family, staff and local community members worked together to build the roundhouse and binhouses with green, living roofs, in addition to groups from a wide variety of organisations across south Wales, with the support of the Down to Earth Project team.

WBEES – BEEHIVE INSTALLATION

We have installed a beehive at our Talbot Green Welsh Blood Service site and we have a group of dedicated staff volunteers, who have all been trained to look after the hive. To design the logo for our honey jars, we ran an all Wales competition (for staff and donors!). Staff were invited to pick from the shortlisted designs, and the winning design will be printed on all jars once the honey is ready to be collected.

PLASTIC REDUCTION

The Trust is actively reducing single use plastic where possible. Following the success of our pilot project, we have been rolling out biodegradable cups on all donor clinics across Wales, stopping nearly 150,000 plastic cups from landfill annually. Further to this, we have stopped purchasing plastic stirrers across all sites. At VCS, biodegradable coffee cup and takeaway containers have been introduced, preventing 98,000 plastic containers and 28,000 plastic coffee lids going to landfill annually.

WEAVING VELINDRE

The ‘Weaving Velindre’ art project invited staff to take a creative break whilst embedding the principles of the circular economy, by using old uniforms and materials associated with the hospital to fabric weave a piece of artwork celebrating Velindre Cancer Centres history. All materials used would have been thrown away, but instead have been repurposed to create a piece of artwork.

SUSTAINABLE JAMBOREES

Throughout August, a 'Sustainable Summer Jambori' was held in the Cancer Centre for staff, patients, families and the local community. The Trust Sustainability Team together with the new Velindre Cancer Centre project team held a month-long event programme featuring staff, patient and community engagement events over the summer. There was a breadth of different activities, linking themes of sustainability, well-being and art. Due to the success of the events, an Autumn Jamboree was held, along with a Sustainable Spring Jamboree organised for VCS and WBS staff, with

themes of biodiversity and active travel. The Jamborees take the form of mini festivals - engaging with patients, families, staff and communities through arts and crafts to demonstrate the benefits of undertaking creative activities in a green space and educate on sustainability and biodiversity matters.

WELSH LANGUAGE REGULATIONS AND COMPLIANCE

Introduction:

This will be the Trust's fourth annual report dedicated to the delivery, promotion and monitoring of the Welsh Language Standards. The Trust's focus is strongly embedded in the cultural promotion of the Welsh Language and within this we are committed to comply with the legal requirements of the language as a provider of services for Patients and Donors.

Our delivery of the Welsh Language Standards and the 'More than Just words...' framework continues to be the driver for us to ensure compliance and we now have strong governance processess to monitor our performance.

Last year our focus was very much around the commitment to recruitment structures and embedding an ethos of culutral understanding, and this year we continue to stregnthen this. Understanding the language needs of our workforce has driven forward simple yet effective measures to promote our services and has opened discussions with patients around the 'active offer' concept.

It is our ambition to ensure our patients and donors are aware of their Welsh Language rights and our response to this awareness becomes even more proactive. Providing bilingual services as a matter of course rather than request is our ultimate aim.

Celebrating Welsh Culture:

The Trust continues to actively seek ways in which to engage its staff in the culture of Wales as well as its languages. We recognise the need to comply with its legal obligations but we aim to do more than is needed as this celebrates the diversity of our staff and services.

This reporting year we have drafted a Cultural Plan that aims to strengthen our engagement with staff around the language and Culture of Wales and promote a value of inclusion that encompasses all that we believe. The Executive management board have taken on roles of responsibility for certain aspects of the Equality and Diverstity agenda and this includes an Ambasador role responsible for the Welsh language.

The Trusts draft Cultural plan aims to be as inclusive as possible and the Welsh language Ambasador will drive the ethos of this plan throughout the work of the Executive Board.

Highlights at a glance:

To support its working group the Welsh Blood Service have developed a specific intranet page that complements the work of the Trust. The service has its own specific requriements and felt a need to support staff visually as well as using Trust wide guidance. This has strengthened the division's understanding and enables

staff to see the relevance to their work in promoting and supporting bilingual donor needs.

Velindre Cancer Centre have increased its 'Active offer' presence. A simple visual approach has given patients the opportunity to verbalise their language needs.

Staff have reported patients identifying themselves as Welsh speakers as part of the care process and this has ensured a talored bilingual service to their care pathway.

Increased translation investment again this year means the Trust continues to support patients and donors that need Welsh Language services

Partnership working with other Welsh Language Managers gives an opportunity to share best practice and begin the development of a shared IT system

Welsh language Standards Compliance:

Governance structure

We continue to work with our divisions to ensure a local approach to the development of the Standards. The divisional groups report frequently into the Trust wide WelshLlanguage group and information is fed directly to the Executive team and the Trust Board.

It has proved to be an extremely successful way to ensure information is shared and it informs the Trust Board of any regulatory changes that need discussion at Board level.

Our Board Welsh Language Champion continues to support and challenge our Welsh Language compliance.

The Trust is a host organisation for Health Technology Wales and NHS Wales Shared Services Partnership and they are both working diligently to support the development of the Welsh Language standards.

Training

The Trust continues to actively promote Welsh Language online training and in this reporting year eight members of staff have completed the Part 1 course. We also secured our second Foundation Welsh language course for staff but unfortunately the identified front line members were unable to complete the course.

We are reviewing our approach to training and will be running specific awareness sessions for staff from May 2023 prioritising staff that answer the telephone in line with the requirements of the Welsh Language Standards.

Staff have also been attending a Welsh Language confidence course run by HEIW and will be offered this opportunity again following a positive response. Partnership approaches to this course has proved to be extremely positive.

The newly introduced Welsh Language awareness 'more than just words...' on line course has been welcomed by the Trust and staff have embraced the course positively.

Since its introduction in December 2023 we can demonstrate a positive approach to compliance.

Welsh language awareness – More than Just words	**By February 2023 % of staff**
Corporate	50.00
Research, Development and innovation	55.10
Transforming Cancer Services	44.44
Velindre Cancer Centre	40.72
Welsh Blood Service	70.48
Velindre Organisations	50.85

Recording our staff competancy levels in ESR ensures our workforce planning considers the language needs of our services. Currently over 86% of the workforce are completing the competancy field within ESR.

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|LANG|Listening/Speaking Welsh|	1571	1571	1378	87.71%
NHS|LANG|Reading Welsh|	1571	1571	1367	87.01%
NHS|LANG|Welsh Language Awareness - 3 Years|	1571	1571	803	51.11%
NHS|LANG|Writing Welsh|	1571	1571	1363	86.76%

Workforce planning

We continue to work diligently on ensuring a Trust wide compliance with the Welsh Language standards whilst promoting and suppporting the ethos of ‘more than just words...’

Our Governance structure is embedded successfully and our document used to monitor compliance demonstrates a stregnthened compliance level. As a Trsut we continue to use this as a benchmark for delivery of our Welsh Language services.

As part of the Supply and Shape activity, work is currently being undertaken to gather a baseline assessment of our workforce, part of this is to assess the current capability of colleagues to speak, read and write in Welsh. The work will also consider how our workforce reflects the local population average, as well as looking at the capability levels of future colleagues (i.e., students currently enrolled on commissioned courses) this will provide a picture of the potential gap that we face as an organisation.

Working with partners we will then implement steps to reduce this gap and meet our requirements as articulated in the ‘More than Just Words’ action plan.’

Translation

Our increase in investment over the last two years has meant we have been able to increase our translation capacity. In 2023-24 we will be a team of three dedicted translators and utilising a Service level agreement with NWSSP.

In 2019/20 we were translating almsot 380,000 words. In 2022/23 we have translated just over 1,059,053. This is around 178% increase in the number of words translated in two years.

Job descriptions and recruitment

Translation has supported the time the Trust has given to strengthening its assessment of language needs whilst recruiting. Workforce planning is critical in order to ensure the Trust supports its patients and donors and is proactive with its recritment priorities.

This year we have focussed heavily on ensuring recruitmet managers are aware of the Welsh language recruitment process, we have invested heavily in structures to support this and the workforce team alongside the Welsh language department have now embedded the process securly.

In 2021-22 the translation team dealt with the translation of 24 job descriptions. Since the investment into a recruitment assessment process for Welsh language skills this has increased to 219 job descriptions to the beginning of March 2022-23.

Velindre University NHS Trust 2022-2023

Total number of vacancies advertised as:	
Welsh language skills are essential	1
Welsh language skills are desirable	157
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	5
Total Number of vacancies advertised 01/04/2022 - 31/03/2023	163

From the data we can confirm that the one post identified as essential was a front line, telephony post. The no skills necessary related to posts within a clinical laboritory service with no patient or donor contact.

Contractual obligations at Velindre Cancer Centre

Integrating our bilingual obligations into all that we do is essential to 'normalise' the use of the langauge and an understanding of our commitment to the development and promotion of the Welsh language Standards. As such, as we plan our services we have ensured that our obligations are highlighted in all that we do.

At the Cancer centre a revision of service level agreements has encouraged us to ensure the Welsh language is considered by our suppliers as well as our internal services. A simple yet effective way to ensure our compliance and encourage discussions with providers. It highlights our expectations of the provider and supports a discussion previously not considered:

Welsh Language Obligations

The Provider warrants and undertakes that it will not discharge its obligations under the Agreement in such a way as to render the Commissioner in breach of its obligations in respect of the Welsh language including, but not limited to, the Welsh Language Act 1993, the Government of Wales Act 1993, the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards (No. 7) Regulations 2018.

Clinical consultations

Our clinical consultation plan has been reviewed and a structure for assessing its actions put in place this year. The plan highlights the struggles of providing bilingual consultations for patients and donors but it also recogises the need to ensure a clear understanding of what skills are needed and where. The divisional groups have been charged with monitoring the action plan and will inform the Trust development group of concerns etc.

This year the WBS have conducted a skills audit as the first step in recognising where Welsh language skills lie. This audit will inform the next process of understanding how we can transfer the need to fit the skill especially as part of the donor collection process and the need for language communication on the front line.

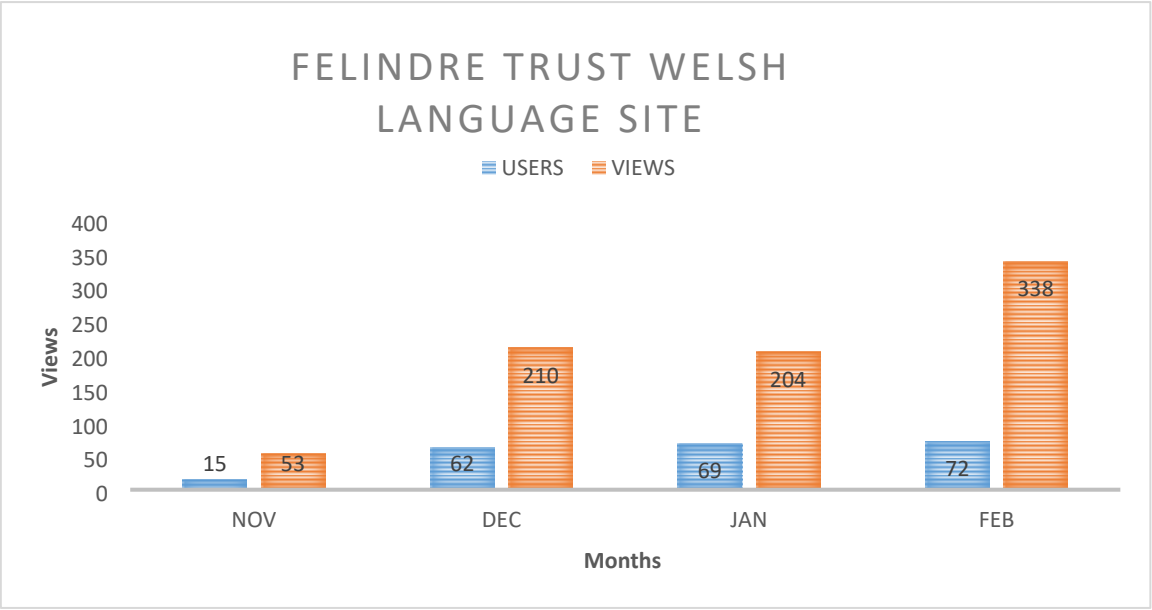
We will continue to work with the divisional groups to ensure our plan is revised and is informed by the language needs of our services.

At Velindre Cancer Centre the strengthening of the Active offer has seen three patients through the appointment system, recieving care and returning for care, in the Welsh language. With new IT systems in place and a commitment from the department to the Active offer, it has enabled the department to respond to the specific needs of their patients.

Website

The new Trust website has been embedded and from November 2022 we ar now able to monitor the Welsh language interest in our information.

English: https://velindre.nhs.wales/	Welsh: https://felindre.gig.cymru/
November 2.3k users 6.9k page views **December** 8.1k users 24k page views **January** 9.2k users 31k page views **February** 9.1k users 30k page views	**November** 15 users 53 page views **December** 62 users 210 page views **January** 69 users 204 page views **February** 72 users 338 page views



It is encouraging to note that there has been a 537% increase over four months in views to the Welsh language site

Telephone Communication

Perfomance indicators for the Welsh Blood Service donor contact centre from January 1 – March 16 2023

English language calls: 9,716

Welsh language calls: 366

Welsh language calls work out as around 4% of the calls.

Calls to Velindre Cancer Centre and the Trust headquaters are not measured, however specific actions for staff directly working on the telephone have been communciated. A specific question and answer session was also held to ensure staff understood their duties.

Promotion

We continue to highlight important events in the Welsh language calendar. This means an additional opportunity for staff to engage with the culture of Wales as well as the language.

This year the Trust has participated in a number of awareness raising days including St David's Day, Santes Dwynwen, Shw'mae day and 'mae gen ti hawl'.

Information on these events runs alongside our regular communication where we promote Welsh language traning, on line and face to face.

Our social media accounts have been incredibly busy this year with both divisions taking part in events. We are now offering bilingual approaches to all our promotional videos.

This year we were also fortunate enough to showcase our commitment to Welsh Culture at the HPMA (Healthcare People Management Association) Conference. This is a high profile event and Welsh culture was celebrated in a day long conference with Velindre University NHS Trust showcasing it's commitment.

Concerns and Complaints

The Trust welcomes feed back on its services. Concerns or complaints are used to ensure we continue to understand the needs of our patients and donors. Welsh language users are becoming increasingly aware of their rights to use the language and it is our duty to ensure we can provide those services to the best of our ability. This year we have recieved four official complaints and one formal investigation.

The formal investigation focussed on the Trust's ability to answer the telephone bilingually and to continue a discussion in the Welsh language. The investigation

has not been concluded however the Trust has been proactive and will be providing direct trainig on raising confidenceá to those answering the telephone.

Overall the Trust's concerns and complaints around the provision of Welsh language services are small, however, we are aware of the need to continuously monitor our provision and have this year updated our Concerns policy to reflect Welsh language provision.

NHS Wales Shared Services Partnership

Welsh Language Review Highlights 2022/23

The Welsh Language Unit at NHS Wales Shared Services Partnership has continued to support NWSSP divisions and services with advice on compliance and service delivery to our customers through the medium of Welsh and have supported the organisation and other NHS Organisations with translation support during 2022/23. The demand for translation services continues to grow, and this year we've translated even more words that in 2021/22. In 2022/23 NWSSP has translated a total of over 5.2million words for the following organisations:

- NHS Wales Shared Services Partnership
- Velindre University NHS Trust
- Public Health Wales NHS Trust
- Digital Health Care Wales
- Health Education Improvement Wales
- Wales Ambulance Service Trust
- Value in Health Care
- WHSSC

Compliance with Standard 106A

NHS Wales Shared Services categorises vacant or newly created posts as either Welsh essential or Welsh desirable, and we have introduced a matrix to determine which skill category is most relevant to each vacancy.

We have devised a protocol and a system whereby all advertisements are translated and published on the TRAC recruitment system and NHS Jobs in both Welsh and English since June 2022. We regularly review the system to capture any issues that arise in the creating vacancy advert process.

Easy-read Patient Information Leaflets

During the year, we've undertaken a full review of existing easy-read leaflets and new leaflets and have ensured that the translation of these leaflets are suitable for the audience for which they are intended.

Student Awards System

We reviewed the old system to ensure that the user journey was entirely through the medium of Welsh. During 2022/23 we have commissioned a new developer and a new Student Awards System, whereby the interface for students will be available through the medium of Welsh as well as any mail tips, correspondence and messages that are generated by the system. This work will continue into 2023/24.

Workforce Reporting System

This site provides a Web Portal for Primary Care Data accessible to GP practice staff, Clusters and Health Boards of NHS Wales and other approved stakeholder organisations. This site is only available to registered users. However, we have ensured that the system is bilingual.

Duty of Candour Public Video

We have supported the production of an animated video for the public in Wales about the duty of candour in collaboration with Welsh Government.

The video is available in both Welsh and English.

Counter Fraud Awareness Course and App

The Counter Fraud Awareness Course for all Wales NHS Staff is available in Welsh, as is the application for NHS Staff to report fraud or suspicion of fraud in NHS Wales.

All Wales GDPR Awareness Course

We have been supporting the production of the All Wales GDPR Awareness Course through the medium of Welsh and this will be available to launch in 2023/24.

All Wales Occupational Health System for NHS Wales Staff

The specification in the tender process for this system has included detailed requirements for the system interface and any correspondence/messages and mail tips to be available through the medium of Welsh as well as English. Further work on this system will continue in 2023/24.

Assessment of compliance across our services

Following on from the pandemic, we have re-introduced annual local assessments across our services in order to identify areas of best practice, identify areas of risk. Local improvement and action plans are established in order to strengthen our Welsh language services offer across all NWSSP services and programmes.

A copy of the full Annual Report for NWSSP can be found on our website:

Welsh Language Standards - NHS Wales Shared Services Partnership

Moving forward

Cultural change continues to be high on our priorities. Without a deeper understanding of the need for bilingual services we will continue to enhance a provision that does not have strong foundations, relying heavily on the willingness of supportive staff.

The Trust induction programme is being updated and will again include the importance of the Welsh language, sitting alongside other areas such as Equality and Diversity and the Future Generations Act. Our commitment to these areas are as important to us as our clinical requirements as we know how important they are to our patients and donors. Communication is key to safe care.

The Cultural plan will be revised and a refreshed action plan drawn highlighting opportunities for staff to familiarise themselves with the language and opportunities to learn. We will also be connecting this to the 'more than just words...' framework as our actions relate positivily to the aims of the framework.

Our recruitment and workforce planning will also play a key role. Planning with our community needs in mind ensures a targeted approach to recruitment. With this in mind our recruitment process will be supported by strong monitoring to ensure the Welsh language skills needed are highlighted correctly. This continues to be challenging for us as the nature of our services calls upon a small pool of clinical specialisms but we are commited to this agenda.

CONCLUSION AND FORWARD LOOK

We have produced our Integrated Medium Term Plan for 2023/24 – 2025/26 (insert link) which sets out how we will deliver services from 1st April 2023 to 31st March 2026. It describes what services we will provide, where they will be provided from and how we will continue to ensure patient, donor and staff safety. It also outlines the arrangements we have in place for managing our capacity so that we can meet the expected increase in demand for our services.

The next three years will undoubtedly provide both challenge and opportunity in equal measure. Our intention is to see the challenges as opportunities to place quality, safety and experience at the heart of everything we do. We are committed to working with patients, donors and our health and public service partners to understand, design and deliver services which are truly person focused and deliver the experience and outcomes that people value most.

Note: The Conclusion and Forward Look will be reviewed following feedback received through the Trust internal approval process.

Annex - Glossary of Terms

IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality and Planning Delivery
IPC	Infection Prevention Control
Linac	Linear Accelerator
RT	Radiotherapy
SACT	Systemic Anti-Cancer Therapy
VCS	Velindre Cancer Centre
WBS	Welsh Blood Service
CCLG	Collaborative Cancer Leadership Group
nVCS	New Velndre Cancer Centre
WCP	Welsh Clinical Portal
WRP	Welsh Risk Pool
LfER	Learning from Events Report
EAP	Employee Assistance Programme
TCS	Transforming Cancer Services
CDPS	Centre for Digital Public Services
DCW	Digital Communities Wales
WPAS	Welsh Patient Administration System
DHCW	Digital Healthcare Record
WTAIL	Welsh Transplantation & Immunogenetics Laboratory
BECS	Blood Establishment Computer System
WNCR	Welsh Nursing Care Record
NWSSP	NHS Wales Shared Services Partnership
HTW	Health Technology Wales
ESR	Electronic Staff Record

TRUST BOARD

AUDIT WALES – AUDIT OF ACCOUNTS (ISA 260) REPORT

DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris, Head of Financial Planning & Reporting
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Audit Committee	26/07/2023	Endorsed for Approval

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Audit Wales' Audit of Accounts Report at July 2023 is attached for the Committee's information.

1.2 The Trust Board is asked to REVIEW and APPROVE the Wales Audit Report which provides an opinion of the financial statements for 2022-23.

1.3 Duly authorise the Chair and Chief Executive officer to sign the Letter of Representation contained with the audit report.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The report has been prepared as part of Audit Wales work undertaken in accordance with statutory functions.

2.2 In the report, Audit Wales describe their intention to issue an unqualified true and fair audit opinion on the Trust's accounts for the year ended 2022/2023.

3. IMPACT ASSESSMENT

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

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

4. RECOMMENDATION

4.1 The Trust Board is asked to REVIEW and APPROVE the Wales Audit Report which provides an opinion of the financial statements for 2022-23.

4.2 Duly AUTHORISE the Chair and Chief Executive Officer to sign the Letter of Representation contained with the audit report.

Archwilio Cymru
Audit Wales

Audit of Accounts Report
Velindre University NHS Trust

Audit year: 2022-23

Date issued: July 2023

Document reference: 3701A2023

This document has been prepared as part of work performed in accordance with statutory functions.

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

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

Contents

We intend to issue an unqualified audit report on your Accounts. There are some issues to report to you prior to their approval.

Audit of Accounts Report

Appendices

Audit of Accounts Report

Introduction

1 We summarise the main findings from our audit of your 2022-23 annual report and accounts in this report.

2 We have already discussed these issues with the Executive Director of Finance and senior finance colleagues.

3 Auditors can never give complete assurance that accounts are correctly stated. Instead, we work to a level of 'materiality'. This level of materiality is set to try to identify and correct misstatements that might otherwise cause a user of the accounts into being misled.

4 We set this level at £9.7 million for this year's audit.

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

- Remuneration report / senior pay disclosure - £5,000; and
- Related parties - £10,000 for individuals interests.

6 We have now substantially completed this year's audit but the following work is outstanding:

- The review of the revised financial statements and Annual Report;
- Obtaining responses to some outstanding document requests in regard to our IT audit work; and
- The completion of our internal file review arrangements.

7 In our professional view, we have complied with the ethical standards that apply to our work; remain independent of yourselves; and our objectivity has not been compromised in any way. There are no relationships between ourselves and yourselves that we believe could undermine our objectivity and independence.

8 The timeline of the audit is set out in **Exhibit 1** below:

Exhibit 1 – audit timetable

Timetable	• We received the draft accounts on 5 May 2023 • Our deadline for completing our audit has been extended to 31 July 2023 • We expect your audit report to be signed by the Auditor General on 31 July 2023

Proposed audit opinion

9 We intend to issue an unqualified audit opinion on this year's accounts once you have provided us with a Letter of Representation based on that set out in **Appendix 1**.

10 We issue a 'qualified' audit opinion where we have material concerns about some aspects of your accounts; otherwise we issue an unqualified opinion.

11 The Letter of Representation contains certain confirmations we are required to obtain from you under auditing standards.

12 Our proposed audit report is set out in **Appendix 2**.

Significant issues arising from the audit

Uncorrected misstatements

13 There are no misstatements identified in the accounts, which remain uncorrected.

Corrected misstatements

14 As a result of our audit there have been a number of adjustments to the financial statements. These adjustments are summarised, for information, in **Appendix 3**.

Other significant issues arising from the audit

15 In the course of the audit, we consider a number of other matters relating to the accounts, including any qualitative issues, and report any significant issues arising to you.

16 There is one issue to report concerning the difficulties we have experienced obtaining timely responses to clear some audit queries which has delayed the completion of our audit. A major issue impacting on this has been the staffing capacity within the Trust's finance team to support the audit process. The planned secondment to Welsh Government (from the start of June) of the Head of Financial Operations and the unforeseen sickness absence of her replacement had a significant contribution to this.

Recommendations

17 We will be reporting a number of recommendations in a separate report to the Trust which will be presented to a future Audit Committee. None of these recommendations are considered of to be sufficiently significant to necessitate reporting at this time.

Appendix 1

Final Letter of Representation

Audited body's letterhead

Auditor General for Wales
Wales Audit Office
1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Representations regarding the 2022-23 financial statements

This letter is provided in connection with your audit of the financial statements (including that part of the Remuneration Report that is subject to audit) of Velindre University NHS Trust for the year ended 31st March 2023 for the purpose of expressing an opinion on their truth and fairness, their proper preparation and the regularity of income and expenditure.

We confirm that to the best of our knowledge and belief, having made enquiries as we consider sufficient, we can make the following representations to you.

Management representations

Responsibilities

As Chief Executive and Accountable Officer I have fulfilled my responsibility for:

- Preparing the financial statements in accordance with legislative requirements and the Treasury's Financial Reporting Manual. In preparing the financial statements, I am required to:
  - observe the accounts directions issued by Welsh Ministers/HM Treasury, including the relevant accounting and disclosure requirements and apply appropriate accounting policies on a consistent basis;
  - make judgements and estimates on a reasonable basis;
  - state whether applicable accounting standards have been followed and disclosed and explain any material departures from them; and
  - prepare them on a going concern basis on the presumption that the services of Velindre University NHS Trust will continue in operation.
- Ensuring the regularity of any expenditure and other transactions incurred.

- The design, implementation and maintenance of internal control to prevent and detect error.

Information provided

We have provided you with:

- Full access to:
  - all information of which we are aware that is relevant to the preparation of the financial statements such as books of account and supporting documentation, minutes of meetings and other matters;
  - additional information that you have requested from us for the purpose of the audit; and
  - unrestricted access to staff from whom you determined it necessary to obtain audit evidence.
- The results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.
- Our knowledge of fraud or suspected fraud that we are aware of and that affects Velindre University NHS Trust and involves:
  - management;
  - employees who have significant roles in internal control; or
  - others where the fraud could have a material effect on the financial statements.
- Our knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators or others.
- Our knowledge of all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.
- The identity of all related parties and all the related party relationships and transactions of which we are aware.
- Our knowledge of all possible and actual instances of irregular transactions.

Financial statement representations

All transactions, assets and liabilities have been recorded in the accounting records and are reflected in the financial statements.

The methods, the data and the significant assumptions used in making accounting estimates, and their related disclosures are appropriate to achieve recognition, measurement or disclosure that is reasonable in the context of the applicable financial reporting framework.

Related party relationships and transactions have been appropriately accounted for and disclosed.

All events occurring subsequent to the reporting date which require adjustment or disclosure have been adjusted for or disclosed.

All known actual or possible litigation and claims whose effects should be considered when preparing the financial statements have been disclosed to the auditor and accounted for and disclosed in accordance with the applicable financial reporting framework.

The financial statements are free of material misstatements, including omissions. The effects of uncorrected misstatements identified during the audit are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Representations by the Board of Velindre University NHS Trust

We acknowledge that the representations made by management, above, have been discussed with us.

We acknowledge our responsibility for the preparation of true and fair financial statements in accordance with the applicable financial reporting framework. The financial statements were approved by the Board on 27th July 2023.

We confirm that we have taken all the steps that we ought to have taken in order to make ourselves aware of any relevant audit information and to establish that it has been communicated to you. We confirm that, as far as we are aware, there is no relevant audit information of which you are unaware.

Signed by:	Signed by:
Chief Executive	Chair of the Trust
Date:	Date:

Appendix 2

Proposed Audit Report

The Certificate and report of the Auditor General for Wales to the Senedd

Opinion on financial statements

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

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

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

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

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

Opinion on regularity

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

Basis for opinions

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

My staff and I are independent of the trust in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK including the Financial Reporting Council's Ethical Standard, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinions.

Conclusions relating to going concern

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

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

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

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

Other Information

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

I have nothing to report in this regard.

Opinion on other matters

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

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

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with the National Health Service (Wales) Act 2006 and directions made there under by Welsh Minsters' directions; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent

with the financial statements and in accordance with Welsh Ministers' guidance.

Matters on which I report by exception

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

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

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

Responsibilities of Directors and the Chief Executive for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

My procedures included the following:

- Enquiring of management, the audited entity's internal auditors and those charged with governance, including obtaining and reviewing supporting documentation relating to Velindre University NHS Trust's policies and procedures concerned with:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations.
- Considering as an audit team how and where fraud might occur in the financial statements and any potential indicators of fraud;
- Obtaining an understanding of Velindre University NHS Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of Velindre University NHS Trust; and
- Obtaining an understanding of related party relationships

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

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management about actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether

the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

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

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

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

Other auditor's responsibilities

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

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

Report

I have no observations to make on these financial statements.

Adrian Crompton
Auditor General for Wales
31 July 2023

1 Capital Quarter
Tyndall Street
Cardiff
CF10 4BZ

Appendix 3

Summary of Corrections Made

Following our audit some adjustments have been made to the Financial Statements. These have been corrected by management. A summary of the most significant corrections made are summarised below.

Exhibit 2: summary of corrections made

Value of correction	Nature of correction
£4.587m	**Welsh Risk Pool Provisions** Reduction in the Welsh Risk Pool Provisions and corresponding debtor due from the Welsh Government due to the duplication of a case that became a Structured Settlement case in the year
£7.090m	**Property Plant and Equipment (Note 13)** There has been an increase in the closing Net Book Value of the Trust's property plant and equipment as a result of the correction of a validation error raised by the Welsh Government.
Various	**Reclassifications – NHS income and expenditure** Reclassification of NHS income and expenditure to provide an analysis in Notes 3, 4 and 5 that is consistent with the prior year and in line with the requirements of the Welsh Government.
Various	**Remuneration Report** Corrections have been made to the disclosures to ensure compliance with the Manual for Accounts. These include correcting the median pay disclosure and the remuneration bandings of several individuals.
£3.852m	**Trade & Other Payables (Note 20)** A classification error between Tangible and Intangible capital payables has been corrected.

Value of correction	Nature of correction
Narrative only	**Related Party Transactions (Note 33)** A small number of additional and revised disclosures have been made concerning transactions between the Trust and other bodies. This includes some bodies that individuals have declared an interest with that were not disclosed in the original draft accounts.
Various	**Cashflow Statement** Updating of the template accounts to ensure only cash movements are included.
Reclassification and narrative amendment	**Lease disclosures (Note 9)** Adjustments have made to the disclosure note to correctly reflect the Trust's lease liabilities.
Narrative only	**Note 32 - Events after the balance sheet date** Narrative included to disclose the value of the non-consolidated recovery payments made to the Trust's employees.
Narrative and presentational amendments	**Various** A number of other narrative and presentational amendments were made to supporting notes throughout the final financial statements and the annual report.

Audit Wales

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Website: www.audit.wales

We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

TRUST BOARD

2022/23 HEAD OF INTERNAL AUDIT OPINION & ANNUAL REPORT

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Emma Rees, Deputy Head of Internal Audit
PRESENTED BY	Simon Cookson, Director of Audit & Assurance
APPROVED BY	Simon Cookson, Director of Audit & Assurance Matthew Bunce, Director of Finance
EXECUTIVE SUMMARY	The purpose of this report is to present the 2022/23 Head of Internal Audit Opinion and Annual Report (the Opinion).
RECOMMENDATION / ACTIONS	The Trust Board is invited to **NOTE** the content of the 2022/23 Opinion.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Board Development Session	18/04/2023

Audit Committee	26/07/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS **Board Development Session:** The draft 2022/23 Opinion was considered as part of the Board's discussions on the 2022/23 annual Governance & Accountability Assessment / Trust Board Effectiveness, which forms part of the Governance Statement within the Accountability Report. **Audit Committee:** The Audit Committee **NOTED** the final 2022/23 Opinion.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Not applicable for Head of Internal Audit Opinion For 2023/24 onward, the 7 levels of assurance for individual internal audit reports will be detailed in individual covers papers where applicable.

APPENDICES (included within Opinion document)	
Appendix A	Conformance with Internal Audit Standards
Appendix B	Audit Assurance Ratings

1. SITUATION

In accordance with the Public Sector Internal Audit Standards, we (NWSSP Audit & Assurance Services) present the 2022/23 Head of Internal Audit Opinion & Annual Report (the Opinion) to support the development of the Trust's Annual Governance Statement.

2. BACKGROUND

The Board is invited to **NOTE** the content of the 2022/23 Head of Internal Audit Opinion & Annual Report.

3. ASSESSMENT

The 2022/23 Opinion provides the Board with **reasonable assurance** that arrangements to secure governance, risk management and internal control, within those areas under review, are suitably designed and applied effectively. Some

matters require management attention in control design or compliance with low to moderate impact on residual risk exposure until resolved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

In developing the Opinion, we have considered:

- 17 completed reviews undertaken as part of the Trust's Annual Internal Audit Plan (14 assurance reviews and three advisory reviews); and
- ten reviews undertaken at NHS Wales Shared Services Partnership (four assurance reports and one advisory review report) and Digital Health and Care Wales (five assurance reports).

We also considered the status of the nVCC and Enabling Works Integrated Audit & Assurance Plans. Five 2022/23 nVCC IAAP elements were deferred to 2023/24 (in alignment with nVCC project progress) and reporting was paused on our 2022/23 Enabling Works audit to consider and reflect on changes to critical nVCC project timelines.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
NO From 2023/24 onward, Internal Audit reports will be linked to the strategic goals in the cover paper for each individual report, where applicable.	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	☐ ☐ ☐ ☐ ☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance Internal Audit reports are linked to the TAF in the Annual Internal Audit Plan. From 2023/24 onward, they will also be linked in the cover paper for each individual report, where applicable.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	Individual Internal Audit reports may provide assurance over the Quality Domains and Enablers. Internal Audit reports are linked to the Quality Domains and Enablers in the individual audit briefs. From 2023/24 onward, this will also be done in the cover paper for each individual report, where applicable.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Annual Head of Internal Audit Opinion

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	Individual Internal Audit reports may provide assurance over the Wellbeing Goals.
	For 2023/24 onwards, Internal Audit reports will be linked to the Wellbeing Goals in the cover paper for each individual report, where applicable.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Annual Head of Internal Audit Opinion
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Legal risks identified in our audits will be highlighted in the cover report for each individual report, where applicable.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Internal Audits are linked to the Trust Risk Register in the Annual Internal Audit Plan. From 2023/24 onward, we will include this link in the cover paper for each individual report.
WHAT IS THE CURRENT RISK SCORE	N/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/a
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/a
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	N/a
All risks must be evidenced and consistent with those recorded in Datix	

Head of Internal Audit Opinion & Annual Report 2022/23

July 2023

Velindre University NHS Trust

Contents

Report status: Final
Draft report issued: 11th April 2023
Final report issued: 19th July 2023
Author: Emma Rees, Deputy Head of Internal Audit
Executive Clearance: Lauren Fear, Director of Corporate Governance & Chief of Staff
Matthew Bunce, Director of Finance
Audit Committee: July 2023

1. EXECUTIVE SUMMARY

1.1 Purpose of this Report

Velindre University NHS Trust's (the Trust) Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall assurance opinion from the Head of Internal Audit.

This report sets out the Head of Internal Audit Opinion together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards.

1.2 Head of Internal Audit Opinion 2022-23

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Chief Executive as Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. The approved Internal Audit plan is focused on risk and therefore the Board will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement. The overall opinion for 2022/23 is that:

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

1.3 Delivery of the Audit Plan

The Internal Audit Plan for 2022/23 year was presented to the Committee in May 2022. Changes to the plan have been made during the year and these changes have been reported to the Audit Committee as part of our regular progress reporting. We confirm that we have undertaken sufficient audit work during the year to be able to give an overall opinion in line with the requirements of the Public Sector Internal Audit Standards.

There are, as in previous years, audits undertaken at NWSSP and DHCW that support the overall opinion for NHS Wales health bodies (see section 3).

Our latest External Quality Assessment (EQA), conducted by the Chartered Institute of Public Finance and Accountancy in 2023, and our own annual Quality Assurance and Improvement Programme (QAIP) have both confirmed that our internal audit work 'fully conforms' to the requirements of the Public Sector Internal Audit Standards (PSIAS) for 2022/23.

1.4 Summary of Audit Assignments

This report summarises the outcomes from our work undertaken in the year. In some cases, audit work from previous years may also be included and where this is the case, details are given. This report also references assurances received through the internal audit of control systems operated by other NHS Wales organisations (again, see section 3).

The audit coverage in the plan agreed with management has been deliberately focused on key strategic and operational risk areas; the outcome of these audit reviews may therefore highlight control weaknesses that impact on the overall assurance opinion.

Overall, we can provide the following assurances to the Board that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively in the areas in the table below.

Where we have identified high priority matters arising, management are aware of the specific issues identified and have agreed action plans to improve control in these areas. These planned control improvements should be referenced in the Annual Governance Statement where it is appropriate to do so.

A summary of the audits undertaken in the year and the results are summarised in table 1.

Table 1 – Summary of Audits 2022/23

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

Please note that our overall opinion has also considered the number and significance of any audits that have been deferred during the year (see section 5.7) and other information obtained during the year that we deem to be relevant to our work (see section 2.4.2).

2. HEAD OF INTERNAL AUDIT OPINION

2.1 Roles and Responsibilities

The Board is collectively accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is a statement made by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control, as evidenced by a description of the risk management and review processes, including compliance with the Health & Care Standards; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The Trust's risk management process and system of assurance should bring together all of the evidence required to support the Annual Governance Statement.

In accordance with the Public Sector Internal Audit Standards (PSIAS), the Head of Internal Audit (HIA) is required to provide an annual opinion, based upon and limited to the work performed on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. This is achieved through an audit plan that has been focussed on key strategic and operational risk areas and known improvement opportunities, agreed with executive management and approved by the Audit Committee, which should provide an appropriate level of assurance.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the Trust. The opinion is substantially derived from the conduct of risk-based audit work formulated around a selection of key organisational systems and risks. As such, it is a key component that the Board considers but is not intended to provide a comprehensive view.

The Board, through the Audit Committee, will need to consider the Head of Internal Audit opinion together with assurances from other sources including reports issued by other review bodies, assurances given by management and other relevant information when forming a rounded picture on governance, risk management and control for completing its Governance Statement.

2.2 Purpose of the Head of Internal Audit Opinion

The purpose of the annual Head of Internal Audit opinion is to contribute to the assurances available to the Accountable Officer and the Board of Velindre University NHS Trust which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

This opinion will in turn assist the Board in the completion of its Annual Governance Statement and may also be considered by regulators including Healthcare Inspectorate Wales in assessing compliance with the Health & Care Standards in Wales, and by Audit Wales in the context of both their external audit and performance reviews.

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

2.3 Assurance Rating System for the Head of Internal Audit Opinion

The overall opinion is based primarily on the outcome of the work undertaken during the 2021/22 audit year. We also consider other information available to us such as our overall knowledge of the organisation, the findings of other assurance providers and inspectors, and the work we undertake at other NHS Wales organisations. The Head of Internal Audit considers the outcomes of the audit work undertaken and exercises professional judgement to arrive at the most appropriate opinion for each organisation.

A quality assurance review process has been applied by the Director of Audit & Assurance and the Head of Internal Audit in the annual reporting process to ensure the overall opinion is consistent with the underlying audit evidence.

We take this approach into account when considering our assessment of our compliance with the requirements of PSIAS.

The assurance rating system based upon the colour-coded barometer and applied to individual audit reports remains unchanged. The descriptive narrative used in these definitions has proven effective in giving an objective and consistent measure of assurance in the context of assessed risk and associated control in those areas examined.

This same assurance rating system is applied to the overall Head of Internal Audit opinion on governance, risk management and control as to individual assignment audit reviews. The assurance rating system together with definitions is included at **Appendix B**.

The individual conclusions arising from detailed audits undertaken during the year have been summarised by the assurance ratings received. The aggregation of audit results gives a better picture of assurance to the Board and also provides a rational basis for drawing an overall audit opinion. However, please note that for presentational purposes we have shown the results using the eight areas that were used to frame the audit planning at its outset (see section 2.4.2).

2.4 Head of Internal Audit Opinion

2.4.1 Scope of opinion

The scope of my opinion is confined to those areas examined in the risk-based audit plan which has been agreed with senior management and approved by the Audit Committee. The Head of Internal Audit assessment should be interpreted in this context when reviewing the effectiveness of the system of internal control and be seen as an internal driver for continuous improvement. The Head of Internal Audit opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control is set out below.

Reasonable Assurance

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

This opinion will need to be reflected within the Annual Governance Statement along with confirmation of action planned to address the issues raised. Particular focus should be placed on the agreed response to any significant recommendations made.

2.4.2 Basis for Forming the Opinion

The audit work undertaken during 2022/23 and reported to the Audit Committee has been aggregated at Section 5.

The evidence-base upon which the overall opinion is formed is as follows:

- An assessment of the range of individual opinions and outputs arising from risk-based audit assignments contained within the Internal Audit plan that have been reported to the Audit Committee throughout the year. In addition, and where appropriate, work at either draft report stage or in progress but substantially complete has also been considered, and where this is the case then it is identified in the report. This assessment has taken account of the relative materiality of these areas and the results of any follow-up audits in progressing control improvements (see section 2.4.3).
- Other assurance reviews which impact on the Head of Internal Audit opinion including audit work performed at other organisations (see Section 3).
- Other knowledge and information that the Head of Internal Audit has obtained during the year including cumulative information and knowledge over time; observation of Board and other key committee meetings; meetings with Executive Directors, senior managers and Independent Members; the results of *ad hoc* work and support provided; liaison with other assurance providers and inspectors; research; and cumulative audit knowledge of the organisation that the Head of Internal Audit considers relevant to the Opinion for this year.

As stated above, these detailed results have been aggregated to build a picture of assurance across the Trust.

In reaching this opinion we have identified that all reviews during the year concluded positively, with robust control arrangements operating in most areas.

From the opinions issued during the year, three were allocated Substantial Assurance, eight were allocated Reasonable Assurance and two were allocated Limited Assurance. No reports were allocated 'no assurance' opinion. In addition, three advisory or non-opinion reports were also issued. At the time of writing, five audits were at fieldwork stage.

In addition, the Head of Internal Audit has considered residual risk exposure across those assignments where limited assurance was reported. Further, the Head of Internal Audit has considered the impact where audit assignments planned this year did not proceed to full audits following preliminary planning work and these were either: removed from the plan; removed from the plan and replaced with another audit; or deferred until a future audit year. The reasons for changes to the audit plan were presented to the Audit Committee for consideration and approval. Notwithstanding that the opinion is restricted to those areas which were subject to audit review, the Head of Internal Audit has considered the impact of changes made to the plan when forming their overall opinion.

A summary of the findings is shown below. We have reported the findings using the eight areas of the Trust's activities that we use to structure both our 3-year strategic and 1-year operational plans.

Corporate Governance, Risk Management and Regulatory Compliance

We have undertaken **one review** in this area, with a further **one in progress** planned for inclusion in the 2022/23 opinion:

- Decarbonisation (Advisory): this advisory review sought to affirm common themes across Welsh health bodies relating to Decarbonisation Action Plans and to provide an overview of the overarching position across NHS Wales. Our work identified that all health bodies were broadly at an early stage of implementation. Some progress was observed, but this has been restricted by the availability of financial and staff resource.
- Follow Up: this review received a reasonable assurance opinion. We considered timely implementation of internal audit recommendations and governance of the Audit Action Tracker. We also followed up on recommendations contained in our 2021/22 Trust Assurance Framework, Board Committee Effectiveness and Follow-up of Previous Recommendations reports. We found that nine of the thirteen recommendations followed up had been fully implemented and the remaining four had been partially implemented. Of the four, one was deemed to be medium priority (continued improvement to Audit Action Tracker governance) and three were low priority.

Strategic Planning, Performance Management & Reporting

We have undertaken **one audit** in this area, with a further **one in progress** planned for inclusion in the 2022/23 opinion:

- Performance Management Framework (PMF): receiving a reasonable assurance opinion, this review provided assurance over phase 1 of evolving the Trust's PMF and planned actions for phases 2 and 3. We found the Trust to have developed a comprehensive new PMF reporting format, with phase 1 having been well managed. We did not identify any significant matters for reporting.
- Trust Priorities: this audit aimed to provide assurance over the robustness of the Trust's prioritisation exercise and the governance mechanisms over the delivery of priority programmes. It received a reasonable assurance opinion. No significant matters for reporting were identified, although we flagged areas where the prioritisation approach could be used to enhance annual financial and resource planning.

Financial Governance and Management

Under this domain, we undertook **one review**:

- Finance & Service Sustainability: focusing on the fundamental processes underpinning financial and service sustainability − namely budgetary control (revenue budgets) and savings plans − we provided a reasonable assurance opinion on this audit. No significant matters for reporting were identified, although we flagged several areas where improvement was needed to comply, or demonstrate compliance, with the Standing Orders / Standing Financial Instructions and Budgetary Control FCP.

Audits at other bodies: the audits of the payment systems provided by NWSSP, which we audit each year, concluded with positive assurance. The audits of Payroll and Accounts Payable both received reasonable assurance opinion ratings. Additionally, the audit of Procurement Services − National Sourcing also received a reasonable assurance opinion.

Quality & Safety

Three reviews were planned under the Quality & Safety domain, of which **two were completed** and one deferred.

Completed audits:

- Clinical Audit: receiving a reasonable assurance opinion, the audit considered the Trust's Clinical Audit Strategy and Plans and the governance mechanisms over clinical audit activities, specifically around improvement actions and learning. We highlighted recommendations to support the Trust's ongoing journey in improving clinical audit.
- Patient & Donor Experience: our review identified that the Trust has patient and donor experience governance, reporting and scrutiny mechanisms in place, is using technology to capture feedback data, and is using this data to identify and implement service improvements. We provided a reasonable assurance opinion, having identified areas where further work is needed to ensure the mechanisms in place are robust and embedded throughout the Trust.

Deferred audits:

- Quality & Safety Framework: we agreed to defer this audit to the 2023/24 plan due to the overlap with the Audit Wales Quality Governance report, which was presented to the Trust's Quality, Safety & Performance Committee in November 2022.

Information Governance & Security

We undertook **three reviews** in this area:

- Digital Health & Care Record (DHCR) – Implementation: this audit considered the Trust's preparedness for the November 2022 'go live' of the DHCR solution and received a substantial assurance opinion. We did identify any matters for reporting;
- Cyber Security: this report considered improvement work and progress against the Trust's Cyber Security Strategic Delivery Plan (the CSSPD), cyber security reporting, and back-up procedures. Whilst we found that the Trust had made good progress with its cyber security improvements and the report received a substantial assurance opinion, we noted that recent resource pressures had slowed progress against the CSSDP.
- Information Governance: we provided a reasonable assurance opinion on this audit, concluding that the Trust has an active Information Governance function which is engaged in the ongoing development and enhancement of the Trust's information governance activities. Most of the findings identified were already included in the Trust's Information Governance Development Plan. No significant matters were identified for reporting.

Audits at other bodies: five audits which may provide assurance to the Trust were undertaken as part of the DHCW internal audit plan. The Technical Resilience and Cyber Security audits received substantial assurance opinions. Audits of Switching Services, Embedding the Stakeholder Engagement Plan and the Microsoft 365 Centre of Excellence received reasonable assurance opinions.

Operational Service and Functional Management

Two audits were undertaken under this domain:

- Managing Attendance at Work: overall, we concluded that the Trust's processes regarding managing attendance at work were adequately designed, with robust performance reporting and monitoring processes. Whilst a reasonable assurance opinion was given, we identified issues around absence documentation not being stored in the appropriate location and delays in holding Long Term Sickness meetings.
- Research & Development: we provided a substantial assurance opinion over this review, which considered the governance and management arrangements over the Trust's research and development function. We did identify any matters for reporting. The positive outcome was a result of the focus and work undertaken by the Trust in this area.

Workforce Management

We undertook **one review** under this domain:

- Staff Wellbeing (Advisory): this advisory review sought to consider the effectiveness of staff wellbeing support and initiatives utilised by the Trust, including throughout the Covid-19 pandemic. We identified that the Trust has significant wellbeing activity ongoing, including numerous interventions to support wellbeing improvement. We identified areas that we considered could be enhanced or strengthened around measures for monitoring success of interventions and consideration of standard wellbeing frameworks, models or research.

The Managing Attendance at Work audit, detailed under the Operational Service and Functional Management domain above, also falls into the Workforce Management domain.

Audits at other bodies: the Recruitment Services audit undertaken as part of the internal audit programme at NWSSP received a reasonable assurance opinion.

Capital & Estates Management

We have undertaken **five audits** in this area. This includes audits within the Integrated Audit & Assurance Plans (IAAPs) for the nVCC Enabling Works and nVCC Main Scheme projects.

Reviews within the general annual Internal Audit Plan:

- Capital Systems: this audit – which received a reasonable assurance opinion – evaluated the Trust's systems for the prioritisation and allocation of discretionary capital. We concluded that a robust procedural framework was in place with compliance generally evident at divisional level, although recommendations were made to strengthen governance within the framework.

Integrated Audit & Assurance Plans:

In accordance with the Welsh Government's NHS Wales Infrastructure Investment Guidance, the new Velindre Cancer Centre (nVCC) Outline Business Case (OBC) and Enabling Works Full Business Case (FBC), we have sought to provide the integrated audit approach at the project(s) during 2022/23. This included ongoing observation at key project meetings, interim audit reviews and ad hoc input as required by Trust management.

The 2022/23 completed audits included:

- nVCC Enabling Works (b/f 2021/22) – reasonable assurance;
- nVCC Enabling Works Security Contract – advisory; and
- nVCC Contract Management – limited assurance.

During 2022/23, audit activity continued to focus on the delivery of the enabling works (EW) contract. Our initial review (to January 2023), identified significant concerns associated with the slippage in the works programme. This effectively meant that at the date of the audit fieldwork, the EW project completion no longer aligned with the original target for Financial Close for the nVCC project, which ultimately could impact on the progression and delivery of the main works. However, recognising subsequent changes in the critical timelines (primarily financial close), it is important that these are acknowledged, and accordingly further audit work is to be progressed during 2023/24 to reflect and consider the new delivery timetable.

Noting the above, the following IAAP audits planned for 2022/23 were deferred to 2023/24:

- nVCC Design & Change Management;
- nVCC Planning; and
- nVCC Procurement & Approvals.

Our access has been limited due to project development pressures and we acknowledge the balance required between accessing management at critical stages and delivering the agreed audit programmes.

We will seek to continue to provide an integrated audit provision at the project ensuring appropriate focus through to the delivery and commissioning of the new facility. To enable the same, Executive support and management engagement is required to enable the update of the integrated audit plan for inclusion within the FBC (now scheduled for submission for scrutiny during Winter 2023).

2.4.3 Approach to Follow Up of Recommendations

As part of our audit work, we consider the progress made in implementing the actions agreed from our previous reports.

In 2022/23, we considered progress made on a risk-based sample of findings from 2021/22 reports, focusing mainly on high and medium priority findings from key reports, namely the Trust Assurance Framework, Board Committee Effectiveness and Follow-up of Previous Recommendations. We also undertook testing on the completeness, accuracy and effectiveness of the Audit Action Tracker. Our work identified that:

- nine of the thirteen recommendations followed up had been fully implemented; and
- the remaining four had been partially implemented. Of these, one was deemed to be medium priority (continued improvement to Audit Action Tracker governance) and three were low priority.

We provided a reasonable assurance opinion over the 2022/23 follow-up audit.

In addition, Audit Committees monitor the progress in implementing recommendations (this is wider than just Internal Audit recommendations) through their own recommendation tracker processes. We attend all audit committee meetings and observe the quality and rigour around these processes.

We have considered the impact of our follow-up work on both our ability to give an overall opinion (in compliance with the PSIAS) and the level of overall assurance that we can give.

2.4.4 Limitations to the Audit Opinion

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding the achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems.

As mentioned above the scope of the audit opinion is restricted to those areas which were the subject of audit review through the performance of the risk-based Internal Audit plan. In accordance with auditing standards, and with the agreement of senior management and the Board, Internal Audit work is deliberately prioritised according to risk and materiality. Accordingly, the Internal Audit work and reported outcomes will bias towards known weaknesses as a driver to improve governance risk management and control. This context is important in understanding the overall opinion and balancing that across the various assurances which feature in the Annual Governance Statement.

Caution should be exercised when making comparisons with prior years. Audit coverage will vary from year to year based upon risk assessment and cyclical coverage on key control systems. In addition, the impact of COVID-19 on this previous years' programmes makes any comparison even more difficult.

2.4.5 Period covered by the Opinion

Internal Audit provides a continuous flow of assurance to the Board and, subject to the key financials and other mandated items being completed in-year, the cut-off point for annual reporting purposes can be set by agreement with management. To enable the Head of Internal Audit opinion to be better aligned with the production of the Annual Governance Statement a pragmatic cut-off point has been applied to Internal Audit work in progress.

By previous agreement with the Trust, audit work reported to draft stage has been included in the overall assessment, with all other work in progress rolled-forward and reported within the overall opinion for next year.

Most audit reviews will relate to the systems and processes in operation during 2022/23 unless otherwise stated and reflect the condition of internal controls pertaining at the point of audit assessment.

Follow-up work will provide an assessment of action taken by management on recommendations made in prior periods and will therefore provide a limited scope update on the current condition of control and a measure of direction of travel.

There are some specific assurance reviews which remain relevant to the reporting of the organisation's Annual Report required to be published after the year end. Where required, any specified assurance work would be aligned with the timeline for production of the Trust's Annual Report and accordingly will be completed and reported to management and the Audit Committee subsequent to this Head of Internal Audit Opinion. However, the Head of Internal Audit's assessment of arrangements in these areas would be legitimately informed by drawing on the assurance work completed as part of this current year's plan.

2.5 Required Work

Please note that following discussions with Welsh Government we were not mandated to audit any areas in 2022/23.

2.6 Statement of Conformance

The Welsh Government determined that the Public Sector Internal Audit Standards (PSIAS) would apply across the NHS in Wales from 2013/14.

The provision of professional quality Internal Audit is a fundamental aim of our service delivery methodology and compliance with PSIAS is central to our audit approach. Quality is controlled by the Head of Internal Audit on an ongoing basis and monitored by the Director of Audit & Assurance. The work of Internal Audit is also subject to an annual assessment by Audit Wales.

In addition, at least once every five years, we are required to have an External Quality Assessment (EQA). This was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 2023. CIPFA concluded that NWSSP's Audit & Assurance Services 'fully conforms' with the Public Sector Internal Audit Standards. It is therefore appropriate for NWSSP Audit & Assurance Services to say in reports and other literature that it conforms to the IIA's professional standards and to PSIAS.'

NWSSP Audit and Assurance Services can assure the Audit Committee that it has conducted its audits at Trust in conformance with the Public Sector Internal Audit Standards for 2022/23.

Our conformance statement for 2022/23 is based upon:

- the results of our internal Quality Assurance and Improvement Programme (QAIP) for 2022/23 which will be reported formally in the Summer of 2023;
- the results of the work completed by Audit Wales; and
- the results of the EQA undertaken by CIPFA in 2023.

We have set out, in **Appendix A**, the key requirements of the Public Sector Internal Audit Standards and our assessment of conformance against these requirements. The full results and actions from our QAIP will be included in the 2022/23 QAIP report. There are no significant matters arising that need to be reported in this document.

We also note that there have been no impairments to the independence of the Head of Internal Audit or to any other members of NWSSP's Audit & Assurance Service who undertook work on the Trust's audit programme for 2022/23.

2.7 Completion of the Annual Governance Statement

While the overall Internal Audit opinion will inform the review of effectiveness for the Annual Governance Statement, the Accountable Officer and the Board need to take into account other assurances and risks when preparing their statement. These sources of assurances will have been identified within the Board's own performance management and assurance framework and will include, but are not limited to:

- direct assurances from management on the operation of internal controls through the upward chain of accountability;
- internally assessed performance against the Health & Care Standards;
- results of internal compliance functions including Local Counter-Fraud, Post Payment Verification, and risk management;
- reported compliance via the Welsh Risk Pool regarding claims standards and other specialty specific standards reviewed during the period; and
- reviews completed by external regulation and inspection bodies including Audit Wales and Healthcare Inspectorate Wales.

3. OTHER WORK RELEVANT TO THE TRUST

As our internal audit work covers all NHS Wales organisations there are a number of audits that we undertake each year which, while undertaken formally as part of a particular health organisation's audit programme, will cover activities relating to other Health bodies. These are set about below, with relevant comments and opinions attached, and relate to work at:

- NHS Wales Shared Services Partnership; and
- Digital Health & Care Wales.

NHS Wales Shared Services Partnership (NWSSP)

As part of the internal audit programme at NHS Wales Shared Services Partnership, a hosted body of Velindre University NHS Trust, several audits were undertaken which are relevant to the Trust. These audits of the financial systems operated by NWSSP, processing transactions on behalf of the Trust, derived the following opinion ratings:

Audit	Opinion	Outline scope
Accounts Payable	Reasonable	To evaluate and determine the adequacy of the systems and controls in place over the management of the NWSSP Accounts Payable service.
Payroll (draft report)	Reasonable	To evaluate and determine the adequacy of the systems and controls in place for the management of Payroll Services.
Recruitment Services	Reasonable	To review the adequacy of the systems and controls in place for the management of Recruitment Services.
Procurement Services – National Sourcing (draft report)	Limited	To review the consistency of operations with Procurement Services – National Sourcing and to ensure that procurement procedures are being complied with.
Decarbonisation	Advisory	To affirm common themes across Welsh health bodies relating to Decarbonisation Action Plans and provide an overview of the overarching position across NHS Wales.

Please note that other audits of NWSSP activities are undertaken as part of the overall NWSSP internal audit programme. The overall Head of Internal Audit Opinion for NWSSP is Reasonable Assurance.

Digital Health & Care Wales (DHCW)

As part of the internal audit programme at DHCW, a Special Health Authority that started operating from 1 April 2021, several audits were undertaken which are relevant to the Trust. These audits derived the following opinion ratings:

Audit	Opinion	Outline scope
Technical Resilience	Substantial	To establish and assess the organisation's position to maintain acceptable service levels through, and beyond, severe disruptions to its critical processes and the IT systems which support them.
Switching Services	Reasonable	To ensure that the Switching Service is maintained appropriately and that risks to the operation of the service are appropriately managed.
Cyber Security	Substantial	To provide an opinion over whether appropriate progress has been made with the improvement plan.
Centre of Excellence	Reasonable	To provide an opinion over the controls for the establishment of the Microsoft 365 Centre of Excellence
Embedding the External Stakeholder Engagement Plan	Reasonable	To provide an opinion over the arrangements for the embedding of the External Stakeholder Engagement Plan.

Please note that other audits of DHCW activities are undertaken as part of the overall DHCW internal audit programme. The overall Head of Internal Audit Opinion for DHCW is Reasonable Assurance.

Full details of the NWSSP audits are included in the NWSSP Head of Internal Audit Opinion and Annual Report and are summarised in the Velindre University NHS Trust Head of Internal Audit Opinion and Annual Report. DHCW audits are summarised in the DHCW Head of Internal Audit Opinion and Annual Report.

4. DELIVERY OF THE INTERNAL AUDIT PLAN

4.1 Performance against the Audit Plan

The Internal Audit Plan has been delivered substantially in accordance with the schedule agreed with the Audit Committee, subject to changes agreed as the year progressed. Regular audit progress reports have been submitted to the Audit Committee during the year. Audits that remain to be reported but are reflected within this Annual Report will be reported alongside audits from the 2023/24 operational audit plan.

The audit plan approved by the Committee in May 2022 contained 14 planned reviews (excluding the separately agreed Integrated Audit and Assurance Plans for the new Velindre Cancer Centre and related Enabling Works). Changes have been made to the plan, with one audit deferred and one audit added. All these changes have been reported to and approved by the Audit Committee. As a result of these agreed changes, we have delivered 14 reviews under the core audit plan.

Additionally, we have delivered three reviews relating to the nVCC and Enabling Works Integrated Audit and Assurance Plans. A further four 2022/23 planned IAAP reviews were deferred to the 2023/24 plan to align with nVCC project progress, including where reporting on our Enabling Works audit was paused to undertake further work to reflect on subsequent changes in the project critical timeline.

The assignment status summary is reported at section 5.

In addition, we may respond to requests for advice and/or assistance across a variety of business areas across the Trust. This advisory work, undertaken in addition to the assurance plan, is permitted under the standards to assist management in improving governance, risk management and control. This activity is reported during the year within our progress reports to the Audit Committee.

4.2 Service Performance Indicators

To monitor aspects of the service delivered by Internal Audit, a range of service performance indicators have been developed.

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Operational Audit Plan agreed for 2022/23	G	May 2022[1]	By April 2022	Not agreed	Draft plan	Final plan
Total assignments reported against adjusted plan for 2022/23	G	100%	100%	v>20%	10%<v<20%	v<10%

[1] Early May 2022 Audit Committee

Indicator Reported to NWSSP Audit Committee	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 working days]	G	88%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time taken for management response to draft report [15 working days]	R	53%	80%	v>20%	10%<v<20%	v<10%
Report turnaround: time from management response to issue of final report [10 working days]	G	100%	80%	v>20%	10%<v<20%	v<10%
Audit reports to agreed Audit Committee	G	Yes	Yes	No	N/a	Yes

5. RISK BASED AUDIT ASSIGNMENTS

The overall opinion provided in Section 1 and our conclusions on individual assurance domains is limited to the scope and objectives of the reviews we have undertaken, detailed information on which has been provided within the individual audit reports.

5.1 Overall summary of results

In total 18 audit reviews were reported during the year. Figure 2 below presents the assurance ratings and the number of audits derived for each.

Figure 2

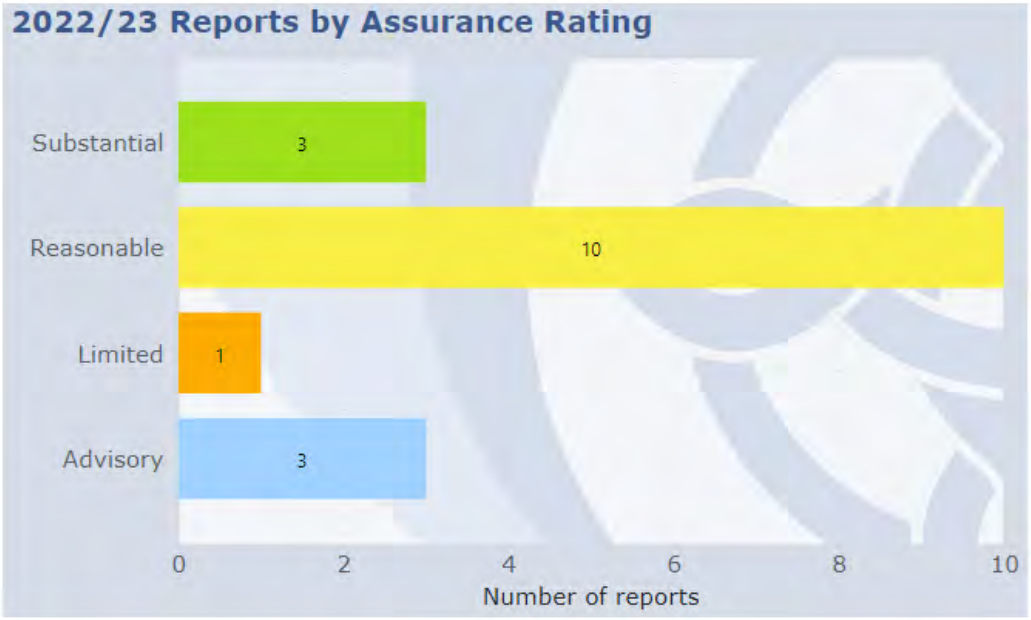


Figure 2 above does not include the audit ratings for the reviews undertaken at NWSSP and DHCW.

The assurance ratings and definitions used for reporting audit assignments are included in **Appendix B**.

The following sections provide a summary of the scope and objective for each assignment undertaken within the year along with the assurance rating.

5.2 Substantial Assurance (Green)

In the following review areas the Board can take **substantial assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Those few matters that may require attention are compliance or advisory in nature with low impact on residual risk exposure.

Review Title	Objective
Digital Health & Care Record – Implementation	To provide assurance that the Trust was prepared for the November 2022 'go live' date for the DHCR. This audit focused on the process for managing the implementation of DHCR, it did not provide assurance on the ongoing, successful use of the solution.
Research & Development	To provide assurance that there are effective systems, processes and governance in place around the Trust's research and development function, including partnership working.
Cyber Security	To ensure the Trust is working to improve its cyber security position, and that appropriate reporting is in place that shows the status. Also included assurance over cyber security back-up and procedures.

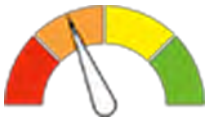
5.3 Reasonable Assurance (Yellow)

In the following review areas the Board can take **reasonable assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. Some matters require management attention in either control design or operational compliance and these will have low to moderate impact on residual risk exposure until resolved.

Review Title	Objective
Trust Priorities	To provide assurance over the robustness of the Trust's prioritisation exercise and the governance mechanisms over the delivery of priority programmes.
Capital Systems	To evaluate the process and procedures operating to support the prioritisation and allocation of the Trust's discretionary capital funds.
Clinical Audit	To provide assurance that the Trust has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services.

Review Title	Objective
Managing Attendance at Work	To ensure the Trust is adequately managing staff sickness absence at a divisional, directorate and operational service group level.
Finance & Service Sustainability	To review the arrangements within the Trust to ensure sustainability of services. Our 2022/23 review focused on the fundamental processes underpinning financial and service sustainability, namely budgetary control (revenue budgets) and savings plans.
Information Governance *This audit replaced the deferred audit in section 5.7.*	To assess the effectiveness of the Trust's Information Governance processes and provide assurance that principles and practices are followed and working as intended.
nVCC Enabling Works (deferred from 2021/22)	To determine the adequacy of arrangements in place at the Enabling Works project, forming part of the wider nVCC project (covering the period from May 2021 to June 2022).
Patient & Donor Experience	To review the Trust's processes for capturing patient and donor reported experience measures, and how data is used to effectively inform service improvement.
Performance Management Framework	To provide the Trust with assurance over phase 1 of evolving its PMF and actions for phases 2 and 3.
Follow-up of Prior Year Recommendations	To provide the Trust with assurance that: • recommendations are implemented in a timely manner and have addressed identified risks; and • the Audit Action Tracker provides complete and accurate updates on progress to the Audit Committee.

5.4 Limited Assurance (Amber)



In the following review areas, the Board can take **limited assurance** that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. More significant matters require management attention in either control design or operational compliance and these will have moderate impact on residual risk exposure until resolved.

Review Title	Objective
nVCC MIM Contract Management *This audit included follow-up of previously agreed management actions; therefore no separate follow-up report was produced for the IAAP.*	To determine whether appropriate contract management arrangements were in place, and operating effectively, for technical and advisory services that have been procured to: • widen the areas of expertise available to the project; and • strengthen the support provided in development of project deliverables.

5.5 No Assurance (Red)

No reviews were assigned a **'no assurance'** opinion.

5.6 Assurance Not Applicable (Grey)

The following reviews were undertaken as part of the audit plan and reported without the standard assurance rating indicator, owing to the nature of the audit approach. The level of assurance given for these reviews are deemed not applicable – these are reviews and other assistance to management, provided as part of the audit plan, to which the assurance definitions are not appropriate but which are relevant to the evidence base upon which the overall opinion is formed.

Review Title	Objective
Staff Wellbeing	To consider the effectiveness of staff wellbeing support and initiatives utilized by the Trust, including throughout the Covid-19 pandemic, and to determine if improvements can be made through consideration of the approaches within other NHS organisations.
nVCC Enabling Works Security Contract	To ensure compliance with the agreed contractual arrangements for security in place at the Northern Meadows site, and associated

Review Title	Objective
	payments, at the time of the tree clearance works (January to February 2022).
Decarbonisation	To affirm common themes across Welsh health bodies relating to Decarbonisation Action Plans and provide an overview of the overarching position across NHS Wales.

5.7 Deferred Audits

Additionally, the following audits were deferred for the reasons outlined below. We have considered these reviews and the reason for their deferment when compiling the Head of Internal Audit Opinion.

Review Title	Objective / Reason for Deferral
Quality & Safety Framework	To review key aspects of the Trust Quality and Safety Framework to ensure it is operating effectively in practice. *Deferred to the 2023/24 plan due to the overlap with the Audit Wales Quality Governance report, which was presented to the Trust's Quality, Safety & Performance Committee in November 2022.*
nVCC Enabling Works (2022/23) (draft report)	To evaluate the progression and delivery of the Enabling Works project (part of the wider nVCC project) against key business case objectives and to assess the adequacy of systems and controls in place to support its successful delivery. The audit covered the period from July 2022 to January 2023. *Further audit work is to be undertaken to evaluate the enabling works critical timeline deliverables against the revised delivery programme for the FBC and financial close for the main scheme.*
nVCC Design & Change Management	To determine whether appropriate design development and change management processes are in place at the nVCC project. *Deferred, recognising Welsh Government Scrutiny of the FBC Estates Annex.*
nVCC Planning	To evaluate and assess the adequacy of the systems and controls in place to support the successful management of planning applications, approvals and conditions of the project. *Deferred to align with progress on the nVCC project.*
nVCC Procurement & Approvals	To evaluate and assess the adequacy of the systems and controls in place to support the successful management of the MIM procurement process, and the progression through CAPs, against defined MIM procedures (including the Descriptive Document, Delegations Framework and the Procurement Strategy). *Deferred recognising other external reviews of the procurement processes.*

6. ACKNOWLEDGEMENT

In closing I would like to acknowledge the time and co-operation given by Directors and staff of the Trust to support delivery of the Internal Audit assignments undertaken within the 2022/23 plan.

Simon Cookson

Gyfarwyddwr Archwilio a Sicrwydd / Director of Audit & Assurance
Gwasanaethau Archwilio a Sicrwydd / Audit and Assurance Services

Partneriaeth Cydwasanaethau GIG Cymru / NHS Wales Shared Services Partnership

July 2023

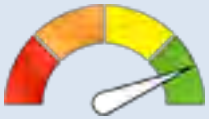
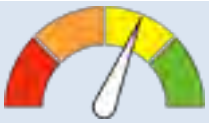
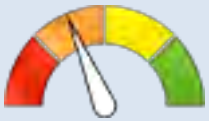
Appendix A – Conformance with Internal Audit Standards

ATTRIBUTE STANDARDS	
1000 Purpose, authority and responsibility	Internal Audit arrangements are derived ultimately from the NHS organisation's Standing orders and Financial Instructions. These arrangements are embodied in the Internal Audit Charter adopted by the Audit Committee on an annual basis.
1100 Independence and objectivity	Appropriate structures and reporting arrangements are in place. Internal Audit does not have any management responsibilities. Internal audit staff are required to declare any conflicts of interests. The Head of Internal Audit has direct access to the Chief Executive and Audit Committee chair. There have been no impairments to our independence during 2022/23.
1200 Proficiency and due professional care	Staff are aware of the Public Sector Internal Audit Standards and code of ethics. Appropriate staff are allocated to assignments based on knowledge and experience. Training and Development exist for all staff. The Head of Internal Audit is professionally qualified.
1300 Quality assurance and improvement programme	Head of Internal Audit undertakes quality reviews of assignments and reports as set out in internal procedures. Internal quality monitoring against standards is performed by the Head of Internal Audit and Director of Audit & Assurance. Audit Wales complete an annual assessment. An EQA was undertaken in 2023.
PERFORMANCE STANDARDS	
2000 Managing the internal audit activity	The Internal Audit activity is managed through the NHS Wales Shared Services Partnership. The audit service delivery plan forms part of the NWSSP integrated medium term plan. A risk based strategic and annual operational plan is developed for the organisation. The operational plan gives detail of specific assignments and sets out overall resource requirement. The audit strategy and annual plan is approved by Audit Committee. Policies and procedures which guide the Internal Audit activity are set out in an Audit Quality Manual. There is structured liaison with Audit Wales, HIW and LCFS.
2100 Nature of work	The risk-based plan is developed and assignments performed in a way that allows for evaluation and improvement of governance, risk management and control processes, using a systematic and disciplined approach.
2200 Engagement planning	The Audit Quality Manual guides the planning of audit assignments which include the agreement of an audit brief with management covering scope, objectives, timing and resource allocation.

2300 Performing the engagement	The Audit Quality Manual guides the performance of each audit assignment and report is quality reviewed before issue.
2400 Communicating results	Assignment reports are issued at draft and final stages. The report includes the assignment scope, objectives, conclusions and improvement actions agreed with management. An audit progress report is presented at each meeting of the Audit Committee. An annual report and opinion is produced for the Audit Committee giving assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.
2500 Monitoring progress	An internal follow-up process is maintained by management to monitor progress with implementation of agreed management actions. This is reported to the Audit Committee. In addition audit reports are followed-up by Internal Audit on a selective basis as part of the operational plan.
2600 Communicating the acceptance of risks	If Internal Audit considers that a level of inappropriate risk is being accepted by management it would be discussed and will be escalated to Board level for resolution.

Appendix B – Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ
Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Professor Donna Mead OBE, Velindre University NHS Trust 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.
- Welsh Blood Service Donor Awards – Llandrindod Wells.
- World Blood Cancer Day.
- National Armed Forces Week (unfurling of Armed Forces Day flag).
- Ministry of Defence Employer Recognition Scheme Gold Award.
- Pride in Veterans Standard (PiV)
- NHS75 National Service of Thanksgiving to celebrate the 75th Anniversary of the NHS in Wales.
- Launch of the Tripartite Agreement.
- RCN Nurse of the Year Awards.
- Chair's Annual Appraisal.
- OBE Award.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1. Board Development Sessions

27th June 2023

A Board Development Session was held on 27th June 2023. Topics discussed were:

- Implementation of an Effective Quality Management System and drafting of a Velindre University NHS Trust Quality Management System Proposal.
- Radiotherapy Time to Treatment Targets (formerly COSC) and new Quality Performance Indicators within Radiotherapy.
- Immuno-Oncology (current) and Advanced Therapies (future) – current landscape and future direction (further information below).

Immuno-Oncology and Advanced Therapies – Following the Immunotherapy Toxicity team presentation at June's Board Development Session, the Team was nominated (by Professor Tom Crosby) and subsequently shortlisted for the UK Macmillan Innovation Excellence Award. Delivery of a virtual presentation to a panel of judges in September 2023 will be followed by an awards ceremony in Glasgow in November. This is a significant achievement, which recognises the work undertaken to develop the regional Acute Oncology Services Project and the work of the wider Project Team to support the setup of the Immunotherapy Service.

2.2. Welsh Blood Service Donor Awards – Llandrindod Wells

69 milestone donors from mid-Wales were celebrated by the Welsh Blood Service for their commitment to patients, with guests reaching their 50th, 75th and 100th donations after decades of blood donation. Platelet and bone marrow donors were also celebrated. Two awards ceremonies were held during May 2023 at the Metropole Hotel in Llandrindod Wells (the first ceremony to take place following the pandemic). The Chair, Professor Donna Mead OBE, attended both evenings and presented awards to our donors.

2.3 World Blood Cancer Day (May 28th 2023)

Welsh Comedian, television presenter, proud Velindre Patron and former Velindre patient Rhod Gilbert urged 17-30 year olds to help patients with blood cancer on World Blood Cancer Day, by supporting the Welsh Blood Service's "Chilled Out Lifesaver" campaign, which aims to recruit 4,000 volunteer donors to its Welsh Bone Marrow Donor Registry over the next year.

2.4 National Armed Forces Week

The Trust was delighted to Support Armed Forces Week (commencing 19th June 2023) as part of its continued commitment to the Armed Forces Covenant. A programme of events and educational sessions took place throughout the week, in addition to stories from staff members who previously served or are serving in the forces. The week began with the unfurling of the flag at Velindre Cancer Centre with the Chair and Chief Executive and members of staff who have served and who are serving in the forces were present.

2.5 Ministry of Defence Employer Recognition Scheme Gold Award

Velindre University NHS Trust is honoured to win the Ministry of Defence's Employer Recognition Scheme (ERS) gold award. The award is the highest badge of honour and recognises the role that employers play in supporting the Armed Forces community. To win a gold award from the Ministry of Defence, organisations must provide 10 extra paid days leave for Reservists, in addition to having supportive HR policies in place for Reservists, Veterans, Cadet Forces and their families. Organisations must also advocate the benefits of supporting those within the Armed Forces Community, encouraging others to sign the Armed Forces Covenant and engage with the Employer Recognition Scheme. Further public communications will follow the Award ceremony planned for the Autumn. Velindre is proud of its commitment to meet the special needs of veterans alongside other vulnerable groups.

2.6 Pride in Veterans Standard (PiVs)

As part of its commitment to supporting the Armed Forces the Trust has been successful in achieving the Pride in Veterans Standard. This Standard is a programme run by Fighting with Pride a trusted and respected LGBT+ military charity that has lived experience and knowledge to support organisations wanting to develop or improve their services for LGBT+ veterans.

2.7 NHS75 National Service of Thanksgiving to celebrate the 75th Anniversary of the NHS in Wales

The 5th July 2023 marked 75 years of the National Health Service. The Welsh NHS Confederation hosted an NHS 75 celebratory event at the Senedd on Wednesday 5th July, attended by the Chief Executive. In addition, a day earlier, the Chair and Chief Executive were both in attendance at a national service held in The Church of the Resurrection, Ely, on the 4th July, the eve of the anniversary. The museum at St Fagans had loaned the George Cross which was displayed in the church. The George Cross was given to the 4 NHS health services in the UK by her Late Majesty Queen Elizabeth II, in recognition of the service given to the county by the NHS. This was the first time most of those present had seen it and it was an amazing experience.

2.8 Launch of the Tripartite Agreement

The establishment of the Tripartite Deed of Association between Velindre University NHS Trust, the University of Wales and the University of Wales Trinity St David and other post 16 education providers in Wales was acknowledged at its formal launch, which took place at the Senedd on the 20th July 2023. This was attended by the Chair and Executive Director of Nursing, Allied Health Professionals and Health Sciences, Nicola Williams, and will be followed by a bespoke Trust celebration during September 2023. The Tripartite Deed of Association will enable the establishment of a 'Velindre Oncology Academy' within the Trust, in addition to facilitating the formal accreditation of courses delivered via the Academy.

2.9 RCN Nurse of the Year Awards

In an exciting ceremony on the 29th June 2023 the Royal College of Nursing celebrated the outstanding achievements of their award finalists. The 10th annual awards event held at City Hall, Cardiff, was attended by the Chair, Chief Executive and Executive Director of Nursing, together with other staff from the Velindre Cancer Service and Welsh Blood Service. The Trust Sponsored the Nurse of the year award which was presented to the winner, Tara Rees, by Nicola Williams.

2.10 Chair's Annual Appraisal

The Chair's appraisal was held with the Minister on 17th July 2023. The Minister sought assurance around Digital investment, financial savings and developments in quality. The Minister thanked the Trust for all its hard work during the appraisal period and recognised the scale of change taking place within the organisation. The Minister's feedback letter will be circulated to the Board following receipt.

2.11 OBE Award

The Chair would also like to extend her congratulations to Neil Frow (Managing Director, NHS Wales Shared Services Partnership) for receiving the award of an OBE in the King's first honour list.

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 content of this update report from the Trust Chair.

TRUST BOARD

VICE CHAIR'S REPORT

DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Stephen Harries, Vice Chair
PRESENTED BY	Stephen Harries, Vice Chair
EXECUTIVE SPONSOR APPROVED	
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	

This Report provides an update from the Vice Chair.

Trust Board & Committees

During the period, I have attended the following Board Meetings/Sessions:

- Extraordinary Trust Board - 22 June 2023
- Board Development Session - 27 June 2023
- Extraordinary Trust Board - 6 July 2023

I have Chaired the following Committee and Sub-committee meetings:

- TCS Scrutiny Sub-Committee, Public and Private Meetings – 19 June 2023
- TCS Scrutiny Sub-Committee, Extraordinary Private Meeting – 4 July 2023
- Strategic Development Committee, Public Meeting – 6 July 2023

I have attended the following Committee meetings:

- Remuneration Committee – 28 June 2023

External Meetings

On 20 June 2023 I attended the Meeting of the Health Minister with Chairs of Health Boards and Trusts, on behalf of the Trust Chair.

On 10 July 2023 I attended the All-Wales Independent Members Digital Network Peer Group. At that meeting we received update presentations on various national and strategic digital technologies plans and developments including a forward-look from the recently appointed Chief Digital & Innovation Office at the NHS Wales Executive.

Internal Meetings

I have scheduled 1-1 monthly meetings with the Director of Strategic Transformation, Planning & Digital, and with the Chief Operating Officer (COO). At my most recent meeting with the COO I investigated and explored in some considerable detail the practical challenges to the retrospective reporting of Radiotherapy performance against targets, following the migration from the CANISC system to the new Digital Health Care Record.

Staff Wellbeing

On 12 June 2023, in my role of “Staff Wellbeing Champion” I met with the Director of OD & Workforce, and the Head of Organisational Development to receive an update on, and discuss, Staff Wellbeing issues. Topics discussed included potential future Board Briefing/Development topics, and the production and presentation of the Annual Report to the Board. Following my visit to view the staff Wellbeing Hub at the Velindre Cancer Centre in March 2023, a similar visit to facilities at the Welsh Blood Service is being arranged.

I have a standing invitation to the Trust’s Healthy and Engaged Steering Group and receive the papers for review (I was unfortunately not able to attend the most recent meeting during this period).

Duty of Candour

On 4 July 2023 I attended and presented at the second Duty of Candour and Quality Staff Update Session.

Personal Training, Compliance and Development

On 30 May 2023 I undertook an ESR “statutory and mandatory training” refresher training session and have subsequently completed (refreshed) all required modules.

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	27/07/2023

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	

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 Meeting/ Integrated Medium Term Plan update
- Welcome to new Trust Head of Innovation

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Industrial Action

In a written statement of 24th May 2023 the Minister for Health and Social Care confirmed that the pay offer for Agenda for Change NHS staff for 2022-23 and 2023-24 had been accepted by the collective trade union side. It was also confirmed that separate talks are ongoing with the British Medical Association (BMA) regarding Consultants, Junior and SAS Doctors.

Despite the majority collective position of Agenda for Change health unions, two unions – the Royal College of Nursing (RCN) and the Society of Radiographers (SoR) - remained in dispute regarding the 2022-23 pay award. While maintaining the collective agreement, Welsh Government officials continued discussions with RCN and SoR in order to seek to address specific concerns and to avoid any further industrial action. No further actions was taken on that basis.

On the 20th July a further Ministerial Statement was issued that confirmed that discussions had progressed and clarified some of the non-pay elements of the award which were of most concern to the professions represented by the two unions. RCN and SoR will now consult their respective members with a view to establishing whether this is sufficient to resolve their dispute.

The pay awards for Agenda for Change Staff were paid in July 2023 pay.

2.2 Joint Executive Team (JET) Meeting/ Integrated Medium Term Plan (IMTP) update

Further to the updates provided by the Chief Executive Officer in the May 2023 Trust Board meeting, the formal feedback on the recent JET meeting and IMTP submission are yet to be received from Welsh Government officials. The feedback in both cases will be shared with the Trust Board when received.

2.3 Welcome to new Trust Head of Innovation

The Chief Executive Officer would like to welcome Jennet Holmes as the Trust's new Head of Innovation. Jennet worked for over ten years as a civil servant holding senior positions in Circular Economy, Governance, Brexit and Innovation. Jennet's most recent role was at Welsh Government, Health and Social Services Group, as Head of Innovation and Collaborative Partnerships. Jennet has worked closely with the Innovation Leads across Wales, Industry and Government and will continue to foster these relationships to enable innovation and collaboration opportunities at Velindre.

Prior to joining the Civil Service Jennet spent her career as a business consultant, working with the private, public and third sector implementation health, safety, quality and environmental management systems, providing bespoke business support. She is also a lead environmental auditor.

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

BOARD CHAMPION (RESEARCH) REPORT

DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Professor Andrew Westwell
PRESENTED BY	Professor Andrew Westwell
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director
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	
ABUHB	Aneurin Bevan University Health Board
CTUHB	Cwm Taf Morgannwg University Health Board
CVUHB	Cardiff & Vale University Health Board
HCRW	Health & Care Research Wales (part of Welsh Government R&D)
IP	Intellectual Property
NSCLC	Non-Small Cell Lung Cancer
RDI	Research, Development and Innovation

Velindre University NHS Trust

Board Update: Research (Board Champion – Prof. Andrew Westwell)

Research within VUNHST – Background and Context

- Research within this report includes the closely allied Trust missions in Development and Innovation (i.e., the translation of research into patient and stakeholder benefit).
- Research in the context of this report covers the RD&I activities of the Velindre Cancer Centre (linking between SE Wales UHBs at CVUHB, ABUHB, and CTMUHB), and the Welsh Blood Service. This report excludes Trust hosted organisations such as Heath Technology Wales, or closely aligned education & training provision plans (e.g., the Velindre Oncology Academy).
- The Trust RD&I Division includes the R&D office, research nursing delivery teams, early phase team, innovation team, and administrative staff such as trials coordinators and data managers. Some research active staff (e.g., pharmacy and radiotherapy research staff) are managed and reported within relevant divisions (e.g., VCS).
- The 2022/23 financial plan comprises targets to:
  - Spend £3M on research activities, of which £2.8M is salary costs (management, trial support, data, administration (40%); nursing staff (33%); medical staff (13%)).
  - Secure income/awards of £3.25M from multiple sources (Health & Care Research Wales (34%); commercial clinical trials (22%); Velindre charity (26%)).
  - Manage a further c. £500K, held in grant funding from external bodies such as Cancer Research UK, for specific research trials led by VUNHST.
- The Cardiff Cancer Research Hub (Nuffield independent report recommendation, 2020) and Integrated Radiotherapy Solutions projects are major and essential pillars of the 'Transforming Cancer Services' project. They will position the research infrastructure within VUNHST at the forefront of clinical research and delivery in future years, within the context of the nVCC, UHW (cancer research hub for early phase trials / advanced therapies, co-located with HDU/ITU), and regional health board partners.
- Within multidisciplinary and multicentre non-surgical cancer clinical trials arena, the Trust sponsors or participates in both non-commercial and commercial trials.
- The Trust seeks to grow the capacity of staff involvement in RD&I, which in turn will help with recruitment and retention of a diverse and highly skilled workforce. The PADR process provides a useful conversation around staff ambitions for research involvement, facilitating further advanced training opportunities where necessary.
- The Trust seeks to augment patient involvement in the design and delivery of RD&I. Greater level of patient and public involvement in research will facilitate improved patient experience, and reduced inequality and variation in outcomes across diverse patient groups.
- High quality research, by its very nature is highly collaborative, encompassing multiple interactions with charities, industry, and Welsh Government; and scientific interactions across UK and international centres.
- Manipulation of large patient data sets to enhance personalised therapies of the future, making use of modern data science (machine learning/AI) to inform earlier diagnosis and effective treatments.
- New ways of working, based on R&D evidence-based care, should be consistent with net zero ambitions for the Trust estate. For example, consultation/treatment should be administered either at home, or close to home where possible, enabled by developments in digital technologies.
- Measurable research outputs, including important metrics such grant awards/income, and publication in leading international journals, are important reputational esteem markers helping to establish VUNHT as a trusted and high value partner addressing the most important healthcare challenges.

- Trust R&D communications and marketing via multiple channels including academic publication and conference presentation, augmented by a diverse social media footprint, will remain a focus for research visibility and dissemination of good RD&I news stories.
- Within Trust governance structures, research is represented by the Velindre RD&I (Research, Development, and Innovation) committee, chaired by Andrew Westwell. The Velindre RDI group is a sub-committee reporting to both the Strategic Development, and Quality, Safety & Performance, committees.
- The Trust RD&I committee has oversight of the Trust IP policy, approved at Board level, which encourages relevant protection of novel Trust IP for potential clinical and commercial benefit.
- The Trust RD&I division maintains a risk register in line with risk appetite, escalating through governance structures when risk thresholds are significant.

Research Benefits

- There is a growing body of evidence to show that research active organisations deliver better standards of care and improved patient outcomes, in terms of:
  - Better patient care outcomes – more confidence in staff, reduced mortality, and improved cancer survival rates (Jonker *et al.* 2019; Ozdemir *et al.* 2015; Downing *et al.* 2016)
  - A happier workforce – helping retain recruitment in medical posts, and the inverse relationship between time spent on work physicians find meaningful and the risk of burnout (Rees & Bracewell 2019; Shanafelt *et al.* 2009).
  - Benefits for the health & care system – research improving clinical practice, reducing the cost of healthcare, and driving policy change (Medical Schools Council 2022).

Recent Research Achievements - Selected Examples

- *Cancer clinical trial completion.* FAKTION Phase II study (capivasertib + fulvestrant) led by Velindre and Manchester trial centres. Delivered decisive data (time-to-progression and progression-free survival) improving outcomes for locally advanced or metastatic ER+/HER2- breast cancer patients compared to placebo + fulvestrant (standard-of-care). Trust was the leading UK recruiter to the subsequent Phase III double blind, randomised study (CAPitello-291).
- *Cancer clinical trial recruitment.* IO102-IO103-022 multi-arm Phase II trial, investigating the safety and efficacy of IO102-IO1-3 in combination with pembrolizumab, as first-line treatment for patients with metastatic NSCLC, squamous cell carcinoma of H&N, or metastatic urothelial bladder cancer. The Trust continues to be the top recruiter globally.
- *Welsh Blood Service.* Recent highlights include pioneering work on cold storage of platelets (Advancing Healthcare Awards Cymru 2022, to component development lab), and research towards improving kidney transplantation outcomes (transplantation and immunogenetics lab).
- *Innovation activities* – recent examples include RITA (chatbot); localising Pfizer's global patient cancer app.

The Board Champion Role (with HCRW oversight)

- Each NHS Wales health board and trust has appointed a research champion. The group, convened by Heath and Care Research Wales (HCRW), have started to meet quarterly to compare experiences and work together to promote research.
- HCRW has a clear intent to facilitate the promotion and discussion of research at Board level, maximising collaborative funding and driving increased research volume and scale.
- HCRW to work with health boards and trusts towards ensuring that high quality research and development is embedded as part of normal day-to-day activities.

Policy Contexts and References

1. Saving and improving lives: the future of UK clinical research delivery (March 2021) https://www.gov.uk/government/publications/the-future-of-uk-clinical-research-delivery/saving-and-improving-lives-the-future-of-uk-clinical-research-delivery
2. A Healthier Wales: our plan for health and social care (updated Nov 2022): https://www.gov.wales/healthier-wales-long-term-plan-health-and-social-care
3. VUNHST Overarching cancer research and development ambitions 2021-31: https://velindre.nhs.wales/about-us/research-development-and-innovation/rdi-strategies/overarching-cancer-research-and-development-ambitions-for-velindre-university-nhs-trust-2021-31/
4. Welsh Blood Service Research & Development strategy (under review): https://www.welsh-blood.org.uk/wp-content/uploads/2022/07/WBS-RD-Strategy-1.pdf
5. Jonker *et al.* (2019): https://onlinelibrary.wiley.com/doi/10.1111/jep.13118
6. Ozdemir *et al.* (2015): https://pubmed.ncbi.nlm.nih.gov/25719608/
7. Downing *et al.* (2016): https://pubmed.ncbi.nlm.nih.gov/27797935/
8. Rees & Bracewell (2019): https://academic.oup.com/pmj/article/95/1124/323/6983980
9. Shanafelt *et al.* (2009): https://pubmed.ncbi.nlm.nih.gov/19468093/
10. Medical Schools Council (2022): https://www.medschools.ac.uk/media/3004/health_of_the_nation_aw_accessible.pdf

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	27.07.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the 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**
EMB Run	29.06.2023
Quality, Safety and Performance Committee	13.07.2023
Audit Committee (meeting has not taken place at time of publishing)	26.07.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Discussion around the length of time risks are open versus the risk rating took place. This issue will be considered in the next cycle. .	

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

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR				2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.			

APPENDICES	
1	Current risk register data.
2	Risk data graphs

1. SITUATION

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

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Risk Register

- The risk register detail in Appendix 1 is for consideration by the Audit Committee.
- Considerable work has been undertaken to ensure each risk has an action plan. The action plans are continually under review in divisions with transition to SMART. All risks reported in this report now have action plans in place.
- To note all actions in the Datix action plan section have assigned owners – however given named individuals on the system, this is not included in reporting. If any member would like further details, this can be provided.
- All risks reported are on target with review dates.
- An audit of risk titles has been carried out and titles amended as per the naming conventions on Datix where appropriate. Some risk titles are nationally agreed and remain unchanged on Datix.
- There was discussion in Executive Management Board on what are the key gaps in achieving a level 3 level of assurance, which is defined as

"Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed." There was an in-depth discussion on given the length of time some risks are open at a high residual score. This suggests actions are not addressing root causes effectively in these cases and this will be the area of focus for the next cycle.

4.2 Risk In Depth Review

At Quality, Safety and Performance Committee on 13.07.2023 an in depth review if two risks took place, 3001, Workforce risk, and 3042, Laboratory Information Management System (LIMS).

The length of time risks were open versus the lack of movement towards the target risk was raised and agreement reached that the focus in the next cycle of review would include this.

The need to demonstrate month on month management towards reaching target risk rates was discussed.

4.3 Digital Risks

In consideration of risks at Quality, Safety and Performance Committee there was a request to reflect on risks relating to digital systems. Following review of the risks there are no evident trends in digital risks; individual risks related to digital development are unique to each system.

In depth discussion took place in respect of risk 3042, LIMS, which relates to service provision as a result of maintaining a legacy system. The contract is currently moving through the governance system for approval.

Risk 3011 has been closed following review at the DHCR Operational Group, the detail of this risk can be viewed on the risk register in appendix 1.

Risk 2465 relates to email traffic; work is underway to reduce the amount of email traffic and duplication. The Head of Information Governance has launched an audit of the use of email in clinical decision making, which commenced on 17.07.2023. The full scope of the audit remains flexible with an estimated completion date of 04.08.2023.

4.4 Next Steps in Engagement and Embedding

- The approved Policy and Procedure are now on the intranet, with links on both divisional intranet pages.

- The Datix 'How To' guide has been updated and can be accessed via the intranet: DATIX How To Guide
- Level 1 mandatory training for all staff has been live in individual ESR Learning Matrixes, as of 17th April 2023. Initial management of completion of training will be tracked via the Trust risk weekly meeting and reported into Executive Management Board.
- As of 23rd June 2023 an Introduction to Risk training has a completion rate of 53.70% across VCS, WBS and Corporate.

Compliance Area	Compliance Rate
Corporate	49.7%
Research Development and Innovation	56.0%
Transforming Cancer Services	48.0%
Velindre Cancer Centre	51.3%
Welsh Blood Service	60.4%

Compliant with statutory and mandatory training a period of six months is set for initial completion, the on-going requirement will be to complete the training every two years.

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY

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

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

6. RISKS

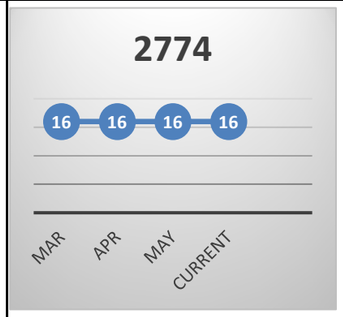
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.

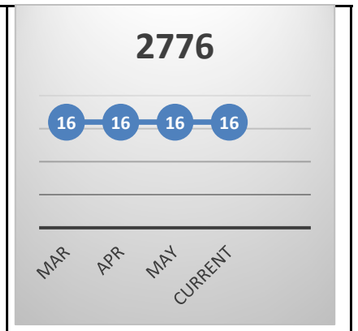
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require further work.
BY WHEN?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

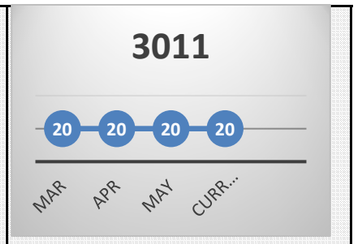
APPENDIX 1

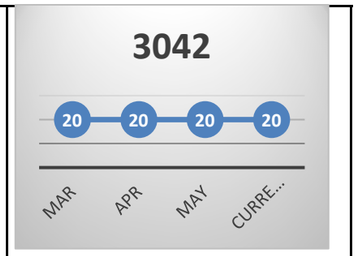
Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

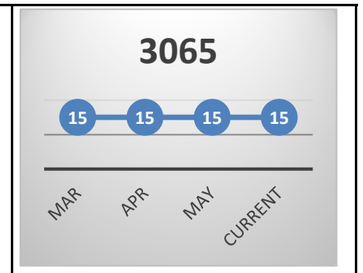
RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions,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

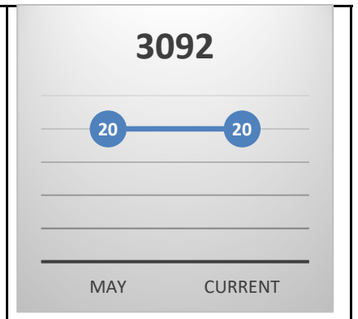
ID	Risk Title - New	Risk Type	Opened	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Plan	Days Open	Risk Trend
2774	There is a risk to quality/complaints /audit/GxP as a result of use of outdated legacy systems, leading to increased risk of incorrect test results and clinical advice.	Quality	27/10/2022	Welsh Blood Service	Middleware has been developed in house to support interfacing to transfer data from a single laboratory software (HLA Fusion) to WHAIS IT. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 2.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. Staff are required to print results from analysers and manually enter complex, scientific results into IT systems that require either double entry or verification by a 2nd scientist. Increased risk of data entry/transcription errors could potentially lead to incorrect test results and clinical advice which could impact patient safety.	16	4	01/09/2023	Complete actions for replacement LIMS - see risk 2776 Individual Actions recorded in risk 2776: Secure Funding by 28/04/2023 Tender for replacement LIMS by 31/05/2023 Implement replacement LIMS by 31/07/2024 Report to the Laboratories Digital Transformation Board Due date 31.07.2024	273	

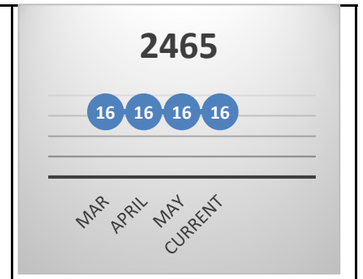
2776	There is a risk to performance and service sustainability as a result of the ongoing use of outdated, legacy systems, leading to the inability to enhance services to meet business needs.	Performance and Service Sustainability	27/10/2022	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work, shore up the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT SME resource. Patient results are verified prior to issue.	(This refers to line reference number 6.0 on FMEA) WHAIS in-house developed IT applications are built using legacy FoxPro and DOS based technology that is no longer supported. There is only one FoxPro developer within WBS Digital Services team and there is limited ability to access agency resource with required level of FoxPro expertise. This may lead to inability to enhance WHAIS services to meet business needs and/or other factors such as changes to external regulatory requirements. Increased risk of data entry/transcription errors could lead to incorrect test results and clinical advice, potentially impacting patient safety. This could also lead to reputational damage as unable to update systems in line with stakeholders requests.	16	4	01/09/2023	Tender for replacement LIMS Completion of Procurement Brief, URS and supporting documentation. Issue of tender. Report to Laboratories Digital Transformation Board. Update 06/06/2023 - "Due date" extended to 30/06/2023. Tender has been delayed due to other projects being prioritised by Procurement. New estimated timeline proposed by Procurement is to go out to tender by end of June. Due date 30.06.2023 Implement replacement LIMS Report to Laboratories Digital Transformation Board	273	

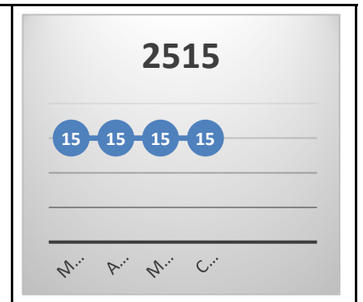
3011	There is a risk to the safety of patient care as a result of delays in scheduling patient appointments due to a technical error in the processing of Outpatient Oncology Note Outcomes leading to possible harm.	Safety	22/12/2022	Velindre Cancer Centre	Immediate escalation to DHCW for investigation. Identified bugs to be resolved. DHCW to extend the Contractor to apply identified development to support resolution of issue. Rewrite the VCC import process to complete a full reconciliation between what is held by DHCW and what is held by VCC each refresh Additional support to be identified and put in place to process and book all patient activity. Patients to be contacted by telephone and verbally advised of appointment due within 14 days to reduce risk Phlebotomy to be completed at VCC to reduce risk of delay to treatment (where the next appointment is scheduled to take place within 14 days)	Technical failure of the data shredding process within the national service has meant that not all clinic outcome instructions are being made available within the Outpatient Oncology Note Report, and therefore not acted upon.	15	5	30/06/2023	Digital Health Care Wales (DHCW) will be applying a fix/development that will prevent a delay/restart of the servers following automated regular up-dates. This has previously stopped/delayed the shredding process taking place. Delays encountered due to bugs identified during the UAT period. Further development work required with an amended delivery date of 14.07.23. DHSW to maintain communication/up-dates.	217	 This risk has now been closed - 18.07.2023 - following a system adaptation the risk was reviewed and outstanding actions completed and reviewed by the DHCR Operation Group, who approved the risk for closure. The progress has been updated on Datix.

3042	There is a risk to performance IF the new Laboratory Information Management System (LIMS) service is not fully deployed before the contract for the current LIMS expires in June 2025 THEN operational delivery of pathology services may be severely impacted RESULTING IN potential delays in treatments, affecting the quality and safety of a broad spectrum of clinical services and the potential for financial and workforce impact. **NATIONAL LINC RISK**	Performance and Service Sustainability	07/02/2023	Velindre Cancer Centre	Business continuity options are being explored including extending the contract for the current LIMS to cover any short term gap in provisions. An expert stock take review of the LINC programme has been completed with findings presented to Collaborative Executive Group (CEG) to inform next steps.	The current (InterSystems) contract for TrakCare Lab is due to end in June 2025. The LINC programme has been established to deliver a replacement all-Wales LIMS system - the contract has been awarded to Citadel Health. VCC pathology services are provided to Velindre by C&V ULHB. If the Citadel Health solution is not deployed into C&V UHB before June 2025, there is a risk to service delivery for the C&V-managed pathology laboratory. The national DHCW / LINC programme team have requested this risk be recorded on all HB/Trust risk registers, to ensure appropriate visibility and ongoing monitoring.	20	5	07/08/2023	Active ongoing engagement in national programme. Confirmation of internal governance and escalation process across the Trust.Due date: 30.06.2025	170	

3065	There is a risk to COMPLIANCE as a result of the permanent deletion of email mailboxes for VUNHST staff who have fully left the NHS since September 2021, leading to a potential issue should those emails be required by a 3rd party investigation - e.g. COVID enquiry.	Compliance	10/03/2023	Corporate Services	Upon identification of the incident, DHCW have put in place temporary measures - effective from 17/02/2023 - to prevent further deletion of mailboxes for staff leaving the NHS Wales. DHCW are also engaging with Microsoft to explore what, if any, opportunity there is to retrieve the deleted emails/mailboxes.	NHS Wales deployed O365 in July 2019. The national tenancy was established with the intention of ensuring emails / mailboxes for staff who left the NHS (i.e. there O365 account was closed) would be retained for a 7ear year retention period, as per the national NHS Wales Email Policy. Investigations prompted by an enquiry by C&V UHB in February 2023 confirmed that this policy was not what was configured on the NHS Wales tenancy. As such, any emails / mailboxes for staff who have left the NHS will have been deleted after 30 days of account closure, unless another form of manual 'hold' was in place on the account. In VUNHST, 'litigation hold' was in place by default on all accounts up to 22/09/2021, when a national change was made to remove litigation hold for VUNHST O365 accounts. As such, the risk for VUNHST is that staff who have left NHS Wales in the period 23/09/2021 - 17/02/2023 will be that emails for those staff will not be retrievable for (e.g.) FoI, evidence for COVID-19 enquiry etc.	15	3	01/08/2023	Review staff list to assess impact of mailbox deletion for VUNHST O365 accounts. List of impacted mailboxes has been produced by Digital Services - to be reviewed by Head of IG & Head of Digital Delivery to assess overall impact of deletion. List of impacted mailboxes has been produced by Digital Services Due date 30.06.2023	139	

3092	there is a risk that patients may receive inappropriate management/treatment as a result of inaccurate manual data entry into WPAS/EIRRMER following implementation of DHCR leading to patients being allocated to an inappropriate treatment pathway/clinician.	Multiple Risk Domains	27/04/2023	Velindre Cancer Centre	- A series of deep dives to understand problem areas have been undertaken - Clear actions plans have been developed across directorates - An operational management group have been stood up to oversee delivery of actions and determine wider trends, reporting to the Business Planning Group (BPG) and Senior Leadership Team (SLT) - Refresher training being provided across VCC	there is a risk that patients may receive inappropriate management/treatment as a result of inaccurate manual data entry into WPAS/EIRRMER following implementation of DHCR leading to patients being allocated to an inappropriate treatment pathway/clinician.	20	8	31/07/2023	summary of actions required by clinicians to address data quality issues with WPAS being collated and will be shared via SMSC in June. Due dte 31.07.2023	91	
3139	Clearance Limitations There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	Performance and Service Sustainability	21/06/2023	Transforming Cancer Services	1) Application to be clear on expected plan for clearance works 2) Alternative plan should limitations be put in place 3) Sceure 3rd party opinion on clearance	There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	15	6	10/07/2023	1) Application to be clear on expected plan for clearance works 2) Alternative plan should limitations be put in place 3) Secure 3rd party opinion on clearance 1) application has been submitted stating the anticipated planned clearance areas and schedule to provide NRW with clear view of works including habitat creation requirements Due date 10.7.2023	36	NEW RISK - NO TREND DATA

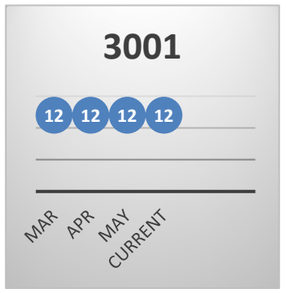
3140	EPSL Application Approval There is a risk that the EPSL application will not be approved or takes longer than planned to be approved by the NRW leading to delays to required clearance or miss the clearance window causing approx 6 month further delay.	Performance and Service Sustainability	21/06/2023	Transforming Cancer Services	1) Resolution of habitat management matters to provide NRW with assurance they require 2) Respond to any queries as a matter of priority 3) Liaise with Cardiff Council to agree approach 4) Work with WG to intervene if required 5) Maintain Actions Tracker	There is a risk that the EPSL application will not be approved or takes longer than planned to be approved by the NRW leading to delays to required clearance or miss the clearance window causing approx 6 month further delay.	15	6	30/06/2023	1) Resolution of habitat management matters to provide NRW with assurance they require - ongoing 2) Respond to any queries as a matter of priority - ongoing 3) Liaise with Cardiff Council to agree approach - ongoing 4) Work with WG to intervene if required - ongoing Due date: 30.06.2023	36	NEW RISK - NO TREND DATA
2465	There is a risk to safety as a result of significant increase in email traffic leading to critical emails being missed or not responded to in a timely manner leading to patient care and staff well being	Safety	05/11/2021	Velindre Cancer Centre	staff reminded to be considerate when 'replying to all'	There is a risk of missing critical emails especially critical clinical questions due to the volume of emails. Clinical questions may not be responded to in a timely way or responses may not be accurate due to the pressure of responding to the number of emails received. This may lead to impact on patient care and staff wellbeing through stress, working additional hours to catch-up and potential for medical error due to distraction from other critical tasks. There is a secondary risk when colleagues are away so emails are not being actioned, and when they return, there is a huge backlog of messages to catch up on.	16	4	30/06/2023	An audit/survey to be undertaken to identify themes in order to determine how best to minimise taking into account clinical and service needs. Due date: 30.06.2023 email etiquette to be developed as part of hybrid working tool kit and shared widely. Due date 30.06.2023	629	

2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	Performance and Service Sustainability	09/02/2022	Velindre Cancer Centre	Service provision across all specialties is managed by careful examination of rotas and managing leave within the teams. Clinical Oncology: One Consultant Urologist is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. One Speciality Doctor was appointed to Gynae Oncology Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence. Radiotherapy: Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team.	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service. Clinical Oncology: There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience. A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST Radiotherapy: Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover. Time demands from DXR administration and treatments conflict with brachytherapy service provision and training.	15	15	30/09/2023	to improve resilience in MPE service training of further brachy MPE. Prioritised by Head of Service. Target completion date 31st July due date: 31.07.2023 workforce review in Q1/2 2023 to look at demand for next 5 years. Due date: 31.09.2023	533	

					A training schedule for staff is in place to ensure increased resilience from cross cover of tasks. A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC. Theatre: Staffing hours have been increased (March 2023) to improve resilience of the service provision. Training plans are under consideration to further increase resilience through cross cover of tasks. Vacant HCA post was filled (March 2023). Physics: A training plan is under implementation to increase the	Theatre: One member of the team is currently on long term sick. Return to work due May 2023. Physics: Currently two Brachytherapy MPEs appointed. A recent resignation (April 2023) of a staff member in MPE training and one MPE due to start maternity leave in July 2023 has left the service vulnerable to a future MPE single point of failure. This could lead to service discontinuity.						

implementation to increase the number of Brachytherapy MPE and Registered Clinical Scientists competent to perform MPE duties under written guidelines and supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service.

Future Planning:
An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service model to meet forecast demand over a 1 to 5 year period. A workforce paper will be drawn up to staff the model to include resilience and succession planning. A business case will be submitted if required. Staff model completion due

ID	Risk Title - New	Risk Type	Opened	Division	RR - Current Controls	Risk (in brief)	Rating (current)	Rating (Target)	Review date	Action Plan	Days Open	Risk Trend
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	Safety	09/12/2022	Corporate Services	Policies and Procedures Managing Attendance @ Work Policy, Training and Toolkit Respect and Resolution Policy, Training and Toolkit Equality, Diversity and Inclusion Policy Managing Organisational Change Policy and Toolkit Hybrid working Flexible working Job descriptions/PADR process Training Development of 'Building our futures together programme' – Leadership Development, Behaviours, Compassionate Leadership Training and education managers on compassionate leadership (Inspire Programme) Access to internal and external training/career development Online resources Wellbeing and Engagement online resources Work in Confidence Platform External awards Corporate Health Standard Platinum Award Time to Change Wales signatory Monitoring of staff wellbeing Annual Staff Engagement Survey Monitoring of sickness absence figures by Board External wellbeing audits Organisational support Staff networks Occupational Health Employee Assistance Programme Mental Health First Aider network Access to Complementary therapy Mindfulness App Individual Stress risk assessments completed by manager Purchase of annual leave Financial advice, Salary sacrifice schemes	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. HSE defines stress as 'the adverse reaction people have to excessive pressure or other types of demand places on them'. Staff employed by the Trust have a wide variety of roles including clinical and non-clinical, administrative support and patient/donor facing. Work in carried out at VUNHST premises, donation venues, in outreach centres. Some staff work in an agile way, working both at VUNHST premises and other locations including at home. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work. Not all of this will be work related. The risk relates to all Trust employees HSE identifies six main areas that may lead to work-related stress if not properly managed: demands, control, support, relationships, role and change. Demand – workload, ability to do work required, conflicting priorities, work patterns, physical environment and violence and aggression. Control – pace of work and ability to take breaks. Development and use of professional skills. Support – lack of support for staff from managers and colleagues. Staff not know what support is available and how to access it. Relationship – negative behaviours, interpersonal and/or inter-team conflict, perceived unfairness. Bullying. Poor communication. Resolution procedures not accessed in a timely way. Role – lack of clarity and communication	12	9	30/06/2023	Divisions/Departments do not all have proactive stress risk assessments Healthy and Engaged steering Group to communicate with Divisions and Departments about stress risk assessments by 30 June 2023. To be monitored by the Healthy and Engaged Steering Group Due date: 09.12.2023 The Trust needs to use evidence to determine what the organisational factors are that are impacting on levels of stress on individuals. These factors need to be understood and communicated. Plans in those areas of work already in place need to be aligned to this risk or new plans developed. The work plan derived from this should sit under the 'Building Our Future Together' Portfolio. Due date 22.12.2023	230	

					Financial advice, Salary sacrifice schemes. Blue light discounts. Car lease scheme. Cycle to work scheme Wellbeing activities/events Wellbeing rooms/facilities Healthy and Engaged Steering Group Clinical Psychologist for staff and teams – including proactive programme of engagement. Dialogue with Trade Unions	Role – lack of clarity and communication around roles and responsibilities. Change – lack of communication or poorly understood communication about proposed changes. Lack of support for staff during periods of change. Home/family/personal issues which may add to stress at work					

Trust Board

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT AND SUPPORTING ANALYSIS FOR MAY 2023/24

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance / Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	**CATH O'BRIEN, CHIEF OPERATING OFFICER, SARAH MORLEY, EXECUTIVE DIRECTOR OD & WORKFORCE, MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANC**
APPROVED BY	**CARL JAMES, EXECUTIVE DIRECTOR OF STRATEGIC TRANSFORMATION, PLANNING AND DIGITAL**

EXECUTIVE SUMMARY	**1. VELINDRE NHST PERFORMANCE MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD MAY 2023/24** **1.1** This paper reports on the performance of our Trust for the month of May 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.

RECOMMENDATION / ACTIONS	**The Trust Board is asked to:** • The Trust Board is asked to **NOTE** 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.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	18 JUNE 2023
VCS SLT / Performance Review	19 JUNE 2023
Executive Management Board	29 JULY 2023
Quality Safety Performance Committee	13 JULY 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report has been considered at the VCS and WBS Performance Review meetings and by the Executive Management Board and QSP Committee and is presented to the Trust Board for information and noting.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full

APPENDICES	
1	Velindre Cancer Services – PMF Supporting KPI Data Graphics and Analysis
2	Blood and Transplant Services – PMF Supporting KPI Data Graphics and Analysis
3	Trust-wide Services – PMF Supporting KPI Data Graphics and Analysis

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

2. SITUATION AND BACKGROUND
VELINDRE NHST PERFORMANCE REPORT EXECUTIVE SUMMARY FOR MAY 2023

The following paragraphs provide a high-level executive summary of our Trust-wide performance against key performance metrics through to the end of May 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, SACT emergency waiting times, Hospital Acquired Thrombosis, Physiotherapy, Occupational Therapy and Speech and Language Therapy waiting times.

There were four Delayed Transfers of Care (DToCs) in May, resulting from of bed capacity challenges across the wider healthcare system. It is anticipated this could continue as capacity within Health Boards remains challenged. Invariably, this will influence the ability for Velindre Cancer Centre to discharge. Led by the Delivery Unit, work continues across the system at a national level to explore the wider challenges for managing delayed discharges. Velindre Cancer Centre is a member of that group, allowing system wide knowledge to form part of our planning assumptions moving forward.

In this reporting period, SACT 21-day performance showed a further reduction. The causes are multifactorial including increased referrals, booking team resources shortages due to ill health, as well as PICC (Peripherally Inserted Central Catheter) scheduling capacity. It is recognised that whilst these issues create a pressure on the pathway which leads to reduced performance, further challenges with staffing resource are compounding opportunities to recover. Current pressures are being recognised in nursing with not only high levels of maternity leave but more concerning, increased levels of vacancies with poor interest during the recruitment phase. This follows well publicised resource pressures across NHS. Despite this, the service is working with Workforce and Organisational Development colleagues to develop a further recruitment campaign and is in active discussion with HEIW to determine other opportunities for recruitment further afield.

The capacity within the SACT booking team has been reviewed and additional resource has been identified as part of a wider proposal to support data quality management. In an attempt to explore all options, VCC's service improvement team have also been deployed to

work with SACT, reviewing the pathway as a priority. We continue to experience operational challenges with the bedding in of the Digital Health Care Record (DHCR) with the prioritisation of the administrative functions to support the clinical delivery of service.

PICC capacity has been immediately increased by 20%, whilst further work will be undertaken to review service utilisation and booking rules. Additionally, a peer review of the IV access service is commencing in July with colleagues from Aneurin Bevan University Health Board (ABUHB). Improvements undertaken by the service have also led to weekly referral and waiting time data being available to the service manager to better help manage demand and resultant activity.

Following the adoption of revised Quality Performance Indicators (QPIs), the radiotherapy service continues to show underperformance against all of the performance metrics. This in part is related to the interpretation and categorisation of patients against the definitions for each group of patients in the new radiotherapy QPIs (which replaced the Royal College of Radiologists Joint Collegiate Council for Oncology's targets in January 2023). We continue to work with the Clinical Oncology Sub-Committee (COSC) national group to standardise reporting, share best practice and align the application of the new measures in a consistent manner in line with national reporting standards.

A formal capacity planning group is working to deliver a balanced demand and capacity plan, including individual plans for Brachytherapy, Medical Physics and delineation planning and scanning. In addition, as part of a wider programme of pathway work, a clinically led group has reviewed current pathways against defined optimum pathways in order to identify variation and clarify where focused work is required. Baseline data is being sourced to support this work from Business Intelligence.

An activity list is produced from the digital systems followed by a manual review to cross check the activity list against digital system reports, to ensure that all patients are managed through the treatment pathway. This does lead to additional staff pressure but, needs to continue until further warehouse developments and changes are made. Patients continue to be prioritised in line with national guidance.

Data quality related to the implementation of DHCR remains an issue and is creating a significant administrative burden. Significant progress has been made in processing the backlog of unprocessed outcomes. This has been undertaken with additional resource. The DHCR Operational Group has completed a piece of work to identify the additional resource required to support the ongoing management of DHCR and the changes that have come with the new system. The paper will be presented to the DHCR Project Board in July, alongside a paper on the requirements for further refresher training and the resource required to support this on an interim basis.

2.2 Welsh Blood Service Overview

WBS have continued to perform well during May and all clinical demand was met. At 98% quality incident investigations closed within 30 days has improved again this month and continues to exceed the 90% target.

WBS have continued to perform well during May and all clinical demand was met, despite a number of bank holidays. At 98% quality incident investigations closed within 30 days has improved again this month and continues to exceed the 90% target.

There were two reportable events submitted to the MHRA in May:

SABRE-106 (submission 02/05/2022) "Malaria residency not assessed correctly"

A donor's malarial residency status was correctly assessed via screening questions and the required malaria test sample was taken; however, the electronic donor record was not updated correctly. This was the donor's third attendance. It was then established that the donor's malaria residency had been incorrectly assessed on two previous occasions. This presents a risk that the donor was positive for malaria at the time of the first and second donations, and contaminated blood components could have entered the supply chain.

- A deferral was immediately applied to the donor record.
- Malarial screening of archived samples was undertaken for previous donations from this donor (18/02/12 and 17/08/20). Both results were negative, therefore there was no actual risk to patient safety.
- A lookback process has been completed; no products required discard.
- An additional 174 donor records were checked, with only one further issue identified. This has been included in the RCA report and recorded separately within Datix.
- To ensure this issue does not exist for other donors with a declaration of previous malaria residency Digital Services will run a report to identify all donors declaring they were born outside of the UK; further checks will be made to ensure RN review was completed as expected – any anomalies will be reported and managed as a separate event.
- Training awareness has been delivered to all collection team RNs.
- A peer review of the RN process will be undertaken to identify additional learning or service improvements.
- WBS have not received any reports of transfusion transmitted malaria.
- Malaria residency not assessed correctly (date notified 02/05/2023) – the incident was complex and highlighted the potential for further issues around assessment of malaria residency which required exploration. A root-cause analysis has been undertaken and has highlighted additional staff training is required. This is now underway.
- Deviation from platelet release process. Platelets released before all testing results were available (date notified 22/05/2023). Testing results confirmed negative before transfusion therefore no clinical risk. Investigation complete and a number of preventative actions identified.

SABRE 107 (submission 22/05/23): “Contingency Issue PC (CIPC) used to issue unreleased platelet.”

This was a “near miss” event - if the platelets had been needed for an urgent transfusion they could have been transfused before the bacteriology results were known; this may have had an adverse patient impact if bacterial growth had occurred. A root cause analysis investigation has been undertaken.

- The system does not prevent issue of stock via CIPC - this is reliant on users making the correct decision about its use.
- A new stock of platelets had been received by the Stock Holding Unit but were still under ‘12-hour bacteriology hold’.
- The person undertaking issuing of platelet felt under pressure to issue platelets that were required urgently by a customer hospital late at night.
- They made an error of judgement, believing their decision was safe as the platelet would be released from hold by the time it arrived at the customer hospital and if there had been a positive result the platelet would have been recalled.
- The staff member recognises their error and has undertaken reflective practice.
- Junior staff members must be supported in their decision making in such circumstances
- The process will be updated to introduce the requirement for formal authorisation of the use of the CIPC by the on-call medic or on-call SMT lead

An additional reportable event was submitted to the MHRA in February and has been included in this report because, due to the reporting cycle, the PMF for February was taken to EMB only and not to the QSP meeting.

SABRE-105 (submission 10/02/2023) “BactAlert failure”

The larger of two BactAlert modules failed, resulting in the blood establishment computer system (eProgesa) allowing platelets to be released without live bacteriology monitoring taking place. This presented a risk that positive results were not recorded and units with bacterial growth could have been released to customer hospitals for transfusion.

- Remedial action to support business continuity was managed via the WBS Emergency planning group.
- The immediate risk was from platelets available for transfusion on days 6 and 7 (these are safe for transfusion up to day 5).
- Affected platelets were identified and all hospitals notified immediately, enacting the product recall process, and quarantining affected platelets.
- Neonatal platelets were imported to cover requests from customer hospitals.
- All remaining WBS stock was converted to a 5 day shelf-life.

- A specialist engineer repaired the fault.
- The old BactAlert system has since been replaced with a completely new system (this was a scheduled change and not in direct response to this event).
- A fix has been applied within the new system to prevent a similar event occurring.

Donor satisfaction continues to be above the 95% target and has remained at 97% in May. Donor award events recommenced in May and this has resulted in positive feedback from our donors. 7,203 donors were registered at donation clinics with 6 informal concerns (0.08%) reported during this period. All were managed within the 2 working day deadline as 'early resolution'. No formal concerns were raised during May.

Reference Serology turnaround performance continued to meet target in May, after achieving target in April for the first time in 8 months. Performance continues to be impacted by ongoing training of new staff, however, this is a much improved picture compared to recent months.

All clinical demand for platelets was met representing a strong performance against this metric. Platelet wastage reduced again in May and met target for the second month in a row. This is attributed to the planned changes to production made in April. The May bank holidays brought about significant challenges in maintaining the balance between supply and demand, however platelet expiry was kept controlled by modelling expected issues against production.

Collection efficiency is slightly below the 1.25% target at 1.13%. Contributory factors influencing the May performance include short term staff sickness and staff vacancies.

Performance for new bone marrow volunteers improved slightly in May but was well below target with only 160 new volunteers (131 from blood and 29 from swabs). The summer months are typically lower due to the reduced blood donor clinics in educational establishments. Work is ongoing to understand how we can address this by considerably increasing swab recruitment. We are currently analysing the data from previous swab recruitment campaigns to inform the way forward. 466 eligible donors attended blood sessions with a 28% conversion rate.

The total stem cells collected in May was 3 (2 collections were cancelled for patient reasons and 2 for donor reasons). The total stem cell provision for the service was 4 (3 collected and 1 imported for a Welsh patient). 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 ability of skilled people to provide the key services within the Trust remains one of the most significant risks for the Trust, alongside ensuring those we do employee are supported, valued and feel their wellbeing is central while in the workplace. The Trust's People Strategy ensures progress towards; a planned and sustained workforce with skilled and developed people who are healthy and engaged in the workplace. Alongside these there are key metrics the Trust analyses and evaluates to ensure the effective performance of the workforce. Trust wide sickness absence data continues to remain high month on month with the current rolling absence of 5.99% to May 2023 still above the Welsh Government Target of 3.45%. Trust wide PADRs this month remains at 72% for a third consecutive month, whereas Statutory and mandatory training remains above target at 87% and has been consecutively on target for the whole year to May 2023. Details of interventions can be found in the SPC's for these metrics and corresponding action plans.

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?' (98%) and 'Your Velindre experience?' (68%) both set against a 95% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 97% that continues to meet the target.

2.6 Digital Services

Steady improvement in the rolling 12-month number of significant IT business continuity (11); however, this remains a focus of work for the team, with a view to achieving the target of 6 incidents in a rolling 12 month period. The Digital Services team continue to implement improvements to address the legacy IT estate in VCC, which is where the majority of the incidents are occurring. This work will continue through 2023/24.

Performance in respect of the timescales for resolving service requests and incidents remains largely stable at approx. 80% for both indicators. Team capacity remains a contributory factor – 2wte Service Desk Officers commenced work in early June 2023 – performance expected to improve through Q1 into Q2 2023/24.

Reporting arrangements for two indicators are still being developed, routine reporting delayed due to competing priorities. Aim is to establish routine reporting in Q2 2023/24 for the following indicators:

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role (interviews scheduled for July 2023).
- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Initial reporting has been developed for WBS Appointments System (>99.9% uptime) However, these reports are still undergoing validation to ensure accuracy of the reported data.

2.7 Estates Infrastructure and Sustainability

The period through to May has realised high levels of compliance for PPM and reactive tasks which are currently listed as green. Recruitment has progressed significantly with three posts currently out to advert. The Team are focussed on management through the availability of data which is now evident through the consolidation of compliance figures.

Energy management is intrinsically linked to Estates resourcing and will be improved with recruitment in the Estates Department, and implementation of the decarbonisation plan. Recent events have hindered the availability of utility data which is largely due to the introduction of Energy Bill Relief Scheme (EBRS) which continues to be an issue with reporting data.

Fire Safety and Health & Safety KPIs are at acceptable levels with the exception of training, which is a constant challenge. New initiatives have been rolled out working closely with Education and Development Colleagues which is having a positive impact on performance, there is now sufficient training capacity to meet the needs of the organisation.
Module C training (Violence and Aggression) is currently listed as red, due to this being new course which is currently being rolled out to relevant areas. It is anticipated that this figure will rise with availability of training moving forward. Divisions have reinvigorated H&S meeting which will support improvement of training, by approaching issues at operational level, working with trainers and departments to tailor a package that meets departmental requirements, this is underpinned by support from SLT.

2.8 Finance

The overall position against the profiled revenue budget to the end of May 2023 is an underspend of £0.004m and is currently expecting to achieve an outturn forecast of Breakeven. The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

The approved Capital Expenditure Limit (CEL) as at May 2023 is £24.416m. This represents all Wales Capital funding of £22.773m, and Discretionary funding of £1.683m. The Trust reported Capital spend to May'23 of £3.026m and is forecasting to remain within the CEL of £24.416m.

During May ’23 the Trust (core) achieved a compliance level of 97.6% of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of 98.1% as at the end of month 2, and a Trust position (including hosted) of 98.7% compared to the target of 95%.

At this stage the Trust is currently planning to fully achieve the savings target during 2023-24, however a risk of under delivery remains on several schemes that are still RAG rated amber.

3. ASSESSMENT OF PERFORMANCE / SUMMARY OF MATTERS FOR CONSIDERATION
VELINDRE NHST PERFORMANCE SCORECARDS FOR MAY 2023

3.1 Cancer Services Scorecard as at May (Month 2) 2023/24

QSF Domain	Cancer Services Safety Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	➔	KPV.01
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	➔	KPV.02
	% Patients with a Sepsis NEWS score >or= 3 receiving all 6 treatment elements within 1 hour	National	Monthly	100%	100%	100%	✓	➔	KPV.03
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓	➔	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	1	✗	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	0	✓	➔	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	1	✗	➔	KPV.04
	Hand Hygiene compliance against best practice standards	Prof. Std.	Monthly	TBA	TBA	TBA	✓	➔	KPV.08
	Number of Health and Safety Incidents recorded	Local	Monthly	9	0	3	✗	➔	KPV.56
	% compliance for staff who have completed the Core Skills and Training Framework Level 1	National	Monthly	85%	85%	85%	✓	➔	KPV.59

	Number of Staff RIDDOR Incidents, Injuries and Work Related Accidents	**Local**	**Monthly**	**0**	**0**	**0**	✓	➔	KPV.54
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				**Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓**					

QSF Domain	**Cancer Services Effectiveness Scorecard**			**Performance as at Month 02 (May)**			**Compliance against Target or Standard**		**Data Link**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Effectiveness	Number of Delayed Transfers of Care (DToCs)	**National**	**Monthly**	**1**	**0**	**4**	✗	➔	KPV.05
	% Personal Appraisal Development Reviews (PADR) Compliance	**National**	**Monthly**	**72%**	**85%**	**70%**	✗	↓	KPV.56
	% Rolling average Staff sickness levels	**National**	**Monthly**	**6.43%**	**3.54**	**6.13%**	✗	↓	KPV.57
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				**Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓**					

QSF Domain	**Cancer Services Experience Scorecard**			**Performance as at Month 02 (May)**			**Compliance against Target or Standard**		**Data Link**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Patient/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	**Prof. Std.**	**Monthly**	**95**	**95%**	**98%**	✓	➔	KPV.11
	% of 'formal' concerns responded to within 30 working days	**Local**	**Monthly**	**100**	**85%**	**100**	✓	➔	KPV.12
	Number of Incidents of violence and aggression to staff	**Local**	**Monthly**	**7**	**0**	**0**	✓	↑↓	KPV.53
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				**Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓**					

QSF Domain	Cancer Services Timeliness Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	29% 47%	80% 100%	16% 45%	✗	→	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	National	Monthly	6% 50%	80% 100%	9% 49%	✗	→	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	National	Monthly	94% 100%	80% 100%	81% 94%	✗	→	KPV.16
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	National	Monthly	27% 32%	80% 100%	53% 56%	✗	→	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	90%	✗	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	↑	KPV.21
	% Outpatients seen within 30 minutes of scheduled time	Local	Monthly	paused	100%	paused	✗	→	KPV.22
	% Patients receiving equitable and timely access to Therapy Services	Local	Monthly	100%	100%	100%	✓	→	KPV.23
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓					

QSF Domain	Cancer Services Efficient Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% Outpatient Did Not Attend (DNA) rates	National	Monthly	3%	5%	nda	✓	→	KPV.24
	Electricity performance in kilowatt hours (kWh)against target consumption budget profile	National	Monthly	N/A	263k	296k	✗	↑↓	KPV.62
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	National	Monthly	N/A	175k	178k	✗	↑↓	KPV.62

	Water performance usage in cubic metres against target consumption	**Local**	**Monthly**	**N/A**	**1750m3**	**1550m3**	✓	↑	KPV.67
	Financial Balance – achievement of VCC forecast (£k) in line with revenue expenditure profile	**National**	**Monthly**	**£0k**	**£0k**	**£3k**	✓	→	KPV.71
	VCC expenditure (£k) on Bank and Agency staff against target budget profile	**National**	**Annually**	**£99k**	**£99k**	**£66k**	✓	↑	KPV.72
	Cost Improvement Programme – VCC achievement of savings (£k) in line with profile	**National**	**Monthly**	**N/A**	**£40k**	**£68k**	✓	↑	KPV.74
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Cancer Services Equitable Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	→	KPV.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	→	KPV.79
	Diversity of Workforce – % People with a Disability	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	→	KPV.80
	% of Workforce declared Welsh Speakers at Level 1	**National**	**Quarterly**	**TBA**	**TBA**	**TBA**	✓	→	KPV.81
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

3.2 Blood and Transplant Scorecard as at May (Month 2) 2023/24.

QSF Domain	Blood and Transplant Safety Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	Number of Health and Safety Incidents recorded	Local	Monthly	5	N/A	10	✗	➔	KPI.57
	Quality Incidents closed within 30 days	Local	Monthly	96%	90%	98%	✓	🡅	KPI.11
	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	2	✗	🡇	KPI.30
	Numbers of critical and major non-conformances through external audits or inspections	Best practice	Monthly	0	0	0	✓	➔	KPI.32
	% staff compliance who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	95%	85%	93%	✓	🡅	KPI.59
	Number of Staff RIDDOR Incidents, injuries, and work-related accidents.	Local	Monthly	0	0	0	✓	➔	KPI.54
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving 🡅 stable ➔ fluctuating 🡅🡇 deteriorating 🡇									

QSF Domain	Blood and Transplant Effectiveness Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	New Whole Blood Donors	Local	Quarterly	1660	2750				KPI.27
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	97%	✗	🡇	KPI.04
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	117%	✓	🡇	KPI.05
	Red Blood Cell Stock Level (below 3 days)	Local	Monthly	0	0	0	✓	➔	KPI.07
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	8%	✓	🡅	KPI.25
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0.7%	✓	🡇	KPI.26

	New Apheresis Donors	Local	Quarterly	21	14				KPI.19
	Number of Stem Cell Collections per month	Local	Monthly	6	7	3	✗	🡻	KPI.13
	New Bone Marrow Donors	National	Monthly	1742	333	160	✗	🡹	KPI.20
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	National	Monthly	86%	85%	87%	✓	🡻	KPI.56
	% Rolling average Staff sickness levels	National	Monthly	6.8%	3.54%	7.16%	✗	🡹	KPI.58
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable 🡺 fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	Blood and Transplant Experience Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Donor/ Staff Experience	% Unsuccessful Venepuncture	Best practice	Monthly	1.7%	2.0%	0.9%	✓	🡹	KPI.14
	% Part Blood Bags collected	Best practice	Monthly	2.7%	3.0%	2.5%	✓	🡻	KPI.16
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓	🡹	KPI.09
	Number of Concerns	Local	Monthly	9	N/A	6	✓	🡹	KPI.28
	% Responses to informal concerns within required 2-day timescale	Local	Monthly	100%	100%	100%	✓	🡺	KPI.06
	% Responses to formal concerns within 30 working days	Local	Monthly	100%	90%	N/A	✓	🡺	KPI.03
	Number of incidents of violence and aggression to staff	Local	Monthly	1	0	4	✗	🡹🡻	KPI.53
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable 🡺 fluctuating 🡹🡻 deteriorating 🡻									

QSF Domain	Blood and Transplant Timeliness Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	

Timeliness	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	**Best practice**	**Quarterly**	**83%**	**90%**				KPI.17
	% Antenatal Turnaround Times (within 3 working days)	**Best practice**	**Monthly**	**96%**	90%	**95%**	✓	→	KPI.18
	% Reference Serology Turnaround Times (2 working days)	**Best practice**	**Monthly**	70%	80%	81%	✓	→	KPI.23
	% Turnaround Time (Deceased Donors Typing / Cross matching)	**Best practice**	**Quarterly**	**84%**	**80%**				KPI.24
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Blood and Transplant Efficient Scorecard			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Whole Blood Collection Productivity	**Best practice**	**Monthly**	**1.12**	**1.25**	**1.13**	✗	→	KPI .08
	Manufacturing Productivity	**Best practice**	**Monthly**	**418**	**392**	**424**	✓	↑	KPI.10
	% Controllable Manufacturing Losses	**Best practice**	**Monthly**	**0.06%**	**0.5%**	**0.03%**	✓	→	KPI.12
	Electricity performance kilowatt hours (kWh) against target consumption budget profile	**National**	**Annually**	**N/A**	**140k**	**130k**	✓	→	KPI.63
	Gas performance in kilowatt hours (kWh) against target consumption budget profile	**National**	**Annually**	**N/A**	**71k**	**59k**	✓	→	KPI.63
	Water performance usage in cubic metres against target consumption	**Local**	**Monthly**	**N/A**	**250m3 Mar**	**250m3 Mar**	✓	↑	KPI.67
	Financial Balance – achievement of WBS forecast (£k) in line with revenue expenditure profile	**National**	**Monthly**	**£0k**	**£0k**	**£1k**	✓	→	KPI.71
	WBS expenditure (£k) on Bank and Agency staff against target budget profile	**National**	**Annually**	**£0k**	**£0k**	**£1k**	✗	↓	KPI.72
	Cost Improvement Programme – WBS achievement of savings (£k) in line with profile	**National**	**Monthly**	**N/A**	**£32k**	**£27k**	✓	→	KPI.74
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Blood and Transplant Equitable Scorecard			Performance as at Month 02 (May)			Compliance against Target Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	TBA	TBA	TBA	N/A	N/A	KPI.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	TBA	TBA	TBA	N/A	N/A	KPI.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	TBA	TBA	TBA	N/A	N/A	KPI.80
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	TBA	TBA	TBA	N/A	N/A	KPI.81
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡅 stable 🡆 fluctuating 🡅🡇 deteriorating 🡇									

3.3 Trust-wide Services Scorecards as at May (Month 02) 2023/24
Estates Services.

QSF Domain	Estates Safety Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	

Safety	Carbon Emissions – carbon parts per million by volume	**National**	**Annually**	**2020/21 C/m3**	**TBA**	**118.9 C/m3**	✓	➔	EST.06
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	**Estates Effectiveness Scorecard – Trust-wide position**			**Performance as at Month 02 (May)**			**Compliance against Target or Standard**		**Data Link**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Effectiveness	Compliance with Sustainable Development Assessment Tool (SDAT)	**Local**	**Annually**	**TBA**	**TBA**	**TBA**	✓	➔	EST.25
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	**Estates Timeliness Scorecard – Trust-wide position**			**Performance as at Month 02 (May)**			**Compliance against Target or Standard**		**Data Link**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Timeliness	% PPM undertaken completed against plan	**Local**	**Quarterly**	**90%**	**95%**	**90%**	✗	➔	EST.54
	% Reactive maintenance achieved within agreed days/hours	**Local**	**Quarterly**	**80%**	**95%**	**80%**	✗	➔	EST.54
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	**Estates Efficient Scorecard – Trust-wide position**			**Performance as at Month 02 (May)**			**Compliance against Target or Standard**		**Data Link**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	

Efficient	Trust HQ Electricity performance in kilowatt hours (kWh) against target consumption budget	**National**	**Quarterly**	**N/A**	**2011**	**1696**	✓	↑	EST.6 4
	Trust HQ Gas performance in kilowatt hours (kWh) against target consumption budget	**National**	**Quarterly**	**N/A**	**1437**	**1680**	✗	↑	EST.6 4
	Trust Waste Recycling performance by weight (Kg)	**Local**	**Monthly**	**4500Kg**	**4500Kg**	**5500Kg**	✓	↑	EST.6 8
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				**Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓**					

Health and Safety Services

QSF Domain	Health and Safety Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Safety	% RIDDOR reportable incidents of workforce	**Local**	**Quarterly**	**0**	**0**	**0**	✓	→	H&S. 14
	% Fire Action Plan actions implemented	**Local**	**Quarterly**	**78%**	**100%**	**78%**	✗	→	H&S. 17
	Number of Health and safety incidents recorded	**Local**	**Monthly**	**15**	**0**	**13**	✗	↑↓	H&S. 55
	% Fire Drills completed accordance with schedule	**Local**	**Quarterly**	**paused**	**100%**	**paused**	✓	→	H&S. 16
Symbols Key: In Month = Compliant ✓ Non-compliant ✖				**Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓**					

QSF Domain	Health and Safety Effectiveness Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	

Effectiveness	% staff overall compliance with Level 1 (Essential) Level 2 (fire Warden) & Level 3 Fire safety training	**Local**	**Monthly**	**89%**	**85%**	**88%**	✓	➔	H&S.27
	% Training compliance – Manual Handling (level 1 and 2), Health & Safety, Violence and Aggression (module A and B) and Display Screen Equipment	**Local**	**Monthly**	**80%**	**85%**	**80%**	✗	↑	H&S.26
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	**Health and Safety Experience Scorecard – Trust-wide position**			**Performance as at Month 02 (May)**			**Compliance against Target or Standard**		**Data Link**
	Key Performance Indicator (KPI)	**Target**	**Reported**	**Baseline March 23**	**Target**	**Actual**	**In Month Position**	**Cumulative data trend**	
Patient/ Donor/ Staff Experience	Number of Incidents of violence and aggression to staff	**Local**	**Monthly**	**7**	**0**	**4**	✗	↑	H&S.43
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

Workforce and Organisational Development

QSF Domain	Workforce and OD Safety Scorecard – Trust-wide position			Performance as at Month 01 (April)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% staff compliance who have completed the Core Skills and Training Framework Level 1 competences	National	Monthly	87%	85%	87%	✓	↑	WOD. 19
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Workforce and OD Effectiveness Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	72%	✗	↑↓	WOD. 36
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54%	5.99%	✗	↓	WOD. 37
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Workforce and OD Experience Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	March 23	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	

Patient/ Donor/ Staff Experience	% staff who rate Trust as a good employer	National	Annually	TBA	TBA	TBA	✓	➔	WOD. 13
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable ➔ fluctuating ↑↓ deteriorating ↓									

QSF Domain	Workforce and OD Equitable Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
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 ↓									

Digital Services

QSF Domain	Digital Safety Scorecard – Trust-wide position	Performance as at Month 02 (May)	Compliance against Target or Standard	Data

	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	Link
Safety	% compliance against NCSC "10 Steps to Cyber Security" best practice standards	**Local**	**Bi-annual**	**88%**	**90%**	**88%**	→	↑	DIG.62
	Number of significant IT business continuity incidents	**Local**	**Monthly (rolling 12 months)**	**12**	**6**	**11**	↑	↓	DIG.61
	Cyber Security - % of employees clicking on internal phishing campaigns	**Local**	**Quarterly**	**TBA**	**TBA**	**TBA**	-	-	DIG.63

Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

QSF Domain	Digital Experience Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Patient/ Donor/ Staff Experience	% User satisfaction with Digital Service Desk	**Local**	**Quarterly**	**87%**	**95%**	**87%**	→	✗	DIG.51

Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

QSF Domain	Digital Timeliness Scorecard – Trust-wide position	Performance as at Month 02 (May)	Compliance against Target or Standard	Data

	KPI Measure	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	Link
Timeliness	% Digital Service Desk requests resolved within agreed (SLA) timescales	Local	Monthly	81%	85%	81%	→	-	DIG.58
	% Digital Service Desk incidents resolved within agreed (SLA) timescales	Local	Monthly	80%	85%	79%	↓	-	DIG.59
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Digital Efficient Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	% uptime of critical digital systems (% availability by service, excl. planned maintenance windows)	Local	Monthly	TBA	99%	TBA	-	-	DIG.69
Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

Finance Services

QSF Domain	Finance Timeliness Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	KPI Measure	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Timeliness	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	→	FIN.60
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

QSF Domain	Finance Efficient Scorecard – Trust-wide position			Performance as at Month 02 (May)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.004 m)	✓	→	FIN.71
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.115 m	£0.77m	✓	↑	FIN.72
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£1.673 M	£1.673 M	✓	→	FIN.73
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£0.084 m	£0.108 m	✓	↑	FIN.74
Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓									

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	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). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	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** Please explain if 'other' source of funding selected: Click or tap here to enter text **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	PMF report is focused upon monitoring performance against statutory and local stretch targets
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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*There are no risks at this point in the business case development process*
WHAT IS THE CURRENT RISK SCORE	

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Performance Management Framework supporting KPI Data Graphics and Analysis

APPENDIX 1: CANCER SERVICES

SAFETY

KPI Indicator KPV.01

Return to Top

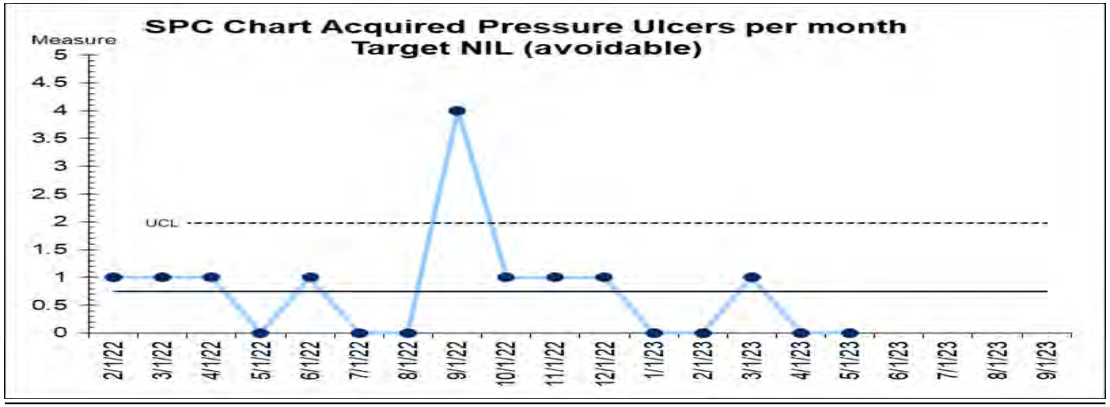
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Apr 23	May 23
Actual Number	1	1	0	1	0	0	4	1	1	1	0	0	1	0	0
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 Analysis

The SPC chart shows common cause or normal variation, apart from Sept '22 over the last 15 months.

Performance

No avoidable Pressure Ulcers in month

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 KPV.02

Return to Top

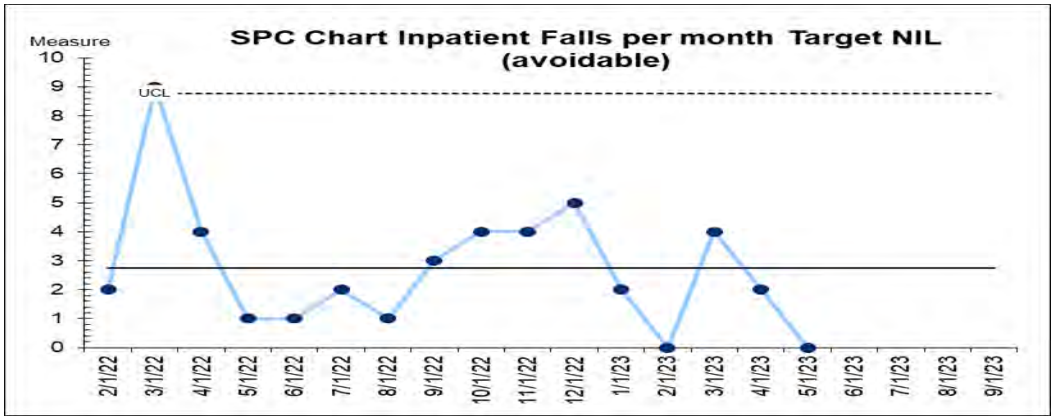
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Apr 23	May 23
Actual Number	9	4	1	1	2	1	3	4	4	5	2	0	4	2	0
Avoidable Falls	0	1	1	0	2	0	1	2	2	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 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.

Performance

No avoidable falls in May 2023

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.03

Return to Top

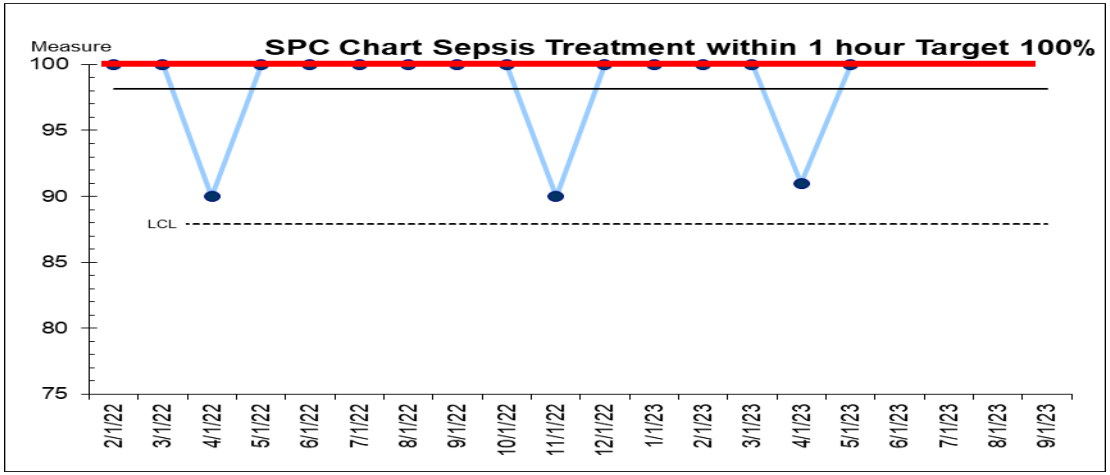
Patients with a NEWS Score Greater Than or Equal to 3 who Receive All 6 Elements in Required Timeframe

Target: 100%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

	Mr22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	100	90	100	100	100	100	100	100	90	100	100	100	100	91	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



SPC Chart Analysis

The SPC chart shows common cause or normal variation for the 15 month period.

Performance

Assessment of current performance, set out key points:

20 patients in total were admitted to VCC with query sepsis
12 patients were diagnosed with SEPSIS and all were compliant with sepsis 6
6 patients were treated as query SEPSIS but not diagnosed as SEPSIS and each received full compliance with the sepsis 6 bundle
2 patients – the bundle was started – abx were not given based on medical decisions. Neither of these patients were diagnosed with SEPSIS – other causes were clearly documented.
Another positive this month – documentation was very good, every patient had either a clinical note or a DAL and the diagnoses were clearly documented for all patients involved in the audit.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate
Continued 100% compliance with the sepsis bundle

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.08

Return to Top

Hand Hygiene compliance against Best Practice

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene Compliance

VCC	Mr22	Apr 22	My 22	Jun 22	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Hand Hygiene															
Target Nil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Performance Target measures are in development

Performance

Assessment of current performance, set out key points:

- Performance is on target

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.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	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	Apr 23	May 23
Hospital Acquired Thromboses	1	0	0	0	1	0	0	0	0	0	0	0	2	1	0
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:

On target for the month

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.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 February 2022 to April 2023

VCC	Mr22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
C.diff	1	0	0	0	0	0	0	0	0	1	1	0	0	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	1	0	0	0	0	0
E.coli	0	0	0	0	1	0	0	0	0	1	3	1	0	1	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1
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	1	4	1	0	1	1

Performance

Assessment of current performance, set out key points:

- 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 KPV.54

Return to Top

Graph title - Number of RIDDOR reportable incidents by Division

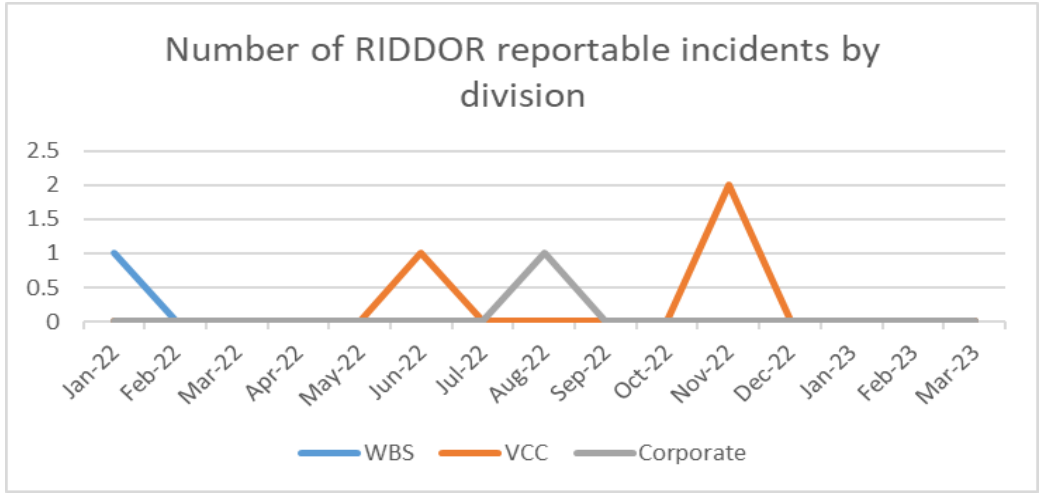
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard -

Performance - remains stable

	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	Apr 23	May 23
WBS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VCC	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0
Corporate	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0



Service Improvement Actions – Immediate (0 to 3 months)

Lessons learned from previous RIDDOR incidents implemented	Timescale Q4 2022/23. VCC H&S Integrated care and Ed& Dev

Expected Performance gain
Lessons learned and implemented

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale :**

Expected Performance gain
Lessons learned to prevent reoccurrence of incident and prevent similar ones

Risks to future performance

Incomplete incident investigation – **action** quality check by H&S, implementation of manager H&S training including risk assessment and incident training.

Operational pressures making it challenging for staff to training – **Action –** flexible onsite provision of training

Some departments not completing departmental inspections – escalated to SLT.

KPI Indicator KPV.59

Return to Top

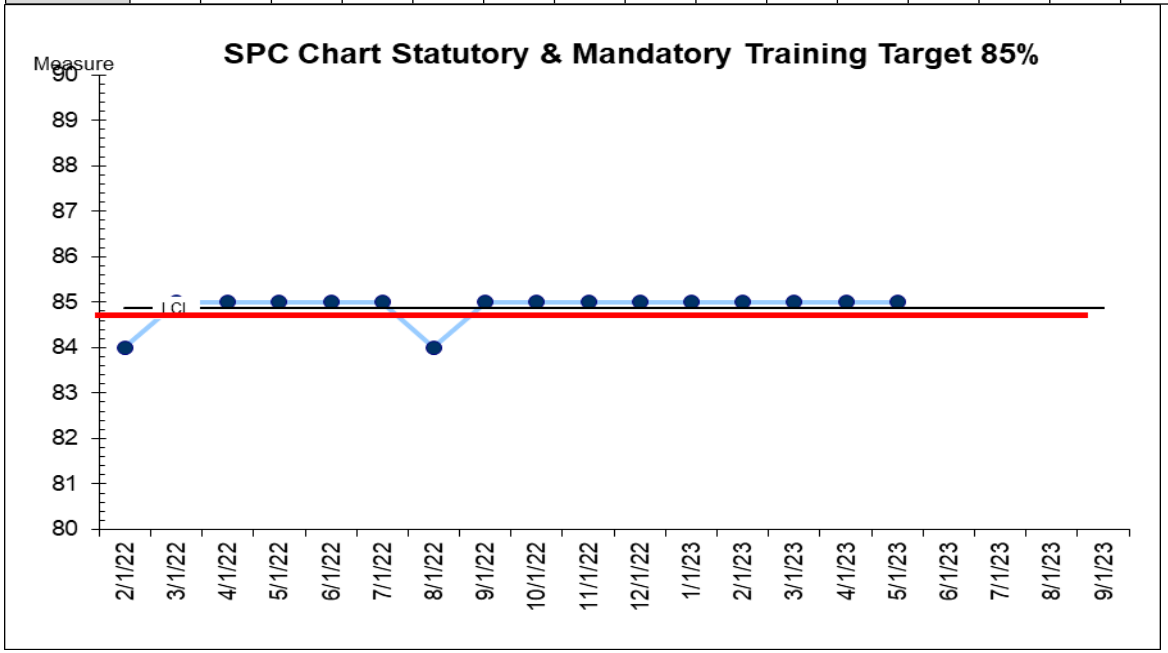
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	Ma22	Apr 22	My 22	Jun22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %	85	85	85	85	85	84	85	85	85	85	85	85	85	85	85
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 6 months

Performance

Assessment of current performance, set out key points:

Statutory and Mandatory compliance for this month reports as 85.37% compliance and remains just above the target of 85%.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
As compliance is just above the Trust target level, managers should continue to ensure staff are completing all statutory and mandatory modules and look to increase this compliance rate.	N/A	Ongoing, all managers in the division

Expected Performance gain – immediate

To continue to improve compliance for statutory and mandatory training.

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. & M and compliance framework in the All Wales network	Continuous	Head of OD
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Continuous	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.

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.56

Return to Top

Graph title - Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division

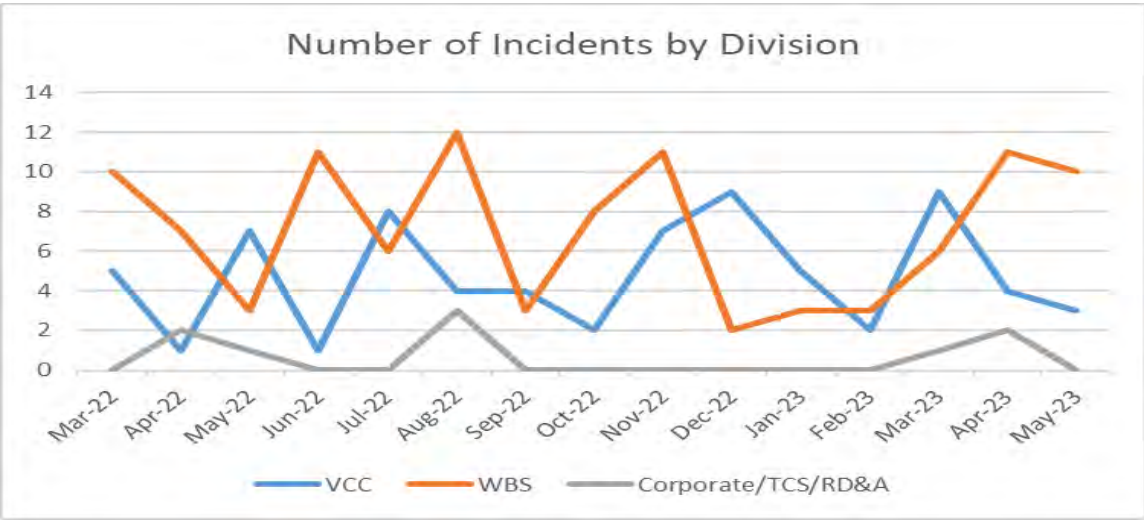
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	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	Apr 23	May 23
VCC	7	5	1	7	1	8	4	4	2	7	9	5	2	9	4	3
WBS	4	10	7	3	11	6	12	3	8	11	2	3	3	6	2	10
Corporate	1	0	1	1	0	0	2	0	0	0	0	0	0	0	2	0



Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incidents investigated. H&S incident investigation training scheduled January, March 2023 and April	Q4 2022/23.

Expected Performance gain

Improved identification root causes VCC & Corporate

Improved data quality in incident records

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale:**

Expected Performance gain

Risks to future performance

Incomplete incident investigation – **action** monitoring and short incident training January and March 2023 at VCC and Corporate

Some departments not completing departmental inspections at VCC

action – refresh of Dept. inspection process

EFFECTIVENESS

KPI Indicator KPV.05

Return to Top

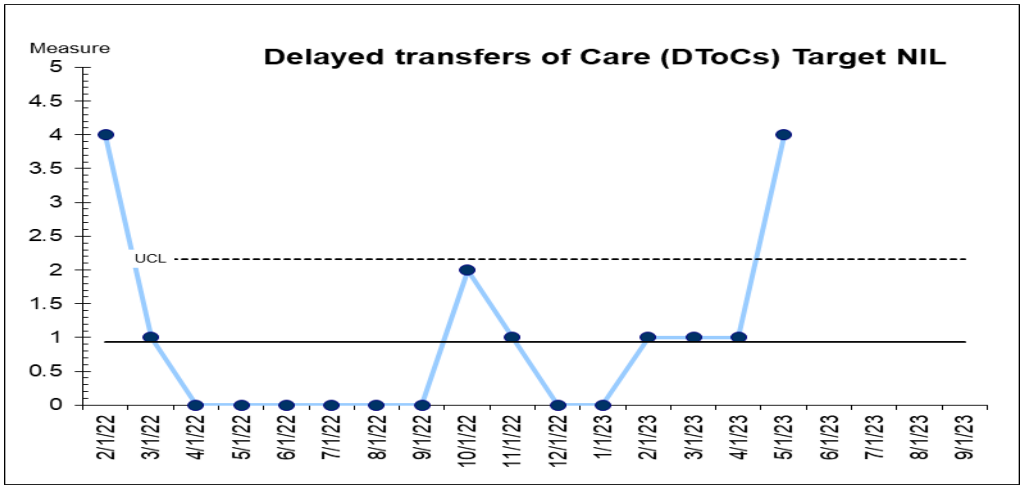
Number of Delayed Transfers of Care (DToC) Should we change this to the new WG descriptor i.e. Pathways of Care Delays (PoCD)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	No v 22	Dec 22	Jan 23	Feb 23	Ma r 23	Apr 23	Ma y 23
Actual %	1	0	0	0	0	0	0	2	1	0	0	1	1	1	4
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC Chart shows a 'special cause' or exceptional variation in May of 4 DToCs

Performance

Assessment of current performance, set out key points:

There were 4 DToC reported in May 2023.

Repatriation:

One patient was awaiting repatriation to local DGH.

Patient 1: 2 day delay

PoCD

Two patients were delayed due to awaiting start dates for Community Resource Team.

Patient 1: 10 day delay Patient 2: 4 day delay

One patient was delayed due to awaiting start of a new home care package, however was then transferred to YCR. Patient 1: 14 day delay

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 have assisted and data is now being uploaded nationally as required.		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.		Matthew Walters Senior Operational Nurse

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.56

Return to Top

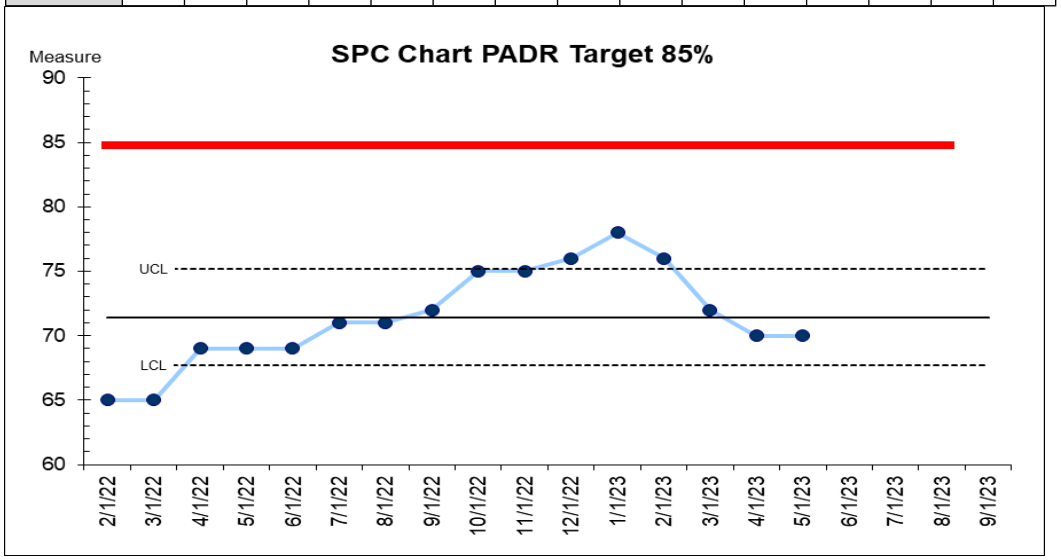
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

VCC Position	Ma 22	Apr 22	My 22	Jun 22	Jul 22	Au g22	Sep 22	Oct 22	No v 22	Dc 22	Jan 23	Fe b 23	Ma r 23	Ap r 23	Ma y 23
Actual %	65	69	69	69	71	71	72	75	75	76	78	76	72	70	70
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows some improvement for the last 15 months but returning to averaging 70%, and consistently falling short of the 85% target.

Performance

Assessment of current performance, set out key points:

PADR compliance has increased slightly this month and is reporting as 70.30%. Compliance remains below the target of 85%.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale	Lead:
Managers in Clinical Audit (25%), CSMO (57.69%), Nursing (59.18%), Pharmacy (53.52%), Private Patients Office (50%), Medical Staffing (63.64%), and Psychology Section (30%) to understand (from BI) who hasn't received their PADR and to ensure these are scheduled to take place as a priority. *To note that some of the areas noted above have low staffing numbers, which is reflecting in the % and in some areas there has been no change or a decrease in compliance from the previous month. Given the target compliance rate is not being met, urgent action is required to increase PADR compliance and other areas, where compliance is not at the target rate should also plan in outstanding PADRs*	31/07/23	Various line managers depending on the area

Expected Performance gain - immediate

Hope to see an improvement in overall compliance and specifically across the areas mentioned above.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	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 KPV.57

Return to Top

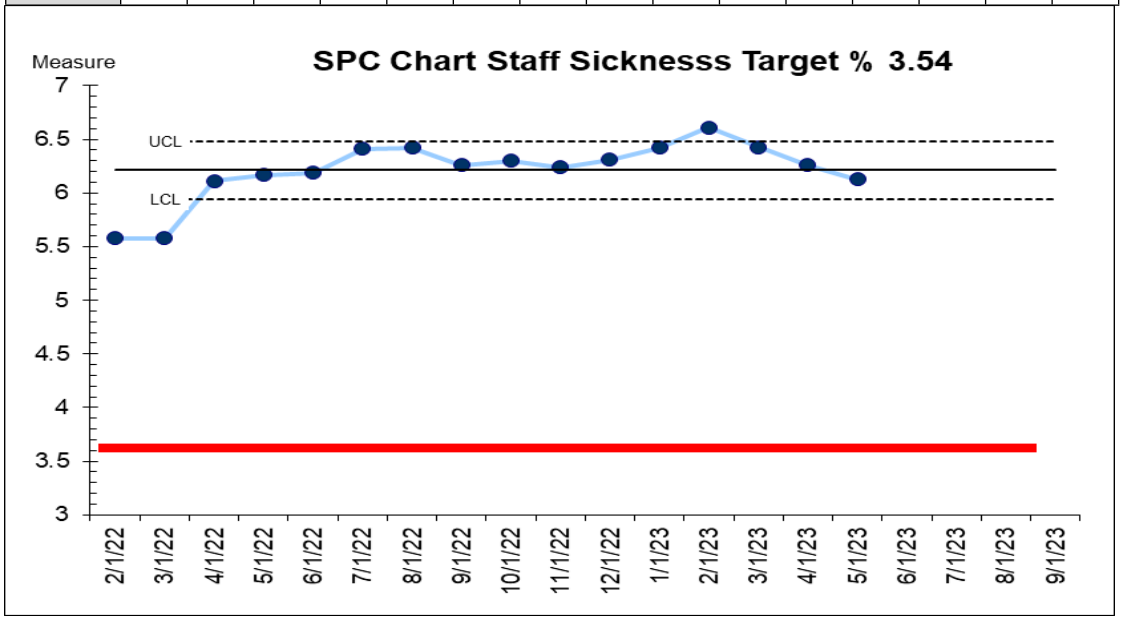
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

VCC Position	Ma 22	Apr 22	My 22	Jun 22	Jul22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	Ma y 23
Actual %	5.58	6.18	6.28	6.19	6.41	6.42	6.26	6.30	6.24	6.31	6.42	6.61	6.43	6.26	6.13
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 6.2% sickness level remaining higher than the 3.54% target

Performance

Assessment of current performance, set out key points:

In month sickness has decreased this month to 4.52%.

Service Improvement Actions – Immediate (0 to 3 months)

Managers in Operational Services (8.44%), Radiotherapy (6.30%) and Nursing (6.61%) to review sickness absence cases in their areas and discuss any actions necessary with the People Team, ensuring that the absences are being managed under the MAAW Policy. *Psychology (16.89%) are also reporting high levels of absence. Given that there are low staffing numbers in these areas, this will impact the % reported, however managers in this area are also asked to review any absences.*	**Timescale:**31/07/23	**Lead:** Various line managers depending on the area

Expected Performance gain - immediate

Reassurance that all sickness absence cases are being managed in line with policy. Monthly KPI meetings with People Advisors to support sickness absence management continue to take place.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

PATIENT EXPERIENCE.

KPI Indicator KPV.11

Return to Top

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

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Performance

VCC	Ma 22	Apr 22	My 22	Jun 22	Jul22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Would you recommend us? %						89	89	88	nda	nda	93	96	95	95	98
Your Velindre Experience? %									nda	nda	84	86	82	82	68
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

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 98% in MaY was due to 55 survey responses to the VCC 'Would you recommend us? CIVICA survey.

44 patients responded to "Your Velindre Experience" CIVICA survey. Of these 44 responses, 28 responded 9/10 and 10/10. 11 patients responded 7 and 8 out of 10, with 5 patients scoring 5 and below. Review of the responses identify

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	SLT
Q+S team to work with each directorate to provide further analysis on responses		Q+S manager
CIVICA working group established with attendees from each directorate		

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 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

VCC	Mar 22	Apr 22	M 22	Jun 22	Jul 22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %					100	100	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

Performance

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 KPV.53

Return to Top

Graph title - Incidents of Violence and Aggression

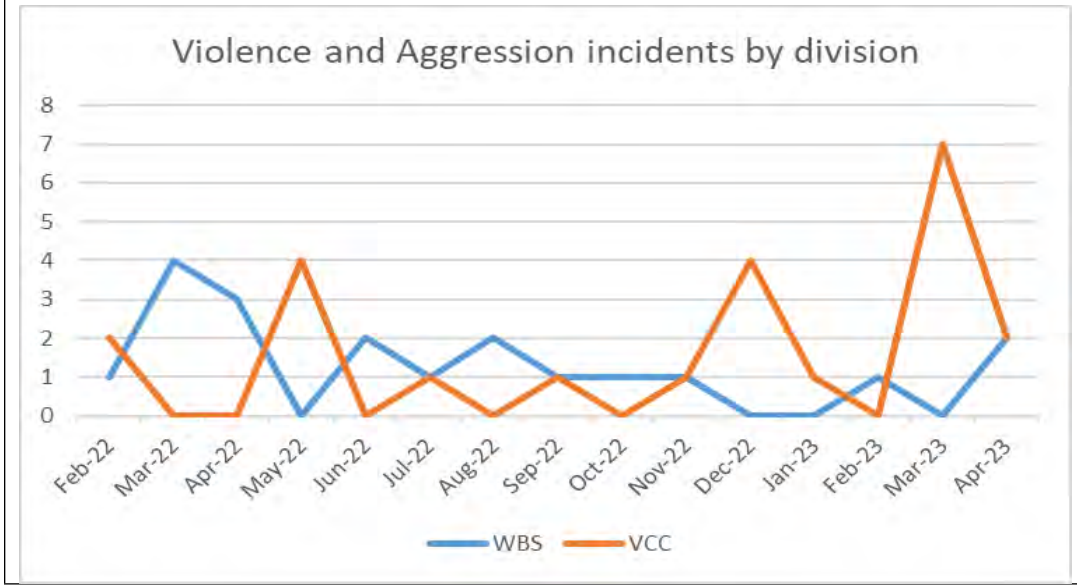
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard –

Performance - Stable

	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	Apr 23	May 23	**Total**
WBS	4	3	0	2	1	2	1	1	1	0	0	1	**0**	**2**	**4**	**24**
VCC	0	0	4	0	1	0	1	0	1	4	1	0	**7**	**2**	**0**	**27**



Service Improvement Actions – Immediate (0 to 3 months)

Incidents at VCC include – 3 incidents of dangerous driving/verbal aggression in car park – **actions** - being reviewed to identify actions, 3 incidents involving a confused patient on FFW, additional training provided for staff, one patient requiring intervention with a behavioural contract, **action** contract issued.	Timescale VCC and WBS safety advisors Q 1 & 2 2023

Expected Performance gain – immediate Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit

Service Improvement Actions – tactical (12 months +)

Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit	H&S Team Timescale :Q3&4 2023

Expected Performance gain – longer-term

Risks to future performance

VCC and Corporate – V&A from patients and families due to treatment delays
VCC management of confused patients on FFW. Aggression in relation to parking pressures.
WBS – verbal aggression from donors.

TIMELINESS

KPI Indicator KPV.14

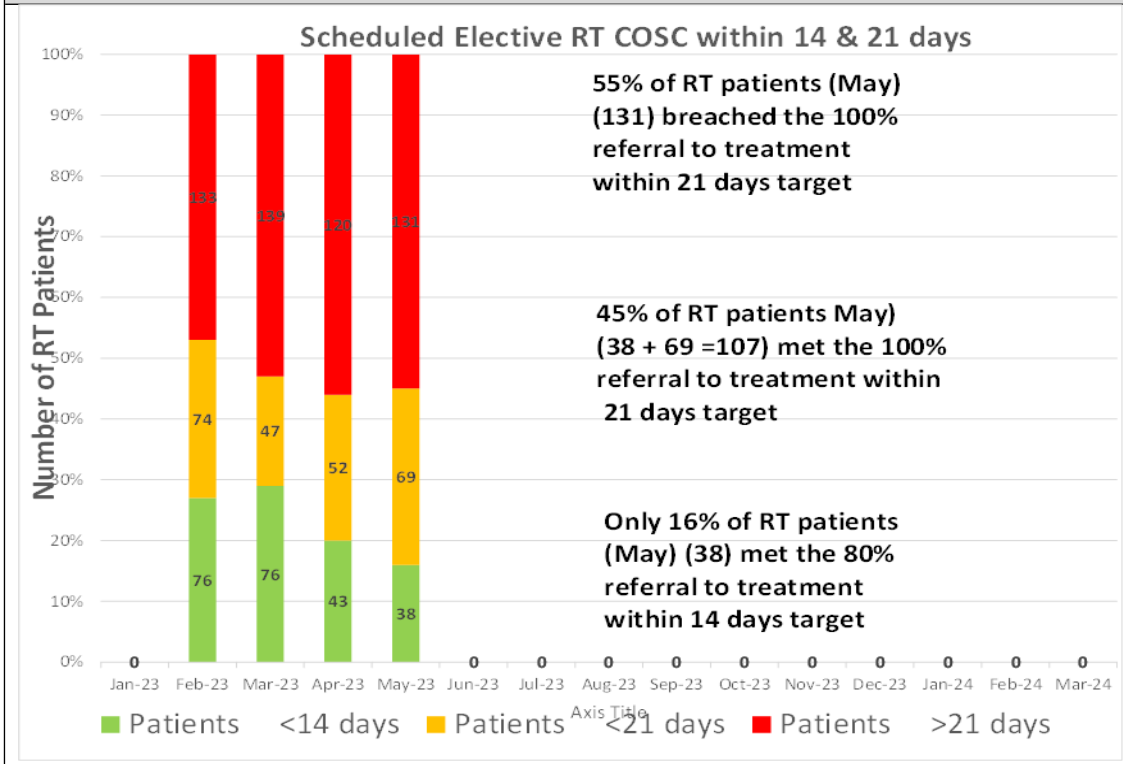
Return to Top

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

Target: 80% within 14 Days and 100% within 21 Days (COSC)

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



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:

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	238	
treated within 14 days of referral (80% target)	38	16%
treated within 21 days of referral (100% target)	107	45%

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. Additional validation resources to be provided.	Commenced and ongoing	Helen Payne
Task and finish group established to provide detailed action plan to address immediate challenges and short term pathway improvements	Commenced plan in place by end of June	Helen Payne 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.	October 2023	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 commenced

KPI Indicator KPV.15

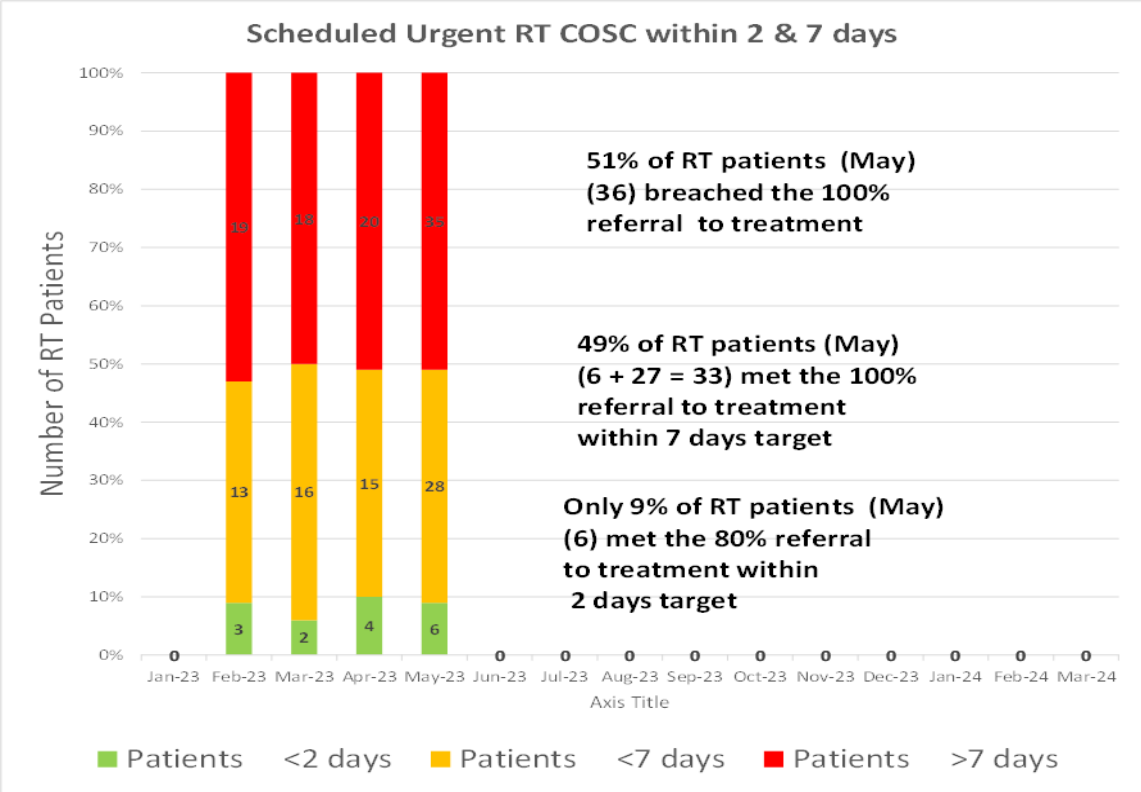
Return to Top

Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)

Target: 80% within 2 Days and 100% within 7 days (COSC)

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



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	67	
treated within 2 days of referral (80% target)	6	9%
treated within 7 days of referral (100% target)	33	49%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve •		

Expected Performance gain – longer-term

Risks to future performance

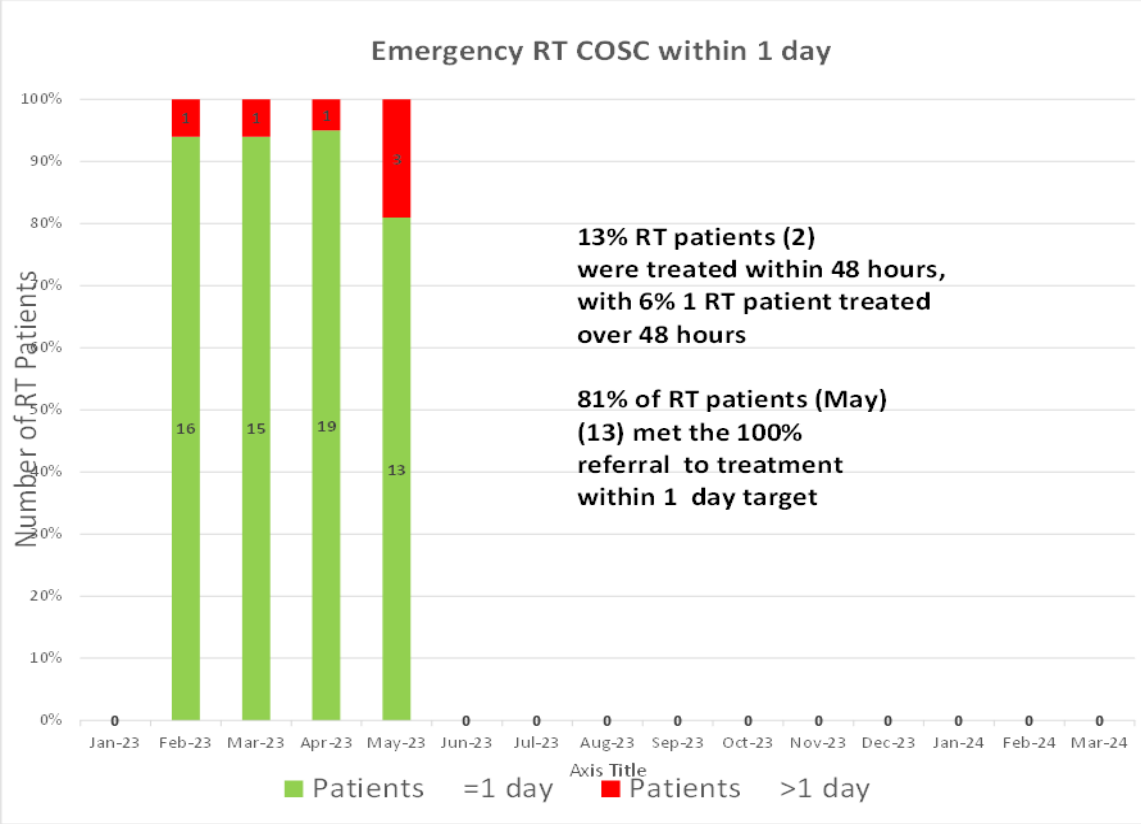
Set out risks which could affect future performance

•

KPI Indicator KPV.16

Return to Top

Emergency Radiotherapy Patients Treated Within 1 Day (COSC)	
Target: 100%	**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:

Target Achieved

Number of referrals	16	
% treated within 24 hours of referral	13	81%
% treated within 48hours of referral	15	94%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve • As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

Return to Top

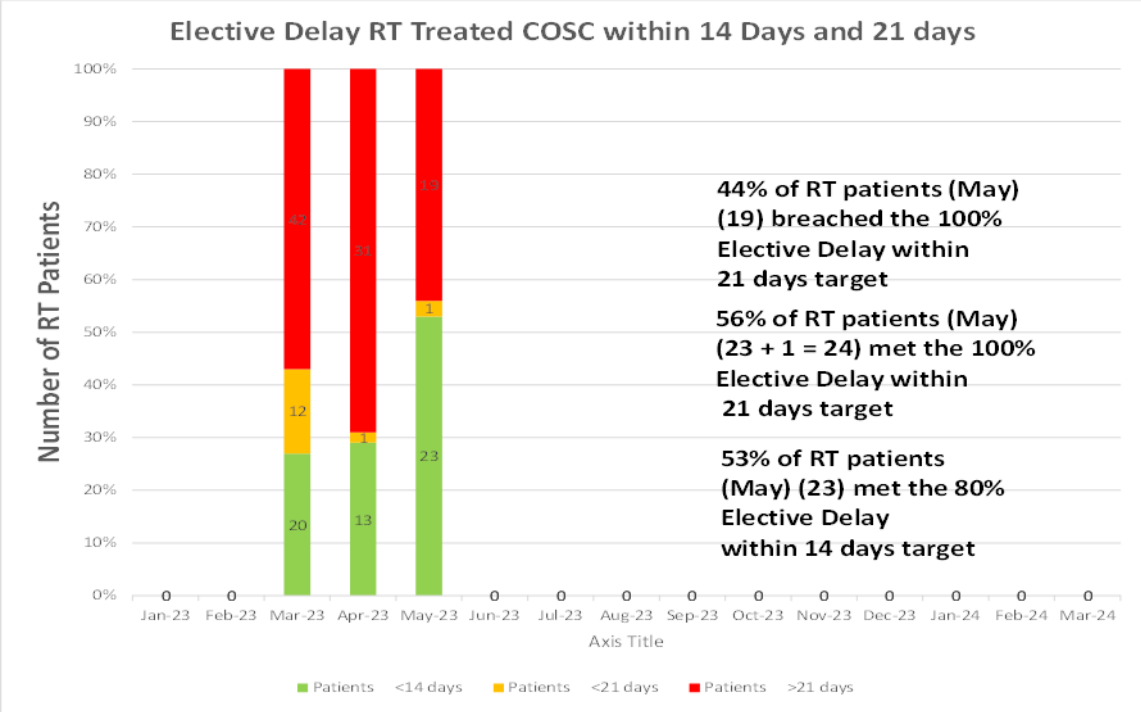
Elective delay Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)

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



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	43	
treated within 14 days of referral (80% target)	23	53%
treated within 21 days of referral (100% target)	24	56%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve • As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve •		

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

	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	Apr 23	May 23
Actual %	71	69	61	59	66	77	89	96	98	96	97	98	98	93	90
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days	118	116	146	147				14	6	12	9	9	8	26	40
Within 21 days	400	375	375	355				341	354	322	336	388	409	343	354

The number of patients scheduled to begin non-emergency SACT treatment in April 2023 (369) was lower than the number in March (409) and may be due to the Easter Holiday period.

	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							

Performance

Of 394 patients treated, 40 patients waited over 21 days = performance of 90%. Target Not Achieved

Intent /Days -	22-28	29-35	36-42	43 da1ys +
Non-emergency (21-day target)	33	5	1	1

19 patients were primarily as a result of booking capacity, 9 were attributed to administrative delays associated with referrals to the PICC insertion service and 7 were day case resource (nurse/pharm).

Service Improvement Actions – Immediate (0 to 3 months)

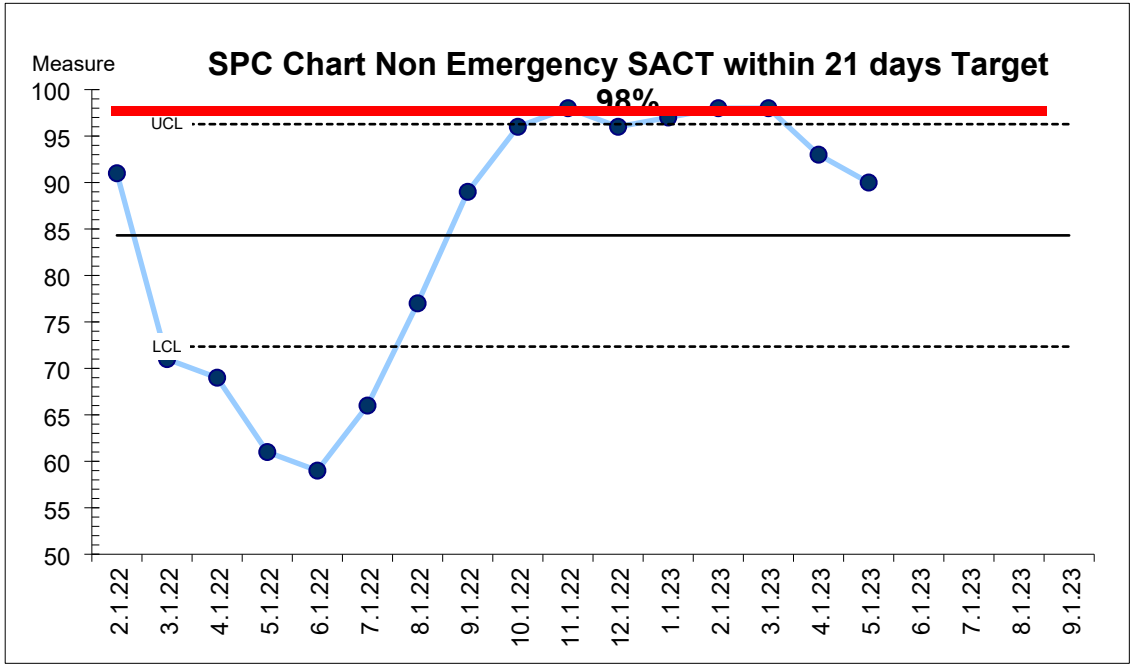
Actions: what we are doing to improve	Timescale:	Lead:
Through DH and CR Ops group, impact assessment to be submitted to increase SACT Treatment Booking Team resource.	21/06/23 01/07/23	BT
Review and confirm resource requirements of PICC service		MW
Continue to progress SACT nurse and booking review recommendations.		BT

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale: 01/08/23	Lead:

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.



SPC Chart Analysis
The system improvements leading to recovery have been maintained over recent months

• Re-determine the impact of continued growth in demand across SACT teams • Determine additional staff resources/ recruitment plan to meet revised forecasts across all staffing groups (nursing, pharmacy and booking teams) • Engage with HB partner to deliver onVCC strategy to deliver care closer to home	**01/09/23**	BT/WJ BT

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Staff recruitment and retention: nursing and pharmacy. Availability of suitably skilled workforce
- Financial ability to recruit ahead of increased demand, in order for training
- Timescales for on-boarding of HB partner outreach locations and available VCC accommodation capacity

KPI Indicator KPV.21

Return to Top

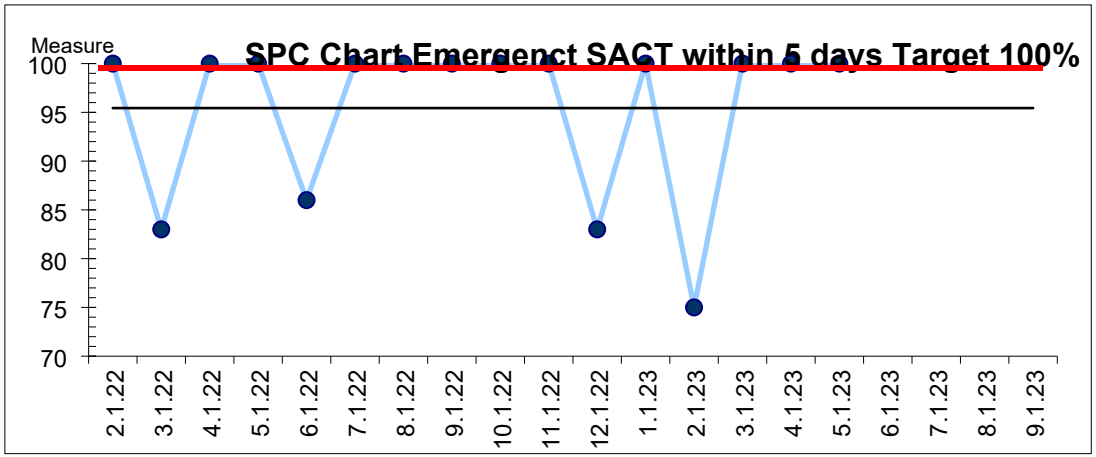
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Ma 22	Apr 22	My 22	Jun 22	Jul22	Au22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual %	83	100	100	86	100	100	100	100	100	83	100	75	100	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	1	0	0	2	0	0	0	0	0	1	0	1	0	0	0
Within 5 days	6	7	9	7			0	5	6	5	8	3		5	0



SPC Chart Analysis

The SPC chart shows a fluctuating process with average 95 % against the 100% target, however note small numbers involved.

Performance

11 patients referred for emergency SACT treatment were scheduled to begin treatment in May 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.	Continuous	BT

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

•

KPI Indicator KPV.22

Return to Top

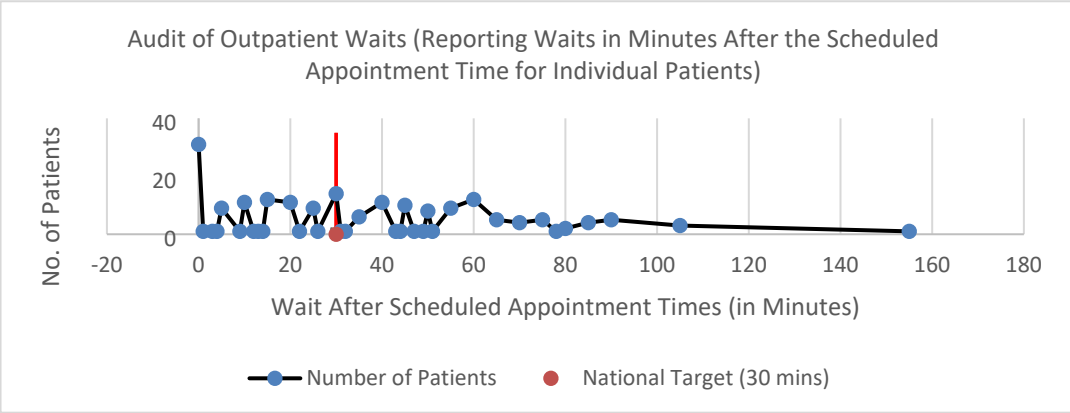
Outpatient Appointments seen within 30 minutes of Scheduled Time

Target: 100%

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

VCC	Ma 22	Apr 22	My 22	Jun 22	Ju l22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual %					70	47	57	68							
Target 100%	100	100	100	100	100	100	100	100							



Performance reported for September 2022 was 57%.
Note: This is based on a sample size of 2% of the total number of patients seen at outpatients in Aug. (305 patients)
Reporting had been paused between December 2021 and June 2022 over concerns regarding the representativeness of the sample size and ongoing discussions to move the data collection to an integral part of outpatient processes. These discussions have not produced a sustainable solution to date.

Performance

Assessment of current performance, set out key points:
Currently paused due to DHCR implementation

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
•	31/12/2022	Head of OSD
	Ongoing	Lead Nurse, OPD

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•	Q1/2 2023	Head of OSD

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.23

Return to Top

Equitable and Timely access to Therapy Services (Dietetics; Physiotherapy; Occupational; SLT)

Target: 100% for all Therapies

SLT Lead: Viv Cooper/Kate Baker

Current Performance against Target or Standard

VCC	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	Apr 23	My 23
Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days															
Dietetics	100	100	100	100	100	96	95	100	100	100	100	100	100	100	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
SLT	100	67	100	100	100	100	100	100	100	100	100	100	100	100	100
Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks															
Dietetics	100	100	100	100	100	100	100	100	98	100	91	100	98	84	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	100	67	100	100	100	100	100
SLT	100	100	100	100	100	100	50	100	100	100	100	100	100	100	100
Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks															
Dietetics	100	100	100	100	100	100	100	100	100	100	100	100	100	96	94
Physio	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
OT	78	100	100	100	100	97	100	78	100	100	96	100	96	100	100
SLT	96	100	100	100	100	96	100	100	100	100	100	100	100	100	100

Performance

For the month of May, breaches occurred for Dietetics

Routine outpatients = x5 breach.

All breaches occurred due to vacancies. We had a turnover of locums, a gap where we lost 2 locums and the start of a new locum. Limited clinic cover meant these patients breached.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Ongoing recruitment to fill vacancies • Review cross cover arrangements within each team. Small team makes cross cover a challenge. • Maintaining locum where possible cover for dietetics while recruitment is underway. • Linking with local Health Boards to see where more joint up working can occur	Ongoing	Head of Therapies

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Assessment of current performance • Developing a Therapies workforce plan		Head of Therapies

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- A current risk is open on the Directorate risk register regarding the challenge of therapies recruitment nationally which is affecting VCC. We prioritise cover on a daily basis. This is particularly affecting Dietetics at present while we hold 2.9wte qualified vacancies in April 2023.
- Securing locum staff with the appropriate skill set is also a challenge.

EFFICIENCY

KPI Indicator KPV.24

Return to Top

Outpatient Did Not Attend (DNA) Rates

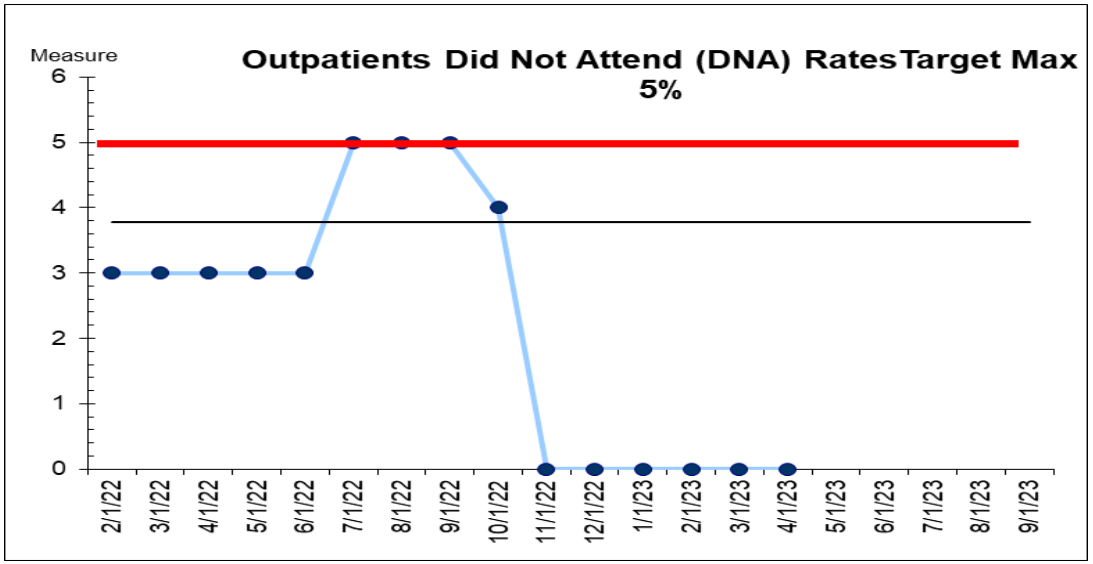
Target: maximum 5%

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

Performance

VCC	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	Apr 23	My 23
Actual %	3	3	3	3	5	5	5	4	nda	nda	nda	nda	nda	nda	nda
Target Max 5%	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5



SPC Chart Analysis

The SPC chart shows common cause variation for the period to October '22 when data was available

Assessment of current performance, set out key points:

Currently paused due to DHCR implementation

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• No actions Required		L Miller

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.62

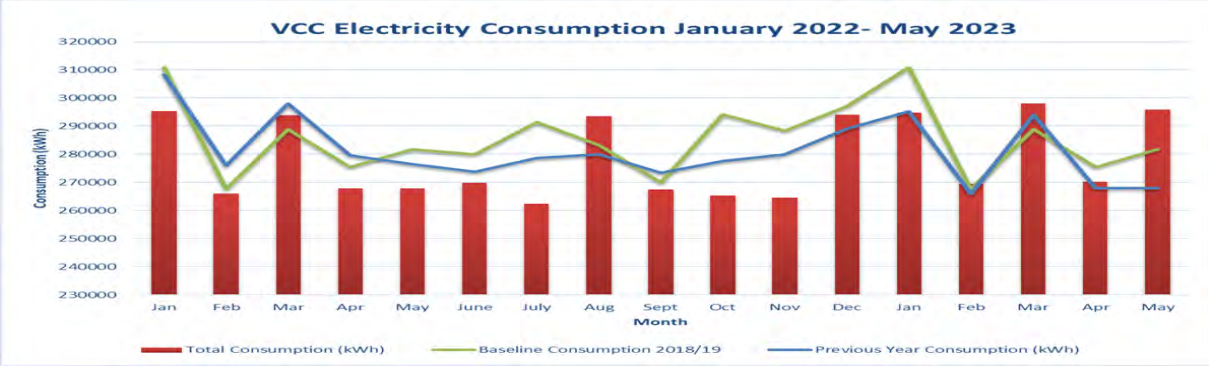
Return to Top

VCC - Energy (Gas and Elect) performance consumption

Target: -2% on 2020/21

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard



Trust Position	Mar22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number (kWh	2939 42.33	2679 27.50	2679 29.50	2699 02.00	2624 87.50	2936 16.00	2674 97.7	2652 45.59	2646 30.40	2940 36.80	2947 87.10	2695 60.00	2980 17.60	2702 09.7	2959 33

Performance

Assessment of current performance, set out key points:

Currently, Electricity and Gas both below 2018/19 baseline consumption target and following similar pattern to previous year.

Gas data continues to decrease due to energy optimisation on ward areas.

Electricity increase due to increase air conditioned units across site.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Electricity - SMART metering installed	3 month	Jon Fear
Gas - Integration of energy performance software (Sigma) to BMS	**3 months**	Milburn Mounter
BMS upgrades	**3 months**	Milburn Mounter

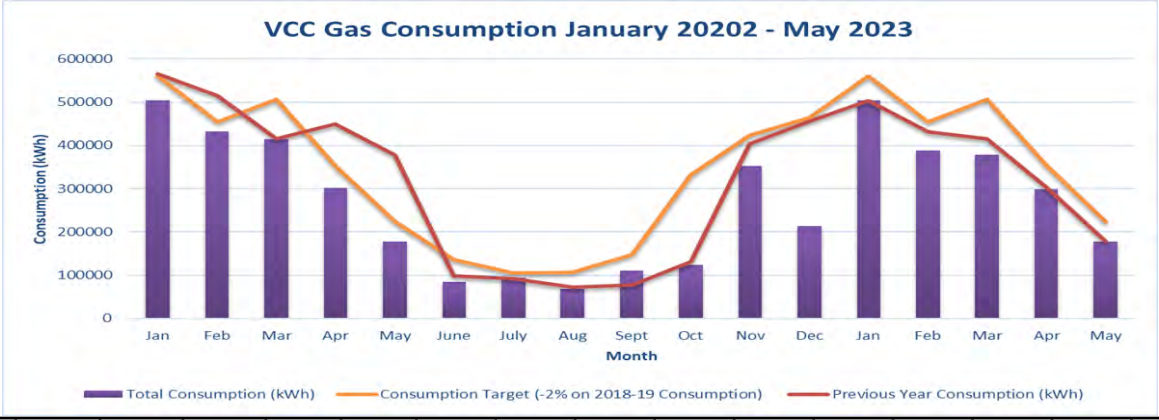
Expected Performance gain - immediate

Continue to monitor energy performance

Promote ways to reduce electricity usage

Service Improvement Actions – tactical (12 months +)

Target number previous year	2920 12.20	2740 46.91	2710 65.26	2682 32.86	2730 81.31	2743 13.66	2679 55.13	2720 50.74	2743 41.89	2833 18.39	2893 76.95	2606 52.95	2880 63.48	2625 68.95	2625 70.91
Target -2%	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**2%**	**-2%**	**2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**



Trust Position	**Mar 22**	**Apr 22**	**My 22**	**Jun 22**	**July 22**	**Aug 22**	**Sep 22**	**Oct 22**	**Nov 22**	**Dec 22**	**Jan 23**	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**
Actual Number (kWh)	41516 1.49	30200 9.08	17811 5.55	8499 5.18	9436 9.57	6760 9.2,	1114 14.96	1236 58.88 ,	3519 83.95	2136 54.29	5039 27.87	3884 74.24	3791 93.76	2990 86.8	1777 94.13

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Metering strategy	**12 months**	Jason Hoskins
Plant optimisation	**12 months**	Jon Fear

Expected Performance gain – longer-term
Continue to monitor consumption, increase metering.
Plant optimisation.

Risks to future performance

Set out risks which could affect future performance
Anticipation of increased electricity usage due to heatwave / increase of air conditioning units.

Target number previous year	406,737	441,204	369,333	96,680	89,534	70,735	76086	128,945	395,764	446,228	494017	423,674	406,858	295968.90	174553.24
Target -2%	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**	**-2%**

KPI Indicator KPV.67

Return to Top

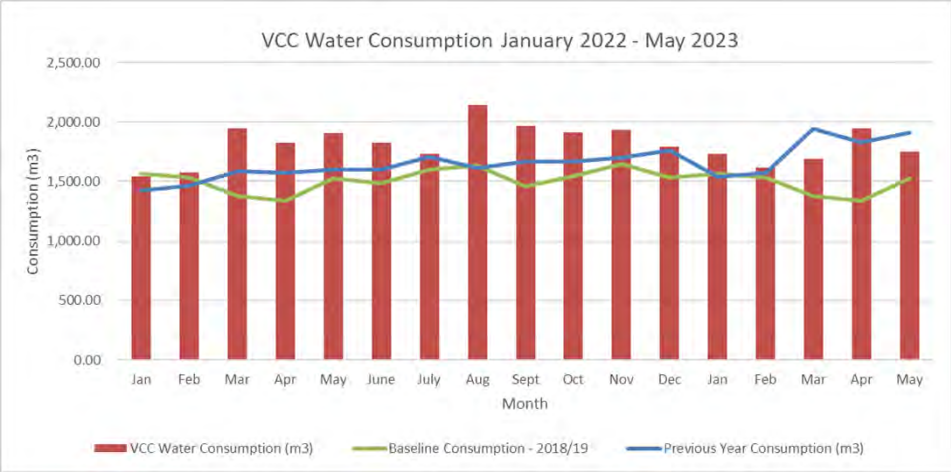
Graph title -Water

Target: Continued monitoring to identify and mitigate trends

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available



If performance is not at required level, set out what the main causes are:
Decrease in May consumption comapred to previous year

- There has been an increase in water consumption at VCC compared to compared to the baseline data due to an increased flushing regime to comply with water safety regulations
- Across all sites there has also been Increased hygiene requirements to comply with IP & C guidance

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Capturing water data at WBS has changed year therefore [previous data is displayed in quarters] Going forward, increased monitoring and integration into the BMS to ensure monthly figures are monitored	3 months	**Matthew Bellamy**
Integrating the water consumption to the BMS at VCC	3 months	**Milburn Mounter**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

• Increased metering across all sites • Dedicated resource to capture the metering	**12 months**	Jason Hoskins

Expected Performance gain – longer-term
Continue to monitor consumption resulting in targeted initiatives and improvements reducing consumption.

Risks to future performance

Increased flushing regimes to adhere to water safety regulations

KPI Indicator KPV.71

Return to Top

Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual £k	14	2	3										
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	0

VCC Revenue reported Position for May 23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	11.753	11.962	0.210	72.971	72.971	0.000
Expenditure						
Staff	8.350	8.430	(0.080)	45.765	45.765	0.000
Non Staff	10.053	10.186	(0.133)	64.210	64.210	0.000
Sub Total	18.403	18.616	(0.212)	109.976	109.976	0.000
Total	(6.650)	(6.653)	0.003	(37.005)	(37.005)	0.000

Performance

The reported financial position for Velindre Cancer Services as at the end of May 2023 was a small underspend of **£0.003m**, and an expected outturn position of **breakeven**.
Income at Month 2 represents an overachievement of **£0.210m**. Overachievement on Private Patients drugs due to activity and VAT savings from delivery SACT homecare is offsetting the divisional management savings target.

VCS have reported a year to date overspend of **£(0.080)m** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave across several services which is largely offsetting both the vacancy savings target and to support posts appointed without funding agreement. The recurrent impact of the pay award is expected to be neutralised when the Trust receives funding from WG.
Non-Staff Expenditure at Month 2 was **£(0.133)m** overspent which is a result of increased activity in a few areas including use of PICC and SACT following treatment returning to Neville Hall.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Quarterly Performance Reviews with each Directorate	30/06/2023	Paul Wilkins

Expected Performance gain - immediate
Opportunities and challenges understood.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Investment process and funding flows linked to contract performance income	Sept 2023	Chris Moreton

Expected Performance gain – longer-term
Identification of resource opportunities and challenges with emphasis on delivering Value Based Healthcare

Risks to future performance

KPI Indicator KPV.72

Return to Top

Usage of Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

VCC Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	874	66	60										
Target per IMTP £0.435M Forecast		99	99	99	39	38	38	8	8	8	0	0	0

Performance

The spend on agency for May 23 was £0.060m, which gives a cumulative year to date position of £0.126m and a forecast outturn position of c£0.655m.

At this stage of the year the division is expecting to reduce the use of agency by transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Radiotherapy Workforce Plan addressing substantive employment	July 2023	Kathy Ikin

Expected Performance gain - immediate

Reduced agency premium

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Sustainable workforce modelling and deployment	Dec 2023	Paul Wilkins

Expected Performance gain – longer-term

Reduced reliance on agency via sustainable workforce

Risks to future performance

Set out risks which could affect future performance

- Workforce market, demand, significant change programmes

KPI Indicator KPV.74

Return to Top

Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

Performance

VCC Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual Cumm	700	40	68										
Target £950k Forecast		40	40	40	92	92	92	92	92	92	92	92	92

VCC Cost Improvement Programme – Target £950k

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes							
Service Workforce Re-design (VCS)	Amber	50	0	0	0	50	0
Establishment Control (VCS)	Green	175	0	29	29	175	0
Pay Controls - Rationalisation of Service	Amber	150	0	0	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	21	21	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	8	8	0	50	0
Procurement Supply Chain (VCS)	Amber	100	0	0	0	100	0
Total Saving Schemes		**650**	29	58	29	650	0
Income Generation							
Expand SACT Delivery (VCS)	Green	200	33	33	0	200	0
Private Patient Income (R) (VCS)	Green	50	8	8	0	50	0
Private Patient Income (NR) (VCS)	Green	50	8	8	0	50	0
Total Income Generation		**300**	50	50	0	300	0
TRUST TOTAL SAVINGS		**950**	**79**	**108**	**29**	**950**	**0**

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.
The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).
Currently several of the schemes are still RAG rated amber with current expectation that these schemes will turn green as the year progresses, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

The procurement supply chain saving schemes is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. The services will continue to collaborate with procurement colleagues in order to identify further opportunities for efficiency savings that are cash releasing.

Work will need to continue with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented, or mitigations put in place to ensure that the Savings target is met for 2023-24.

	Service Improvement Actions – Immediate (0 to 3 months)		
	Actions: what we are doing to improve • Extraordinary Savings meetings with SLT for alternative delivery should targets not be met	**Timescale:** 31/03/24	**Lead:** Paul Wilkins
	Expected Performance gain - immediate Delivery of current savings and planned savings for 23/24 financial year		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve • Delivery of savings and efficiencies under project management, with focus on Value Based Healthcare	**Timescale:** Dec 2023	**Lead:** Paul Wilkins
	Expected Performance gain – longer-term Delivery of efficiencies		
	Risks to future performance		
	Set out risks which could affect future performance • Balance of organisational capacity, demand, and available workforce.		

EQUITY

KPI Indicator KPV.81

Return to Top

% Workforce declared Welsh Speakers in Trust at Level 1

Target: TBA%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	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	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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 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
- insert text

KPI Indicator KPV.78

Return to Top

Diversity of Workforce (Gender) % of Women in Senior Leadership positions

Target: TBA%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	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	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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 KPV.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: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	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	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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 KPV.80

Return to Top

Diversity of Workforce – People with a Disability

Target: TBA%

SLT Lead: VCC Divisional Director

Current Performance against Target or Standard

VCC Position	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	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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

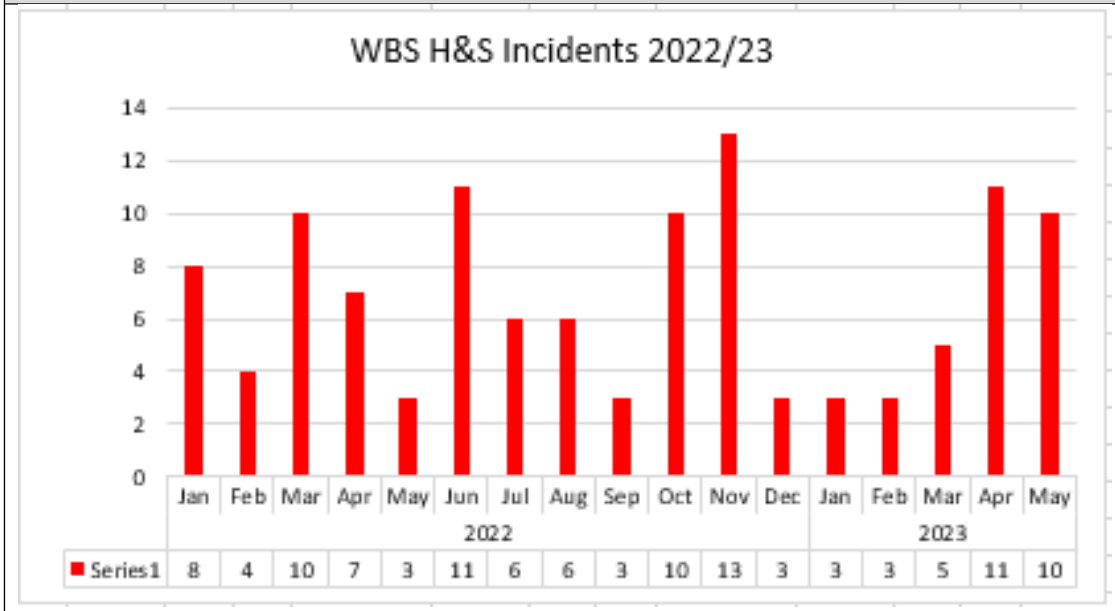
APPENDIX 2: BLOOD AND TRANSPLANT SERVICES

SAFETY

KPI Indicator KPI.57

Return to Top

Health & Safety Total number of incidents by division	
WBS Target: Continued monitoring to identify and mitigate trends	**SLT Lead: Sarah Richards**
Current Performance against Target or Standard – stable	**Performance**



Incidents that relate to Staff/Contractor.

(Include Accident, Behaviour including violence & aggression, Work related ill health, infrastructure inc staffing, facilities, environment, Security/Safeguarding.

excluding non-H&S related incidents, Ill health, non-work related, Infrastructure, including staffing, facilities, environment excluding non-H&S related incidents, fire, & Security.

No discernible trend in incidents that are reported at WBS. Mainly reported from Collection teams. However, incident reporting rates are at a good level enabling us to monitor and investigate H&S incidents that may occur.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale :**	**Lead:**
H&S and Environmental Compliance Manager at WBS continuing to monitor and work with relevant sections to investigate incidents. Continue to monitor incident data at divisional and Trust H&S meetings. Report Incident numbers and categories to SMT – monthly. Identify trends and actions to mitigate trends. Ensure incidents investigated, lessons learned & actions implemented.	Ongoing	Trust and divisional H&S Env Compliance Manager

Expected Performance gain - immediate

Continue to monitor incidents. Embed Investigation training organized by Q&S.
Embed use of Datix Investigation module.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale :**	**Lead:**
Continue to encourage / promote incident reporting. Ensure that investigation training organized by Q&S is embedded long term for H&S incidents. Embed training long term in use of Datix system. Monitor incident data at divisional and Trust H&S meetings. Continue to identify trends and actions to mitigate. Proactive improvement in management of H&S use of HSG65 audit & staff training.	Ongoing	Trust and divisional H&S Managers

Expected Performance gain – longer-term

Continue to monitor incidents highlight problems and focus on these to prevent re-occurrence of incidents. Embed long term Investigation training organized by Q&S leading to

	improved investigation of incidents, identification of lessons learned and prevention of reoccurrence of incidents. Embed use of Datix Incident reporting module.
	Risks to future performance
	N/A

KPI Indicator KPI.11

Return to Top

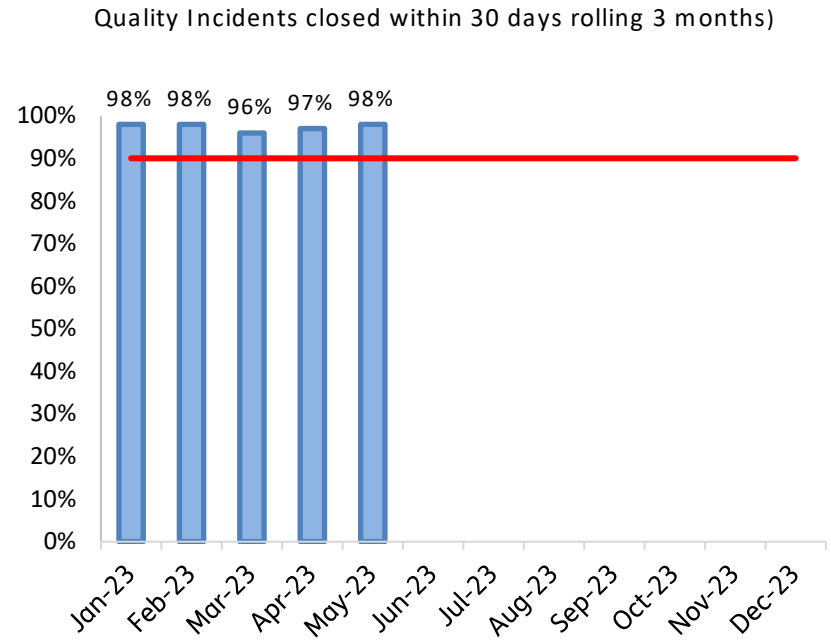
% Quality Incidents (recorded in DATIX & QPulse), closed within 30 days over a rolling 3-month period

Target: 90%

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	85	86	86	98	99	98	98	97	96	96	98	98	96	97	98
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:
Quality incident investigations continue to exceed the target of 90% closed within 30 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale	Lead:
Continue to closely monitor performance. Each incident report is reviewed within a working day of being reported ensuring effective risk assessment and investigation detail is captured. The review identifies complex investigations that may need multi-disciplinary support to establish a root cause.	Every incident reported is reviewed within 1 working day of being reported	Peter Richardson

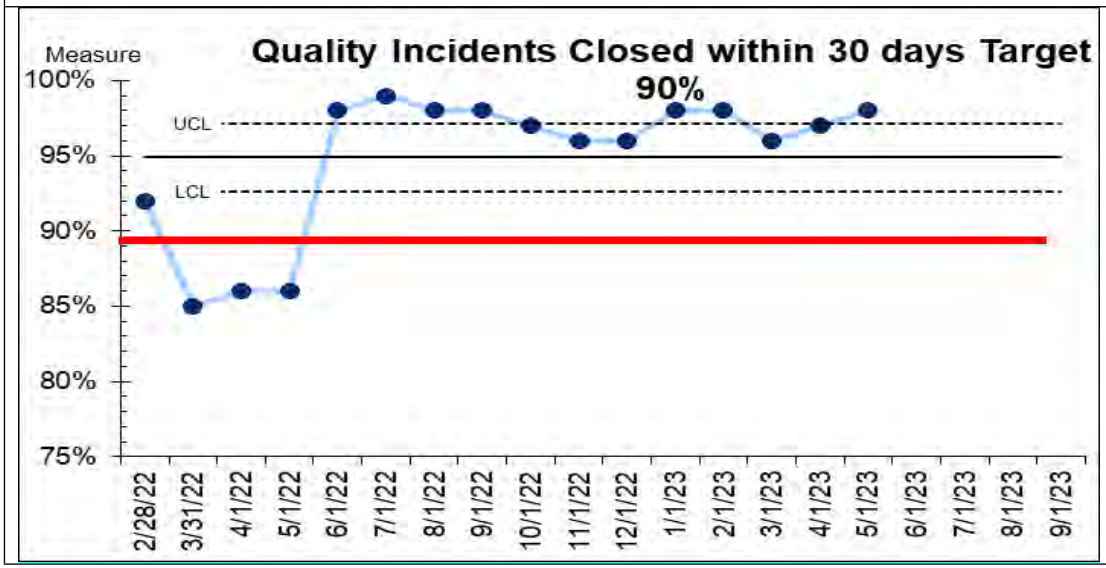
Expected Performance gain - immediate.
We expect the multidisciplinary approach to investigating complex incidents to enable faster identification of root cause and more effective preventative action to be put in place.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Close monitoring of actions to address incidents. The QA Triage Team have changed the day they issue weekly updates alerting owners/managers of actions that are likely to breach close-out deadlines.	Weekly updates	Peter Richardson

Expected Performance gain – longer-term.
Performance is on target and will be continued to be monitored.

Risks to future performance

	Set out risks which could affect future performance. • Anticipated short-term absence of key QA staff during Q1 may impact our ability to prepare for the MHRA inspection due in Q2. The QA team are working with other operational teams to free up suitably experienced staff should it be needed.
	**SPC Chart Analysis** The SPC chart shows common cause or normal variation over a 12 month period. The average performance of 95% consistently exceeding the 90% target.

KPI Indicator KPI.30

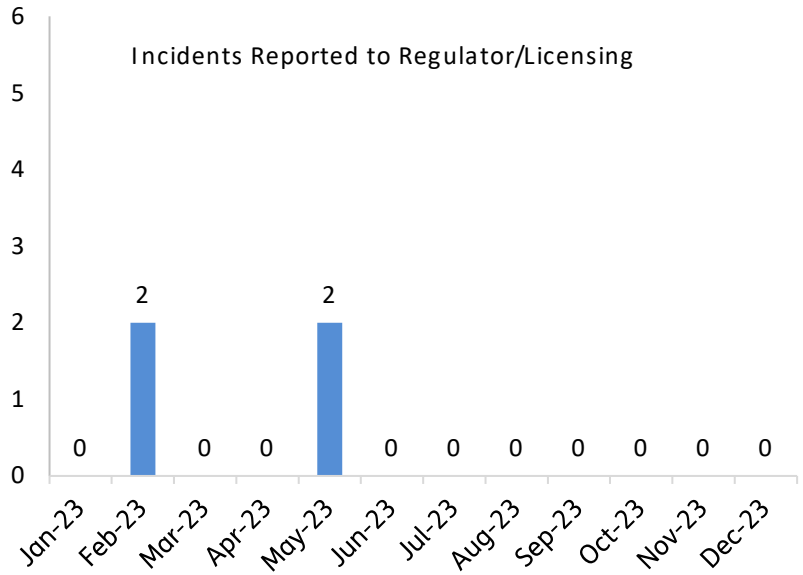
Return to Top

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

Target: NIL

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual	0	3	0	0	1	1	0	0	0	2	0	2	0	0	2
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SLT Lead: Peter Richardson

Performance

Assessment of current performance, set out key points:
There were two reportable events submitted to the MHRA in May:

• **SABRE-106 (02/05/2022) "Malaria residency not assessed correctly"**
At a recent collection session, a donor's malarial residency status was correctly assessed, and a malaria test sample was taken at donor screening. However, the digital donor record was incorrectly updated, this triggered an investigation. It was subsequently established that the donor's malaria residency was incorrectly assessed on two previous occasions.

This presents a risk that the donor tests for malaria at previous donations could have been positive, potentially resulting in contaminated blood components entering the supply chain.

• S**ABRE 107 (22/05/23): "Contingency Issue PC (CIPC) used to issue unreleased platelet."**

The CIPC procedure was incorrectly used and resulted in a Potential "near miss" - if the platelets were needed for an urgent transfusion they could have been transfused before the bacteriology results were known; this may have had an adverse patient impact if bacterial growth had occurred.

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 is monitored via monthly reporting into RAGG.	Peter Richardson

Expected Performance gain - immediate
N/A

Service Improvement Actions – tactical (12 months +)

	Actions: what we are doing to improve Actions will be introduced as outcome of root cause analysis of these incidents.	**Timescale:**	**Lead:**
	Expected Performance gain – longer-term N/A		
	Risks to future performance		
	N/A		

KPI Indicator KPI.32

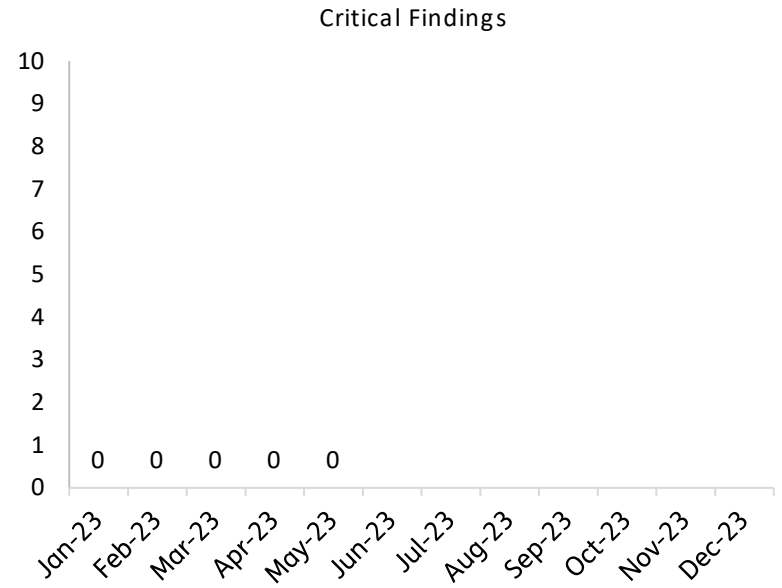
Return to Top

Numbers of critical and major non-conformances through external audits or inspections

Target: NIL

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SLT Lead: Peter Richardson

Performance

Assessment of current performance, set out key points.
A UKAS inspection of 17043:2010 occurred on 19/05/23, no major findings were raised.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Audit schedule for 2023/24 has been completed and risk assessed. All findings in forthcoming audits will have a CAPA assigned to ensure continuous improvement. Information Governance Audits of the respective WBS Departments has commenced.	March 2024.	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		

Expected Performance gain – longer-term
N/A

Risks to future performance

Anticipated short-term absence of key QA staff during Q1 may impact our ability to prepare for the MHRA inspection due in Q2. The QA team are working with other operational teams to free up suitably experienced staff should it be needed.

KPI Indicator KPI.59

Return to Top

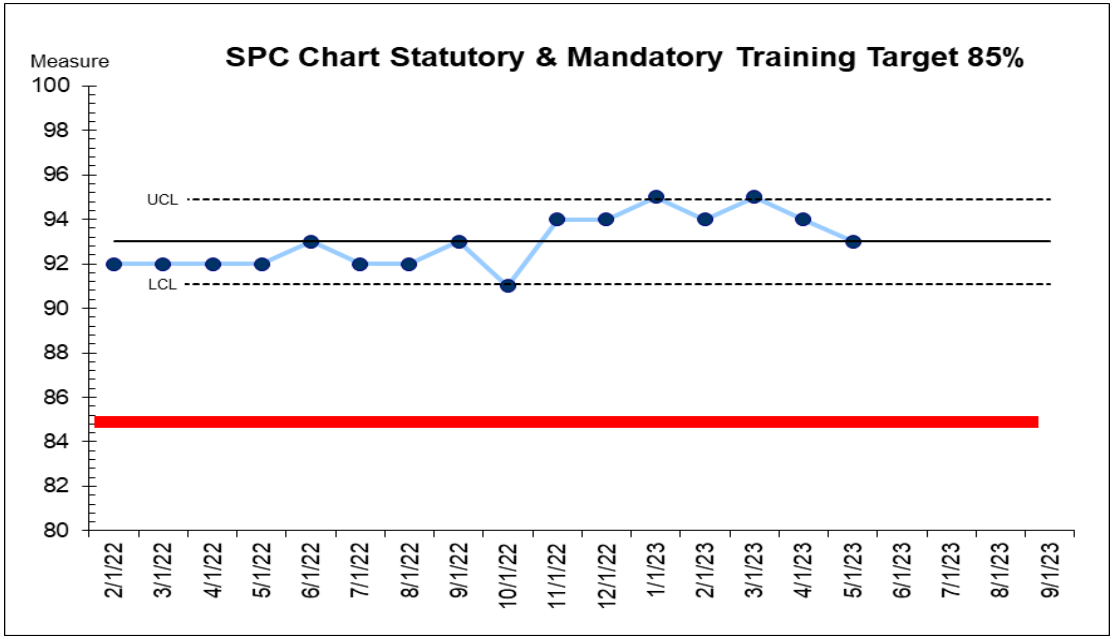
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	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	Apr 23	My 23
Actual %	92	92	92	93	92	92	93	91	94	94	95	94	95	94	93
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 92.5% against the 85% target.

Performance

Assessment of current performance, set out key points:

Statutory & Mandatory (S&M) target compliance is being met.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
WOD provides WBS SMT with monthly compliance data to show progress against target. Where figures decrease, the service will decide what action to take.	Monthly ongoing	Senior People & OD Business Partner

Expected Performance gain - immediate

All staff are compliant and appropriately trained in their roles.

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 S&M and compliance framework in the All Wales network.	Continuous	Head of OD
The WBS Senior Business Partner will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Continuous	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.

Risks to future performance

Set out risks which could affect future performance

Recruitment and sickness levels may affect staffing levels and ability to release staff to undertake training.

KPI Indicator KPI.54

Return to Top

Number of Staff RIDDOR Incidents, injuries and work-related accidents

Target: NIL

SLT Lead: Sarah Richards

Current Performance against Target or Standard

WBS Position	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	Apr 23	My 23
Actual	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

Performance

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

No RIDDOR reportable incidents reported for WBS since January 2022. Number of RIDDOR reportable incidents remains low. No discernible trends.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Ongoing monitoring, investigation and mitigation of incident.	Ongoing	WBS H,S&Env Compliance Manager

Expected Performance gain - immediate

Continue without H&S incidents and report RDDOR related incidents.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to monitor RIDDOR incidents.	Ongoing	WBS H,S&Env Compliance Manager

Expected Performance gain – longer-term

Continue with low numbers of RIDDOR incidents. H&S inspections on WBS sites and venues to identify hazards that may cause incidents of near misses. Ensure that these are mitigated.

Risks to future performance

Set out risks which could affect future performance

Staffing pressures could impact on overall Health and Safety Performance.
Limited control over RIDDOR incidents, can only carry out H&S inspections and audits to highlight the hazards, mitigate and try to prevent RIDDOR incidents occurring.
If a RIDDOR incident occurs investigate and implement measures to prevent re-occurrence.

EFFECTIVENESS

KPI Indicator KPI.04

Return to Top

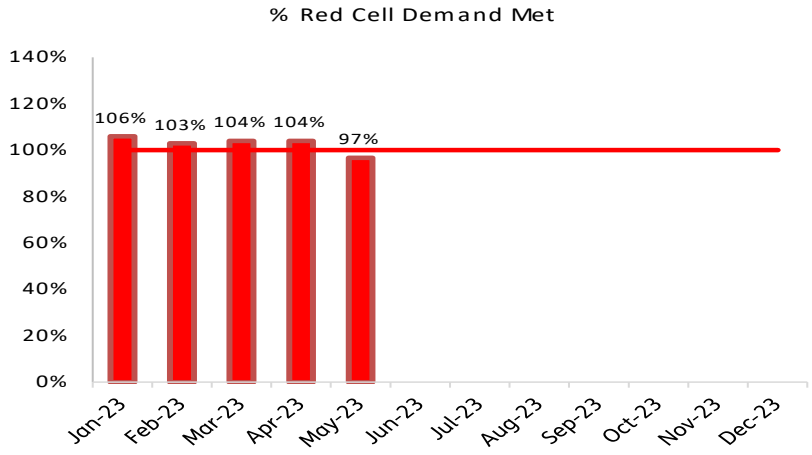
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	100	102	102	100	107	112	105	115	115	94	106	103	104	104	97
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

May contained three bank holidays which provided less bleed days for the manufacture of red cells, resulting in 97%.

April was used to build stock in preparation for May bank holidays, therefore, all clinical demand was met. No mutual aid was required.

Demand (full weeks) averaged at 1413 units per week which is slightly higher than the previous period.

Service Improvement Actions – Immediate (0 to 3 months)

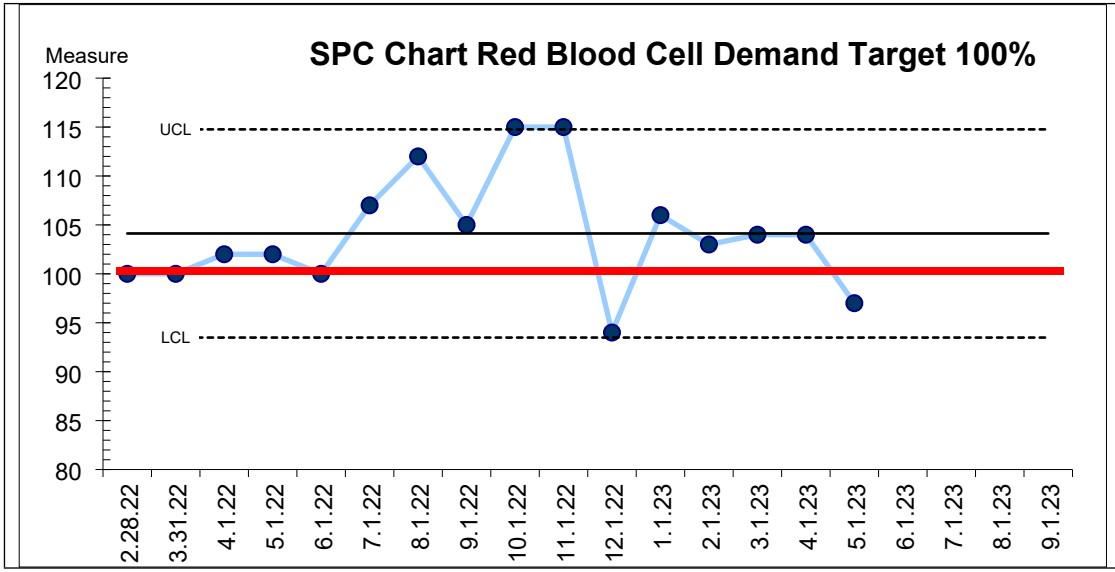
Actions: what we are doing to improve	**Timescale:**
The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain. At the meetings, business intelligence data 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.07

Return to Top

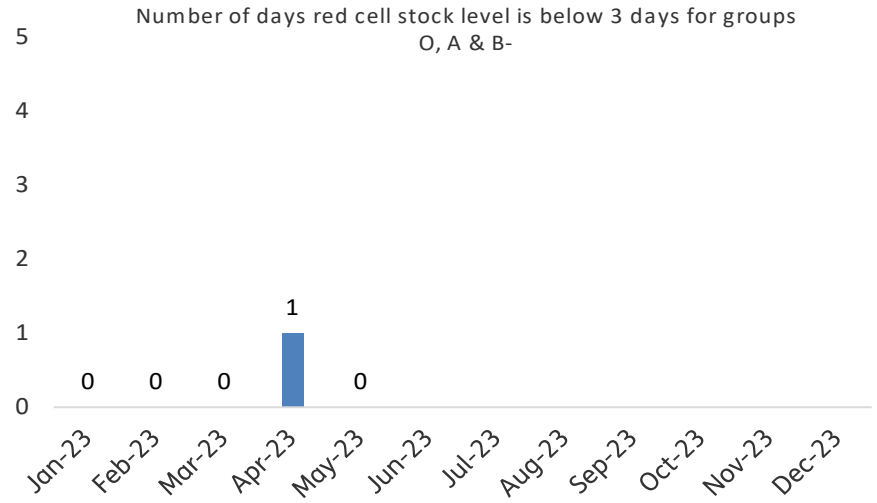
Red Blood Cell Stock Level (below 3 days) – number of days in the month when red cell stockholding fell below 3 days for blood groups O, A and B+

Target: zero days

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual	0	0	0	4	6	0	0	0	0	0	0	0	0	1	0
Target (days)	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 days in May where stock for Blood Groups **O, A & B-** fell below 3 days:

A Blue Alert for **A -** was declared on 25th May 2023 and was in place for one week to protect stocks and allow recovery of the stock position. This does not impact clinical use of blood.

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' meeting. At the meetings, business intelligence data is reviewed which facilitates operational responses to the challenges identified.	Daily Business as Usual (BAU) **Lead:** Tracey Rees

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.	Daily **Lead:** Alan Prosser

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).

KPI Indicator KPI.05

Return to Top

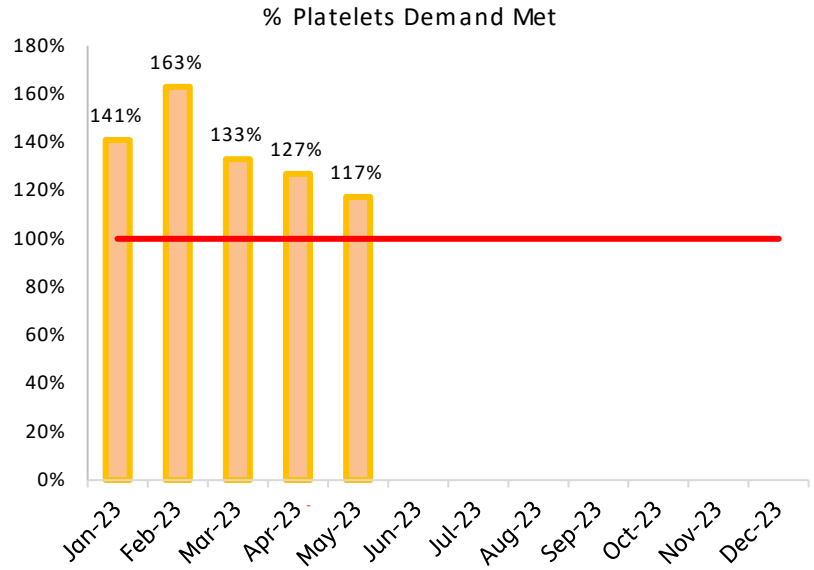
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	125	150	125	128	145	164	132	126	139	145	141	168	133	127	117
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

Assessment of current performance, set out key points:
All clinical demand for platelets was met representing a strong performance against this metric. Platelet demand was 170 units per week on average. This is higher than the previous period, with the May bank holidays added considerable challenge to meeting this performance target.

Service Improvement Actions – Immediate (0 to 3 months)

Daily monitoring to alter production as required	**Lead:** Tracey Rees Daily - BAU **Timescale:** **Tracey Rees Timescale**

Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs.

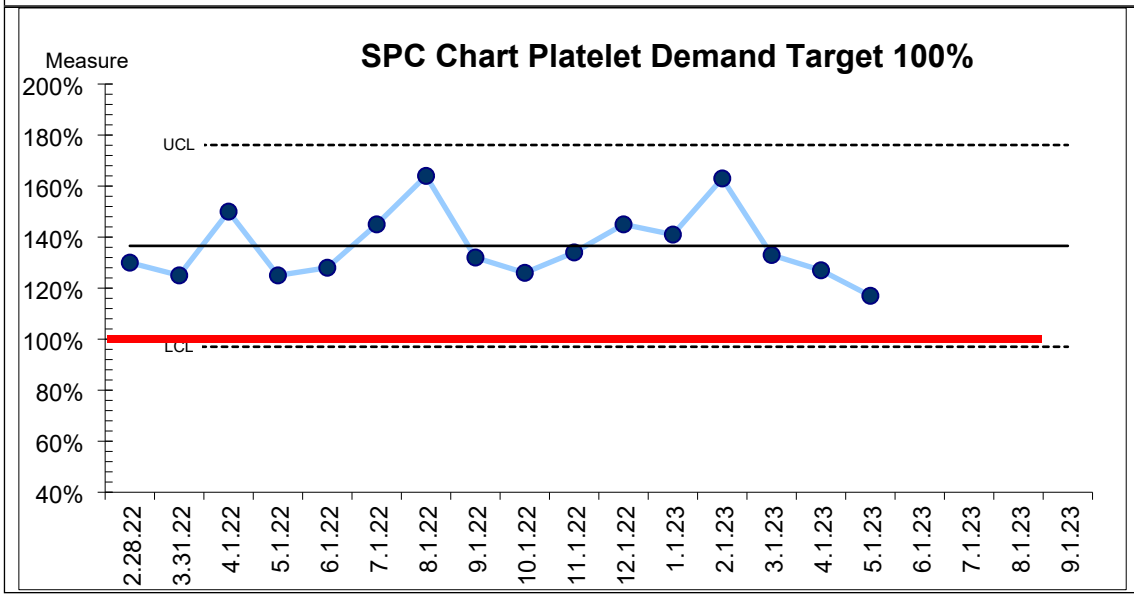
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve A focus on balance of aphereis versus pooled platelets and timing of aphereis clinics will be conducted as part of the WBS futures programme under Labortory Modernisation. Consideraton of a digital tool to enable prediction/requirement for platelet production will also be include	**Timescale:** Dec 2023 **Lead:** Tracey Rees

NB: A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.

Expected Performance gain – longer-term.
Optimised clinic collection plan for Apheresis and a forecasting tool to inform decisions around pooled platelet manufacture.

Risks to future performance
Fluctuations in platelet demand.
Impact of industrial action on availability of sufficient platelet supply to meet demand (ongoing).



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 140% consistently exceeding the 100% target.

KPI Indicator KPI.25

Return to Top

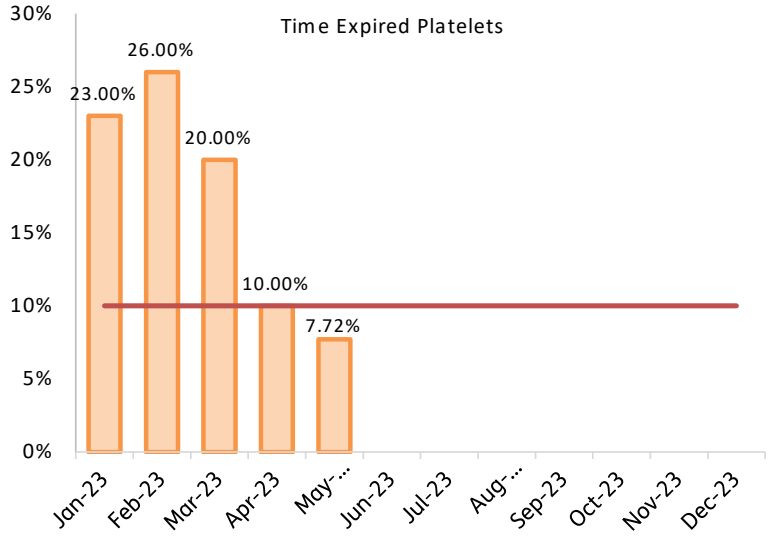
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	14	16	15	23	19	30	25	14	15	27	23	25	20	10	8
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



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 expiry improved and met target in May because of the changes to production made in April. Whilst the May bank holidays provided a significant challenge in balancing supply and demand, expiry levels were controlled by modelling expected issues against production in platelet manufacturing.

NB:

- Platelet expiry is based on a % of production, as platelet production reduces, the % contribution to expiry for each individual platelet increases.
- Production is set at 165 per week on the basis that the average demand was impacted by a single exceptional week. This was amended for bank holiday weeks.

Service Improvement Actions – Immediate (0 to 3 months)

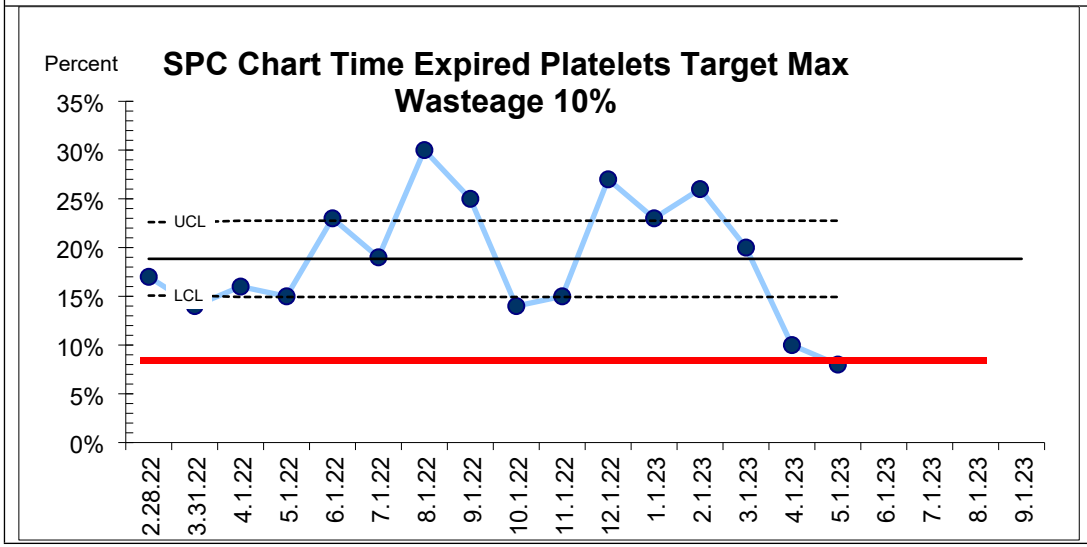
Actions: what we are doing to improve	Lead / Timescale
a. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings.	**Lead:** Tracey Rees **Timescale:**
b. Pooled platelet reductions have been implemented and are being reviewed as a measured approach to the declining demand trend.	Daily (BAU)
c. 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. This will sit under the WBS Futures Initiative under the Lab Services Modernisation Programme.	June 2023
d. Develop a forecasting tool to inform decisions around pooled platelet manufacture (Task & Finish Group 1). This action has been delayed due to insufficient capacity within the Business Intelligence Team.	Q2 - TBC

Expected Performance gain – immediate.

Controlled platelet production leading to reduced wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
Reviewing the clinic collection pan for Apheresis (Task & Finish Group 2) to ensure the clinic times are optimised to reflect changes to 7-day platelet expiry.	Qtr 2 & 3 onwards

	Embedding the demand planning tools for platelets into routine practice.	**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 - noting unexpected spike in demand may require imports. Future Bank holidays.	
	**SPC Chart Analysis** The SPC chart shows fluctuating special cause variation over 4 of the last 6 month period, with the beginnings of a favourable trend over the last four months. The average performance of 18% remains above the maximum wastage limit of 10%.	

KPI Indicator KPI.26

Return to Top

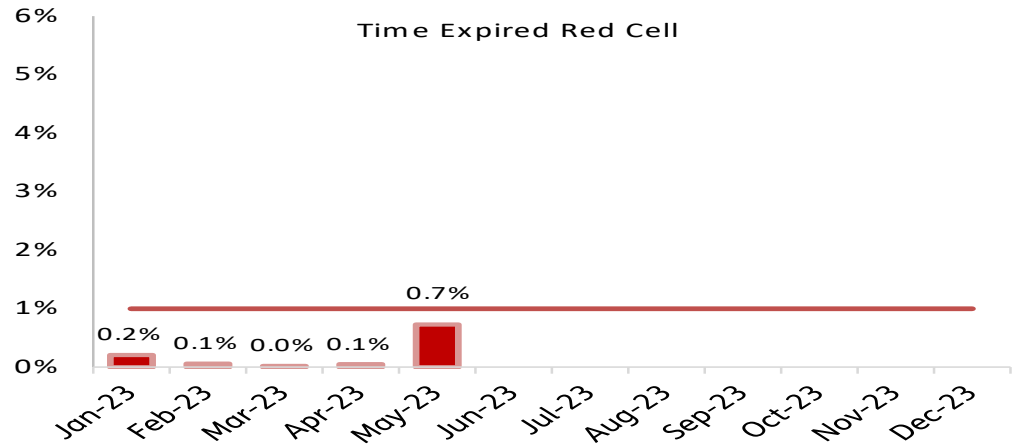
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	0.08	0.08	0.00	0.02	0.01	0.03	0.35	0.01	0.33	0.36	0.21	0.05	0.02	0.05	0.7
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.

The expiry rate increased in May due to Group **B+** units stock exceeding demand.

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

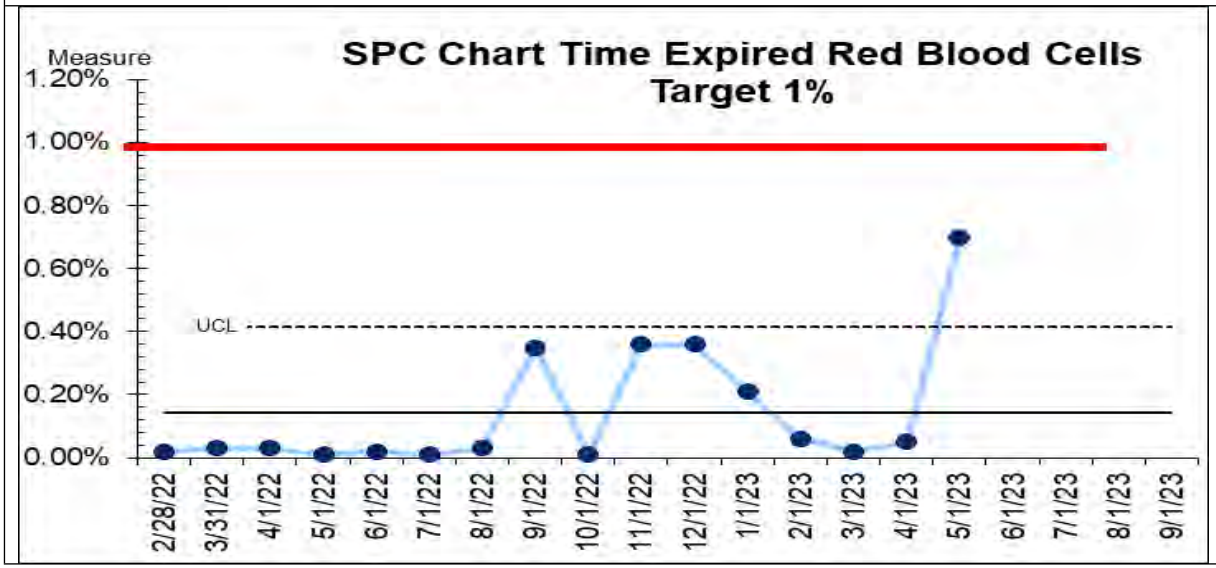
Expected Performance gain - immediate.
Continued effective management of blood stocks to minimise the number of wasted units.

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 common cause variation over the last 6 month period, with one 'special cause variation' in the month of May. However, the average performance of 0.10% remains well within the maximum 1%

KPI Indicator KPI.13

Return to Top

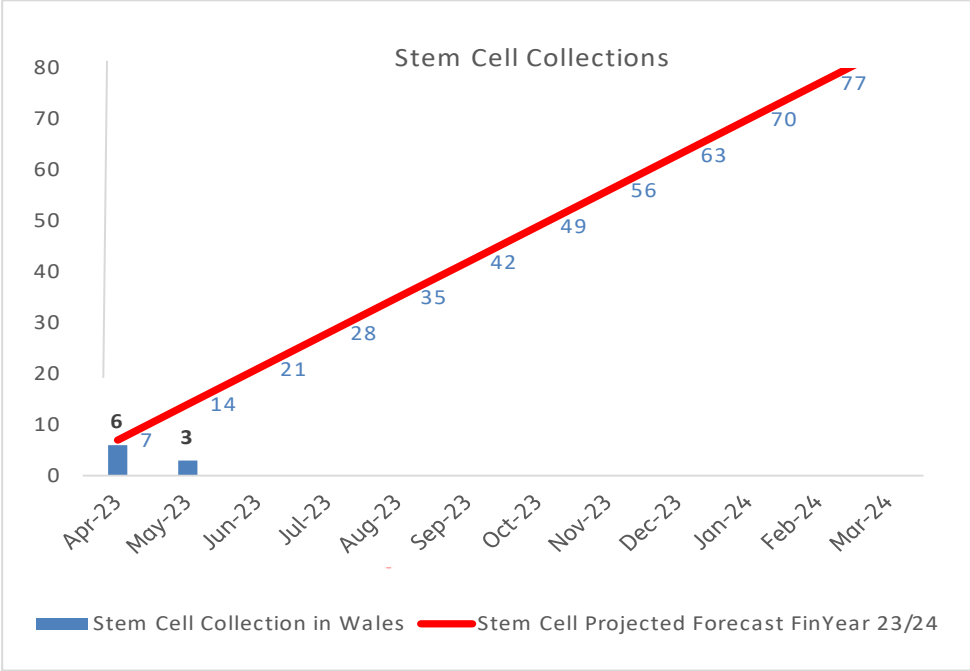
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Cumulative Actual	47	1	2	8	8	12	14	14	15	19	23	26	32	3	6
Cumulative Target p/a	80	7	14	20	27	34	40	47	54	60	67	74	81	7	14



Performance

3 collections were performed during May. 2 collections were cancelled for patient reasons and 2 for donor reasons.

The total stem cell provision for the Service was 4, made up of 3 collections and 1 imported for a Welsh patient.

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.

NB: Projected Forecast detail does not include stem cells collections sourced globally for patients in Wales.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:** / **Lead:**
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	**Timescale:** Qtr 1 **Lead:** Tracey Rees

	Expected Performance gain - immediate. As above
	Service Improvement Actions – tactical (12 months +)
	Implementation of the five-year strategy. — **Timescale:** Qtr 2 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 KPI.19

Return to Top

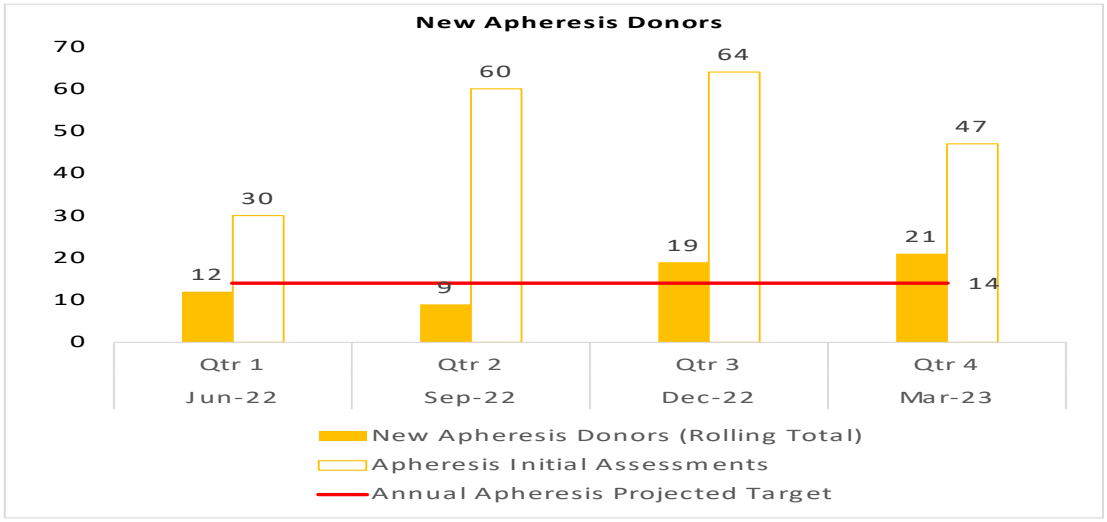
Number of New Apheresis Donors 14 per quarter (+56 per annum)

Target: 14 per quarter

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Quarterly Actual	12			9			19			21					
Quarterly Target	14			14			14			14					
Cumulative Actual	12			21			40			61					
Cumulative Target 56 pa	14			28			42			56					



Performance

Assessment of current performance, set out key points:

All demand for apheresis derived platelets has been met. There were 21 new apheresis donors in Quarter 4, as reported in March 2023. This was 7 above the quarterly recruitment target of 14 and 5 above 56 as the 2022/23 target with 61 new apheresis donors. Low platelet demand continues at present, with apheresis activity focused on special bleeds provided by existing donors.

All demand for apheresis derived platelets has been met.

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** **Q2 2023/24**
Incorporate recruitment requirements into Platelet Strategy programme of works	**Lead:** Jayne Davey

Expected Performance gain – longer-term

Sustained growth in apheresis panel.

Risks to future performance

Capacity to release staff for enhanced training.

KPI Indicator KPI.27

Return to Top

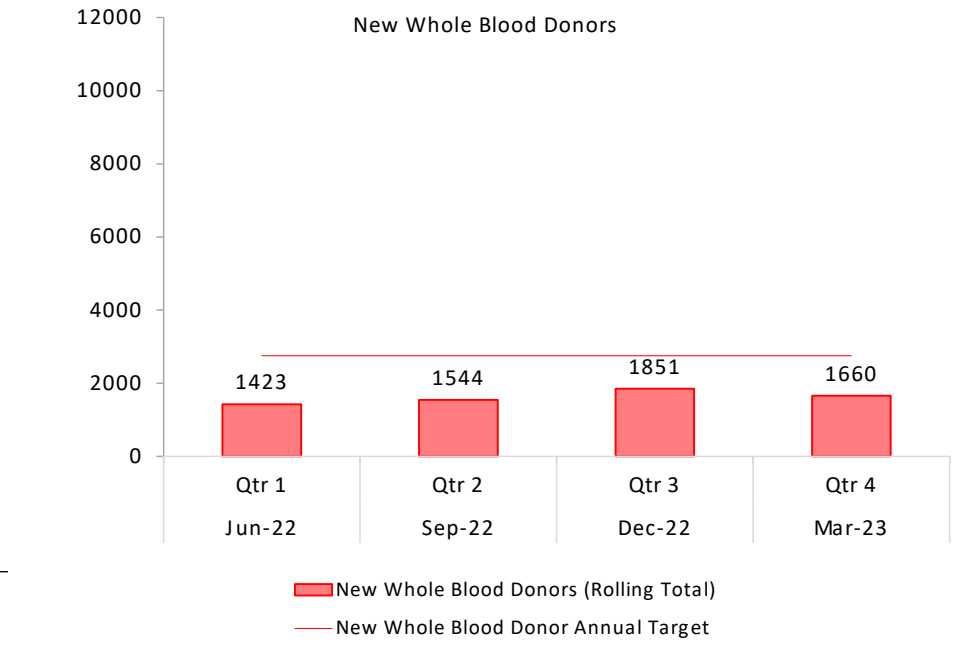
Number of New Blood Donors (2750 per quarter) recruited to the Donor Panel

Target: 11000 per annum

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23
Quarterly updated	**1423**			**1544**			**1851**			**1660**					
Cumul-ative Target 11000 p/a	2750			5500			8300			11000					



Performance

Assessment of current performance, set out key points:

At 6,478, new donor figures did not meet the annual target of 11,000 for the 2022/23 financial year.

The requirement to intensify 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, inhibited the recruitment of new donors.

In addition, campaigns to optimise appointment uptake left fewer appointments for new donors, due to their unknown blood type status. At 90.6%, appointment uptake from existing donors was above target for 2022/23. However, this success provided less opportunities for non-donors to book their first donation.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve:	**Timescale**
Creating a new community partnership targeting donations made through their 'workplaces', in consideration of the new business world post-COVID with more staff working from home.	By June 2023 **Lead:** Andrew Harris

Expected Performance gain – immediate.

Making potential new donors aware of the opportunities to donate around them and encouraging organisations to educate staff on WBS.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale**
Donor Strategy is in development which aims to increase opportunities for both young donors and ethnic minority donors to give blood.	2024-2027 **Lead:** Andrew Harris

	There is a planned increase in clinics to be held at education settings in 2023/24.	**Timescale** 2023/24 **Lead:** Aiysha Baillie
	Expected Performance gain – longer-term Likelihood of hitting target will depend on the overall demand for blood increasing back to pre-COVID levels, and the donation sessions being held at education settings and businesses.	
	Risks to future performance	
	Set out risks which could affect future performance Fluctuations in the demand for blood.	

KPI Indicator KPI.20

Return to Top

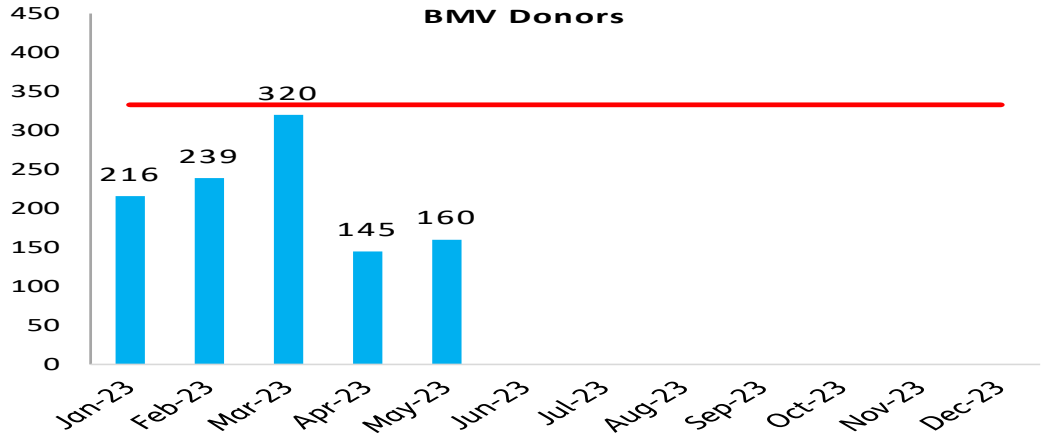
Number of New Bone Marrow Registry (WBMDR) Volunteers aged 17 – 30 recruited in month (4000 per annum cumulative)

Target: 4000 per annum (333 per month)

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
No. of new donors per month	283	141	163	200	215	243	151	203	315	137	216	239	320	145	160
Target Per/Month	333	333	333	333	333	333	333	333	333	333	333	333	333	333	333
Cumulative Actual Performance 4000 p/financial year	2582	138	327	496	679	856	995	1198	1531	1667	1883	1422	1742	145	305



Performance

Performance in May improved slightly but was well below target with only 160 new BMVs (131 from blood and 29 from swabs).

The summer months are typically lower due to the reduced blood donor clinics in educational establishments. Work is ongoing to understand how we can address this by considerably increasing swab recruitment. We are currently analysing the data from previous swab recruitment campaigns to inform the way forward.

466 eligible donors attended blood sessions with a 28% conversion rate.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale**
Recovery Plan is being implemented to increase recruitment of bone marrow volunteers, including: • Establishing key contacts in the National BAME Transplant Alliance (NBTA) to discuss opportunities for using their expertise to support our recruitment process. • Visits to Armed Forces to discuss marketing opportunities. • Advertising around World Cancer Day & Blood Donor Week.	Quarters 1-4 **Lead:** Jayne Davey / Tracey Rees

	• Pilot with donors who requested further info on session to understand why they aren't signing up. • Pilot to understand why swab kits aren't returned despite two follow up emails. • Paid advertising. • WBMDR Website refresh. • Engagement with external marketing companies. • Develop Ambassador Programme • Focus groups • Engaging ethnic minority communities. • Staff Champions – extended training for collection team champions.	
	Expected Performance gain – immediate. Increased number of bone marrow volunteers joining register.	
	Service Improvement Actions – tactical (12 months +)	
	Actions: what we are doing to improve The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, continues to be developed.	**Timescale** Quarter 2 (2023) **Lead:** Jayne Davey / Tracey Rees
	Expected Performance gain – longer-term. Meet current agreed targets with a strategy in place to enable increased recruitment as required.	
	Risks to future performance	
	Set out risks which could affect future performance. Failure to align to UK Stem Cell Strategic Forum recommendations agreed by Welsh Government.	

KPI Indicator KPI.56

Return to Top

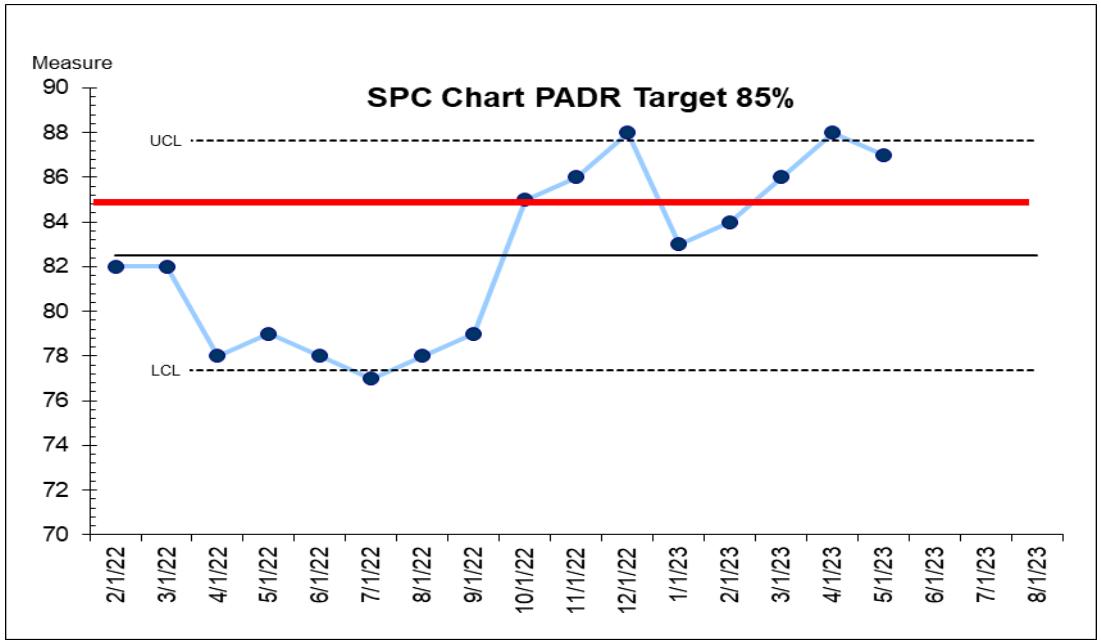
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

WBS Position	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	Apr 23	My 23
Actual %	82	78	79	78	77	78	79	85	86	88	83	84	86	88	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 variation for the last 15 months averaging 81%, but with an improving trend now meeting the 85% target.

Performance

Compliance has increased this month and are now above target, demonstrating the effort made in this area to achieve compliance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
WBS is provided with monthly reports to identify which staff are due their PADR.	Monthly ongoing	ESR Manager
Each team is booking in PADR meetings with their teams, in advance of the deadlines.	Monthly ongoing	Service Managers

Expected Performance gain - immediate

Staff that are due incremental pay increases will receive these on time when PADR meetings are undertaken in a timely manner.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Current measures are working well. Regulatory compliance has now been met, and will be monitored for compliance ongoing.

Risks to future performance

Set out risks which could affect future performance

If further strike action takes place, this could have an impact on achieving compliance, with a depleted workforce.

KPI Indicator KPI.58

Return to Top

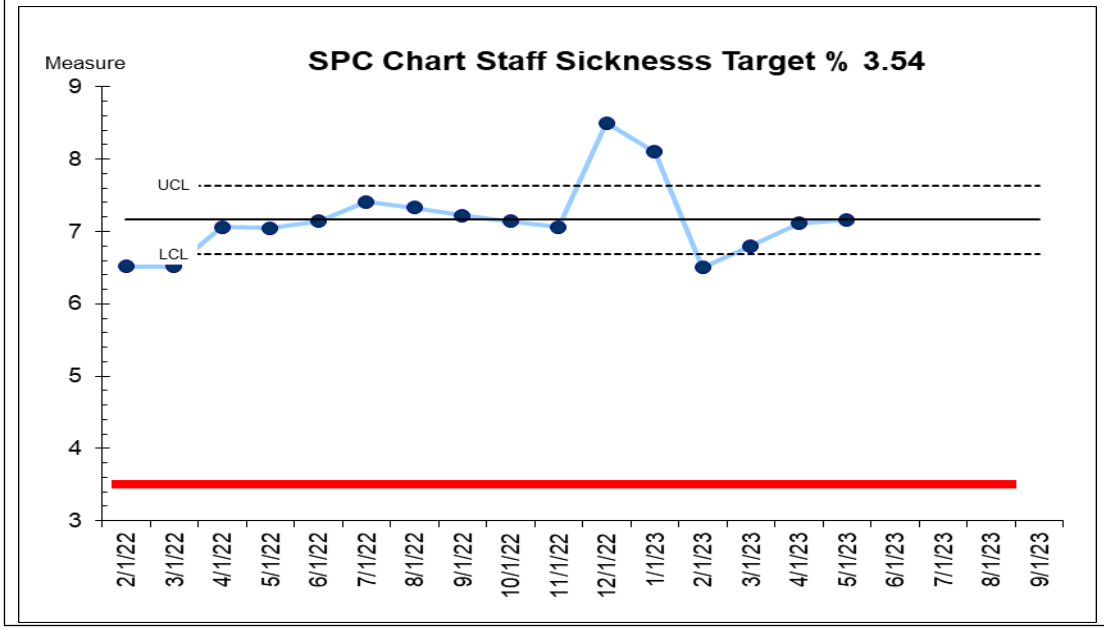
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

WBS Position	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	Apr 23	May 23
Actual %	6.52	7.05	7.04	7.14	7.41	7.33	7.22	7.14	7.06	8.5	8.1	6.5	6.8	7.11	7.16
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



Performance

Assessment of current performance, set out key points:
Sickness absence has marginally increased overall. Short-term and long-term sickness have both increased, which has impacted on figures overall.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale	Lead:
Guidance on management of COVID infections has been refreshed and communicated to all staff.	Ongoing	Director of WOD
The People and OD team continue to have monthly support meetings with managers to assist them in management of sickness absence.	Monthly	People and Relationship Advisors

Expected Performance gain - immediate
WBS continue to implement any recommended measures to ensure COVID Risk Assessments are followed and staff are able to limit their exposure to COVID infections in the workplace.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale	Lead:
There are lots of wellbeing initiatives taking place throughout the year and staff are regularly reminded about the Wellbeing offers that they can access at any time.	**Ongoing**	Head of OD

Expected Performance gain – longer-term

Risks to future performance

SPC Chart Analysis	Set out risks which could affect future performance
The SPC chart shows a deteriorating trend over the last 15 months with the overall average 6.9% sickness level remains higher than the 3.54% target	Strikes and Recruitment pressures could increase sickness absence.

DONOR & STAFF EXPERIENCE

KPI Indicator KPI.09

Return to Top

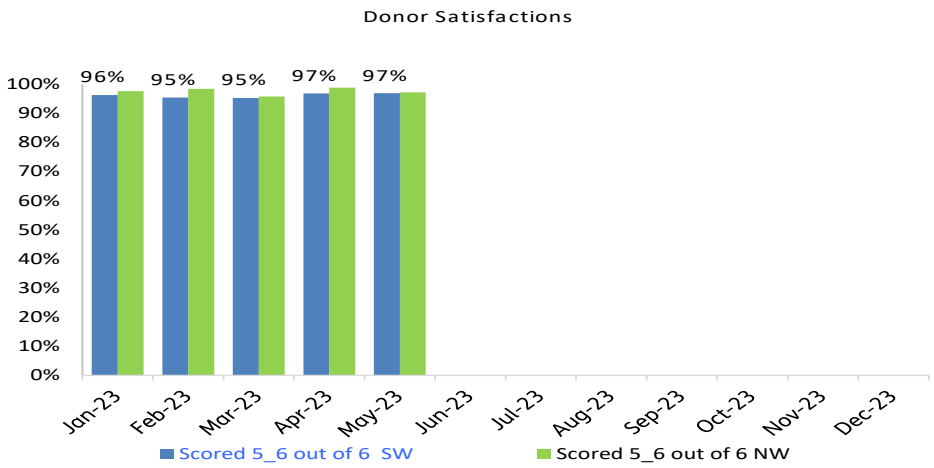
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	97	96	96	97	96	97	97	96	96	95	97	97	95	97	97
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 97.0% donor satisfaction exceeded target for May. In total there were 936 respondents to the donor survey, 153 from North Wales (scoring satisfaction at 97.2%), and 761 from South or West Wales (scoring satisfaction at 96.9%).

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 metrics are now being explored to evaluate if 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 KPI.14

Return to Top

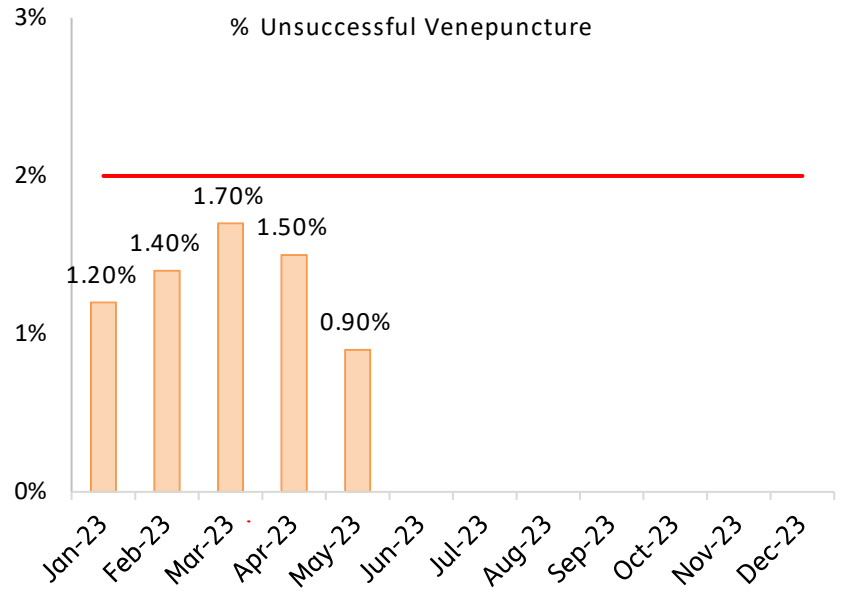
% Unsuccessful Venepuncture (FVP)

Target: 2%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	1.5	1.2	1.1	1.0	1.2	1.4	1.4	1.5	1.8	1.6	1.2	1.4	1.7	1.5	0.9
Target 2%	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2



Performance

Assessment of current performance, set out key points:
Performance target has been met and the unsuccessful venepuncture rate was stable during May 2023. No issues or practice trends have been identified.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale
Unsuccessful venepuncture rate remains stable and within tolerance. Continuous monitoring to continue to both provide assurance and identify any practice trends to identify improvement opportunities.	Continuous **Lead:** Edwin Massey

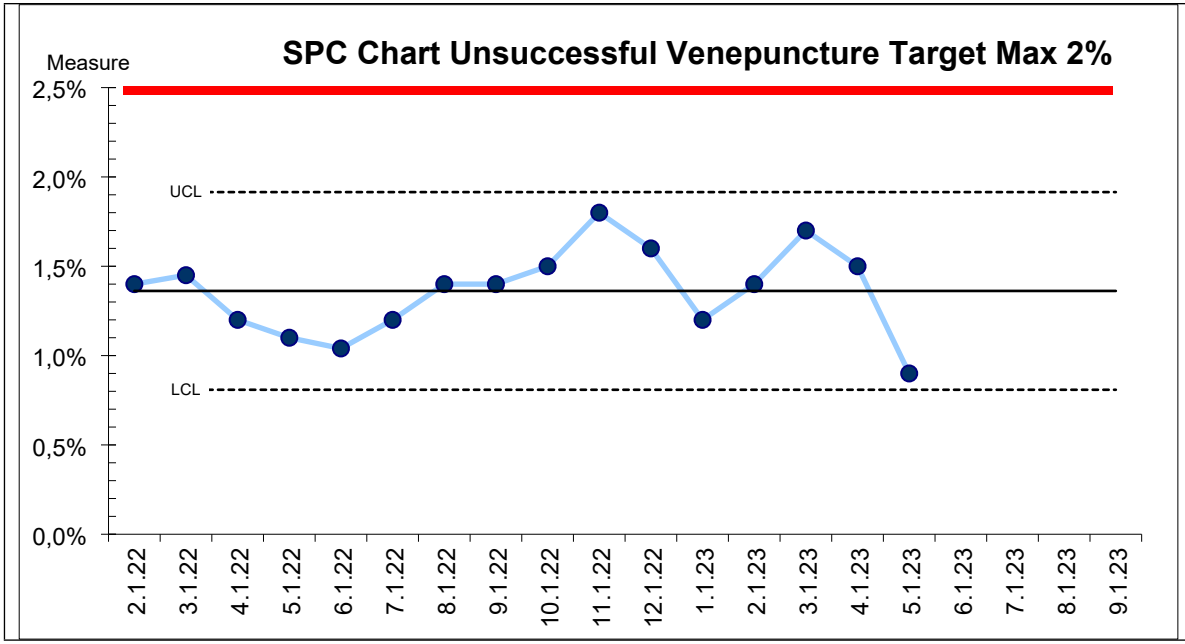
Expected Performance gain – immediate.
To ensure continuous provision of safe, effective, efficient, equitable care provision for donors across Wales.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
Continuous monitoring and oversight to ensure safe and high-quality care provision.	**Lead: Edwin Massey**

Expected Performance gain – longer-term.
To minimise unsuccessful venepuncture occurrences to ensure provision of high quality, safe and efficient care provision to donors across Wales.

Risks to future performance
Nil identified.



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 1.4% consistently within the required maximum 2% target.

KPI Indicator KPI.16

Return to Top

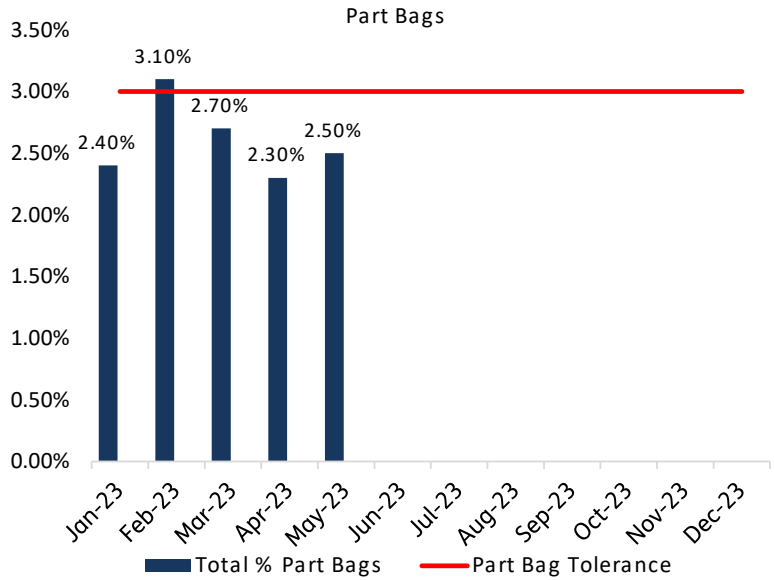
% Part Blood Bags Collected

Target: 3%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	2.32	2.30	2.21	2.02	2.09	2.00	2.30	2.60	2.92	2.26	2.4	3.1	2.7	2.3	2.5
Target Below 3%	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3



Performance

At 2.5% the part bag rate in May remains stable and below 3% target on an All-Wales basis. A 'Whole Blood' clinic in Talbot Green was re-established in May 2023, and this was the only clinic to breach tolerance at 3.6%. However, this performance is not considered statistically significant due to low number of donors bled (n=56).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
Continuous analysis of part bag incidents across all collection teams to minimise part bag incidences and identify and address any practice trends or issues.	Continuous **Lead:** Edwin Massey

Expected Performance gain - immediate.
Minimise Part Bag rates across Wales.

Service Improvement Actions – tactical (12 months +)

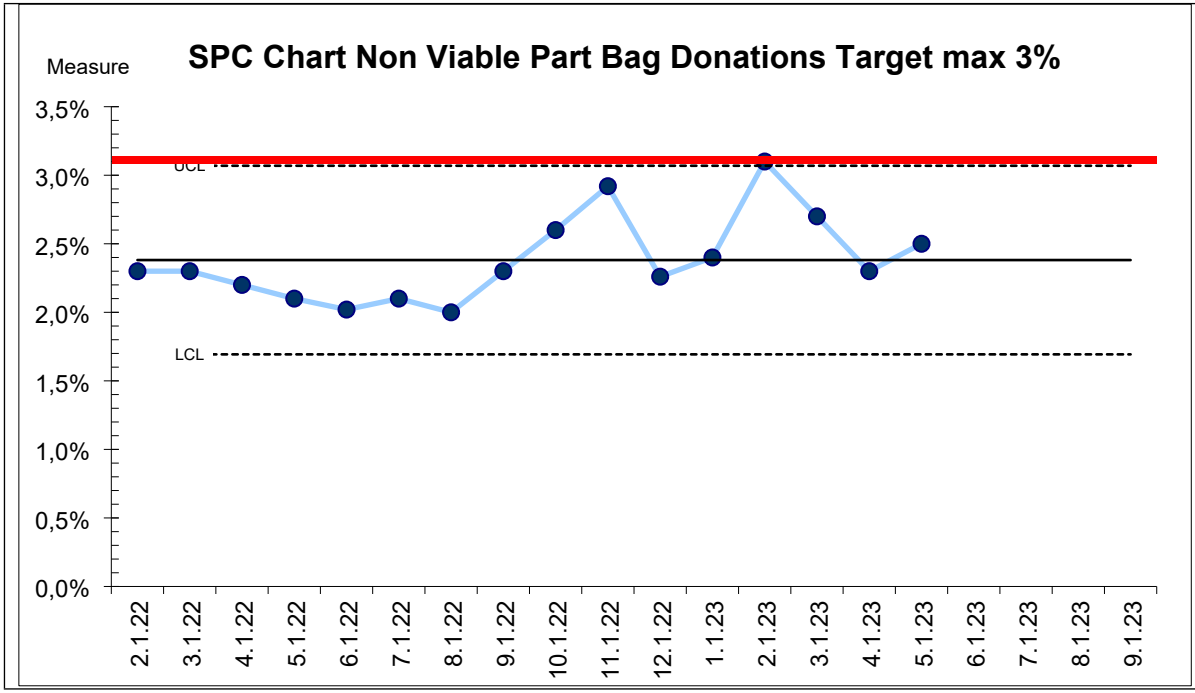
Actions: what we are doing to improve	**Timescale**
Continue oversight and trend analysis. Address identified trends as required.	On-going **Lead:** Edwin Massey

Expected Performance gain – longer-term.
Minimise part bag rates

Risks to future performance

New staff recruitment and induction/ training period within collection teams with impact upon initial level of knowledge and skills.

NB. Causes of Part Bags are various (needle placement, clinical risk, donor is unwell, donor request to stop donation, late donor information and equipment failure) and at times cessation of donation resulting in a part bag is clinically appropriate. This is a separate factor to Failed Venepuncture (FVPs).	Need to discontinue collection due to individual clinical requirements e.g., Donor Adverse Event or late donor information, which although clinically appropriate will result in a part bag.



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 2.4%.

KPI Indicator KPI.28

Return to Top

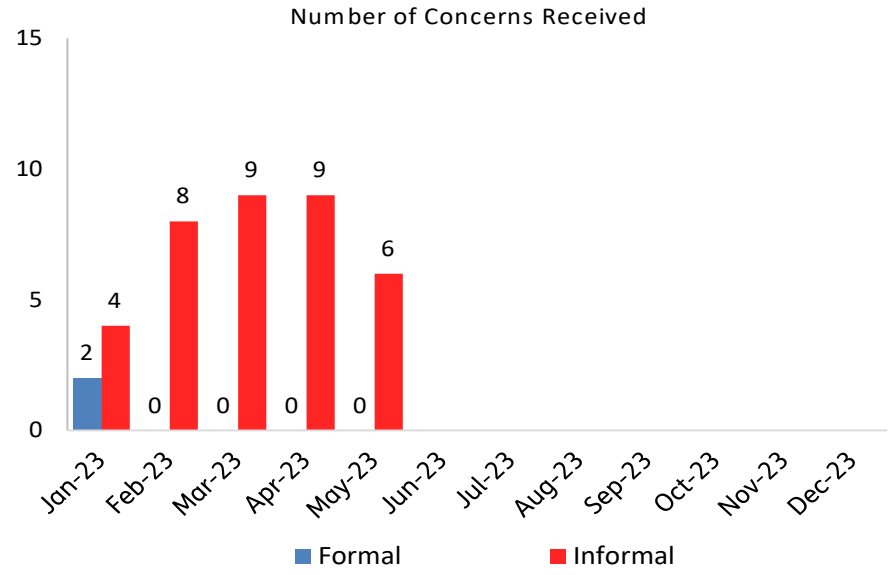
Number of WBS "Formal" and "Informal" concerns received from blood donors

Target: NIL

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	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	Apr 23	My 23
Actual Formal	0	0	2	2	0	0	0	1	1	1	2	0	0	0	0
Actual Informal	8	9	6	3	4	2	6	7	7	6	4	8	9	9	6
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:

During May 2023 the Service received no formal concerns. However, 6 informal concerns were received, managed as "Early Resolution" and resolved within the 2 working day deadline.

7,203 donors were registered at donation clinics. 6 informal concerns represent 0.08% of all donations in May 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Time scale**
– Continuous oversight and management of concerns in line with Putting Things Right Regulations. – Review of all concerns received to ensure learning and improvement opportunities are addressed.	Ongoing **Lead:** Edwin Massey

Expected Performance gain – immediate.

Improved performance, improved donor experience and satisfaction.

Service Improvement Actions – tactical (12 months +)

Actions:	**Timescale**
Continue to Review current practices to reduce concerns in line with donor feedback.	On-going **Lead:** Zoe Gibson/Julie Reynish/Julie Curry

Expected Performance gain – longer-term.

Utilisation of service user feedback to improve service provision, donor experience and satisfaction.

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.06

Return to Top

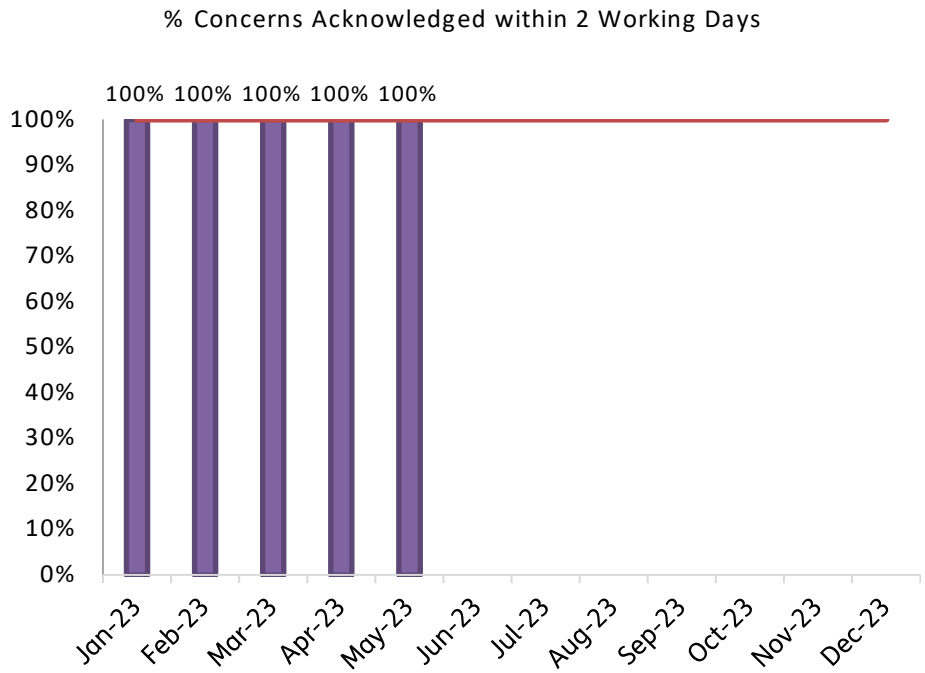
% All concerns acknowledged under "Putting Things Right" (PTR) within required 2-day Timescale

Target: 90%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	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	Apr 23	May 23
Actual %	100	100	88	100	100	100	100	75	100	100	100	100	100	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

Assessment of current performance, set out key points:
All individual concerns were addressed by relevant heads of departments and managed within the 2 working day timeline for early resolution. 6 donors were contacted to discuss their concerns and were happy with outcomes of conversations and actions.

The 2 informal concerns originally lodged in October 2022, and reopened April 2023 were managed by VCC/Corporate team and a formal response was issued by the Trust Chief Executive on 30/05/23, and the record closed.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:** Ongoing **Lead:** Edwin Massey
Continued monitoring and assurance of standard being achieved.	

Expected Performance gain – immediate.
Effective management of concerns in line with Putting Things Right Regulations.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve.	**Timescale** Ongoing **Lead:** Edwin Massey
Continued oversight and monitoring of concerns management to ensure response time responsibilities continue to be met.	

Expected Performance gain – longer-term.
Improved donor satisfaction and experience through service improvement.

Set out risks which could affect future performance

KPI Indicator KPI.03

Return to Top

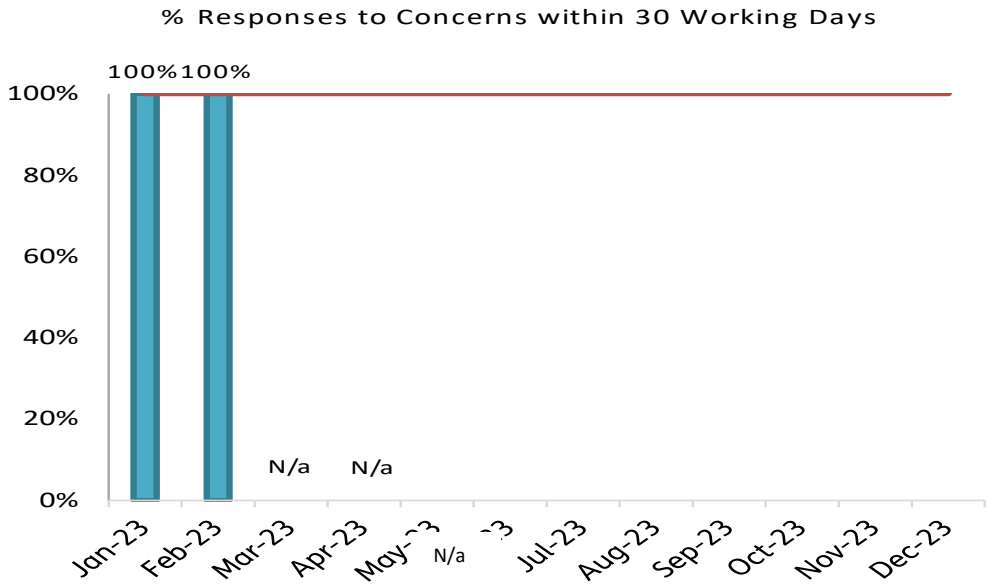
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	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	Apr 23	May 23
Actual %	n/a	n/a	n/a	100	100	n/a	n/a	100	100	N/A	100	100	N/A	N/A	N/A
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



NB:
Performance against target only shown the month when a formal concern has been raised.
Under Putting Things Right (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 May 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. – Adherence to Duty of Candour requirements.	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.

KPI Indicator KPI.53

Return to Top

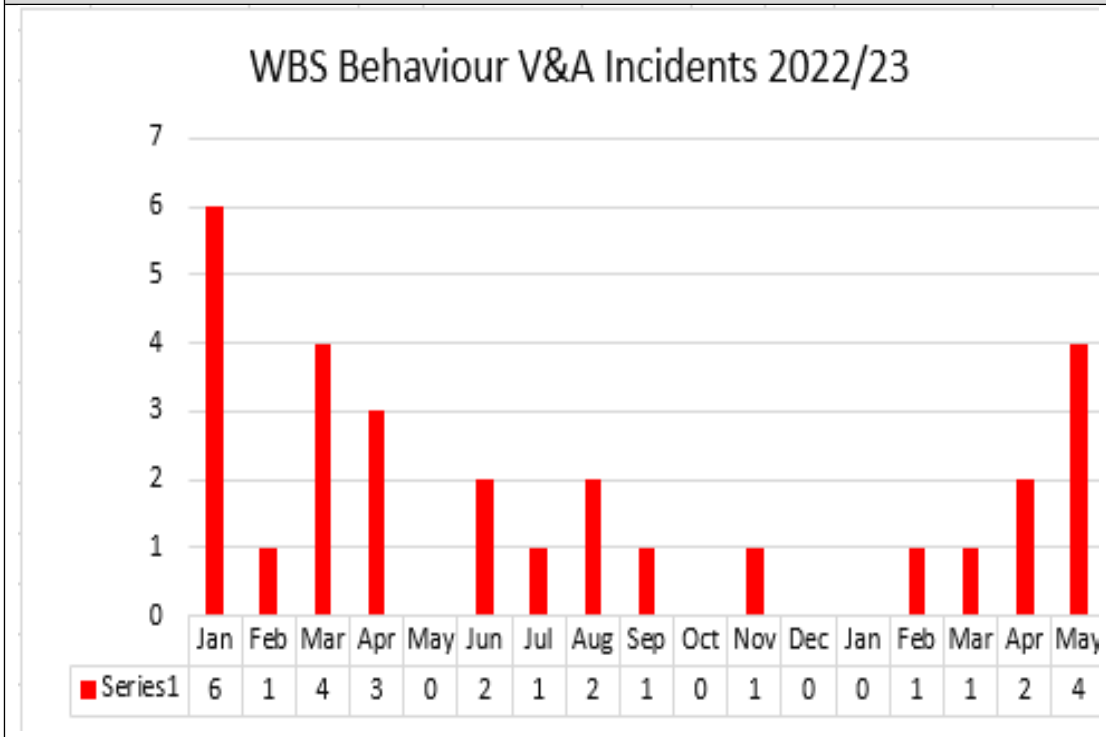
Health & Safety Total number of violence and aggression incidents by division

Target: Continued monitoring to identify and mitigate trends

SLT Lead: Sarah Richards

Current Performance against Target or Standard - stable

Performance – fluctuating dependent on individual incidents - no discernible trends available



Cases at WBS involve angry Donors that may turn up late for an appointment or may need to be turned away from donating due to medical issues or failure to meet the criteria to safely donate. No physical V&A incidents to date.

If performance is not at required level, set out what the main causes are:
Donors at venues are the main cause of the V&A incidents experienced at WBS, e.g. late / missed appointments, turned away from donating due to not meeting criteria etc.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Ongoing monitoring. Review each case. Training on ESR.	Q4 2022 and Q 1 & 2 2023	VCC H&S Advisor WBS Health Safety & Env Mgr

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Ongoing monitoring of V&A cases at WBS. SOP in place. Discussion on a case-by-case basis with the Collections and Nursing Managers to decide the most appropriate course of action. Collection Team Training V&A and Customer Service	Q3&4 2023	H&S Team Ed & Dev

Expected Performance gain – longer-term
Collection team staff trained with the ability to deal with any V&A incidents.
Team staff that can safely de-escalate the situation.
Robust SOP in place to provide guidance to team staff on the ground and managers on dealing with V&A incidents.

Risks to future performance –

Set out risks which could affect future performance
Team staffing – stretched team's increases stress levels may impact on ability to deal with a potential V&A situation.

Communication with donors when booking to donate. Ensure that they are aware of the donation criteria and are provided with update / confirmation of their donation times and date.

TIMELINESS

KPI Indicator KPI.17

Return to Top

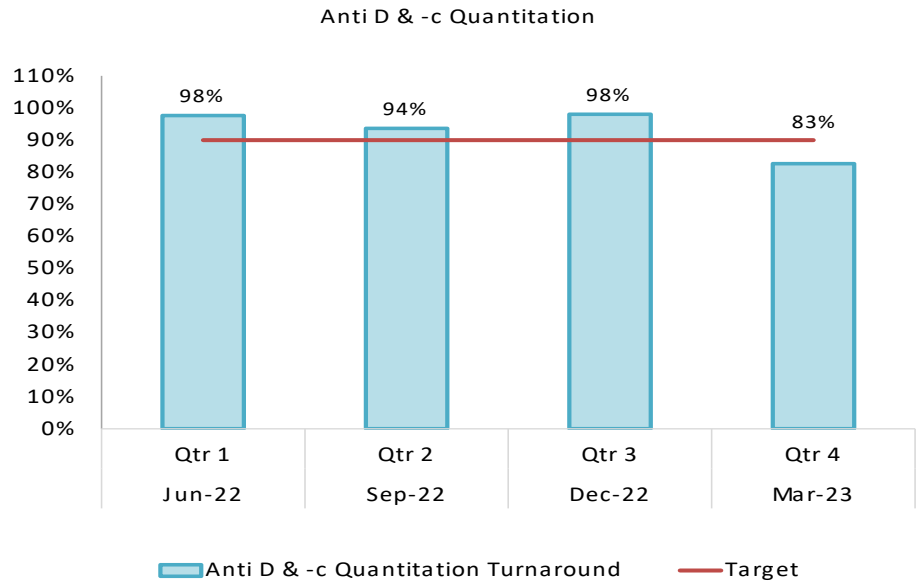
% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	96	100	99	83	99	96	99	99	96	97	96	60	92	97	
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	



Performance

On Target

Service Improvement Actions – Immediate (0 to 3 months)

N/A	**Timescale:**	**Lead:**

Expected Performance gain - immediate.

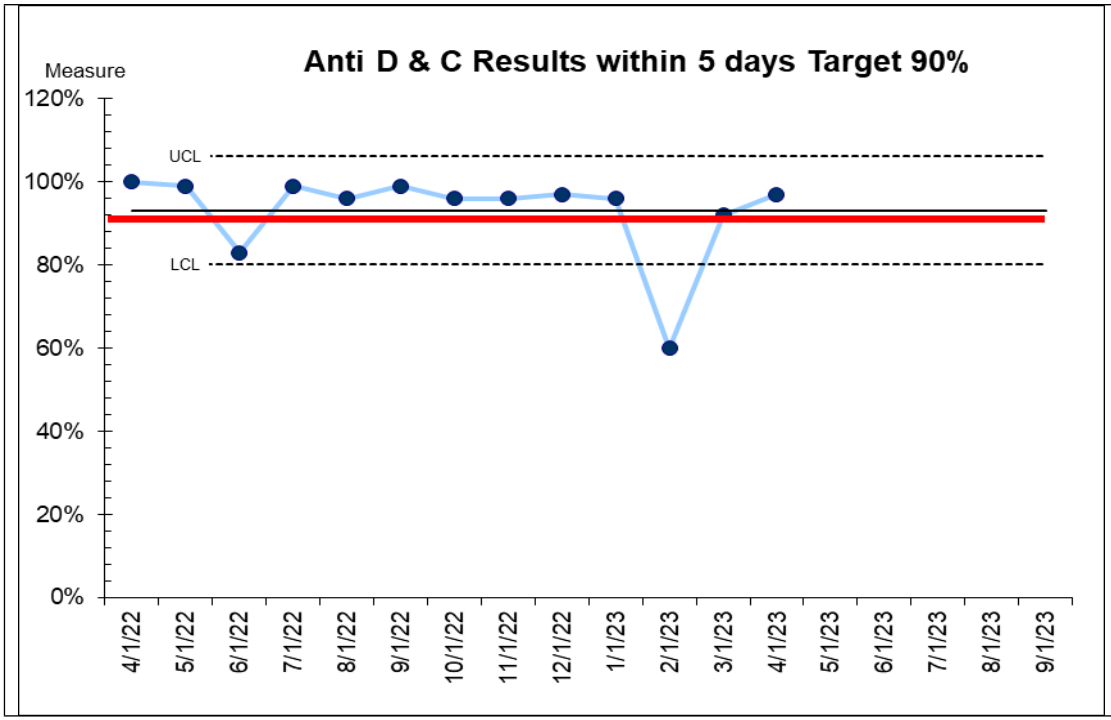
Service Improvement Actions – tactical (12 months +)

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.



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 four. However, the average performance of 96% exceeds the 90% target overall.

KPI Indicator KPI.18

Return to Top

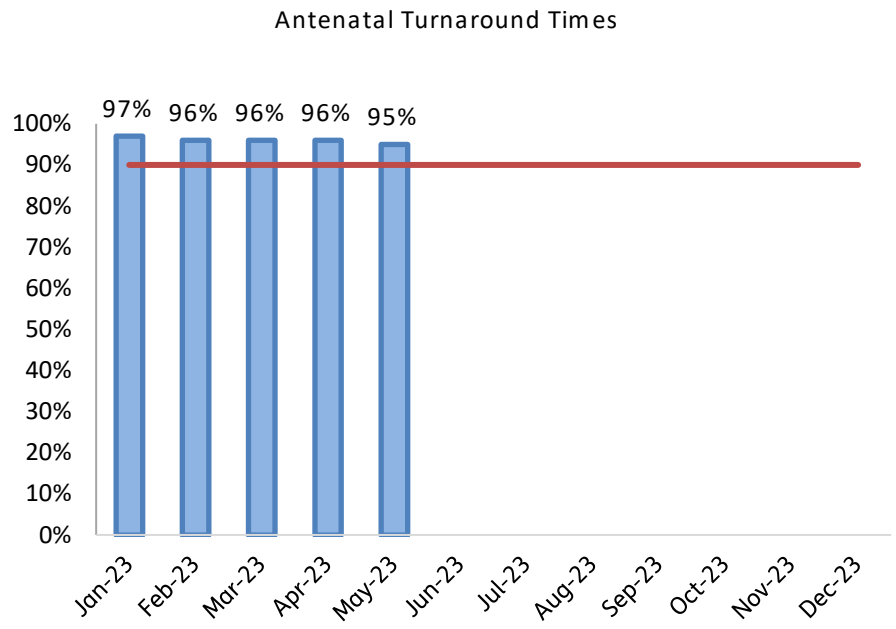
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	96	95	96	95	96	97	97	98	96	87	97	96	96	96	95
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 95% the turnaround time performance for routine Antenatal tests continued to exceed target in May 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.

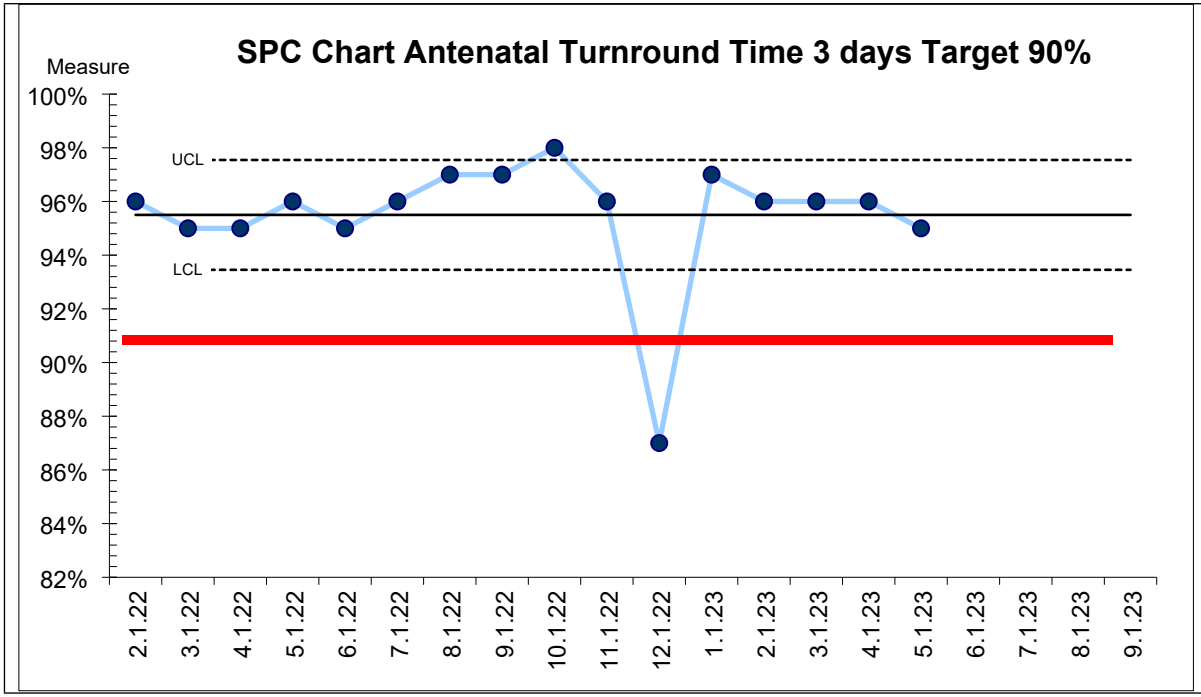
Service Improvement Actions – tactical (12 months +)

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 due to an IT incident The average performance of nearly 96% exceeds the 90% target.

KPI Indicator KPI.23

Return to Top

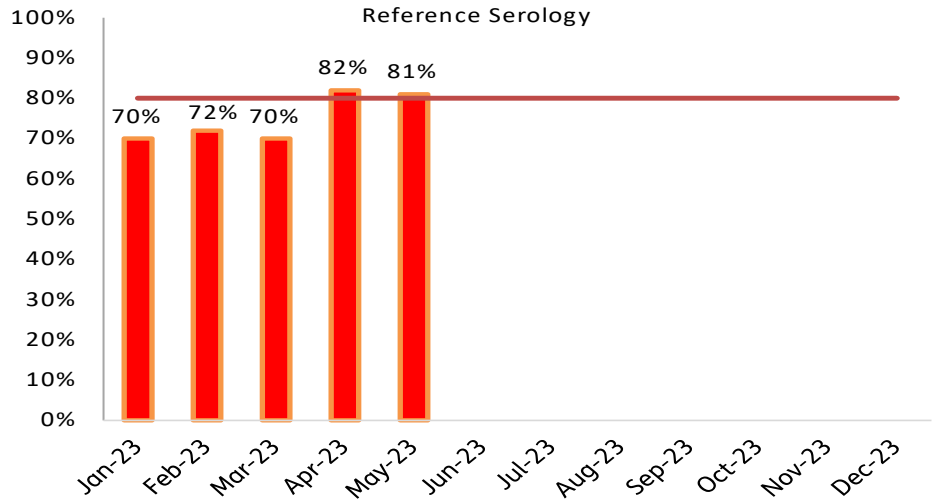
Reference Serology Turnaround Times – results provided to hospital within 2 working days

Target: 80%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual %	65	68	68	63	80	61	73	77	65	61	70	72	70	82	81
Target 80%	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80



Performance

Assessment of current performance, set out key points:
Reference Serology 'Turnaround' performance met target in May.

NB:
Turnaround performance over 5 working days is at 93% for May (following on from 93% in 5 days achieved in March & April) and shows a consistent improvement and closer performance to the NHSBT benchmark of 95%.

Compatibility testing (approx. 43% of referrals) continues to meet clinical target whilst all "Time-Critical" tests continue to be prioritised and completed on time maintaining safety of clinical care.

Performance continues to be impacted by ongoing training of new staff; however, this is an improving picture compared to recent winter months.

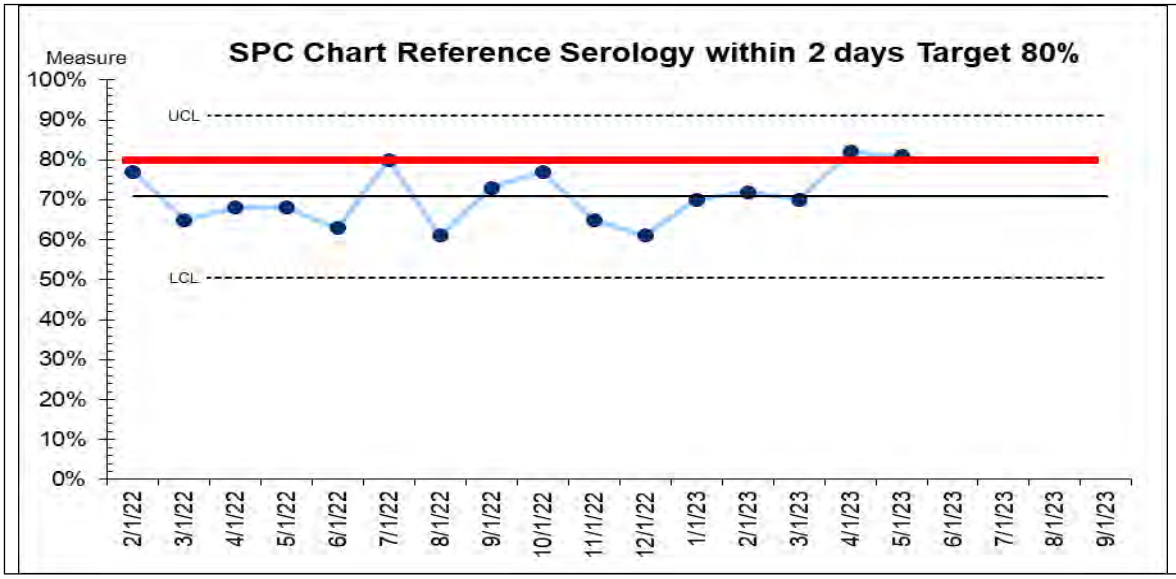
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale	Lead:
• An additional Band 6 trainee Specialist Biomedical Scientist resource to increase complex testing has been appointed. Training is expected to be completed in July.	July 2023	Tracey Rees
• An additional trainee Band 6 Specialist Biomedical Scientist has been appointed, with training expected to take 18-24 months.	April 2025	

Expected Performance gain - immediate.
Improvement in Reference Serology Turnaround times

Service Improvement Actions – tactical (12 months +)

	Actions: what we are doing to improve • A service improvement project linked to the use of the new automated analyser is ongoing. A number of automated tests are currently embedding (ABO, Rh, & partial red cell phenotyping). • Further validation for additional Red Cell Phenotyping was expected to be completed by the end of March 2023, but was not achieved due to the prioritised staff training. • Validation for additional Red Cell Phenotyping is now expected to be completed by the end of June 2023.	**Timescale:** June 2023	**Lead:** Tracey Rees
	Expected Performance gain – longer-term. Improved analytical efficiency and testing turnaround times.		
	Risks to future performance		
	Set out risks which could affect future performance. The target requires review as it is not in line with other UK services. Specifically, NHSBT target is set at 95% within 5 working days, IBTS 100% within 7 working days		



SPC Chart Analysis
The SPC chart shows common cause or normal variation over the 15-month period. However, the average performance of 70% consistently falls to meet the 80% target.

KPI Indicator KPI.24

Return to Top

Number of Deceased Donor Typing / Cross Matching reported in month

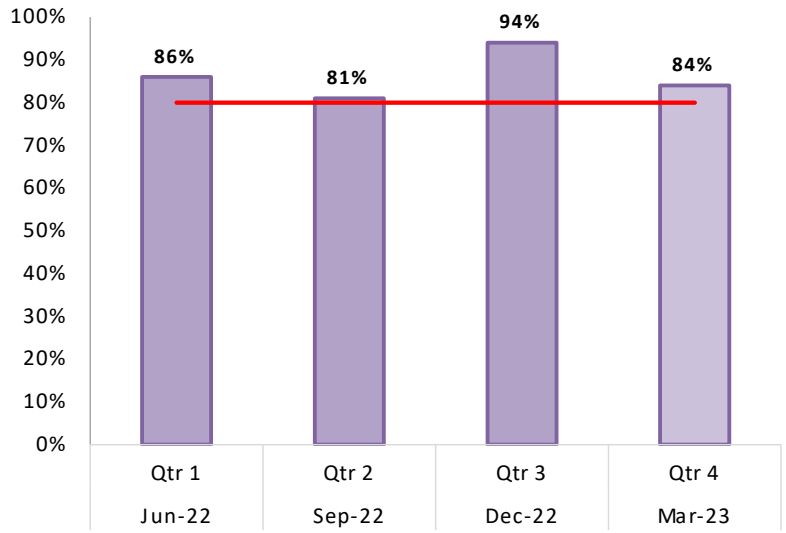
Target: 80% Quarterly

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23
Actual %	86			81			94			84					
Target 80%	80			80			80			80					

Turnaround Times (Deceased Donor Typing/Crossmatching)



Performance

Assessment of current performance, set out key points:
Performance for this quarter above target at 84%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to monitor performance	Ongoing	Tracey Rees

Expected Performance gain - immediate.
N/A

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.

EFFICIENCY

KPI Indicator KPI.08

Return to Top

Whole Blood Collection Efficiency – number of Blood Components Collected per Standardised Full Time Equivalent Staff Member

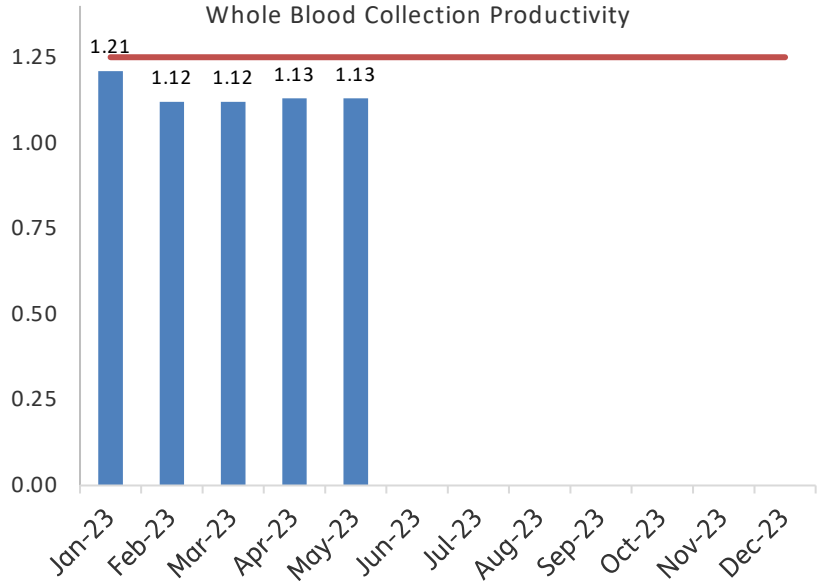
Target: 1.25 Weighted Factor

SLT Lead: Jayne Davey

Current Performance against Target or Standard

Performance

	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	Apr 23	May 23
Actual FTE	0.99	1.07	1.12	1.15	1.13	1.15	1.22	1.10	1.03	1.02	1.21	1.12	1.12	1.13	1.13
Target 1.25 FTE	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25



Assessment of current performance, set out key points:

Collection efficiency performance in May failed to meet target.

Contributory factors influencing the May performance include:

1. Reduced clinics duration due to short notice sickness absence.
2. Reduction of clinic hours because of fire alarm activation on session.
3. Existing vacancies yet to be filled across Wales, which, with 8 staff in training has impacted staffing capacity at larger sessions.
4. Lower donation capacity due to staff sickness in North Wales resulting in donation sessions staged with 2 donor chairs. Usually, these teams operate 4-6 donation chairs, depending on the venue size.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve

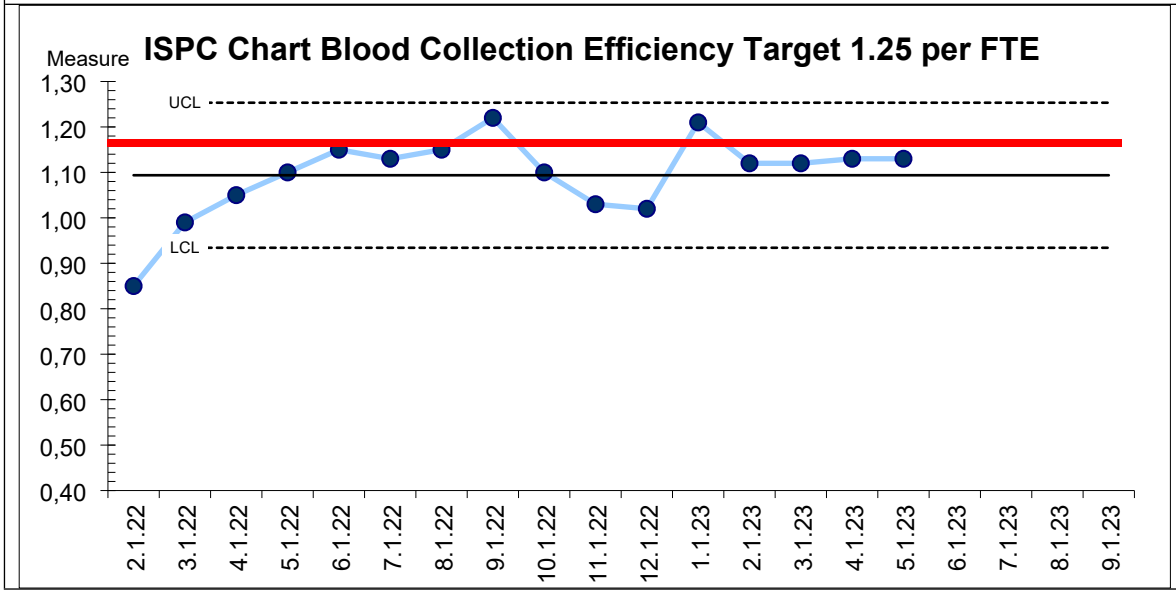
- Daily review of stock levels in conjunction with the wider service to support correct 'days of blood' by-blood group stock levels.
- 7 staff in training for 12 weeks on starting. Once trained the staff will supplement staffing levels to maximise clinic capacity.
- Further recruitment to fill funded vacancies planned in June & July 2023.

Timescale:
by August 2023

Lead:
Jayne Davey

Expected Performance gain – immediate.

Improved ability to respond to demand by increasing donor appointment opportunities and improved ability to record Collection Team 'non donor' working hours (i.e., personal appraisals/e-learning/training).



Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
– Daily monitoring of hospital demand to support increases in collections capacity if required.	Quarter 1
– Updating the efficiency reporting tool to capture non-donor facing hours, leading to improved accuracy in reporting 'Collection Efficiency'.	Quarter 1
– Review all opportunities to maximise donation clinic efficiency.	**Lead:** Jayne Davey

Expected Performance gain – longer-term.
Improved accuracy of reporting.

Risks to future performance

Set out risks which could affect future performance.
– Industrial action.
– Increase in hospital demand.
– Increase in sickness.

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The improving trend approaching the target productivity target of 1.25 FTE has remained consistent over the past few months. However, the average performance of 1.10% currently fails to meet the target.

KPI Indicator KPI.10

Return to Top

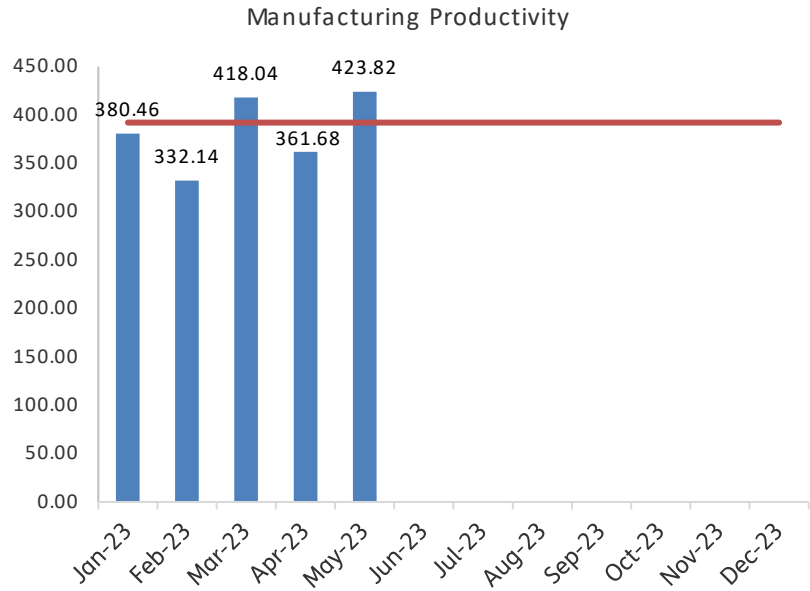
Blood Product Manufacturing Productivity

Target: 392 per month

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual	332	386	386	377	416	391	357	372	401	356	380	332	418	362	424
Target 392	392	392	392	392	392	392	392	392	392	392	392	392	392	392	392



Performance

Assessment of current performance, set out key points:
The Manufacturing & Distribution department continues to operate effectively with performance for May within acceptable variance (10%). Also review of the SPC chart demonstrates this is variation around the target.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
This target is based on the Pre COVID operating model and is due to be reviewed as part of the ongoing development of the reporting framework. Identifying the acceptable fluctuation range will improve interpretation and monitoring of this standard.	**Lead:**

Expected Performance gain - immediate.

Service Improvement Actions – tactical (12 months +)

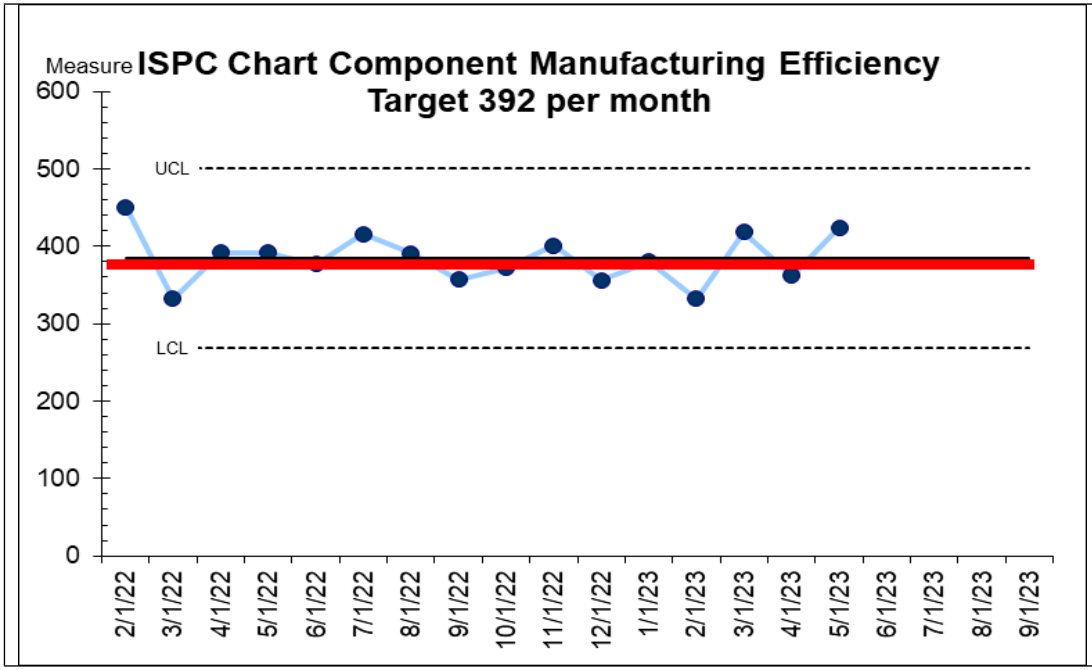
As Above	**Timescale:** **Lead:**

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance

NB: Manufacturing Efficiency is calculated by dividing working time available by the amount of work completed. The work completed relates to clinical components and does not include other work (such as commercial plasma sales) performed by the department.	



SPC Chart Analysis
The SPC chart shows common cause or normal variation over the 15-month period. With the average performance of 400 just above the target.

KPI Indicator KPI.12

Return to Top

Controllable Manufacturing Losses - % of unusable Red Cell donations against total collections

Target: maximum 0.5% per month

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	Apr 23	May 23
Actual	0.03	0.03	0.06	0.1	0.1	0.2	0.05	0.03	0.13	0.05	0.15	0.15	0.06	0.02	0.03
Target Max 0.5%	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5

Performance

Assessment of current performance, set out key points:
Controllable losses were low at 0.03% and remain within tolerance and below the target of 0.5% representing good performance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Active management of the controllable losses is in place, including vigilance and reporting of all units lost.	Business as Usual, reviewed monthly	Tracey Rees

Expected Performance gain - immediate.
Ongoing monitoring of losses to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis.

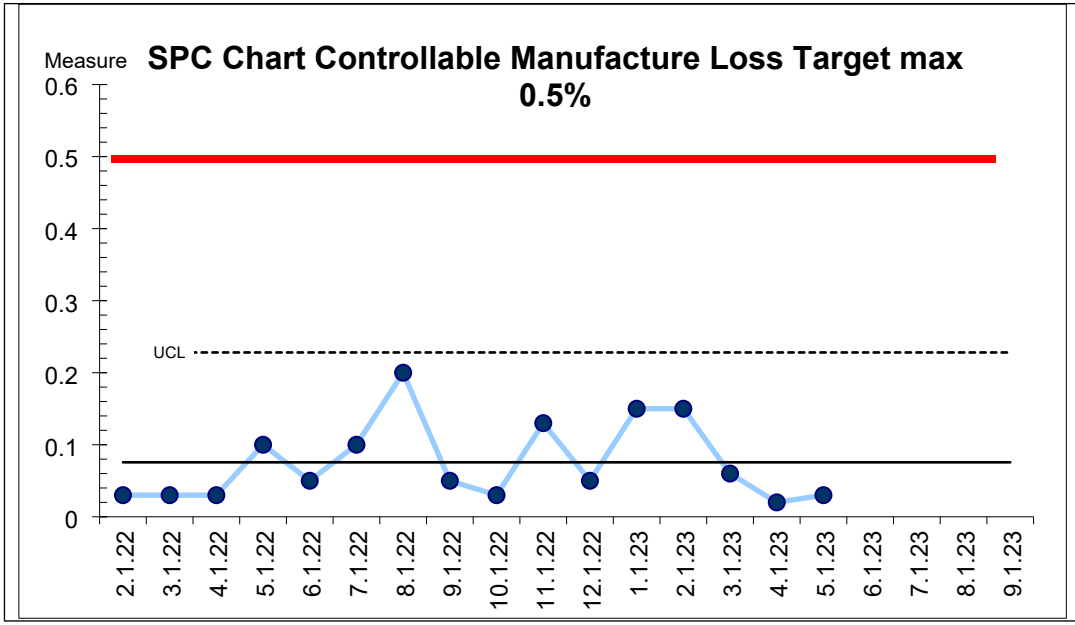
Service Improvement Actions – tactical (12 months +)

	Timescale:	**Lead:**
N/A		

Expected Performance gain – longer-term

Risks to future performance

	Set out risks which could affect future performance. N/A



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 0.1% is consistently within the required maximum 0.5% target.

KPI Indicator KPI.63

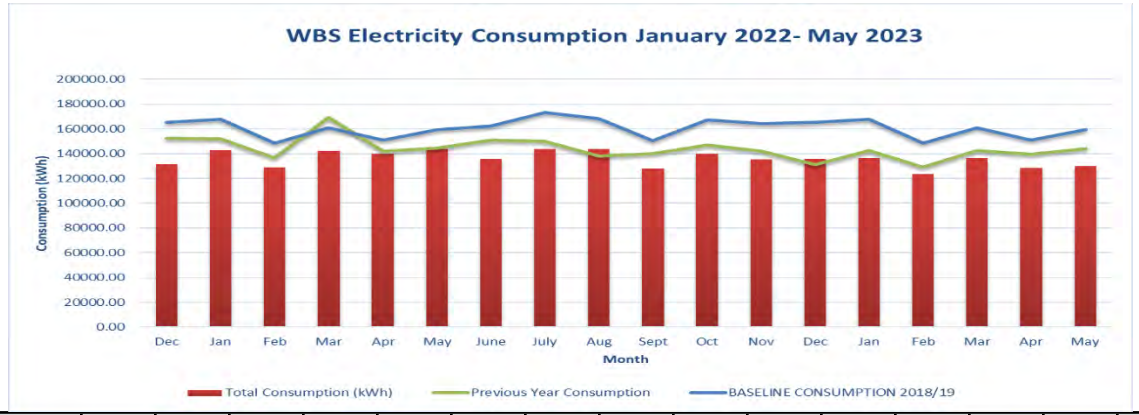
Return to Top

WBS - Energy (Gas and Elect) performance consumption

Target: -3% on 2020/21

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard



Trust Position	Mar 22	Apr2 2	My2 2	Jun2 2	July2 2	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number (kWh)	142494.30	139706.40	143839.00	136016.20	143888.40	143968.80	128059.82	140033.03	135393.79	135804.47	136437.92	123728.62	132305.10	128603.9	129804.7
Target number previous year	147453.58	137940.11	140141.72	146471.75	145412.51	133847.87	135755.77	142701.36	138024.70	127410.08	138294.65	125162.30	138219.47	135515.21	139523.83
Target -3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%

Performance

Assessment of current performance, set out key points:

Electricity and Gas consumption following similar pattern to previous year, with some reduced electricity usage February to June 2022.

Spike in gas usage at Talbot Green and Bangor sites following boiler service

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Electricity - SMART metering installed	3 month	Jon Fear
Gas - Integration of energy performance software (Sigma) to BMS	3 months	Milburn Mounter

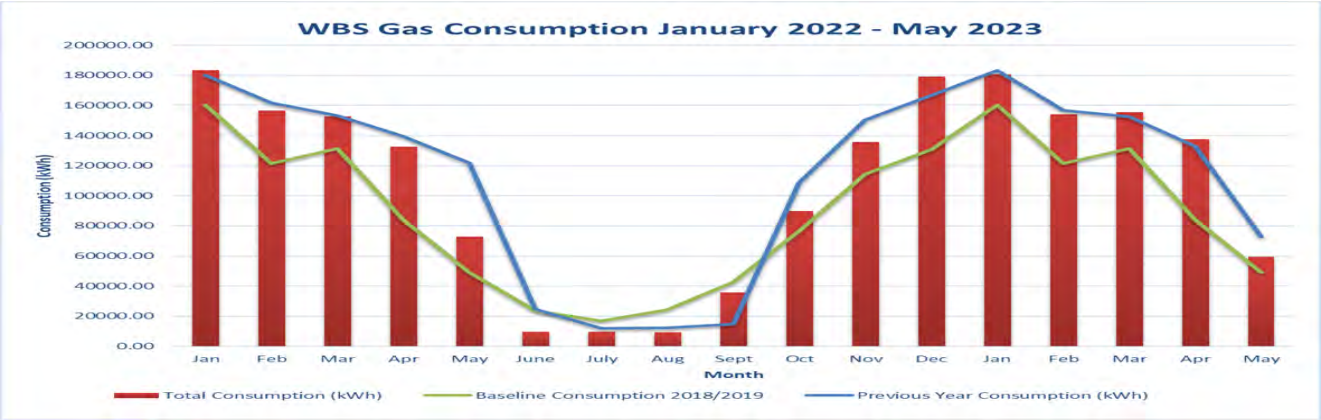
Expected Performance gain - immediate

Continue to monitor energy performance

Promote ways to reduce electricity usage.

Communication and engagement campaign for energy reduction (for staff working from home and in the office) to be held.

At Talbot Green, work to address increase gas consumption is underway, including reducing the Outdoor Air Temperature which triggers the



Trust Position	Mar 22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 2 3	Mar 23	Apr 23	May 23
Actual Number (kWh)	150456.05	132580.87	72820.43	9760.56	9556.40	9377.90	35711.02	89680.78	135716.44	179090.93	180564.58	154244.21	155424.94	137515.21	59395.68
Target number previous year	148531.25	135212.31	118264.06	23969.35	11801.26	12024.33	14373.16	105636.38,	145757.13	161491.63	177834.71	151952.26	148075.24	128603.44	70635.82
Target -3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%

heating being on. This will be under review with lab staff to ensure it is the correct temperature of services.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Metering strategy	12 months	Jason Hoskins

Expected Performance gain – longer-term

Continue to monitor consumption

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.67

Return to Top

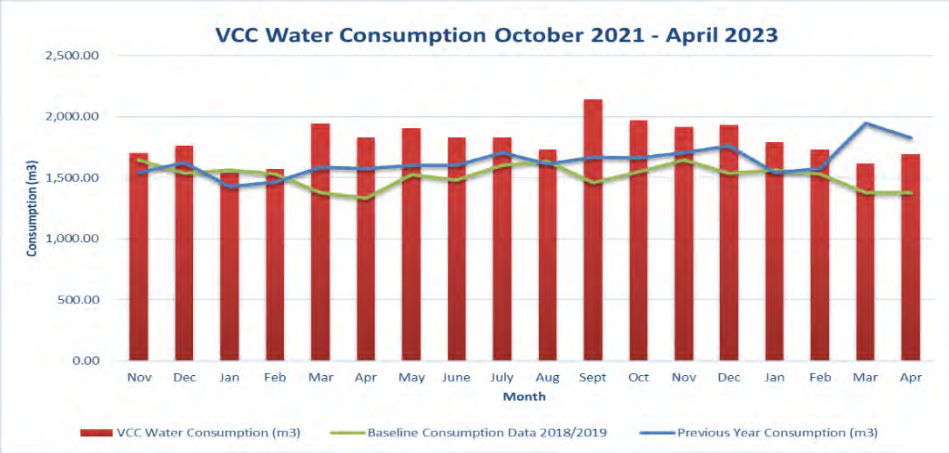
Graph title -Water

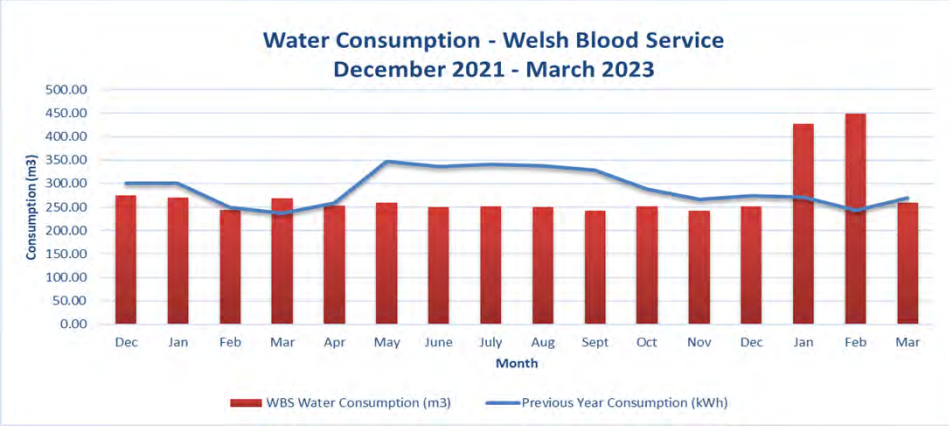
Target: Continued monitoring to identify and mitigate trends

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available





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

January figures are awaited from our utilities provider.

- Across all sites there has also been Increased hygiene requirements to comply with IP & C guidance
- There has been a significant increase in water consumption at Talbot Green this due to a water meter fitted
- Upgraded water meters at two sites to have tighter control & management of water consumption

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Capturing water data at WBS has changed year therefore [previous data is displayed in quarters] Going forward, increased monitoring and integration into the BMS to ensure monthly figures are monitored	3 months	**Matthew Bellamy**
Integrating the water consumption to the BMS at VCC	3 months	**Milburn Mounter**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

• Increased metering across all sites • Dedicated resource to capture the metering	**12 months**	Jason Hoskins

Expected Performance gain – longer-term

Continue to monitor consumption resulting in targeted initiatives and improvements reducing consumption.

Risks to future performance

Increased flushing regimes to adhere to water safety regulations

KPI Indicator KPI.71

Return to Top

Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual £k	1	0	1										
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	0

WBS Revenue Position as at May 23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	4.478	4.541	0.064	26.674	26.674	0.000
Expenditure						
Staff	3.016	3.064	(0.047)	16.935	16.935	0.000
Non Staff	4.675	4.692	(0.017)	29.555	29.555	0.000
Sub Total	7.691	7.755	(0.064)	46.490	46.490	0.000
Total	(3.214)	(3.214)	0.001	(19.816)	(19.816)	0.000

Performance

The reported financial position for the Welsh Blood Service at the end of May 2023 was a small underspend of **£0.001m** with an outturn forecast position of **breakeven** currently expected.

Income overachievement of **£0.064m** to month 2. Targeted income generation on plasma sales through increased activity is being largely offset by lower than planned Bone Marrow activity.

There has been a lack of growth in the bone marrow registry which was largely impacted during the pandemic and is yet to see signs of recovery. WBS have been running campaigns to try and grow the panel in sites such as schools and universities.

Staff reported a **£(0.047)m** overspend to May. Vacancies are helping to offset the overspend from posts supported without identified funding source. This 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.

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.

The recurrent impact of the pay award is expected to be neutralised when the Trust receives funding from WG.

Non-Staff reported a small overspend of **£(0.017)m** to May. Energy price rises expected to be funded centrally by the Trust as agreed at the IMTP planning stage are being offset by savings against stem cell activity and testing.

Service Improvement Actions – Immediate (0 to 3 months)

	Actions: what we are doing to improve • Quarterly Performance Reviews • WTAIL Bone Marrow Business Plan	**Timescale:** 31/03/24 Jun 2023	**Lead:** Alan Prosser
	Expected Performance gain - immediate Identification of recovery trajectory for Bone Marrow. Financial opportunities and challenges understood.		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve • Review of productivity and operating model requirements	**Timescale:** Sept 2023	**Lead:** Alan Prosser
	Expected Performance gain – longer-term Identification of resource opportunities and challenges with emphasis on delivering Value Based Healthcare		
	Risks to future performance		
	Set out risks which could affect future performance • Competing demand, available resources and service resilience.		

KPI Indicator KPI.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

WBS Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	100	7	1										
Target Per IMTP £0k Opening Forecast		0	0	0	0	0	0	0	0	0	0	0	0

Performance

The spend on agency for WBS during May 23 was £0.001m, which gives a cumulative year to date spend of £0.008m and a forecast outturn spend of £0.013m. Agency spend within facilities and administrative support is being targeted with the aim to remove use over the next couple of months.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Facilities review of operating model and remove reliance on temporary support • Departmental planned removal of usage into vacancies	Sep 2023	Sarah Richards

Expected Performance gain - immediate

Planned reduction of agency use

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Implement model • Departmental planned removal of usage into vacancies	Sep 2023	Sarah Richards/SMT

Expected Performance gain – longer-term

Sustainable operating model

Risks to future performance

Set out risks which could affect future performance

- Workforce constraints

KPI Indicator KPI.74

Return to Top

Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

Performance

WBS Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual Cummulative	500	32	27										
Target £700k Forecast		32	32	32	67	67	67	67	67	67	67	67	700

WBS Cost Improvement Programme for 2023-24 - Target £700k

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes							
Procurement Supply Chain (WBS)	Amber	100	0	0	0	100	0
Collection Team Costs Reduction (WBS)	Green	10	2	2	0	10	0
Collection Team Costs Reduction (WBS)	Green	8	1	1	0	8	0
Establishment Control (WBS)	Green	60	10	10	0	60	0
Reduced use of Nitrogen (WBS)	Amber	55	0	0	0	55	0
Reduced Research Investment (WBS)	Green	25	4	0	(4)	25	0
Stock Management (WBS)	Green	125	21	21	0	125	0
Reduced Transport Maintenance (WBS)	Amber	30	0	0	0	30	0
Demand Planning - Volume Driven Benefits (WBS)	Amber	137	0	0	0	137	0
Total Saving Schemes		**550**	38	34	(4)	550	0
Income Generation							
Sale of Plasma (WBS)	Green	150	25	25	0	150	0
Total Income Generation		**150**	25	25	0	150	0
TRUST WBS SAVINGS		**700**	**63**	**59**	**(4)**	**700**	**0**
				100%		**100%**	

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.
The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).
Currently several of the schemes are still RAG rated amber with current expectation that these schemes will turn green during quarter two, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

The procurement supply chain saving schemes is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. The services will continue to collaborate with procurement colleagues in order to identify further opportunities for efficiency savings that are cash releasing.

Work will need to continue with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.
It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented or mitigations put in place to ensure that the Savings target is met for 2023-24.

	Service Improvement Actions – Immediate (0 to 3 months)		
	Actions: what we are doing to improve • Extraordinary Savings meetings with SLT for year delivery should targets not be met	**Timescale:** 31/03/24	**Lead:** Alan Prosser
	Expected Performance gain - immediate Delivery of current savings and planned savings for 23/24 financial year		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve • Delivery of savings and efficiencies under project management, with focus on Value Based Healthcare	**Timescale:** Dec 2023	**Lead:** Alan Prosser
	Expected Performance gain – longer-term Delivery of efficiencies		
	Risks to future performance		
	Set out risks which could affect future performance • Competing demand and implementation of operating models		

EQUITY

KPI Indicator KPI.81

Return to Top

% Workforce declared Welsh Speakers in Trust at Level 1

Target: TBA%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	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	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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 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
- insert text

KPI Indicator KPI.78

Return to Top

Diversity of Workforce (Gender) % of Women in Senior Leadership positions

Target: TBA%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	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	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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 KPI.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: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	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	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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 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 KPI.80

Return to Top

Diversity of Workforce – People with a Disability

Target: TBA%

SLT Lead: WBS Divisional Director

Current Performance against Target or Standard

WBS Position	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	Apr 23	My 23
Actual %															
Target TBA%															

[Graph and data to be inserted under development at the Divisional level]

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 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
-

APPENDIX 3: TRUST-WIDE SERVICES

SAFETY

KPI Indicator H&S.14

Return to Top

Graph title - Number of RIDDOR reportable incidents by Division

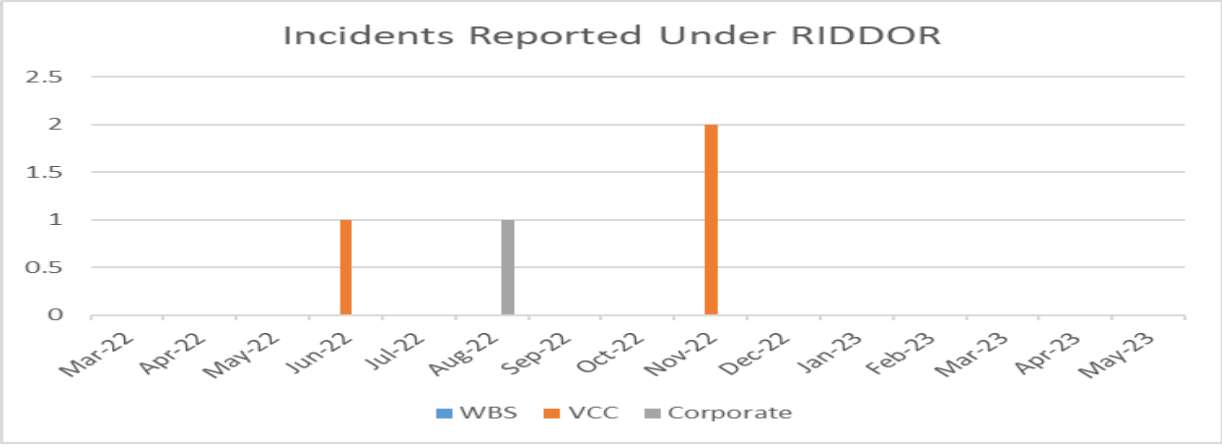
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard -

Performance - remains stable

	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	Apr 23	May 23
WBS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VCC	0	0	0	1	0	0	0	0	2	0	0	0	0	0	0
Corporate	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0



Service Improvement Actions – Immediate (0 to 3 months)

Lessons learned from previous RIDDOR incidents implemented	Timescale Q4 2022/23. VCC H&S Integrated care and Ed& Dev

Expected Performance gain
Lessons learned and implemented

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale :**

Expected Performance gain
Lessons learned to prevent reoccurrence of incident and prevent similar ones

Risks to future performance

Incomplete incident investigation – **action** quality check by H&S, implementation of manager H&S training including risk assessment and incident training.

Operational pressures making it challenging for staff to training – **Action –** flexible onsite provision of training

Some departments not completing departmental inspections – escalated to SLT.

KPI Indicator H&S.17

Return to Top

KPI 4 – Percentage of actions closed

Target: 100%

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

	Q4 2021-22			Q1 2022-23			Q2 2022-23			Q3 2022 -23			Q4 2022-23			Q1 2023-24		
	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	Apr 23	May 23	Jun 23
Actual %			73			64			71			76			78			
Target			100			100			100			100			100			100

Analysis

NB: KPI set to quarterly reporting at Trust Estates Compliance meetings prior to new Performance Management Framework arrangements in 2022 and this frequency of reporting will remain.

Performance

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

a) Current mandated NWSSP module for recording FRAs is not functioning correctly [loss of access; failure to save data] which has affected review and update of FRAs.

b) NWSSP have small fund from WG to update/replace FRA module and all-Wales task & finish group currently working on this issue.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
a) Review FRAs and keep hardcopy for upload onto NWSSP system.	2022/23 Q3	Trust FSM

Expected Performance gain - immediate

a) Issue outside Trust control; FRAs are reviewed and updated with potential lag for formal update on NWSSP module.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
A) NWSSP and working group to consider next steps and roll out across Wales.	n/a	n/a

Expected Performance gain – longer-term

a) Continuation of FRA reviews on robust, sustainable platform

Risks to future performance

Set out risks which could affect future performance

a. Non-compliance with statutory and mandatory duties.

b. Failure to identify and manage risk.

KPI Indicator H&S.16

Return to Top

KPI 10 - Percentage of premises/Zones where fire drills or evacuation exercises have been undertaken in the past 12 months.

Target:

Current Performance against Target or Standard

	Q4 2021-22			Q1 2022-23			Q2 2022-23			Q3 2022 -23			Q4 2022-23			Q1 2023-24		
	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	Apr 23	May 23	Jun 23
Actual %			*nda*			*nda*			*nda*			*nda*			*nda*			
Target			100			100			100			100			100			100

Analysis

Fire drills / exercises have been held in abeyance due to the pandemic and current working practices.

It is anticipated that the Trust will pick these up again as part of the return to normal business activity in Q3.

SLT Lead: Head of Operational Services and Delivery

Performance

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

a) Divisions to reinstate regular schedule of evacuation drills / exercises

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
a) Divisions to establish schedule of regular drills/exercises.	Q2	Divisional leads

Expected Performance gain - immediate

a) Staff have opportunity to practice learning.

b) Evaluation of procedures leading to change/improvement [Lessons Learnt]

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
n/a	n/a	n/a

Expected Performance gain – longer-term

As immediate performance gain(s) above.

Risks to future performance

Set out risks which could affect future performance

a) Failure to identify deficiencies in existing emergency procedures

KPI Indicator H&S.55

Return to Top

Graph title - Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division

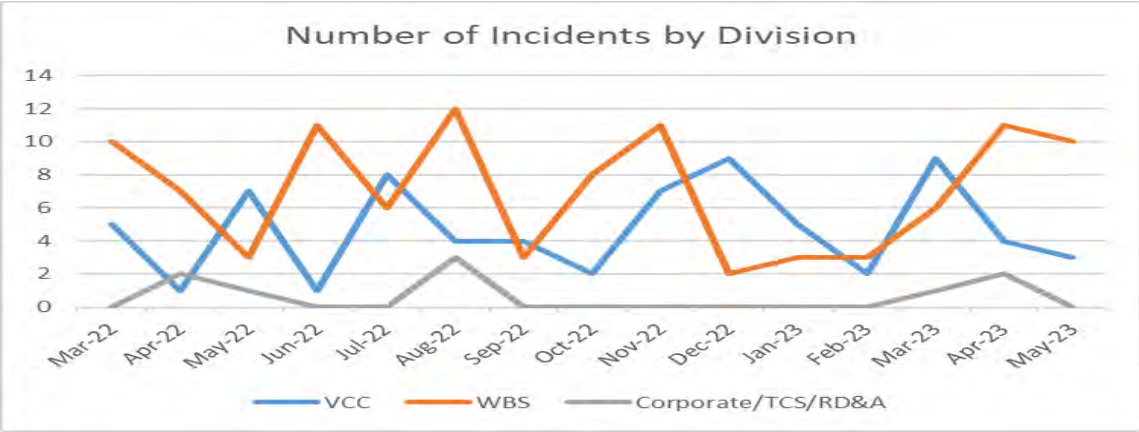
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	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	Apr 23	May 23
VCC	5	1	7	1	8	4	4	2	7	9	5	2	9	4	3
WBS	10	7	3	11	6	12	3	8	11	2	3	3	6	2	10
Corporate	0	1	1	0	0	2	0	0	0	0	0	0	0	2	0



VCC – 2 patient accident slip trip fall ongoing pattern with chairs in SACT ongoing discussion to RA and SOP in development /ongoing investigation. Assigned investigator conducting assessment.
Staff incident – member of staff struck by barrier, additional signage in place.
WBS – 4 behaviour V&A / 2 contact with object / 4 manual handling / all accidents being investigated no clear trends. Further discussion on the use of roll cage use as this appears to be a theme. Inanimate Load Training is a priority

Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incidents investigated. H&S incident investigation training scheduled January March and April 2023 VCC.	Q4 2022/23.

Expected Performance gain
Improved identification root causes VCC & Corporate
Improved data quality in incident records

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale:**

Expected Performance gain

Risks to future performance

Incomplete incident investigation – **action** monitoring and short incident training January and March 2023 at VCC and Corporate
Some departments not completing departmental inspections
action – refresh of dept inspection process

KPI Indicator WOD.19

Return to Top

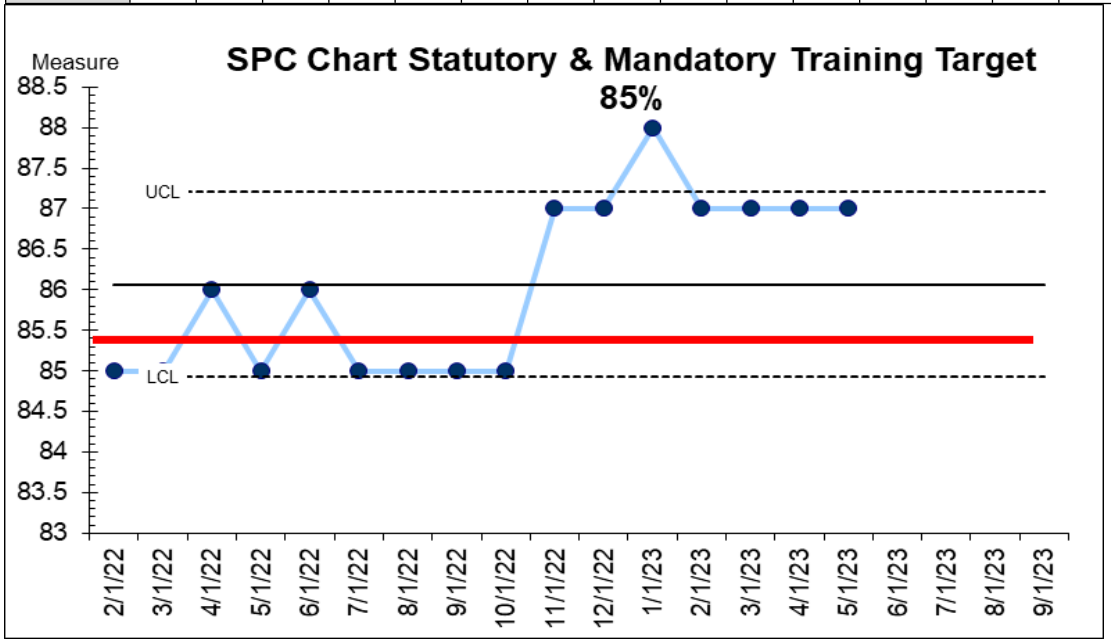
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	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	Apr 23	My 23
Actual %	85	86	85	86	85	85	85	85	87	87	88	87	87	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

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 performance 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	**Monthly**	Head of OD People and OD Senior Business Partner
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.		

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 H&S.43

Return to Top

Graph title - Incidents of Violence and Aggression

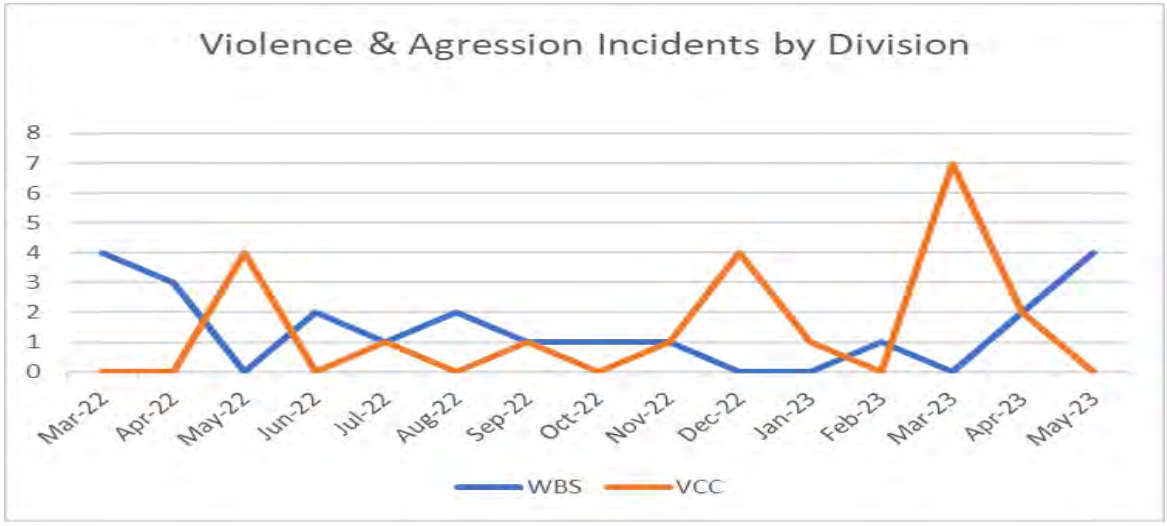
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard –

Performance - Stable

	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	Apr 23	May 23	Total
WBS	4	3	0	2	1	2	1	1	1	0	0	1	0	**2**	**4**	**26**
VCC	0	0	4	0	1	0	1	0	1	4	1	0	7	**2**	**0**	**25**



WBS – 4 behaviour V&A – Training provided to staff to support dealing with such instances
Retrospective note 1 of the incidents in VCC that occurred during April resulted in issue of behaviour contract. This will be monitored moving forward

Service Improvement Actions – Immediate (0 to 3 months)

The four incidents recoreded in WBS were behavioural, relating to donors not being able to give blood. Staff training has been rolled out to support dealing with such issues.	Timescale VCC and WBS safety advisors Q 1 & 2 2023

Expected Performance gain – immediate Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit

Service Improvement Actions – tactical (12 months +)

Actions: Trust wide bespoke training in targeted areas in addition to V&A Passport Scheme. Monitoring through HSG65 audit	H&S Team Timescale:Q3& 4 2023

Expected Performance gain – longer-term

Risks to future performance

VCC and Corporate – V&A from patients and families due to treatment delays
VCC management of confused patients on FFW. Aggression in relation to parking pressures.
WBS – verbal aggression from donors.

KPI Indicator EST.06

Return to Top

% reduction in Carbon Footprint/Emissions by 2025 against 20/22 baseline

Target: -16% against 2020/21

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr23	May 23
Actual Number	164.45	131.07	104.41	104.46	102.74	110.99	124.43	173.50	159.92	215.57	181.39	189.03	149.441	118.975
Target -16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%	-16%

Target = -16% Carbon Footprint/Emissions Statutory Regulations reduction by 2025 against 2021/22 baseline – measure carbon parts per million by volume

Performance

Assessment of current performance, set out key points:

- The carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.

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:
• Continuing monitoring	XX/XX/XX	AN Other
• Improvement to monitoring energy through the BMS	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Reduced carbon footprint

Improvement across sites from the capital projects – namely nVCC and Talbot Green Infrastructure.

Risks to future performance

	Set out risks which could affect future performance •

KPI Indicator DIG.61

Return to Top

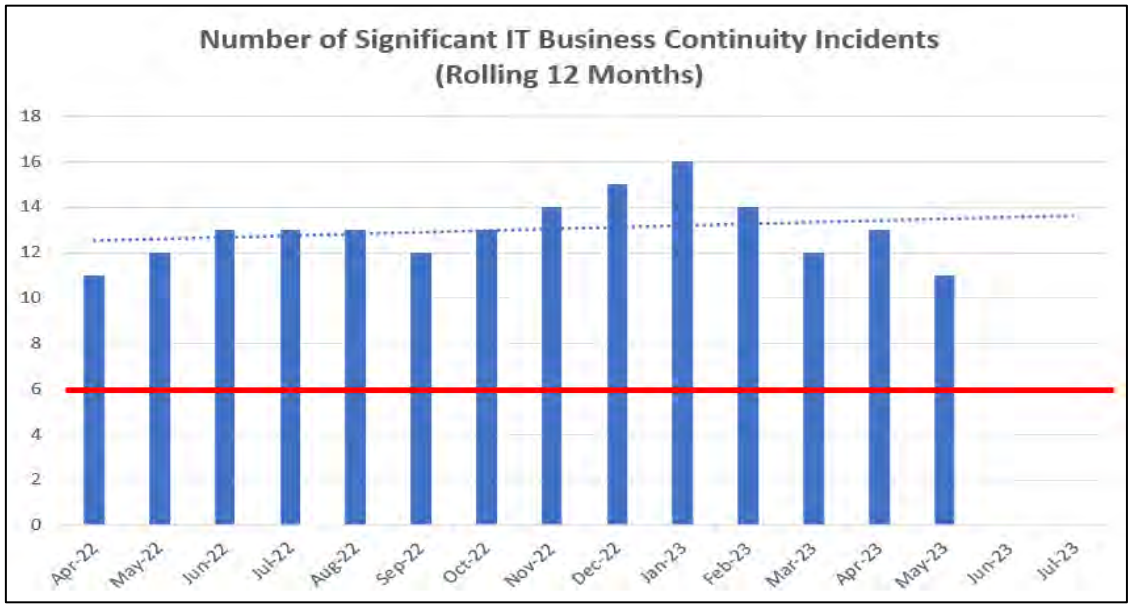
Digital Infrastructure: Number of Significant IT Business Continuity Incidents (Rolling 12 Months)

Target: 6 Incidents (Rolling 12 Months)

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	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	Apr 23	May 23
Actual	-	11	12	13	13	13	12	13	14	15	16	14	12	13	11
Target	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6



Performance

Assessment of current performance, set out key points:

- In month reported figure reflects number of significant IT business continuity incidents in the previous 12-months.
- Significant volume of outages through mid/late-2022, steadily downward trend in recent months reflects improved stability
- Outages generally relate to network and application outages in VCC – some incidents relate to outages associated with national applications (e.g. WCP, LIMS) and/or ageing local IT infrastructure equipment / inefficient network design.
- Outages associated with national applications are reviewed via national service management boards, with the aim of reducing the likelihood of future service interruptions.
- Recruitment of additional band 6 IT infrastructure resource into VCC team ongoing – failed recruitment in June 2023, role back out to advert.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• External baseline assessment of VCC network / IT infrastructure – delayed from Dec 22	31/03/2023 (delayed to Q2 2023/24)	DMH
• Recruitment of additional technical expertise to support planned IT infrastructure works – delayed from Dec 2022.	28/02/2022 **(ONGOING)** (1 of 2 roles filled)	DMH

Expected Performance gain – immediate

Reduced number of service outages, improved resilience and performance.

Service Improvement Actions – tactical (12 months +)

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

	• Full telephony upgrade, as part of Trust-wide telephony platform • Removal of 'end of life' / legacy IT infrastructure	31/03/2024 31/03/2024	DMH DMH
	Expected Performance gain – longer-term Reduced number of service outages, improved resilience and performance.		
	Risks to future performance		
	Set out risks which could affect future performance • Number of 'end of life' IT equipment in operational use in VCC – replacement being expedited as part of ongoing technology refresh programme. • Limited resources / skills within Digital Services team – recruitment ongoing to increase capacity. Training credits and associated plan to be delivered through 2023/24.		

KPI Indicator DIG.62

Return to Top

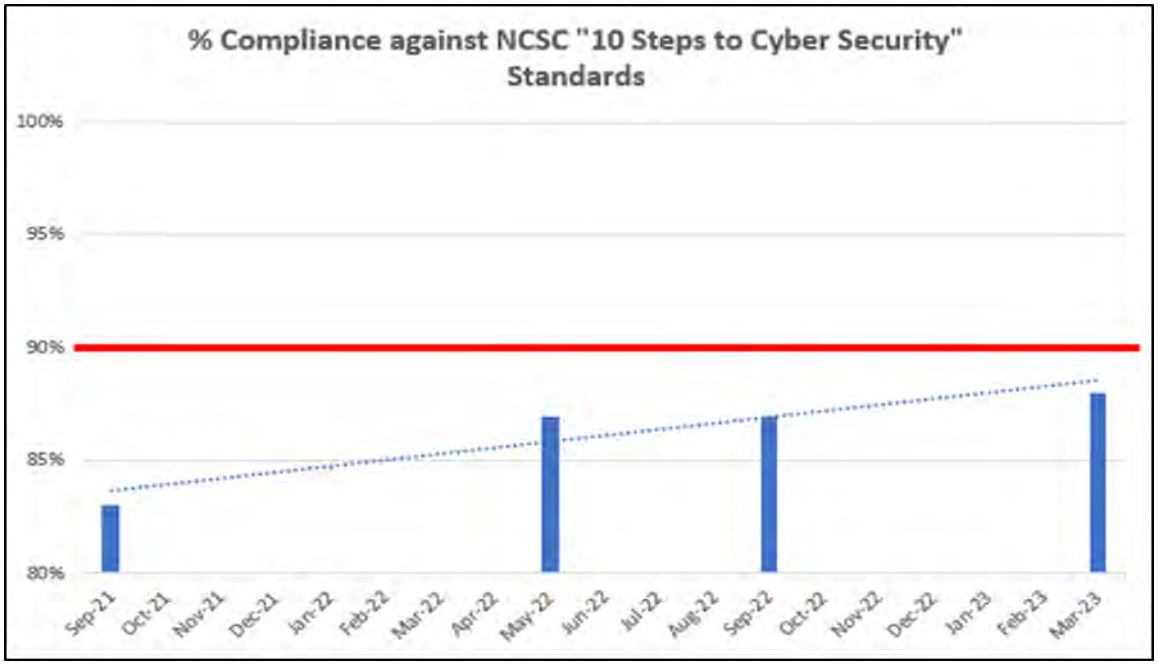
% compliance against NCSC "10 Steps to Cyber Security" best practice standards

Target: 90%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	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	Apr 23	May 23
Actual (%)	-	-	-	87	-	-	87	-	-	-	-	-	88	-	-
Target (90%)	-	-	-	90	-	-	90	-	-	90	-	-	90	-	-



Performance

Assessment of current performance, set out key points:

- First assessment – undertaken Sep 2021. Mid Year review completed in March 2023. Next update Sep 2023.
- Performance slightly improved since Sep 2022 update.
- Progress slowed due to delay in recruiting to Cyber Security Officer/Manager role. Competitive marketplace – difficult to recruit.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Recruit replacement Cyber Security Manager – interviews scheduled for July 2023	30/01/2023 (delayed)	DMH
• Deploy various IT infrastructure (e.g. new firewalls) to enhance cyber security posture)	Ongoing	DMH
• Re-establish regular simulated phishing campaigns for staff.	30/01/2023 (delayed)	DMH

Expected Performance gain - immediate

Original performance target aimed to achieve target compliance (90%) by 31/03/2023. Work will continue with the aim of achieving this target in September 2023.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Board Development Sessions re: Cyber Security.	30/09/2023	DMH
• Deploy various IT infrastructure, further	Ongoing	DMH

	vulnerability monitoring etc. to enhance cyber security posture. • Increase number of cyber security staff within Digital Services team.	30/06/2023	DMH
	Expected Performance gain – longer-term Original performance target aimed to achieve target compliance (90%) by 31/03/2023. Work will continue with the aim of achieving this target in September 2023.		
	Risks to future performance		
	Set out risks which could affect future performance • Limited cyber security capacity / expertise within Digital Services team. Cyber Security Officer left Trust in July 2022 – failure to recruit replacement after two rounds of recruitment. New Band 7 Cyber Security Manager role approved via Scrutiny – interviews scheduled for July 2023 • Board-level understanding of cyber security requires further development.		

KPI Indicator DIG.63

Return to Top

Cyber Security – % of employees clicking on internal phishing campaigns

Target: TBA

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	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	Apr 23	May 23
Actual %	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Target TBA	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Performance

Assessment of current performance, set out key points:
Currently unable to routinely report compliance.
Aim to establish reporting in Q4 2023/23 – delayed pending recruitment of Cyber Security Manager (interviews scheduled for July 2023).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Re-establish regular simulated phishing campaigns for staff (delayed due to failure to recruit Cyber Security Officer – new Band 7 role created)	30/01/2023 **(DELAYED)**	DMH

Expected Performance gain - immediate
TBC

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• n/a	n/a	n/a

Expected Performance gain – longer-term
TBC

Risks to future performance

Set out risks which could affect future performance

- Limited cyber security capacity / expertise within Digital Services team. Cyber Security Officer left Trust in July 2022. Failure to recruit replacement following two attempts – job description updated to Band 7 Cyber Security Manager, interviews scheduled for July 2023

EFFECTIVENESS

KPI Indicator WOD.36

Return to Top

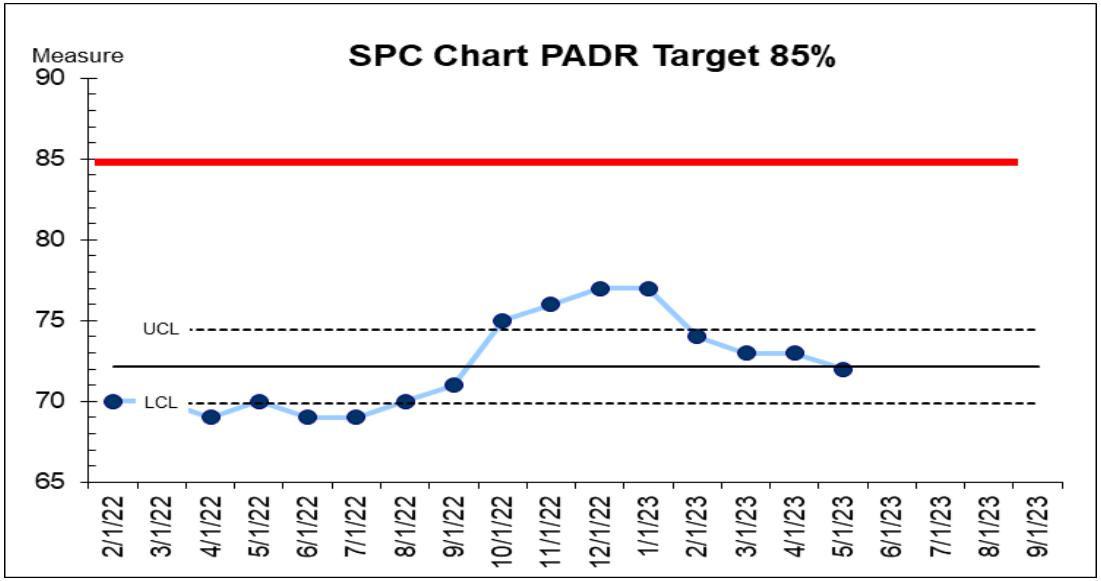
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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	Apr 23	My 23
Actual %	70	69	70	69	69	70	71	75	76	77	77	74	73	73	72
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:

As anticipated, there was short-term growth in PADR activity during the early implementation of the new Pay Progression Policy in Autumn 2022, however we see once more a decline in the Trust wide data with a specific cause for concern in Transforming Cancer Services that has been below 50% consecutively since November 2022.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Support TCS with improvement plan	01/09/2023	Senior BP Head of Workforce
Continue to monitor for hotspot areas of concern and provide interventions for improvement.	01/09/2023	

Expected Performance gain - immediate

With targeted interventions in hotspot areas that are continually preforming significantly below the expectations this should see a growth in the overall compliance within the Trust.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Ongoing Monthly	Business Partners alongside SMT/SLT

Expected Performance gain – longer-term

As regular monitoring and reviews of compliance is undertaken in the divisional operational meetings 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

KPI Indicator WOD.37

Return to Top

Staff Sickness levels against Target

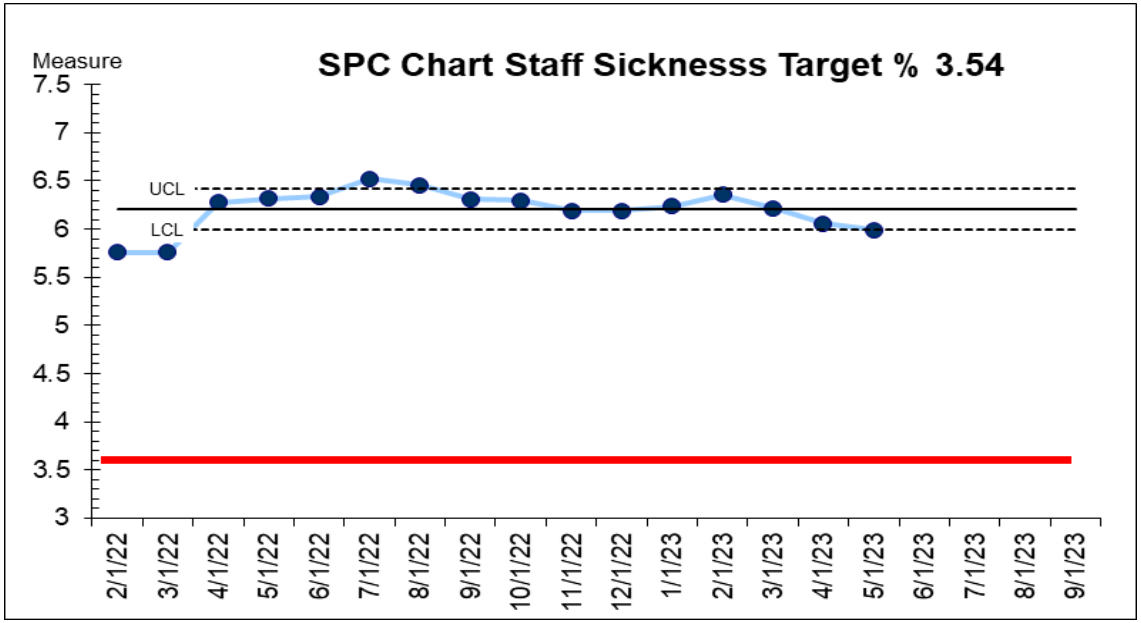
Target: 3.54%

SLT Lead: WOD Director

Current Performance against Target or Standard

Performance

Trust Position	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	Apr 23	May 23
Actual %	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	6.06	5.99
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



Assessment of current performance, set out key points:

There is a slight decline in sickness following the winter months and as the People and Relationship Team continue to support managers in the application of the sickness policy.

Short-term absence has once more dropped to 1% in May 2023 therefore prioritisation on long-term management will be key going forward.

Anxiety/stress/depression/other psychiatric illnesses, remaining as highest reason for absence, both in month and on a rolling average.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Quarterly random sickness audits to be undertaken in: • ICT • RD&I • Private Patients	01/09/2023 01/08/2023	Head of Workforce
Detailed analysis of anxiety/stress/depression and other psychiatric illness to be undertaken		Head of Workforce

Expected Performance gain - immediate

Regular monitoring against the application of the policy will ensure our staff are supported and encouraged to improve their health and areas where there are concerns are provided with immediate interventions to improve practice.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engegments sessions in Autumn 2022 the following	30/04/2024	Head of OD

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	actions are being taken over the coming 12 months • Staff wellbeing support survey • Developing a Menopause friendly culture • Launch benefit platforms (HealthShield, Wagestream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation	Ongoing	Head of OD and Trust Board
	Expected Performance gain – longer-term The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.		
	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 EST.25

Return to Top

Delivering wider social value (Sustainable Development Assessment Tool (SDAT)

Target: TBA

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard

Trust	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	Apr 23	My 23
Actual %															
Target 85%															

[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 • insert text • 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 • insert text • 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
- insert text

KPI Indicator H&S.27

Return to Top

KPI 7 – Compliance with fire safety training need analysis (TNA): ***Basic Awareness*** [Level 1]

Target: 85%

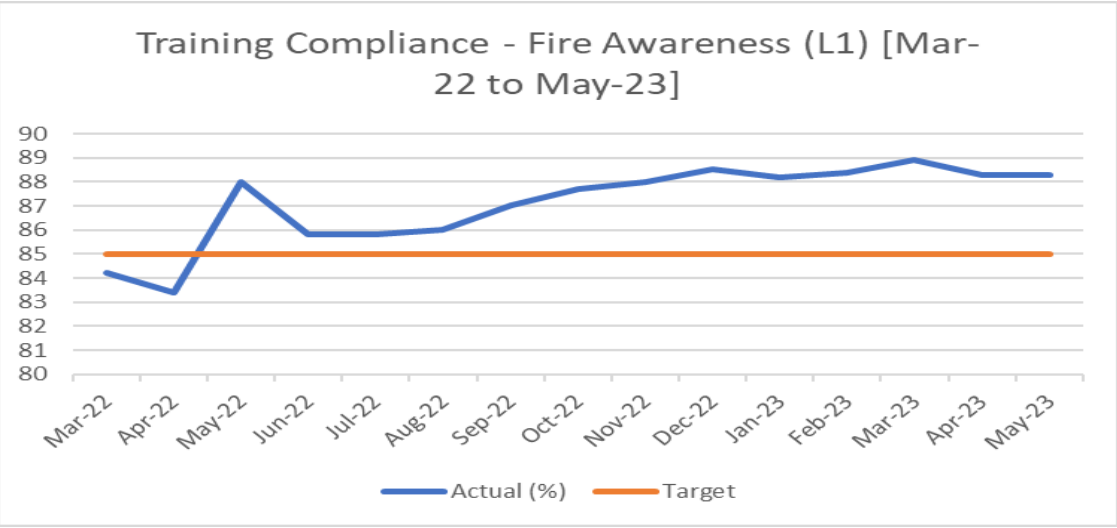
SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

MONTH	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	Apr 23	May 23
Actual (%)	84	83	88	86	86	86	87	88	88	89	88	88	89	88	88
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

nda – No Data Available

NB: KPI previously set to quarterly reporting at Trust Estates Compliance meetings prior to new Performance Management Framework arrangements in 2022.



Analysis

Compliance has remained static with no marked increae compared to previous month [April 2023].

Performance

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

- Training compliance is still affected by reduction in staffing due to the pandemic and changes in working patterns i.e., agile/hybrid working.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continued liaison with divisions and managers to develop local arrangements for delivery of training.	COMPLETE Q1	Trust FSM Trust FSM

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
In support of blended approach for training, consider and develop new ways of delivering training which reflect current working practices and barriers i.e. develop modular/"toolbox" approach to delivering training.	Q2	Trust FSM

Expected Performance gain – longer-term

- Staff have wider access to training which can be delivered at a time and place to suit their needs.
- Increase in training compliance.

Risks to future performance

Set out risks which could affect future performance

a) Failure of Trust and staff to comply with statutory and mandatory duties.

b) Insufficient training has the potential to result in fire incident.

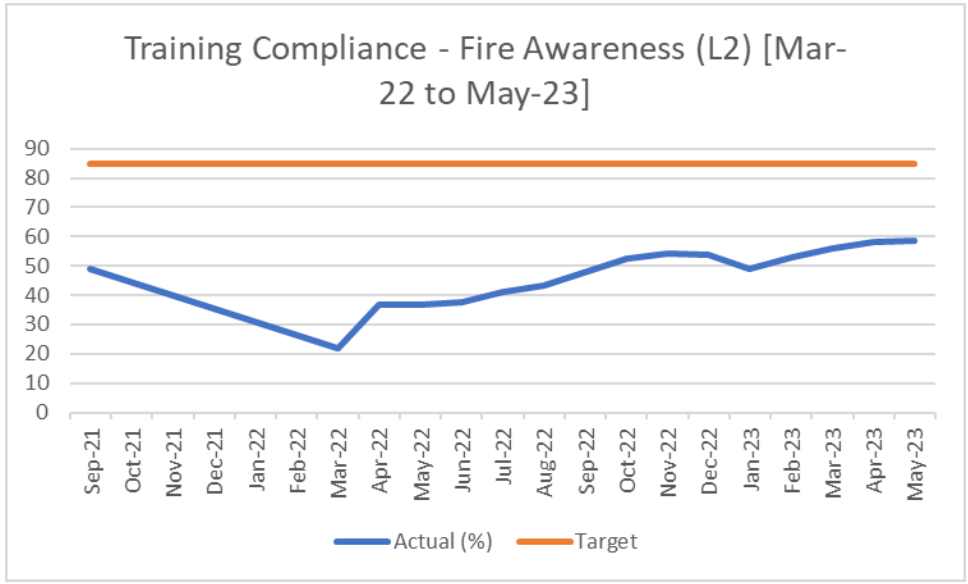
KPI 8 – Compliance with fire safety training need analysis (TNA): ***Operational Response*** [Level 2]

Target:

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

ONTH	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-21	Oct-22	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual (%)	22	37	37	38	41	43	49	53	54	54	49	53	56	58	59
Target	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Analysis

Marginal improvement in complince caompared to previous month [April 2023].

Performance

Despite marginal rise in training compliance, figures still below Trust benchmark due to service needs and resurgence of the pandemic, some training for staff has been restricted; both the FSM and Trust Ed & Dev team are actively working with departments to identify alternative approaches to the delivery of fire training.

Training compliance is still affected by reduction in staffing due to the pandemic and changes in working patterns i.e. agile/hybrid working.

49.0

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continued liaison with divisions and managers to develop local arrangements for delivery of training.	Q1	Trust FSM

Expected Performance gain - immediate

Divisions and managers accept some ownership of training and advise how staff can receive training to fit in with current ways of working and other barriers.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
In support of blended approach for training, consider and develop new ways of delivering training which reflect current working practices and barriers i.e. develop modular/"toolbox" approach to delivering training.	Q2	As KPI 7

Expected Performance gain – longer-term

Staff have wider access to training which can be delivered at a time and place to suit their needs. Increase in training compliance.

Risks to future performance

Set out risks which could affect future performance

Failure of Trust and staff to comply with statutory and mandatory duties. Insufficient training has the potential to result in fire incident.

KPI 9 - Compliance with fire safety training need analysis (TNA): ***Tactical Response*** [Level 3]

Target:

SLT Lead: Head of Operational Services and Delivery

Current Performance against Target or Standard

	Q1 2022-23			Q2 2022-23			Q3 2022-23			Q4 2022-23			Q1 2023-24		
	Apr 22	May 22	Jun 22	Jul 22	Apr 22	May 22	Jun 22	Jul 22	Apr 22	May 22	Jun 22	Jul 22	Apr 23	May 23	Jun 23
Actual %	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*	*nda*
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Analysis

As noted under KPI 7, a paper was submitted to the Trust Education Steering Group in July to rationalize fire training into three distinct levels including fire [Tactical] response.

Performance

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

- Lack of clarity on training criteria

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
a) Adopt more structured TNA for fire safety as outlined in paper to the trust's Education Steering group	Q2	Trust FSM Trust Ed & Dev team

Expected Performance gain - immediate

a) Managers and staff have clearer idea of the training they need to complete.

b) Training can be more focused around staff groups / departments.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
n/a	n/a	n/a

Expected Performance gain – longer-term

n/a

Risks to future performance

Set out risks which could affect future performance

Failure of Trust and staff to comply with statutory and mandatory duties. Insufficient training has the potential to result in fire incident.

KPI Indicator H&S.26

Return to Top

Graph title - Trust Health and Safety Training Compliance by Course

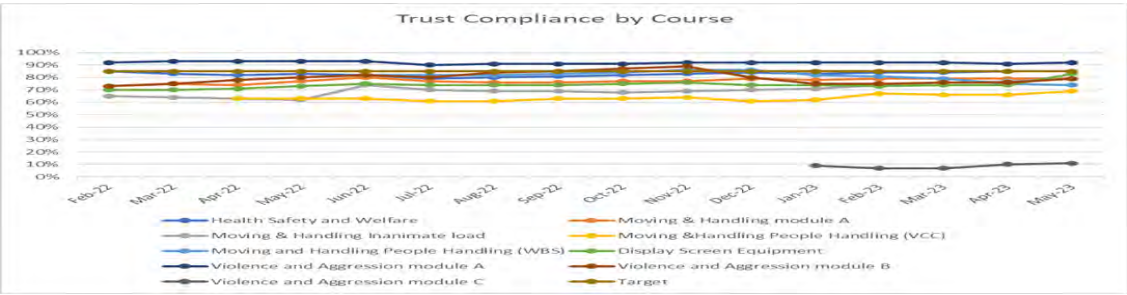
Target: 85%

SLT Lead: Carl James

Current Performance against Target or Standard – below 85% in 7 out of 9 areas

Performance - Level below target

	Health Safety and Welfare	Moving & Handling module A	Moving & Handling Inanimate load	Moving &Handling People Handling (VCC)	Moving and Handling People Handling (WBS)	Display Screen Equipment	Violence and Aggression module A	Violence and Aggression module B	Violence and Aggression module C
Mar-22	83%	75%	64%			70%	93%	75%	
Apr-22	82%	74%	63%	63%		71%	93%	78%	
May-22	83%	77%	62%	63%		73%	93%	80%	
Jun-22	82%	80%	74%	63%	82%	75%	93%	82%	
Jul-22	79%	77%	70%	61%	82%	74%	90%	80%	
Aug-22	80%	76%	69%	61%	82%	74%	91%	84%	
Sep-22	81%	76%	69%	63%	83%	74%	91%	85%	
Oct-22	82%	77%	68%	63%	84%	75%	91%	87%	
Nov-22	83%	77%	69%	64%	86%	76%	92%	89%	
Dec-22	84%	79%	70%	61%	86%	74%	92%	80%	
Jan-23	83%	78%	71%	62%	82%	74%	92%	75%	9.00%
Feb-23	84%	79%	74%	67%	81%	73%	92%	75%	7%
Mar-23	84%	79%	76%	66%	79%	74%	92%	76%	7%
Apr 23	85%	79%	77%	66%	75%	74%	91%	76%	10%
May 23	85%	79%	79%	69%	74%	83%	92%	79%	11%



Service Improvement Actions – Immediate (0 to 3 months)

Provision of training is maintaining if not marginally improving the overall position. Positive feedback received from the divisions in response to the onsite delivery model, rolled out through the course of this year.

The TNA conducted earlier in the year also identified an increase need for training which has resulted in an extra 324 training courses. Consolidation against this uplifted figure demonstrates that training figures are improving. V&A Module C continues to improve with marginal gains. Note this training has only recently been identified and there is a body of people identified through TNA earlier this year.

Action Additional dates added to the calendar up to December to support chieving compliance

Timescale and Lead Q1 2023/24 Lead: Department Heads

Expected Performance gain – immediate steady improvement in compliance

Service Improvement Actions – tactical (12 months +)

Actions: As above

Timescale:Q1 & Q22023/24 Lead: Departmental Heads

Expected Performance gain – longer-term Compliance with WG 85% target

Risks to future performance

Staff unable to be released due to operational pressures. - **Action** courses timetabled before rotas released. Dialogue with departments about scheduling courses. Staff access to IT equipment – Action DigiHub available for ESR training.

Volume of Statutory and Mandatory training which staff have to complete online

Graph title - Trust Health and Safety Training Compliance by Division

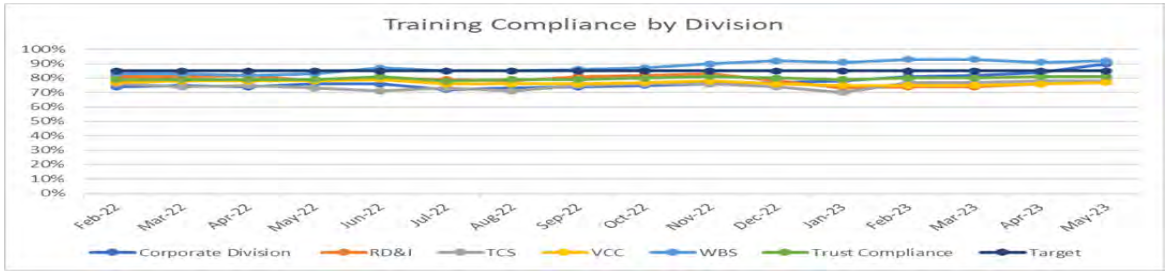
Target: 85%

SLT Lead: Carl James

Current Performance against Target or Standard – Below 85% I 5 out of 5 areas

Performance - Level below target

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar23	Apr 23	May 23
Corporate Division	75%	74%	76%	76%	72%	73%	74%	75%	76%	77%	78%	80.70%	82%	84%	90%
RD&I	81%	82%	78%	80%	79%	78%	81%	82%	83%	78%	73%	74%	74%	76%	78%
TCS	74%	75%	73%	71%	73%	71%	75%	76%	76%	74%	70%	77%	77%	78%	78%
VCC	78%	78%	78%	79%	76%	76%	76%	77%	78%	76%	75%	75%	75%	76%	77%
WBS	83%	82%	83%	87%	85%	85%	86%	87%	90%	92%	91%	93%	93%	91%	92%
Trust Compliance	79%	79%	79%	81%	78%	79%	79%	80%	81.20%	80%	79%	80%	80%	81%	81%



On the back of actions listed last month the overall picture has marginally improved. Continue to manage.

There is sufficient capacity in terms of training places offered, the challenge remains releasing staff to attend face-to-face training and staff completing mandatory online training.
Volume of Statutory and mandatory training required.

Timescale
Q1 2023/24
Lead: Departmental Managers

Expected Performance gain – steady improvement in compliance

Service Improvement Actions – tactical (12 months +)

Actions: As above

Timescale:
Q1 & Q2 2023/24
Lead: Departmental Managers

Expected Performance gain – longer-term Compliance with WG 85% target

Risks to future performance

Staff unable to be released due to operational pressures. –

Staff unable to be released due to operational pressures.

Volume of Statutory and Mandatory training which staff have to complete on line

STAFF EXPERIENCE

KPI Indicator DIG.51

Return to Top

Digital Service Desk % User Satisfaction with Digital Service Desk

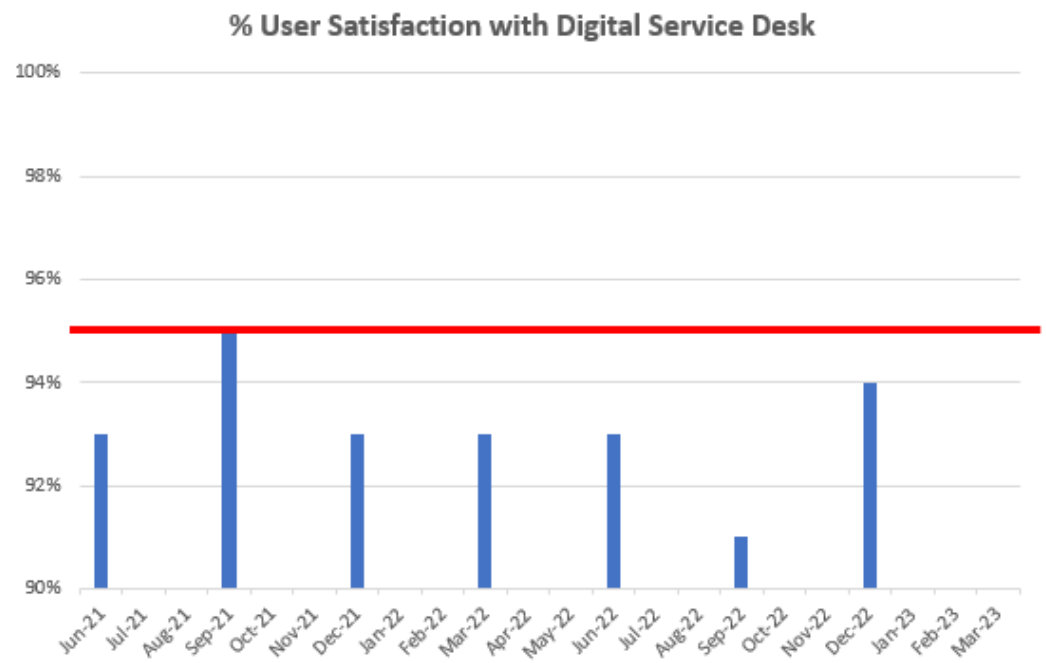
Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Performance

Trust	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23
Actual %	93%			91%			94%			87%					
Target 95%	95%			95%			95%			95%					



Assessment of current performance, set out key points:

Quarterly measure – next performance due to be reported in July 2023, for Q1 2023/24.

Previous dip in performance partly linked to staffing capacity challenges associated with various recruitment within the team. Two Service Desk Officers promoted within the team in Q4, presenting some short term capacity challenges. Recruitment of replacement staff completed – both started in post in June 2023.

New Digital Operations Manager role has been created – focus of role is to achieve a range of improved performance in respect of 1st and 2nd line IT support. Successful recruitment – commenced in post in early June.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Routine review of performance and associated feedback within Digital Services Infrastructure Team meetings to identify areas for improvement.	Ongoing	G Daniels

Expected Performance gain - immediate

Aiming to achieve and subsequently maintain 95% target by April 2023.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Deploy new IT Service Management (ITSM) tool, to support improved ways of	31/03/2024	G Daniels

	working across Digital Service Desk. • Automation of Service Desk activities – improved turnaround time to resolution. • Increase volume of calls that can be managed directly by 1st line support.	31/03/2024 (ongoing) 31/03/2024 (ongoing)	G Daniels G Daniels
	Expected Performance gain – longer-term Improved customer experience, to ensure 95% target is maintained.		
	Risks to future performance		
	Set out risks which could affect future performance • Unable to fund procurement of new ITSM tool. • National ITSM project (part of the All Wales Infrastructure Programme) does not proceed at sufficient pace.		

KPI Indicator WOD.13

Return to Top

% staff who rate us as a good employer in Annual Staff Survey

Target: TBA%

SLT Lead: Carl James

Current Performance against Target or Standard

Trust	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	Apr 23	My 23
Actual %															
Target 90%															

[Graph and data to be inserted under development]

SPC Analysis

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

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 • insert text • 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 • insert text • 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
- insert text

TIMELINESS

KPI Indicator DIG.58

Return to Top

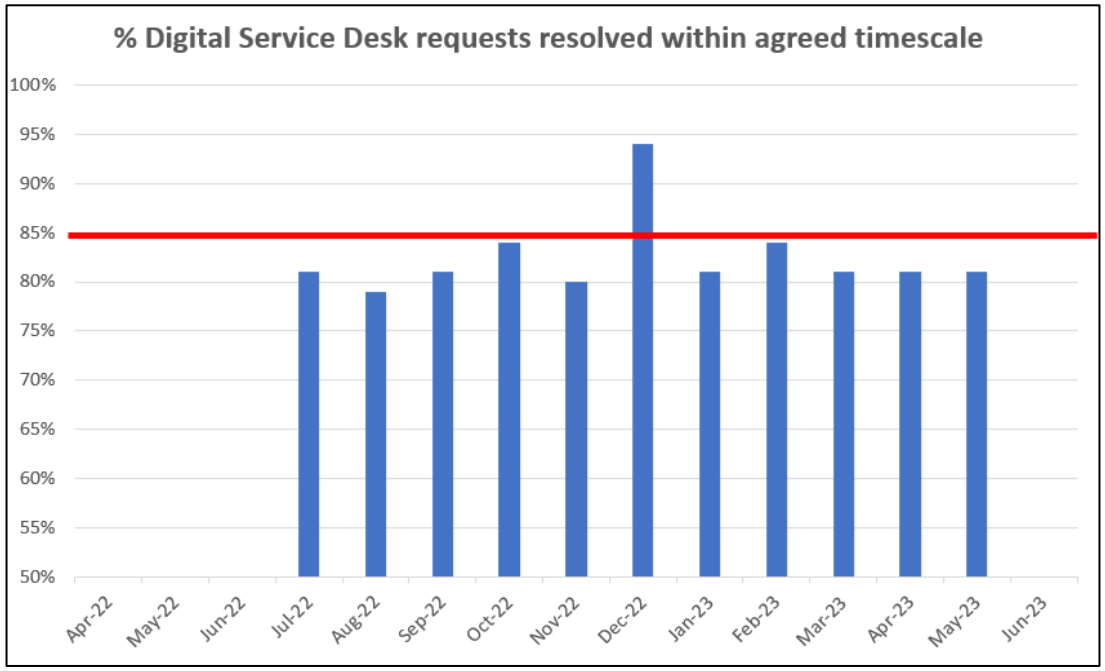
Digital Services: % Service Requests resolved within agreed (SLA) timescales

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	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	Apr 23	My 23
Actual %	n/a	n/a	n/a	n/a	81%	79%	81%	84%	80%	94%	81%	84%	81%	81%	81%
Target 95%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Performance

Assessment of current performance, set out key points :

Performance largely stable at approx. 81%.
Recruitment of 2 x Service Desk Officers – started work early June 2023.
Work ongoing to improve the quality and timeliness of service desk responses, to include increased use of automation – focus on increasing rates of first-time fixes by 1st line support team.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Backfill 2 wte Service Desk Officer staff.	31/05/2023 **(COMPLETED)**	DMH

Expected Performance gain - immediate

Aim to routinely achieve 85% target by start of Q2 2023/24 financial year.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Automation of Service Desk activities – improved turnaround time to resolution.	31/03/2024 (ongoing)	G Daniels
• Increase volume of calls that can be managed directly by 1st line support.	31/03/2024 (ongoing)	G Daniels

Expected Performance gain – longer-term

Maintain and exceed target performance.

Risks to future performance

Set out risks which could affect future performance

- Current IT Service Management (ITSM) tooling (Service Point – maintained by DHCW) insufficient to support required improvements to Digital Service Desk workflows (e.g. automation).
- Initial scoping exercise completed as part of All Wales Infrastructure Programme (AWIP) – procurement to take place through 2023/24.

KPI Indicator DIG.59

Return to Top

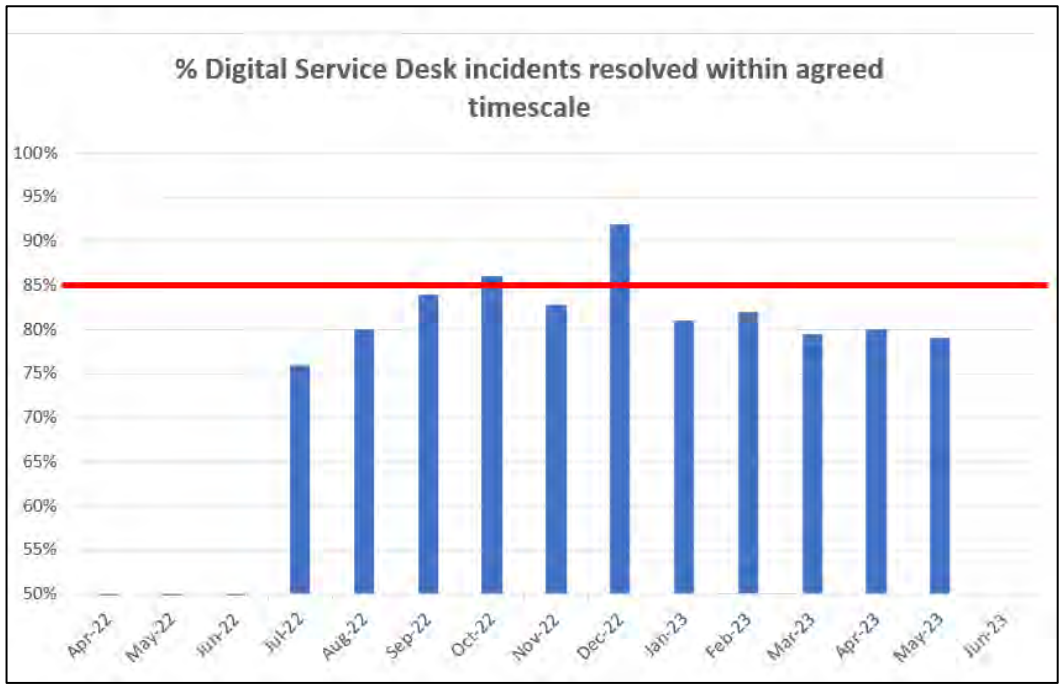
Digital Services: % Incidents resolved within agreed (SLA) timescales

Target: 95%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust Position	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	Apr 23	My 23
Actual %	n/a	n/a	n/a	n/a	76%	80%	84%	86%	83%	92%	81%	82%	80%	80%	79%
Target 95%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



Performance

Assessment of current performance, set out key points:

Target attained for first time in December 2022; however, performance currently stable at approx. 81%.

Recruitment of 2 x Service Desk Officers completed.

Work ongoing to improve the quality and timeliness of service desk responses, to include increased use of automation – focus on increasing rates of first-time fixes by 1st line support team.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Backfill 2 wte Service Desk Officer staff.	31/05/2023 **(COMPLETED)**	DMH

Expected Performance gain - immediate

Aim to routinely achieve 85% target by start of 2023/24 financial year.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Automation of Service Desk activities – improved turnaround time to resolution.	31/03/2024 (ongoing)	G Daniels
• Increase volume of calls that can be managed directly by 1st line support.	31/03/2024 (ongoing)	G Daniels

Expected Performance gain – longer-term

Maintain and exceed target performance.

Risks to future performance

Set out risks which could affect future performance

- Current IT Service Management (ITSM) tooling (Service Point – maintained by DHCW) insufficient to support required improvements to Digital Service Desk workflows (e.g. automation).
- Initial scoping exercise completed as part of All Wales Infrastructure Programme (AWIP) – procurement to take place through 2023/24.

KPI Indicator EST.54

Return to Top

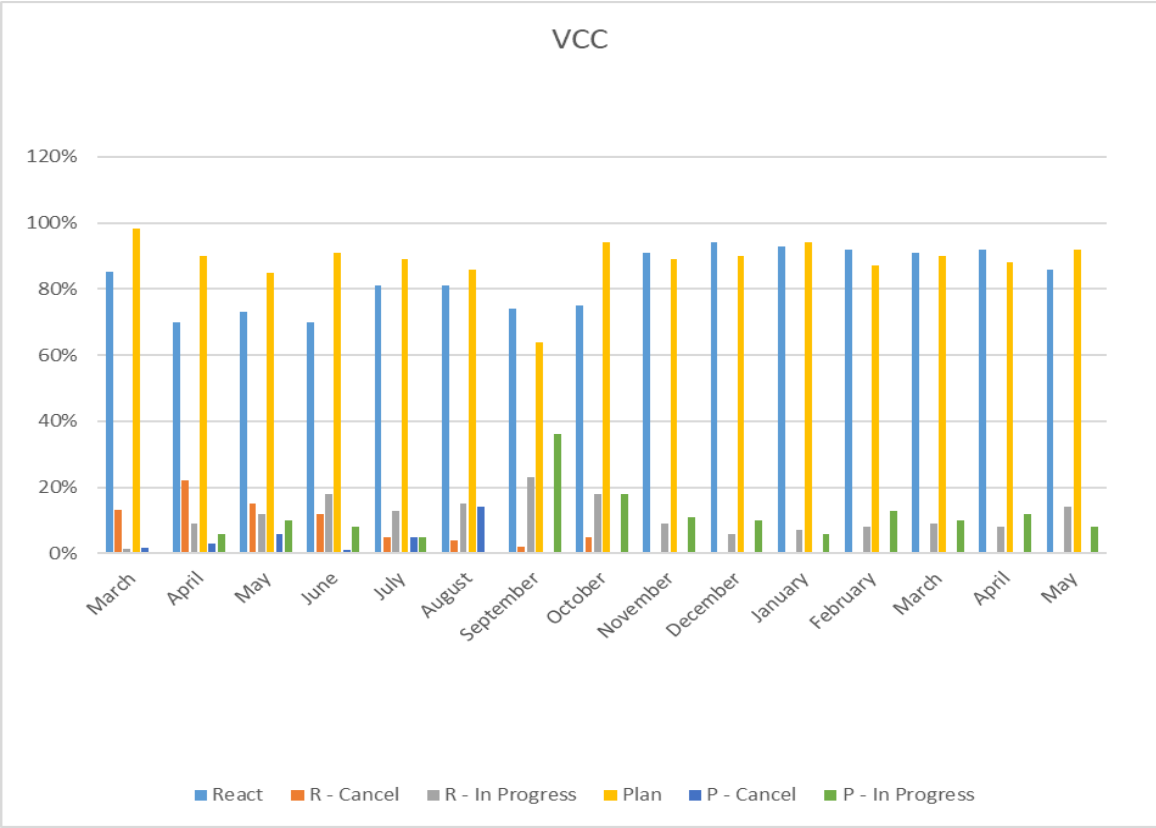
Graph title – 15 month Data PPM & Reactive Work Orders Velindre Cancer Centre

Target: 95% compliance of completion of PPM & Reactive tasks

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard – stable

Performance - no discernible trends available



If performance is not at required level, set out what the main causes are:
The estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale: 0-3 months**	**Lead: Jonathan Fear**
Short Term Source contractors for additional support to maintain a level of service delivery		

Planned Tasks – 86% In Progress – 14%
Reactive Tasks – 92% In Progress Jobs – 8%
Cancelled Jobs – 0% Planned & Reactive
There is a marked improvement on the compliance levels at VCC due to recruitment & additional planning and management of Planned and Reactive tasks. There were also no cancelled jobs during this period.

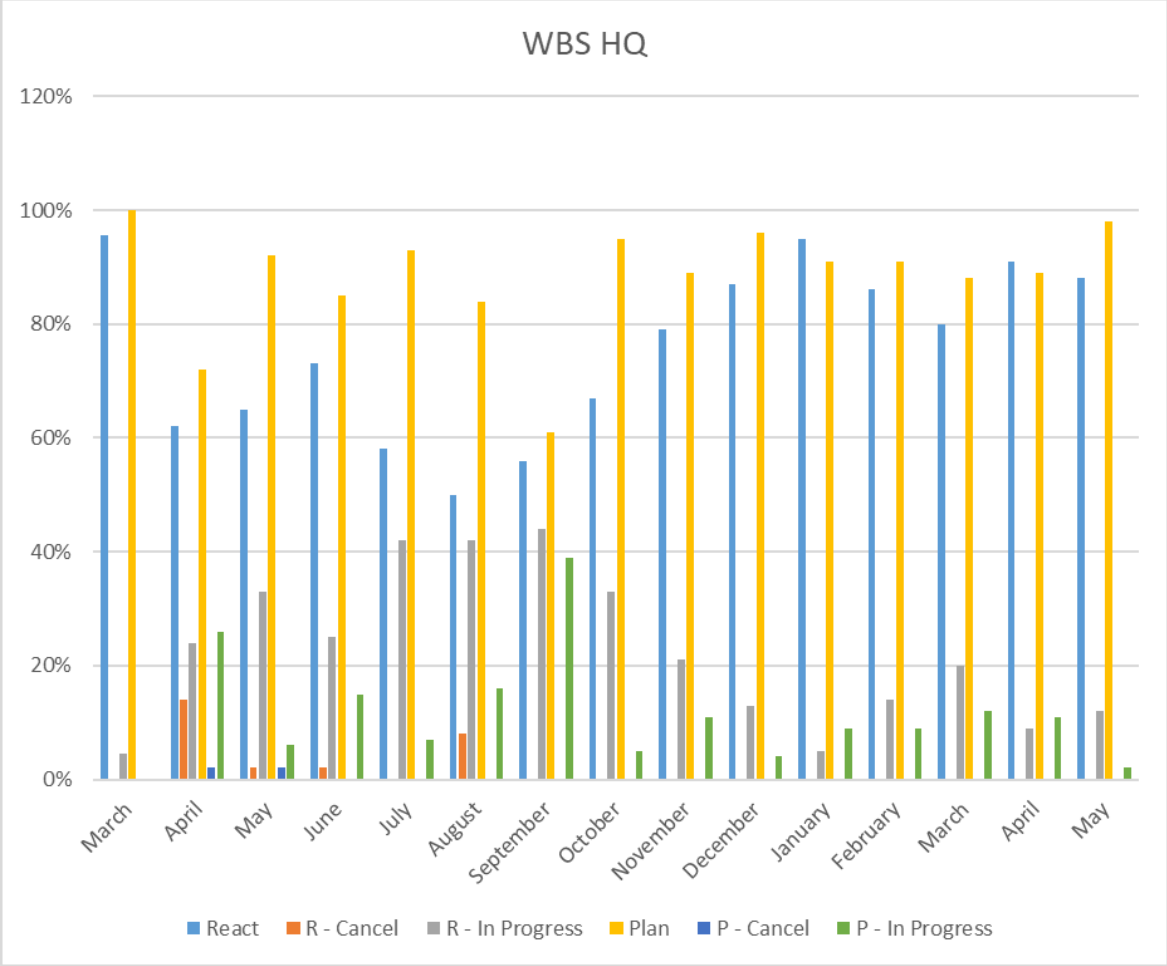
Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

Expected Performance gain – longer-term
Continue to improve compliance levels at VCC and across the Trust. Further recruitment posts to support longer term goals.

Risks to future performance
Works are being prioritised to ensure high risk and statutory activities are closed out. There is an ongoing risk that items may be missed however this will be addressed in full, with recruitment of staff and improvement to the CAFM System.

Graph title – 15 month Data PPM & Reactive Work Orders WBS HQ	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



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

The estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Source contractors for additional support to maintain a level of service delivery	**0-3 months**	**Jonathan Fear**

Planned Tasks – 98% Planned In Progress – 2%
Reactive Tasks – 88% In Progress Jobs – 12%
Cancelled Jobs – 0% Planned & Reactive
Compliance has improved this month and has hit its target above 98%

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

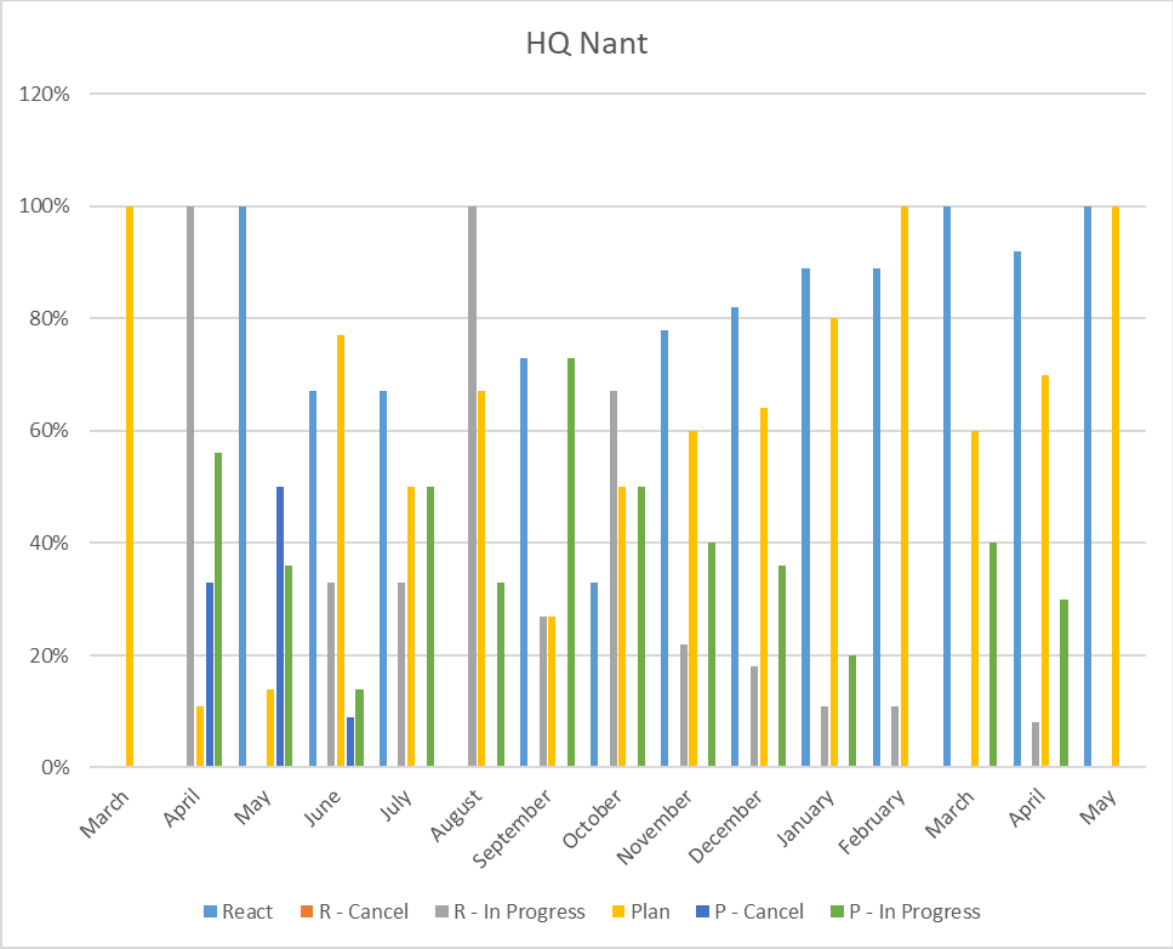
Expected Performance gain – longer-term

Decreased number of late/cancelled jobs as there will be an adequate workforce. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance

Works are being prioritised to ensure high risk and statutory activities are closed out. There is an ongoing risk that items may be missed however this will be addressed in full, with recruitment of staff and improvement to the CAFM System.

Graph title – 15 month Data PPM & Reactive Work Orders Headquarters Nantgarw	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



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

The estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Source contractors for additional support to maintain a level of service delivery	**0-3 months**	**Jonathan Fear**

Planned Tasks – 100 Planned in Progress – 0%
Reactive Tasks – 100% In Progress Jobs – 0%
Cancelled Jobs – 0% Planned & Reactive
Maintain high figures of compliance.

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

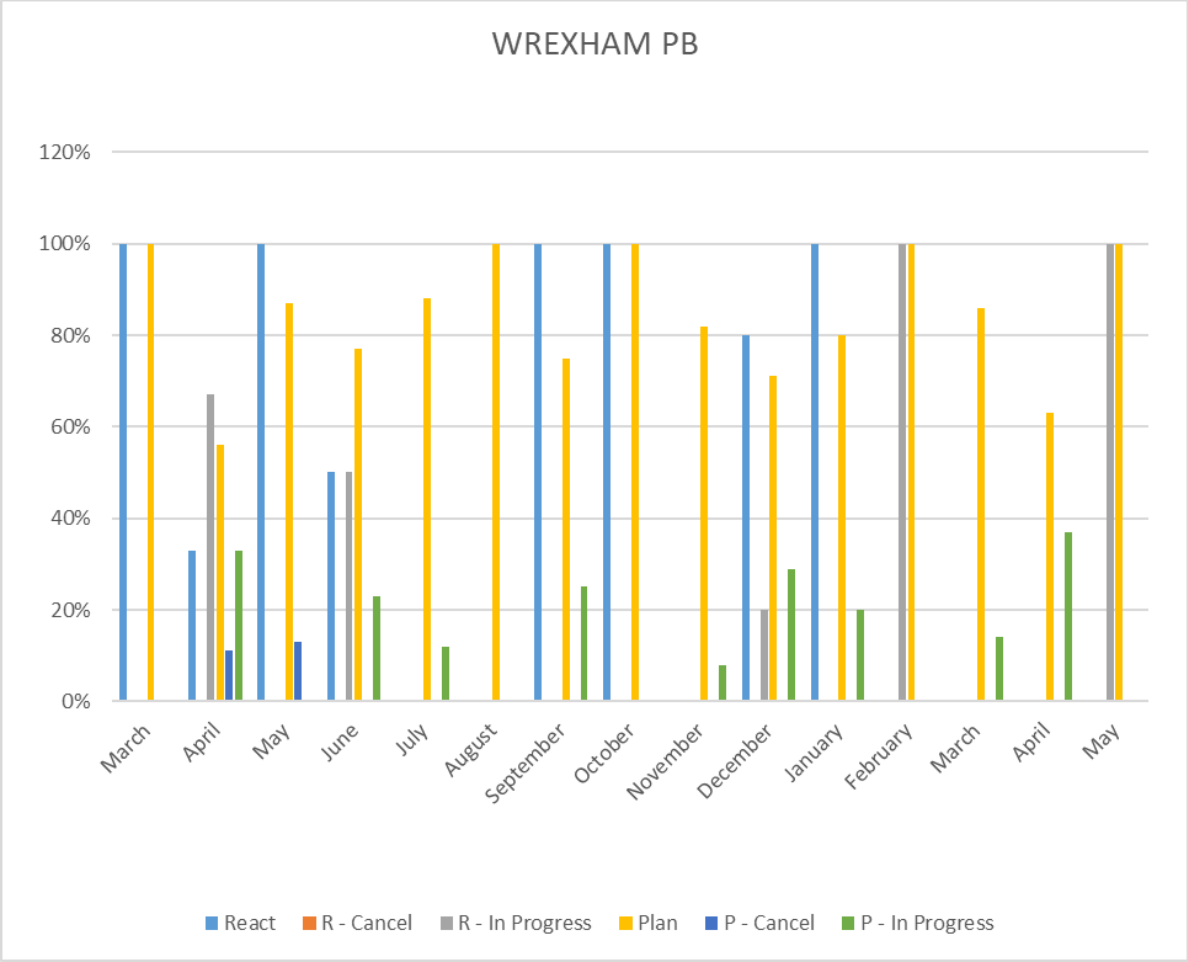
Expected Performance gain – longer-term

No cancelled jobs in this period however improvements are required to adress Planned tasks in HQ Nantgarw.

Risks to future performance

Works are being prioritised to ensure high risk activities are closed out. There is an ongoing risk that items may be missed however this will be addressed in full with, recruitment of staff and improvement to the CAFM System.

Graph title – 15 month Data PPM & Reactive Work Orders Headquarters NantgaWrexham	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



If performance is not at required level, set out what the main causes are:
The estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Source contractors for additional support to maintain a level of service delivery	**0-3 months**	**Jonathan Fear**

Expected Performance gain - immediate
Planned Tasks – 100% Planned in Progress – 0%
Reactive Tasks – 100% In Progress Jobs – 0%
Cancelled Jobs – 0% Planned & Reactive
Maintain High Standards of compliance

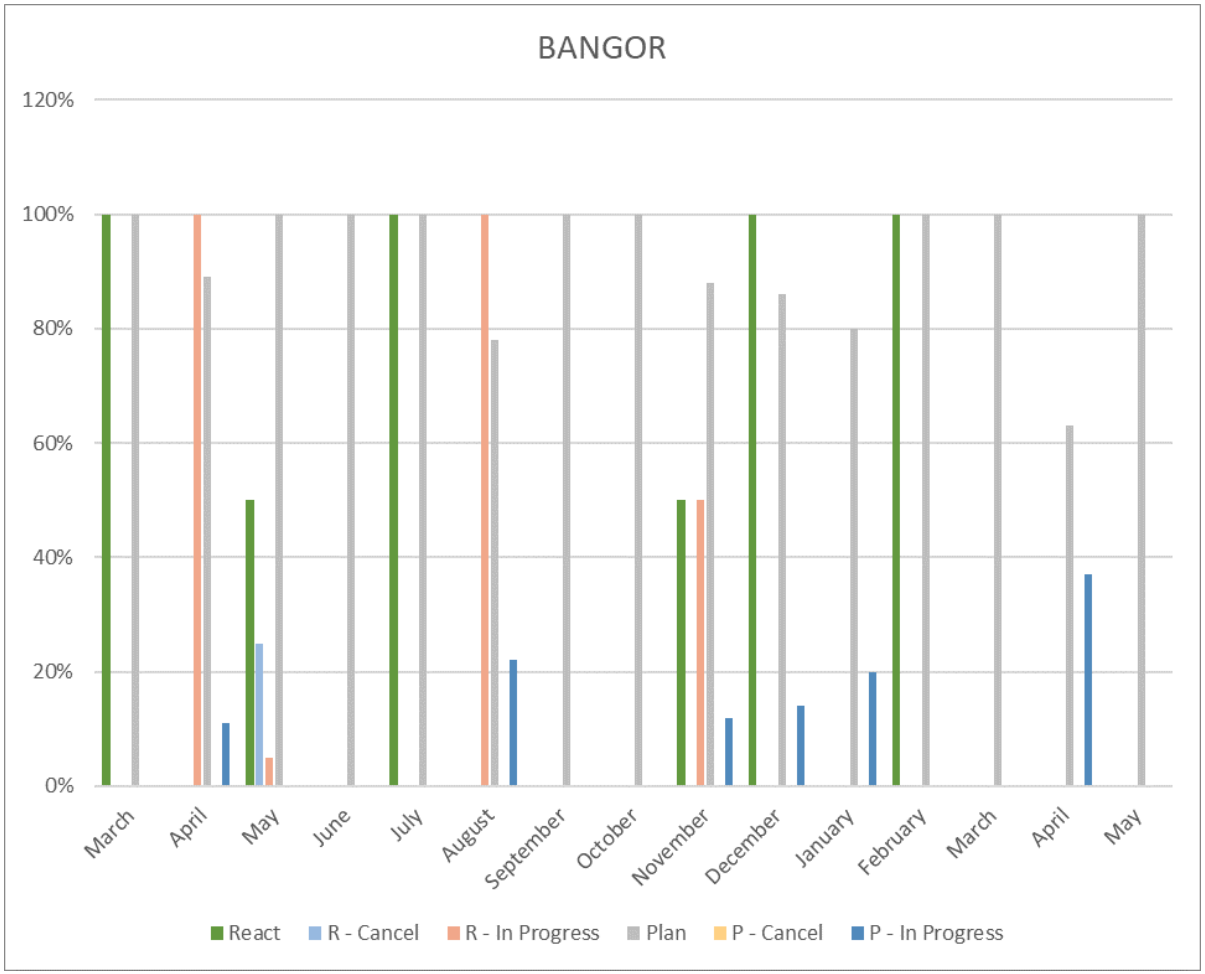
Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

Expected Performance gain – longer-term
0% late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance
Maintain High Levels of Compliance.

Graph title – 15 month Data PPM & Reactive Work Orders Bangor	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



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

The estates team is currently completing the final stages of recruitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Planned Tasks – 100% Planned in Progress – 0% Reactive Tasks – 100% In Progress Jobs – 0% Cancelled Jobs – 0% Planned & Reactive	0-3 months	Jonathan Fear

Expected Performance gain - immediate

Maintain High Levels of Compliance.

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	recruitment phase 6 months CAFM Improvements ongoing	Jason Hoskins

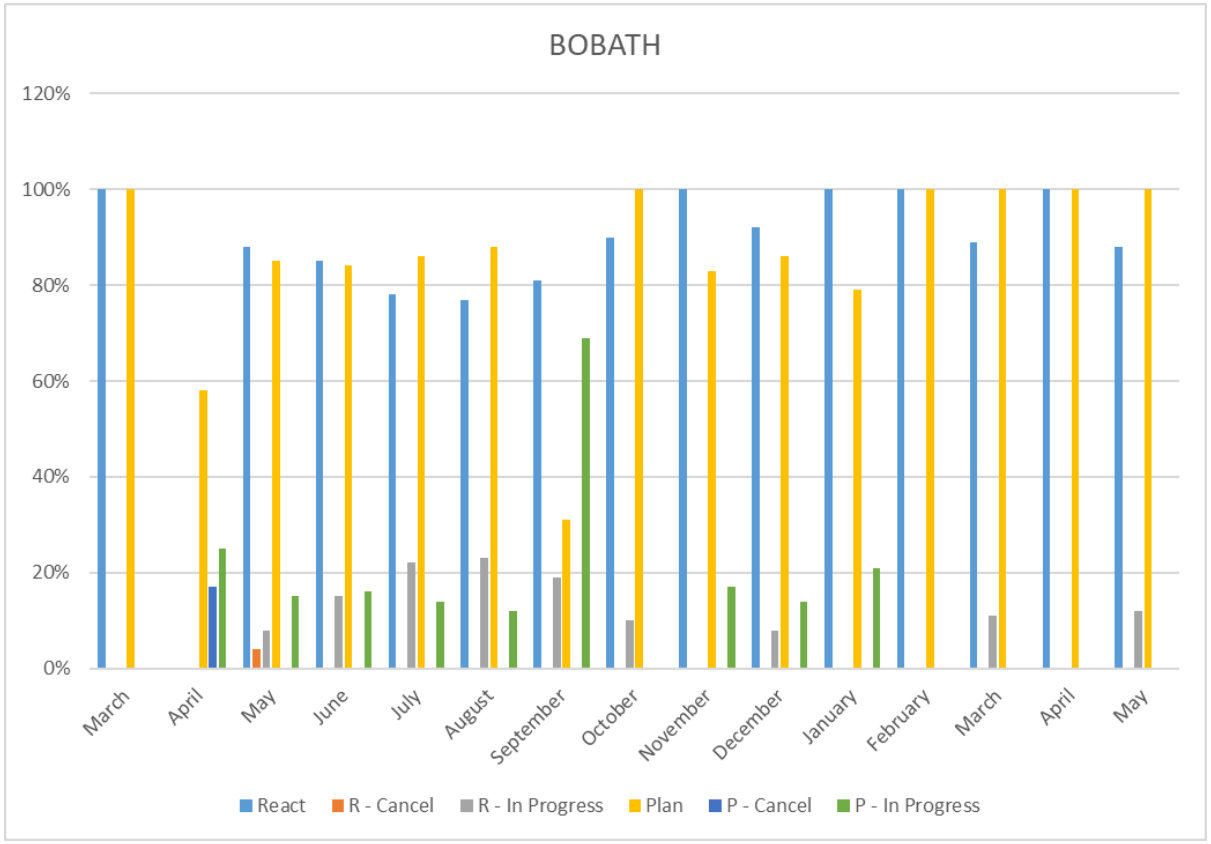
Expected Performance gain – longer-term

0% late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards

Risks to future performance

Maintain High Levels of Compliance.

Graph title – 15 month Data PPM & Reactive Work Orders 19 Park Road	
Target: 95% compliance of completion of PPM & Reactive tasks	**SLT Lead: Assistant Director of Estates**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**



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

he estates team is currently completing the final stages of recreuitment and have 3 positions left to fill.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Short Term Source contractors for additional support to maintain a level of service delivery	**0-3 months**	**Jonathan Fear**

Expected Performance gain - immediate

Planned Tasks – 100% Planned in Progress – 0%
Reactive Tasks – 88% In Progress Jobs – 12%
Cancelled Jobs – 0% Planned & Reactive

Service Improvement Actions – tactical (12 months +)

Recruitment to address the shortfall in structure to meet the needs of the estates Alignment of CAFM System to meet industry standards, provide accuracy of reporting, and improved transparency.	**recruitment phase 6 months CAFM Improvements ongoing**	**Jason Hoskins**

Expected Performance gain – longer-term

0% of late/cancelled jobs. Realignment of CAFM software to provide transparency and accuracy of reporting aligning to industry standards
Improve reactive task compliance.

Risks to future performance

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 (core)	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual £k	64	1	4										
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at May 23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(6.650)	(6.653)	(0.003)	(37.005)	(37.005)	0.000
RD&I	(0.142)	(0.142)	0.000	0.144	0.144	0.000
WBS	(3.214)	(3.214)	(0.001)	(19.816)	(19.816)	0.000
Sub-Total Divisions	**(10.006)**	**(10.009)**	**(0.003)**	**(56.677)**	**(56.677)**	**0.000**
Corporate Services Directorates	**(1.914)**	**(1.903)**	**0.011**	**(11.483)**	**(11.483)**	**0.000**
Delegated Budget Position	**(11.920)**	**(11.912)**	**(0.007)**	**(68.161)**	**(68.161)**	**0.000**
TCS	(0.124)	(0.127)	0.003	(0.611)	(0.611)	0.000
Health Technology Wales	0.000	0.000	(0.000)	0.000	0.000	0.000
Trust Income / Reserves	12.043	12.043	(0.000)	68.772	68.772	0.000
Trust Position	0.000	0.004	0.004	0.000	0.000	0.000

Performance

The overall position against the profiled revenue budget to the end of May 2023 is an underspend of £0.004m and is currently expecting to achieve an outturn forecast of Breakeven.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

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

- Non Delivery of recurrent savings plans
- Contract performance income is not expected to match the internal level of investment which has been made to support the planned care backlog capacity which may leave a potential funding shortfall.

KPI Indicator FIN.72

Return to Top

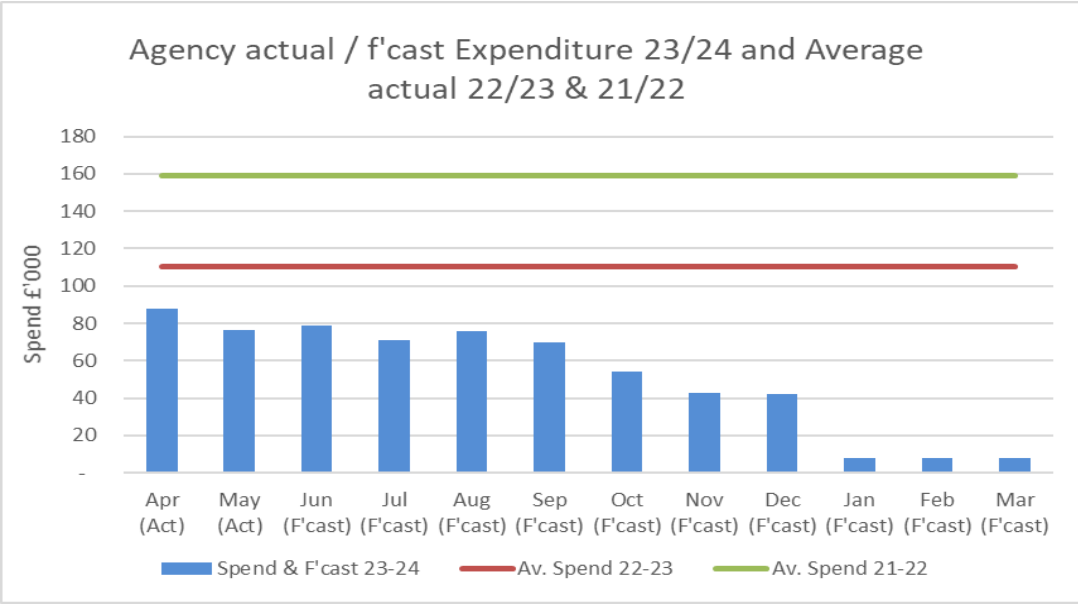
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.323	88	77										
Target (per IMTP) £0.543M Forecast		115	115	115	58	50	50	16	16	0	0	0	0



Performance

The spend on agency for May'23 was **£0.077m,** which gives a cumulative year to date spend of £0.165m and a current forecast outturn spend of circa **£0.623m** (£1.323m 2022/23).

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

At this stage of the year the expectation is that the Radiotherapy, Medical Physics and Estates agency staff will transition into substantive positions within the Trust which is following investment decisions in these areas. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging.

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.73

Return to Top

Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	27.8	1.389m	1.637m										
Target £24.416m CEL		1.389m	1.637m										

Capital Position as at May 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M2 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	2.688	0.000	8.208	10.896	0.000
Integrated Radiotherapy Solutions (IRS)	10.326	0.307	0.000	10.019	10.326	0.000
IRS Satellite Centre (RSC)	1.347	0.000	0.000	1.347	1.347	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Total All Wales Capital Programme	22.733	2.995	0.000	19.738	22.733	0.000
Discretionary Capital	1.683	0.031	0.000	1.652	1.683	0.000
Total	24.416	3.026	0.000	21.390	24.416	0.000

Performance

The approved Capital Expenditure Limit (CEL) as at May 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.773m**, and Discretionary funding of **£1.683m.**

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 202223.

To date c£0.762m has been previously committed against the discretionary programme leaving a balance of £0.927m for 2023-24. Allocation of the remaining balance is expected to take place at the Capital planning and Delivery group in June, before being submitted to the Strategic Capital Board for endorsement to be approved by EMB.

Performance to date

The actual expenditure to May 2023 on the All-Wales Capital Programme schemes was £2.995m, this is broken down between spend on the nVCC enabling works £2.668m and the IRS £0.307m. Spend to date on Discretionary Capital is currently £0.031m.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position

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.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

Performance

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.300	0.084m	0.108m										
Target £1.8M Forecast		0.084M	0.084m	0.084m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	1.8M

Overall VUNHST Cost Improvement Programme £1.8M

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Currently several of the schemes are still RAG rated amber with current expectation that these schemes will turn green during quarter two, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

The procurement supply chain saving schemes is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. The services will continue to collaborate with procurement colleagues in order to identify further opportunities for efficiency savings that are cash releasing.

Work will need to continue with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented or mitigations put in place to ensure that the Savings target is met for 2023-24.

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

	22/23	Apr 23	My 23.	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
Trust Position															
Capital & Revenue Invoices	95	98	98												
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	

Performance

During May '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.1%** as at the end of month 2, and a Trust position (including hosted) of **98.7%** compared to the target of 95%.

Work between the finance team, NWSSP accounts payable team and the service will need to continue in order to maintain performance throughout 2023/24.

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:
Work between Finance, NWSSP and the service will continue throughout 2023-24 in order to maintain performance.	31/03/2024	M Bunce

Expected Performance gain – longer-term.
Ensured compliance

Risks to future performance

Set out risks which could affect future performance

KPI Indicator EST.64

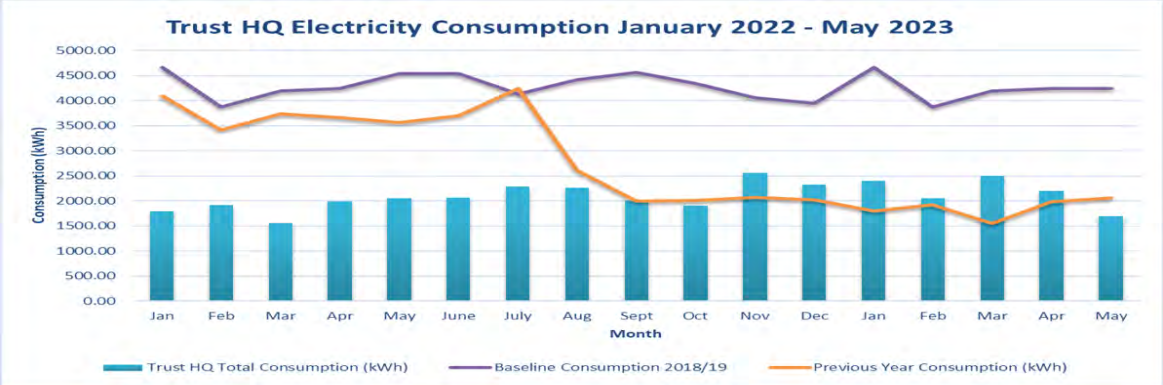
Return to Top

Trust HQ - Energy (Gas and Elect) performance consumption

Target: -2% on 2020/21

SLT Lead: Assistant Director of Estates

Current Performance against Target or Standard



Trust Position	Mar 22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23
Actual Number (kWh)	1557.00	1991.00	2053.00	2064.00	2284.00	2263.00	1526	1905	2553	1835	2403	2501	2502	2203	1696
Target number previous year	4018.00	3587.78	3492.72	3628.94	4155.20	2560.74	1962.94	1966	2029	1975	1761	1879.64	1525.86	1951.18	2011
Target -2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%

Performance

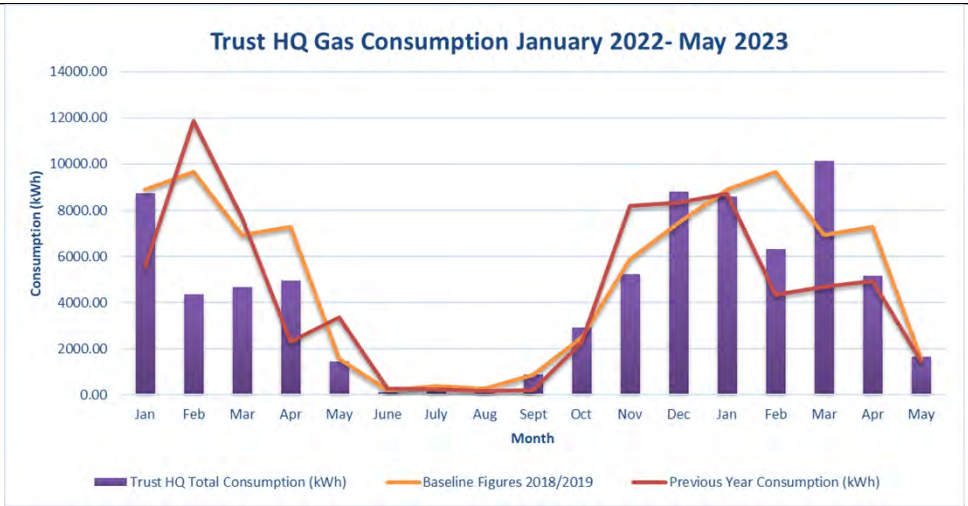
, The boiler heating is thought to be short circuiting around the boiler circuit. The Trust is currently waiting for quotes to make adjustments to the header heating system to ensure the boiler flow temperature will be circulating the central heating system increase radiator temperatures. The issues was identified and rectified by the Estates Manager, and going forward enhanced monitoring of consumption at Trust HQ will be undertaken (with dedicated staff member reviewing the BMS).

Electricity continues to be consistently lower than the baseline figures from 2018/19.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Electricity - SMART metering installed	3 month	Jon Fear
Gas - Integration of energy performance software (Sigma) to BMS	**3 months**	Milburn Mounter

Expected Performance gain - immediate
Continue to monitor energy performance



Trust Position	Mar 22	Apr 22	My 22	Jun 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23
Actual Number (kWh)	4685.28	4941.05	1466.12	111.35	222.79	178.62	156.29	2913	4952	8809.65,	8585.83	6331.76	10124.91	4728.34	1679.63
Target number previous year	7504.62	2248.12	3306.55	283.73	241.91	185.98	207.84	2220.93	803.36	8152.77	8554.67	4255.87	4591.57	4792.82	1436.8
Target -2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%	-2%

Promote ways to reduce electricity usage. Communication campaign underdevelopment to promote to staff how to reduce electricity / heating usage.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Metering strategy	12 months	Jason Hoskins
Dedicated staff member reviewing BMS	6 moths	Milburn Mounter

Expected Performance gain – longer-term

Continue to monitor consumption

Energy and Estates Optimisation project is currently being scoped for Trust Headquarters to review how to more efficently use the estate.

Risks to future performance

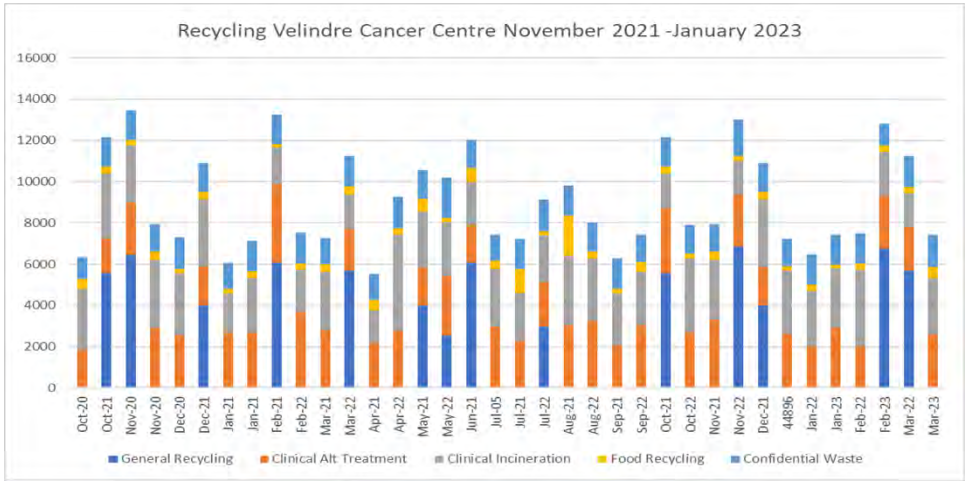
Set out risks which could affect future performance

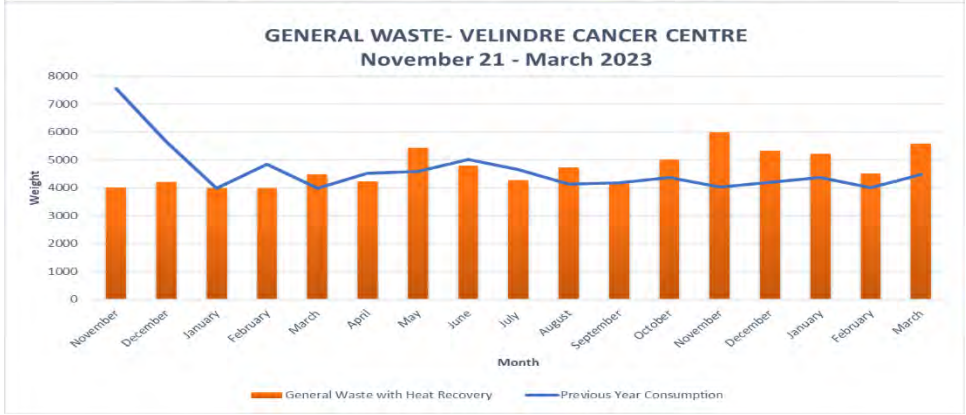
Increase in gas usage due to cold weather.

KPI Indicator EST.68

Return to Top

Graph title -Waste	
Target: Continued monitoring to identify and mitigate trends	**SLT Lead: Carl James**
Current Performance against Target or Standard – stable	**Performance - no discernible trends available**





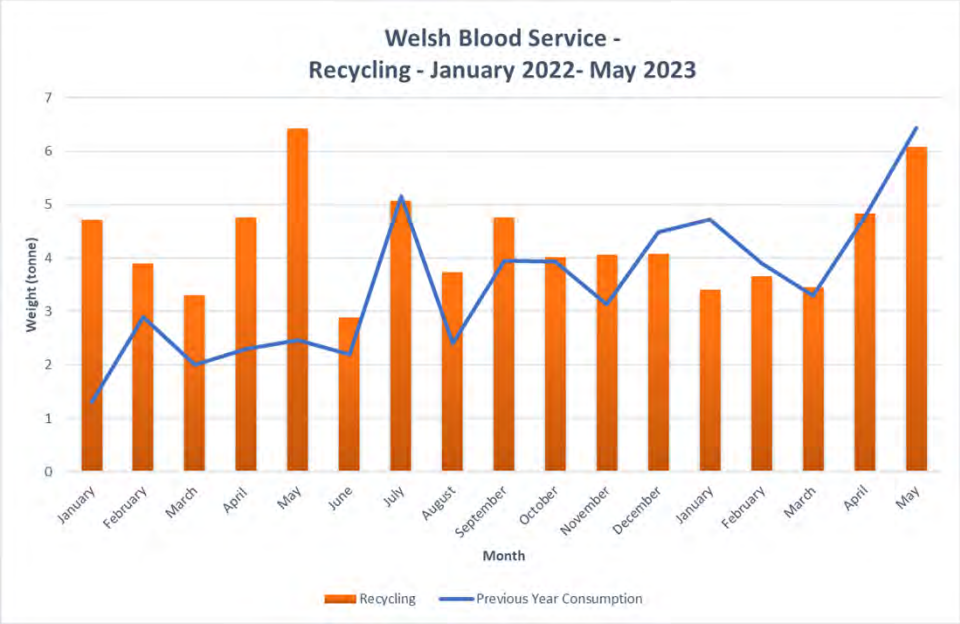
If performance is not at required level, set out what the main causes are:

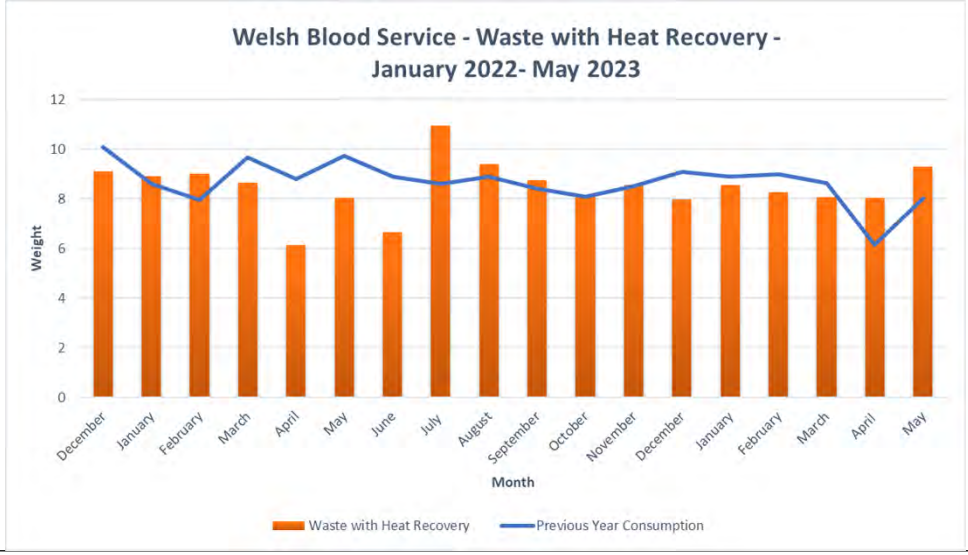
Recycling has increase compared to previous year at VCC & WBS. The food bin trial has begun rollout in VCC. Alongside the introduction of food bins, staff are provided with information about the new waste stream.
VCC Recycling graph now includes confidential waste.
Communication Events held in Talbot Green and VCC to engage with staff and promote waste streams.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Introduction of food waste bins to all staff kitchens in VCC	3 months	**Dave Harding**
Improved signage with new bins	3 months	**Rhiannon Freshney**

Expected Performance gain - immediate
Looking to invest in new bins at VCC (in line with the WBS bins).





Service Improvement Actions – tactical (12 months +)		
- Removal of plastic cups on Donor clinics – full roll out of biodegradable cups on - Waste promotional / educational events and guidance for staff	**12 months** **12 months**	Matthew Bellamy Rhiannon Freshney / Dave Harding

Expected Performance gain – longer-term

Reduction of general waste and increase in recycling

Risks to future performance

KPI Indicator DIG.69

Return to Top

Digital Service % uptime of critical systems (% availability by service, excl. planned maintenance windows)

Target: 99%

SLT Lead: Chief Digital Officer

Current Performance against Target or Standard

Trust	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	Apr 23	May 23
Actual (%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
Target 99%	99	99	99	99	99	99	99	99	99	99	99	99	99	99	

Performance

Assessment of current performance, set out key points:

- Currently unable to report performance.
- Initial list of critical systems identified:
  - ePrognosa
  - WBS Appts. System (client & public-facing service)
  - WTAIL IT Systems
  - Prometheus (WBS)
  - WPAS
  - WCP
  - WNCR
  - ChemoCare
  - WellSky (Careflow)
  - RISP / Synapse
- Performance reporting established for WBS Appts. System, subject to validation of data. Aiming to provide first reported performance in May 2023 – reports will aim to cover locally-managed systems in the first instance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Proof of Concept for IT network and end user performance monitoring solution.	30/06/2023 (Pilot due to begin in April 2023)	DMH

Expected Performance gain – immediate

TBC

Service Improvement Actions – tactical (12 months +)

	Actions: what we are doing to improve • Deploy IT, network and end user performance monitoring platform	**Timescale:** 30/09/2023 (Pilot due to begin in April 2023)	**Lead:** DMH
	Expected Performance gain – longer-term TBC		
	Risks to future performance		
	Set out risks which could affect future performance • Insufficient funding available to enable permanent deployment of required monitoring solution.		

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

Trust Position	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	Apr 23	My 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

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 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
- 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	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	Apr 23	My 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 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.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

Trust Position	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	Apr 23	My 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

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 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	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	Apr 23	My 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
-

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST MAY (M2)

DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / 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 RUN QSP	29/06/2023 13/07/2023	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

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 financial position and performance for the period to the end of May 2023.

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. 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).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.003	0.004	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.637	3.026	24.416
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.8%	98.8%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget remains in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of May'23 is an underspend of **£0.004m**, with an outturn forecast of **Breakeven** expected.

It is expected that cost pressures will be managed by budget holders in line with the Trust's budgetary control procedures to ensure the delegated expenditure control limits are not exceeded.

Several saving schemes currently remain RAG rated amber and therefore it is important that those schemes that have not yet gone live are reviewed at divisional level with a view to either turn green or find replacement schemes.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the planned savings targets are achieved, and that all financial risks are mitigated during 2032-24.

2.3 PSPP Performance

PSPP performance for the whole Trust is currently 98.7% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently achieving a target of 98.1%

2.4 Covid Expenditure

Covid Programme Costs

In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast for 2023/24 reduced to £0.167m.

Covid Recovery and Planned Care Capacity

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners from 2023-24. However, there remains a risk that the contract performance income does not match the internal level of investment which has been made to support the planned care backlog capacity which may leave a potential funding shortfall. This risk will be managed through the Trust's budgetary control procedures.

2.5 Reserves

The financial strategy for 2023-24 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 balance and allocation of the recurrent non-recurrent reserve is still to be agreed for 2023/24.

2.6 Financial Risks

The financial risks for 2023/24 rated high or medium are as follows:

DHCR – Risk £2.000m / Likelihood – Medium

The Digital Health Care Record system was implemented in 2022/23. However, there have been challenges in the operational use and accurate data capture within the system. This means that activity data is not accurately being captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team are reviewing the situation and putting in place plans to address the issues. However, if this is not rectified there is a risk that £2.000m income related to unrecorded activity could be lost.

Non-Delivery of Savings *Risk £0.622m / Likelihood - Medium*

Several schemes remain in amber, with current expectation that these schemes will turn green as this year progresses, however, there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

There are several potential opportunities that are described in the report which could be utilised to support any risks should they crystallise.

2.7 Capital

All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget.

Other Major Schemes in development that are detailed in the main finance report will be considered during 2023-24 or beyond in conjunction with WG.

Discretionary Programme

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022-23.

To date c£0.762m has been previously committed against the discretionary programme leaving a balance of £0.927m for 2023-24. Allocation of the remaining balance is expected to take place at the Capital planning and Delivery group in June, before being submitted to the Strategic Capital Board for endorsement to be approved by EMB.

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 **£0.004m** for May'23 which is in line with the IMTP

4. RECOMMENDATION

Trust Board is asked to:

4.1 **NOTE** the contents of the May 2023 financial report and in particular the yearend financial performance which at this stage is reporting a **breakeven** position.

4.2 **NOTE** the TCS Programme financial report for May which is attached as **Appendix 1.**
TCS REPORT TO FOLLOW

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Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED MAY 2023/24

TRUST BOARD
27/07/2023

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 2023-24.

2. Background / Context

The draft Trust IMTP Financial Plan for the period 2023-2026 was set within the following context.

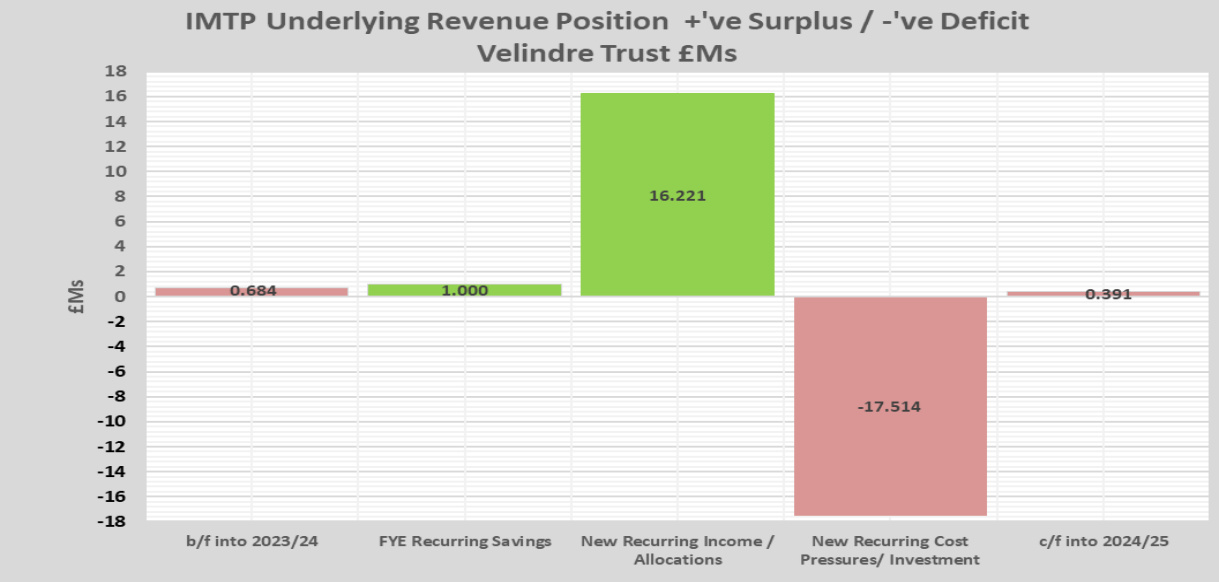
- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

- For 2023-24 the Plan included;
  - an underlying **Surplus of £0.684m** brought forward from 2022-23,
  - FYE **of new cost pressures / Investment** of **-£17.514m,**
  - offset by **new recurring Income** of **£16.221m,**
  - and Recurring FYE **savings schemes** of **£1.000m,**
  - Allowing **a £0.391m surplus position** to be carried into 2023-24.

- The Trust has a carry forward underlying surplus of £0.684m, which relates to the 2022-23 discretionary uplift funding that was held due to the uncertainty of WG funding support for the increase in energy prices and to cover the possible LTA income shortfall risk against the Covid capacity cost investment.

- The balance of the underlying surplus is forecast to reduce year-on-year as cost pressures increase over the 3-year planning period. IMTP planning assumptions assumed that a £0.391m underlying surplus will be c/fwd into 2024-25.

- **In order to achieve the c/fwd underlying surplus of £0.391m the savings target set for 2023-24 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2023/24	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.684	1.000	16.221	-17.514	0.391

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	Year to date £m	Year End Forecast £m
Revenue	Variance	0.003	0.004	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.637	3.026	24.416
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.8%	98.8%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	25	25	0

Revenue

The Trust has reported a **£0.003m** in-month underspend position for May'23, which gives a year to date cumulative underspend of **£0.004m** and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at May 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.733m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to May'23 of £3.026m and is forecasting to remain within the CEL of £24.416m.

The Trust's current CEL is broken down as follows:

	£m
Discretionary Capital	**1.683**
All Wales Capital:	
nVCC Enabling Works	10.896
IRS	10.326
Digital Priority Investment	0.164
RSC Satellite Centre	1.347
Total All Wales Capital	**22.733**
Total CEL	**24.416**

PSPP

During May '23 the Trust (core) achieved a compliance level of **97.6%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.1%** as at the end of month 2, and a Trust position (including hosted) of **98.7%** compared to the target of 95%.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2023-24, however a risk of under delivery remains on several schemes that are still RAG rated amber.

Revenue Position

Cumulative				Forecast		
£0.004m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(29.274)	(29.773)	0.500	(185.421)	(185.421)	0.000
Pay	12.869	13.002	(0.133)	76.608	76.608	0.000
Non Pay	16.405	16.768	(0.362)	108.813	108.813	0.000
Total	**0.000**	**(0.004)**	**0.004**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of May 2023 is an underspend of **£0.004m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

As highlighted above in the IMTP Financial plan the Trust brought forward a surplus of £0.684m from 2022-23 and is forecast to reduce year-on-year as additional cost pressures arise over the 3-year planning period.

The ability to carry forward a surplus into 2024-25 will depend, in part, on whether energy prices remain at a high level following the volatility seen in 2022/23 period, and also the ability for the Trust to deliver on its recurrent savings target.

Other factors which will determine the carry forward position into 2024-25 will be the Trusts capacity to either fund or mitigate both current and potential new cost pressures which may emerge over the course of the year.

Income Highlights / Key Issues

The Trust expects to secure Covid recovery and planned care backlog funding from Commissioners through LTA activity performance related marginal income. All LTA/ SLA documents have been issued in line with the funding flows mechanism agreed at Directors of Finance Forum, with expectation that all LTA/ SLA's will be signed by the 30th June. However, the level of this funding remains a risk compared to the cost of additional capacity investment.

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises.

VCS and WBS overachievement from Private Patient, SACT Homecare and Plasma sales.

Pay Highlights / Key Issue

Although not yet invoiced the Trust is expecting to receive full funding from WG for the 1.5% consolidated pay award which was accounted for in 2022/23 and processed during May 23 (back dated to April 22).

At this stage the Trust is also expecting to receive full funding for both the one off recovery pay award which will be processed in June, and the 5% consolidated pay award relating to 2023/24 to be paid in July.

A number of posts in VCS 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 VCS 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.

As at 2023/24 on top of the savings plans VCS (£0.600m) and WBS (£0.450m) hold a vacancy factor target, which will need to be achieved during 2023-24 in order to balance the overall Trust financial position.

Non Pay Key Issues

The latest Energy forecast position for 2023-24 from NWSSP suggests a further reduction of c£0.740m from the forecast presented at the IMTP planning stage. This potentially releases funding which will be used to support some of the local growth and cost pressures which are within the service divisions.

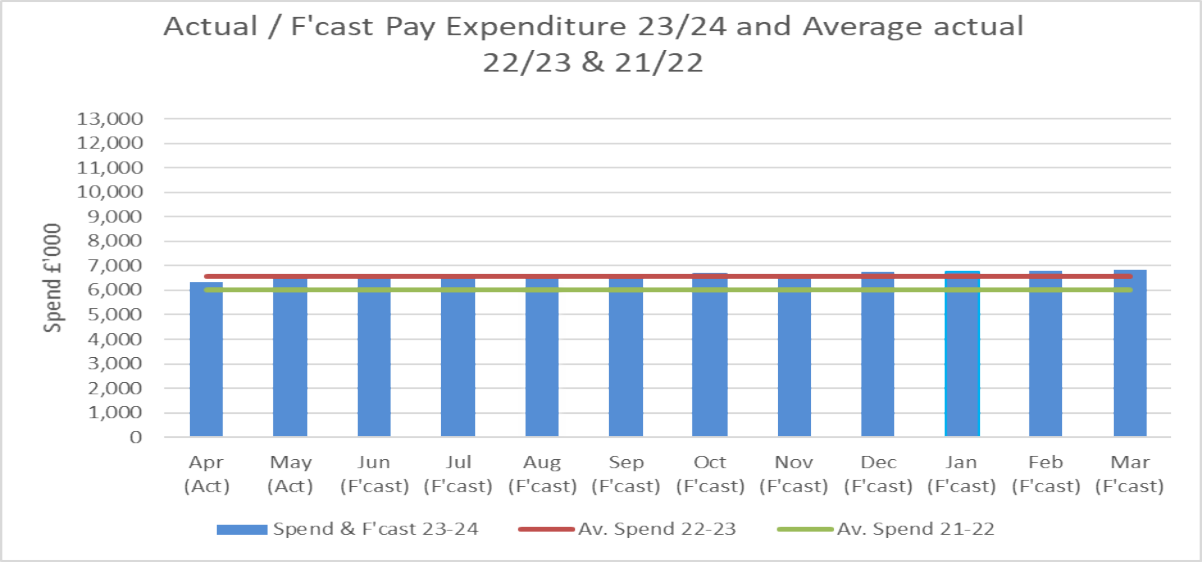
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust IMTP savings target for each division was set as VCS £0.950m, WBS £0.700m and Corporate £0.150m for 2023-24.

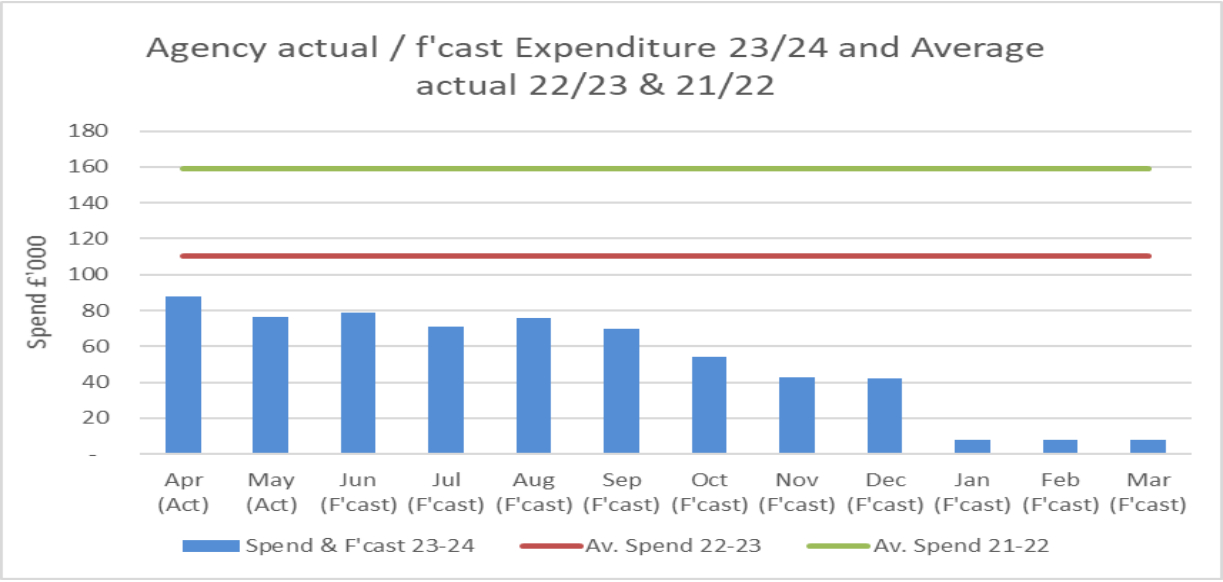
The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

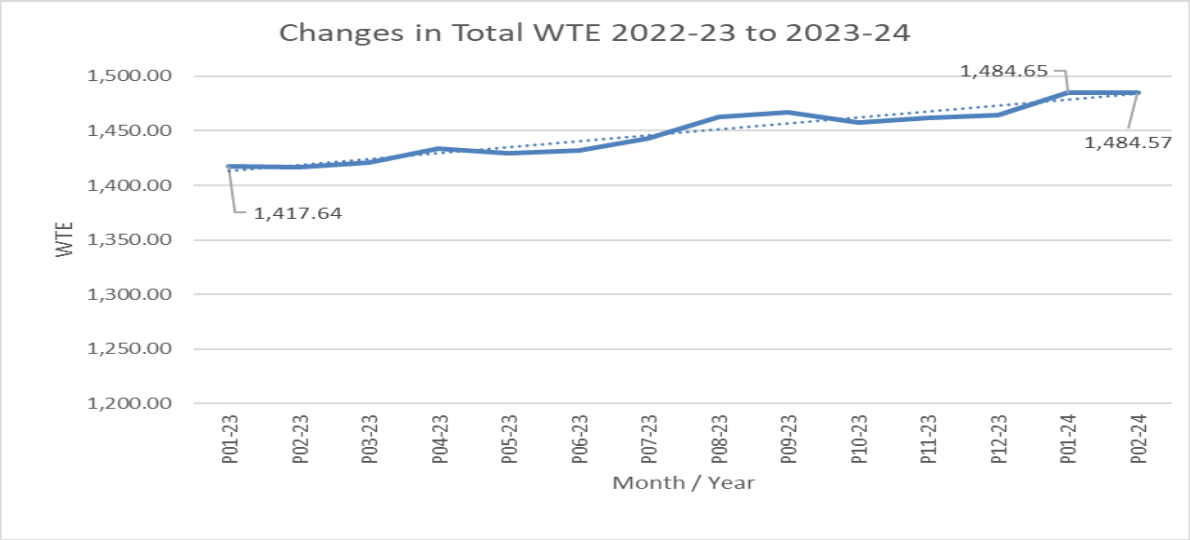
Whilst the pay award for 2023-24 has now been agreed in line with WG reporting guidance for the Trust monitoring returns (MMR) these costs are not yet reflected in the forecast pay spend.

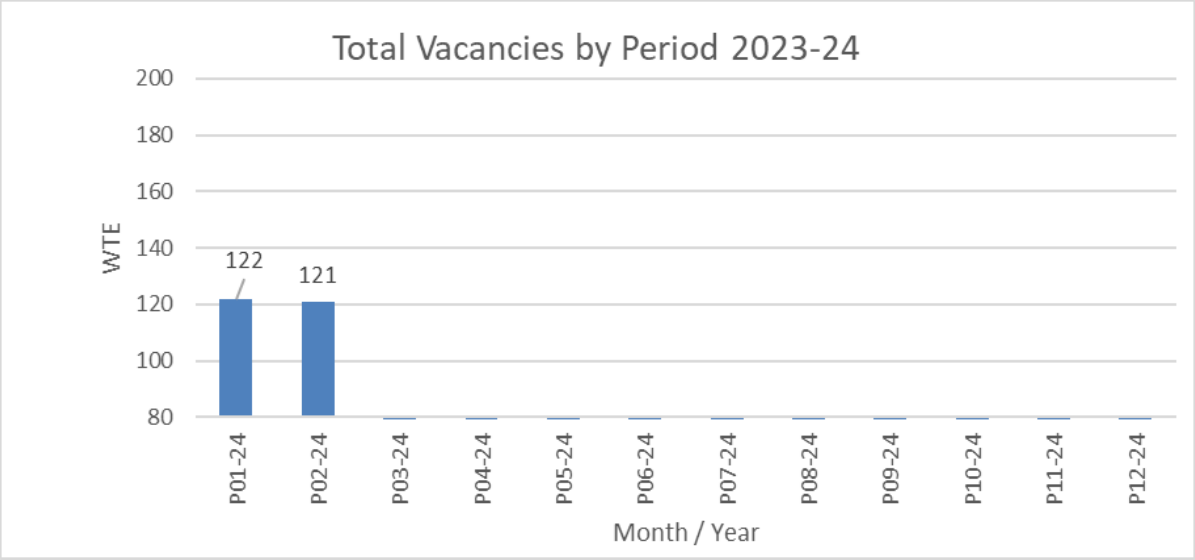
Per the IMTP the Trust is aiming to significantly decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. At this stage of the year we are still expecting to transition the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging





The spend on agency for May'23 was **£0.077m,** which gives a cumulative year to date spend of £0.165m and a current forecast outturn spend of circa **£0.623m** (£1.323m 2022/23).

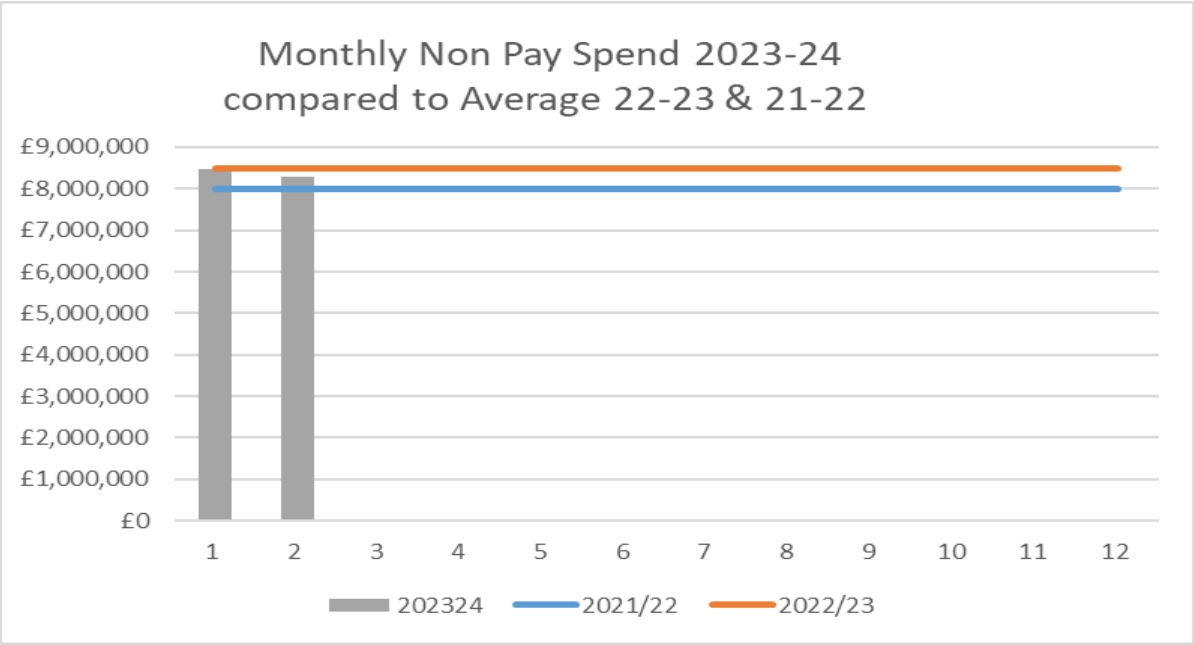




The total Trust vacancies as at May 2023 is 121wte, VCC (78wte), WBS (17wte), Corporate (11wte), R&D (12wte), TCS (0wte) and HTW (3wte).

4.3 Non Pay

The average monthly spend for 2022-23 was £8.5m which was £0.5m higher than the reported monthly average spend for 2021-22. Most of the monthly average increase related to the WBS wholesaling costs, along with the growth in energy costs and general inflation. Average non-pay spend so far for 2023/24 is £8.34m per month which is a slight reduction from the previous year average.



4.4 Covid-19

Covid Programme Costs

Last year there was clear expectation from WG that following issue of their Covid de-escalation letter that organisations will be extricating themselves from many of the Covid response costs. Therefore, WG have only committed to cover the financial costs of ongoing Covid response and national programme costs as set out in the Director General of Health & Social Services letter dated 22nd December 2022. These programme costs will include support towards mass vaccination, and the provision of PPE which will be allocated to the Trust based on actuals during 2023/24.

At present the Trust is only expecting to draw funding from WG towards PPE costs with the forecast requirement for 2023/24 as at May 23 being £0.167m which is a reduction of £0.073m from the £0.240m being requested as part of the IMTP, however if the Trust is required to support the HB's with the vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Covid Recovery and Planned Care Capacity

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners from 2023-24. However, the contract performance income is not expected to match the internal level of investment which has been made to support the planned care backlog capacity which may leave a potential funding shortfall.

The committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.500m during 2022-23. The recurrent income funding for this additional capacity flows via performance related LTA contracting income from Commissioners.

Whilst the gap in funding has reduced since the IMTP planning stage work is continuing to review all Covid recovery investment within Velindre Cancer Services, with a view to understanding the direct capacity related benefits and mitigations such as reducing, removing or repurposing these costs.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Currently several of the schemes are still RAG rated amber with current expectation that these schemes will turn green during quarter two, but there remain challenges in achieving this. Those schemes that are still amber are either workforce related or impacted as a result of current market conditions.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

The procurement supply chain saving schemes is again expected to be affected by both procurement constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. The services will continue to collaborate with procurement colleagues in order to identify further opportunities for efficiency savings that are cash releasing.

Work will need to continue with the service in order to review current savings plans with a view to deliver or find replacement schemes if required.

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented, or mitigations put in place to ensure that the Savings target is met for 2023-24.

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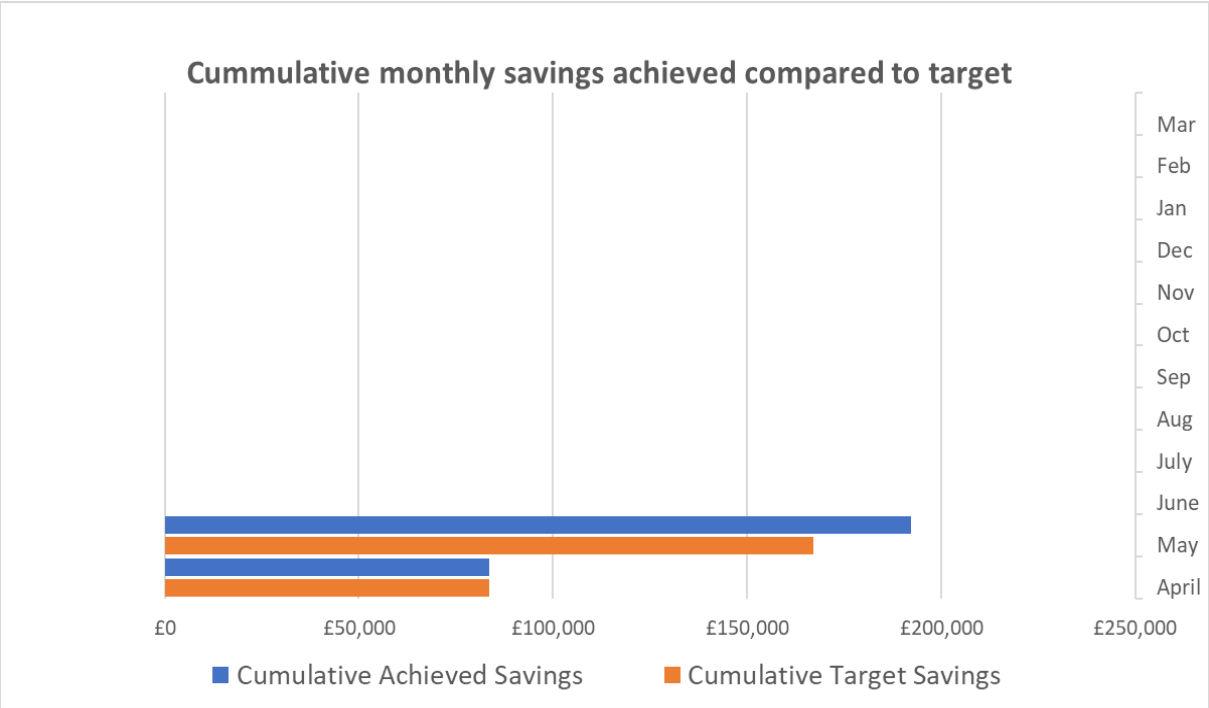
Savings Schemes							
Establishment Control (Corporate)	Green	75	13	13	0	75	0
Procurement Supply Chain (WBS)	Amber	100	0	0	0	100	0
Collection Team Costs Reduction (WBS)	Green	10	2	2	0	10	0
Collection Team Costs Reduction (WBS)	Green	8	1	1	0	8	0
Establishment Control (WBS)	Green	60	10	10	0	60	0
Reduced use of Nitrogen (WBS)	Amber	55	0	0	0	55	0
Reduced Research Investment (WBS)	Green	25	4	0	(4)	25	0
Stock Management (WBS)	Green	125	21	21	0	125	0
Reduced Transport Maintenance (WBS)	Amber	30	0	0	0	30	0
Demand Planning - Volume Driven Benefits (WBS)	Amber	137	0	0	0	137	0
Service Workforce Re-design (VCS)	Amber	50	0	0	0	50	0
Establishment Control (VCS)	Green	175	0	29	29	175	0
Pay Controls - Rationalisation of Service	Amber	150	0	0	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	21	21	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	8	8	0	50	0
Procurement Supply Chain (VCS)	Amber	100	0	0	0	100	0
Total Saving Schemes		**1,275**	80	105	25	1,275	0

Income Generation							
Bank Interest (Corporate)	Green	75	13	13	0	75	0
Sale of Plasma (WBS)	Green	150	25	25	0	150	0
Expand SACT Delivery (VCS)	Green	200	33	33	0	200	0
Private Patient Income (R) (VCS)	Green	50	8	8	0	50	0
Private Patient Income (NR) (VCS)	Green	50	8	8	0	50	0
Total Income Generation		**525**	88	88	0	525	0

TRUST TOTAL SAVINGS		**1,800**	**167**	**192**	**25**	**1,800**	**0**
				115%		**100%**	



5. Reserves

The financial strategy for 2023-24 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 balance and allocation of recurrent and non-recurrent reserves is currently under review for 2023/24 and is depended on a number of factors including the direction of energy prices, the ability to achieve the Trust savings target, and the cost of Covid recovery and planned care backlog capacity not covered by LTA income.

6. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a number of risks which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

DHCR – *Risk £2.000m / Likelihood – Medium*

The Digital Health Care Record system was implemented in 2022/23. However, there have been challenges in the operational use and accurate data capture within the system. This means that activity data is not accurately being captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team are reviewing the situation and putting in place plans to address the issues. However, if this is not rectified there is a risk that £2.000m income related to unrecorded activity could be lost.

Non-Delivery of Savings - *Risk £0.622m / Likelihood - Medium*

The Trust as part of the IMTP identified £1.800m of Savings and Income Generation to be achieved during 2023-24. This savings target was set to ensure that the Trust had the ability to support local cost pressures, the increase in energy prices and the cost of Covid recovery and planned care backlog capacity not covered by LTA income.

Due to an increased savings target for 2023-24 and the ongoing legacy impact of the pandemic which has resulted in higher than usual sickness levels throughout the Trust, there is a potential inability to enact several of these savings which are currently reflected as RAG rated amber. Current expectation is that these schemes will be implemented and start to deliver as the year progresses, however achievement remains a risk. The Trust will continue to review the savings schemes with a view to either ensure delivery, or to find replacement schemes.

Further rise in Energy Prices above forecast MTP plans- *Risk £0.500m / Likelihood - Low*

Latest forecast from NWSSP suggests a further downward trajectory on energy prices, however a risk remains that costs may increase from the forecast position which was included in the IMTP plan.

Management of Operational Cost Pressures – *Risk £0.900m / Likelihood - Low*

There are several cost pressures that are already within the service divisions which are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a risk that these current pressures may be beyond divisional control which is being recognised.

In addition, new cost pressures may materialise over the period which may be beyond divisional control or ability to manage through the overall Trust funding envelope.

SDEC Funding – *Risk £0.935m / Likelihood - Medium*

At time of submission of its Business Cases the Trust received assurance from WG Officers that the SDEC funding was recurrent in nature, however the Trust is yet to receive written confirmation to confirm the recurrent funding. Whilst the funding has been confirmed for the current financial year, if this is not secured recurrently it would impact the Trust's underlying position to be carried into 2024/25.

There are several potential opportunities which could be utilised to support any risks should they crystallise. These include but are not limited to; Activity increasing and therefore helps to close the gap in funding against the investment made in Covid Capacity and backlog infrastructure, a further reduction in energy prices, and utilisation of the reserve that the Trust holds for emergencies.

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	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M2 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	2.688	0.000	8.208	10.896	0.000
Integrated Radiotherapy Solutions (IRS)	10.326	0.307	0.000	10.019	10.326	0.000
IRS Satellite Centre (RSC)	1.347	0.000	0.000	1.347	1.347	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Total All Wales Capital Programme	22.733	2.995	0.000	19.738	22.733	0.000
Discretionary Capital	1.683	0.031	0.000	1.652	1.683	0.000
Total	24.416	3.026	0.000	21.390	24.416	0.000

The approved Capital Expenditure Limit (CEL) as at May 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.733m**, and Discretionary funding of **£1.683m.**

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022/23.

To date c£0.762m has been previously committed against the discretionary programme leaving a balance of £0.927m for 2023-24. Allocation of the remaining balance is expected to take place at the Capital planning and Delivery group in June, before being submitted to the Strategic Capital Board for endorsement to be approved by EMB.

Performance to date

The actual expenditure to May 2023 on the All-Wales Capital Programme schemes was £2.995m, this is broken down between spend on the nVCC enabling works £2.668m and the IRS £0.307m.

Spend to date on Discretionary Capital is currently £0.031m.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position.

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	10.896	0.000	1.547			12.443
Integrated Radiotherapy Solution (IRS)	10.326	14.697	6.150			31.173
IRS Satellite Centre	1.347	10.065				11.412
Digital Priority Fund - WHIAS Project	0.167					0.167
Total Approved Capital Schemes	**22.736**	**24.762**	**7.697**	**0.000**	**0.000**	**55.195**
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 Scannining 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	**35.036**	**63.092**	**28.752**	**10.896**	**10.961**	**148.737**

8. BALANCE SHEET (Including Hosted Organisations)

The balance sheet will be reported from Month 3.

9. CASH FLOW (Includes Hosted Organisations)

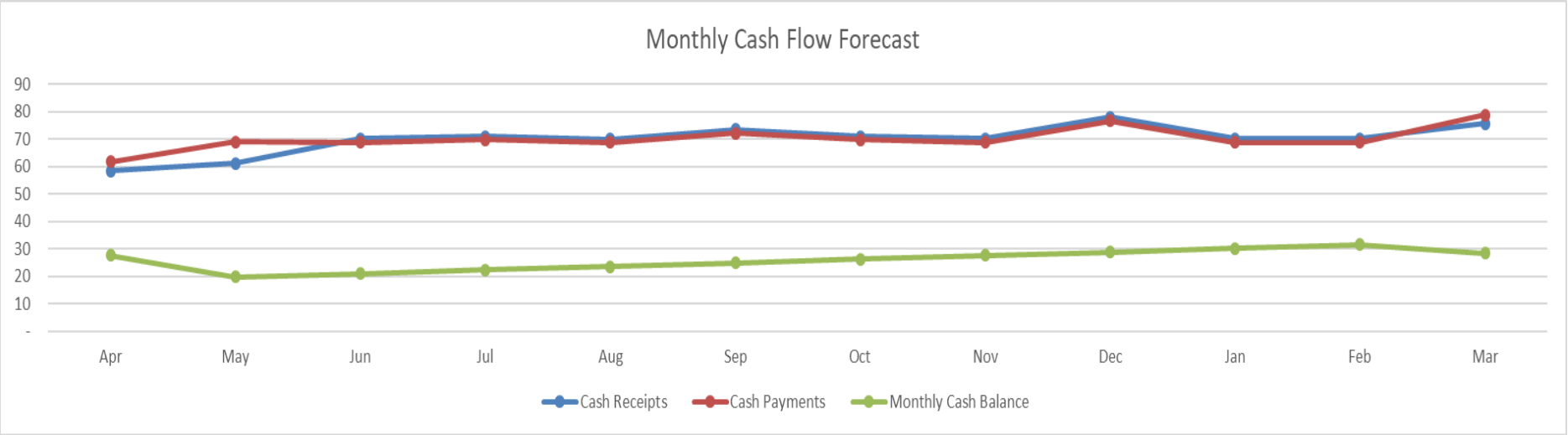
The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of 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 ongoing 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.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	Income from other Welsh NHS	14.460	18.799	23.870	24.872	23.878	23.894	23.923	23.908	23.906	23.909	23.910	26.158	275.484
2	WG Income	37.581	38.378	41.799	41.631	41.631	41.631	42.605	41.756	41.706	41.756	41.756	43.171	495.401
3	Short Term Loans													0.000
4	PDC				0.000								0.000	0.000
5	Interest Receivable	0.149	0.162	0.176	0.150	0.150	0.150	0.150	0.150	0.150	0.150	0.150	0.150	1.836
6	Sale of Assets													0.000
7	Other	6.156	3.753	4.363	4.382	4.382	7.802	4.401	4.401	12.331	4.428	4.428	6.232	67.059
8	TOTAL RECEIPTS	**58.346**	**61.092**	**70.208**	**71.035**	**70.041**	**73.477**	**71.079**	**70.215**	**78.092**	**70.242**	**70.243**	**75.711**	**839.781**
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	32.216	32.309	32.315	32.461	32.483	32.497	32.561	32.593	32.627	32.899	391.482
10	Non pay items	28.882	33.947	34.997	34.291	35.593	38.691	35.996	35.840	43.623	34.970	35.083	45.117	437.031
11	Short Term Loan Repayment											0.000		0.000
12	PDC Repayment													0.000
14	Capital Payment	1.123	0.394	1.703	3.146	0.846	1.012	1.276	0.553	0.583	1.351	1.205	0.899	14.091
15	Other items													0.000
16	TOTAL PAYMENTS	**61.807**	**69.062**	**68.916**	**69.746**	**68.754**	**72.164**	**69.755**	**68.891**	**76.767**	**68.914**	**68.915**	**78.916**	**842.604**
17	Net cash inflow/outflow	(3.461)	(7.970)	1.292	1.289	1.287	1.313	1.324	1.324	1.325	1.328	1.328	(3.204)	
18	Balance b/f	31.119	27.658	19.688	20.980	22.269	23.556	24.869	26.194	27.518	28.843	30.171	31.500	
19	Balance c/f	27.658	19.688	20.980	22.269	23.556	24.869	26.194	27.518	28.843	30.171	31.500	28.296	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(6.650)	(6.653)	(0.003)	(37.005)	(37.005)	0.000
RD&I	(0.142)	(0.142)	0.000	0.144	0.144	0.000
WBS	(3.214)	(3.214)	(0.001)	(19.816)	(19.816)	0.000
Sub-Total Divisions	**(10.006)**	**(10.009)**	**(0.003)**	**(56.677)**	**(56.677)**	**0.000**
Corporate Services Directorates	**(1.914)**	**(1.903)**	**0.011**	**(11.483)**	**(11.483)**	**0.000**
Delegated Budget Position	**(11.920)**	**(11.912)**	**(0.007)**	**(68.161)**	**(68.161)**	**0.000**
TCS	(0.124)	(0.127)	0.003	(0.611)	(0.611)	0.000
Health Technology Wales	0.000	0.000	(0.000)	0.000	0.000	0.000
Trust Income / Reserves	12.043	12.043	(0.000)	68.772	68.772	0.000
Trust Position	0.000	0.004	0.004	0.000	0.000	0.000

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**11.753**	**11.962**	**0.210**	**72.971**	**72.971**	**0.000**
Expenditure						
Staff	**8.350**	**8.430**	**(0.080)**	**45.765**	**45.765**	**0.000**
Non Staff	**10.053**	**10.186**	**(0.133)**	**64.210**	**64.210**	**0.000**
Sub Total	**18.403**	**18.616**	**(0.212)**	**109.976**	**109.976**	**0.000**
Total	**(6.650)**	**(6.653)**	0.003	**(37.005)**	**(37.005)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of May 2023 was a small underspend of **£0.003m**, and an expected outturn position of **breakeven**.

Income at Month 2 represents a surplus of **£0.210m**. Overachievement on Private Patients drugs due to activity and VAT savings from delivery SACT homecare is offsetting the divisional management savings target.

VCS have reported a year to date overspend of **£(0.080)m** against staff. The division continues to have a high level of vacancies, sickness, and maternity leave across several services which is largely offsetting both the vacancy savings target and to support posts appointed without funding

agreement. The recurrent impact of the pay award is expected to be neutralised when the Trust receives funding from WG.

Non-Staff Expenditure at Month 2 was **£(0.133)m** overspent which is a result of increased activity in a few areas including use of PICC and SACT following treatment returning to Neville Hall.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**4.478**	**4.541**	**0.064**	**26.674**	**26.674**	**0.000**
Expenditure						
Staff	**3.016**	**3.064**	**(0.047)**	**16.935**	**16.935**	**0.000**
Non Staff	**4.675**	**4.692**	**(0.017)**	**29.555**	**29.555**	**0.000**
Sub Total	**7.691**	**7.755**	**(0.064)**	**46.490**	**46.490**	**0.000**
Total	**(3.214)**	**(3.214)**	0.001	**(19.816)**	**(19.816)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of May 2023 was a small underspend of **£0.001m** with an outturn forecast position of **breakeven** currently expected.

Income overachievement of **£0.064m** to month 2. Targeted income generation on plasma sales through increased activity is being largely offset by lower than planned Bone Marrow activity.

There has been a lack of growth in the bone marrow registry which was largely impacted during the pandemic and is yet to see signs of recovery. WBS have been running campaigns to try and grow the panel in sites such as schools and universities.

Staff reported a **£(0.047)m** overspend to May. Vacancies are helping to offset the overspend from posts supported without identified funding source. This 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.

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.

The recurrent impact of the pay award is expected to be neutralised when the Trust receives funding from WG.

Non-Staff reported a small overspend of **£(0.017)m** to May. Energy price rises expected to be funded centrally by the Trust as agreed at the IMTP planning stage are being offset by savings against stem cell activity and testing.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**0.437**	**0.609**	**0.171**	**1.893**	**1.893**	**0.000**
Expenditure						
Staff	**1.864**	**1.834**	**0.030**	**10.454**	**10.454**	**0.000**
Non Staff	**0.487**	**0.678**	**(0.191)**	**2.923**	**2.923**	**0.000**
Sub Total	**2.351**	**2.512**	**(0.161)**	**13.376**	**13.376**	**0.000**
Total	**(1.914)**	**(1.903)**	0.011	**(11.483)**	**(11.483)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of May 2023 was an underspend of **£0.011m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust continues to benefit from receiving greater returns on cash being held in the bank due to the rise in interest rates.

Staff expectation is that vacancies within the division, will help offset use of agency and the divisional savings target.

Non pay overspend largely relates to the divisional savings target and the increased running costs associated with the hospital estate.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.334**	**0.367**	**0.033**	**3.207**	**3.207**	**0.000**
Expenditure						
Staff	**0.455**	**0.486**	**(0.031)**	**2.831**	**2.831**	**0.000**
Non Staff	**0.021**	**0.023**	**(0.002)**	**0.232**	**0.232**	**0.000**
Sub Total	**0.476**	**0.509**	**(0.033)**	**3.063**	**3.063**	**0.000**
Total	**(0.142)**	**(0.142)**	(0.000)	**0.144**	**0.144**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of May 2023 was **breakeven** with a current forecast outturn position of **breakeven**.

Income variance due to one off increase in trials being recognised, with fluctuations still expected throughout the year

Pay overspend to be neutralised by award funding in month 3.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.000**	**0.022**	**0.022**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.110**	**0.116**	**(0.005)**	**0.598**	**0.598**	**0.000**
Non Staff	**0.013**	**0.034**	**(0.020)**	**0.013**	**0.013**	**0.000**
Sub Total	**0.124**	**0.149**	**(0.026)**	**0.611**	**0.611**	**0.000**
Total	**(0.124)**	**(0.127)**	0.003	**(0.611)**	**(0.611)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of May 2023 is a small underspend of **£3k** with a forecasted outturn position of **Breakeven.**

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.258**	**0.258**	**(0.000)**	**1.697**	**1.697**	**0.000**
Expenditure						
Staff	**0.246**	**0.245**	**0.000**	**1.449**	**1.449**	**0.000**
Non Staff	**0.013**	**0.012**	**0.000**	**0.248**	**0.248**	**0.000**
Sub Total	**0.258**	**0.258**	**0.000**	**1.697**	**1.697**	**0.000**
Total	**0.000**	**0.000**	(0.000)	**0.000**	**0.000**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of May 2023 was **breakeven,** with a forecasted outturn position of **breakeven.**

HTW is funded directly by WG.

TRUST BOARD

Trust 2022/2023 Patient and Donor Experience Annual Report

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Jade Coleman – Quality, Safety and Assurance Manager
PRESENTED BY	Jade Coleman – Quality, Safety and Assurance Manager and Zoe Gibson, Interim Head of Quality, Safety & Assurance.
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	The highlights and summary of matters for consideration within this report for period 1st April 2022-31st March 2023 are: • **1036** patients / families provided experience feedback in relation to care, and treatment received at Velindre Cancer Service via the CIVICA electronic real-time patient experience system with **93%** reporting that their experiences were 'excellent'. • **8631** donors of the Welsh Blood Service provided 'real time' (at the tea table) donor experience feedback since the introduction of the CIVICA system at the Welsh Blood Service in August 2022 with **98%** of donors advising they were 'completely satisfied with their overall donation experience. • **154** complaints were raised which is lower than previous years: 190 in 2021-22 and 183 in 2020/21, suggesting

	that the Trust is learning and improving in areas where previous concerns were raised.

RECOMMENDATION / ACTIONS	To **APPROVE** the 2022 – 2023 Trust Patient and Donor Experience Annual Report. Following approval, the report will be translated into Welsh and uploaded on the Trust Intranet site.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Quality, Safety & Performance Committee	29th June 2023 13TH July 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***Executive Management Board***: Report discussed in detail and endorsed. Divisions were asked to co-present the report in respect of their core learning at the Quality, Safety & Performance Committee. ***Quality, Safety & Performance Committee***: Report discussed in detail and endorsed. Clarity requested in respect of donor feedback data. The infographic in respect of this was subsequently amended.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

1. SITUATION

The 2022-2023 Velindre University NHS Trust Patient and Donor Experience Annual Report summarises the experience feedback received from patients and donors and how this has been used by divisions to make changes to further improve the experience of their patients and donors during the period 1st April 2022 to 31st March 2023.

2. BACKGROUND

Velindre University NHS Trust's Strategy and Quality & Safety Framework places patients and donors at the heart of everything we do, seeking to ensure that all of our patients and donors receive positive care and great experiences. Therefore, it is critically important that managers and divisions receive real-time feedback in respect of the experiences their patients and donors are having so that they hear what the care and services they are responsible for are like for our patients and donors and that they can use this to improve the services they provide. We must also ensure staff at all levels receive this feedback to drive improvements and to further enhance the experiences of our patients and donors. It is only through openly listening that we can ensure our services continuously improve, are a safe environment and are truly patient and donor centred.

3. ASSESSMENT AND SUMMARY OF MATTER FOR CONSIDERATION

The 2022/2023 Trust Patient and Donor Annual Report is attached.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations X • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe X Timely X Effective X Equitable X Efficient X Patient Centred X
	Feedback received from patients and donors whether good or bad has allowed us to continually improve our services and helped to inform decision making and prioritisation. Openly listening to our patients and donors has assisted in taking efficient improvement actions where required, preventing reoccurrences. The CIVICA feedback system has allowed the Trust to connect directly with patient and donors within each service area for a more effective approach in engaging service users.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no items or matters arising within the report that have an adverse impact on social economic equality issues or experiences.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Obtaining feedback from patients and donors contributes greatly to understanding where service improvements can be made, leading to huge benefits in the future care and service provided within the Trust.
	There is no direct impact on resources as a result of the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	**Source of Funding**: Other (please explain) No financial request or impact as a result of this report
	Not required - please outline why this is not required
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
	There are no specific legal implications related to the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Putting Things Right Regulations (2011) Wales Quality & Engagement Act (2020)

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust 2022 / 2023
Patient and Donor Experience Annual Report

Canolfan Ganser Felindre
Velindre Cancer Centre

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Contents

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 areas including, treating patients with chemotherapy, Systemic Anti-Cancer Treatments (SACTs), immunotherapy and radiotherapy together with caring for patients with specialist palliative care needs. The Velindre Cancer Service is a leading organisation in respect of teaching, research and innovation for non-surgical oncology.

The Welsh Blood Service provides blood, blood products and transplantation products for the population of Wales. The service ensures that the donor's gift of blood is transformed into safe and effective blood components, including bone marrow donations, stem cells and immunogenetics services, helping to improve and save the lives of many thousands of people in Wales every year.

Velindre University NHS Trust is committed to ensuring that patient and donors are at the heart of everything that we do, striving to ensure that all of our patients and donors receive positive care and experiences.

Velindre Cancer Service obtained feedback from **1036** patients, **6%** of the **18,619** patients who were treated or attended for an Outpatient referral, including phlebotomy and Healthcare at Home), day-cases, SACT, radiotherapy, inpatients and radiology.

8631 Welsh Blood Service donors provided feedback from 1st August 2022 when the CIVICA system was introduced**, 59,484** donors attended session during this time, equating to **14.4%** of donors providing feedback at the tea table via the CIVICA system.

Velindre University NHS Trust has significantly strengthened its approach in order to capture patient and donor feedback, by introducing the CIVICA digital real time patient experience system which facilitates all service areas to easily provide feedback on their experiences before they leave the venue or care or service delivery.

Receiving real time feedback on the experiences of our patients and donors is extremely important and it allows through email alerts issues to be identified and be nipped in the bud by responsible managers. Feedback received by patients and donors, whether good or bad has allowed us to continually improve and also ensures that feedback helps to inform decision making and prioritisation.

Trust staff are encouraged and are extremely grateful to receive positive feedback and compliments from patients and donors about the experiences they have received from Velindre Cancer Centre and Welsh Blood Services.

This report covers the year: 1st April 2023 – 31st March 2023.

Capturing Patient & Donor Feedback

The Trust continues to have several different mechanisms to encourage and obtain patient and donor feedback. This has been further enhanced over the year with the roll out of the All Wales electronic CIVICA experience feedback tool. Our key focus is to ensure that patients and donors can provide feedback in an easy, simple, and straight forward way and that this feedback is available to managers in real time. The CIVICA system provides patients and donors with a wider choice of channels to use to provide their feedback.

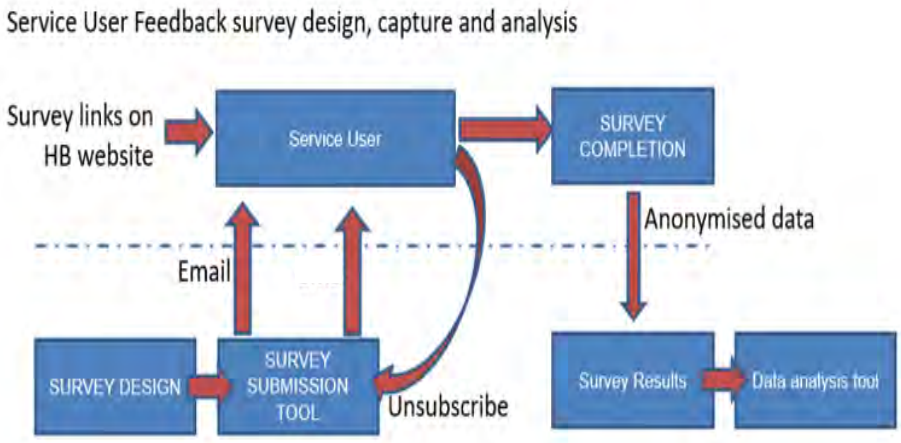
Feedback reporting channels include:

ONLINE | TABLET | EMAIL | PHONE | QR CODES

The CIVICA system is used to capture 'real time' insights into patient and donor feedback enabling rapid actions to be taken to address any areas of concern.

The All-Wales Patient Experience survey includes a suite of standard experience survey questions. The Trust is also able to generate specific, more in-depth surveys to gain feedback within service areas, teams, and projects. This allows for an adaptable approach to gathering information on how existing or new services are performing. The links to all of these surveys can be published or emailed independently of the system by the Trust.

When a patient or donor completes a survey, anonymised data is fed into the system and passed into the data analysis tool. Trust CIVICA leads are responsible for redacting any personal identifiable information into responses (particularly if free text fields are used) and service users always have the option to opt out of live and future surveys.



The Experience of Velindre Cancer Service Patients

Velindre Cancer Service continue to receive feedback from its patients, carers and family members in relation to the care and treatment received every day. The feedback received provides invaluable learning opportunities to improve the care for every patient.

During the year experience feedback was received from **1036** patients and or their family member which is **6%** of the **18619** patients who were treated or attended for an Outpatient referral, including phlebotomy and Healthcare at Home), day-cases, SACT, radiotherapy, inpatients and radiology.

A total of 1036 surveys returned (1st April 2022 to 31st March 2023)			
	93% scored their experience as 'Excellent' (>9 out of 10)		85% indicated their experience was within the last 6 months
	89% stated they always felt cared for		96% felt they were always listened to
	42% said their time spent waiting was shorter than expected		52% said their waiting time was about right
	95% felt they always had assistance when they needed it		83% always understood what was happening with their care
	86% said explanations were given in a why they could understand		90% felt they were involved as much as they wanted to be in decisions about their care

Velindre Cancer Service Learning

An important part of receiving feedback is to ensure that lessons are learnt from identified failings and that actions are taken to reduce the likelihood of reoccurrence. The Trust have a range of processes in place to share learning from complaints, including direct feedback to staff members involved, team meetings, newsletters, and clinical audits.

The following spotlight on learning provides examples of how we improved and developed our services following feedback received during the year:

Patient Engagement	**The Velindre Cancer Service has appointed a Patient and Donor experience manager who leads on the investigations when concerns and incidents are raised. Additionally, a Head of Patient Engagement has been recruited as part of the governance around the Patient Engagement Strategy. An Operational Management Group was set up in addition to a Steering Group which was chaired by Independent Board Member, Hilary Jones. The Steering Group consists of Community Health Councils reps, staff, patients, Diverse Cymru and Patient Liaison Group members.**
Patient appointments	**A whiteboard has been installed within the phlebotomy department to ensure that if a patient doesn't hear their name being called, they can also view their name on the board as well.**
Training	**Following an increase in new Systemic Anti-Cancer Therapy (SACT) and different regimes, SACT clinical educator nurses along with the medicine management nurse are carrying out additional training to help support junior staff. Over a 12-month period approximately 31,700 SACT treatments were administered by the nursing SACT staff. This type of incident had an error rate of approximately 0.026%.**
Outpatient	**A TV screen has been installed within the outpatient's department to display to patients an approximate time they will have to wait to see their specific consultant.**
Medication	**Hypersensitivity reactions (HSRs) are a known common side effect to Systemic Anti-Cancer Therapy (SACT). Currently recorded within the Trust Datix Cymru reporting system, they are not classified as incidents. A Task and Finish group was established to look at alternative ways of collecting these events outside of Datix Cymru. These events were reported to the SACT and Medicines Management Operational Group (SMMOG) and over the previous 12 months there have been 105 hypersensitivity reactions documented onto the DATIX system, and all incidents are now closed.**
Records Management	**The Cancer service have introduced an identifier to all patient records to clearly identify whether the individual is a "cancer" or "non cancer" patient.**
Consent Forms	**Explicit use of CRUK & RCR consent forms are now used for SACT & radiotherapy patients, ensuring all patients are fully informed of the intended benefits, potential side effects & risks of their treatment.**
Risk of falls	**There is now clear guidance for First Floor ward nursing staff around when**

	patients identified as at risk of falls, need to be referred to the physiotherapy team. The role of the physiotherapist working on the weekend has now been clearly defined to support patients at risk of falls.
Information Governance	New controls have been put in place to ensure that Velindre Cancer Service Business Intelligence (BI) team receive a detailed written specification for every BI request. This data has a second quality assurance check completed, and that the quality assurance documentation is completed before data is shared.
Enteral Feeding	A task and finish group has been established to improve processes around enteral feeding. This includes training for nursing staff, improved signage in the storeroom, updated discharge checklist and uploading patient training videos to the Velindre internet site.

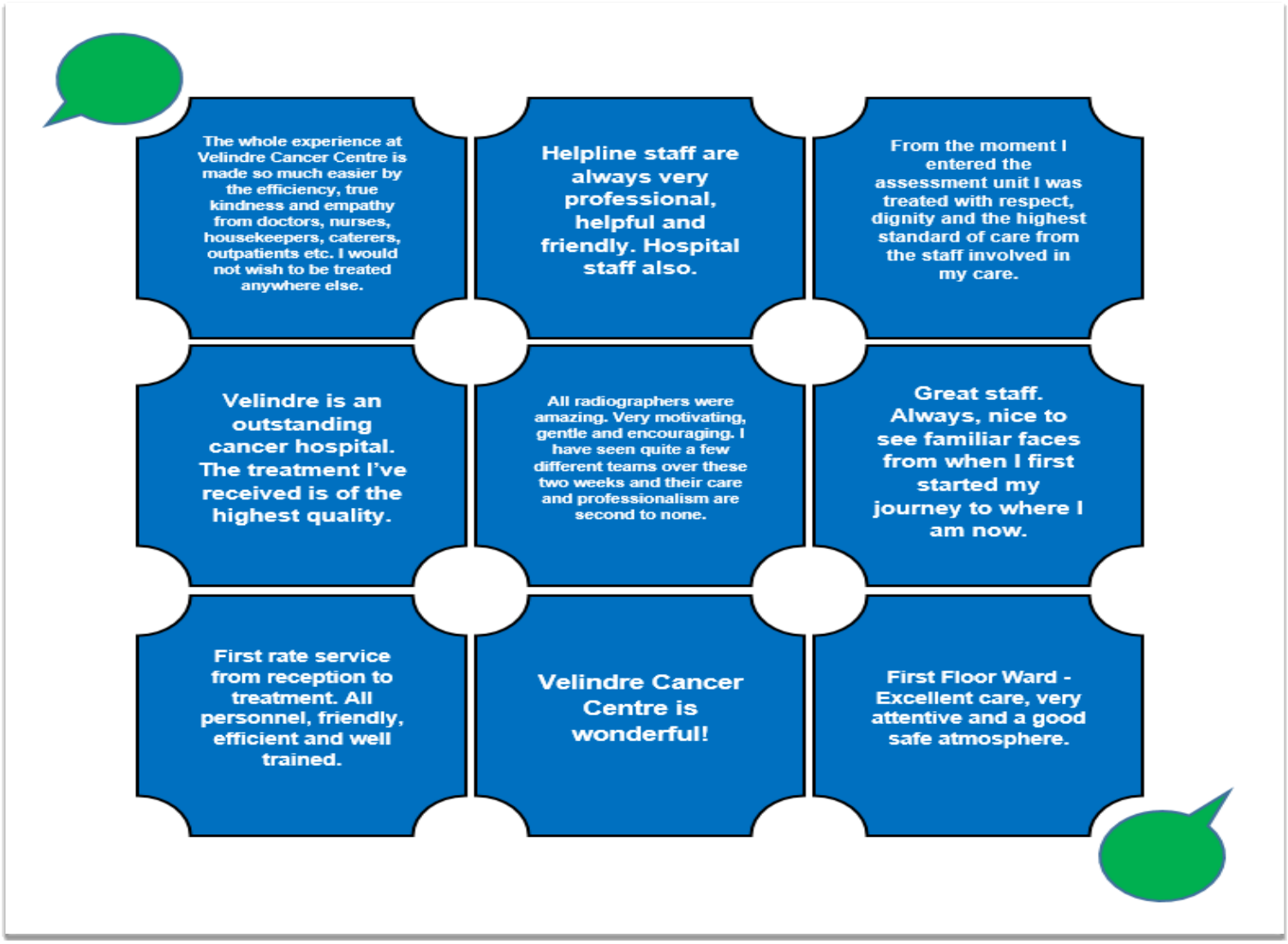
Comments received into Velindre Cancer Service

Patients, relatives, and carers regularly contact the Trust to let us know about the good care and service they have received. Comments and compliments are received via many different routes including, verbally or via social media, by letter and messages in thank you cards. The introduction of the CIVICA feedback system has seen an improvement in the way the Trust captures digital feedback from all service users, enabling specific data to be reviewed in an effective, timely and meaningful way.

We appreciate the time taken by patients, relatives, and carers to let us know about their experience of our service and care that has been received. The individuals and teams involved in the care and service provided are pleased and encouraged by such feedback.

During the year qualitative feedback received was mainly very positive, and many supportive messages were received from our patients, family members and service users during this time. There were also some comments that provided opportunities for improvement. The wordle below summarises the key words used in narrative provided.

The box below summarises some of the compliments received:



Velindre Cancer Service Engagement

As part of the Trust's Patient Engagement Strategy plans an additional CIVICA module – 'Engage', has been procured to facilitate the capture of information in line with the Velindre Voices mechanism.

The Velindre Cancer Service Patient Liaison Group continued to meet during the year, mainly focussing on providing feedback on the new Velindre Cancer Centre design etc. Specific events have been held in relation to wayfinding, design, and external areas. A member of the Patient Liaison Group joined the Outpatient Design Group whereby the suggestion to incorporate a 'quiet exit door' was approved. This was based upon their experience of witnessing distressed and upset patients and families exiting through a busy waiting area.

During the year, the Patient Liaison Group have reviewed the generic Velindre Charity information leaflets and attended staff educational sessions to share their lived experience. The Chair of the Patient Liaison Group attends the Trust Board Meetings.

Another key focus has been on building relationships with organisations that support, advocate, and promote the role of the Armed Forces.

https://velindre.nhs.wales/news/latest-news/4-february-is-world-cancer-day/

Every year, Velindre Cancer Service celebrates World Cancer Day, the day brings together people, communities, and countries from across the world to raise awareness and take action.

Between 2022 and 2024, the theme is Close the Care Gap. Focussing on realising the problem during 2021-22, the attention during 2022-23 turned to uniting our voices and taking action.

Throughout World Cancer Day, Velindre Cancer Services took to social media and featured individual members of staff who discussed what this day means to them.

The experiences of the Welsh Blood Service Donors

Welsh Blood Service continue to receive high numbers of engaged donors who actively share and communicate both good and bad feedback. The feedback received provides invaluable insight into the day-to-day experiences that donors have when visiting clinics and mobile donor units.

Following the introduction of the CIVICA system in the Welsh Blood Service on 1st August 2022, the Welsh Blood Service have captured **8631** real time responses from Donors at the tea table after their donation this equates to **14.4%** of the **59,484** donators during that period.

A total of 8,631 surveys returned (1st April 2022 to 31st March 2023)			
	98% scored their experience as completely satisfied/satisfied with overall experience		99.5% of donors found a good standard of hygiene and cleanliness
	99% of donors found staff welcoming and friendly		99% of donors found staff helpful and knowledgeable
	99% of donors felt they were treated with dignity and respect		100% of donors said they felt safe
	99% of donors felt they were offered quality of care		99% of donors found staff compassionate and caring
	99% of donors were provided with enough information about the donation process		99% of donors felt they received adequate emotional and physical support

Welsh Blood Service Learning

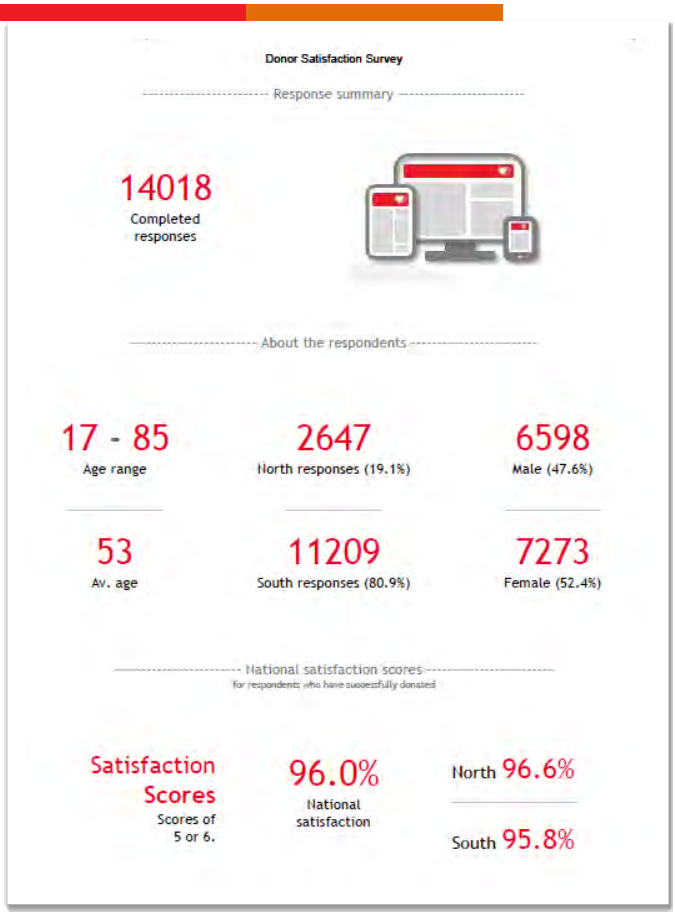
An important part of receiving feedback is to ensure that lessons are learnt when donor experience was not as good as it could be and that actions are taken to improve this for future donors. The Trust have a range of processes in place to share learning, including direct feedback to staff members involved, team meetings, newsletters, and clinical audits.

The following spotlight on learning provides examples of how we improved and developed our services following feedback received during the year:

Clinic Management	Individual risk assessments are now undertaken to allow frontline blood donation staff to gain donor consent for children to be in attendance when donating.
Communication	A review was undertaken into the number of concerns raised relating to communication issues when donors were liaising with staff. The investigation identified a trend in staff feeling unhappy with certain elements of the donation process i.e., working on the Mobile Donor Units (MDU). Operational Management have listened and recognised the issues raised and continue to monitor and evaluate concerns raised by donors to enhance donor and staff satisfaction.
Dietary Requirements	There is now a variety of vegan biscuits and dairy free milk available across the collection teams for our donors to enjoy following feedback received.
Blood Donations	Donors sometimes report experiencing uncomfortable donations when needles are inserted and/or removed from the venepuncture site. Following a concern raised when a donor noticed a lump on completion at the venepuncture site, the investigation found several breaches of duty relating to the immediate and subsequent care of donor which led to a review of the current training practices and has brought out a safe collaboration project looking at documentation of such events.
Language Line	The Welsh Blood Service have introduced an electronic system 'Translation on Wheels' so a face-to-face British Sign Language Interpreter (BSL) can be called on at short notice to support Deaf donors through the blood donation process.
Appointment Times	Appointment cut off times have been reviewed, particularly during lunch times and end of day appointment slots, to accommodate donors who attend late for their allocated time. A ten-minute grace period is offered to donors for each appointment.
Access to Service	Positive interactions with Donors have been arranged to navigate the online booking system to enable Donors who wish to do so, can book their own appointments via the online booking system.
Transgender terminology	Following consultations with donors and consulting the Diversity and Inclusion Manager the Welsh Blood Service have introduced asking all donors their assigned sex at birth (ASB) to ensure the safety of the blood supply when making plasma rich components from blood products.
Welsh Medium	Hoffwn gwyno yn unol â Mesur yr Iaith Gymraeg am sawl peth yn ymwneud â'r Gymraeg sydd yn gyfrifoldeb i Ymddiriedolaeth Felindre. Cyfeiriaf atynt yn eu tro isod gan obeithio y byddant yn arwain at welliant yn y ddarpariaeth Gymraeg rydych yn eu cynnig i'r cyhoedd. A full review of the Welsh Blood Service website identified several areas for improvement in relation to the use of the Welsh Language. The website was updated to ensure all areas were available in a bilingual format.

Comments received into Welsh Blood Service

The Welsh Blood Service strengthen engagement by proactively inviting all Donors who have attended a donation clinic within the previous month to complete a digital satisfaction survey via Snap survey. The results are collated, analysed, and reported at the Trust Collections' Operational Service Group to improve the level of service provided by the Welsh Blood Service.



The Donor Contact Centre is to be the first point of contact for blood donors in Wales, with main functions including: booking appointments, answering queries, seeking feedback, and keeping consistent lines of communication with our donors via telephone, email and social media.

The Donor Contact Centre's key aim is to deliver an exceptional standard of Service, care and safety for our donors, whilst ensuring that hospital blood stocks are consistently at the optimum levels.

Making contact with donors to advise on last-minute changes with clinics.

Continue to drive SMS invites, replacing letters, to allow for greater agility with clinic changes, supporting greater opportunity to react in real time.

Focus on implementing more bespoke Donor journeys. Driving consistency in Donor experience. Enabling better ability for Donors to self-serve.

Maintained appointment bookings at an average of 92%

Implemented same day SMS appointment reminder, driving 4% improvement in Donor attendance.

Total calls handled by Contact Centre were 90,000 (46,000 inbound calls, 31,000 outbound calls, 13,000 bespoke campaign calls)

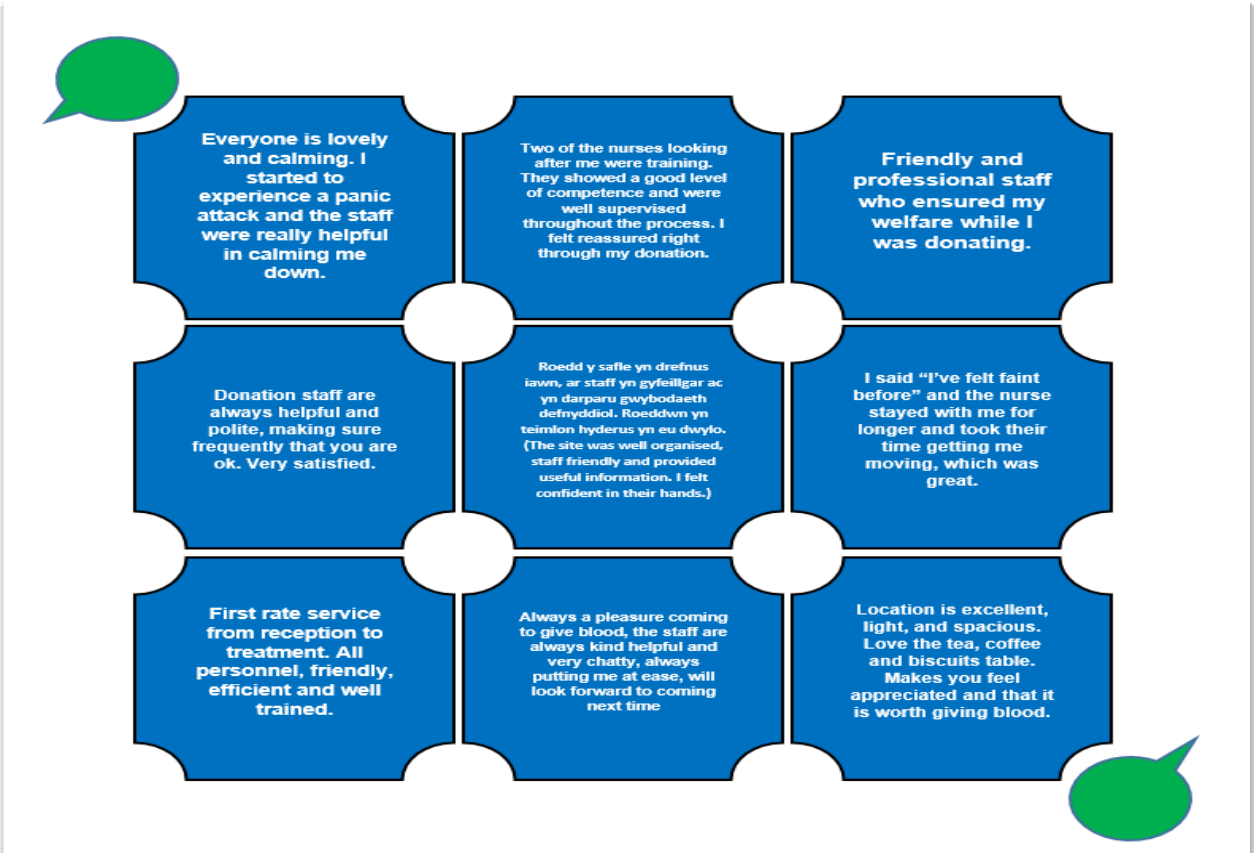
Total appointments booked from calls: 14,200 (13,961 inbound appointments & 239 outbound appointments).

Comments received into Welsh Blood Service

Donors regularly contact the Trust to feedback about the experiences they have received whilst using the service. Comments and compliments are received via many different routes including, verbally or via social media, by email and by letter. The introduction of the CIVICA feedback system has helped improve the way we capture Donor feedback, enabling specific data to be reviewed in an effective, timely and meaningful way.

We appreciate the time taken by Donors to let us know about their experiences and during the year, qualitative feedback received was mainly very positive. The wordle summarises the key words used in the narrative within the CIVICA responses.

There were also some comments that provided opportunities for improvement and a snapshot of compliments received during the year have also been included below:



Welsh Blood Service Engagement

The Trust is committed to engaging and working in partnership with our patients and donors so we can ensure that our services truly meet the needs of our patients and donors. Donor Engagement is hugely important, not only to ensure the donor experience is optimised, and people engage with the Service, but also to ensure we maintain a steady supply of blood and blood products.

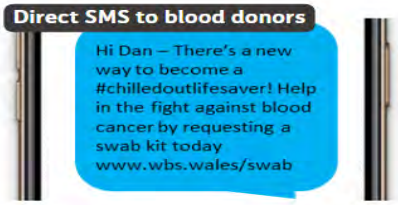
The donor engagement team strategically utilises local influencers, from hairdressers and butchers to local football teams and running clubs, to boost booking percentages of new donors. The strategy undertaken in Wales has now been internationally recognised by peers, with several blood establishments engaging with the Welsh Blood Service to explore implementation in their own areas.

Bone Marrow Donation Campaign

Robert Morgan overcame cancer thanks to a lifesaving bone marrow donation from a complete stranger, Tom Heaven. The duo recently met for the first time to launch Welsh Blood Service's #ChilledOutLifesaver campaign, urging more people to join the Welsh Bone Marrow Donor Registry to help other patients in need.

Supporters webpage

Direct SMS to blood donors



Influencer specific comms and content

Football Association of Wales partnership

Our first community partnership is now celebrating its third season with over 2,500 lives potentially saved.

More than 70 clubs across Wales have been encouraging fans to support our 'Blood, Sweat and Cheers' campaign both on and off the pitch to highlight the importance of donating blood, platelets and bone marrow.

Clubs receive bespoke toolkits with planned PR content throughout the season to keep the content compelling.

For the first time the Welsh Blood Service has recently introduced a direct mailing platform which was used to boost the number of 17- to 30-year-olds joining the Welsh Blood Marrow Donor Registry.

Concerns received by Patients and Donors

154 concerns were raised during 2022-23, equating to less than **0.5%** of patients and donors raising concerns in relation to the care or treatment being provided. These records are significantly lower than 2021-22, where 190 complaints were raised and, 183 recorded in 2020/21 in comparison. This suggests that the Trust is learning and improving in areas where previous concerns were raised. When a complaint is investigated under Putting Things Right, an acknowledgment is provided to the complainant within two working days of the concern being raised. Welsh Government requires Health Bodies within Wales to thoroughly investigate all

complaints received and, that 75% of all complaints be resolved, ensuring a formal response is produced within 30 working days of receipt. During the period, 84% of concerns were resolved within 30 working days of receipt and therefore achieving the Welsh Government target of 75% compliance of closing concerns received within 30 days.

Our aims and priorities for 2023-24

1. **Velindre University NHS Trust will continue to actively listen to its patients (their carers) and donors, putting things right where things have gone wrong.**
2. **To fully implement and embed the new requirements of the Health and Care Quality Standards.**
3. **The Quality and Safety Team will develop a Trust wide repository where learning and outcomes from patient and donor experiences can be saved and shared.**
4. **The Trust will establish "Always on" reporting metrics to aid continual improvement opportunities and real time investigation of concerns that are raised and publish these monthly.**
5. **The Trust will ensure that the feedback from our patients and donors is shared systematically with all teams and staff.**


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

TRUST BOARD

2022/2023 Trust Annual Putting Things Right Report

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Jade Coleman, Quality, Safety and Assurance Manager
PRESENTED BY	Jade Coleman, Quality, Safety and Assurance Manager & Zoe Gibson, Interim Head of Quality & Safety
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Velindre University NHS Trust Putting Things Right 2022-2023 Annual Report covers the period 1st April 2022 to 31st March 2023. The highlights for the year are: • 154 complaints were raised, equating to less than 0.06% of patients and donors raising a complaint in relation to the care, services or treatment provided. • 55% of complaints were received via e-mail. • Over 94% of complaints were low level (graded level 1 or 2), and 70% were successfully resolved via the 'early resolution' process (verbally within 48 hours of receipt), an 11% increase in comparison to 2021/2022. • 7 complaints were re- opened. All were

	swiftly investigated and managed through to final closure to the satisfaction of the complainant. • Since April 2022 there has been a steady decrease in the number of Covid related complaints. • 8 claims have been managed during the year, 1 new claim received, 4 claims settled and closed, with 5 remaining open at the end of the year. • 7 Redress cases were managed during the year, 4 new redress cases opened, 1 case closed, 1 offer made and decision awaited, with 6 cases remaining open at the end of the year. • 2,023 incidents were reported across the Trust throughout. 74% were fully investigated and closed within 60 days of the incident being reported. • There were 9 National Reportable Incidents (compared with 12 in 2021-22 and 15 2020-21). All 9 related to Velindre Cancer Service: 2 related to the SACT treatment helpline, 3 related to patient falls, 2 related to booking mechanisms, 1 related to an extravasation incident (leakage of fluid into the tissue around a cannula) and 1 incident relating to flood damage to a medical records facility. • There were 7 inquests being managed during the year. These included 3 new inquests being opened, 2 being completed and closed, with 5 remaining open at the end of the year. • A key theme from the report is the need to enhance and improve clinical communications

RECOMMENDATION / ACTIONS	To **APPROVE** the 2022-2023 Velindre University NHS Trust Putting Things Right Annual Report. Once approved, the report will be translated into Welsh and uploaded on the Trust Intranet site.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
• Integrated Quality & Safety Group • Executive Management Board • Quality, Safety & Performance Committee	Throughout 2022/23 29th June 2023 13TH JULY 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Trust 2022/23 Putting Things Right Annual Report was discussed, and content agreed at the Integrated Quality & Safety Group.	

Report Endorsed by Executive Management Board Discussion took place at the Quality, Safety Performance Committee in respect of the level of assurance being identified as a level 3, as deemed potentially too low, as the report evidenced a positive improvement. Subsequent review has increased assurance rating to level 4.

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES	
1.	2022/2023 Trust Annual Putting Things Right Report

1. SITUATION

The 2022-2023 Velindre University NHS Trust Putting Things Right Annual Report provides an overview of the concerns activity undertaken between 1st April 2022 and 31st March 2023 including the key issues and outcomes in relation to performance, overview of key themes and trends, analysis of some of the cases managed, and details of the learning accomplished and assurance given of the Trust's ongoing commitment to learning and improvement and highlights concerns, compliments, claims, inquest and redress cases.

2. BACKGROUND

All NHS bodies in Wales must ensure that they have effective processes for managing concerns raised by patients and staff in accordance with the NHS (Concerns, Complaints of and Redress Arrangements) (Wales) Regulations 2011. The aim of the Putting Things Right Regulations is to give guidance on how concerns that are received should be investigated and responded to in order to promptly and fairly facilitate resolution of issues at a local level for both users of the service, their representatives and carers and also the staff involved.

The National Putting Things Right Guidance details the requirements to assist staff in interpreting the Regulations and provide practical advice on applying best practice at the various stages of handling and investigating a concern. The guidance sets out the general principles for handling concerns, raising a concern and investigating a concern. The guidance details managing Redress cases including payments of any financial compensation and finally serious incident reporting and investigation requirements.

The Trust is committed to being open and discussing compassionately with the service user, family member or representative acting on their behalf. Openness and honesty assist in preventing events from becoming litigated claims. When concerns arise, the Trust, in the interests of justice, endeavours to resolve these amicably and as swiftly as possible.

Velindre University NHS Trust is committed to ensuring the provision of an effective and timely process for responding to concerns, which ensures concerns are thoroughly and

appropriately investigated and enables the Trust to improve its services based on lessons learned.

3. ASSESSMENT AND SUMMARY OF MATTERS FOR CONSIDERATION

The Trust 2022/23 Putting Things Right Annual Report is attached in appendix 1. Whilst we pride ourselves in delivering high quality and safe services, there are occasions when things go wrong. When this happens, we are committed to resolving all complaints and incidents in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) commonly known as Putting Things Right (PTR).

4. IMPACT ASSESSMENT

<table>
<tr><td colspan="2">TRUST STRATEGIC GOAL(S)</td></tr>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
YES - Select Relevant Goals below</td></tr>
<tr><td colspan="2">If yes - please select all relevant goals:
• Outstanding for quality, safety and experience ☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒
• A beacon for research, development and innovation in our stated areas of priority ☐
• An established 'University' Trust which provides highly valued knowledge for learning for all. ☒
• A sustainable organisation that plays its part in creating a better future for people across the globe ☒</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>06 - Quality and Safety</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below</td></tr>
<tr><td>Safe ☒
Timely ☒
Effective ☒
Equitable ☒
Efficient ☒
Patient Centred ☒</td></tr>
<tr><td rowspan="2">SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:
For more information: https://www.gov.wales/socio-economic-duty-overview</td><td>Not required</td></tr>
<tr><td>The Putting Things Right Regulations ensures that in the interests of justice there is a requirement to be open and honest and to ensure that adequate provision is made to assist those who are socially disadvantaged when dealing with concerns. As part of the concerns governing processes, there is a need</td></tr>
</table>

	to assess if any equality/social economic issues arise that could potentially have a consequence on the service user or those representing the service user's best interests in relation to a concern. Reducing inequalities prevent social injustice. The Trust is under a duty to offer appropriate support and signpost to relevant services where required, as part of the governance processes in place for the provision of concerns. This helps to facilitate better outcomes for the individual and aligns with the well-being goals and five ways of working provided by the Future Generations (Wales) Act 2015
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	As part of the complaints process, there is the need to take in account the wishes of the individual. This leads to better wellbeing and health choices. By involving the individual in the decision-making process this ensures an effective outcome. When concerns are raised, wellbeing plays an important part in how the individual feels treated by the Trust in raising their complaint. The Trust is committed to providing timely responses, including thorough and appropriate investigations which enables the Trust to improve its services based on lessons learned, leading to huge benefits in the future care and service provided within the Trust.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Other (please explain) The report contains details of legal claims against the Trust which give rise to financial impact in addition to potential reputational damage and lack of confidence in the services provided, all of which has the potential for adverse financial consequences **Type of Funding:** **Revenue** Financial impact of the Trust claims is outlined in the Claims Policy, Welsh Risk Pool Procedures and Welsh Risk Pool Indemnity arrangements. **Scale of Change** Please detail the value of revenue and/or capital

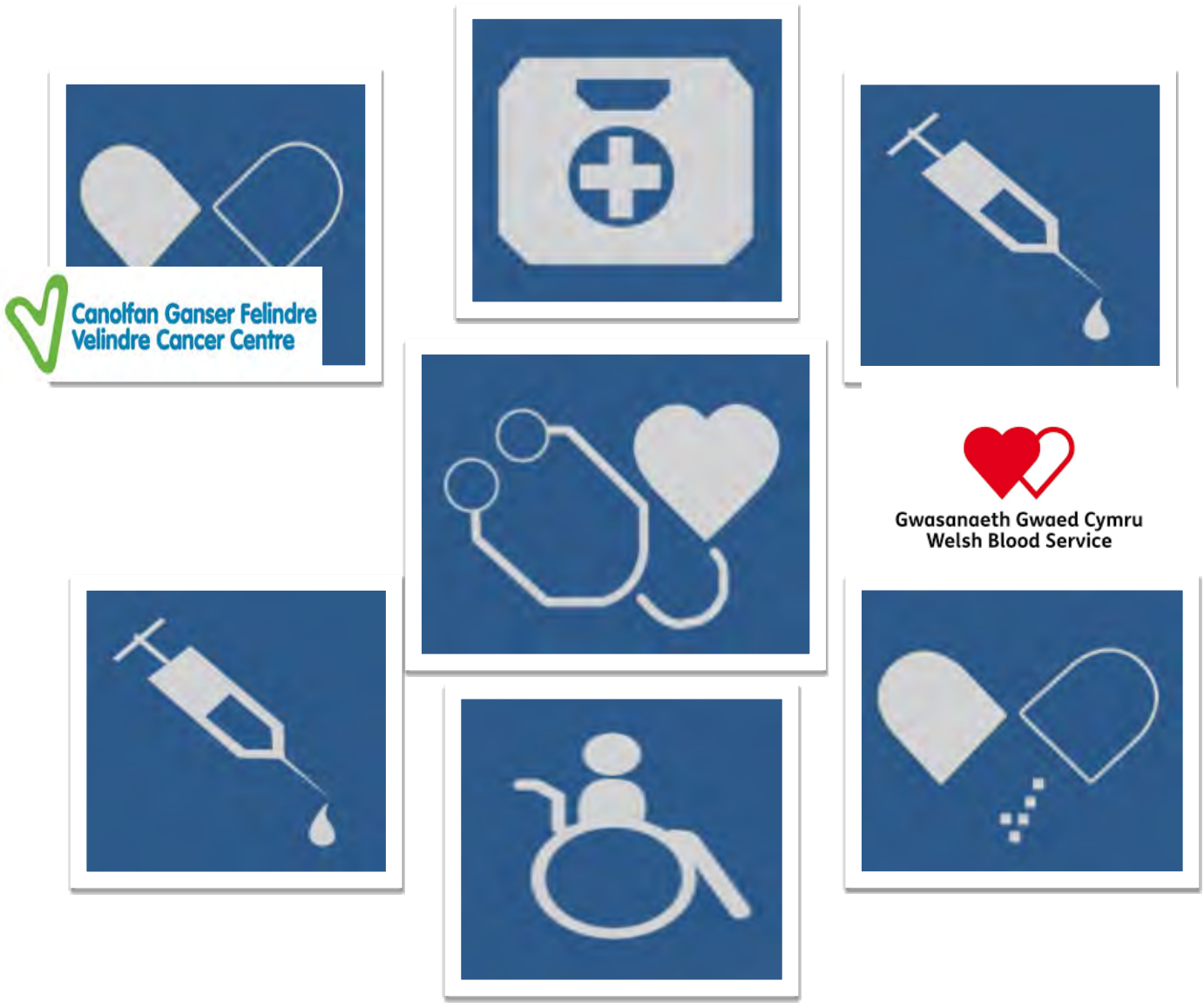
	impact: The estimated financial liability of the current caseload of claims is predicted to be in the region of approximately £924,576 The Welsh Risk Pool indemnifies the Trust in respect to the payments made, deducting the first £25,000, which is the financial cost borne by the Trust. The Trust liability, if it were to settle its current caseload of claims is estimated in the region of £119,224. **Type of Change** **Other (please explain)Other (please explain)** Please explain if 'other' source of funding selected: Not applicable.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	The equality impact assessment is designed to ensure that decision-making processes are fair and do not present barriers or disadvantages to protected groups. There are legal implications for concerns if there is inequality in the Trust's processes and policies that could potentially prejudice service users. By enable service users to raise concerns safely and in the knowledge that they will be listened to and actions taken appropriately to address concerns, the risk is mitigated.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	In addition to litigated claims, the Trust is responsible for addressing Part 6 of the Putting Things Right Regulations. This places an onus on the Trust to ensure that concerns are properly investigated and appropriate Redress remedies offered. When both a breach of duty and harm and/or loss have been identified, amounting to a qualifying liability, the Trust is required to make a suitable financial offer within the PTR threshold (i.e. up to the maximum limit of £25,000). Concerns (consisting of complaints, incidents and claims), have legal and financial implications, as outlined above.
	Potential financial implications arise when it is identified that errors have occurred, omissions to act or there have been system failures

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
Themes and trends arising from analysis of concerns represent a risk for the Trust, especially when it is identified that errors and mistakes have been made which potentially has legal and financial consequences. The Trust is operationally responsible for the management of concerns and must ensure that it is compliant with delegated authority limits and for securing the most cost-effective resolution of concerns. All members of staff are encouraged to report adverse incidents, including those that may lead to claims for compensation. Failure to do so, increase risk. Staff have a duty to provide assistance as part of an investigation when called upon to do so and, where appropriate, are required to support the complaints, redress and inquests processes, when required. Risks are evidenced through Datix Cymru and is consistent with analysis of themes and trends data. Any risks identified are escalated through the concerns governance processes, as required.	

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Velindre University NHS Trust
2022/2023 Putting Things Right Annual Report



Contents

Introduction

Velindre University NHS Trust provides specialist cancer, blood and transplantation services, bringing together expert staff, high quality cancer care, donor and transplantation services, together with excellence in research, development and innovation. We have built a strong reputation across the United Kingdom, Europe and internationally for the services we provide.

The Trust has two main divisions: Velindre Cancer Service (which provides specialist tertiary non-surgical cancer care) and the Welsh Blood Service (which is responsible for the provision of blood and blood products) to NHS Wales.

The effects of harm, when something goes wrong, can be widespread and have devastating emotional and physical consequences, not only for the service users, but also for family members or representatives acting on their behalf.

The Trust is committed to be open and transparent when things go wrong in order to learn and improve and prevent harm from re-occurring.

The Trust places a high value on ensuring that we always keep our patients and donors at the heart of everything that we do, and we are grateful for the continued levels of assistance, encouragement and positive feedback that we get from our patients, donors, staff, sand partners.

Whilst we pride ourselves in delivering high quality and safe services, there are occasions when things go wrong. When this happens, we are committed to resolving these matters with utmost transparency and in accordance with legislative and national requirements in particular in line with the NHS (Concerns, Complaints and Redress Arrangements) (Wales) commonly known as **Putting Things Right** (PTR) (2011).

Velindre University NHS Trust 2022 - 2023 Putting Things Right Annual Report provides an overview of how the Trust has managed concerns (complaints, serious incidents, claims, redress, and inquests) during the period of the 1st April 2022 to the 31st March 2023.

The report also provides information on how our systems and processes have developed for the effective investigation and engagement with patients/donors and their families, providing comprehensive responses to each concern raised. This ensures that changes have been made, lessons have been learnt and action outcomes disseminated following the investigations.

Trust Complaints Received

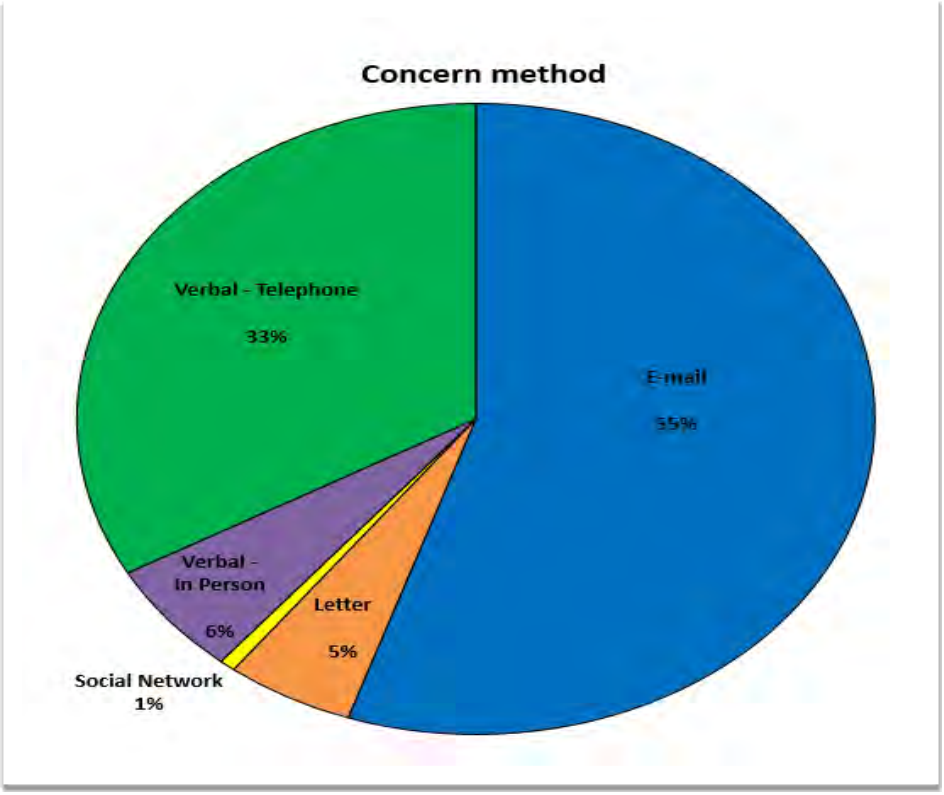
Raising a concern will be easy and information will be widely accessible. Put the complainant at the centre of the process and provide support for individual requirements.
Listen to concerns and treat everyone with dignity and respect.

When a complaint does not require a formal investigation, we aim to resolve it within 2 working days of receipt, called 'Early Resolutions'. These do not need to be formally considered under the Putting Things Right Regulations (PTR). Where it has not been possible to resolve a complaint within this timescale, or where an in-depth investigation is required, the complaint is managed under the Putting Things Right Regulations.

Complaints are received via a number of routes and is evident that e-mail communication remains the preferred method of contacting the Velindre University NHS Trust, with **55%** of complaints being received in this way during 2022-23.

Feedback reporting channels include:

ONLINE | TABLET | EMAIL | PHONE | QR CODES



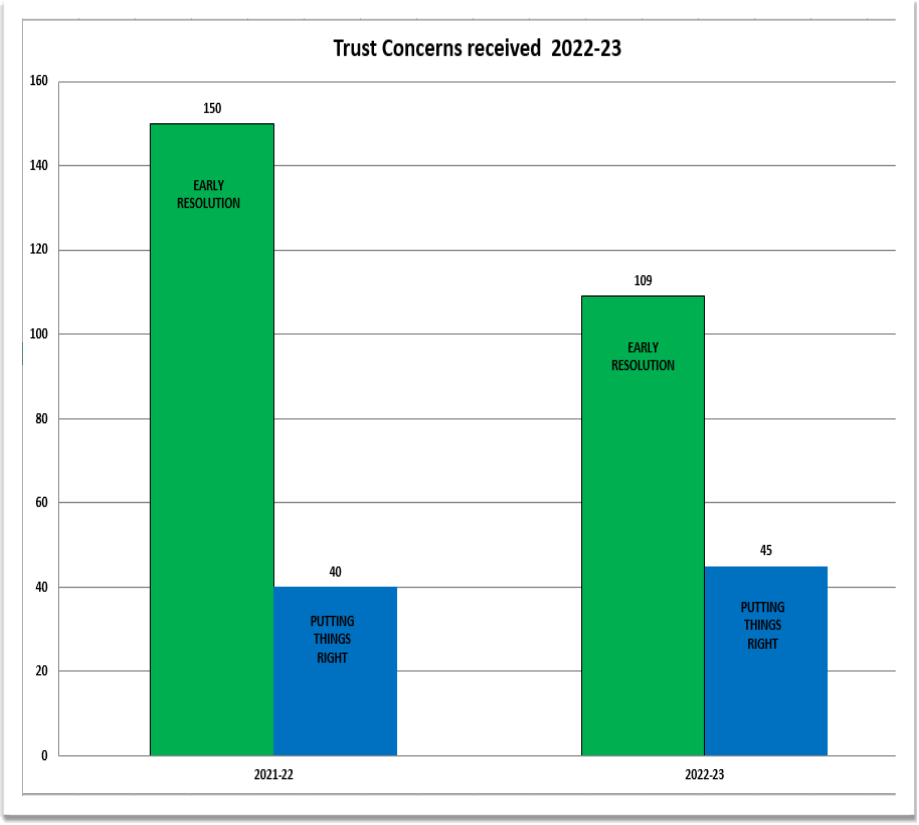
Reporting and Monitoring Structure

The Trust continues to improve its reporting in order to contribute to reducing harm to service users by turning the data that it holds into useful information. This drives operational efficiency and enhances the level of insight such data offers. This includes analysing themes and trends and escalating where necessary. Monitoring claims is a fundamental tool of risk management, the aim of which is to collect information regarding claims that will help to facilitate wider organisational learning. Quarterly PTR related reports covering all elements are combined into an overarching Trust Quality and Safety report, provided to the Integrated Quality and Safety Group, divisional quality and safety groups, Executive Management Board and Quarterly and Safety Performance Committee and presented by the Executive Director of Nursing, AHP and Healthcare Science who is the Executive Director responsible for Putting Things Right.

Complaints received between 1st April 2022 and 31st March 2023

Acknowledge all concerns within 2 working days.
Aim to resolve concerns at source, or by the end of the next working day. Responses required under PTR will be provided within the legislative timescales.

154 complaints were raised, equating to less than **0.06%** of patients and donors raising concerns in relation to the care or treatment provided (this is based on 183,691 patient attendances and 79547 Welsh Blood Donations). This activity rate is lower than previous years (190 raised in 2021/22 and 183 patients/donors in 2020/21). When a concern is investigated under Putting Things Right, an acknowledgment is provided to the complainant within 2 working days of the concern being raised. Welsh Government requires Health Bodies within Wales to thoroughly investigate all concern received and, that 75% of all complaints be resolved, ensuring a formal response is produced within 30 working days of receipt.



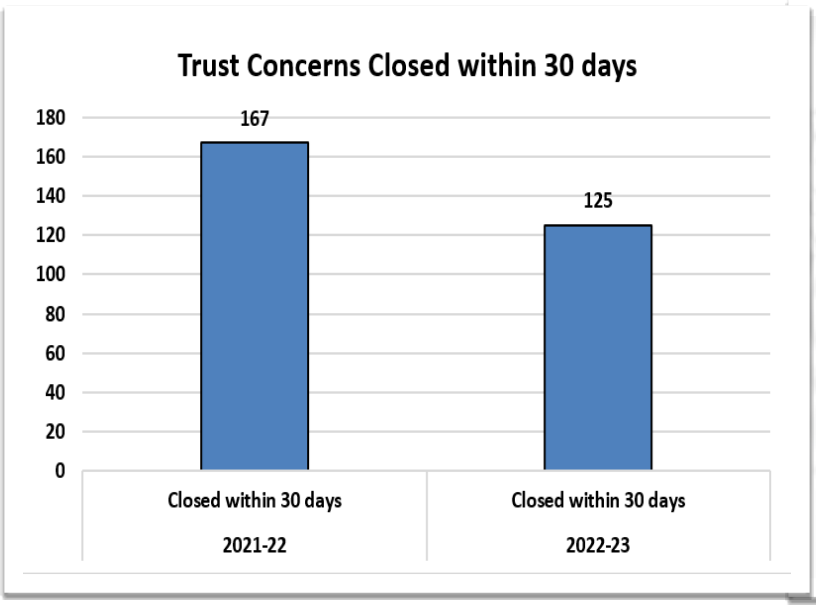
How is the Trust doing in its Complaints Management

The Datix Cymru system was fully introduced across the Trust by April 2021 enabling this year's Putting Things Right annual report to display 2 full years of data collection. Over this period the Trust has implemented robust systems to capture concerns raised, address the issues, engage with the service user(s) and learn from the outcomes of the investigations completed.

The Trust has continued to respond comprehensively to all complaints during 2022-23, with 84% being investigated, resolved and closed within 30 working days of receipt (Welsh Government target is at least 75%).

Due to a recent validation of the PTR closure within 30-day return figures by the Welsh Risk Pool, an anomaly was found where the day on which a PTR concern was received being classed by the Trust as "day zero", when this should have been classed as "day one" which has impacted the overall compliance for the year. However, all concerns effected were completed within 31 working days of receipt.

This issue has been addressed and all future Putting Things Right concerns will be classed as "day one" on the date of receipt.

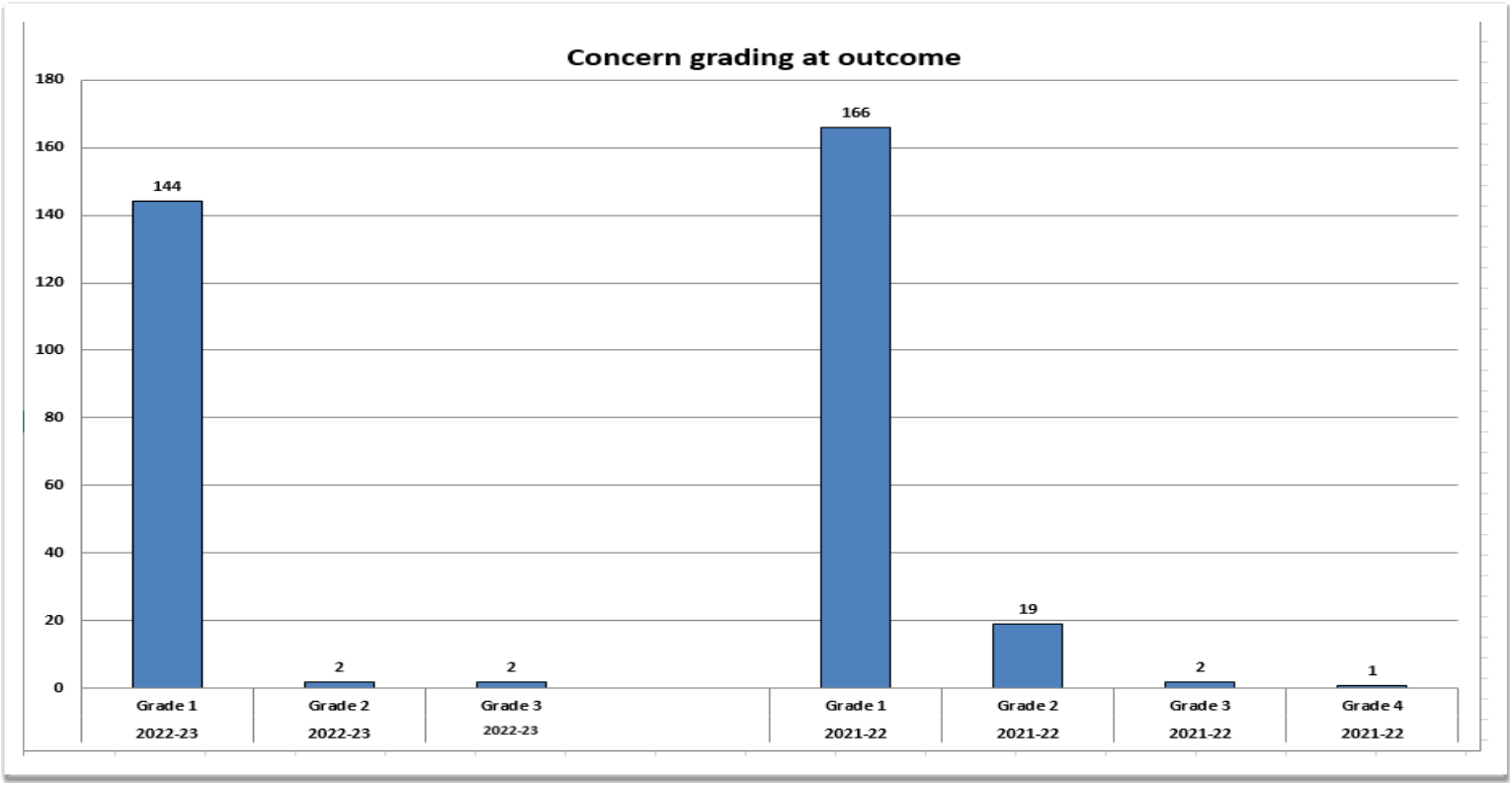


Complaint Grading

All complaints are graded upon receipt (complaints grading table attached in **Appendix 1).** All complaints received undergo an assessment of harm to determine the grading and whether there is a possibility that the Trust may have breached its duty of care, to ensure that the appropriate level of investigation is commissioned.

Over 94% of the complaints raised were low level with no or low harm and graded a level 1 or 2, and 70% were successfully resolved via the 'early resolution' process which is an 11% increase in comparison to 2021/22.

There were two grade 3 complaints that related to: a delay and disconnect in care and treatment in relation to a cancer patient who passed away *and*, a patient who was not made aware of the risks, nor consented to the possible side effects from radiotherapy, which later developed into a secondary tumor following the initial treatment plan. Both were initially investigated under the Putting Things Right Regulations and subsequently escalated to be managed through Redress procedures.



Re-opened Complaints

Occasionally a complainant will be dissatisfied with the formal response they have received or require further information and will contact the Trust back. In these instances the complaint will be re-opened. The number of re-opened complaints could be an indicator of the quality of complaint investigations and responses.

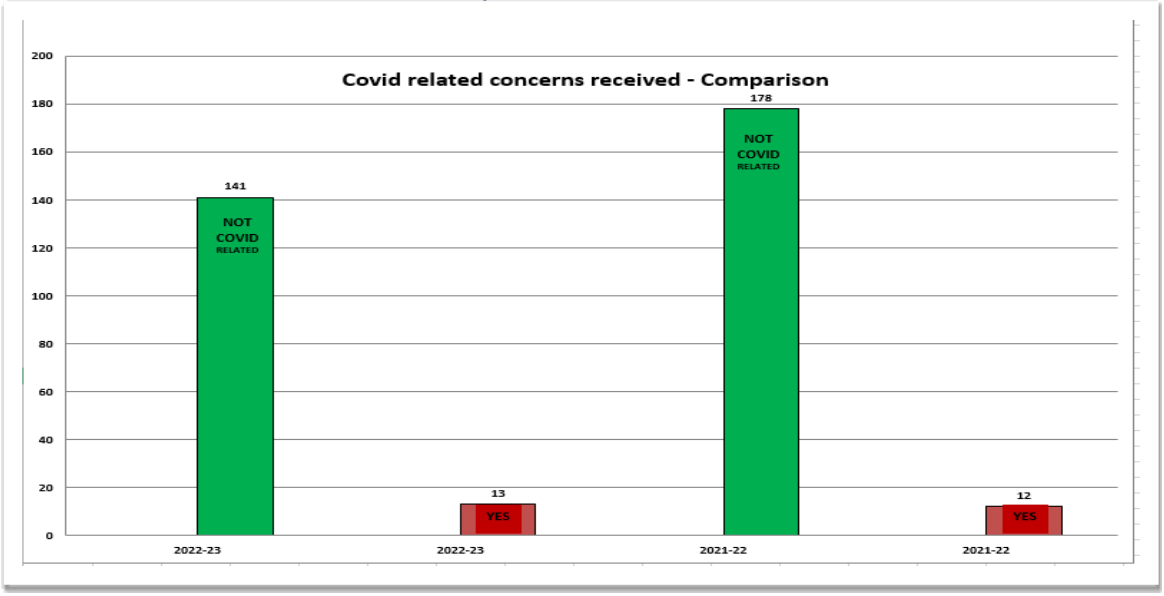
There were **7** complaints re-opened during the year (8 re-opened during 2021/22). All 7 were swiftly investigated and managed, through to final closure.

As part of our complaint response improvement work, we have focused on ensuring the provision of a comprehensive initial response to each complaint. The 7 cases during 2022-23 were re-opened as a result of the complainant raising further queries following the Trust formal response. The majority of the them related to the complainant seeking further clarification on particular elements of the response and a small number of re-opened cases identified the importance of working closely, and in partnership with other NHS organisations (Health Boards), ensuring collective detail is established when more than one organisation has been involved in the care or treatment of the service user.

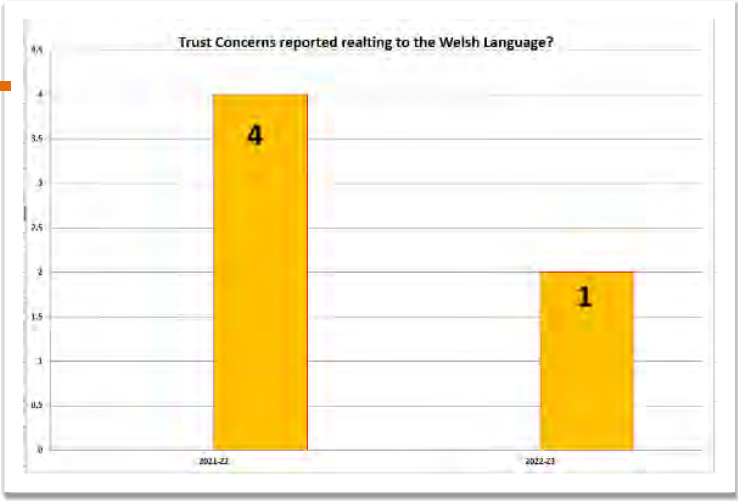
COVID related Complaints

There were **13** COVID related complaints (compared to 12 during 2021/22). The Covid related complaints have related to the impact on cancer patients due to delays in referral and treatment because of the COVID pandemic. In the Welsh Blood Service, the complaints received were due to the reduced number of venues available to donate, following some venues having to close during the pandemic and not reopening. As part of the Trust's Covid recovery plan, the Welsh Blood Service has recently been able to reinstate the use of the Blood Donation trailers across Wales, providing each community with more appointment time and location options, for people who wish to donate.

Since April 2022 there has been a steady decrease in the number of Covid related complaints reported to Trust. The last Covid related concern was reported in November 2022 with none received during Quarter 4.



Welsh Language Complaints



The Trust received **1** complaint relating to the provision of services in the medium of Welsh in respect of the Welsh Language provision in several areas on patient and donor facing Internet pages. The Complaint was investigated under the Putting Things Right Regulations by the Trust Welsh Language Officer and the following key areas were addressed as part of the response and improvement plans for the Trust websites:

- Updating the current platform to include all content in both the English and Welsh languages.
- Uploading Welsh versions of Trust policies and procedures in line with Welsh Language Standards requirements.
- Revision of the Trust's Welsh language policy and uploading the updated version on the Trust website.

Learning and outcomes

An important part of the management of complaints is to ensure that lessons are learnt from identified failings and that actions are taken to reduce the likelihood of reoccurrence. The Trust have a range of processes in place to share learning from concerns including direct feedback to staff members involved, team meetings, newsletters and clinical audits.

We continue to work in partnership with other Health Boards across Wales to investigate and resolve complaints. Where other organisations are involved, the Trust Quality & Safety Team work collaboratively with the relevant organisation to ensure a single, co-ordinated complaint response is provided. The Trust continued to engage the Community Health Council (Llais since April 2023) and signpost patient and donors to the advocacy services they provide for people who want to raise a complaint. The following provides examples of how we improved and developed our services following complaints:

Velindre Cancer Service Learning

Patient Engagement	Velindre Cancer Service now has an appointed Patient and Donor experience manager in post who lead on the investigations when concerns and incidents are raised. Additionally, a Head of Patient Engagement has been recruited as part of the governance around the Patient Engagement Strategy. An Operational Management Group was set up in addition to a Steering Group which was chaired by Independent Board Member, Hilary Jones. The Steering Group consists of Community Health Councils reps, staff, patients, Diverse Cymru and Patient Liaison Group members.

Outpatient	A TV screen has been installed within the outpatient's department to display to patients an approximate time they will have to wait to see their specific consultant.
Records Management	The Cancer service have introduced an identifier to all patient records to clearly identify whether the individual is a "cancer" or "non cancer" patient following a concern relating to patient record management.
Consent Forms	Explicit use of CRUK & RCR consent forms are now used for SACT & radiotherapy patients, ensuring all patients are fully informed of the intended benefits, potential side effects & risks of their treatment.
Risk of falls	There is now clear guidance for First Floor ward nursing staff around when patients identified as at risk of falls need to be referred to the physiotherapy team. The role of the physiotherapist working on the weekend has now been clearly defined to support patients at risk of falls

Welsh Blood Service Learning

Clinic Management	Individual risk assessments are now undertaken to allow frontline blood donation staff to gain donor consent for children to be in attendance when donating.
Communication	A review was undertaken into the number of concerns raised relating to communication issues when donors were liaising with staff. The investigation identified a trend in staff feeling unhappy with certain elements of the donation process i.e. working on the Mobile Donor Units (MDU). Operational Management have listened and recognised the issues raised and continue to monitor and evaluate concerns raised by donors to enhance donor and staff satisfaction.
Dietary Requirements	There is now a variety of vegan biscuits and dairy free milk available across the collection teams for our donors to enjoy following feedback received.
Blood Donations	Donors sometimes report experiencing uncomfortable donations when needles are inserted and/or removed from the venepuncture site. Following a concern raised when a donor noticed a lump on completion at the venepuncture site, the investigation found several breaches of duty relating to the immediate and subsequent care of donor which led to a review of the current training practices and has brought out a safe collaboration project looking at documentation of such events.
Appointment Times	Appointment cut off times have been reviewed, particularly during lunch times and end of day appointment slots, to accommodate donors who attend late for their allocated time. A ten minute grace period is offered to donors for each appointment.
Transgender terminology	Following consultations with donors and consulting the Diversity and Inclusion Manager the Welsh Blood Service have introduced asking all donors their assigned sex at birth (ASB) to ensure the safety of the blood

	supply when making plasma rich components from blood products.
Welsh Medium	Hoffwn gwyno yn unol â Mesur yr laith Gymraeg am sawl peth yn ymwneud â'r Gymraeg sydd yn gyfrifoldeb i Ymddiriedolaeth Felindre. Cyfeiriaf atynt yn eu tro isod gan obeithio y byddant yn arwain at welliant yn y ddarpariaeth Gymraeg rydych yn eu cynnig i'r cyhoedd. A full review of the Welsh Blood Service website identified several areas for improvement in relation to the use of the Welsh Language. The website was updated to ensure all areas were available in a bilingual format.

Public Services Ombudsman for Wales

When a complaint cannot be resolved to the satisfaction of the complainant, the complainant can refer the matter to the Public Service Ombudsman for Wales (PSOW), an independent government body offering free, impartial services to those wishing to raise complaints in relation to public bodies and NHS organisations throughout Wales. PSOW have legal powers to uphold complaints and make recommendations for learning and improvements to prevent similar incidents from happening again. Where an investigation outcome finds that significant injustice has occurred to a complainant, the PSOW can make public its findings. Any public report is shared wider across the NHS. The PSOW can also make recommendations for compensation to be paid to a complainant, in addition to requesting an NHS organisation to put in place remedial measures to address learning. During the year 8 Public Service Ombudsman cases were dealt with. This included:

- 4 existing cases that continued under investigation during the reporting period
- 4 new complaints raised with the PSOW. As part of the governance process, the Trust complied with requests for information within a timely fashion and ensured that the Trust responded to the concerns raised within a satisfactory timescale
- 1 enquiry received, related to a hosted service
- 2 cases closed following ex-gratia settlements, one related to a lost wedding ring and the other related to case 3 summarised below.
- 3 Ombudsman cases remained open at the end of the year.
- 3 investigations conducted by the Public Service Ombudsman found failings by Velindre University NHS Trust. These investigations were upheld / partially upheld, and a summary of the learning and improvement undertaken by the Trust are outlined below:

Issues raised	Ombudsman Findings	Learning	Status
•Delay in discussing prognosis and failure to fully discuss treatment options • incorrect information given regarding	There was a missed opportunity to explore the patient's understanding of the condition and prognosis, miscommunication over the suitability of different available drugs and insufficient thought into	• Formal apology provided • Reflective practice undertaken by the clinician • A Consent Task and Finish Group established to review the processes in relation to consenting patients for treatment.	Complaint Upheld. Final PSOW report issued

the suitability of different drugs • poor completion and submission of an Independent Patient Funding Request form ("IPFR").	the IPFR submission. **Recommendations:** • the Trust to make a formal apology • Review of chemotherapy consent forms • Clinician to reflect on communication with patients	• Roll out of Cancer Research UK and Royal College of Radiologists consent forms, specific to SACT and radiotherapy treatment. • A review of consent training and education • An audit was undertaken of current consenting processes	
• Clinician communication regarding postponed cancer treatment. • Failure to communicate essential information to the GP leading to failures in care • The adequacy and robustness of the Trust's complaints handling.	There was a failure to communicate essential information to the GP which contributed to failures in the patient's care and inadequacy of the Trust's complaint handling **Recommendations:** • Apologise to the complainant • Review systems and processes for communication between the SACT Helpline and clinical teams • Remind practitioners on the Helpline of the need to ensure clear documentation and the escalation follow up management plan where significant clinical symptoms are reported. • Take measures to improve communication between the Cancer Centre, patients, and GPs.	• Clinician undertook a reflection • Clinical staff reminded of the importance of ensuring appropriate information is provided to GPs and other healthcare and of the Department of Health Copying letters to Patients Good Practice Guidelines and the BMA Welsh Standards 12 • An enhanced digital system, was introduced in November 2022, designed to support healthcare practitioners to capture the patient's clinical picture on one system. • Enhanced training and reassessments undertaken to improve consistency of clinical assessment in relation to the Systemic Anti-Cancer Treatment Helpline. • A new VCS Concerns Manager, incorporating Patient Experience role, appointed. • External concerns handing training provided. • Apology provided to the complainant for the failings identified	Complaint partially upheld. Final PSOW report issued
• Communication failures in respect of discussing	The Trust failed to inform the patient of the scan results and subsequent decisions regarding the	• Enhancements to VCS Complaints management processes.	Partially upheld. final PSOW report issued. Ex-

scan results, blood test results, MDT plan and outcome	management of the lesion. The Trust to reflect on the way blood test results were given. **Recommendations** • Apology to be provided to the complainant • A sum of £250 to be paid in recognition of the distress caused to the family • Reflective learning practice • Improvements to clinical communications • Review the way in which MDT decisions and outcomes are communicated.	• Awareness raised awareness amongst clinicians and clinical teams of the importance of improving communication with patients, families and other health professionals • Clinicians reminded of the Department of Health Copying Letters to Patients, Good Practice Guidelines and the BMA Welsh Standards 12. • A new Standard Operating Procedure (SOP) developed, which will outline the use of the Document Management System (DMS), to facilitate automatic transfer of approved letters to GP Practices	gratia payment made of £250

Redress

A case is transferred under the Redress arrangements of the Putting Things Right Regulations (2011), when it is identified at the Trust's Putting Things Right Panel that a breach in the duty of care has occurred and a service user has suffered harm or potential harm caused by the breach of duty. When considering if the matter is suitable for Redress, the Trust must consider that if a qualifying liability were to be established that exceeds the Putting Things Right threshold of £25,000, the matter cannot be transferred to Redress, and the service user or their representative are notified to seek legal advice. Where the investigation concludes that a breach of duty and harm has occurred, the case is presented to the Trust's Putting Things Right Redress Panel who determines if a qualifying liability exists / may exist. The remedies available in relation to the Redress arrangements in accordance with the Putting Things Right Regulations include:

- A full explanation of what happened
- A written apology
- A report on the action which has been or will be taken to prevent similar cases arising and/or
- An offer of financial compensation and/or remedial treatment.

7 cases were managed under redress: four remain open whilst investigations are underway, 1 resulted in no qualifying liability being identified. £21,937.38 was paid out in redress payments involving 3 cases during the year. One redress case was concluded, and settlement agreed. The case remains open

pending whilst the financials are being finalised. Two redress cases have been concluded and the learning from each is summarised below:

Case Summary	Learning Outcome	Status
Patient not informed of recommendation for biopsy and was unable to make an informed choice regarding treatment.	• Awareness/reflective practice to optimise learning and understanding of what went wrong. • Look back review to improve communication links with NHS colleagues across Wales • Liaison with Multi-Disciplinary Teams to improve clinical and radiologist information to inform next steps. • Audits to ensure supplemental reports are received • Improved healthcare systems - Supplemental reports included on the Welsh Clinical Portal. • Training Reminder issued to staff on the importance of ensuring service users are aware of treatment options to make informed choice and training delivered by NWSSP Legal & Risk on the importance of Informed Consent.	Qualifying liability identified. Financial compensation offered and accepted. Welsh Risk Pool reimbursement approved. Redress case closed.
Patient did not receive joined up care nor signposted for palliative intervention.	• Appointment of a navigator and clinical nurse specialist to oversee referrals and signposting for patients. • The non-clinical Standard Operating Procedures (SOPs) have been updated. • Training provided to nursing staff.	Qualifying Liability determined. Financial offer made. Awaiting acceptance

Claims

The effects of harm, when something goes wrong, can be widespread and have devastating emotional and physical consequences, not only for the service users, but also for family members or representatives acting on their behalf and staff. When claims arise, the Trust will, in the interests of justice, endeavour to resolve these amicably and as swiftly as possible, to prevent excessive litigation cost. However, this does not mean that all claims are settled, and those that are brought without merit, are robustly defended by the Trust. Throughout these challenging times, the Trust continues to mitigate the risks posed with emphasis on:

- reducing harm
- improving the response to harm and
- dealing with claims as cost effectively as possible.

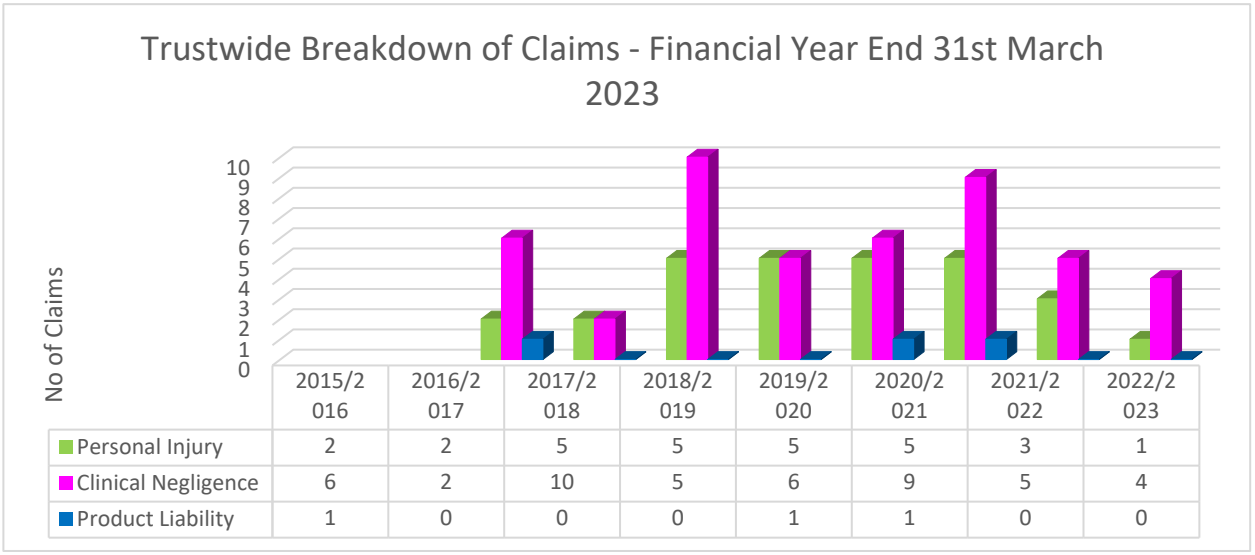
Many of the liabilities arising from healthcare provision are covered by arrangements already in place by the Welsh Risk Pool. Although the amount paid out on claims was greater in the last financial year, the Trust has seen an overall reduction in claims for 2022-2023

Breakdown of Claims

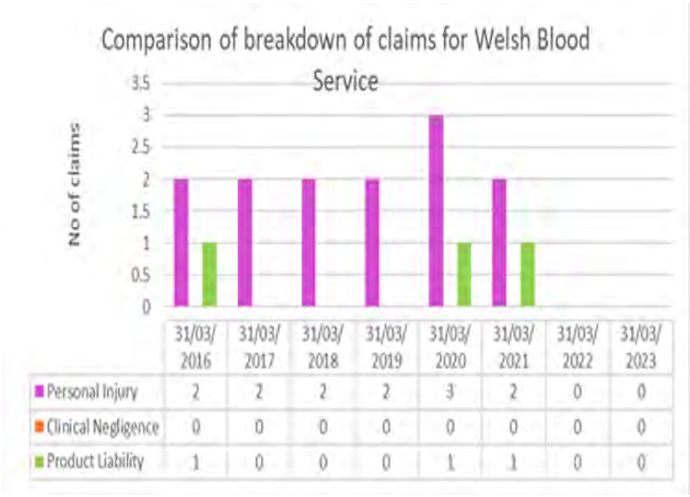
The Trust managed a caseload of 8 claims:

- 4 claims were settled
- 1 new claim was received
- 5 claims remain open at the end of the reporting period.

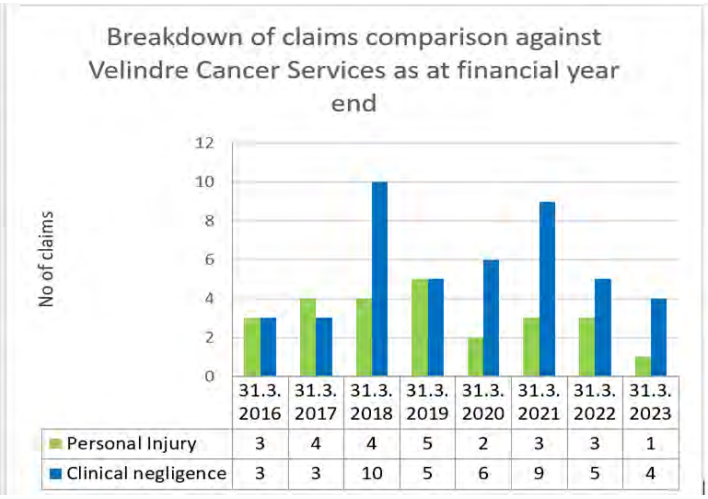
The graphs below provide a comparison of open claims at year-end for financial years dating from 2015/16 to 2022/2023



	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Personal Injury	2	2	5	5	5	5	3	1
Clinical Negligence	6	2	10	5	6	9	5	4
Product Liability	1	0	0	0	1	1	0	0



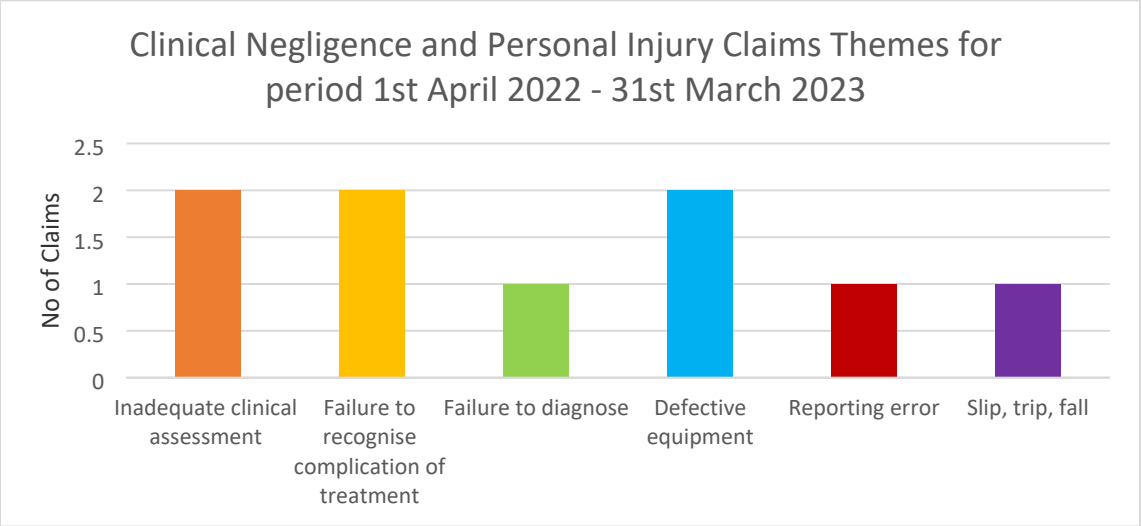
	31/03/2016	31/03/2017	31/03/2018	31/03/2019	31/03/2020	31/03/2021	31/03/2022	31/03/2023
Personal Injury	2	2	2	2	3	2	0	0
Clinical Negligence	0	0	0	0	0	0	0	0
Product Liability	1	0	0	0	1	1	0	0



	31.3.2016	31.3.2017	31.3.2018	31.3.2019	31.3.2020	31.3.2021	31.3.2022	31.3.2023
Personal Injury	3	4	4	5	2	3	3	1
Clinical negligence	3	3	10	5	6	9	5	4

Clinical Negligence and Personal Injury Themes

The trends and themes relating to clinical negligence and personal injury claims for both new and existing claim for the reporting period, are highlighted below.



Welsh Risk Pool Indemnity

The Welsh Risk Pool provides the means by which all Welsh NHS organisations are able to indemnify against risk and offers an integrated approach towards risk assessments concerning claims management and reimbursement, by promoting and supporting the development of improvements and learning to enhance patient safety and outcomes. The scope of the risk pooling arrangement is contained in the all-Wales Policy on Insurance and Indemnity and Scope of Risk Pooling arrangements. All payments associated with losses are subject to Welsh Risk Pool determinations. The three main drivers that underpin the principles of the reimbursement procedures are:

- Scrutiny of Learning, Intervention & Improvement
- Financial Analysis
- Review of Case Management

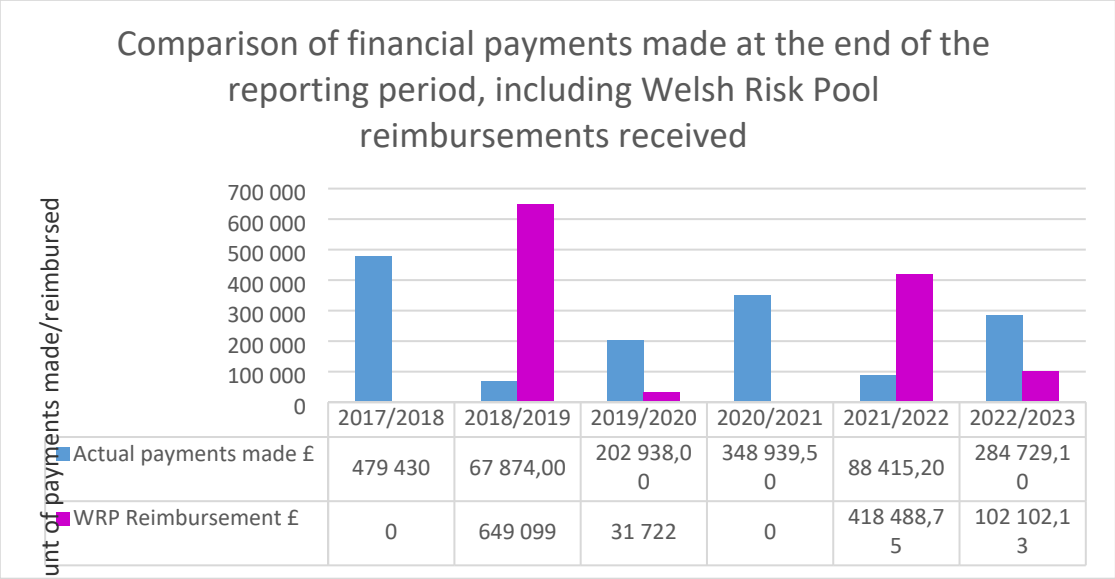
The Trust is responsible for paying the first £25,000 of a claim. Thereafter, it seeks reimbursement from the WRP for any claim that exceeds the threshold of £25,000, excluding VAT.

4 Case Management Records were submitted to the Welsh Risk Pool during the reporting period for Claims and Redress, seeking reimbursement on cases that exceed £25,000. These were all approved by the Welsh Risk Pool and the monies reimbursed.

Financial implication of Active Claims

The following figures are estimations provided by NHS Wales Shared Services Partnership (NWSP) Legal and Risk Services in the event a claim is successful.

- The estimated financial liability of the current caseload of claims is predicted to be in the region of approximately £924,576
- The Welsh Risk Pool indemnifies the Trust in respect to the payments made, deducting the first £25,000, which is the financial cost borne by the Trust. The Trust liability, if it were to settle its current caseload of claims is estimated in the region of £119,224.



	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Actual payments made £	479 430	67 874,00	202 938,00	348 939,50	88 415,20	284 729,10
WRP Reimbursement £	0	649 099	31 722	0	418 488,75	102 102,13

Welsh Risk Pool Claims & Redress Audit

In March 2023, the Welsh Risk Pool undertook an assessment of the Trust's claims and redress management for the period 1st January-31st March 2022 with the purpose of ensuring that the Trust has adequate governance processes in place in respect of claims. The outcome of the audit is awaited. This review included:

- Evaluated the adequacy of the systems and controls in place for the management of claims reimbursement
- Provides assurance that claims management continues to maintain high standards
- Retains compliance with statutory and obligatory regulations
- Mitigates against risk and
- Analyses the reimbursements sought and recouped during the reporting period to ensure that that the Welsh Risk Pool criteria and standard in data record keeping continues to be met.
- Demonstrates that learning continues to be a fundamental priority to minimise risk of recurrence and harm.

Learning and Improvement

Learning and improving continues to be a fundamental priority for the Trust, as all learning contributes to the overall safety of service users and also a reduction in claims and litigated costs. Throughout the year, divisions have undertaken a number of learning actions to address claims when failings have been identified. This safeguards against risk and also minimises the likelihood of recurrence. Assurance is provided by way of approvals received from the Welsh Risk Pool following submission of Learning from Events Reports and submission of requests for reimbursements of claims, settled in excess of £25,000. These approvals indicate the Trust's ongoing commitment in achieving best practice through learning outcomes and demonstrates compliance with the Welsh Risk Pool's governance procedures and processes. Key Learning outcomes from Claims closed during the year were:

- Revision of falls standard operating procedures to include an appropriate escalation process when an outpatient service user suffers a fall, including a step-by-step flow chart on the actions to be taken.
- Awareness email issued to Radiotherapy Department of the revisions made to the Monitoring of Care Review.
- Highlight Report presented to the Health, Safety and Fire Subgroup raising awareness and learning undertaken regarding preventable patient fall.
- Discussion at Falls Scrutiny Panel for ongoing monitoring and learning. All outpatients who suffer falls now receive an outpatient clinical check-up and follow up the day after the incident.
- Tenable audit of outpatient chairs undertaken
- Inspection Report produced for general estate checks and maintenance of chairs
- Removal and replacement of waiting room chairs that were identified as requiring replacement.

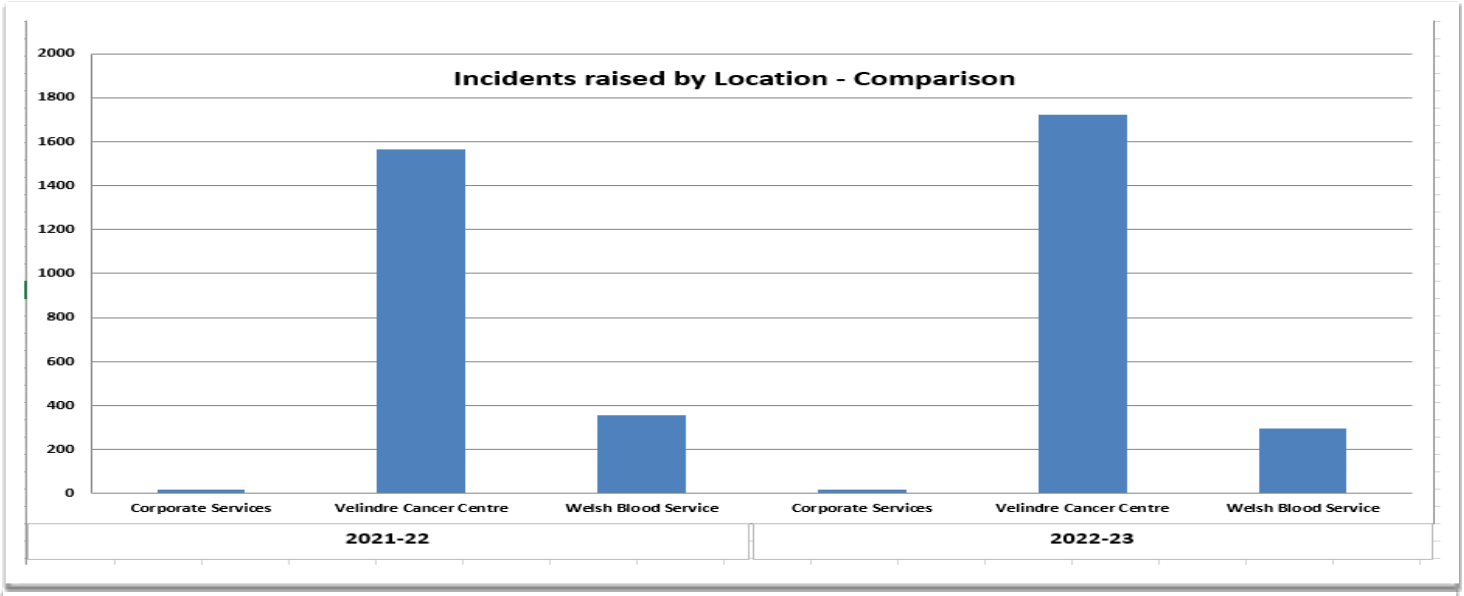
- Introduction of regular audit meetings to discuss CT scan findings
- Introduction of peer reviews and MDT reviews Discrepancy meetings to review adverse events
- Introduction of mentoring to support and discuss opinions
- Introduction of time factored into the job plan for radiologists to review imaging.
- Sourcing of a governance lead to support radiology resource.
- Radiologist appointees made to strengthen clinical governance and provide further monitoring and assurance.

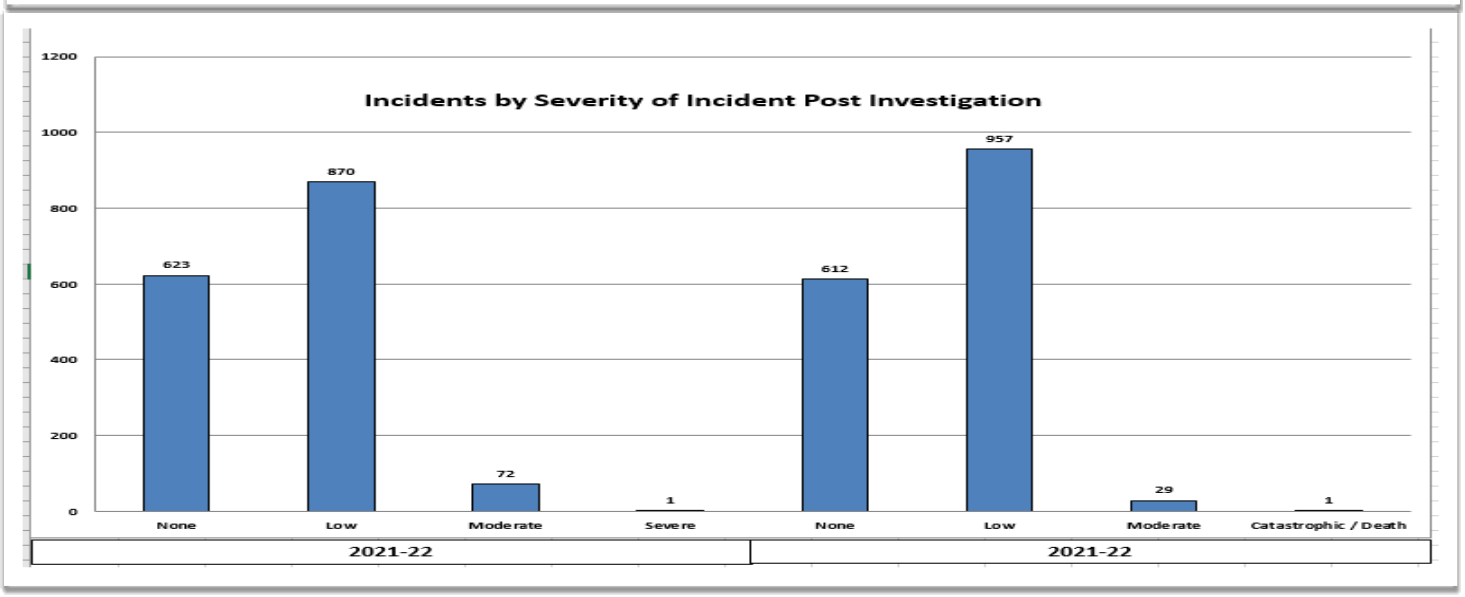
Incidents

The Trust record all Incidents and National reportable incidents within the Once for Wales Datix reporting system. Welsh NHS bodies are required to report all serious patient safety incidents to the Welsh Government in line with their National Reportable Incident policy.

It is the responsibility of the allocated manager to review each incident reported and forms part of the initial management review to consider the detail of the incident and whether the reported level of harm is appropriate.

2,023 incidents were reported across the Trust throughout 2022/23. The Trust recorded 183,691 patient attendances and 79,547 blood donations equating to a 0.8% activity rate. The graph below displays the number of incidents by each Division and investigated with the severity confirmed at closure. **84%** of incidents were formally closed within the year with **74%** being fully investigated and formally closed within 60 days of the incident being reported. During the year:





National Reportable Incidents

Velindre University NHS Trust report a small number of Nationally Reportable Incidents through to Welsh Government and Health Inspectorate Wales each year, in line with the required reporting parameters.

The Trust reported **22** Ionising Radiation (Medical Exposure) Regulation (IR(ME)R Incidents to Health Inspectorate Wales between the 1st April 2022 and 31st March 2023. All of these incidents were no or low harm but met the reporting classification specifications. A number of these incidents were in relation to a known manufacturer fault with the radiotherapy system and the service arranged a meeting with a representative from UK Health Security Agency for assurance that management of the equipment fault

issues was appropriate and in line with other centres throughout the UK. No concerns were raised by UK Health Security Agency or Health Inspectorate Wales at the inspection regarding these incidents.

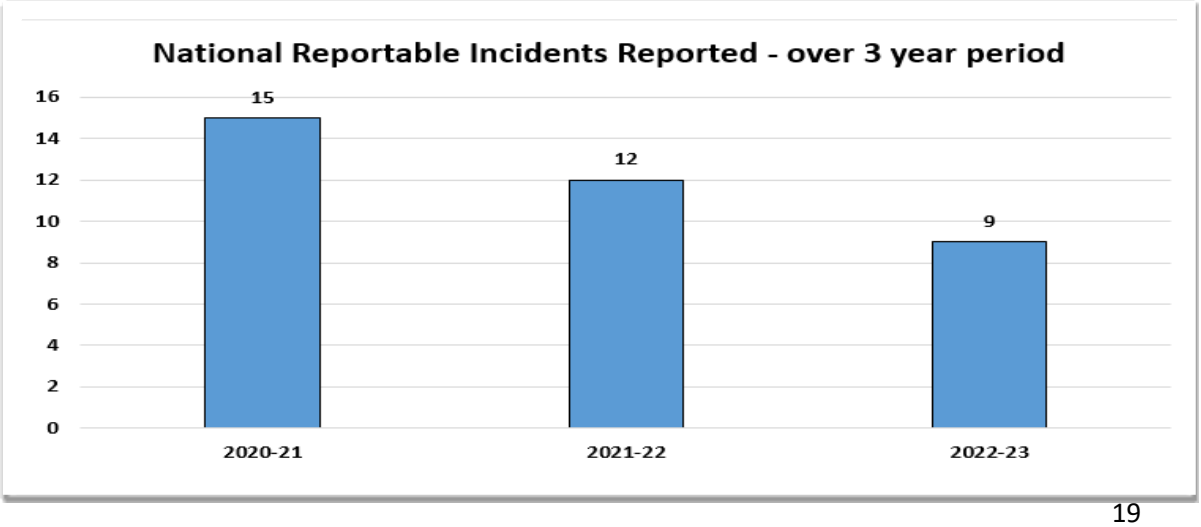
The radiation services department are fully aware of the equipment related issue to mitigate against the known manufacturing fault and the following key learning and improvements during the year include:

- Regular and thorough monitoring of these faults has helped to identify the trends, recommended interventions, and the occurrence of radiation incidents, as early as possible.
- These incidents reiterate that the changes to the guidance surrounding reporting of unintended exposures, that was issued in August 2020, increased the likelihood of reportable incidents occurring due to the ongoing national issue with the Elekta XVi system.
- The above guidance has again been updated in April 2023 and our understanding of this updated guidance is that none of the incidents reported due to equipment fault would now meet the requirements of a reportable incident individually.

The Trust reported **9** National Reportable Incidents compared with 12 in 2021-22 and 15 2020-21. All 9 related to Velindre Cancer Service: 2 related to the SACT treatment helpline, 3 related to patient falls, 2 related to booking mechanisms, one extravasation incident and one incident relating to flood damage to medical records storage facility. These are summarised in the table below:

National Reportable Incident	Key Learning
Flood damage in an off-site externally managed medical records storage facility.	• The setting up of an Incident Management Team be considered sooner in the initial phase of an incident so that Trust resources can be brought to bear more quickly, and that this approach be included in SOP's for business continuity planning.
Patient fell within the outpatient chemotherapy resulting in a fractured neck of femur.	• Clearer referral criteria for referring patients with a history of falls to the physiotherapy team developed • Clarity gained about the availability and role of the physiotherapy team on weekends.
Death of a patient after contacting the SACT treatment helpline	• Changes to working practice were agreed through a formal governance and assurance process. • Staff have protected time for supervision and debriefs • The UKONS Triage assessment toolkit is adhered too and formalized in the Cancer Centre. • Escalation for further medical assessment guidance identified • Full Review of the Trust Treatment helpline is required – this is being undertaken as a Safe Care Collaborative improvement
Patient attended for third planned Radiotherapy administration following a butterfly being used to gain venous access the injection was drawn back approximately 8 to 10 times.	• Update NM RAT 4006 to provide information about extravasation risk • Create an extravasation checklist and flowchart to supplement the extravasation procedure to include

	gamma camera assessment of the site. Retraining of operators in the extravasation procedure. • Implement best practice administration methods with training in cannulation
Triage outcome following call to treatment helpline did not recognise the patient's clinical condition	• Changes to working practice were agreed through a formal governance and assurance process. • Staff have protected time for supervision and debriefs • The UKONS Triage assessment toolkit is adhered too and formalized in the Cancer Centre. • Escalation processes enhanced • Full Review of the Trust Treatment helpline is required – this is being undertaken as a Safe Care Collaborative improvement
Treatment incorrectly allocated on Chemocare resulting in delay in treatment.	• Less risk of this error occurring in the newest version of Chemocare (version 6) as opposed to version 5 to ensure that when a patient is planned to start SACT that it is allocated on Chemocare as "Cycle 1"
Inpatient fall resulting in fractured elbow.	• Clearer referral criteria for referring patients with a history of falls to the physiotherapy team developed • Clarity gained about the availability and role of the physiotherapy team on weekends.
Inpatient fall, patient reported trying to mobilise herself to use the commode lost balance and fell to the floor.	• Ensure there is a documented conversation regarding the risks of keeping the commode by the bedside, while being mindful about the psychological impact • To use the Hoverjack routinely for patients that are not able to mobilise from the floor rather than a sling hoist
Failure to refer a patient for treatment after emergency care provision resulting in disease progression.	• Discharge advise leaflet (DAL) – feasibility given the learning from this incident of adding a follow up prompt • Development/revision of a ward discharge checklist to be considered • Early learning communications to be produced and discussed with medical & nursing teams (speedy cascade format)



Inquests

An inquest is an inquiry into the circumstances surrounding a person's death. Coroners are independent judicial officers i.e., members of the judiciary (like that of a judge), appointed by the local authority, to investigate certain deaths within their geographical area. When a person dies, the responsibility is to hold an inquest in the area where the person died, not where the person resides. Coroners are responsible for investigating the cause of deaths in accordance with the Coroners and Justice Act 2009.

7 inquests were managed by the Trust during the reporting period, comprising of:

- 3 new inquest notifications. Witness statements from treating clinicians and staff have been submitted during this period, together with relevant copy medical records.
- 4 inquests were heard: Learning was identified in one which is detailed below:

The inquest was held in December 2022 and identified a need for enhanced partnership working across key organisations comprising of nursing care, tertiary centres, and community care and to seek clarity and responsibility for assessing and treating Percutaneous Endoscopic Gastrostomy (PEG – feeding tube) infections with a view to preventing sepsis. A multi-disciplinary task and finish group has been established by the Head and Neck and Altered Airways Advance Nurse Practitioner.

Compliments from Patients and Donors

Receiving real time feedback on the experiences of our patients and donors is very important to us. Feedback received by patients and donors, whether good or bad has allowed us to continually improve and also ensures that feedback helps to inform decision making and prioritisation.

During the year 155 compliments were captured and recorded onto Datix Cymru. 151 were recorded by Velindre Cancer Service and 4 compliments captured for Welsh Blood Service, this is compared with 174 compared with 2021-23. (110 Velindre Cancer Service and 64 Welsh Blood Service).

Trust staff are encouraged and are extremely grateful to receive positive feedback and compliments from patients and donors about the experiences they have received from Velindre Cancer Centre and Welsh Blood Services. Divisions are reviewing how to enhance the capture of compliments within the Datix system.

CONCLUSION

The Velindre University NHS Trust Putting Things Right Annual Report 2022- 2023 overarching conclusions have been drawn for the Trust:

- Directorate leads are continuously focusing their efforts on learning, retraining and intervention where we have high numbers of incidents and concerns.
- Senior Management have focused on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, to successfully investigate and close any outstanding incidents.
- Focused efforts are underway to ensure the timely investigation and closure of Incidents. Improvements have been seen at the Welsh Blood Service however, overall, this area has been identified and escalated to the senior leadership team for review and action to improve compliance with the national timeframes for the investigation of incidents. Dashboards have been created within Datix to show all open incidents and for every directorate. These Dashboards have been introduced in the monthly directorate meetings.
- There are many improvement plans in place across the Trust to address some of the themes, these improvement plans are monitored through the Velindre Futures, and Senior Management Teams.
- There is evidence that incidents, complaints and compliments are managed appropriately and compliant with the PTR regulations. Lessons learnt and actions are implemented and monitored by Directorate leads and their teams, we recognise that a formal repository is required to store and share learning.
- The Trust remains committed to learning from all concerns and incidents raised, and investigation training is currently underway for all key staff to strengthen our ability to investigate and learn from all concerns and incidents objectively and comprehensively.

2023-24 Priorities

The Trust aims for the successful delivery of its goals and priorities. It is envisaged that throughout 2023/2024, the Quality and Safety team will provide support and assistance in contributing towards reduction in harm to patients, a reduction in distress caused to both patients and healthcare staff involved when a claim or concern arises. A reduction in the cost required to deliver fair resolution, thereby releasing public funds for other priorities, including healthcare. These priorities will ensure indemnity arrangements are a driver for positive change across our Trust.

1. Velindre University NHS Trust will continue to actively listen to its patients (their carers) and donors, putting things right where things have gone wrong.

2. To fully implement and embed the new requirements of the Health and Care Quality Standards.

3. The Trust will establish a Quality Management System

4. Five Quality priorities identified through the analysis for Putting Things Right outcomes will be fully implemented

5. The Trust will establish "Always on" reporting metrics to aid continual improvement opportunities and real time investigation of concerns that are raised.

6. Implementation of a revised Complaints, Incident and Claims Policy to bring it up-to-date in line with current legislation and Welsh Risk Pool protocols.

7. Devise and implement standard operating protocols which will incorporate Learning from Events flowcharts, PTR Panel and Redress flowcharts.

8. Development of a "Getting it Right First Time" (GIRFT) Claims package to support and assists staff in relation to the claims process.

9. Review and audit Once for Wales Datix Cymru system for all our concerns modules.

10. Continue professional development.

11. Divisions to enhance the recording of compliments on the Datix system.

Health and Care Quality Standards

The Health and Care Quality Standards provide a framework to assess quality and to guide improvement, delivering care that is *safe, timely, effective, efficient, equitable and person centred.*

The Health and Social Care (Quality and Engagement) (Wales) Act was passed in 2020. The enactment of the Duty of Candour and Duty of Quality came into force on the 1st April 2023.

The Duty of Candour statutory guidance, revised Putting Things Right Regulations and Duty of Quality statutory guidance was published during March 2023 in readiness to introduce an All Wales approach to the implementation of the two Duties.

Velindre University NHS Trust continues to prepare and implement the requirements of the Duties with a high degree of confidence following the Trust's preparedness to meet the requirements of the Duty of Candour from 1st April 2023.

SAFE	Our healthcare system is a high quality, highly reliable and safe system that avoids preventable harm, maximising the things that go right and learning from when things go wrong to prevent them occurring again. People's health, safety and welfare are actively promoted and protected; risks are identified and monitored and where possible, risks to safety are reduced or prevented. We promote and protect the wellbeing, and safety of children and adults who become vulnerable or at risk at any time. Where children or adults may be experiencing or are at risk of abuse or neglect, we take appropriate, timely action and report concerns.
TIMELY	Our healthcare system ensures people have access to the high-quality advice, guidance and care they need quickly and easily, in the right place, first time. We care for those with the greatest health need first, and where treatment is identified as necessary, we treat people based on their identified and agreed clinical priority.
EFFECTIVE	Our healthcare system ensures decision-making, care and treatment reflects evidence-based best practice, to ensure that people receive the right care to achieve the optimal and possible outcomes that matter to them. We design transformative, evidenced-based, whole-of-life pathways that cover prevention, care and treatment, rehabilitation and embed these into local service delivery.
EFFICIENT	Our health care system takes a value-based approach to improve outcomes that matter most to people in a way that is as sustainable as possible and avoids waste. We make the most effective use of resources to achieve best value in an efficient way. We only do what is needed and undertake treatments that ensure any interventions represent the best value that will improve outcomes for people.
EQUITABLE	Our health care system provides everyone with an equal opportunity to attain their full potential for a healthy life which does not vary in quality because of personal characteristics (such as age, gender, sexual orientation, race, language preference, disability, religion or beliefs, socio-economic status or political affiliation). We embed equality and human rights in our health care system and promote.
PERSON CENTERED	Our health care system meets people's needs and ensures that their preferences, needs and values guide decision-making that is made in partnership between individuals and the workforce. We care about the well-being of individuals, their families, carers and our staff. We ensure that everyone is always treated with kindness, empathy and compassion and we respect their privacy, dignity and human rights. We are committed to working better together to put people and their families at the centre of decisions, seeing them as experts working alongside professionals to get the best outcome and experience.

TRUST BOARD

LOCAL PARTNERSHIP FORUM ANNUAL REPORT

DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	AMANDA JENKINS, HEAD OF WORKFORCE
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	29/06/23	NOTED
Quality, Safety and Performance Committee	13/07/23	NOTED

ACRONYMS	
LPF	Local Partnership Forum

TUC	Trade Union Congress
EMB	Executive Management Board

1. SITUATION/BACKGROUND

This report reflects the Local Partnership Forum's (LPF) role and functions and summarises the key areas of trade union partnership activity, undertaken by Velindre University NHS Trust between April 2022 and March 2023. It also highlights some of the key issues which the Local Partnership Forum intends to give further consideration to, over the next 12 months.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Role and Responsibilities of the LPF

The LPF provides a formal mechanism where the Trust and Trade Unions colleagues, representing Trust employees, work together as the collective representative's views and interests of staff with the objective of improving health services provided by the Trust. The broad term used to describe this is "partnership working".

All members of the LPF are full and equal members and collectively share responsibility for the decisions made by the forum. The Chair is responsible for ensuring key and appropriate issues are discussed by the forum with all the necessary information and advice being made available to members to inform the debate and ultimate decisions.

In taking forward their responsibilities the LPF acts in accordance with the six principles of partnership working set out by the Trade Union Congress (TUC) and the working arrangements under the Department of Health's Partnership Agreement.

Purpose of the LPF

The purpose of the LPF is to provide advice to the Board in aspects of Trust business that impact upon or people, specifically by:

- engaging with our people, through their representatives, on key discussions and decisions taking place within the Trust

- providing Trade Union colleagues with an opportunity to contribute to decisions of the Trust
- enabling management and Trade Union colleagues the opportunity to propose and discuss issues which affect the Trust's people
- providing opportunities for Trade Union colleagues to contribute to the Trust's service delivery plans at an early stage and to consider implications for our people in service reviews and/or organisational change
- reviewing and discussing the Trust's activities against performance targets and providing the opportunity to jointly consider interventions
- appraising Trade Union colleagues of the financial performance of the Trust
- informing Trade Union colleagues of any intention by the Trust to begin formal consultation on any issue affecting individual departments or services

Duties of the LPF

The LPF provides the formal mechanism for consultation, negotiation and communication between the recognised trade unions, their members and management of the Trust.

The scope of the LPF is limited to staff and service issues, under the scope of the Trust.

LPF Membership, Frequency and Attendance

All members of the LPF are full and equal members and share responsibility for actions undertaken by the forum. As the trade unions with the majority of members in the Trust, UNISON (through MIP) and UNITE act as the coordinators of representative views within the Trust.

Trade union representation at the LPF allows for a representative from each recognised trade union, from each division / hosted organisation, to represent the interests of their members.

All Trust trade union representatives are nominated via their trade union, from the membership in their Division or hosted organisation. Union representatives must be employed by Velindre University NHS Trust, and accredited by their respective trade union organisation. If a representative ceases to be employed by the Trust, then they automatically cease to be a member of the LPF. Full time officers of trade unions may attend Local Partnership Forum meetings.

The management representatives are drawn from members of the Executive Management Board, VCC and WBS Senior Management Teams and the Workforce & OD function.

Meetings are held at least four times per year, or as and when the group determines necessary. Every effort is made by all parties to maintain a stable membership of the LPF. There should be at least three management and three Trade Union representatives for the meeting to be quorate.

During the year, the LPF met on the following four occasions:

- 5th May 2022
- 5th July 2022
- 6th September 2022
- 7th March 2023

Review of Local Partnership Forum Activity

Partnership Working Action Plan

The LPF developed and approved an action plan in partnership to enhance the way in which partnership working is conducted across the organisation. Work is underway to implement the agree actions. This action plan is owned by the LPF and the implementation of its actions form part of the LPF agenda.

Engagement with LPF members

LPF has provided the opportunity to inform, discuss and appraise trade union representatives on the following issues over the past 12 months:

- Progress being made against the Welsh Blood Service, Collections Team Organisational Change.
- Consultation and information on the Welsh Blood Service, Senior Leadership Team review and possible Organisational Change.
- updates and briefings on the Trust's IMTP;
- Updates and briefings on the Trust's People Strategy

- progress being made on the Transforming Cancer Services Project;
    - nVCC
    - Outreach
- the Trust's Equality Monitoring Report and the actions being made to monitor progress against the agreed objectives;
- updates and briefing on the restructuring and modernisation of the Workforce Team
- updated from the Healthy and Engagement Steering Group
- updates from the Education Steering Group
- discussions on the Trust's Workforce Metrics, in relation to sickness absence, statutory and mandatory training and PADR compliance;
- updates on the Trust's financial performance;

Reporting and Communication

The LPF's papers, including the minutes from all the meetings are routinely published on the Trust's intranet site.

Conclusions and Way Forward

The Executive Management Board and the Senior Leadership Teams are very grateful for the engagement and participation of trade union representatives, in the activities of the LPF and other Trust meetings and activities. The positive and constructive way in which they have contributed has enabled the Trust to meet and deliver on its organisational objectives.

The next 12 months yet again provides an opportunity for the LPF to continue to build on this year's successes, in addressing new and emerging workforce and service priorities.

Future Proposed Activity

The LPF has agreed to undertake the following key actions, as identified in the Working in Partnership Action Plan, over the course of the next 12 months:

- development of the partnership working philosophy into the values and culture of the Trust
- engage with the development of employee relations within the Trust, looking to reduce employee harm where possible
- continued partnership working in possible Organisational Change processes

- continued engagement with the developments ongoing in Transforming Cancer Services
  - o nVCC
  - o Outreach

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The effective implementation of partnership working ensure effective quality management systems are in place to support staff to deliver the organisations objectives in a safe and quality way.
RELATED HEALTHCARE STANDARD	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	No identified equality concerns. The remit of the LPF is to ensure equality assessments are fully considered in the systems and processes within the Trust.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Effective employee relations underpin the relationship between employer, employee and the state ensuring statutory acts are effectively implements and relationships remain effective to reduce potential employment tribunal claims.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Effective employee relations underpin the health and wellbeing of the workforce by building a positive and engaging culture. Without the work undertaken by the LPF staff engagement may decline making the organisation less productive in meeting its objective.

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the content of this annual report.

Trust Board

Annual Equality Report 31 March 2023

DATE OF MEETING	27 July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Budgen: Head of Organisational Development,
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	**29 June 2023**	**Endorsed for committee approval**
QSP	**13 July 2023**	**Endorsed for Board approval**

ACRONYMS	
VCC	Velindre Cancer Centre

WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 This report provides the equality monitoring data in line with the Equality Act 2010 and the Public Sector Equality Duty (2011). The equality duty was created under the Equality Act 2010. The equality duty replaced the race, disability and gender equality duties. The workforce statistics relating to protected characteristics as at 31 March 2023 can be seen in appendices 1 and 2. The data presented at Appendix 1 covers the full legal entity, including NHS Wales Shared Services, and the data presented at Appendix 2 is Velindre only, covering Velindre Cancer Centre, Welsh Blood Service and Trust Wide Services.

1.2 The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year. The production of this report has been brought forward to align with the Trust cycle of business which now sees the majority of Annual Reports in the public domain from July each year. The Trust is required to publish this report by March 2024.

1.3 The essential purpose of the specific duties under the Equality Act, in relation to monitoring, is to help authorities to have better due regard to the need to achieve the three aims of the general duty, which are to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it;
- foster good relations between people who share a protected characteristic and people who do not share it.

Therefore, as a specific duty itself, the role of annual reporting is to support the Trust in meeting the general duty. It also has a role in setting out achievements and progress towards meeting the other specific duties. In particular, the annual report supports the Trust to have a better due regard to the duties by providing an opportunity to;

- Monitor and review progress;
- Monitor and review the effectiveness and appropriateness of arrangements;
- Review objectives and processes in light of new legislation and other new developments;
- Engage with stakeholders around these issues, providing partners and the public with transparency.

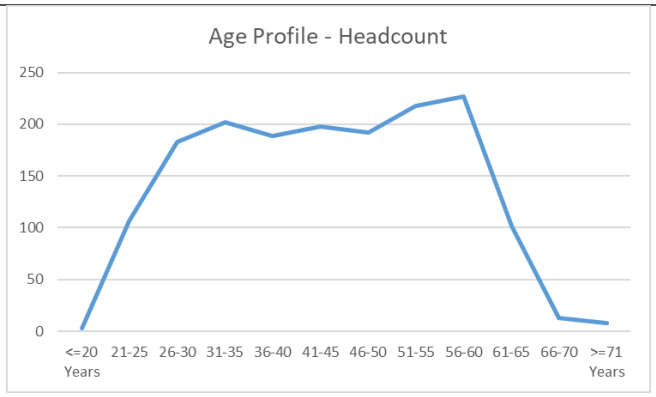
1.4 The report also includes a synopsis of progress made against the Trust's Strategic Equality Plan objectives, which run from 2020 to 2024.

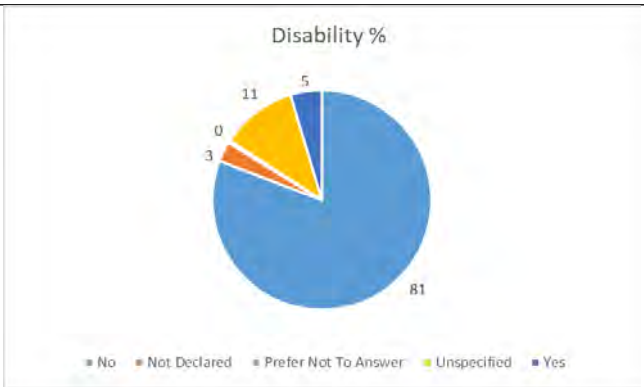
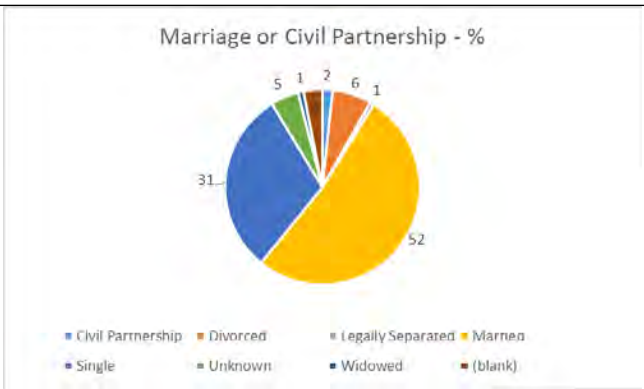
1.5 The Census 2021 results were published in 2022 and key statistics from this have been included to offer a measure of the Trust's demographic alignment in relation to that of the population of Wales. As the Trust has a variety of services, some on a south east Wales footprint, others on an all Wales remit and that our workforce is drawn from across the country, the data is shown at a Wales level.

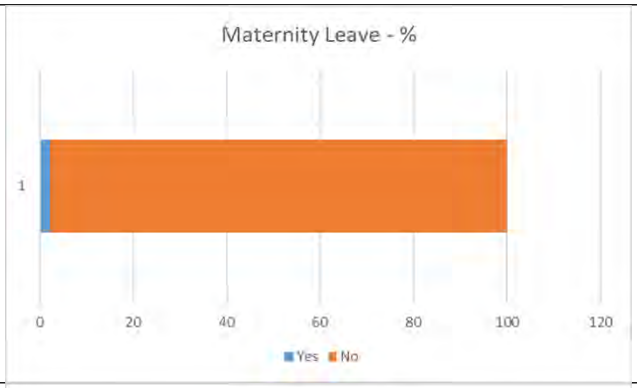
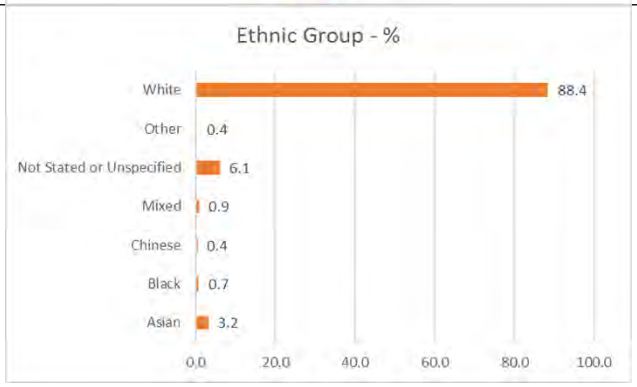
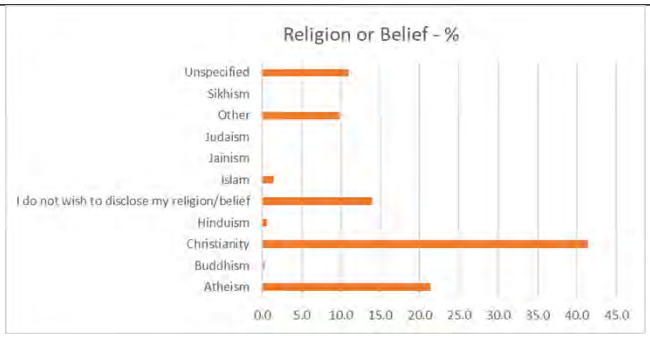
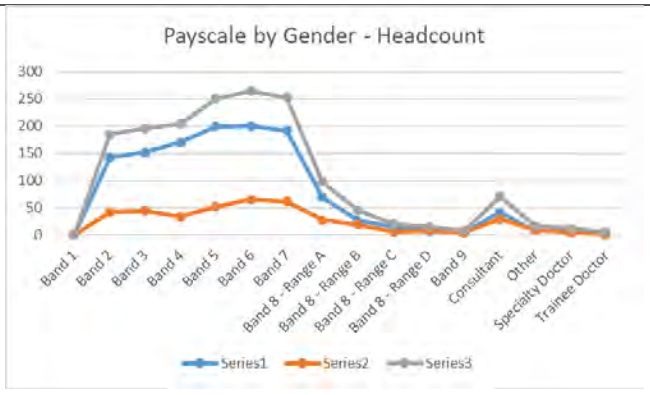
2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

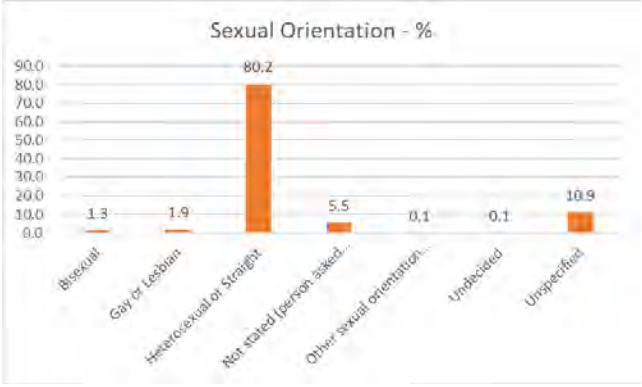
There are nine protected characteristics under the Equality Act 2010 which all public sector organisations report on annually. Statistics are neutral; it is the picture they paint that can help us understand difference in experience of employees from different backgrounds.

The data for the combined organisation of 7,143 people is available at Appendix 1. The analysis below focuses on the 1,642 people at Velindre (excluding hosted) only, shown at Appendix 2. This group has increased by 29 people since March 2022, a 1.8% rise.

1	**Age** The age profile is slightly flatter this year with peak in age 31-35 being less acute, reflecting growth in age brackets before and after 31-35 and a drop in 31-35. The peak at age 56-60 has crept up by <1% and represents a challenge for workforce planning over the next five years. This age profile is not dissimilar to that of Wales. Out of the 50.4% of the population between the ages of 20 and 65, the largest third is aged 50-64, reflecting the trend towards an older population.	

2	**Disability** 5% of the workforce have declared a disability compared with 3% last year. The proportion reporting as Not Disabled has risen in the same period from 76% to 81%. This means the percentage of unknown has reduced from 21% to 15%. However, the Census reports 78% of the population as Not Disabled, 22% Disabled. This shows that the Trust is underrepresenting this group by between 3% and 17%.	
3	**Gender Reassignment** ESR does not record Gender Reassignment and therefore we do not hold statistics on this characteristic. The Census reports 93% of the population age 16+ as identifying as the same gender as registered at birth, with 6% not answered and 1% combined of trans men, trans women, non-binary, different or not specified gender identity. Whilst we cannot present statistics on Gender Reassignment the Trust has a Supporting Transgender Staff Policy which provides a framework for staff who have transitioned or who are in the process of transitioning their gender.	
4	**Marriage or Civil Partnership** Half the workforce is married and almost a third are single. Other categories make up the remaining 20%. This pattern is very similar to last year's. There is a higher rate of married status within the organisation than for the population at large where 43.8% are married and 37% never married/single.	

5	**Pregnancy or Maternity** 2.19% of the workforce were on Maternity Leave on 31 March 2023 compared to 2.85% last year. The census does not report rates of pregnancy or maternity.	
6	**Race** 88% of staff are recorded as White, up from 86% last year, with the second largest group being Asian at 3%. These results compare to the Census showing 94% of the population of Wales as White and the second largest group being Asian, at 3%. The percentage of staff records showing Not Stated has fallen from 9% to 6%.	
7	**Religion or Belief** 41% of the workforce are Christian, 21% Atheist and 12% all other religions. The number being Unspecified has fallen from 252 to 180, showing our data has improved. The Census showed 43% as Christian and 46% No Religion, which may not correlate exactly with Atheist.	
8	**Sex (Gender)** Despite the population of Wales being 51% female, 49% male, the Trust has a 75:25 gender split. This has not changed since last year. Similarly, the uptake of full time and part time work has not changed, with 58% of women in full time roles compared with 84% of men. There is a clear pattern of women being over-represented in Bands 7 and below;	

	employment in Bands 8A and above is equally shared between the genders despite the workforce being 75% female.	
9	**Sexual Orientation** The proportion of staff reporting as Straight has risen from 75% to 80%. There has been a corresponding drop in Unspecified from 15% last year to 11% this year. 5% of people chose not to state their sexual orientation and 1.3% were Bisexual, 1.9% Gay or Lesbian and less than 1% reported Other Sexual Orientation or Undecided. This is a more varied pattern than for Wales as a whole where the census reports 89.4% as Straight.	

2.1 Progress with the five objectives in the Strategic Equality Plan is outlined below.

2.1.1 Increase workforce diversity and inclusion

A Widening Access Coordinator postholder has been working with local colleges and the community to offer a wider variety of routes into working in healthcare. The Trust has provided Internships and Apprenticeships to local people to support their education and employment experience. The Trust is working with HEIW on national careers initiatives, for clinical and non-clinical roles.

The Trust signed up to the RCN Nurse Cadet scheme to offer young people placements within a clinical setting as part of an educational experience, to offer a taste of working in health care, both in VCC and WBS. The first cohort is expected in Summer 2023.

As part of the Defence Employer Recognition Scheme the Trust works closely with Armed Forces to ensure Velindre remains an inclusive place to work, with its vision to achieve Gold standard, a commitment to the Armed Forces Covenant.

The Trust is accredited at Level 2 of Disability Confident and is working towards Level 3 which will develop our capability as a leader in the employment of disabled people.

2.1.2 Eliminate pay gaps

A refreshed approach to conducting Equality Impact Assessments, including a Toolkit, was introduced at the end of March 2023. This will help highlight issues where employment may be skewed to one gender over another, which is the underpinning cause of gender pay disparity. More broadly, the introduction of the Workforce Race Equality Standard later in 2023 will support the analysis of pay gap according to race and provide new insights for taking action.

The process for applying for incremental credit in respect of experience gained prior to joining the Trust is now emphasised during recruitment to reduce disparity in starting salaries between people with a protected characteristic and those without.

2.1.3 Engage with the community

In relation to cancer services and the new Velindre Cancer Centre, the voice of the patient, their families and carers are at the heart of the Patient Engagement Strategy. It was developed via a comprehensive engagement exercise and formally agreed by the VUNHST Board in May 2022. It sets out a plan for the ambition as well as the mechanisms and structures that will enable its delivery, including plans for a renewal of the current Patient Liaison Group and managing the work carried out by our volunteers. One of the most important changes will be setting up a new patient panel; a large group of patients who have expressed an interest in helping us.

In May 2023 the Trust launched Velindre Voices a means for anyone to engage with us, influence our work and have their voices 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

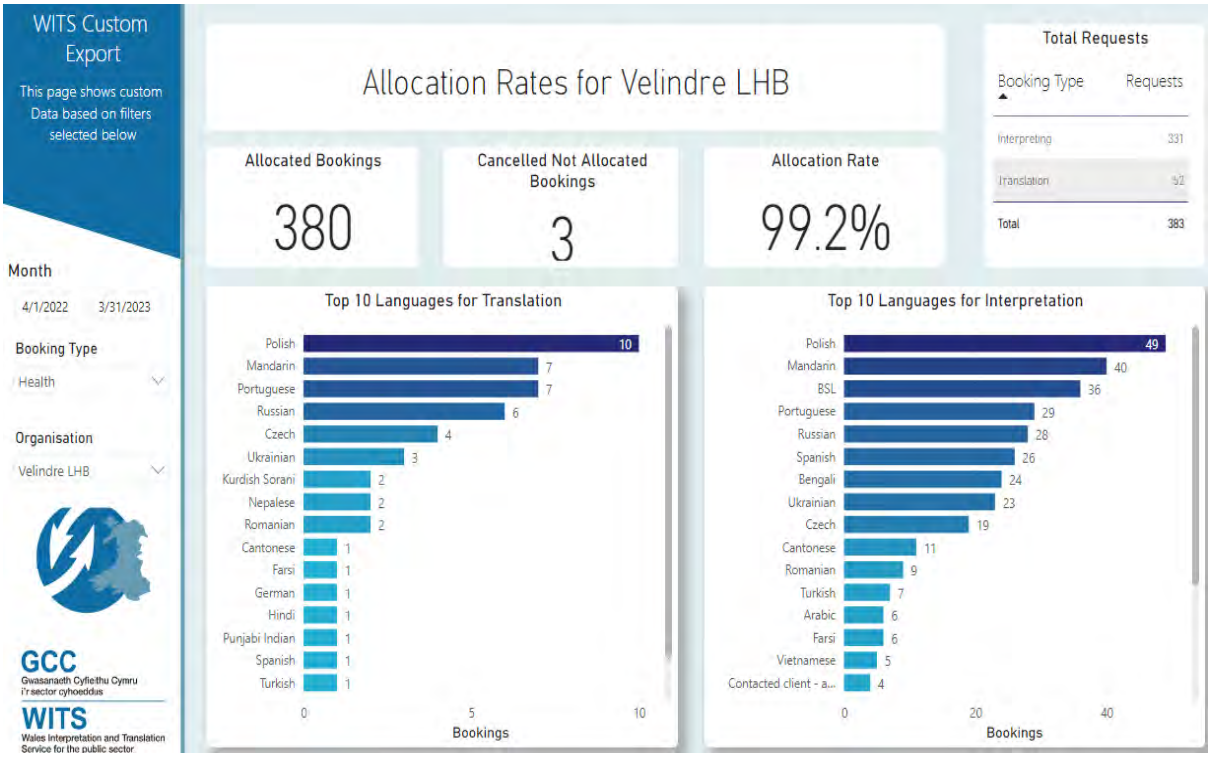
2.1.4 We communicate with people in ways that meet their needs

The refreshed Equality Impact Assessment process invites managers to consider how suitable communication methods are in relation to the people involved.

The Trust has implemented the Active Offer in relation to the Welsh language in VCC and WBS. Improvements have been achieved in the range of ways patients and donors can access services through the medium of Welsh.

The Trust uses the Wales Interpretation and Translation service which provides 24/7 translation support in 135 languages including BSL. Staff can access this when it will assist in

communicating with patients who do not communicate effectively in English. The usage of WITS during the year is illustrated below, showing the top three languages for interpretation as Policy, Mandarin and BSL.



2.1.5 Ensure service delivery reflects individual need.

The case study below illustrates listening to services users and acting on their feedback was taken from WBS earlier this year:

A blood donor experienced a difficult when trying to arrange to give blood via the online booking process following a miscarriage. The donor had contacted the Welsh Blood Service to advise that during completion of the eligibility questionnaire, she had duly answered yes to having been pregnant during the last six months and assumed further questions surrounding her individual circumstances would follow. The next page displayed a statement indicating that she would be welcome to donate 6 months after the birth of her baby and contained upsetting images of a dummy. As she had sadly suffered a miscarriage, she was unclear as to her eligibility as no options were available to her. The Donor provided feedback in respect of this to the Welsh Blood Service and received a phone call with an apology the following day, along with assurance that the matter was being investigated as a matter of urgency. A telephone call was also made to the donor to discuss her donation options. Following a prompt review of the online questionnaire and all web pages referencing childbirth, new wording was drafted and the donor was invited to review this before refreshing the web pages.

The donor expressed gratitude and acknowledged the swift response and sensitive handling of the matter and the incident was received as a positive outcome for both the donor and Welsh Blood Service. The Committee noted that regular reviews of the website will be undertaken by the clinical team going forward.

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
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The work described in this report supports the organisation in its achievements of its duties under Equality legislation which benefits people across all protected characteristics
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust is required to publish its Equality Monitoring Information of 31 March 2023 by 31 March 2024.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Board is asked to **Approve** this report.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 1
Equality Monitoring Data Velindre University NHS Trust including NWSSP

Employment Category	Headcount	%
Full Time	5028	77.29
Part Time	1477	22.71
Grand Total	**6505**	**100.00**

Age Band	Headcount	%
<=20 Years	23	0.35
21-25	744	11.44
26-30	1287	19.78
31-35	1241	19.08
36-40	700	10.76
41-45	549	8.44
46-50	537	8.26
51-55	554	8.52
56-60	525	8.07
61-65	266	4.09
66-70	53	0.81
>=71 Years	26	0.40
Grand Total	**6505**	**100.00**

Staff Group	Headcount	%
Add Prof Scientific and Technic	79	1.21
Additional Clinical Services	403	6.20
Administrative and Clerical	2181	33.53
Allied Health Professionals	153	2.35
Estates and Ancillary	605	9.30
Healthcare Scientists	165	2.54
Medical and Dental	2675	41.12
Nursing and Midwifery Registered	241	3.70
Students	3	0.05
Grand Total	**6505**	**100.00**

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	2713	2315	5028
Part Time	1207	270	1477
Grand Total	**3920**	**2585**	**6505**

Pay Grade By Gender	Female	Male	Total
Band 1	1	1	2
Band 2	303	422	725
Band 3	486	233	719
Band 4	414	158	572
Band 5	369	153	522
Band 6	334	137	471
Band 7	267	120	387
Band 8 - Range A	114	62	176
Band 8 - Range B	65	42	107
Band 8 - Range C	32	34	66
Band 8 - Range D	12	17	29
Band 9	5	10	15
Consultant	51	42	93
Other	23	21	44
Specialty Doctor	8	5	13
Trainee Doctor	1436	1128	2564
Grand Total	**3920**	**2585**	**6505**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	54	25	79
Additional Clinical Services	291	112	403
Administrative and Clerical	1475	706	2181
Allied Health Professionals	129	24	153
Estates and Ancillary	146	459	605
Healthcare Scientists	100	65	165
Medical and Dental	1499	1176	2675
Nursing and Midwifery Registered	223	18	241
Students	3	0	3
Grand Total	**3920**	**2585.00**	**6505**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	1731	1381	3112
Permanent	2189	1204	3393
Grand Total	**3920**	**2585.00**	**6505**

Gender	Headcount	%
Female	3920	60.26
Male	2585	39.74
Grand Total	**6505**	**100.00**

Sexuality	Headcount	%
Bisexual	67	1.03
Gay or Lesbian	91	1.40
Heterosexual or Straight	3979	61.17
Not stated (person asked but declined to provide a response)	355	5.46
Other sexual orientation not listed	4	0.06
Undecided	1	0.02
Unspecified	2008	30.87
Grand Total	**6505**	**100.00**

Religious Belief	Headcount	%
Atheism	1116	17.16
Buddhism	45	0.69
Christianity	2064	31.73
Hinduism	97	1.49
I do not wish to disclose my religion/belief	661	10.16
Islam	342	5.26
Judaism	4	0.06
Other	393	6.04
Sikhism	15	0.00
Unspecified	1768	27.18
Grand Total	**6505**	**100.00**

Ethnic Origin	Headcount	%
Asian	446	6.86
Black	146	2.24
Chinese	31	0.48
Mixed	89	1.37
Not Stated or Unspecified	1491	22.92
Other	48	0.74
White	4254	65.40
Grand Total	**6505**	**100.00**

Disability	Headcount	%
No	5056	77.72
Not Declared	246	3.78
Prefer Not To Answer	5	0.08
Unspecified	1035	15.91
Yes	163	2.51
Grand Total	**6505**	**100.00**

Marital Status	Headcount	%
Civil Partnership	72	1.11
Divorced	231	3.55
Legally Separated	30	0.46
Married	2294	35.27
Single	1762	27.09
Unknown	1389	21.35
Widowed	28	0.43
(blank)	699	10.75
Grand Total	**6505**	**100.00**

On Maternity	Headcount	%
Yes	160	2.46
No	6345	97.54
Grand Total	**6505**	**100.00**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 2

Equality Monitoring Data Velindre University NHS Trust excluding NWSSP

Employment Category	Headcount	%
Full Time	1066	64.92
Part Time	576	35.08
Grand Total	**1642**	**100**

Age Band	Headcount	%
<=20 Years	3	0.18
21-25	107	6.52
26-30	183	11.14
31-35	202	12.30
36-40	189	11.51
41-45	198	12.06
46-50	192	11.69
51-55	218	13.28
56-60	227	13.82
61-65	102	6.21
66-70	13	0.79
>=71 Years	8	0.49
Add Prof Scientific and Technic	61	3.71
Additional Clinical Services	271	16.50
Administrative and Clerical	575	35.02
Allied Health Professionals	153	9.32
Estates and Ancillary	70	4.26
Healthcare Scientists	178	10.84
Medical and Dental	88	5.36
Nursing and Midwifery Registered	244	14.86
Students	2	0.12
Grand Total	**1642**	**100**

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	723	343	1066
Part Time	513	63	576
Grand Total	**1236**	**406**	**1642**

Pay Grade By Gender	Female	Male	Total
Band 1	0	0	0
Band 2	142	42	184
Band 3	151	44	195
Band 4	170	34	204
Band 5	199	52	251
Band 6	200	65	265
Band 7	191	61	252
Band 8 - Range A	69	28	97
Band 8 - Range B	26	19	45
Band 8 - Range C	15	6	21
Band 8 - Range D	7	8	15
Band 9	4	4	8
Consultant	42	29	71
Other	8	9	17
Specialty Doctor	8	4	12
Trainee Doctor	4	1	5
Grand Total	**1236**	**406**	**1642**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	47	14	61
Additional Clinical Services	203	68	271
Administrative and Clerical	430	145	575
Allied Health Professionals	127	26	153
Estates and Ancillary	34	36	70
Healthcare Scientists	108	70	178
Medical and Dental	54	34	88
Nursing and Midwifery Registered	231	13	244
Students	2		2
Grand Total	**1236**	**406**	**1642**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	92	41	133
Permanent	1144	365	1509
Grand Total	**1236**	**406**	**1642**

Gender	Headcount	%
Female	1236	75.27
Male	406	24.73
Grand Total	**1642**	**100**

Sexuality	Headcount	%
Bisexual	21	1.28
Gay or Lesbian	31	1.89
Heterosexual or Straight	1317	80.21
Not stated (person asked but declined to provide	90	5.48
Other sexual orientation not listed	2	0.12
Undecided	2	0.12
Unspecified	179	10.90
Grand Total	**1642**	**100**

Religious Belief	Headcount	%
Atheism	351	21.38
Buddhism	4	0.24
Hinduism	10	0.61
Islam	24	1.46
Jainism	0	0.00
Judaism	1	0.06
Other	162	9.87
Sikhism	0	0.00
Unspecified	180	10.96
Grand Total	**1642**	**100**

Ethnic Origin	Headcount	%
Asian	52	3.17
Black	12	0.73
Chinese	7	0.43
Mixed	14	0.85
Not Stated or Unspecified	100	6.09
Other	6	0.37
White	1451	88.37
Grand Total	**1642**	**100**

Disability	Headcount	%
No	1327	80.82
Not Declared	48	2.92
Prefer Not To Answer	6	0.37
Unspecified	185	11.27
Yes	76	4.63
Grand Total	**1642**	**100**

Marital Status	Headcount	%
Civil Partnership	28	1.71
Divorced	106	6.46
Legally Separated	11	0.67
Married	854	52.01
Single	501	30.51
Unknown	76	4.63
Widowed	15	0.91
(blank)	51	3.11
Grand Total	**1642**	**100**

On Maternity	Headcount	%
Yes	36	2.19
No	1606	97.81
Grand Total	**1642**	**100**

Trust Board

Gender Pay Gap Report 2023

DATE OF MEETING	27 July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Budgen: Head of Organisational Development
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	29.6.23	ENDORSED FOR APPROVAL
QSP	13.7.23	ENDORSED FOR APPROVAL

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 apply to a list of 'specified public authorities' in relation to the publication of their gender pay gap data, which came into force on 31 March 2017. These regulations underpin the Public-Sector Equality Duty and require relevant organisations to publish their gender pay gap by 30 March each year. This includes the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.

1.2 It is important for the Trust to analyse its pay data, to gain an understanding of any gaps, what this means for its workforce and as appropriate, use this information and data to develop an action plan that will respond to bridging any identified gender pay gaps.

1.3 The analysis of pay data as of 30 March 2023 has been conducted earlier in the year to fall in with the Trust's Annual Reports schedule. The deadline for reporting these figures remains 30 March 2024.

1.4 The report attached therefore provides the Executive Management Board with the information to endorse for Board Approval the publication of the Trust Annual Gender Pay Gap Report.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached report provides data and narrative of activities for the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile to ensure the Trust meets its legal requirements.

2.2 The report shows information of the summary of statistics below that are being detailed in the Gender Pay Gap Report. Velindre – including Hosted.

The **Mean Gender Pay Gap** is £1.40 an hour. Women are paid 6% less than men. The mean average hourly rate is £21.56 for women and £22.96 for men.	The **Median Gender Pay Gap** is £3.03 an hour. Women are paid 14% less than men. The median average hourly rate is £19.21 for women and £22.24 for men.	Men's mean bonus payment is £3,012 more than women's, a **Mean Bonus Pay Gap** of 36%
		Men's median bonus payment is £122 more than women's, a **Median Bonus Pay Gap** of 2%

2.3 This report also analyses the situation for Velindre core services, when NHS Shared Services Partnership data is excluded. This level of detail has shown a different picture than that for the legal entity as a whole. In particular:

- The Mean Gender Pay Gap is 13%, which has fallen from 14% during the year.
- The spread between the Quartiles is very similar year on year. The biggest gender disparity remains in Quartile 4, with a split of 32:68 male to female compared with an overall split of 25:75 male to female across the workforce as a whole.

Six actions were agreed in March 2022 linked to the previous Gender Pay Gap report which remain the key focus for work to reduce the gender pay gap.

1. **Listening to women.**
   The Board participated in a briefing session by the Executive Ambassador for Gender Equality during the year which raised awareness of issues for women from clinical and employment perspectives. During 2022-23 a number of Menopause Cafes have run to allow women, in particular, to raise their voices and help develop a Menopause Friendly Culture. This will be built on in 2023-24 through running a survey to identify what people are looking for regarding Menopause support and putting that in place. We are offering options for staff, male and female, to share their experiences and ideas relating to improving gender equality in the workplace. This will include options such as setting up an internal Gender Equality Network, joining other external Equality Networks and/or the introduction of Allyship in support of women.

2. **Implementing our Education Strategy in an equal and fair way**. We have analysed access to our Inspire management development programme to understand if it is helping close the Gender Pay Gap. To date, 71% of delegates have been women which

is lower than the percentage of women in the workforce as a whole. This suggests we may benefit from some further exploration of why women are not as likely as men to come forward for the training and whether any form of positive actions would help close the Gender Pay Gap. In 2023-24 we will further develop our monitoring of development opportunities to see in the round how to use continuous professional development to help close the gender pay gap

3. **Utilising our development projects such as nVCC to create development opportunities for people at all levels of the organisation.** Where necessary, additional encouragement will be offered to offset any gender disparity in uptake. Project roles and responsibilities will be offered as development opportunities to existing staff, either as a secondment or as an addition to their current role.

4. **To deliver an Attraction, Recruitment and Retention project.** In 2022-23 the Recruitment Policy and toolkit was updated and they highlight the importance of having a diverse shortlisting and interview panel to make a rounded decision. The Flexible Working Policy is also promoted within recruitment to broaden the appeal of working in the Trust to people with a range of other commitments, which may including caring responsibilities. This is in turn helps bring women into a range of roles, given that women are more likely than men to be carers within our society.

5. **To promote inclusive language within education and development training inside our organisation, to keep raising awareness and continue to develop a culture of inclusivity.** Equality, Diversity and Inclusion training for managers during 2023-24 will include how to build a culture of inclusion and how to manage bias.

6. **Monitoring of engagement with initiatives by gender.** A new EQIA Toolkit was introduced in April 2023 which provides support to managers in systematically identifying whether initiatives may have an adverse impact on any protected characteristic, including Gender. Alongside this, we are developing an annual Employee Relations report for NHS Wales which will measure representation within standard HR processes in light of protected characteristics. This is being developed during 2023-24 with the first formal report due in April 2024.

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
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal requirement to publish by 30 March 2024
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

1. RECOMMENDATION

The Board is asked to **APPROVE** the Gender Pay Gap report.

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

GENDER PAY GAP

2023 REPORT

FORWARD

Velindre University NHS Trust aims to ensure that people are treated fairly and equally at work. Our focus ensures that staff has the same access and opportunities to reward, recognition, and career development.

The Trust believes that it is important to analyse its pay data, to gain an understanding of any gaps, what this means for our workforce, and as appropriate, to use this information and data to develop an action plan that will respond to any identified gender pay gaps.

WHAT IS THE GENDER PAY GAP

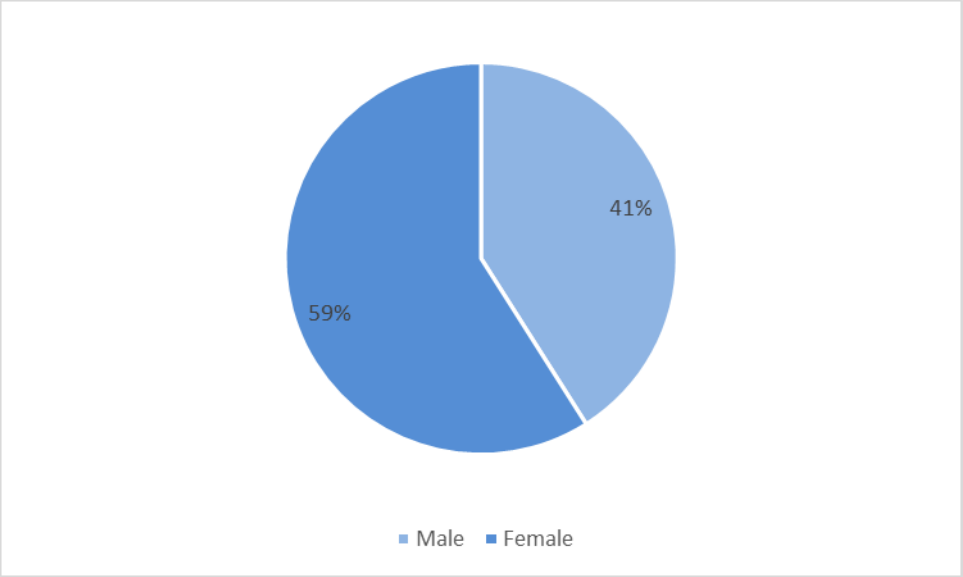
The gender pay gap shows the difference between the average (mean or median) earnings of male and female employees. It should be noted that gender pay gap analysis differs from that of equal pay issues, which deal with the pay differences between male and female employees who carry out the same jobs, or similar jobs, or work of equal value. It is unlawful to pay employees unequally because of their gender.

When gender pay reporting is used to its full potential, it provides a valuable tool to assist an organisation to assess levels of equality in the workplace, male and female participation, and how effectively talent is being maximised. A high gender pay gap can be an indication that there may be a number of issues that the organisation may need to deal with as a matter of priority. The individual gender pay calculations may help the organisation to identify what those issues are.

This document reports pay data on 31 March 2023. It represents Velindre University NHS Trust as a legal entity that also includes hosted organisations, NHS Wales Shared Services Partnership and Health Technology Wales. To better understand our pay gap, we have drilled down to some of the Divisions within the organisation and created actions to address issues which were not evident in the data for the composite organisation.

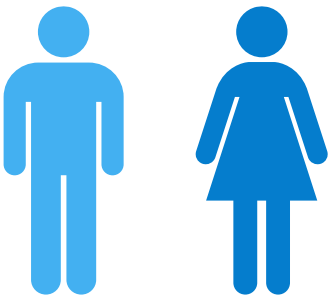
OUR GENDER PAY PROFILE 2023

On 31 March 2023 VUNHST employed 7,143 people, 41% male 59% female.



Mean and Median Pay

The **Mean Gender Pay Gap** is £1.40 an hour. Women are paid 6% less than men. The mean average hourly rate is £21.56 for women and £22.96 for men.



The **Median Gender Pay Gap** is £3.03 an hour. Women are paid 14% less than men. The median average hourly rate is £19.21 for women and £22.24 for men.

Bonus Pay

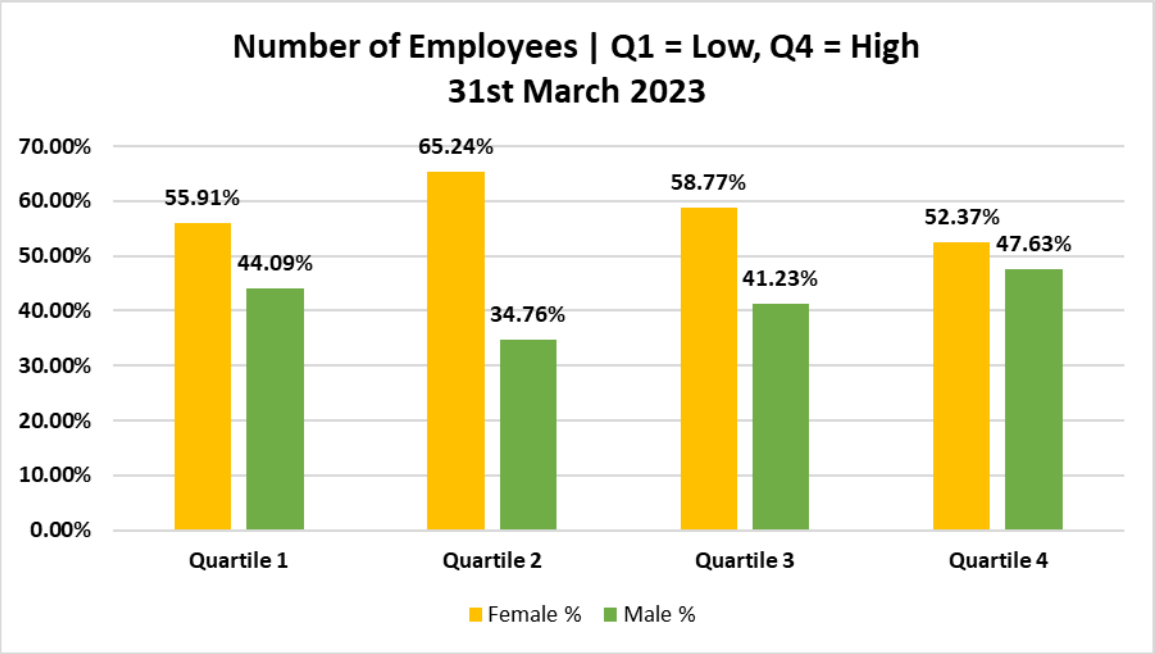
1.34% of men receive a bonus
1.24% of women receive a bonus

Men's mean bonus payment is £3,012 more than women's, a **Mean Bonus Pay Gap** of 36%

Men's median bonus payment is £122 more than women's, a **Median Bonus Pay Gap** of 2%

Quartile Range

When dividing the female workforce and the male workforce into four equal parts, men's pay and women's pay show different patterns with women being clustered in the middle quartiles and men more concentrated in the lowest and highest quartiles.



Note – Hourly Rates per Quartile and approximate match in Agenda for Change Pay Band

Quartile 1	£4.79 - £12.25	Equates to Band 3 and below
Quartile 2	£12.71 - £18.33	Equates to Band 4 and 5
Quartile 3	£18.19 - £23.77	Equates to Band 6 and 7
Quartile 4	£24.38 - £30.52	Equates to Band 8 and above

MOVEMENT BETWEEN 2022 AND 2023

The Mean Gender Pay Gap has stay increased from 88p to £1.40 an hour, or 4% to 6%. The Median Gap has also increased from 2% in 2022 to 14% in 2023.

The Mean Bonus Gap decreased from 43% to 36% and the Median Bonus Gap decreased from 9% to 2%.

The spread between the Quartiles for each gender is also very similar between 2022 and 2023 with Women over-represented in Band 4 and 5 with respect to them comprising 59% of the workforce overall and Men over-represented in Band 8 and above, compared with them being 41% of the workforce overall.

LOOKING BENEATH THE ORGANISATIONAL LEVEL DATA

The above report is based on the legal entity of 7,143 employees, 77% of whom work for NHS Wales Shared Services Partnership. If these people are taken out of the analysis, there are 1,642 employees in Velindre Cancer Centre, Welsh Blood Service and Corporate and other functions.

These 1,642 employees are spread between two Divisions and a combination of Corporate and other functions, as follows:

	Women	Men	Percentage Women	Percentage Men	Total Employees
Velindre Cancer Centre	701	182	79%	21%	883
Welsh Blood Service	340	118	74%	26%	458
Corporate and Other Functions	195	106	65%	35%	301
TOTAL	1,236	406	**75%**	**25%**	**1,642**

This shows that all three Divisions are female dominated, with 79% of the Velindre Cancer Centre workforce, 74% of Welsh Blood Service and 65% of Corporate staff being Female.

Similarly, all staff groups are predominantly Female, however this becomes particularly pronounced with Allied Health Professionals and Nursing and Midwifery. The Staff Groups are ranked in order of gender diversity below.

Staff Group	Female to Male Ratio
Estates and Ancillary	48:52
Medical and Dental	61:39
Healthcare Scientists	61:39
Additional Professional, Scientific and Technical	77:23
Administrative and Clerical	75:25
Additional Clinical Services	75:25
Allied Health Professions	83:17
Nursing and Midwifery	95:5

The key statistics for Gender Pay Gap reporting are shown below. This shows a marked difference between the Trust position as a whole and that for Velindre. The Mean Gender Pay Gap is 13%, compared with 6% for the combined organisation, The gap between the two scores has narrowed since 2022 from 10 percentage points last year to 7 percentage points

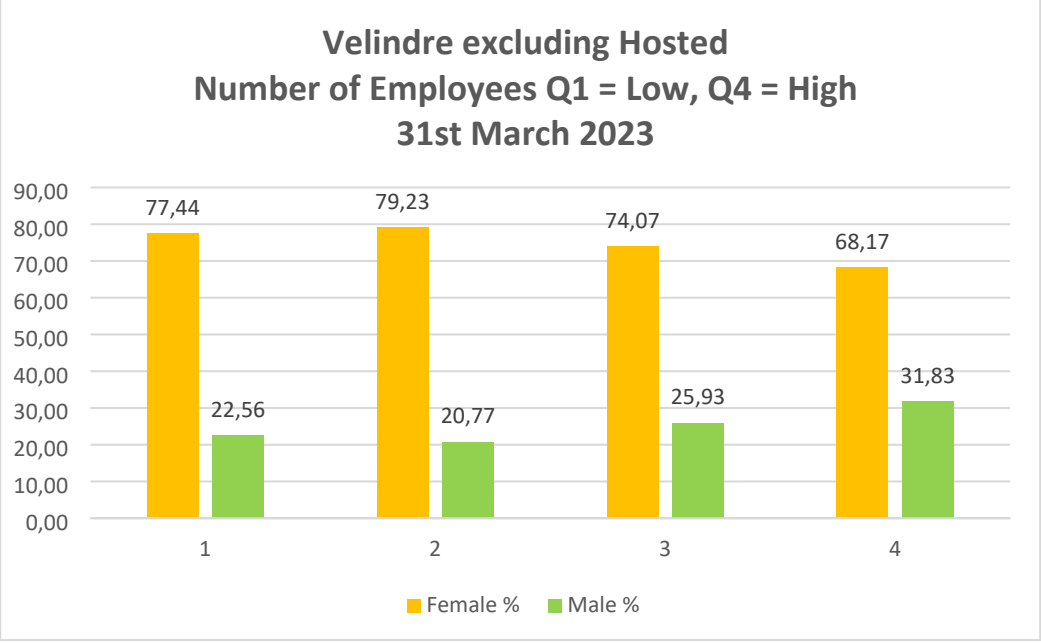
this year. Looking at Bonuses, the mean gap in Velindre (excluding hosted) has stayed the same at 47% whilst the combined organisation's mean bonus gap has fallen from 43% to 36%. These figures show that there are different patterns within core Velindre and its hosted organisation of NHS Wales Shared Services Partnership.

	2022 Velindre	2023 Velindre	2022 NWSSP	2023 NWSSP	2022 Combined	2023 Combined
Mean Gap hourly rate	£2.95	£2.99	3p	57p	88p	£1.40
Mean Gap	14%	13%	<1%	2%	4%	6%
Median Gap hourly rate	65p	£1.09	0	£2.52	44p	£3.03
Median Gap	4%	6%	0	11%	2%	14%
Mean Bonus Gap	£6,648	£6,847	£813	£360	£3,113	£3,012
Mean Bonus Gap	47%	47%	25%	8%	43%	36%
Median Bonus Gap	-£434	£833	£1,319	£650	£307	£122
Median Bonus Gap	-7%	12%	37%	13%	9%	2%

Note

The mean gap has been able to rise from £2.95 to £2.99 whilst the percentage has fallen from 14% to 13% due to the effect of pay rises in the period.

As with the pattern of distribution for the Trust including NWSSP, Women peak in Quartile 2, Bands 4 and 5, whereas men peak in Quartile 4, Bands 8 and above. This pattern is the same as in 2022.



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Quartile 3	£17.24 - £22.79	Equates to Band 6 and 7

Quartile 4 £22.79 - £83.61 Equates to Band 8 and above

CONCLUSIONS

- There has been a small change in our headline figures between 2022 and 2023. The Mean Gender Pay Gap increased from 4% to 6% overall with a Mean Bonus Gap reducing from 43% to 36%. The Median figures present a mixed picture with the Median Pay Gap rising from 2% to 14% and the Median Bonus Gap falling from 9% to 2% in the year. However, the gender split in the workforce has become slightly less polarised, going from 60% women in 2022 to 59% women in 2023. This reflects the picture for Velindre University NHS Trust, including NHS Wales Shared Services Partnership.

- When we drill down, we see that although the Mean Pay Gap for the Velindre University NHS Trust is 6%, when Shared Services are discounted it changes to 13%. This is an improvement on one percentage point compared with 2022. Nevertheless, this shows that specific actions are need in the clinical and corporate areas of the Trust.

- The Bonus Pay Gap reflects a small number of payments which tends to produce larger percentages. The Median Bonus Pay Gap for Velindre went from -7% in 2022 to 12% in 2023 reflecting a small number of payments made within the Medical staff group.

- All staff groups are female dominated and this is markedly so in Allied Health Professionals and Nursing and Midwifery. This does not necessarily cause a gender pay gap – it would depend on salaries earned being comparable to those in other staff groups. However, a more even gender balance would be desirable to create more diverse and inclusive teams and help reduce career-based gender stereotypes.

ACTIONS MOVING FORWARD FOR 2023 – 2024

Six actions were agreed in March 2022 linked to the previous Gender Pay Gap report which remain the key focus for work to reduce the gender pay gap.

1. **Listening to women.**
   The Board participated in a briefing session by the Executive Ambassador for Gender Equality during the year which raised awareness of issues for women from clinical and employment perspectives. During 2022-23 a number of Menopause Cafes have run to allow women, in particular, to raise their voices and help develop a Menopause Friendly Culture. This will be built on in 2023-24 through running a survey to identify what people are looking for regarding Menopause support and putting that in place. We are offering options for staff, male and female, to share

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TRUST BOARD

WELSH LANGUAGE ANNUAL REPORT

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	JO WILLIAMS WELSH LANGUAGE MANAGER
PRESENTED BY	SARAH MORLEY
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This is the Trust Welsh Language Annual Report detailing the 22/23 activity and compliance with the Welsh Language Standards
RECOMMENDATION / ACTIONS	To accept the Annual Report prior to publication

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Quality, Safety and Performance Committee	13TH JULY 2023
Executive Management Board	29TH JUNE 2023
Welsh Language Development Group	OUT OF MEETING
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Report previously accepted as part of the Trust wide Performance report section of Trust Annual Report	

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full

APPENDICES	
N/A	

1. SITUATION

The report outlines the Trust's activity relating to the provision of Welsh Language services for patients and donors.

2. ASSESSMENT

An assessment of the previous year's activities relating the Welsh Language has been undertaken.

3. SUMMARY OF MATTERS FOR CONSIDERATION

Please note the positive divisional group actions and the work noted on the Active offer.

4. IMPACT ASSESSMENT

No Impact assessment needed on this performance report, however, impact of bilingual provision is continuously monitored.

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☐ Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☒
	• Equitable care for patients and donors means bilingual communication to reach the best clinical outcome. • *Patient centred care means providing the care needed in the language choice of the patient without them having to request it*

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Report on previous years compliance against the Welsh Language Standards. The Standards come with their own duty and legal framework.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Financial implications only exist when a breach of compliance occurs and an official investigation results in a financial penalty.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Annual report on previous activity
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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	
All risks must be evidenced and consistent with those recorded in Datix	

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

Cymraeg

Adroddiad Blynyddol y Gymraeg 2022-23

Yr Iaith Gymraeg – Cydymffurfiaeth a Hyrwyddo ar draws yr Ymddiriedolaeth

The Welsh language – Compliance and Promotion across the Trust

2022-2023

Introduction

This will be the Trust's fourth annual report dedicated to the delivery, promotion and monitoring of the Welsh Language Standards. The Trust's focus is strongly embedded in the cultural promotion of the Welsh Language and within this we are committed to comply with the legal requirements of the language as a provider of services for Patients and Donors.

Our delivery of the Welsh Language Standards and the 'More than Just words...' framework continues to be the driver for us to ensure compliance and we now have strong governance processess to monitor our performance.

Last year our focus was very much around the commitment to recruitment structures and embedding an ethos of culutral understanding, and this year we continue to stregnthen this. Understanding the language needs of our workforce has driven forward simple yet effective measures to promote our services and has opened discussions with patients around the 'active offer' concept.

It is our ambition to ensure our patients and donors are aware of their Welsh Language rights and our response to this awareness becomes even more proactive. Providing bilingual services as a matter of course rather than request is our ultimate aim.

Steve Ham

Cheif Executive Officer

Highlights at a glance

- To support its working group the Welsh Blood Service have developed a specific intranet page that complements the work of the Trust. The service has its own specific requriements and felt a need to support staff visually as well as using Trust wide guidance. This has strengthened the division's understanding and enables staff to see the relevance to their work in promoting and supporting bilingual donor needs.

•Velindre Cancer Centre have increased its 'Active offer' presence. A simple visual approach has given patients the opportunity to verbalise their language needs.

Staff have reported patients identifying themselves as Welsh speakers as part of the care process and this has ensured a talored bilingual service to their care pathway.

•Increased translation investment again this year means the Trust continues to support patients and donors that need Welsh Language services

•Partnership working with other Welsh Language Managers gives an opportunity to share best practice and begin the development of a shared IT system

Welsh Language Standards compliance

Governance structure

We continue to work with our divisions to ensure a local approach to the development of the Standards. The divisional groups report frequently into the Trust wide WelshLlanguage group and information is fed directly to the Executive team and the Trust Board.

It has proved to be an extremely successful way to ensure information is shared and it informs the Trust Board of any regulatory changes that need discussion at Board level.

Our Board Welsh Language Champion continues to support and challenge our Welsh Language compliance.

The Trust is a host organisation for Health Technology Wales and NHS Wales Shared Services Partnership and they are both working diligently to support the development of the Welsh Language standards.

Training

The Trust continues to actively promote Welsh Language online training and in this reporting year eight members of staff have completed the Part 1 course. We also secured our second Foundation Welsh language course for staff but unfortunately the identified front line members were unable to complete the course.

We are reviewing our approach to training and will be running specific awareness sessions for staff from May 2023 prioritising staff that answer the telephone in line with the requirements of the Welsh Language Standards.

Staff have also been attending a Welsh Language confidence course run by HEIW and will be offered this opportunity again following a positive response. Partnership approaches to this course has proved to be extremely positive.

The newly introduced Welsh Language awareness 'more than just words...' on line course has been welcomed by the Trust and staff have embraced the course positively.

Since its introduction in December 2023 we can demonstrate a positive approach to compliance.

Welsh language awareness – More than Just words	**By February 2023 % of staff**
Corporate	50.00
Research, Development and innovation	55.10
Transforming Cancer Services	44.44
Velindre Cancer Centre	40.72
Welsh Blood Service	70.48
Velindre Organisations	50.85

Recording our staff competancy levels in ESR ensures our workforce planning considers the language needs of our services. Currently over 86% of the workforce are completing the competancy field within ESR.

Competence Name	Assignment Count	Required	Achieved	Compliance %
NHS|LANG|Listening/Speaking Welsh|	1571	1571	1378	87.71%
NHS|LANG|Reading Welsh|	1571	1571	1367	87.01%
NHS|LANG|Welsh Language Awareness - 3 Years|	1571	1571	803	51.11%
NHS|LANG|Writing Welsh|	1571	1571	1363	86.76%

Workforce planning

We continue to work diligently on ensuring a Trust wide compliance with the Welsh Language standards whilst promoting and suppporting the ethos of 'more than just words...'

Our Governance structure is embedded successfully and our document used to monitor compliance demonstrates a stregnthened compliance level. As a Trsut we continue to use this as a benchmark for delivery of our Welsh Language services.

As part of the Supply and Shape activity, work is currently being undertaken to gather a baseline assessment of our workforce, part of this is to assess the current capability of colleagues to speak, read and write in Welsh. The work will also consider how our workforce reflects the local population average, as well as looking at the capability levels of future colleagues (i.e., students currently enrolled on commissioned courses) this will provide a picture of the potential gap that we face as an organisation.

Working with partners we will then implement steps to reduce this gap and meet our requirements as articulated in the 'More than Just Words' action plan.'

Translation

Our increase in investment over the last two years has meant we have been able to increase our translation capacity. In 2023-24 we will be a team of three dedicted translators and utilising a Service level agreement with NWSSP.

In 2019/20 we were translating almsot 380,000 words. In 2022/23 we have translated just over 1,059,053. This is around 178% increase in the number of words translated in two years.

Job descriptions and recruitment

Translation has supported the time the Trust has given to strengthening its assessment of language needs whilst recruiting. Workforce planning is critical in order to ensure the Trust supports its patients and donors and is proactive with its recritment priorities.

This year we have focussed heavily on ensuring recruitmet managers are aware of the Welsh language recruitment process, we have invested heavily in structures to support this and the workforce team alongside the Welsh language department have now embedded the process securly.

In 2021-22 the translation team dealt with the translation of 24 job descriptions. Since the investment into a recruitment assessment process for Welsh language skills this has increased to 219 job descriptions to the beginning of March 2022-23.

Velindre University NHS Trust 2022-2023

Total number of vacancies advertised as:	
Welsh language skills are essential	1
Welsh language skills are desirable	157
Welsh language skills need to be learnt when appointed to the post	0
Welsh language skills are not necessary	5
Total Number of vacancies advertised 01/04/2022 - 31/03/2023	163

From the data we can confirm that the one post identified as essential was a front line, telephony post. The no skills necessary related to posts within a clinical laboritory service with no patient or donor contact.

Contractual obligations at Velindre Cancer Centre

Integrating our bilingual obligations into all that we do is essential to 'normalise' the use of the langauge and an understanding of our commitment to the development and promotion of the Welsh language Standards. As such, as we plan our services we have ensured that our obligations are highlighted in all that we do.

At the Cancer centre a revision of service level agreements has encouraged us to ensure the Welsh language is considered by our suppliers as well as our internal services. A simple yet effective way to ensure our compliance and encourage discussions with providers. It highlights our expectations of the provider and supports a discussion previously not considered:

Welsh Language Obligations

The Provider warrants and undertakes that it will not discharge its obligations under the Agreement in such a way as to render the Commissioner in breach of its obligations in respect of the Welsh language including, but not limited to, the Welsh Language Act 1993, the

Government of Wales Act 1993, the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards (No. 7) Regulations 2018.

Clinical consultations

Our clinical consultation plan has been reviewed and a structure for assessing its actions put in place this year. The plan highlights the struggles of providing bilingual consultations for patients and donors but it also recogises the need to ensure a clear understanding of what skills are needed and where. The divisional groups have been charged with monitoring the action plan and will inform the Trust development group of concerns etc.

This year the WBS have conducted a skills audit as the first step in recognising where Welsh language skills lie. This audit will inform the next process of understanding how we can transfer the need to fit the skill especially as part of the donor collection process and the need for language communication on the front line.

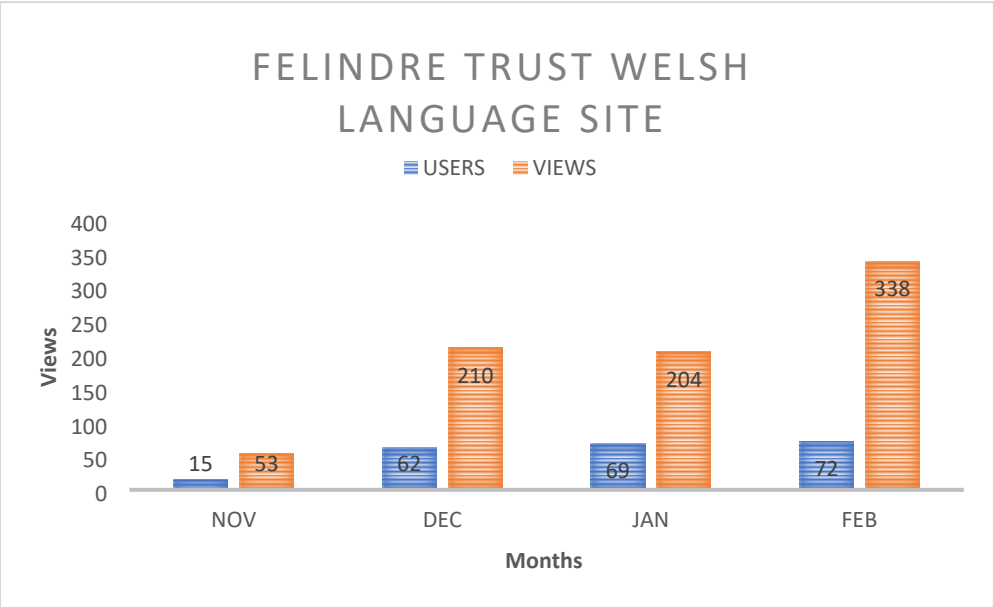
We will continue to work with the divisional groups to ensure our plan is revised and is informed by the language needs of our services.

At Velindre Cancer Centre the strengthening of the Active offer has seen three patients through the appointment system, recieving care and returning for care, in the Welsh language. With new IT systems in place and a commitment from the department to the Active offer, it has enabled the department to respond to the specific needs of their patients.

Website

The new Trust website has been embedded and from November 2022 we ar now able to monitor the Welsh language interest in our information.

English: https://velindre.nhs.wales/	Welsh: https://felindre.gig.cymru/
November 2.3k users 6.9k page views **December** 8.1k users 24k page views **January** 9.2k users 31k page views **February** 9.1k users 30k page views	**November** 15 users 53 page views **December** 62 users 210 page views **January** 69 users 204 page views **February** 72 users 338 page views



It is encouraging to note that there has been a 537% increase over four months in views to the Welsh language site

Telephone Communication

Perfomance indicators for the Welsh Blood Service donor contact centre from January 1 – March 16 2023

English language calls: 9,716

Welsh language calls: 366

Welsh language calls work out as around 4% of the calls.

Calls to Velindre Cancer Centre and the Trust headquaters are not measured, however specific actions for staff directly working on the telephone have been communciated. A specific question and answer session was also held to ensure staff understood their duties.

Promotion

We continue to highlight important events in the Welsh language calendar. This means an additional opportunity for staff to engage with the culture of Wales as well as the language.

This year the Trust has participated in a number of awareness raising days including St David's Day, Santes Dwynwen, Shw'mae day and 'mae gen ti hawl'.

Information on these events runs alongside our regular communication where we promote Welsh language traning, on line and face to face.

Our social media accounts have been incredibly busy this year with both divisions taking part in events. We are now offering bilingual approaches to all our promotional videos.

This year we were also fortunate enough to showcase our commitment to Welsh Culture at the HPMA (Healthcare People Management Association) Conference. This is a high profile event and Welsh culture was celebrated in a day long conference with Velindre University NHS Trust showcasing it's commitment.

Concerns and Complaints

The Trust welcomes feed back on its services. Concerns or complaints are used to ensure we continue to understand the needs of our patients and donors. Welsh language users are becoming increasingly aware of their rights to use the language and it is our duty to ensure we can provide those services to the best of our ability. This year we have recieved four official complaints and one formal investigation.

The formal investigation focussed on the Trust's ability to answer the telephone bilingually and to continue a discussion in the Welsh language. The investigation has not been

concluded however the Trust has been proactive and will be providing direct trainig on raising confidenceá to those answering the telephone.

Overall the Trust's concerns and complaints around the provision of Welsh language services are small, however, we are aware of the need to continuously monitor our provision and have this year updated our Concerns policy to reflect Welsh language provision.

NHS Wales Shared Services Partnership
Welsh Language Review Highlights 2022/23

The Welsh Language Unit at NHS Wales Shared Services Partnership has continued to support NWSSP divisions and services with advice on compliance and service delivery to our customers through the medium of Welsh and have supported the organisation and other NHS Organisations with translation support during 2022/23. The demand for translation services continues to grow, and this year we've translated even more words that in 2021/22. In 2022/23 NWSSP has translated a total of over 5.2million words for the following organisations:

- NHS Wales Shared Services Partnership
- Velindre University NHS Trust
- Public Health Wales NHS Trust
- Digital Health Care Wales
- Health Education Improvement Wales
- Wales Ambulance Service Trust
- Value in Health Care
- WHSSC

Compliance with Standard 106A
NHS Wales Shared Services categorises vacant or newly created posts as either Welsh essential or Welsh desirable, and we have introduced a matrix to determine which skill category is most relevant to each vacancy.
We have devised a protocol and a system whereby all advertisements are translated and published on the TRAC recruitment system and NHS Jobs in both Welsh and English since June 2022. We regularly review the system to capture any issues that arise in the creating vacancy advert process.

Easy-read Patient Information Leaflets
During the year, we've undertaken a full review of existing easy-read leaflets and new leaflets and have ensured that the translation of these leaflets are suitable for the audience for which they are intended.

Student Awards System
We reviewed the old system to ensure that the user journey was entirely through the medium of Welsh. During 2022/23 we have commissioned a new developer and a new Student Awards System, whereby the interface for students will be available through the

medium of Welsh as well as any mail tips, correspondence and messages that are generated by the system. This work will continue into 2023/24.

Workforce Reporting System
This site provides a Web Portal for Primary Care Data accessible to GP practice staff, Clusters and Health Boards of NHS Wales and other approved stakeholder organisations. This site is only available to registered users. However, we have ensured that the system is bilingual.

Duty of Candour Public Video
We have supported the production of an animated video for the public in Wales about the duty of candour in collaboration with Welsh Government.
The video is available in both Welsh and English.

Counter Fraud Awareness Course and App
The Counter Fraud Awareness Course for all Wales NHS Staff is available in Welsh, as is the application for NHS Staff to report fraud or suspicion of fraud in NHS Wales.

All Wales GDPR Awareness Course
We have been supporting the production of the All Wales GDPR Awareness Course through the medium of Welsh and this will be available to launch in 2023/24.

All Wales Occupational Health System for NHS Wales Staff
The specification in the tender process for this system has included detailed requirements for the system interface and any correspondence/messages and mail tips to be available through the medium of Welsh as well as English. Further work on this system will continue in 2023/24.

Assessment of compliance across our services
Following on from the pandemic, we have re-introduced annual local assessments across our services in order to identify areas of best practice, identify areas of risk. Local improvement and action plans are established in order to strengthen our Welsh language services offer across all NWSSP services and programmes.

A copy of the full Annual Report for NWSSP can be found on our website:
Welsh Language Standards - NHS Wales Shared Services Partnership

Moving forward

Cultural change continues to be high on our priorities. Without a deeper understanding of the need for bilingual services we will continue to enhance a provision that does not have strong foundations, relying heavily on the willingness of supportive staff.

The Trust induction programme is being updated and will again include the importance of the Welsh language, sitting alongside other areas such as Equality and Diversity and the Future Generations Act. Our commitment to these areas are as important to us as our clinical requirements as we know how important they are to our patients and donors. Communication is key to safe care.

The Cultural plan will be revised and a refreshed action plan drawn highlighting opportunities for staff to familiarise themselves with the language and opportunities to learn. We will also be connecting this to the 'more than just words...' framework as our actions relate positivily to the aims of the framework.

Our recruitment and workforce planning will also play a key role. Planning with our community needs in mind ensures a targeted approach to recruitment. With this in mind our recruitment process will be supported by strong monitoring to ensure the Welsh language skills needed are highlighted correctly. This continues to be challenging for us as the nature of our services calls upon a small pool of clinical specialisms but we are commited to this agenda.

TRUST BOARD
2022/2023 PROFESSIONAL REGULATION / REVALIDATION ASSURANCE

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Anna Harries, Head of Nursing Professional Standards and Digital Bethan Tranter, Chief Pharmacist Elizabeth Eddie, Executive Medical Business Manager
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Sciences and Dr Jacinta Abraham, Executive Medical Director
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	During 2022/2023 there were / was: • No lapses or breaches in registration in respect of Health Care Professionals Council or General Pharmaceutical Council. • One lapse in registration with the Nursing & Midwifery Council due to a failure to revalidate within the required timescale. The employee did not clinically practice whilst un-registered. • One Nursing & Midwifery Council revalidation sign off issue. • Seventy-four medical appraisals undertaken, nine recommendations to revalidate and one recommendation to defer

RECOMMENDATION / ACTIONS	For **APPROVAL**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nursing Forum	06/07/2023
Executive Management Board	29/06/2023
Quality, Safety & Performance Committee	13/07/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSION Content discussed and report endorsed.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 5 - Majority of actions implemented; outcomes not realised as intended
APPENDICES	
	No appendices

1. SITUATION

This paper is to provide the Trust Board with a high-level summary of any professional registration / revalidation lapses / breaches in respect of staff requiring to be registered with a professional body to undertake their role for the period 1st April 2022- 31st March 2023. This paper covers those requiring live registration with the: Nursing & Midwifery Council (NMC), General Medical Council (GMC), Health & Care Professions Council (HCPC), and General Pharmaceutical Council (GPhC).

This paper is to provide assurance in relation to professional regulation governance.

2. BACKGROUND

All healthcare professionals are required to re-register and some also need to revalidate. Each professional body has different arrangements in place which are detailed below:

2.1 Nursing & Midwifery Council (NMC)

Every qualified nurse on the NMC Professional register is required to complete a process of re-registering yearly and revalidation three yearly. If a registrant does not re-register or revalidate when due their registration will lapse. If registration lapses a registrant cannot practice and they will need to apply to the NMC to be re-registered – this can take up to 6 weeks.

There is a legal requirement for any individual using the protected title of registered nurse or registered midwife in the UK to revalidate every three years. Nurses must evidence that they have met the following requirements in order to revalidate:

- 450 practice hours
- 35 hours of continuing professional development (20 of which must be participatory)
- Five pieces of practice-related feedback
- Five written reflective accounts detailing learning, resultant changes or improvements to practice, and relevance to the Code
- A reflective discussion with another NMC-registered nurse
- Declarations of health and character
- Evidence of appropriate indemnity arrangements.
- Confirmation of adherence with the revalidation process, usually by the employer.

2.2 Health & Care Professions Council (HCPC)

The HCPC regulate 15 professions. These professions have designated titles that are protected by law and professionals must be registered with the HCPC to use them. These are:

Arts Therapists	Clinical Scientists	Occupational Therapists
Biomedical Therapists	Dieticians	Operating Department Practitioners
Chiropodists / Podiatrists	Hearing Aid Dispensers	Orthoptists
Paramedics	Practitioner Psychologists	Radiographers
Physiotherapists	Prosthetists / Orthotists	Speech and Language Therapists

HCPC Registrants need to re-register every two years. Each profession has a set month during the two-yearly cycle when registration is required to be completed by. Registrants will receive notification of renewal deadlines and needs to complete a professional declaration and pay a renewal fee no later than the deadline to avoid being removed from the register. If removed they cannot practice. A random sample of 2.5 percent of the profession will be selected to submit a continuing professional development (CPD) profile for the renewal period.

There are no revalidation requirements.

2.3 General Medical Council (GMC)

Every doctor on the General Medical Council (GMC) register is required to revalidate, normally every five years. To maintain a license to practice a doctor must demonstrate

that they work in line with the principles set out within the GMC's Good Medical Practice Guidance. Medical revalidation, through statutory duties will provide assurance that doctors in the UK are fit to practice.

A Responsible Officer or suitable person is required to make a recommendation to the GMC about whether a doctor connected to them should be revalidated. Following this, the GMC decides whether a doctor can be revalidated based on the recommendation and any other information that they hold. There are three types of revalidation recommendations that can be made:

- Recommendation to revalidate
- Recommendation to defer
- Recommendation of non-engagement

In order to make a recommendation which is consistent, fair and reliable the Responsible Officer requires evidence that a doctor is regularly appraised on their whole practice, ensuring the completeness and quality of supporting information and their reflections on it. Any areas for development in a doctor's practice should be identified and addressed in a targeted way, and concerns about a doctor's fitness to practice referred to the GMC where appropriate.

Connected doctors are required to have annual appraisals where there is evidence of:

- Scope of work
- Review of PDP
- CPD
- Review of complaints and compliments
- Review of Significant events
- Probity and Health declarations
- In every revalidation cycle the doctor additionally is required to provide evidence of Formal patient and colleague feedback.
- Information supporting a quality improvement.

2.4 General Pharmaceutical Council (GPhC)

To practise in Great Britain, pharmacists and pharmacy technicians must be registered with the GPhC and have satisfied the council that they meet its requirements.

Pharmacist and pharmacy technician are protected titles and therefore there is a legal requirement that only registered and re-validated individual can use these titles.

Pharmacies must also be registered with the GPhC (or be a pharmacy department based in a hospital or health centre) to operate in Great Britain and to use the title 'pharmacy'.

Pharmacists, pharmacy technicians and registered pharmacies must renew their registration annually, which involves completing a declaration stating that they meet all professional, fitness to practise and ethical standards.

Annual re-validation for pharmacists and pharmacy technicians includes submission of

- 4 x CPD records,
- a peer review discussion to ensure engagement with others on the individual's learning and practice and
- a reflective account to encourage consideration of how the individual meets professional pharmacy standards.

3 ASSESSMENT

During the year 1st April 2022 – 31st March 2023 the following registration / revalidation issues / breaches occurred:

3.1 NMC

In 2022 a revised NMC standard operating procedure was approved within the Professional Nurse Forum to ensure robust checking procedures are in place. This followed one incident of a lapsed registration in July 2021.

In November 2022 there was one NMC lapsed registration. The employee failed to revalidate by the required timescale. The Nurse was off work at the time. The professional escalation process of this lapse was not followed. An initial review has been undertaken and a further professional review of the situation and management of this to identify any lessons learnt has been commissioned. This will be completed by the 31st July 2023.

The only other professional registration issue that has occurred during this year relates to a NMC registrant who used another NMC registrant's details to authorise revalidation with the Nursing and Midwifery Council despite the revalidation meeting not being held and revalidation process not being signed off. This was identified immediately, escalated, and investigated appropriately through a professional concern and appropriate referral made to the NMC.

3.2 HCPC

There were no HCPC registration issues during the year.

3.3 GMC

3.3.1 Revalidation and Appraisal

Across the Trust there have been seventy-four appraisals undertaken, nine recommendations to revalidate and one recommendation to defer during the past twelve months.

Welsh Revalidation and Appraisal Group reporting as at the 31.03.2023

IMPORTANT: ONLY DOCTORS WITH WHOM THE DESIGNATED BODY HAS A PRESCRIBED CONNECTION SHOULD BE INCLUDED IN THIS SECTION. EACH DOCTOR SHOULD BE INCLUDED IN ONLY ONE CATEGORY	Number of prescribed connections	No of doctors exempt from appraisal due to extenuating circumstances	No of completed appraisals (summary agreed)
Consultants (including honorary contract holders)	68	0	65
Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)	9	2 (less than one year in post therefore appraisal not due)	7
Doctors with practising privileges (for independent healthcare providers only); all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0	0	0
Temporary or short-term contract holders (including trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)	12	9 (less than one year in post therefore appraisal not due	2
Other (Including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.)	0	0	0

3.3.2 HEIW Revalidation Support Unit Quality Assurance Visit – April 2023

An external review undertaken by Health Education Improvement Wales (HEIW) in April 2023 was very positive and the high compliance rate for medical appraisal (Consultants: 92.3%) (Staff Grades, Associate Specialists & Specialty Doctors: 87.5%) was noted, in addition to the low deferral rate for Revalidation (7%, the lowest in Wales), compared to the national average of 26%.

The enthusiasm of the appraisal team, in particular the appraisal lead and appraisal manager was highlighted and the review team were assured that the Trust has robust processes in place.

The review report recommendations included the consideration of lay representation at Revalidation decision meetings, which is currently in progress, and appraiser recruitment and review of the distribution of appraisals, which will make the appraisal pool more sustainable going forwards. Since the report recommendations the Trust has agreed in principle to adopt the national tariff of 0.5 SPA for undertaking 10 appraisals and participating in all training and updates required for the role.

The review team advised that the next Quality Assurance visit would be a virtual visit in 2-3 years, with the next cycle of onsite visits commencing in 5 years.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
	Professional registration is a legal requirement. Having appropriately registered clinical staff is critical for clinical safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below:

	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial impact if staff unable to practice due to failure of this process and potential legal action. No direct financial implication from this paper
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	All Registered staff to be considered in this process, including those on long term leave. The Trust policy would have included this Equality Impact Assessment.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is a legal requirement for registrants to have a live registration when practicing.

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Staff must be registered to practice by legislation*
WHAT IS THE CURRENT RISK SCORE	8
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*The recent lapse is under review to consider learning and review of the SOP in place to include process for staff who are on long term sickness or Maternity*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	24th August 2023
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD

Approval of replacing a 3rd Linac @VCC

DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Angharad Boundford, Programme Manager
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	ENDORSE

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	19/06/23	ENDORSED FOR APPROVAL
SDC	06/07/2023	ENDORSED FOR APPROVAL

ACRONYMS	
IRS	Integrated Radiotherapy Solution

VCC	Velindre Cancer Centre
WG	Welsh Government
LA3	Linac Treatment Machine 3
FBC	Full Business Case

1. SITUATION

Since the initiation of the IRS Implementation Programme in June 2022, following successful award of the procurement process, a number of key milestones have now been achieved, these include

- Establishment of IRS Board and Programme team
- Execution of contract
- Commencement and acceleration of initial Linac replacement (LA6) and planning and agreement of second linac replacement (LA5)
- Installation of the majority of software systems into the department with phased implementation for the first patient on LA6
- The commencement of the build Radiotherapy Satellite Centre (RSC) at Neville Hall hospital and the associate programme board, with an opening date of January 2025.

We continue to operate a mixed fleet from two suppliers, with ongoing fragility and complex configuration. We have also clarified the end-of-life notices for the Elekta fleet (LA1,3,7,8) which will remove LA1 and LA3 from use in May 2024 and LA7 and LA8 in 2025 and 2026 respectively. In the interim, the risk of running machines of this age brings additional maintenance and quality checks and potential breakdowns resulting in downtime and impact on capacity.

In addition, with the more detailed planning work that has now been undertaken based on the experience if implementation of LA6 and changes in the opening date of RSC and nVCC since the IRS case, we need to address a significant lack of treatment capacity from early 2025 until the opening of nVCC.

The detailed programme plan for phase 1 and phase 2 (implementation of the LINAC at RSC) indicates that there is a single time window between February 2024 and August 2024 during which an additional linac treatment machine may be installed and commissioned following minimal refurbishment of the bunker. This will provide resilience and alleviate the anticipated impact on capacity.

As a result, this paper seeks to provide detail and rationale for the proposed replacement of a third Linac at VCC under the phase 1 of IRS Implementation and seek agreement to proceed.

2. BACKGROUND

The IRS implementation programme is being delivered in 3 core phases and includes the realisation of

- new capabilities
- expected deliverables / outcomes
- monitised and non-monitised benefits

The implementation consists of a complex Programme of work that spanned numerous departments, service users and the replacement of multiple systems and high value Radiotherapy Equipment over a 4-year phased implementation plan (consisting of 3 phases).

The Programme of work is the implementation of a long term 14-year partnership contract. Initial scope and planning timelines included the replacement of two Treatment Machines in the existing Velindre Cancer Centre (Phase 1), a new Radiotherapy Satellite Centre (RSC) in 2024 and cumulating in the installation, and commissioning of the final phase in the nVCC in 2025 (Phase 3).

Successful and timely implementation is key for maintaining existing levels of radiotherapy service at VCC, by mitigating the significant end of life service components, and providing the basis for an enhanced and more effective radiotherapy service and mitigate any slippage of phase 2 and 3 will impact which is discussed in further detail in this paper.

Phase 1 of the implementation initially set out the replacement and 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 programme with the replacement of the second linac to commence in July 2023.

Through the implementation of the delivery of the programme, a review and analysis of all three phases of the implementation programme has now been undertaken. It was always recognised that there would be a capacity gap during periods that would need to be managed and planning for this will continue to be developed as the implementation progresses. However, we also need to consider the ongoing fragility of the fleet as well as the operational impact of utilizing an aging fleet in terms of planned and unplanned down time.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

As previously documented and approved, the first machine for replacement was LA6, this was the oldest of the treatment machines and was no longer in clinical use. As service continuity is the next most important factor after age and function, the next machine to be replaced is LA5; commencing in July 2023.

Replacement of these machines will see an eventual efficiency in capacity but not to the levels to mitigate the risks of the ageing fragility of fleet, the known move in date for RSC of Jan 25 slippages in the timelines of RSC and nVCC

The Elekta element of the fleet is approaching end of life, which brings performance challenges and ultimately cessation of use. To illustrate the fleet status below is a summary of all fleet and age. The result of not increasing the capacity of the fleet by installing an additional new Linac treatment machine will require VCC to run very old machines without any manufacturer support and limited opportunity to obtain spare parts when faults develop.

Linac Identifier	Type	Age in 2023	Years over Recommended asset Life (current)	Absolute End of Support
LA1	Elekta Synergy	15	+5	01/05/2024
LA2	Varian Stereotactic	7	-3	-
LA3	Elekta Synergy	15	+5 (recommended 3rd replacement)	01/05/2024
LA4	Varian Stereotactic	9	-1	-
LA5	Will be replaced July 23 operational Dec 23			-
LA6	Replaced Jan 23 operational June 23			-
LA7	Elekta Synergy	13	+3	01/05/2026
LA8	Elekta Synergy	12	+2	01/05/2027[1]

Initial phasing and alignment plans were based on RSC go live 2024 and nVCC 2025. There have been some movement of these dates since contract signature in

[1] From 01/05/2026 LA8 would be an unmatched machine with associated capacity issues

November 2022 when initial planning for phase 1 linac replacements was developed - this movement has significant impact on the radiotherapy service resilience due to the ageing of the existing fleet of linac treatment machines in VCC. With the new dates provided for these major interdependent programmes the IRS implementation team have built a detailed programme and resource plan.

This, in terms of a programme timeline shows that there is a potential to accommodate a replacement of a third linac between February 2024 and August 2024, this would account for the resource interdependencies required to commence clinical commissioning at RSC, at the end of August 2024.

The team required to take forward the commissioning of the equipment is highly skilled and lays with a limited number of staff. As such their time must be planned to undertake this activity sequentially, linac by linac. Failure to agree this replacement and implement within this time slot will result in an inability to replace a further linac before 2026, which then also impedes the installation in nVCC.

Additionally, this proposed replacement would have the potential to mitigate any risks associated with the interdependent construction schemes of RSC and nVCC. It is to be noted this will not be an additional machine but would be the movement of a linac from phase 3 of the programme at nVCC to phase 1 at VCC, to maximise patient treatment capacity and resilience at VCC in the shorter term.

Furthermore, benefits of the 3rd replacement at VCC include the ability to develop treatment pathway solutions for all remaining SSTs to be treated on the new halcyon machines and fully utilising the end-to-end radiotherapy treatment planning system. This will have the potential to allow staff training to commence earlier and positioning the service to be fully operational with the new integrated radiotherapy service ahead of the opening of nVCC.

It should also be noted whist we recognise the need for the very specialised resource to undertake the work and existing pressures on staffing the IRS workforce budget is ring fenced to ensure the deployment of a 3rd linac at VCC is achievable in the timescales detailed.

Contractual and financial arrangements.

The agreement with Welsh Government on the funding for the IRS programme is planned and agreed in line with the phases 1, 2 and 3. This includes equipment purchase and the refurbishment of the bunkers required for the replacements. There is a separate but aligned budget for the RSC programme.

Phase 1 included the refurbishment of two bunkers, but also held a potential contingency that can, with the agreement of Welsh Government, be utilised for a third bunker. There is also proposed provision within the nVCC FBC for £1m funding for additional cost associated with extra linac bunker refurbishments at VCC and subsequent transfer to nVCC. Early discussions have

been undertaken with Welsh Government colleagues to assess this and additionally the revised financial forecast for 2024/25 to understand the movement of capital funding from 2025/26 to fund the 3rd linac replacement early and these are positive and will be confirmed post approval of the decision this paper is seeking.

The decision to replace a 3rd LINAC will requires a contractual change with Varian the provider and this is feasible and straightforward to execute as above this is not additional but a movement within the existing contract. The process is clearly laid out within the contract as change control notice and this can be implemented in a timely manner to meet required deadlines. Approaches have been made to Varian to explore this option and they have confirmed that they are able to accept such a change and deliver in line with our proposal.

It is important to note, work will continue to be undertaken as financial close on the new cancer centre is concluded

Agreement to replace the 3rd LINAC will be followed by the appropriate assurance of budgets and financial approvals.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)Yes (Please see detail below)
	IRS Requirements relate directly to the quality of service that will be capable of being delivered by the solution
RELATED HEALTHCARE STANDARD	Timely CareTimely Care
	Safe care Effective care Staff and resources IRS Requirements relate directly to the quality of service that will be capable of being delivered by the solution
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)No (Include further detail below)
	There will be one for the overall IRS implementation programme.

LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)Yes (Include further detail below)
	Requirements will link to the Contract
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)Yes (Include further detail below)
	As per the approved financial detail within the FBC and spend profile submitted to Welsh Government.

5. RECOMMENDATION

The Trust Board is asked to **ENDORSE** the recommendation to replace a third linac at VCC.

TRUST BOARD

VELINDRE ONCOLOGY ACADEMY

DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Non-Applicable

PREPARED BY	Hannah Russon, Project Lead
PRESENTED BY	Hannah Russon, Project Lead & Nicola Williams, Executive Director of Nursing, AHP & Health Science
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHP & Health Science

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Velindre Cancer Service Senior Management Team	06/04/2023	Endorsed
Executive Management Board	17/04/2023 19/06/2023 17/07/2023	Approved proposals & amendments agreed Endorsed final Business Case
Strategic Development Committee	06/07/2023	Endorsed Proposals and amendments agreed

1. SITUATION

This paper is to ask the Trust Board to ***APPROVE*** the proposal to develop a Velindre Oncology Academy.

2. BACKGROUND

Velindre University NHS Trust has an ambition to be an exemplar nationally and internationally in relation to non-surgical cancer services. Alongside the development of the new Velindre Cancer Centre and the development of regional hubs via the Velindre @ Model, Velindre Cancer Services is in a unique position to lead in improving cancer outcomes and patients' experience of their care. This is not only through the delivery of high-quality clinical services, but through leading on multi-professional cancer education to develop highly skilled oncology leaders.

To support this, a business case has been developed for Velindre University NHS Trust to have, in line with several internationally renowned cancer services, an Academy through which accredited non-surgical oncology education, training and upskilling can be provided to staff of Velindre University NHS Trust, Wales and wider. This will ensure the Trust and Wales oncology workforce can keep abreast of the rapidly developing oncology clinical landscape to support positive patient outcomes and experience. Currently, the majority of specialist oncology training is currently only available outside of Wales. Trust staff need to travel for required specialist oncology training including specialist SACT (systemic anti-cancer treatment) which is a prohibitor in terms of availability of courses, work life balance, time away from clinical area and costs.

The Christie NHS Trust and the Royal Marsden NHS Trust, as well as other oncology centres have well established Schools of Oncology / Oncology Academies which deliver a combination of formalised pre-registration and post graduate educational programmes in conjunction with local universities, in addition to clinical skills training and specialist SACT training. They also host educational events and conferences.

At present, Wales does not have a School of Oncology / Oncology Academy or any formalised multi-professional oncology educational pathways / oncology educational centre. Velindre Cancer Services is well positioned to lead on the development of this – not only regionally, but also nationally (Wales). Velindre Cancer Service provides specialist cancer services to the population of South-East Wales and beyond in partnership with neighbouring Health Boards. It is the strength in these partnerships with Velindre acting as the 'hub' that puts the Cancer Service in a unique position to develop an Oncology Academy. It also aligns with the vision for the 'Transforming Cancer Services' programme with one of the four objectives stating that the cancer centre envisions becoming a leader in education, research, development, and innovation.

A Project Lead commenced in December 2021 to undertake benchmarking, develop a project team, undertake some proof-of-concept educational events and develop the Business Case. The Project lead has been supported to date by an events Co-Ordinator and part time administrative support.

The Executive Management Board has been overseeing the development of the Business Case and making key decisions along its development pathway. The draft business case was received by the Strategic Development Committee and Committee endorsed the development of a Velindre Oncology Academy.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 *Context*

The development of the Velindre Oncology Academy will support the Trust to meet its vision and strategy. One of the four main objectives of the Transforming Cancer Services is to become a leader in education, research, development, and innovation. The Academy would be the delivery vehicle for the development and education of the oncology workforce, ultimately positively affecting patient outcomes and experience. It will align with the workforce strategy to support inhouse development of advanced skills and education training and help to attract the future workforce, retain existing staff and enable the Cancer Service to be recognised on a national and international platform.

The Academy also aligns with the Velindre futures agenda by improving upon the existing education structure and leading on an education service that will embed itself physically into the new cancer centre and centre for collaborative learning.

The workforce required to ensure we can meet the growing cancer demand and complexities in treatment both now and in the future is different to what we have had historically, and the Academy will help us to ensure we have a competent, skilled, educated and robust workforce. Aligning with the Education Strategy the Academy will support the continual evolving of career pathways and frameworks as well as facilitating the Trust delivering on the new NHS Wales Multi-professional Enhanced and Advanced Practice Framework. This will be achieved by working in partnership with universities. The Academy can deliver on these drivers and develop a kind, safe, effective knowledgeable and capable workforce to provide the best possible care and experience for patients with positive treatment outcomes.

The Academy can also provide this non-surgical dedicated oncology training provision for NHS Wales and beyond. To support this ambition, both the Wales Cancer Network and Health Education Improvement Wales (HEIW) are supportive of the development of the Velindre Oncology Academy and early discussions have indicated a desire to enter future Oncology Education Commissioning arrangements with both the Network and HEIW. This includes the education and training ambitions of ARC.

3.2 Main Benefits

- The main beneficiaries of the Academy in its desirable format (see 3.3.2) will ultimately be the cancer patient. Developing a knowledgeable, skilled, and talented multi-professional workforce that works at the top of licence and keeps abreast of the rapidly changing oncology treatment and care requirements will result in better patient outcomes, experience, and survivorship.

- Cancer care and treatments are increasing in complexity and rapidly changing. An Academy can develop an agile workforce by providing them with the skills and knowledge to keep abreast of changes.

- Organisationally the workforce will benefit from the Academy by increasing staff satisfaction in terms of high-quality access to education and professional development and will lead to the retention of existing staff and recruitment of a high calibre of new staff. There is clear evidence within the education sector that demonstrates that relevant professional development opportunities can help boost job satisfaction and allow staff to feel more optimistic about the profession and contributes to good health and wellbeing.

- Significant reduction in the number of staff needing to attend universities / cancer centres outside of Wales to receive their clinically required oncology skills training / education and specialist courses. This will significantly increase the desire to clinically upskill and reduce training costs.

- The organisation will benefit as the Academy will build upon the existing reputation of the trust and cancer centre and help lead on the Transforming Cancer Services programme in terms of the ambitions for the education provision.

- Other public sector organisations (University Health Board partners, trusts and third sector organisations) serve to benefit from the Academy as we will be able to educate cancer professionals outside of our own organisation and become a centre for all oncology education, with the potential to partner with other specialties such as haematology and surgical oncology.

- With our knowledge and expertise, the Academy can centrally offer cancer education across Wales despite the geographical challenges of the country due to new and emerging digital capabilities. The Academy will align with our university status through existing and new partnerships with the higher education institutes and through collaboration we stand to strengthen one another's reputation and standing in the world of academia.

- HEIW commission advanced practice funding annually for clinical staff to undertake post graduate learning. The Academy can utilise this budget to fund our own staff on cancer MSc pathways and in turn the health boards also have this funding available and can use it to fund their own staff on our future programs. HEIW also list cancer care as one of their priority areas for advanced practice funding.

- The organisation will benefit due to the alignment of and collaboration with the Advancing Radiotherapy Cymru (ARC) Academy, increasing education provision further and increasing reputation and education across Wales.

- The potential of the Academy has been responsible for generating enthusiasm within the organisation with a clear energy for its development. If approved, it could also be responsible for generating new training, role development and expansion of service opportunities.

- The Academy has the potential to strengthen the profile of the excellence of the workforce on a national and international stage.

3.3 Velindre Oncology Academy

3.3.1 General Overview:

The Academy plans to improve and build upon the existing education curriculum by providing courses, educational sessions, skills training, and upskilling both internally and externally. In addition, the Academy aims to be agile in developing new courses in line with changing oncology demographics so that we can meet the education requirements of the workforce and offer MSc/BSc Oncology specific pathways alongside individual accredited modules and courses.

This will be developed in partnership with Universities. In the first instance, with the University of Wales Trinity Saint David. The Trust is in the final stages of entering into an association with the University of Wales Trinity St David which will, through the University of Wales Technical Institute facilitate course and module accreditation that will maximise options for course development and bring new course commissioning opportunities.

The business case outlines what is required for the first three years of the Academy. It is recognised that the Academy will expand, and its portfolio of educational offer will grow over time. Funding support will be required for the first three years, following which, it is anticipated (following national benchmarking of similar UK Academies / Schools) that the Academy should be self-funding. This will be achieved through commissioning and course fees. The required financial support will be graduated down through the 3-year period as the commissioning of new courses increases.

Due to the significant work undertaken during the proof-of-concept phase it is proposed if Board approval is given to proceed that year 1 will commence in September 2023. Proof of concept courses are continuing to run, and arrangements are in place to establish formal academic agreements through the University of Wales Technical Institute.

The first year of the Velindre Oncology Academy will focus on building on the progress made to date, during the proof-of-concept phase, to establish the Academy infrastructure that will include the branding, educational digital platform, developing the curriculum and prospectus, commencing accreditation, and developing a three-year delivery plan as well as slowly growing the education provision. As the curriculum develops and grows the delivery workforce will need to expand and grow. As new courses are commissioned additional lecturer / practitioner posts will be required to deliver the increasing curriculum which will be factored into the commissioning / fees for such courses.

It has been agreed that the Education and training element of the Advancing Radiotherapy Cymru Academy (ARC) will be delivered through the Velindre Oncology Academy so that there is a cohesive overarching non-surgical oncology education, skills and training provision aligned with advancing oncology developments. This maximises opportunities and economies of scale efficiencies. The infrastructure costs proportionate to achieving the ARC education and training ambition will be provided from the approved ARC fund.

3.3.2 Velindre Oncology Academy Delivery Options

Three options were considered by the Executive Management Board and the Strategic Development Committee:

- Option 1: Business as Usual (pre-proof-of-concept) education & training offer
- Option 2: Do Minimum (as per proof-of-concept delivery)
- Option 3: Establishment of a full Velindre Oncology Academy in line with the best in the UK

The three options were explored by the Executive Management Board and Strategic Development Committee, and both endorsed option 3.

It was concluded by both that this would ensure the education and training requirements of the non-surgical oncology workforce in Wales and Velindre can be met facilitating the required role transformation and top of licence working that is essential for the increasing complexities in oncology treatments. It was recognised that this would also result in improved patient outcomes and experience as well as having a positive impact on Velindre Cancer Services' reputation aligning with internally renowned cancer services that will positively affect staff recruitment and retention.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	The development of a Velindre Oncology Academy will have a significant positive Quality Impact spanning all 6 domains of quality. It will facilitate more effective recruitment and retention as well as ensuring the Trust & NHS Wales Oncology workforce remain skilled, trained, and competent within an increasingly complex treatment environment.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	An equality impact assessment is being undertaken on the business case
LEGAL IMPLICATIONS / IMPACT	Legal guidance has been sought in relation to the development of the tripartite relationship with University of Wales, Trinity St. David's.
	No legal implications were identified.
FINANCIAL IMPLICATIONS / IMPACT	The working assumption is that the Velindre Oncology Academy will require graduated funding for the first three years whilst its income streams are being strengthened and matured with an ambition to be self-funding from year 4. A proportion of the funding is through existing educational posts that will transfer under the Academy. The full Business Case is provided in Part B given commercial sensitivities.

5. RECOMMENDATION

The Trust Board is asked to **APPROVE** in principle the development of a Velindre Oncology Academy pending consideration of the Business Case.

TRUST BOARD

Framework Scheme of Delegation for Major Capital Projects and Programmes

DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB Shape	20/03/2023	ENDORSED FOR APPROVAL
Audit Committee	25/04/2023	ENDORSED FOR BOARD APPROVAL

ACRONYMS	
IRS	Integrated Radiotherapy Solution
nVCC	New Velindre Cancer Centre
SFIs	Standing Financial Instructions
SOs	Standing Orders
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

The Trust is going through a period of a high level of change as a result of its transformation programme, with a number of Major Capital Projects and Programmes either in progress or coming through the stages of full business case approval, as follows:

- nVCC Enabling Works (contract implementation)
- Integrated Radiotherapy Solution (contract implementation)
- nVCC (full business case in stages of final approval)
- WBS Modernisation (full business case in development)

An internal audit report produced in December 2022 on the nVCC Contract Management provided limited assurance and identified a number of non-compliances with Standing Orders and Standing Financial Instructions in terms of approval of contracts and variations, and implementation of appropriate contract documentation in a timely manner.

There have been occasions on the nVCC programme where contractual commitments have been made without following the required governance processes set out in the SOs/SFIs. This has meant that sign off from the Trust Board has been required on an urgent basis outside of the usual cycle of business.

The Director of Finance and Deputy Director of Finance, with support from Procurement and Internal Audit, have liaised with two Local Health Boards who have recently encountered similar issues in order to learn lessons and apply these learnings within a framework at Velindre in order to address issues with regards to contract management of Major Capital Programmes.

The assessment / summary of matters for consideration are set out in section 2 as follows:

2.1 Major Capital Programmes and Scheme of Delegation and Governance Framework Requirement

2.2 Development of a Model Scheme of Delegation and Governance Framework

2.3 Key Components of the Model Scheme of Delegation and Governance Framework

2.4 Key Roles and Responsibilities within the Scheme of Delegation and Governance Framework

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Major Capital Projects and Programmes and Scheme of Delegation and Governance Framework Requirement

As set out in the Better Business Case Templates guidance[1], the following should be considered with regards to whether a scheme classifies as a Major Capital Programme:

- the value thresholds,
- the complexity and risk involved,
- whether the situation is novel or contentious,
- whether procurement is required and the scale of the procurement, and
- whether there are any dependencies, e.g. with business as usual matters or other projects

In line with the available business case templates, the guidelines below, including value thresholds, help to address which business cases should be classified as a Major Capital Programmes:

For Procurements and Projects (enabling outputs, activities and infrastructure):
1. Single Stage Business Case - Low Value and Risk (£0 to £250k value of procurement).
2. Single Stage Business Case - Medium Value and Risk (£250k to £2 million value of procurement)
3. Three Stage Business Case (SOC, OBC, FBC) – High Value (Over £2 million value of procurement)

For Overarching Programmes (outcomes to be achieved through improved services comprised of enabling projects):
4. Programme Business Case using the Five Case Model

Following this guidance, it is proposed that:

- All Major Capital Programmes will follow a Three Stage Business Case (point 3) and use the appropriate business case templates.
- **A Scheme of Delegation and Governance Framework must be in place for all High Value Procurements and Projects (i.e. Three Stage Business Cases) and Programme Business Case using the Five Case Model.**
- It would be considered **good practice, though not a requirement**, to have a Scheme of Delegation and Governance Framework developed for Low and Medium Value Cases (i.e. Single Stage Business Cases.

[1] Available at: https://www.gov.wales/five-case-model-templates

- Low and Medium Value Cases (i.e. Single Stage Business Cases) are monitored through the Trust's Standing Orders, Standing Financial Instructions and Financial Controls Procedures as part of standard practice.

2.2 Development of a Model Scheme of Delegation and Governance Framework

In order to address the issues identified in the internal audit report for nVCC Enabling Works and to prepare for IRS, nVCC and WBS Modernisation, it is proposed that a model Scheme of Delegation and Governance Framework is prepared for each major capital programme. It is proposed that a Scheme of Delegation and Governance Framework is prepared in line with the scope of each full business case given that the scope, contractual obligations and budget will differ for each programme based on the specific requirements of each.

The overarching process from Full Business Case approval to Programme Implementation is set out in Appendix A. This outlines the key governance activities and the key programme activities and financial control policies.

A draft Scheme of Delegation and Governance Framework has been prepared for the IRS Programme as an example, which can be found in Appendix B.

The draft Scheme of Delegation and Governance Framework was developed through the following approach:

- Review of the internal audit findings and recommendations with regards to nVCC Contract Management.
- Review of the key areas of Standing Orders (SOs) and Standing Financial Instructions (SFIs) with regards to the Scheme of Delegation and contract management.
- Application of lessons learned from two Local Health Boards, which have dealt with similar issues, including a document review of a programme controls framework and a procurement and governance report.
- Write up and drafting of the proposed framework with the IRS Programme Manager and Head of Finance Business Partnering.

The Scheme of Delegation and Governance Framework should be used in conjunction with the following policies and procedures:

- Velindre University NHS Trust Standing Orders (SOs) and Standing Financial Instructions (SFIs)
- Velindre University NHS Trust Financial Control Procedures (FCPs)

- Welsh Government NHS Wales Infrastructure Investment Guidance[2]
- Welsh Government Better Business Cases Investment Decision Making Framework[3]

2.3 Key Components of the Model Scheme of Delegation and Governance Framework

It is proposed that the key components of a model Scheme of Delegation and Governance Framework for each Major Capital Programme will be as follows:

1. Purpose and Scope
2. Scheme of Delegation: Transition from FBC to Programme Implementation
3. Principles for Entering into Contracts
4. Roles, Responsibilities and Authorisation Matrix
5. Governance Framework
6. Capital Expenditure
7. Revenue Expenditure
8. Procurement and Contract Management
9. Contract Change Management and Compensation Events
10. Financial Monitoring and Reporting

The draft Scheme of Delegation and Governance Framework for the IRS Programme sets out the contents and level of detail that would be expected to be included when replicated for other Major Capital Programmes.

2.4 Key Roles and Responsibilities with the Scheme of Delegation and Governance Framework

The Chief Executive is the Accountable Officer for all Major Capital Programmes and will issue a Scheme of Delegation for capital investment management. It is proposed that the Scheme of Delegation will be contained within the Scheme of Delegation and Governance Framework for each Major Capital Programme. To ensure consistency in the approach, a number of key roles and responsibilities shall be consistently included within each Scheme of Delegation, which are proposed as follows:

Role	Responsibility
Chief Executive Officer	Accountable Officer for all Major Capital Programmes
Senior Responsible Officer (SRO)	The SRO will be the member of the Executive team with overarching responsibility for delivery of the Major Capital Programme and will be the programme budget holder.

[2] Available at: https://www.gov.wales/sites/default/files/publications/2020-03/nhs-wales-infrastructure-investment-guidance.pdf
[3] Available at: https://www.gov.wales/better-business-cases-investment-decision-making-framework

Role	Responsibility
(*Budget Holder*)	The SRO will set the delegated budget holders on the programme by gaining approval from the Chief Executive and Executive Management Board.
Programme / Project Director (*Delegated Budget Holder*)	The Programme / Project Director will be responsible for ensuring that the programme is compliant with the Scheme of Delegation, Standing Orders and delegated budget holder responsibilities set out within the SOs / SFIs by overseeing the implementation of effective Project Management Controls.
Programme / Project Manager	The Programme / Project Manager will be responsible for implementing the Project Management Controls and managing the programme / project ensuring that appropriate contract management records are kept including change requests, extensions and variations as set out in SFIs section 11.16 Contract Management.
Procurement lead	The procurement lead will advise on Contract Management best practice and ensure that any procurement processes required as part of the major capital programme are compliant with Public Contract Regulations 2015 and SFIs.
Finance lead	The Finance lead is responsible for ensuring that the programme is compliant with Standing Financial Instructions including financial reporting systems and monitoring arrangements.

3. IMPACT ASSESSMENT

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

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

4. RECOMMENDATION

4.1 Trust Board are requested to:

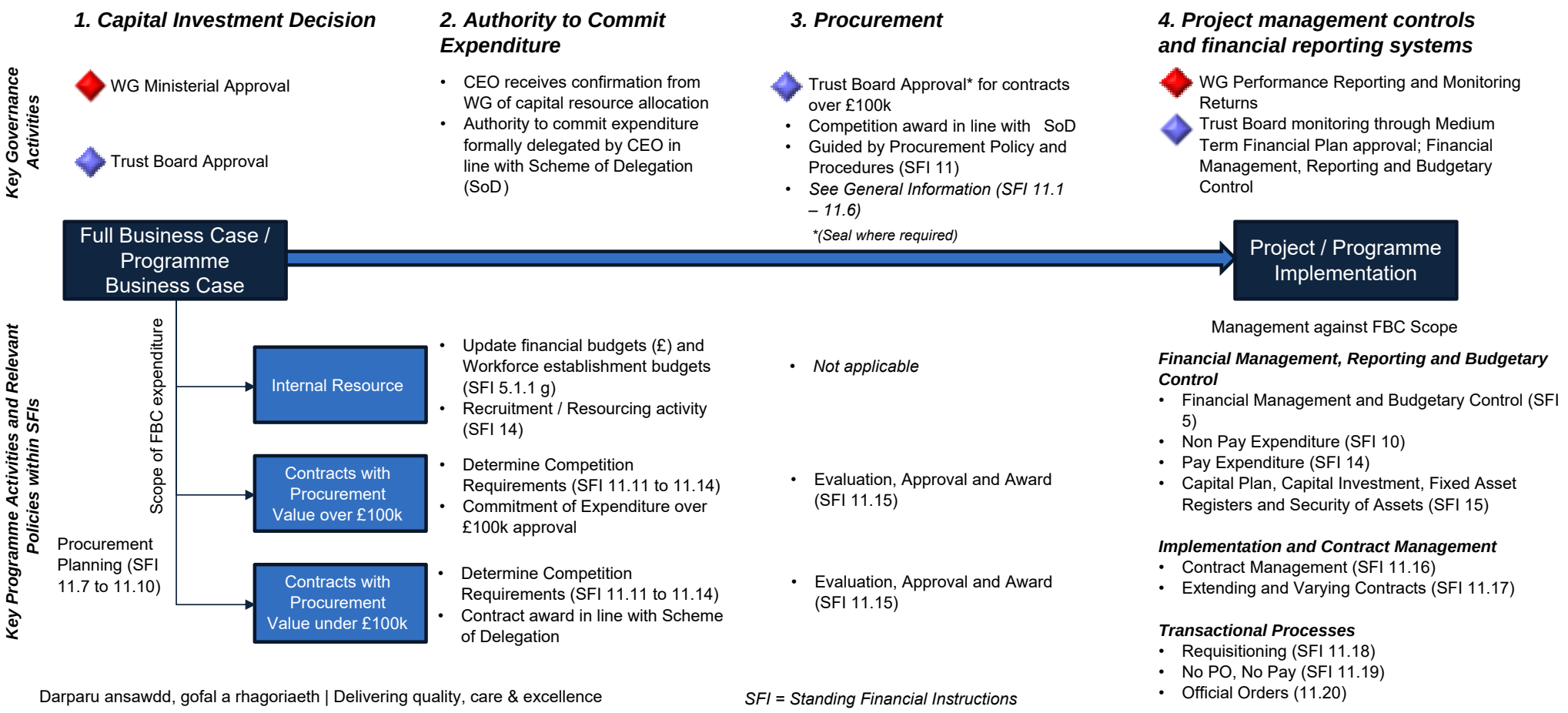
4.1.1 **DISCUSS / REVIEW** the proposed approach to the development of model Scheme of Delegation and Governance Framework for Major Capital Projects and Programmes.

4.1.2 **APPROVE** the approach and application of the model Scheme of Delegation and Governance Framework for Major Capital Projects and Programmes to all Major Capital Schemes.

4.1.3 **APPROVE** the Integrated Radiotherapy Solution (IRS) Programme Scheme of Delegation and Governance Framework

Major Capital Projects and Programmes: Scheme of Delegation and Governance Framework Overview

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust



Darparu ansawdd, gofal a rhagoriaeth | Delivering quality, care & excellence

SFI = Standing Financial Instructions

Integrated Radiotherapy Solution (IRS) Programme Scheme of Delegation and Governance Framework

1. Purpose and Scope

This document outlines the Scheme of Delegation and Governance Framework for contracts within the scope of the Integrated Radiotherapy Solution (IRS) Programme.

This framework forms part of the Trust Standing Orders (SOs) and Standing Financial Instructions (SFIs) Scheme of Delegation and is to be used in conjunction with those guidelines and Financial Control Procedures (FCPs).

This document outlines the management control and financial reporting systems to ensure that the programme is:

- Delivered on time;
- On budget; and
- Within contractual obligations

The scope of this document is the management of pay costs, contracts and non-pay costs within the IRS Programme.

The financial authority limits within this document apply to the IRS Programme and contract as a whole, even though the contract/procurement is in phases and over a period of time. It should be noted that splitting orders or contract commitments to avoid approval at a higher level is strictly prohibited and will be considered a breach of SFIs.

As outlined in section 1.2.2 of the Trust SFIs, ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.

2. Scheme of Delegation: Transition from Full Business Case (FBC) to Programme Implementation

With regards to the IRS Programme, the following process outlines the Scheme of Delegation as the programme transitions from FBC approval into IRS programme implementation:

- The funding for the FBC for the IRS Programme was approved by Welsh Government on 22nd November 2022 and the agreement signed by the Chief Executive and Chair and sealed by the Trust Board on 24th November 2022.
- The scope of contractual services for the IRS, including the Capital and Revenue Budget, has therefore been approved by Welsh Government (WG) and Trust Board in line with FBC submission.
- Prior to the start of each financial year, in line with SFI section 5 Financial Management and Budgetary Control, IRS budgets will be prepared and submitted by the Executive Director of Finance as part of the Trust Financial Plan and Budgets, on behalf of the Chief Executive, to the Trust Board for approval and delegation.
- Following approval of the Trust Integrated Medium Term Plan (IMTP), the Medium Term Financial Plan and Budgets by the Trust Board, the authority to commit expenditure for the programme will be delegated by the Chief Executive, via the Executive Director of Finance, to the Chief Operating Officer (COO) as part of the Trust's Budgetary Control Procedure (FCP1).

- Consequently, each subsequent year IRS financial plans for revenue and capital will need to be submitted through the IMTP process and Medium Term Financial Plan.
- Funding sources for the IRS Programme will be agreed on an annual basis as follows:
    - Capital budget will be agreed with Welsh Government for the IRS programme and allocated through the Capital Expenditure Limit
    - Revenue budget will be agreed with Local Health Board Commissioners as part of the IMTP and added to individual Commissioner Long Term Agreements (LTAs) and then allocated to the COO through the Delegated Expenditure Control Limit

A summary of the business case funding which has been approved is as follows:

Capital

Business Case	**Scope of Contracts within FBC**	**Supplier**	**Budget (£m)**	**Implementation Timeframe**
IRS FBC	IRS Capital	Varian Medical Systems UK Ltd	£26.117	4 years
	Dosimetry, Immobilisation and Digital	TBC - Various	£1.121	2 years
	Bunker Refurbishment	Varian Medical Systems UK Ltd	£2.700	2 years
	Temporary Service Resilience	TBC	£2.750	2 years
	Total (excl. VAT)		**£32.686**	
	VAT		**£6.537**	
	Total (incl. VAT)		**£39.223**	
Business Case	**Scope of Internal Resources within FBC**		**Budget (£m)**	**Implementation Timeframe**
IRS FBC	Internal Resources	Not Applicable	£2.377	2 years
	Total		**£2.377**	
	Total Capital Budget FBC (inc. VAT)		**£41.602**	

Revenue

Business Case	**Scope of Contracts within FBC**	**Supplier**	**Budget (£m)**	**Implementation Timeframe**
IRS FBC	IRS Revenue	Varian Medical Systems UK Ltd	£20.286	13.5 years
	Total (excl. VAT)		**£20.286**	
	Total Revenue Budget FBC (excl. VAT)		**£20.286**	

3. Principles for Entering into Contracts beyond the scope of funding approved in the IRS FBC

This section outlines the key principles for entering into contracts as set out in the Trust's SFIs**. <u>These principles must be considered for any further commitments on the IRS Programme beyond the scope of the revenue and capital funding approved in the IRS FBC</u>.**

Any further contract commitments beyond the funding approved in the IRS business case will require approved additional funding either form WG, Commissioners or another source.

Contracts over £100k (excl. VAT)

In line with Section 5 of the Model Scheme of Reservation and Delegation of Powers, contracts over £100k require Trust Board approval.

Contracts up to the value of £100k should be authorised in line with the IRS Scheme of Delegation outlined in Section 4: Roles, Responsibilities and Authorisation Matrix for the IRS Programme.

WG Contract Notification Arrangements

As outlined in Schedule 1 of the SFIs, the Trust is required to notify WG of entering into contracts as follows:

The process which the Trust entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General Health and Social Services Group (HSSG) prior to tendering for the contract
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award
  All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award

Contracts equal to or less than £100k (excl. VAT)

In line with Section 5 of the Model Scheme of Reservation and Delegation of Powers, contracts equal to or less than £100k can be authorised in accordance with the matrix included in section 4.

4. Roles, Responsibilities and Authorisation Matrix

Key Roles and Responsibilities for Programme Activities and Financial Governance

The table below provides an overview of the key roles and responsibilities related to programme delivery activities and financial governance. These roles and responsibilities will be applicable across all Major Capital Projects and Programmes:

Role	Responsibility
Senior Responsible Officer (SRO) (*Budget Holder*)	The SRO will be the member of the Executive team with overarching responsibility for delivery of the Major Capital Programme and will be the programme budget holder. The SRO will set the delegated budget holders on the programme by gaining approval from the Chief Executive and Executive Management Board.
Programme / Project Director	The Programme / Project Director will be responsible for ensuring that the programme is compliant with the Scheme of Delegation,

(*Delegated Budget Holder*)	Standing Orders and delegated budget holder responsibilities set out within the SOs / SFIs by overseeing the implementation of effective Project Management Controls.
Programme / Project Manager	The Programme / Project Manager will be responsible for implementing the Project Management Controls and managing the programme / project ensuring that appropriate contract management records are kept including change requests, extensions and variations as set out in SFIs section 11.16 Contract Management.
Procurement lead	The procurement lead will advise on Contract Management best practice and ensure that any procurement processes required as part of the major capital programme are compliant with Public Contract Regulations 2015 and SFIs.
Finance lead	The Finance lead is responsible for ensuring that the programme is compliant with SFIs including financial reporting systems and monitoring arrangements.

Authorisation Matrix for Entering into Contracts equal to or less than £100k (excl. VAT) beyond the scope of funding approved in the IRS FBC

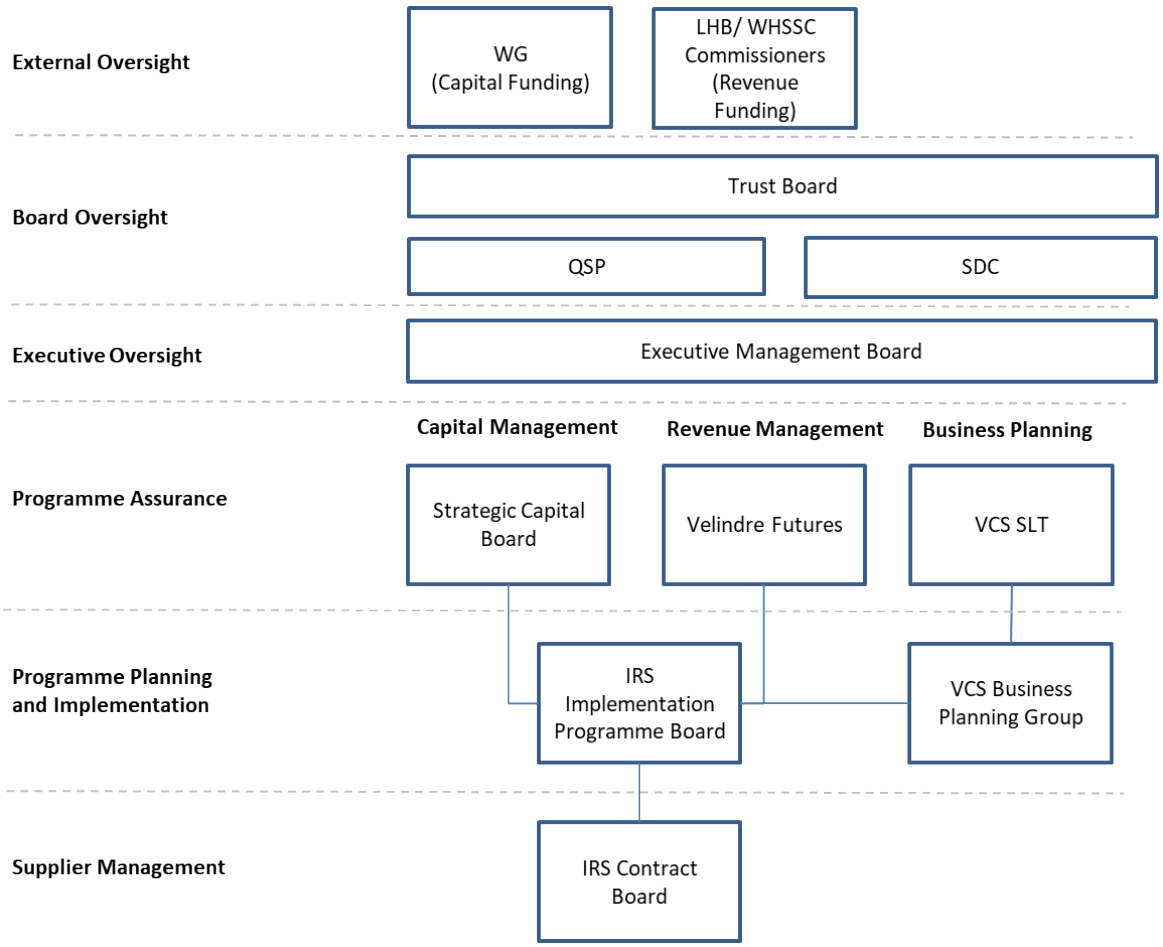
The Accountable Officer for the IRS Programme is the Chief Executive. Key roles, responsibilities and delegated authority limits for revenue and capital spend are set out in the table below:

Role	**Responsibility**	**Delegated Financial Authority Limit (excl. VAT)**
CEO	Accountable Officer	£100k
COO	Senior Responsible Officer – IRS Overarching responsibility for delivery of the IRS Implementation Chair IRS Implementation Programme Board IRS Programme Budget Holder	£60k
VCS Director	Deputy Chair IRS Implementation Programme Board	£60k
Head of Radiation Services	Programme Director IRS Delegated Budget Holder Leadership and Direction of the IRS Programme Chair, IRS Contract Board	£20k
IRS Programme Manager	Management of the IRS Programme	£10k

The Duties of Budget Holders and Managers are set out in section 10.3 of the SFIs.

5. Governance Framework

The diagram below outlines the key bodies, committees and groups involved in the governance of the IRS Programme:



Trust Chair's action on urgent matters

There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Director of Corporate Governance 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 must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

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.

6. Capital Expenditure

The Trust Board has approved the implementation of the IRS programme within the financial budget included in the WG approved FBC £41.602m as set out in the award letter from WG dated 22 November 2022 and titled "Award of Funding to Velindre University NHS Trust in respect of the Integrated Radiotherapy Solution".

Each year, the Trust Board will approve the Financial Plan including the IRS budget as part of the Trust's IMTP.

Management of capital expenditure for the IRS Programme will be conducted in line with the IRS Scheme of Delegation and Governance Framework and the Trust's SFIs, particularly Sections 5, 10 and 15, including all relevant FCPs such as Budgetary Control Procedure (FCP1).

The IRS Implementation Board, chaired by the COO, will provide oversight of the delivery of the programme including all aspects of financial and contract management.

Changes to IRS capital expenditure which are within the allocated budget should be managed internally through FCP1 Budgetary Control Procedure and externally through WG's Performance Reporting and Monitoring requirements.

Any capital expenditure required which is in excess of the approved FBC capital budget for the IRS Programme will be subject to business case approval from the Trust Board and Welsh Government as appropriate.

Any significant variances should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

Should variations to any contracts result in capital expenditure above the approved FBC capital funding, approval will be required in line with the Scheme of Delegation set out in this document and by the Trust Board and Welsh Government (WG), as appropriate, prior to any change.

Budget Virements

Section 4: Delegation of Budgetary Responsibility within the Model Scheme of Reservation and Delegation of Powers in the Trust SFIs outlines the delegated powers of budget virements.

7. Revenue Expenditure

The Trust Board has approved the implementation of the IRS programme within the financial budget included in the Commissioner approved the FBC of £20.286m over 13.5 years.

Each year, the Trust Board will approve the Financial Plan including the IRS budget as part of the Trust's IMTP.

Management of revenue expenditure for the IRS Programme will be conducted in line with the IRS Scheme of Delegation and Governance Framework and the Trust's SFIs, particularly Sections 5 and 10, including all relevant FCPs such as Budgetary Control Procedure (FCP1).

The IRS Implementation Board, chaired by the COO, will provide oversight of the delivery of the programme including all aspects of financial and contract management.

Changes to IRS revenue expenditure which are within the allocated budget should be managed through FCP1 Budgetary Control Procedure.

Any revenue expenditure required, which is in excess of the approved revenue budget for the IRS Programme, will be subject to business case approval from the Trust Board and Commissioners, as appropriate.

Any significant variances in spend against budget should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

Should variations to any contracts result in revenue expenditure above the approved FBC revenue funding, approval will be required in line with the Scheme of Delegation set out in this document and by the Trust Board and Commissioners, as appropriate, prior to any change.

Budget Virements

Section 4: Delegation of Budgetary Responsibility within the Model Scheme of Reservation and Delegation of Powers in the Trusts SFIs outlines the delegated powers of budget virements.

8. Procurement and Contract Management

Procurement and contracts for goods and services must be conducted in accordance with section 11 of the Trust SFIs and relevant FCPs.

Procurement requirements for Deployment Orders, Contract Variations or other Contracts are dependent on the supplier, type of contract and value of contract for both capital and revenue as follows:

Integrated Radiotherapy Solution and Associated Services Agreement

- The "Integrated Radiotherapy Solution and Associated Services Agreement" has been through a competitive tender process culminating with the contract agreement being signed by the Trust Chair and Chief Executive and the Trust Seal being affixed to the contract agreement on 24th November 2022.
- Deployment Orders, Change Control and Variations as set out in the "Integrated Radiotherapy Solution and Associated Services Agreement", which are within the approved scope and budget require no further approvals from Trust Board as they are within the remit and scope of the approved FBC.
- Deployment Orders and Variations with regards to the "Integrated Radiotherapy Solution and Associated Services Contract", that are greater than £100k (Exc. VAT) over the lifetime of the contact and are not within the approved scope or budget (Revenue and / or Capital), require Trust Board approval.
- Deployment Orders and Variations which are outside the scope of the "Integrated Radiotherapy Solution and Associated Services Contract" and / or FBC will be subject to section 11.13 Single Quotation Application or Single Tender Application within the Trust's SFIs.

Contracts for other Equipment, Specialist Advisers or other services

- Any contracts for Equipment, Specialist Advisers or other services greater than £100k (Exc. VAT) over the lifetime of the contact, which are within the approved budget (Revenue and / or Capital), require Trust Board approval.
- Any contracts for Equipment, Specialist Advisers or other services must follow the Competition Requirements set out in SFIs Section 11.11 Procurement Thresholds.

Signing Contracts and Deployment Orders

- Contracts and Deployment Orders equal to or greater than £100k (Exc. VAT) should be signed by the Chief Executive.
- Contracts and Deployment Orders less than £100k (Exc. VAT) should be signed by an appropriate level of authority as outlined in Roles, Responsibilities and Authorisation Matrix in Section 4.

Contract Management, Extension and Variation

- Contract Management, Extension and Variation is to be conducted in accordance with Section 11.16 Contract Management and Section 11.17 Extending and Varying Contracts as set out in the Trust's SFIs.

Out of Committee Contract Approval

- In exceptional circumstances, there may be the need to gain approval for the commitment of expenditure to procure goods and services in relation to the IRS Programme at short notice.
- If this approval is required from the Board as set out in the IRS Programme Scheme of Delegation and Governance Framework, the Head of Corporate Governance must be contacted in order to advise on the process to secure an Out of Committee Board approval through Chairs urgent action.

9. Contract Change Management and Compensation Events

Change Management and Compensation Events Procedure

The Contract Change Management Procedure establishes how "Changes" and "Compensation Events" will be proposed, accepted, monitored and controlled by the Trust. The Change Management Procedure will govern Changes to the IRS Programme after FBC approval through to Completion – i.e. Changes to the Programme Scope, Cost and / or Contractual Obligations.

Procedures for Change Identification

The scope of work contained in the Integrated Radiotherapy Solution and Associated Services Contract sets the Trust's approved 'baseline'. The scope of work is based on the design submitted as part of the approved Full Business Case.

When a Trust initiated change to the approved 'baseline' is identified, the Change will be clearly defined using the Change Request Form.

The Requester (Budget Holder / Manager) completes the Change Request Form and submits it to the Programme Director for review in line with the Scheme of Delegation.

Procedures for Change Analysis

The Budget Holder / Manager will need to identify in the Change Request Form if the proposed Change has a time and / or cost impact. The cost impact will need to differentiate between the following:

- Works costs
- Non-works costs
- Equipment
- IT

At this stage, it is not always possible to quantify the time and / or cost impact. A RAG rating will be applied to identify the potential level of impact for both time and cost.

On the basis of the Change Analysis, the Budget Holder / Manager will determine if the request is reasonable / viable and decide whether the Change Request merits further consideration by the Programme Director, Deputy Head of Commercial and Contract Management, Programme Team and / or the IRS Implementation Programme Board.

Change Request Approval Procedure

To be completed in line with requirements of IRS Contract.

Approval of Compensation Events (CEs)

This will follow the process as set out in the contract with the Supplier and will be managed by the Programme Manager in conjunction with the Deputy Head of Commercial and Contracts Management and Programme Director.

When both the Programme Manager and the Deputy Head of Commercial and Contracts Management agree that a Compensation Event is warranted and the cost impact has been agreed with the Provider, the Programme Director will be required to sign off the Project Control Form.

The Programme Director has delegated authority for sign off up to £20,000 (excl. VAT). For values above that the Trust's Scheme of Delegation, as outlined in Section 4, will need to be followed.

In this context the Programme Team and IRS Implementation Programme Board will need to be kept informed of the approved Compensation Events and the effect on the project contingency.

It should be noted that the above process also needs to be followed for CEs that reduce cost and / or propose moving costs from one cost category to another.

Change Control (CC) and Compensation Event (CE) Tracking

The Programme Manager will maintain a Change Control Register of all Change Requests, Compensation Events and the resolution of each. This will be appended to the monthly Programme Management reports and shared with the Programme Team and IRS Implementation Programme Board at monthly meetings.

10. Financial Monitoring and Reporting

The COO, with the oversight of the IRS Implementation Board, will monitor the delivery of revenue and capital expenditure against the contract. Escalations for variation against the capital budgets will be reported to the Strategic Capital Board and subsequently to EMB. Escalations for variation against the revenue budgets will be reported to the Velindre Futures Programme Board and EMB.

Any significant variances should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

To support the ongoing monitoring of the financial performance of the IRS Programme, the following financial reports will be required:

- Medium Term Financial Plan on an annual basis to be approved by the Trust Board within the IMTP
- Lifetime programme reporting against FBC, inclusive of cashflow, on an annual basis to the IRS Implementation Programme Board for the duration of the capital programme.
- Financial performance reporting including Capital/Revenue/Budgeted Establishment to the IRS Implementation Programme Board and Velindre Futures / VCS Senior Leadership Team on a monthly basis
- Financial reporting, benefits realisation and contractual deliverables for Contract Board with Varian on a quarterly basis, as required
- WG Programme Performance Reporting and Monthly Monitoring Returns

TRUST BOARD

CARDIFF AND VALE UNIVERSITY HEALTH BOARD TRUST BONE MARROW TRANSPLANT - STRATEGIC OUTLINE CASE

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	Choose an item
PREPARED BY	Carl James, Executive Director of Strategic Transformation, Planning, Performance and Digital
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning, Performance and Digital.
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	Cardiff and Vale University Health Board are currently developing a Strategic Outline Case (SOC) to seek investment from the Welsh Government (capital) and other partners (revenue) to support the following: • The development of an agreed ambulatory and inpatient model of treatment delivery for

	haematology/bone marrow transplant patients • The provision of additional capacity to support: - advanced cell therapies - the Cardiff Cancer Research Hub - complex specialist oncology patients The delivery of these services would improve the quality, safety and experience of cancer care across South East Wales/Wales and improve service resilience and sustainability; in accordance with the Cancer Improvement Plan 2023 – 2026 and the Nuffield Trust Independent Advice.

RECOMMENDATION / ACTIONS	The Board Committee is asked to: • Note the progress made in developing the SOC and the improvements it would deliver to the quality of cancer care and the expected benefits for patients and staff. • Note that the developments set out in the SOC which, if they proceed through to delivery, will address a range of national policy, Nuffield Trust recommendations together with the strategic priorities of the various partners. • Note that no financial commitments are being sought at this stage. • Approve the provision of a letter of support for the SOC to Cardiff and Vale UHB which they will send to the Welsh Government to support its consideration of the case.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	19/06/2023
Strategic Development Committee (verbal update)	06/06/2023
Executive Management Board	17/07/2023
TCS Scrutiny Sub-Committee	20/07/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report has been considered at the Executive Management Board and Strategic Development Committee. There was strong support for the proposals contained within it given its direct relationship with the improvement of the quality and sustainability of cancer services in South East Wales/Wales. No strategic / operational risks were considered at this stage given the fact it has not secured Welsh Government support.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full The SOC sets out a plan for improving cancer services together with a detailed approach to the management of delivery (in the Management Case). If the SOC progresses to OBC/FBC the delivery plans will be further detailed and should give high levels of confidence that the desired outputs/outcomes should be delivered and sustained.

APPENDICES	
1	Bone Marrow Transplant Strategic Outline Case

1. SITUATION

1.1 Cardiff and Vale University Health Board are currently developing a Strategic Outline Case (SOC)(see appendix 1) to seek investment from the Welsh Government (capital) and other partners (revenue) to support the following:

- The development of an agreed ambulatory and inpatient model of treatment delivery for haematology/bone marrow transplant patients, which will meet both future service demand and address health and safety deficiencies and meets the requirements for JACIE accreditation
- The provision of additional capacity to support advanced cell therapies
- The provision of additional capacity to support the Cardiff Cancer Research Hub (revenue component subject to separate business case)
- The provision of additional capacity to support the required level of provision for complex specialist oncology patients

1.2 Securing investment for this Programme, both revenue and capital, is essential in supporting both Cardiff and Vale University Health Board and Velindre University NHS Trust in the successful delivery against Wales Cancer Improvement Plan 2023 – 2026 and the recommendations contained within the Nuffield Trust review / report.

2. BACKGROUND

2.1 Cardiff and Vale UHB, Velindre University NHS Trust and Cardiff University have worked in partnership to develop the SOC has been developed in order to ensure that the anticipated benefits to patients are delivered as soon as possible.

2.2 This has provided the opportunity to include a number of key development areas within the SOC which will advance cancer care and support the delivery of the partners shared priorities. It also offers Velindre University NHS Trust the opportunity to progress a number of its specific strategic priorities for cancer services:-

- the Cardiff Cancer Research Hub: a tri-partite development between Velindre University NHS Trust, Cardiff and Vale University Health Board and Cardiff University to develop high quality clinical and translational research in Cardiff across Wales.
- the enhancement of a Complex Specialist Oncology service which will provide specialist care for patients receiving treatments who become unwell

through increased toxicities. This is an important area of service development patients receive immunotherapies.

- the opportunity to work in partnership to develop the capacity and capability in Wales for the implementation of advance therapies i.e. Car-T etc. and prepare for the delivery of Advanced/Cell Therapies.

2.3 The development of the three services set out in the SOC (haematology; an enhanced approach to the multi-disciplinary care for specialist complex oncology patients receiving higher toxic treatments; and the provision of clinical trials/research) presents a real transformational opportunity for cancer services in the region. Importantly, it would enable the alignment and integration of skills, capacity and capability to optimise the quality and resilience of the services.

2.4 It is important to note that if all services are not delivered together it is likely that the same level of quality and resilience would not be achieved as it is essentially the same workforce, operating in an integrated manner, required to support the provision of the three integrated services i.e. the same multi-professional teams will be responsible for providing treatment and care as well as supporting those patients who are on clinical trials.

3. ASSESSMENT

3.1 The Velindre University NHS Trust team (clinical, planning and finance) have worked with partners to provide information for the Cardiff and Value UHB SOC related to the areas set out in para 2.2. The information provided for the SOC includes:

- A baseline assessment of current activity in relation to the VUNHST service developments
- A forecast assessment of future activity in relation to the VUNHST service developments
- Justification (data, feedback from site visits etc.) to support the additional forecast activity and capacity requirements
- A robust estimate of:
  - Capital requirements e.g. number of beds, chairs etc. and a description of the clinical specification requirements. This will support the development of a schedule of accommodation and an outline design.
  - Revenue requirements, with a strong focus on workforce requirements

3.2 It is important to note that the SOC is led by Cardiff and Vale UHB. Notwithstanding this, it seeks to secure approval from the Welsh Government to progress to Outline and Full Business Case. The SOC process simply seeks to secure support from partners and the Welsh Government for the case for change and limited funding to progress to OBC. Therefore, at this stage, no organisation is being asked to make any firm commitment in terms of resources; other than those supporting the work.

3.3 If the SOC is approved by the Welsh Government, and Cardiff and Vale UHB and its partners (including the Trust) are able to proceed to OBC stage there will be more detailed work required to establish the required investment and then secure it. This will be a complex process given the wide range of partners who would be involved in providing investment including Cardiff and Vale UHB; UHB partners; WHSCC; Velindre University NHS Trust; Cardiff University; the Welsh Government; and a range of research grants/potential commercial funding.

3.4 The evidence supporting the proposals set out within the SOC is strong and compelling and includes:

- the clear alignment between the SOC and the delivery of the national cancer quality standards, the Wales Cancer Improvement Plan and the Nuffield Trust recommendations.
- clinical evidence which sets out best practice approaches to delivery cancer care (haematology and oncology).
- a strong and compelling evidence base which demonstrates the importance of high quality clinical and translational research in cancer services which improve current treatments and care and also support the continuous improvement of services through innovation.
- detailed data demonstrating the need to increase capacity and capability to meet the forecast demand for cancer services in South East Wales.
- a clear articulation of the required capacity, capability and infrastructure in South East Wales/Wales to be in a strong position to deliver advance therapies in line with the Welsh Governments' Statement of Intent 2019.

3.5 There are currently no obvious arguments against the development of the services identified in the SOC. The key areas for future consideration, if the SOC is approved to move to OBC/FBC will focus on risks to delivery e.g. availability of capital; capacity/capability to deliver etc.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The SOC sets out a compelling case for change to improve the quality, safety, experience and sustainability of cancer care in South East Wales/Wales in the immediate/medium term.

4.2 It is supported by a compelling evidence base, aligns with the Welsh Government policy, the Nuffield Trust recommendations and the shared priorities of Cardiff and Vale UHB, Velindre University NHS Trust and Cardiff University.

4.3 The approval of the SOC by the Welsh Government would allow the work to progress to detailed planning stage. At this juncture, there is no financial commitment/investment being sought or required from Velindre University NHS Trust or any other partner. This would occur once an OBC/FBC was developed by Cardiff and Vale UHB and would require letters of approval from all funders e.g. WHSCC, University Health Boards, Velindre University NHS Trust and the Welsh Government. One of the key investment areas, the Cardiff Cancer Research Hub, is currently working with Moorhouse to develop an agreed service/partnership model and investment strategy. This will be aligned with the development of the SOC.

4.4 The opportunity to support the continuing transformation of cancer services across the region/Wales is a truly exciting one which has all partners enthused and working collaboratively to ensure it is realised. The benefits to patients, staff and the wider population will be significant and long-lasting.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated areas of priority	☒

<table>
<tr><td colspan="2">

- 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 RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>06 - Quality and Safety</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Select all relevant domains below
Safe ☒
Timely ☐
Effective ☒
Equitable ☐
Efficient ☐
Patient Centred ☒</td></tr>
<tr><td>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 delivery of the SOC proposals would improve the safety and effectiveness of cancer services and ensure a more equitable/patient centred approach to research as more patients will have the opportunity to access clinical trials</td></tr>
<tr><td rowspan="2">SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:
For more information:
https://www.gov.wales/socio-economic-duty-overview</td><td>Not required</td></tr>
<tr><td>[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].

This is a Cardiff and Vale UHB business case and they have advised that there is no</td></tr>
</table>

	requirement to undertake an assessment at this stage of the business case process.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	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: There are no direct financial implications at this stage other than staff's time in undertaking the work. **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item**

	Scale of Change Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This is a Cardiff and Vale UHB business case and they have advised that there is no requirement to undertake an Equality Impact Assessment at this stage of the process. If the SOC is approved there would be a requirement to undertake the assessment at the next stage of the Business Case process. This would be led by Cardiff and Value University Health Board and the Trust would fully contribute to it.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*There are no risks at this point in the business case development process*

WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Implementation, and securing investment to support the proposal, is subject to the approval of Business Cases by the Welsh Government.
All risks must be evidenced and consistent with those recorded in Datix	

Haematology/BMT, Cancer Research and Complex Specialist Oncology

Strategic Outline Case

July 2023 – Final v11

CARING FOR PEOPLE
KEEPING PEOPLE WELL

Document Information

Status	Final
Date	6th July 2023
Authors	Adcuris/CVUHB
Circulation	CVUHB Project Team

Version	Date Issued	Summary of Change	Document Owner
Draft v1	20th October 2022	Initial Draft	Geoff Walsh
Draft v2	21st November 2022	Economic Case drafted	Geoff Walsh
Draft v3	8th December 2022	Updated service information	Geoff Walsh
Draft v4	4th April 2023	Updated to reflect revised scope	Geoff Walsh
Draft v5	20th April 2023	Strategic case updated	Geoff Walsh
Draft v6	11th May 2023	Strategic case updated	Geoff Walsh
Draft v7	24th May 2023	Updated to include Complex Specialist Oncology	Geoff Walsh
Draft v8	8th June 2023	Updated to reflect final option definitions	Geoff Walsh
Draft v9	18th June 2023	Updated to reflect final comments	Geoff Walsh
Final v10	28th June 2023	Updated to include revised clinical data	Geoff Walsh
Final v11	6th July 2023	Updated to include revised clinical data	Geoff Walsh

TABLE OF CONTENTS

TABLE OF TABLES

TABLE OF FIGURES

APPENDICES (SEE SEPARATE DOCUMENT)

Appendix 1 – Summary of Relevant National Legislative, Policy and Strategic Context
Appendix 2 – Summary of Relevant Haematology Context
Appendix 3 – Summary of Relevant Oncology Context
Appendix 4 – Summary of Relevant Regional and Local Context
Appendix 5 – Summary SoA and Clinical Benefits Paper
Appendix 6 – Cost Forms
Appendix 7 – Summary Economic Appraisal Outputs
Appendix 8 – Preferred Option SoA
Appendix 9 – RPA

Overview

1.0 INTRODUCTION

1.1 Overview and introduction

The delivery of a cancer system that provides excellent patient outcomes and experience is a key strategic and ministerial priority for NHS Wales.

Provision of the highest-quality, specialised services and advanced, targeted, therapeutic interventions, underpinned by cutting edge research, is an essential component in achieving this strategic imperative.

The aim of this business case is to seek investment in future proofing and co-locating the following essential specialised cancer services on the University of Wales site:

- Increased capacity for Haematology, Blood and Marrow Transplantation Services (BMT) and Advanced Therapy Medicinal Products (ATMPs) – essential services in the treatment of highly specialised cancers in Wales
- Development of a Cardiff Cancer Research Hub (CCRH) – delivered through a tripartite arrangement with Velindre NHS Trust and Cardiff University for patients who require access to early phase or complex new therapies (e.g. CAR-T)
- Development of Complex Specialist Oncology Services (CSO) – to support the care of the most unwell patients from across South East Wales who are experiencing severe side effects from current systemic anti-cancer therapy including Immuno-oncology ,and future delivery of solid cancer advanced therapies, a core component of the wider clinical model for the delivery of non-surgical tertiary oncology services in South East Wales.

Whilst investment in developing and bringing together these services is essential in delivering Welsh Government aspirations, there are a number of critical drivers underpinning the case for change which make the timing of investment critical.

The three elements of this business case, namely the BMT unit, Cardiff Cancer Research Hub and the Complex Specialist Oncology beds, are inextricably linked and must be co-located so that the required infrastructure, expertise and workforce can be concentrated and shared for the benefit of patients with all types of cancers in Wales. The existing cell therapy expertise that exists within the BMT team will be essential to support the expanding portfolio of advanced immunotherapeutic and cellular therapies in cancer clinical trials for haematology and solid cancer patients, and bringing solid cancer experts from Velindre to work seamlessly alongside Cardiff and Vale and Cardiff University colleagues will help deliver a complex, high-specification service for cancer patients, and also provide the translational pipeline that is required to bring Welsh discoveries through from the laboratory to the clinic to benefit patients in Wales.

1.1.1 Meeting JACIE Standards

Cardiff and Vale UHB is the only provider in Wales of BMT and CAR-T therapies. Maintaining JACIE accreditation is a fundamental requirement of WHSSCs service specification for BMT and CAR-T and of the pharmaceutical companies who supply the products for CAR-T. Due to environmental factors related to infrastructure, CVUHB is at risk of not retaining JACIE accreditation.

In short, if CAVUHB is unable to retain JACIE accreditation, the potential impact on the service could result in steps being taken to decommission BMT and CAR-T, which would fundamentally undermine the delivery of haematological cancer services for the population of South Wales.

1.1.2 Transforming Cancer Services across South East Wales

The development of a Cardiff Cancer Research Hub is inextricably linked to the wider development of high quality regional cancer services across the region. The development of the research hub is also a key element of the TCS programme, working with partners, and one of the recommendations contained within the Nuffield Report (December 2020). Its delivery will support the region in delivering the recommendations and ensure the full range of benefits are realised.

This business case is an essential component in enabling the wider regional clinical model for non-surgical tertiary oncology services, including the new Velindre Cancer Centre, to be fully optimised and achieve the full range of expected benefits

The remainder of this Strategic Outline Case (SOC) will establish the need for investment in more detail, appraise the main options for service delivery, and provide a preferred way forward for further analysis.

1.2 Structure and Content of the Document

This document has been prepared using the agreed standards and format for business cases. It has been developed to reflect the guidance set out in HM Treasury's Green Book (a Guide to Investment Appraisal in the Public Sector) and the Infrastructure Investment Guidance for the NHS in Wales. The approved format is the Five Case Model, which comprises the following key components:

- The strategic case section. This sets out the strategic context and the case for change, together with the supporting spending objectives for the scheme
- The economic case section. This demonstrates that the organisation has selected a preferred way forward, which best meets the existing and future needs of the service and is likely to optimise value for money (VFM)
- The commercial case section. This outlines what any potential deal might look like
- The financial case section. This highlights likely funding and affordability issues and the potential balance sheet treatment of the scheme
- The management case section. This demonstrates that the scheme is achievable and can be delivered successfully in accordance with accepted best practice

Strategic Case

2.0 THE STRATEGIC CASE

2.1 Introduction

This section provides an overview of the context within which the investment will be made. It sets out:

- An overview of the organisation – the size and role of Cardiff and Vale University Health Board and the scale and nature of the demand in the area that it serves
- The national, regional and local strategies that underpin this business case

PART A: THE STRATEGIC CONTEXT

2.2 Organisational Overview

2.2.1 Cardiff and Vale University Health Board

Cardiff and Vale University Health Board (CVUHB) was established in October 2009 as part of a restructuring of NHS Wales and is one of the largest NHS organisations in the UK. It brought together the former Cardiff and Vale NHS Trust and two former Local Health Boards – Cardiff and the Vale of Glamorgan – with the core purpose of improving health and delivering integrated health services.

Since its establishment, Cardiff and Vale UHB's priority has been to provide safe, high quality and sustainable services that compare well with the best in the world, with a focus on developing centres of excellence that support the actions needed to progress and delivery of the strategic mission 'Caring for People, Keeping People Well'.

Cardiff and Vale University Health Board is responsible for planning and delivering health services for people in Cardiff and the Vale of Glamorgan, a population of around 500,000 and is the main provider of specialist services for the people of South Wales – and for some services, the whole of Wales and the wider UK. This includes health promotion and public health functions as well as the provision of local primary care services (GP practices, dentists, optometrists and community pharmacies) and the running of hospitals, health centres, community health teams and mental health services. The Health Board employs approximately 15,000 staff and has an annual budget of £1.6 billion.

As a major teaching and research organisation, there are very close links to Cardiff University playing a significant role in the Welsh economy. This is alongside other academic links with Cardiff Metropolitan University and the University of South Wales. Training the next generation of clinical and non-clinical professionals, in order to develop expertise and improve clinical outcomes, is a key priority for the Health Board.

Figure 1: Map showing area covered by Cardiff and Vale UHB

The Health Board's hospital-based services are currently provided from the following hospital sites:

- University Hospital of Wales (UHW), which incorporates:
  - University Dental Hospital
  - Noah's Ark Children's Hospital for Wales
- UHW provides unselected emergency care, full A&E, Major Trauma Centre, critical care, specialised services and emergency and complex, elective surgery.
- University Hospital Llandough (UHL) provides selected emergency care, Mental Health Facility, Rehabilitation services and routine, elective surgery
- Barry Hospital – range of community services
- Cardiff Royal Infirmary – range of community services
- St. David's Hospital – range of community services

2.2.1.1 The Area Served and its Needs

The population served by the Health Board is:

- Growing rapidly in size, with the latest Welsh Government projections [taken from the statswales.gov.wales website] estimating an increase from 502,000 in 2021 to 521,000 in 2031, around 4%. In contrast to the previous projections published 4 years ago, the rate of growth in the Vale of Glamorgan is predicted to exceed that of Cardiff, with growth in the Vale of Glamorgan of 5.3% over 10 years compared with 3.4% in Cardiff. Actual population growth, particularly in Cardiff, will be highly dependent on progress with large housing developments
- Relatively young in Cardiff compared with the rest of Wales. The proportion of infants (0-4 years) and the young working age population (20-39 years) is higher than the Wales average; this reflects in part, a significant number of students who study in Cardiff

- Ageing – the average age of people in both Cardiff and the Vale of Glamorgan is increasing steadily, with a projected increase in people aged 85 and over in the Vale of Glamorgan of 33% over the next 10 years, and 9% in Cardiff, and
- Ethnically very diverse, particularly compared with much of the rest of Wales, with a wide range of cultural backgrounds and languages spoken. Arabic, Polish, Chinese and Bengali are the four most common languages spoken after English and Welsh. Cardiff is an initial accommodation and dispersal centre for asylum seekers

The haematology service provides a tertiary service to the wider population across South Wales and in some instances (e.g., cellular therapy) to the whole of Wales.

The following table provides the latest population statistics for Wales and Mid and South East Wales:

Key Statistics	Wales	Mid and South East Wales
Total population	3,107,500	1,728,600
Population aged 65 and over	21.3%	20.0%

Source: StatsWales.gov

Table 1: Population Base (Population and household estimates, Wales: Census 2021)

The following population data for Wales is taken from the Statistics Wales Demography Newsletter: August 2022:

- On Census Day, 21 March 2021, the size of the usual resident population in Wales was estimated to be 3,107,500
- The population of Wales has grown by 44,000 (1.4%) since the last census in 2011, when it was 3,063,456
- The rate of population growth in Wales between 2011 and 2021 (1.4%) was lower than the rate between 2001 and 2011, when the population grew by 5.5%
- There were more deaths than births in Wales between 2011 and 2021. The population growth since 2011 is due to positive net migration into Wales
- The local authorities that had the highest rates of population increase since 2011 were in Newport (9.5%), Cardiff (4.7%), and Bridgend (4.5%)
- There were more people than ever before in older age groups in Wales. The proportion of the population who were aged 65 years or older was 21.3% (up from 18.4% in 2011)
- The size of the population aged 90 years or older in Wales (29,700, 1.0%) has increased since 2011, when 25,200 (0.8%) were 90 years or older
- Between 2018 and 2020, the life expectancy for males at birth in Wales was 78.29 years, compared with 82.09 for females

The total population of Wales is projected to grow from 3,189,970 in 2022 to 3,256,957 in 2031.

2.2.1.2 Health Equity and Inequalities

There is considerable variation in health behaviours and health outcomes in the Health Board area, with variation in smoking rates, physical activity, diet and rates of overweight and obesity. Uptake of childhood vaccinations and health screening is also lower in more disadvantaged areas, and people are more likely to experience poor air quality. Life expectancy is around twelve years lower in the most deprived areas compared with the least deprived, and for healthy life expectancy the gap is twenty-two years.

Deprivation is higher in neighbourhoods in South Cardiff, and in Central Vale.

The COVID pandemic exposed these deep-seated inequalities, with impacts seen more heavily in the more deprived areas, and amongst Black, Asian and minority ethnic communities. There are also an increasing number of people across Health Board's catchment area with diabetes, as well as more people with dementia as the population ages. The number of people with more than one long-term illness is increasing.

The Health Board does not yet know the long-term health impact of the COVID pandemic on the population's health but expect there to be adverse impacts on mental well-being which could last for many years; and impacts from "long COVID". The Health Board also anticipate significant negative impacts on the wider determinants of health, for example levels employment and educational attainment; however, there may also be positive changes seen, for example in community cohesion and levels of walking and cycling.

With all these factors in mind, the Health Board has further developed a number of clinical and wellbeing strategies with the ambition to progress the integrated health and social care programme to achieve joined up care based on home first, avoiding harm, waste and variation, empowering people and delivering outcomes that matter to them.

2.2.2 Velindre University NHS Trust

One of the functions of Velindre University NHS Trust is to deliver specialist tertiary non-surgical cancer services to a catchment population of 1.5 million people using a hub and spoke service model. Velindre Cancer Services are currently provided across South East Wales in the following:

- At home: some services are delivered at home such as oral chemotherapy
- Outreach Centres: Some services are delivered on an outreach basis within facilities across South East Wales, including District General Hospitals
- Velindre Cancer Centre (VCC): The core of the Trust's specialist cancer services is a specialist treatment, training, research and development centre for non-surgical oncology

Patients are referred to Velindre Cancer Services (VCS) for treatment by the following routes:

- Following referral by a GP to the relevant Health Board, or
- Following presentation as an emergency at an A&E department

Prior to referral to VCS, all patients will have been investigated and diagnosed with a solid tumour. Some patients may have already undergone surgery. VCS's role is to deliver specialist and tertiary cancer treatment until the patient can be referred back to their host Health Board for ongoing treatment, management, and follow-up.

2.3 Business Strategies

This section summarises the business strategies for Cardiff and Vale University Health Board and related national, regional and local strategies as well as the specific strategies that relate to haematology/BMT and oncology services.

2.3.1 National Strategies

Some of the key Welsh Government policies that have shaped this SOC are:

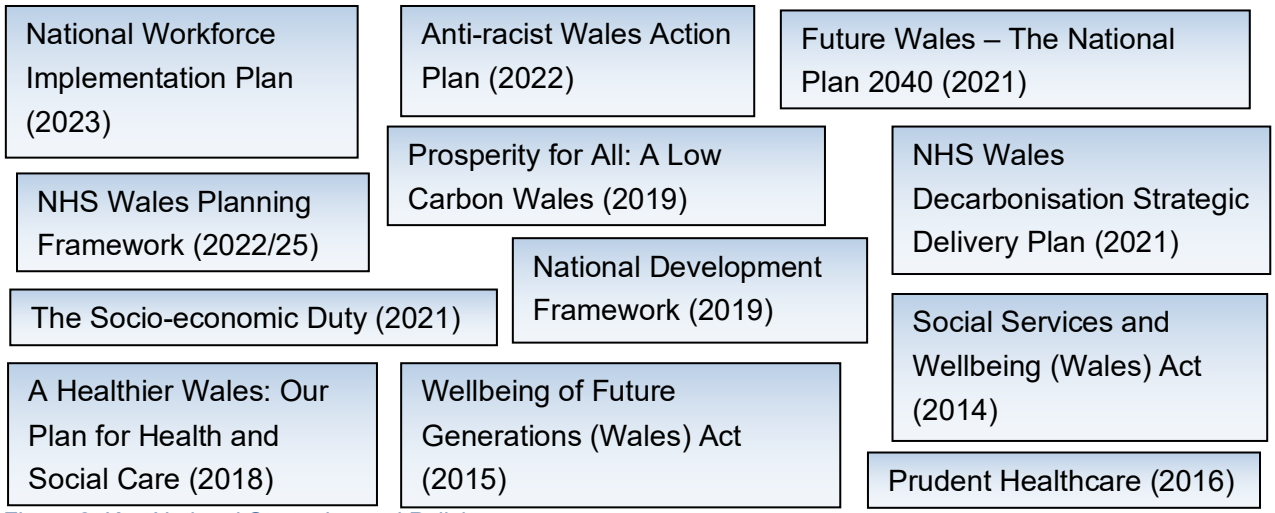


Figure 2: Key National Strategies and Policies

A summary of the above legislation, policies and strategies is summarised in Appendix 1.

This business case is supportive of the national strategies and guidance, which, given the challenges currently facing the haematology/BMT service, clearly need to adopt new ways of working for the development of a safer, high quality, effective and resilient service that addresses the needs of the population, is responsive to current and future policy direction and ensures long term sustainability. The key response to this is the development of the ambulatory care model for haematology which underpins the case for change within this business case

Development of the haematology/BMT service supports a number of national and regional strategic drivers allowing delivery of a modern, efficient, effective, responsive and more economical evidence-based healthcare, leading to better health outcomes and improved patient pathways, including diagnosis and optimising treatment for patients. Specifically:

- It supports working with research partners benefitting patients with access to more effective and targeted treatments and benefitting the NHS in terms of time and cost savings

- Ensuring the service meets the requirements of JACIE to secure its long-term future and provides improved facilities for patients
- Doing things differently: ensuring modern, fit-for-purpose facilities that enable the introduction of best practice with efficient flows and adjacencies to enable the maximum use of facilities
- Backing the NHS workforce: by providing a pleasant working environment which permits the integration of services and collaboration which permits staff to deliver services to standards that are necessary
- Getting the most out of taxpayers' investment in the NHS: ensuring services are delivered efficiently through improvements in workflows and increases in capacity

2.3.2 Context for Haematology/Bone Marrow Transplant and Advanced Therapy

NHS Blood and Transplant Strategic Plan 2022

Welsh Government: Advanced Therapies Statement of Intent (2019)

Haematological cancers: improving outcomes NICE guideline (2016)

A Strategy for the Development and Commissioning of Haematopoietic Stem Cell Transplantation Services in Wales (2011)

Facilities for the treatment of adults with haematological malignancies – 'Levels of Care': BCSH Haemato-Oncology Task Force (2009)

Figure 3: Key National Strategies & Policies for Haematology/Bone Marrow Transplant & Advanced Therapy

A summary of the above legislation, policies and strategies is summarised in Appendix 2.

Haematology (including haemostasis and thrombosis) is the study of the blood and blood-forming tissues. A bone marrow transplant replaces damaged blood cells with healthy ones. It can be used to treat conditions affecting the blood cells, such as leukaemia and lymphoma. Advanced therapy is the transplantation of human cells to replace, repair or reprogramme damaged tissue and/or cells. With new technologies, innovative products, and limitless imagination, many different types of cells may be used as part of a therapy or treatment for a variety of diseases and conditions.

This business case contributes to delivering these strategies through:

- Providing sufficient capacity to meet the clinical demand and ensure that all patients have equitable access to services across South Wales
- Ensuring the safety of patients and the quality of care through the provision of high-quality facilities that fully meet the JACIE Standards
- Providing facilities for research and development to enable the introduction of new treatment modalities, ensuring state-of-the-art cancer care for patients in Wales
- Ensuring the Health Board (that is the only centre in Wales) has capacity to continue to deliver current high-risk Advanced Therapy Medicinal Products (ATMPs) - it is envisaged that in the future demand for this type of therapy will increase as is the case in solid cancers

- Providing advanced cellular products to patients from across Wales within the haematology service. There is an urgent need for an expansion in facilities with designated beds co-located within the BMT service and with rapid access to intensive care unit (ITU) services
- Provide high-quality facilities to enable the Health Board to attract and retain specialist staff

The Welsh Government have demonstrated their support for the development of Advanced Therapies in Wales through their Statement of Intent. This Statement of Intent provides a compelling vision for a strategic approach to harness the benefits from emerging and transformative therapies called Advanced Therapy Medicinal Products (ATMPs). The intention is to create a sustainable platform to enable NHS Wales to provide patients with equitable access to emerging ATMPs, explore how this sector can contribute to the objectives of the Welsh Government's A Healthier Wales: Our Plan for Health and Social Care in Wales and deliver the full potential in the international and UK development of ATMPs'.

This project is key to support the delivery of this plan.

https://www.gov.wales/sites/default/files/inline-documents/2019-04/190409%20-%20VG%20-%20Advanced%20Therapies%20Statement%20of%20Intent%20-%20English.pdf

2.3.3 Context for Cancer Research and Oncology

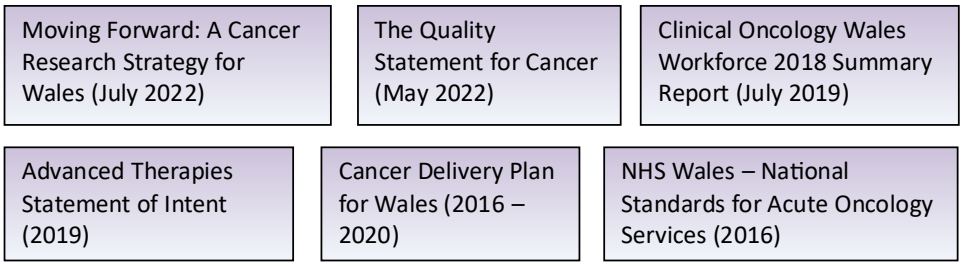


Figure 4: Key Strategies and Policies for Oncology Services

A summary of the above legislation, policies and strategies is summarised in Appendix 3.

Cancer research is research to identify causes and develop strategies for prevention, diagnosis, treatment, and cure of cancer. Cancer research ranges from epidemiology, molecular bioscience to the performance of clinical trials to evaluate and compare applications of new cancer treatments. These applications include surgery, radiotherapy therapy, chemotherapy, hormone therapy, immunotherapy and combined treatment modalities such as chemo-radiotherapy. Starting in the mid-1990s, the emphasis in clinical cancer research has shifted towards testing therapies derived from biotechnology research, such as cancer immunotherapy and gene therapy.

Clinical and translational oncology research is a most important factor in the advancement of treatments for different cancers. According to the National Cancer Institute, clinical research studies are crucial for physicians to find new ways to improve cancer treatments. It is critical to understand the role of clinical research in oncology, as it is central for leading, discovering and improving cancer treatments/interventions for people both within Wales and across the world.

Not only is there much evidence that clinical research within cancer care can provide better treatments, but it can also help researchers better understand the causes and nuances of different cancers. Patients treated in research-active healthcare settings have better outcomes and receive better care, with benefits extending to patients *beyond* those actively involved in research studies. When patients participate in clinical trials, they help add to the knowledge about cancer to improve cancer care for future patients. Clinical trials can help researchers find new ways to prevent and detect cancer, and they can also help improve the quality of life for patients during and after treatment.

One of the main benefits of clinical research is that it can allow cancer patients to gain access to new treatments faster, which could be the difference between life and death for many patients. In many situations, participation in a clinical trial is the standard of care recommended by practice guidelines depending on the patient's stage and response to other therapies. It is known that improving diagnosis in the early stages of cancer offers patients a range of treatments that have a greater chance of being curative than if their cancer is diagnosed at a later stage.

The Cardiff Cancer Research Hub (CCRH) will integrate of cancer research, innovation and education across Velindre, Cardiff and Vale and Cardiff University, jointly pushing forward agreed strategies to maximise opportunities for cancer patients in Wales to access a range of clinical and translational research studies. The CCRH will provide an optimum infrastructure and environment for patients who are involved in research to be provided with the safest and highest quality care, and will be staffed by a highly trained, integrated workforce from the three partner organisations.

Scientific research in Cardiff University will increase our understanding about the biological processes involved in cancer onset, growth, and spread in the body, and enable breakthroughs in future treatments. The CCRH will provide the space where these new discoveries can be translated from the 'bench' to 'bedside', creating the translational engine that is currently missing in Wales. This will, in turn, ensure that patients in Wales benefit early from new discoveries and therapeutics, and that Cardiff and Wales becomes an attractive place for commercial (pharma) and Third sector investment. The CCRH will provide a 'front door' to cancer research in Wales and will provide an ideal environment in which to train the next generation of cancer researchers, innovators and leaders in Wales.

The CCRH is essential to ensure research access for patients from across South Wales (and potentially the whole of Wales) to cutting edge cancer clinical trials in new and Advanced Therapy Medicinal Produces (ATMPs) and Early Phase Trials (EPTs) in It will be critical for the appointment and retention of an expert multi-disciplinary team of staff with experience in cancer care and clinical and translational research. An integrated workforce model will be adopted, bringing together Solid Cancer and Haem-Oncology researchers and research delivery teams, to ensure the best skill mix and staff utilisation (ensuring efficiencies by avoiding duplication) to both develop Welsh led research and to safely deliver these complex and high risk types of trials.

2.3.4 Regional and Local Strategies

Some of the key regional and local strategies and policies that have shaped this SOC are:

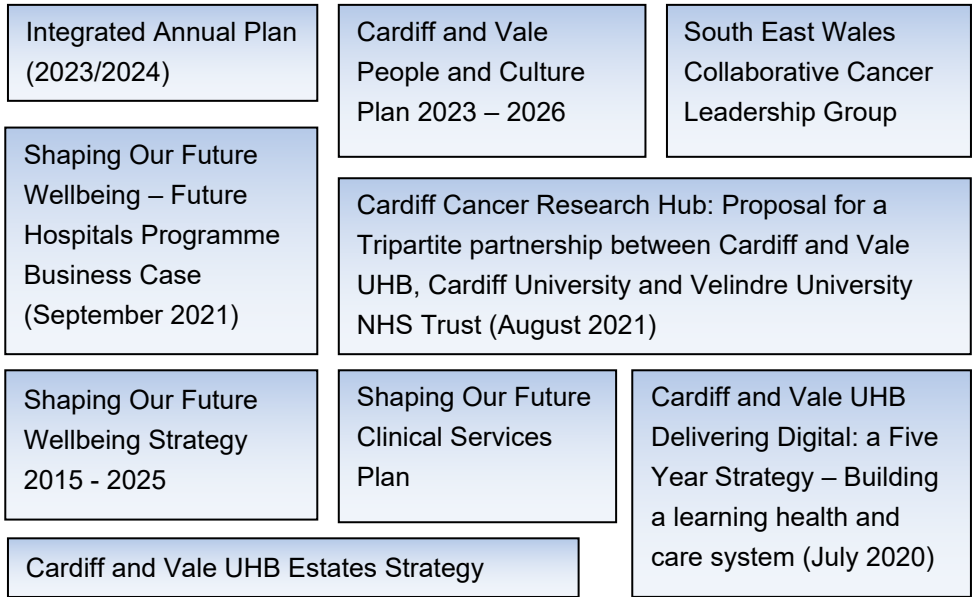


Figure 5: Key Regional and Local Strategies

A summary of the above legislation, policies and strategies is summarised in Appendix 4.

This business case contributes to delivering these strategies through:

- Supporting the key objectives of the South East Wales Collaborative Cancer Leadership Group (CCLG) which has been moving forward the joint research agenda and also improving alignment between haematology/BMT and oncology services
- Emphasising a key area of focus to deliver priority 3 of the Integrated Annual Plan (2023/2024) which is to deliver exceptional specialist and tertiary services for local, regional, and national populations, and make a commitment to develop a combined Outline and Full Business Case for the redevelopment of facilities to meet JACIE Standards and to transform patient experience in Haematology, Bone Marrow Transplant and co-locating a Cardiff Cancer Research Hub. Therefore, this case is recognised as a critical priority for the organisation
- Addressing the compliance issues for BMT which is a key estates risk and therefore features as the top priority in the estate strategy

- Assist the Health Board to meet the themes set out in the Workforce Strategy for Health and Social Care in relation to the CVUHB People and Culture Plan by improving the experience of staff working within the service
- Build upon the Shaping Our Future Wellbeing (SOFW) strategy and Shaping Our Future Clinical Services Plan in relation to providing a co-ordinated approach to transforming services for the future and delivery of improved outcomes and value-based healthcare whilst utilising innovative workforce models and introducing new technologies

2.4 Other Relevant Context/Current Projects

2.4.1 Velindre Cancer Services

The Nuffield Trust was commissioned by Velindre on behalf of the region to provide an independent view on the clinical model for non-surgical tertiary oncology services; including the preferred location of the new Velindre Cancer Centre; together with a high level view of the planning of cancer services across South East Wales. CVUHB are working closely with Velindre and other partners to ensure its recommendations are implemented. This includes ensuring the model provides safe management of patients at higher clinical risk and who require complex specialist oncology services.

There is also a requirement for patients with cancer to access complex, high risk treatment, early phase, and advanced therapy research, all of which need to take place on an acute hospital site.

This business case is to develop BMT and Haematology services to meet JACIE Standards co-located with the Cardiff Cancer Research Hub and provide beds for patients requiring Complex Specialist Oncology (CSO) care. The CCRH and CSO beds are essential components to effectively and efficiently deliver the wider the clinical model and safe clinical pathway, together with the delivery of the Nuffield Trust recommendations.

This business case is an essential component in enabling the wider regional clinical model for non-surgical tertiary oncology services, including the new Velindre Cancer Centre, to be fully optimised and achieve the full range of expected benefits.

2.4.2 Nuffield Trust report on cancer services in South East Wales

The report, published in December 2020, made a number of recommendations for implementation by the regional partners. The recommendations relevant to this proposal are:

- Recommendation 3: In the near future, each LHB needs to: develop and implement a coordinated plan for: analysing and benchmarking cancer activity against their areas advice and decision support from oncology for unscheduled cancer inpatient admissions via A&E acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission an option on a district general hospital site if needed, complemented by the Velindre@ ambulatory model, bringing models for haemato-oncology and solid tumour work together consider the lessons of Covid-19 in terms of remote access for patients and the remote provision of advice,

multidisciplinary team meetings and other methods for improving access to specialist opinion

- Recommendation 4: The new model should not admit patients who are at risk of major escalation to inpatient beds in VCC. These patients should be sent to district general hospital sites if admission is required, to avoid a later transfer. The admission criteria for inpatient admission to VCC therefore needs to be revised to reduce the risks associated with acutely ill patients. Regular review of admissions and transfers should be used to keep this and the operation of the escalation procedures under review
- Recommendation 5: The research strategy, a focus on cancer including haemato-oncology and a **hub for research needs to be established at UHW**. There would be advantages to this being under the management of VCC, but in any case, the pathways between specialists need work in order to streamline cross-referral processes. Such a service would provide many of the benefits of co-location – access to interventional radiology, endoscopy, surgical opinion, critical care and so on – albeit without the convenience of complete proximity
- Rec 6: The ambulatory care offer at the VCC should be expanded to include SACT and other ambulatory services for haemato-oncology patients and more multidisciplinary joint clinics. Consideration should be given to expanding a range of other diagnostics, including endoscopy, to create a major diagnostic resource for South East Wales that will be able to operate without the risk of services being disrupted by emergencies and which would also protect these services in the case of further pandemics
- Rec 8: The development of a refreshed research strategy is a priority and further work is required to fully take advantage of the networked model

2.4.3 Replacement of UHW

The proposed facility would unlikely be able to be linked to any new replacement for UHW. However, much of the equipment would be suitable for transfer, dependent upon the timeframe for the delivery of any new facility. In addition, the facility will enable the development of a combined specialist and multidisciplinary workforce across BMT, haematology, cancer research and complex specialist cancer care and optimise the strategic development of this workforce within UHW2.

PART B: THE CASE FOR CHANGE

This section sets out the case for change from a service and estates perspective of the wider Health Board strategy whilst setting out the spending objectives; the drivers for change and the current issues impacting on the Haematology/BMT services that will be improved by the introduction of improved infrastructure. It also highlights the benefits and risks associated with the project.

2.5 Spending Objectives

The following project spending objectives have been derived by the Project Team and agreed by the Project Board and can be evidenced as SMART (specific, measurable, achievable, relevant and time bound). Consideration has also been given to the NHS Infrastructure Investment Criteria with the objectives also providing desired outcomes such as improved economy, efficiency, effectiveness, replacement and compliance.

Spending Objective 1: Quality and Safety of Services	
Specific	Services that deliver quality care and meet agreed clinical, quality and safety standards, including: ▪ Compliance with legislation, regulations and accreditation standards / performance ▪ Supports rapid adoption of best practice ▪ Clinical effectiveness, including: o Delivering improved outcomes for patients o Supporting research & development ▪ Improves consistency in clinical practice
Measurable	Evidenced by: ▪ Continued 'The Joint Accreditation Committee ISCT-EBMT' (JACIE) accreditation ▪ Elimination of environmental issues within haematology and bone marrow transplant facilities ▪ undertaking of research in the field of cancer that can only be delivered on an acute, tertiary services hospital site ▪ Ensuring all services within the project have sufficient capacity to meet future demand in an area which is rapidly evolving ▪ Adoption of currently commissioned services for which there is no capacity and for which patients are currently being referred to NHS England (e.g., autologous stem cell transplantation for multiple sclerosis and newer NICE-approved indications for CAR-T therapy)
Achievable	By the development of new facilities that meet current standards and allow the implementation of clinical best practice

Relevant	This objective relates to the Health Board's IMTP regarding the strategic priority of taking forward service priorities. In particular delivering on the priorities of the Cardiff Cancer Research Hub, Specialist BMT services, complex specialist oncology and advanced therapy services. This business case is an essential component in delivering the wider regional model for cancer services, including non-surgical tertiary oncology services, and achieving the recommendations set out within the Nuffield Trust advice. The objective is aligned with the NHS Infrastructure Investment Guidance objectives and criteria. In particular: ▪ **Health gain:** Improving patient outcomes and providing sufficient capacity to meet future demand ▪ **Clinical and Skills Sustainability**: Supporting the delivery of safe, sustainable and accessible services, and facilitating high standards of patient care ▪ **Value for Money**: Promoting the maximum efficient utilisation of assets and improving asset condition and performance
Time-bound	This objective will be fully realised within 1 year of the facility being operational
Spending Objective 2: Provide a High Quality Environment	
Specific	To provide facilities that comply with statutory standards and best practice and enable the Health Board to deliver high quality care and provide clinical teams with the appropriate environments in which to care for patients
Measurable	Evidenced by: ▪ Improved estate performance ▪ 'The Joint Accreditation Committee ISCT-EBMT' (JACIE) accreditation ▪ Meeting design and technical standards
Achievable	Providing functionally suitable facilities with better designed and equipped space, appropriately sized to meet patient and staff expectations
Relevant	The 2023/24 Annual Plan outlines how services will develop over the next 3 years. This objective is consistent with the priorities of this plan and contributes to the development and sustainability of clinical services. This business case is an essential component in delivering the wider regional model for cancer services, including non-surgical tertiary oncology services, and achieving the recommendations set out within the Nuffield Trust advice. The objective is aligned with the NHS Infrastructure Investment Guidance objectives and criteria. In particular: ▪ **Health gain:** Improving patient outcomes and providing sufficient capacity to meet future demand ▪ **Clinical and Skills Sustainability**: Supporting the delivery of safe, sustainable and accessible services, and facilitating high standards of patient care ▪ **Value for Money:** Promoting the maximum efficient utilisation of assets and improving asset condition and performance
Time-bound	This objective will be fully realised upon the facility being operational

Spending Objective 3: Access	
Specific	To ensure that the changing needs and expectations of a growing population are met in line with Health Board clinical strategies and national guidance standards and that the solution does not destabilise other clinical services/developments. Access to services is optimised with: ▪ Service capacity that will meet demand in a timely way ▪ Services delivered in an appropriate environment
Measurable	Evidenced by: ▪ Reduced nosocomial infection rates within haematology and bone marrow transplant patients ▪ Improved access to services through appropriate use of technologies ▪ Access to new advanced therapy service to the population of Wales
Achievable	Providing functionally suitable facilities appropriately sized to meet demand with appropriate patient pathways
Relevant	This objective aligns with the IMTP through ensuring performance targets are met. This business case is an essential component in delivering the wider regional model for cancer services, including non-surgical tertiary oncology services, and achieving the recommendations set out within the Nuffield Trust advice. The objective is aligned with the NHS Infrastructure Investment Guidance objectives and criteria. In particular: ▪ **Health gain:** Improving patient outcomes and providing sufficient capacity to meet future demand ▪ **Clinical and Skills Sustainability**: Supporting the delivery of safe, sustainable and accessible services, and facilitating high standards of patient care ▪ **Health Need:** Introduction of new polytrauma and advanced therapy inpatient services
Time-bound	This objective will be fully realised within 6 to 12 months of the facility being operational
Spending Objective 4: Effective Use of Resources	
Specific	To maximise the use of available resource and provide an environment that promotes improved service efficiency through improved productivity and improved patient flows
Measurable	Evidenced by: ▪ Appropriate lengths of stay for inpatients ▪ Reduction in staff turnover/increased staff retention through provision of better-quality facilities ▪ Ability to deliver NICE approved treatments within the Health Board ▪ Services provided within the identified revenue budget
Achievable	Providing functionally suitable facilities appropriately sized to meet demand with appropriate patient pathways

Relevant	This objective relates to the IMTP by ensure delivery of financial break even through using resources effectively. This business case is an essential component in delivering the wider regional model for cancer services, including non-surgical tertiary oncology services, and achieving the recommendations set out within the Nuffield Trust advice. The objective is aligned with the NHS Infrastructure Investment Guidance objectives and criteria. In particular: ▪ **Health gain: P**roviding sufficient capacity to meet future demand ▪ **Clinical and Skills Sustainability**: Supporting the delivery of safe, sustainable and accessible services, and facilitating high standards of patient care ▪ **Value for Money:** Promoting the maximum efficient utilisation of assets and improving asset condition and performance
Time-bound	This objective will be fully realised within 1 year of the facility being operational
Spending Objective 5: Sustainability/Flexibility	
Specific	To provide a solution that will enhance the reputation of the Health Board and will support the delivery of safe, sustainable and accessible services both in the short and medium term and with built-in resilience to adapt to changing needs
Measurable	Evidenced by: ▪ Capacity to meet increased demand ▪ Rooms to be generic and flexible to meet multiple uses wherever appropriate
Achievable	Providing functionally suitable facilities appropriately sized to meet demand with appropriate patient pathways
Relevant	This objective supports the IMTP through taking forward the next steps in delivery clinical services strategy. This business case is an essential component in delivering the wider regional model for cancer services, including non-surgical tertiary oncology services, and achieving the recommendations set out within the Nuffield Trust advice. The objective is aligned with the NHS Infrastructure Investment Guidance objectives and criteria. In particular: ▪ **Health gain: P**roviding sufficient capacity to meet future demand ▪ **Clinical and Skills Sustainability**: Supporting the delivery of safe, sustainable and accessible services, and facilitating high standards of patient care ▪ **Value for Money:** Promoting the maximum efficient utilisation of assets and improving asset condition and performance
Time-bound	This objective will be fully realised within 1 to 2 years of the facility being operational

Table 2: Spending Objectives

2.6 Existing Arrangements

2.6.1 Haematology

The current Cardiff and Vale haematology service provides secondary services, including treatment of malignant and non-malignant disease, to the population of Cardiff and Vale and a tertiary haematology service to the southern Health Boards. It hosts the Haemophilia Comprehensive Care Centre for South Wales and Teenage & Young Adult Cancer Principal Treatment Centre for Mid & South Wales and the specialist inherited anaemia service.

2.6.1.1 Ward B4/A4 Haematology, UHW

This is a 27-bed ward over two areas providing inpatient services for the whole range of haematology disorders, both malignant and non-malignant, for patients aged 25 years and older. Inpatient haematology care includes all inpatient chemotherapy, cellular therapy and complication management of disease or treatment consequences. Patients under 25 years are predominantly treated on the Teenage Cancer Trust Unit, however they often require stays on the B4/A4 footprint due to capacity or clinical requirement. As a result of the changing landscape of therapies for haematological cancers, the patients requiring inpatient treatment receive more complex therapies than a decade ago. This has resulted in a heavier burden to the nursing workforce and medical oversight.

There are six isolation single rooms (HEPA filtered with positive air pressure) and two 2-bed areas (HEPA filtered with positive air pressure and shared toilet facilities) in the transplant part of the ward; and there are two single rooms (no air handling or ensuite facilities), a 3-bedded area and three 4-bedded areas on the general side with shared toilet facilities. No cubicles on B4 haematology have ensuite facilities, meaning patients can be admitted for transplant requiring up to a four week stay with only a commode and wash basin for personal care, toileting and hygiene requirements. This falls below the acceptable standard for patients undergoing BMT who are in isolation.

Since the COVID-19 pandemic, a 4-bedded unscheduled care ward has also been acquired in this footprint, currently based on A4North. This area provides four single cubicle spaces (no air handling) and includes one cubicle with ensuite toilet facilities. This segregated space has been essential to prevent and minimise the spread of infection, including but not limited to COVID-19. We have seen a marked reduction in nosocomial infections since the introduction of the unscheduled care space. Nursing establishment for both areas remain the same, as such, a total of 27 inpatient beds is maintained across the two ward areas.

Due to increasing activity in all parts of the service, and particularly in blood and marrow transplantation (BMT), there are frequently long delays for patients awaiting chemotherapy and patients frequently outlie on other non-haematology wards. General haematology data showed that 22% of elective chemotherapy admissions are delayed for bed capacity reasons with the longest wait being 10 days for a single patient in February 2023. More data are currently being collected regarding emergency admissions via A&E.

As shown in Figure 13, historical data show that up to 50% of patients awaiting BMT have waited longer than KPIs agreed with the commissioners WHSSC. As a consequence, the commissioned bed complement was increased from 8 to 10 beds in 2017 and excess waiting transiently fell to around 30% of patients. However, following the introduction of the CAR-T programme in 2019, which required the sacrificing of a BMT bed, excess waiting times for admission for BMT have crept back up to approximately 50% of patients. Figure 13 shows that these excess waits affect between 40-70 patients per annum.

The 10 WHSSC-commissioned beds within the 27 bed cohort (9 for BMT and 1 for CAR-T) are insufficient to accommodate patients requiring readmission due to complications (a JACIE Standard). As a result, post-transplant patients are readmitted into general haematology beds, negatively impacting the capacity to admit general haematology patients for life-saving chemotherapy. Whilst there are typically 3-4 BMT patients readmitted at any given time, Table 6 shows that BMT readmissions on the CVUHB site can account for up to nearly 1700 bed days per year. Despite this significant readmission rate, estimates are that an additional 30-50% of this number are unable to be readmitted and are treated at referral hospitals with remote support by the BMT team. Not only does this arrangement fall short of the JACIE Standard to have patients readmitted to the transplant centre, but the extensive daily communication also required to safely manage patients "at a distance" adds a significant burden to consultant workload. Furthermore, during the past year 3 autologous transplants were outsourced to centres in England due to lack of capacity and the service is unable to deliver commissioned activity for any new indications including multiple sclerosis, immunodeficiency disorders and the recent (2023) expansion in NICE-approved CAR-T indications.

The ward area also houses Clinical Nurse Specialist offices (spaces for 8, 10 allocated), Sister's Office and medical staff office. All spaces are cramped and over capacity. The ward also has a small patient/family room (with no amenities or facilities) which is used as a consultation space when required. Due to the immunocompromised nature of our patients, children are not allowed on the ward. This family room is the only space that young children can attend to visit their parents/ family but is not fit for purpose and can only accommodate one family at a time.

2.6.1.2 Haematology Day Centre, UHW

The Haematology Day Centre (HDC) provides day care and around 45 patients daily aged over 25 years with malignant and non-malignant conditions are reviewed daily. Post-transplant/ CART consultation is provided for all ages (over 16 years). As a secondary and tertiary facility, patients attend the HDC for medical review, chemotherapy that does not require inpatient stay, blood transfusion/ supportive care and medical procedures such as bone marrow examinations, lumbar punctures, insertion or removal of central venous catheters and collection of peripheral blood stem cells (apheresis) and exchange transfusion for patients with sickle cell disorder. The unit also acts as an initial assessment area for haematology patients presenting unwell or with treatment complications within hours, preventing this complex patient group entering emergency streams within working hours. As a result, often highly acute care is initially managed within the day unit environment for the patient population. Despite this, the day unit has no designated space for such assessments.

The day unit has a busy procedure room which houses procedures including bone marrow aspirations, PICC line insertions and intrathecal chemotherapy administration. There is no proper facility to triage patients for potential contagious infection before they walk on to the

day unit and interact with other immunocompromised patients. The current strategy is to administer a questionnaire in an open corridor (which is also a public thoroughfare) which is demeaning since it affords the patient no privacy when discussing or disclosing potentially sensitive medical issues. Once within the unit, there are limited isolation facilities on the Haematology Day Centre and any patients suspected of having respiratory spread viruses are confined to one of two cubicles during their time on HDC. These are not isolation facilities as there is no individualised air handling facility for the rooms. This severely hampers the normal flow of patients.

In 2019, the Haematology Day Unit was extended and refurbished. However, the facility continues to suffer from insufficient isolation capacity, or a designated triage and assessment area outside the main areas. Whilst the refurbishment allowed more privacy for patients undergoing apheresis procedures, due to space constraints, the layout and resulting patient flow meant that key infection control risks were not addressed. JACIE inspectors continue to report that the facilities are not acceptable in the long term as there remains inadequate isolation facilities within the design specification. This is exacerbated by the additional demand for isolation facilities in the post-COVID era. In order to meet JACIE Standards, a new build for day unit is required.

2.6.1.3 Ambulatory Care, UHW

In 2019, the Haematology Ambulatory Care Unit was created, and the facility is now housed on B1-C1 Link corridor. This is the third iteration of delivering therapy on an ambulatory basis. The unit has a total of four chair spaces: two sharing a double room; one in an isolation cubicle but without individual air handling or ensuite facilities; and the fourth located in the drug preparation and storage area, therefore impeding the work of the nurses whilst simultaneously affording the patient no privacy.

The Ambulatory Care Unit treats patients who would historically have been treated exclusively within an inpatient setting. Adaptations in treatment delivery have overcome practical challenges to allow inpatient treatment delivery in an outpatient setting as a virtual ward environment. Patients receive elective chemotherapies, autologous and allogeneic stem cell transplantation, and CAR-T therapy. Due to expansion of the indications treated within the AC setting, increased activity and scope of service, the unit is already outgrowing its accommodation and requires proper isolation facilities to maximise transplant activities within AC as well as managing those patients who present with symptoms of infection. Due to the isolation of the unit from other areas of the haematology service, additional staff are required to ensure patient safety. Co-location of the AC facility to the ward and haematology day unit would provide a more robust and safe service for our patients whilst benefitting from economies of scale regarding staffing.

2.6.1.4 Hereditary Anaemia, UHW

The HA Service is partly WHSSC funded with provision for patients with sickle cell disorders, thalassaemia, and rare inherited anaemias. There are currently 91 patients registered with the adult service although the number is increasing continually. Medical time is two sessions with support from Clinical Nurse Specialists. Currently the outpatient clinic reviews 6 or 7 patients weekly, although there is no clinic on weeks when the consultant is on ward attending. There is no medical cover for annual leave or other absence.

Since the first Peer Review, the Service has expanded to include routine elective exchange transfusion with 15 patients now on this programme. This shares the Haematology Day Centre space and the same machines that are used for stem cell harvesting. Although the CNS in HA operates the machine, this clearly impacts on BMT. There is no cover for the CNS for leave or other absence negatively impacting on BMT service provision since the BMT apheresis nurses provide ad hoc therapeutic apheresis cover for this service. There is no dedicated area to admit patients with sickle cell disorders presenting in crisis and patients often spend many hours, or even days, in the Emergency Department while in crisis.

Thalassaemia patients are now routinely transfused on the Haematology Day Centre on Saturday mornings to avoid impacting routine HDC care. This is staffed by the CNS with HCSW cover from the HDC establishment.

There is provision for MR imaging of liver iron burden through a contract with Velindre CC and Resonance Health who provide the interpretation. There is no cardiac iron monitoring available in Cardiff and patients are sent to London.

2.6.1.5 Haemophilia Centre, UHW

The Haemophilia Centre at UHW hosts the Wales Bleeding Disorder Network, which provides inpatient and outpatient care for congenital and acquired bleeding disorders (including acquired haemophilia and immune thrombocytopenia – the latter being delivered as a secondary care haematology service whilst all others are delivered as a WHSCC funded, tertiary care service). The other main patient group served by the MDT whose care is delivered by the team is TTP (thrombotic thrombocytopenic purpura). This condition may be congenital or acquired. Congenital TTP can be managed by injection of factor VIII products at home, or regular infusion of plasma. One patient with congenital TTP attends twice weekly for 8 units of plasma. Over time, the service has also started treating patients with idiopathic thrombocytopenic purpura (ITP, 2012) as well as women with a history of NAIT (neonatal alloimmune thrombocytopenia), congenital TTP or under long term follow up for immune TTP.

The haemophilia centre accommodates services for children and adults and has done so since its inception. In the last 10 -15 years it has been recognised that children and adult services should not be co-located. WHSCC has funded an uplift in the nursing and medical team to facilitate the location into dedicated accommodation for children, but the Health

Board has been unable to provide a suitable alternative children's haemophilia centre, where children can be seen, both routinely and on demand by the whole MDT. Children are required to wait in the corridor outside the centre (no seats, just a window sill) which leads to the haematology day unit. There is no dedicated children's waiting area.

The haemophilia centre for the Wales Bleeding Disorder Network comprises 1 consulting room and 2 treatment rooms (1 of which is shared with the Haematology Day Unit). Half of the original area used for patient waiting has been repurposed for storage and phlebotomy to maximise flow through the treatment rooms

The Haemophilia Centre provides varied activity to this lifespan patient cohort. This includes elective infusions of blood products, iron infusions, and factor replacement. There is no designated infusion space for people to be observed.

There is a daily walk-in service for people with bleeding disorders which covers a spectrum of problems and includes musculoskeletal bleed or gastrointestinal bleed, or difficult venous access/ central line management for example. The management of such clinical situations requires a multidisciplinary approach to care, requiring space for medical, physiotherapy and nursing assessment, investigation and management including haemodynamic stabilisation. Referral to other specialities or transfer to inpatient haematology may also be required.

2.6.1.6 Research & Development

The solid cancer Early Phase Clinical Trials (EPCTs) Unit opened at Velindre in 2012, allowing Welsh cancer patients access to Phase 1 trials closer to home (in line with Welsh Government policy), as opposed to travelling to Southampton, Oxford or London. Over the last 6 years Cardiff's Experimental Cancer Medicines Centre (ECMC) and the Wales Cancer Research Centre (WCRC) have provided funding to CVUHB and VUNHST to support Early Phase Clinical Trials (EPCTs) and Advanced Trials (ATs). Since opening, the early phase unit in VCC has conducted 40 EPCTs and has developed a track record of delivering such trials. This has improved the cancer research profile of both VCC and Wales, increasing collaboration between research institutions within Wales to deliver translational cancer research projects. Whilst the research facility is based on the Velindre site, there is no suitable area for patients having higher risk research-based treatment due to a need to be able to access high dependency care (see Nuffield Report). The strengthening of the current arrangements through the provision of high quality, networked research arrangements would enable the region to deliver on the Nuffield Trust recommendations and achieve a strategic step-change including the ambition to achieve CRUK accreditation.

The current patient pathway for research-based treatment and trials, from admission to transfer home is demonstrated below with early phase trials at VCC. The range of treatments delivered are low risk and therefore limited. A small number of moderate risk trials are now managed at UHW.

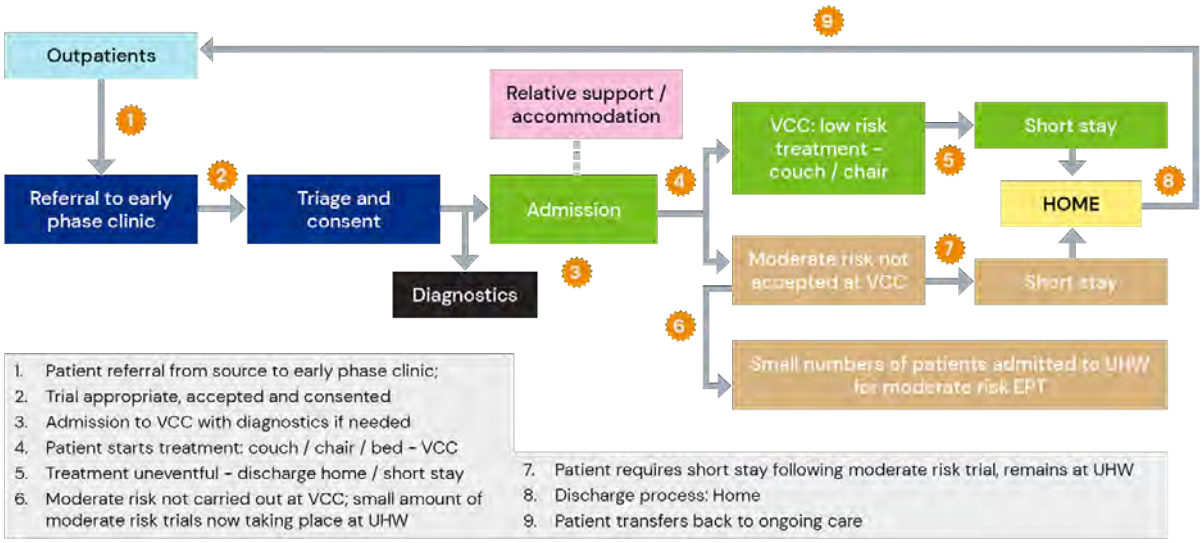


Figure 6: Current Pathway

2.6.1.7 Haematology Outpatient Clinics

All haematology clinics at the UHW site are in the main outpatient suite. Conditions are cramped and waits for blood results can be long. In some instances, two clinics are running in parallel in the same outpatient suite compounding the cramped seating arrangements.

The facilities on the UHW site were heavily criticised by the JACIE Inspectorate in the 2013 and 2019 inspections since they fall well below JACIE standards, particularly with respect to triage, isolation and protecting patients and visitors from nosocomial infections.

Track-and-Trace, a practice which became widely understood during the COVID-19 pandemic, was already a feature for many years in the BMT clinics. This was because the cramped facilities, compounded by the lack of ability to triage, led to patients being exposed to symptomatic patients for several hours prior to confirmation that symptomatic patients were suffering from infectious pathogens. This routinely led to patients being contacted after the event by the BMT clinical nurse specialists to inform them of their exposure and to direct them to their GP for treatment as indicated. Not only was this a time-consuming process, it also unnecessarily exposed vulnerable patients to avoidable harm. During calendar year 2019, prior to the onset of the pandemic in the UK, the SWBMT Programme recorded more than 60 individual incidents of potential nosocomial infection resulting directly from the lack of adequate isolation and/or triage facilities.

The COVID-19 pandemic enforced the moving of the main BMT clinics from the UHW site since it was acknowledged that the space and layout made it impossible to comply with COVID-compliant pathways and protect patients from harm. Clinics were initially held in a local private facility followed by a move to University Hospital Llandough (UHL). Whilst the clinic footprint and layout at UHL does allow for adequate spacing of patients, there is still no suitable triage facility. Additionally, due to the distance from UHW, it is challenging to admit patients who present or become acutely unwell in the clinic, potentially compromising safety.

The BMT clinic relies on a multidisciplinary arrangement with access to consultants, advanced nurse practitioners, clinical nurse specialists, dieticians, physiotherapists, occupational therapists and pharmacists in a sequence. Psychology support is also available depending on the result of screening tests. Cramped facilities, poor layout, absence of triage facilities and insufficient consulting rooms has resulted in clinics being unable to be run at UHW. Whilst the facilities at UHL meet most (but not all – particularly triage) of these requirements, the geographic distance from UHW presents operational challenges as highlighted above. A number of clinics are still run from the UHW site including donor (both sibling and autologous) evaluation, CAR-T (new and follow-up) and the graft-v-host disease clinic. There is therefore a pressing need for adequate clinic facilities that meet JACIE standards on the UHW site, not least because the regulatory requirement for a minimum follow-up of 15 years in CAR-T recipients would lead to increasing demand as CAR-T indications expand, but also because availability on the UHL site is restricted to one day of the week.

2.6.2 Transplant Service

The South Wales Blood and Marrow Transplant (SWBMT) Programme serves adults and children in the catchment area of mid, west and south Wales, accounting for nearly 80% of the Welsh population. It consists of a Clinical Programme supported by Collection and Processing Facilities. Of the 53 transplant centres in the UK and Eire, the SWBMT Programme is one of the few transplant programmes whose activities cover the entire spectrum of clinical, collection, processing and storage services. The service is delivered across two Local Health Boards – Swansea Bay University Health Board (SBUHB) and Cardiff and Vale University Health Board (CVUHB). Although part of the SWBMT Programme, the Paediatric service is separately commissioned from the adult service and provides autologous stem cell transplantation with allogeneic transplantation separately provided by transplant centres in England.

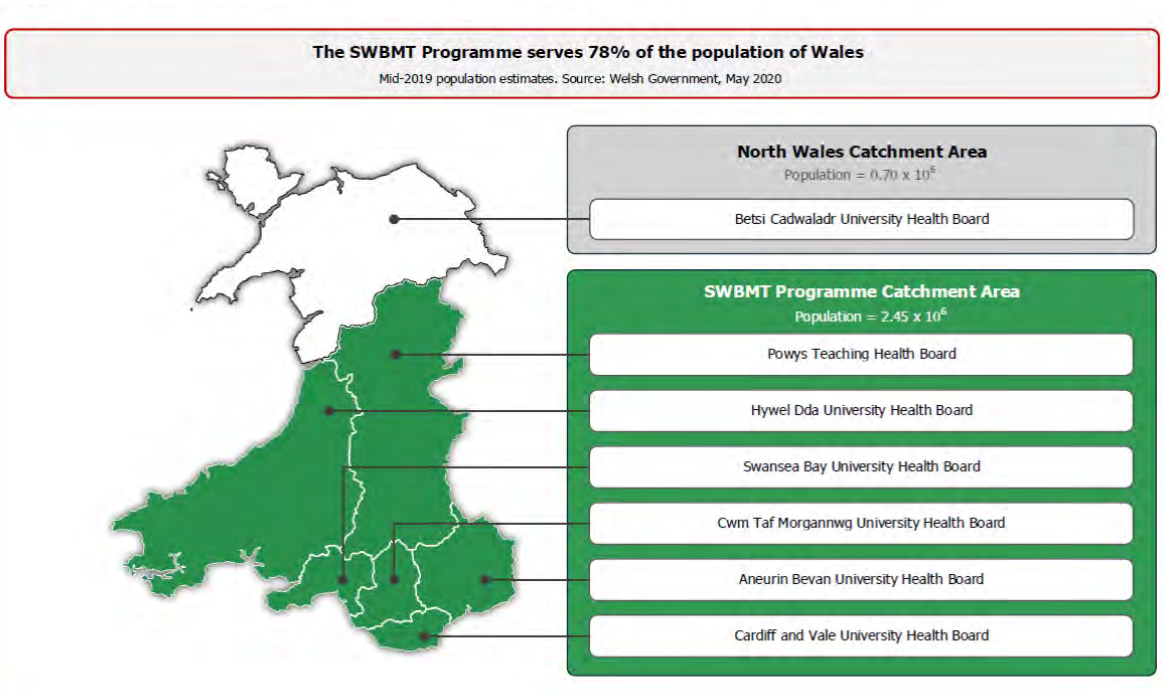


Figure 7: SWBMT Programme Catchment Area

The Programme has been licensed since 2007 by the Human Tissue Authority (HTA) [Licence number 11094] for activities pursuant to the Human Tissue Act 2007 and the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and accredited by JACIE (the Joint Accreditation Committee of the EBMT [European Society for Blood and Marrow Transplantation] and ISCT [International Society for Cell and Gene Therapy]) since 2014. Industry qualification to deliver CAR-T therapy was achieved in December 2018 and in 2019 JACIE accreditation and HTA licensing were extended to include Immune Effector Cell (IEC) therapy to facilitate commissioning to deliver CAR-T therapy on behalf of its catchment area.

The adult service performs 130-140 transplants annually (pre-COVID activity) of which approximately 100 are delivered on the Cardiff and Vale UHB site. These are evenly split between autologous and allogeneic transplants and of the latter (i.e., allogeneic transplants) approximately 80% are undertaken using unrelated donors. In 2020 Health Technology Wales approved the adoption of autologous transplantation for multiple sclerosis in Wales with an estimated demand of up to 10 patients for the SWBMT Programme catchment area.

The Programme also provides non-cellular therapy services including immunosuppressive therapy (IST) for patients with bone marrow failure syndromes, primarily aplastic anaemia and anti-complement antibody therapy for patients with paroxysmal nocturnal haemoglobinuria (PNH).

These services are summarised in the following figure:

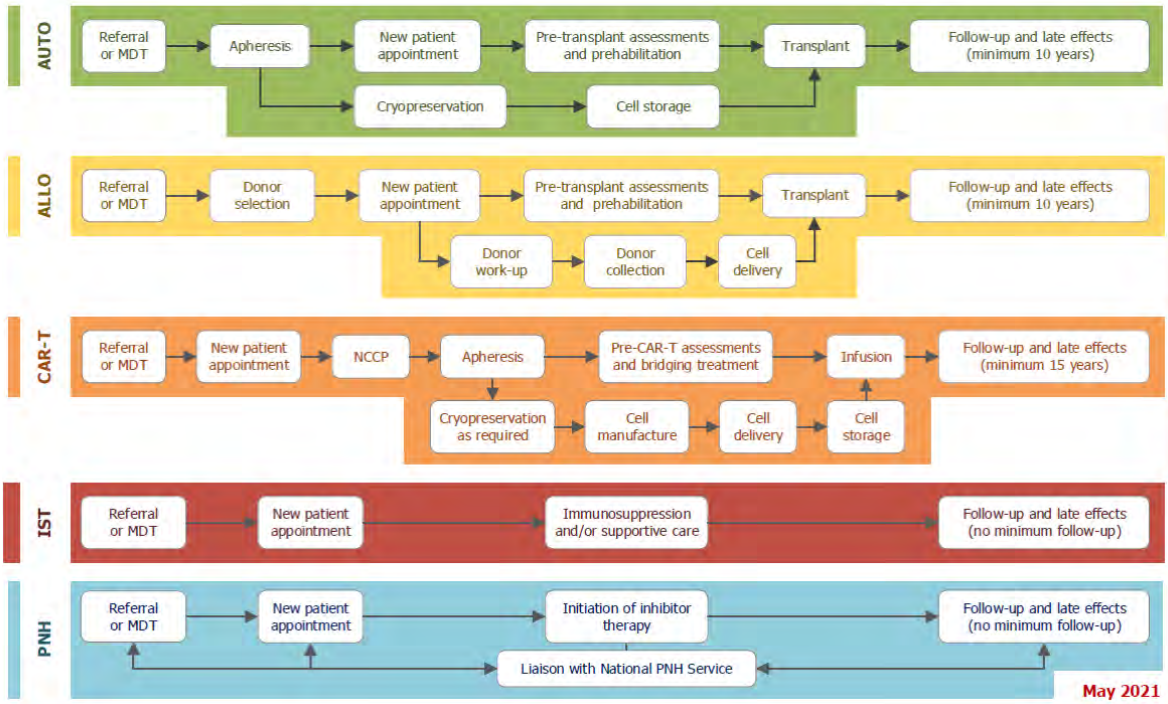


Figure 8: Summary of Services provided by the SWBMT Programme

2.6.2.1 Current Status

In addition to the transplant activity described above, in 2019 NICE approved CAR-T cell therapies for two haematological indications: large B-cell lymphoma (LBCL) after at least two prior systemic therapies (i.e., third line, 3L) and paediatric and young adult (up to age 25 years) acute lymphoblastic leukaemia (ALL). In 2021 mantle cell lymphoma was approved as an additional indication. There was a hiatus in NICE technology appraisals due to the COVID pandemic and in 2023 there has been a flurry of completed appraisals. NICE approved LBCL failing one line of therapy within 12 months, effectively moving CAR-T from the 3L to 2L. Additionally, adult ALL (age >25) was approved in 2023. Although demand for adult ALL will be relatively low at 1-3 per annum, it will raise the feasibility of repatriating adolescent ALL from Bristol since this is the age group that would normally receive allogeneic transplantation by the SWBMT Programme and expertise in treating this age-group already exists. Paediatric patients will remain under the care of Bristol. NICE also rejected follicular lymphoma as a CAR-T indication in 2023 and a myeloma CAR-T manufacturer withdrew its application with the intention of resubmission in 2024/2025, pending maturation of data from one of its trials.

Demand for CAR-T/ATMPs over the next 10 years is particularly difficult to predict with accuracy. Our own estimates had suggested a demand of 60-90 patients per annum should all indications be approved. Horizon scanning by WHSSC resulted in a similar estimate of 80 patients per annum. As indicated above and in Table 3 below, the landscape has already

changed significantly since those 2021 estimates. The biggest challenge will be dealing with demand for patients with myeloma should this indication be approved. Prior to the onset of COVID, around 66 patients received autologous transplants annually, therefore, depending on the positioning of CAR-T in the myeloma treatment pathway, demand for this indication alone could be significant. It should be noted that it is not anticipated that CAR-T for myeloma would displace autologous transplantation.

To accommodate the CAR-T programme, one of the 10 BMT beds was sacrificed to provide a single CAR-T bed. The intention was to cover the BMT bed requirement by increased use of the ambulatory model, with CAR-T bed demand modelled on the clinical trial data which led to marketing authorisation. Our own real-world evidence (RWE) showed that the CAR-T inpatient bed requirement was significantly longer than the clinical trial data such that only 10 patients per annum could be accommodated by the single bed in contrast to the predicted 14-15 patients. Indeed, it is not uncommon to have up to three simultaneous CAR-T inpatients, emphasizing the lack of and the need for surge capacity.

Indication	Estimated Demand	Comments
Diffuse large B-cell lymphoma (LBCL) following >2 systemic therapies	12 – 15 patients per year	NICE approved 2019
Paediatric and adolescent acute lymphoblastic leukaemia	1 – 3 patients per year	NICE approved 2019 Currently delivered by Bristol on behalf of catchment area
Mantle Cell Lymphoma	1 – 3 patients per year	NICE approved 2021
Adult acute lymphoblastic leukaemia	1 – 3 patients per year	NICE approved 2023 Likely to result in repatriation of adolescent patients from Bristol resulting in additional 2-3 patients per annum
Large B-cell lymphoma (LBCL) failing 1 systemic therapy within 12 months	12 – 20 patients per year	NICE approved 2023 Additional to (but will eventually replace) existing third line
Myeloma	15 – 20 patients per year	Deferred by manufacturer Demand dependent on positioning in the treatment pathway and could be significantly higher

Table 3: CAR-T Cell Therapies – Existing and Projected Demand

It should be noted that there will be ATMPs including CAR-T that would be available via the clinical trials route. Clinical trial CAR-Ts have the potential to save the NHS millions of pounds since these patients would not need NHS-funded CAR-Ts. The bed requirement (in terms of JACIE Standards) and clinical expertise would be identical to that required by NHS-funded CAR-Ts and this therefore needs to be accommodated within this development. The ability to facilitate clinical trial CAR-T therapies would also fulfil Welsh Government's

Statement of Intent on Advanced Therapies and would be compliant with the recommendations of the Lord O'Shaughnessy 2023 report on clinical trial activity in the UK.

2.6.3 The Cardiff Cancer Research Hub

There are a total of 30 in-patient beds on Velindre site. The Clinical Research Treatment Unit has 4 beds and 6 chairs. The usual activity from these beds is being managed through day-case work. The day unit has a total of 12 couch/beds for patients receiving treatment on a daytime only basis.

A solid cancer Early Phase Clinical trials (EPCTs) Unit opened at Velindre in 2012, allowing Welsh cancer patients access to Phase 1 trials closer to home (in line with Welsh Government policy), as opposed to travelling to Southampton, Oxford or London. Over the last 6 years Cardiff's Experimental Cancer Medicines Centre (ECMC) and the Wales Cancer Research Centre (WCRC) have provided funding to CVUHB and VUNHST to support cutting edge Early Phase Clinical Trials (EPCTs) and trials of Advanced Therapy Medicinal Products (ATMPs). Since opening, the early phase unit in VCC has conducted 40 EPCTs and has developed a track record of delivering such trials. This has improved the cancer research profile of both VCC and Wales, increasing collaboration between research institutions within Wales to deliver early phase and translational cancer research projects including, the generation of research income through conducting commercial trials. However, because the research facility is based on the Velindre site, there is no suitable area for patients having higher risk research-based treatment due to a need to be able to access high dependency or intensive care (see Nuffield Report). The strengthening of the current arrangements through the provision of high quality, networked research arrangements would enable the region to deliver on the Nuffield Trust recommendations and achieve a strategic step-change by achieving CRUK accreditation.

The current patient pathway for research-based treatment and trials, from admission to transfer home is demonstrated in Figure 6 with early phase trials at VCC. The range of treatments delivered are low risk and therefore limited. A small number of high and moderate risk trials are now managed at UHW, but capacity to deliver such trials is limited without an appropriate facility and integrated workforce to do so. The recent and ongoing explosion of biotech research studies, including cancer vaccines, novel immunotherapeutics, cellular and gene therapies, means there is a current and urgent need to provide facilities for delivery of such treatments to cancer patients in Wales, see section 2.6.4.2. The CCRH will provide this facility, as well as create the translational engine that is required to see new discoveries being made in Wales coming through to the clinic to benefit Welsh patients.

2.6.4 Complex Specialist Oncology

The advances in cancer care continue to accelerate rapidly and the advent of novel therapies which include immunotherapy and Advanced Therapies, which offer the ability to transform the outcomes for cancer patients across the world.

2.6.4.1 Immuno-Oncology

Cancer immunotherapy, also known as immuno-oncology, is a form of cancer treatment that uses the power of the body's own immune system to prevent, control, and eliminate cancer.

Cancer immunotherapy comes in a variety of forms, including targeted antibodies, cancer vaccines, adoptive cell transfer, tumour-infecting viruses, checkpoint inhibitors, cytokines, and adjuvants. The commonest use of cancer immunotherapy in practice currently is the use of immune checkpoint inhibitors (ICI) which are in use to treat multiple tumour sites in neoadjuvant, adjuvant and metastatic settings. In 2023/2024 there is an anticipated growth of 40% in immunotherapy treatments in the next year, with over 20 additional drug indications expected during this financial year. New immunotherapy drugs make up the majority of new Systematic Anti-Cancer Therapy (SACT) IV treatment growth. Whilst this level of growth will not continue indefinitely, newer types of immunotherapy with novel mechanisms of action and toxicities will be approved for clinical practice across tumour sites.

It is recognised that patients receiving immunotherapy can experience severe toxicities, some of whom require complex specialist oncology care.

The immunotherapy toxicity service at Velindre was established to support the early recognition of immune-related adverse events to ensure patients receive prompt treatment to ensure the best outcomes for this group of patients.

The Immunotherapy Toxicity Service (IO) offers support and treatment (e.g., relatively simple steroid treatments) which, if given at the right time, prevent what might otherwise become high grade toxicities. In more severe toxicities other immunosuppressive treatments and long-term hormone replacements are required.

This has been successful for many patients by identifying toxicities early and providing a timely response avoids the need for more intensive and invasive treatments required when toxicities develop unchecked, along with prolonged and expensive spells of hospital care.

However, in spite of early intervention and intense patient education, there remains a cohort of patients who become severely unwell and require highly complex multi-disciplinary inpatient care at UHW or other Health Boards. As a consequence of the wide-ranging use of IO treatments, this group of patients has become more prevalent over the last 12 months. Typically, they may present with symptoms including Neurotoxicity, Cardiotoxicity Pneumonitis and Endocrine failure.

Current Activity

The Immunotherapy Toxicity Service (IO) provided by Velindre Cancer Services was set up in 2021 and was fully implemented from September 2022 and current activity levels are set out below:

		Baseline	Year 1	Year 2
		2020/21	2021/22	2022/23
Patients Nos. Immunotherapy Treatment		450	630	882
Patients with severe toxicities	30%	135	189	265

Table 4: Estimated IO Activity

The data shows an estimated 49% growth in patients receiving severe toxicities from the baseline of 2020/2021 (135) to 2022/23 (265). These patients stay on treatment for several months, with an average of 6 months on treatment, although this varies widely depending on the response to treatment.

One of the main differences between checkpoint inhibitor immunotherapy and many other forms of SACT is the possibility of durable survival and possible cure in Stage 4 metastatic disease.

The acute oncology service data for 2021/22 identified 141 presentations for treatment at UHW following treatment related symptoms i.e., toxicity. The average length of stay was 13 days with the longest being 281 days.

Whilst the data have some quality issues with the identification of grade 3 and 4 toxicity not always clearly identified clinicians confirm that approximately 3 – 4 patients are attending per week with toxicity/severe toxicity which require admission to support their care with an average length of stay of 13 days.

The diagram below sets out the current service arrangements in place to support the ambulatory management of patients receiving solid tumour immunotherapies:

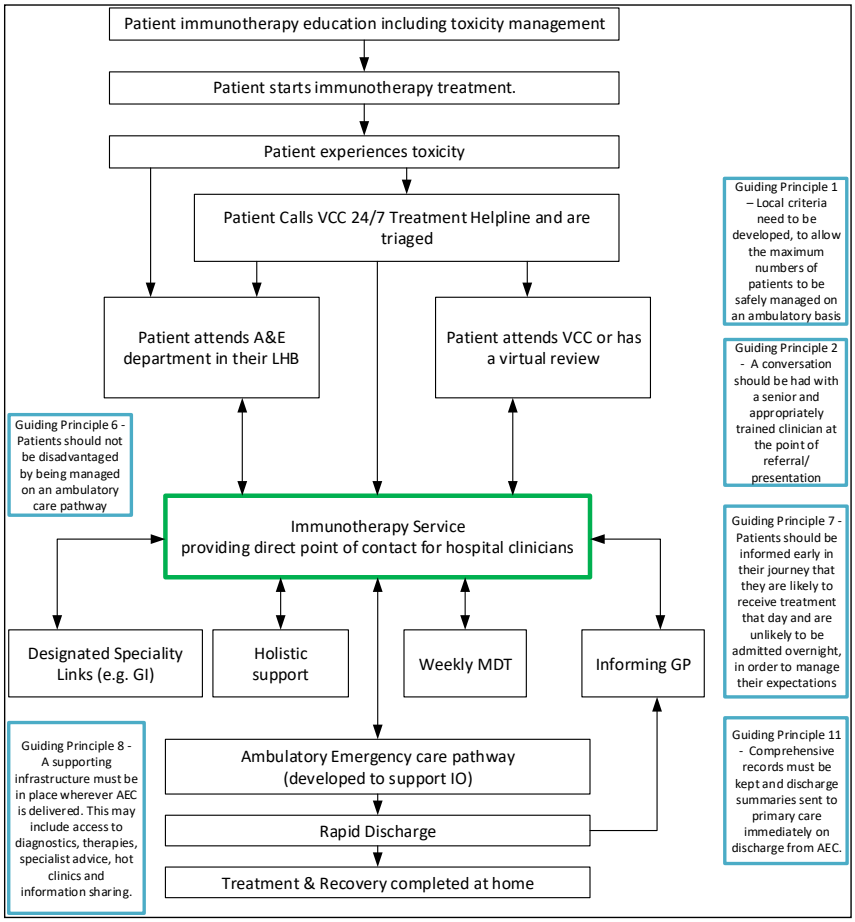


Figure 9: Existing arrangements for patients receiving Immuno-Oncology therapies

2.6.4.2 Advanced Therapies/ Advanced Therapy Medicinal Products (ATMPs): the next phase of new treatments in Wales for solid tumours

In 2019 the Welsh Government published a Statement of Intent which set out a compelling vision for a strategic approach to harness the benefits from emerging and transformative therapies called Advanced Therapy Medicinal Products (ATMPs).

An ATMP can be either:

- Gene therapy (i.e., the transfer of genetic material into the cells of a patient's body to treat the cause or symptoms of a specific disease)
- Cell therapy (i.e., the transfer of intact, live cells into a patient to help lessen or cure a disease). The cells may originate from the patient or a donor
- Tissue engineered product (i.e., a regenerative medicine that replaces or regenerates human cells, tissues or organs to restore or establish normal function)

ATMPs offer significant promise for the long-term management and improved outcomes, especially in areas of high unmet medical need. The current clinical treatment approaches to cancer, heart disease, diabetes, stroke and other conditions will be changed by ATMPs. These therapies will impact many treatment pathways by exploiting techniques and methods to repair, replace, regenerate and re-engineer human genes, cells, tissues or organs in order

to restore or establish normal function. Future plans will need to consider other advanced therapies and parallel healthcare innovations that will affect strategic implementation.

In solid cancer, ATMPS are the subject of ongoing clinical trials across the UK and globally. These treatments are not currently provided in Wales, but it is expected that many will be approved by NICE over the next few years. This will see a wider range of cell and gene therapies available for the treatment of solid tumours which will continue to accelerate over the next decade.

2.7 Business Needs

2.7.1 Scope of service

2.7.1.1 Haematology/BMT

The service is governed by national and international regulatory bodies, including, but not limited to, the Human Tissue Authority (HTA) and the Joint Accreditation Committee of the ISCT and the EBMT (JACIE). The service has had biennial inspections by the HTA since 2007 with the next inspection due in mid-2023; and by JACIE in 2013 and 2019 with the next inspection due in 2025, submission for which needs to be completed in 2024.

The physical fabric of the adult service on the UHW site was heavily criticised by the JACIE Inspectorate in the 2013 and 2019 inspections and had it not been for the excellent clinical outcomes, the Programme would have been recommended for closure following the 2019 inspection.

The current inpatient, day care (Haematology Day Centre) and outpatient facilities (particularly on the UHW site) will likely again fail JACIE Standards on triage, isolation and patient facilities given that no material improvement has occurred following earlier inspections. Since BMT is integrated closely and shares inpatient, ambulatory, day care and outpatient facilities with the rest of haematology, it is logical to pursue an integrated solution that might allow colocation of inpatients, day care, ambulatory care and outpatients across haematology services at the UHW site.

2.7.1.2 Cardiff Cancer Research Hub (CCRH)

The overall ambition is to work in partnership with VUNST, CVUHB, Cardiff University (CU) and other stakeholders in the development of a Cardiff Cancer Research Hub. There are key associated clinical research work programmes suggested within the Hub including the delivery and development of EPCTs and trials of ATMPs (Haem Onc and Solid Tumour) and a harnessed approach (NHS and Academia) for translational research.

Both the Hub and these areas of research have the scope to address the requirements and improve research access for patients in South Wales and beyond, bringing 'benefits and success for all'

2.7.1.3 Cancer Research and Development Ambitions:

Velindre University NHS Trust (VUNHST), Cardiff and Vale UHB (CVUHB) and Cardiff University (CU) have a shared ambition to work in partnership together and with other partners to develop a CCRH. Cancer research in South-East Wales and beyond is considered by clinical and academic teams (as well as the Nuffield Trust Report) to be at a crossroads and a joined up tripartite approach and investment is needed, to make it competitive on the UK cancer research stage. The CCRH will provide focus and facilities for cancer research in Cardiff including:

- Delivery of Early Phase Clinical Trials (EPCTs) and Advanced Therapies (AT) for solid cancer and haematological malignancies, with access to HDU/ITU and specialist services (e.g., surgery, cardiology, immunology, gastroenterology) to manage the complications of therapy and enabling collaboration between solid cancer and haem oncology research
- Delivery of complex late phase research trials which require access to specialist services
- Enabling 'closer working with the university', bringing academic and NHS researchers together and creating the translational pipeline required to bring new discoveries from the laboratory to the clinic in Wales
- Complementary to the research, education and innovation opportunities created by nVCC and the collaborative centre for learning
- An enhanced, integrated, multi-disciplinary Clinical Academic workforce, developing future research and research leaders
- Education and training, inspiring the next generation of cancer researchers in Wales
- Space for associated research infrastructure/partners in Cardiff/Wales

2.7.1.4 Joined-up Tri-partite Approach:

Clinical, academic and executive teams are at an important stage in their joint ambitions to create a functioning CCRH. To succeed they need a joined-up tripartite approach and investment to be competitive on the UK cancer research stage. Previous centre bids from Cardiff to Cancer Research UK (CRUK), the largest single funder of cancer research in the UK were unsuccessful in 2015, 2019 and 2021, and identified that lack of focus and critical mass of cancer researchers, and the absence of a clear translational pipeline from 'bench to bedside' in Cardiff as barriers to securing CRUK funding. The CCRH aims to overcome these barriers to make Cardiff and Wales attractive for future investment, not only from CRUK, but also from other Third Sector funders and commercial companies.

Establishing the CCRH, as a new infrastructure to deliver cancer research in Wales, is one of the recommendations in the first, all-Wales Cancer Research Strategy (CReSt), led by Health and Care Research Wales (HCRW), that was launched in July 2022. The strategy recognises that building on existing research strengths in Wales and establishing closer links between the NHS and academia to enable the translational pathway from discovery science to the clinic, are fundamentally important developments for Cardiff and Wales.

There is clear governmental and organisational commitment to developing the CCRH. Welsh Government's approval for the outline business case (OBC) for the new Velindre Cancer Centre in March 2021 was contingent on a number of required actions by the Trust and its partners and as outlined in the Nuffield Trust report on non-surgical tertiary oncology services in south east Wales – these included the "establishment of the research hub at UHW for patients requiring complex systemic treatments" as well as closer working with haemato-oncology services which will be enabled by the Hub and regional research network.

Partnership Boards have been convened between CVUHB, VCC and CU and a key focus of these Boards is the establishment of the CCRH, associated work-programmes and workforce models for delivery.

2.7.1.5 Complex Specialist Oncology

The development of novel cancer immunotherapies for the treatment of metastatic and high-risk adjuvant cancers has facilitated long term responses and cures in subsets of patients with cancer. In particular the immune checkpoint inhibitors (ICIs) which are designed to enhance the immune response to fight the cancer have improved patient outcomes throughout many site-specific cancers. These ICIs are associated with severe immune related side effects which can occur for up to 2 years after treatment and can be life threatening. Side effects can occur in any organ or system in the body and require prompt intervention and specialist advice.

So, whilst immunotherapies (currently) and advanced therapies (in the future) provide potential durable long-term survival outcomes and potential cure for some patients even with stage 4 disease, there needs to be provision of care for management of toxicity that is secondary to chemotherapy, and which can be life threatening and permanent. These treatments are increasingly used with earlier stage cancer, often in combination, increase cure rates (i.e., not only stage 4 cancer).

Approximately 60% of patients on combination treatments in clinical trials develop severe toxicities (grade 3 and 4). Whilst the IO service in South East Wales (through the SDEC programme) has successfully created patient pathways to educate, prevent and manage toxicities in a proactive fashion, a cohort of patients will still become extremely unwell requiring expert inpatient care. Early recognition and appropriate, timely management of such toxicities would reduce the risk to patients of their health deteriorating or even of death.

Therefore, the provision of these treatments requires a new service to manage this level of toxicity and patients who become severely unwell. These include:

- Improved and standardised local pathways for investigating and managing toxicities which often led to delay in appropriate investigations (e.g., endoscopy for colitis).
- Enhanced access to high dependency, critical and intensive care facilities to manage patients who become severely unwell following the receipt of immunotherapy treatments and advanced therapies/ATMPs.

- Enhanced access to multi-disciplinary teams who can manage severely unwell patients (will include haematologists; acute medicine; intensivists and oncologists).

The number of patients requiring this level of care will continue to grow over the next 5 – 10 years as:

- The Number of NICE approved immunotherapies including ATMP's increase.
- Velindre Cancer Service provide more solid tumour immunotherapies to patients who would benefit from them
- The incidence of cancer continues at its forecast rate
- The benefits of the immunotherapies and advanced therapies (when administered in Wales) are realised. This will see an increase in survival rates and patients staying on the immunotherapies for longer periods of time with the risk of becoming severely unwell a constant one

2.7.2 Service Vision

2.7.2.1 Haematology/BMT

The current haematology service fails to meet national and international standards for the care of patients with haematological malignancies due to a severe lack of space, no specialised isolation facilities, inability to clean outdated facilities to modern infection control standards and no area to triage patients before they mix with other immunocompromised patients.

The vision is to provide safe, timely, compassionate and comprehensive care in an environment suited to the management of patients with leukaemia, myeloma, lymphoma, sickle cell disease, bleeding disorders and those who are having blood and marrow transplantation, CAR-T therapies or other ATMPs. This requires an increase in the number of beds, provision of isolation facilities in the ward, day centre, ambulatory care and outpatient settings, and separate, but neighbouring, facilities for patients with inherited bleeding disorders.

In addition, the vision is to provide more Welsh patients with access to cutting edge advanced cellular therapies, some of which remain experimental while others are already commissioned within the NHS.

For example, the treatment landscape in myeloma is constantly changing with many new and exciting therapies becoming available via the clinical trial or compassionate route. A compassionate use scheme for Talquetamab, a new bi-specific antibody, has just opened for patients with myeloma and the first recipient is already scheduled for treatment the week beginning 10 July 2023. However, this treatment is given on days 1, 4, 8 and 11 and, with side effects similar to but of less intensity than CAR-T recipients, i.e., cytokine release syndrome (CRS) and immune effector cell associated neurotoxicity syndrome (ICANS), patients would need hospitalisation for 48 hours after each dose. CVUHB is likely to be the

only Welsh centre authorised to deliver Talquetamab with obvious implications for bed numbers.

There is an informal arrangement that non-BMT haematology patients receiving novel therapies with CAR-T-like toxicities would be nursed in one of the BMT/CAR-T beds to benefit from nursing expertise and to maximise patient safety; however, as Table 7 demonstrates, there is almost complete lack of elasticity in the system with virtually no surge capacity, requiring intense patient triaging to enable these therapies to be delivered.

Multiple myeloma is the single most common indication for transplantation with around 66 patients receiving autologous transplants annually pre-pandemic. Should novel therapies be available for these patients (whether before or after transplantation) there would be significant bed pressure which we would not be able to alleviate – potentially depriving patients of life-prolonging therapies.

Not only is there early promising data of bi-specific antibody therapy in myeloma (for example, patients on the Magnetismm-5 and Elranatanab trials) there is also promising data in patients with diffuse large B-cell lymphoma who fail (or are ineligible for) CAR-T therapy. Thus, patients originally destined for palliation have an increasing number of therapeutic options.

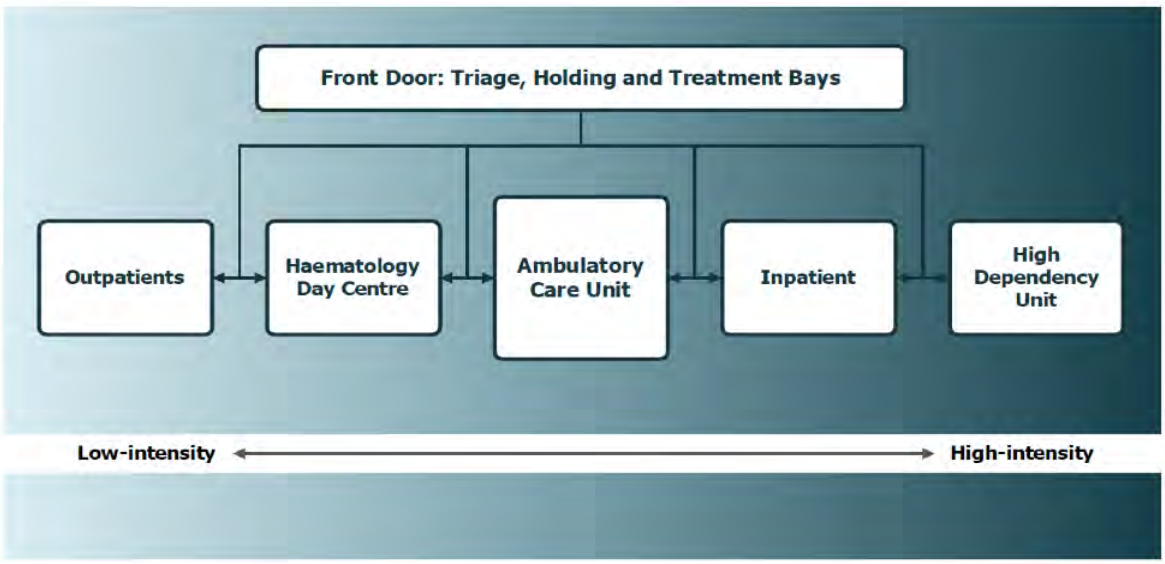


Figure 10: Future Service Vision

Figure 10 shows the desired layout in schematic form, intending to benefit from economies of scale due to service co-location, triaging and "flexible" transitioning from the lower to higher intensity aspects of service delivery. To insulate against uncertain and fluctuating demand, the aim is to treat most patients in the ambulatory setting.

The SWBMT Programme is currently commissioned to deliver 12-15 CAR-T therapies per annum in addition to its commissioned transplant activity. However, the Programme is

unable to accommodate the additional NICE-approved CAR-T indications in 2023 – large B-cell lymphoma in second line and adult acute lymphoblastic leukaemia which together would account for an additional 13-23 patients per year. As indicated earlier, horizon scanning both internally and by WHSSC, suggests that this number could rise to approximately 80 per annum should all indications currently pending a Final Appraisal Determination be approved by NICE.

The Programme is currently unable to accommodate this anticipated increase in CAR-T activity being already unable to accommodate autologous transplantation for multiple sclerosis (up to 10 patients per annum) despite this being approved by Health Technology Wales since 2020. Without an urgent infrastructure upgrade, Welsh patients would potentially be denied access to effective therapies or may need to travel to England, falling foul of Welsh National Cancer Standards.

CAR-T indications for a wide range of haematological malignancies in addition to projected activity in solid tumours and non-haematological indications are currently being considered. The vision of the SWBMT Programme is to support the delivery of ATMPs including CAR-T therapy and other therapies with similar toxicity profiles for patients across South and Mid Wales. This would provide a platform to train and expand a specialist workforce and ensure compliance with regulatory standards.

2.7.2.2 Advanced Therapy Medicinal Products

Advanced Therapy Medicinal Products (ATMPs), as defined by the EU Parliament and Council Directive 2001/83/EC (and as amended by Regulation (EC) No 1394/2007), include any or a combination of the following:

- A gene therapy medicinal product (GTMP)
- A somatic cell therapy medicinal product (SCTMP)
- Tissue engineered product (TEP)
- A combined ATMP

One of the main reasons for the keen interest in ATMPs is the promising early results in patients with relapsed or refractory haematological malignancy – i.e., those normally destined for a palliative approach. For example, the recently updated ZUMA-1 phase 2 trial on the CAR-T axicabtagene ciloleucel (axi-cel) in the treatment of refractory/relapsed large B-cell lymphoma patients who had failed at least two prior lines of systemic therapy showed that after 5 years of follow-up, a survival plateau of 42.6% was maintained with a median survival of 25.8 months. These findings imply that a significant proportion of these survivors are probably cured. What is remarkable is that this population of patients would normally be destined for palliative approaches with a median life expectancy of around 6 months.

Additionally, when compared head-to-head in a phase 3 randomised trial with autologous transplantation in the second line for higher risk patients failing first line therapy within 12 months, axi-cel improved both progression-free and overall survival, effectively displacing

autologous transplantation which stood as the standard of care for nearly 30 years. It is therefore imperative that we have capacity to deliver these products for Welsh patients to benefit from innovative lifesaving and potentially curative technologies.

The conditions to be met to be a CAR-T delivery centre in the UK include:

- JACIE accreditation (to include delivery of immune effector cells, IECs)
- Being an allograft centre (recently relaxed by NHSE to include large autograft centres)
- Having on site ITU facilities of an adequate size and proximity to the treatment centre
- 24h on-site neurology service

The SWBMT Programme achieved qualification by Kite-Gilead as a CAR-T delivery centre in December 2018 – one of the first in the UK to achieve this status. Qualification by other CAR-T manufacturers with a UK marketing authorisation subsequently followed. As the only BCSH (British Committee for Standards in Haematology) Level 4 centre in Wales, no other Welsh centre has the infrastructure or expertise to deliver current CAR-Ts with existing side effect profiles. Whilst future ATMPs with lower side effect profiles may be deliverable elsewhere, there would still be infrastructure and training requirements, emphasizing the need for sufficient capacity on the UHW site both for clinical delivery and to facilitate the SWBMT Programme's vision to serve as a treatment and training platform for all of Wales.

Due to the complex manufacturing process, ATMPs are very expensive, with list prices in the region of £250-300K. Actual UK prices are commercial in confidence having been negotiated by NICE. Due to the significant side-effect profile which requires bespoke care pathways, delivery costs range from £50-100K. Therefore, even with negotiated discounts by NICE these products remain expensive both to procure and deliver given that they are effectively "single-batch" products, with each CAR-T manufactured for a single, specific patient. Pharmaceutical companies are therefore keen to establish novel pathways of access given that these are not conventional pharmaceuticals and do not conform to standard commissioning models.

In conjunction with VUNHST, the SWBMT Programme was selected as a site for delivery of the SOTIO trial, a phase 1 first-in-human trial evaluating a new CAR-T for solid tumours. The SWBMT Programme has also been selected as a site for the CARTITUDE-6 trial which will evaluate CAR-T v standard of care for the first line treatment of multiple myeloma. It is essential that the programme has capacity to undertake these and related clinical trials due to the potential to save NHS Wales millions of pounds given that the therapy is typically made available free of charge when delivered under the auspices of a clinical trial. For example, in the CARTITUDE-6 trial, not only would the CAR-T be available free of charge, but so would be the drugs in the "standard-of-care" arm, many of which are not available on the NHS in the UK.

2.7.2.3 Cardiff Cancer Research Hub (CCRH)

The main aims of the CCRH will be:

- To increase patient access to research, including early phase clinicals trials and trials of advanced therapies medicinal products (ATMPs) trials for solid cancer and haematological malignancies
- Enabling trials of any phase that need access to specialist services at Cardiff and Vale including surgery, radiology, endoscopy, pharmacy and/or high dependency
- Enabling scientists at Cardiff University to bring new discoveries through to the clinic to benefit patients by strengthening the 'bench to bedside' translational pipeline
- Developing a focus for cancer research excellence in Wales to enhance the collective reputation, attract future funding from third sector and Pharma and inspire, train and retain the next generation of cancer researchers

2.7.2.4 Complex Specialist Oncology

It is clear that the world of cancer care is changing rapidly across all aspects. This is no different in the world of oncology and specifically the provision of advanced therapies for solid tumours in cancer patients across South East Wales.

A complex specialist oncology service is required to support the care of this cohort of patients who have the potential for experiencing severe complex side effects from systemic anti-cancer therapy including immunotherapy and to support the introduction of advanced therapies/AMTPs in Wales in the very near future (e.g., CAR-T).

The provision of this service development is inextricably linked to the development of advanced/complex therapies in cancer services and will support the cohort of patients across South East Wales being offered/receiving them.

As the range of new treatments grow and become approved by NICE and the All Wales Medicines Group, and the amount of translation and clinical research increases and proves efficacious, there is potential for these new treatments to move into the 'Business as usual/routine treatments' category of cancer treatment.

As the service becomes more expert at managing these complex toxicities, the incidence may reduce over the next 5 – 10 years, however the anticipated introduction of advanced therapies/ATMPs such as CAR-T cell will introduce a new level of activity with intensive inpatient management for both treatment delivery and toxicities. Similar to haematological malignancies, solid tumour CAR-T cell therapy can only be delivered in a JACIE accredited BMT unit and will require the expertise of haematological oncologists working alongside Advanced Therapy trained oncologists.

The development of this service is relatively easy to achieve as it simply builds upon the good foundations and care pathway currently in place in Cardiff. An additional element would be added to the current pathway (to essentially form a new pathway for complex specialist oncology patients) and would preferably see:

- A dedicated small footprint of between 2-4 beds in UHW.
- Velindre Cancer Service oncologists accessible on-site at UHW to provide oncology expertise for the care of these patients.
- Co-located/adjacent to the haematology unit and Cardiff Cancer Research Hub to allow the multi-disciplinary workforce to effectively best manage their care and avoid any duplication of the workforce due to inefficient work plans with access to:
  - Critical/intensive care facilities
  - Haematologists; acute medicine; surgery; intensivists; palliative medicine and work as a multi-disciplinary team with oncologists and other related professionals
- Operating as local service with the ability to flex to meet regional needs at UHW subject to commissioning discussions with partner Health Boards

The pathway of care would be slightly amended to include the additional capability and capacity of the system would be enhanced to deal with the current and future needs of solid tumour immunotherapies and future advanced therapies/ATMPs.

The new service has been termed complex specialist oncology service. This is distinct from the acute oncology service as it is defined by the Complex Specialist Need and the patient acuity. This service will support the care of the most unwell patients from across SE Wales who are experiencing severe complex side effects from the systemic anti-cancer therapy, or who require access to early phase or complex new therapies (e.g., CAR-T).

Alignment with Acute Oncology Services

Whilst the patients within the complex specialist oncology service are a defined cohort, the service will be aligned with the acute oncology service to ensure a comprehensive approach, allowing effective and efficient use of the multidisciplinary workforce and ensure that any potential duplication is avoided.

This development was highlighted in the Nuffield Trust Independent Advice and is intended to complement the regional acute oncology service which is being implemented across South East Wales. Similar services have been established in other parts of the UK in peer systems e.g., Manchester Cancer Alliance, South East London Cancer Alliance.

2.7.3 Current Issues / Challenges

2.7.3.1 Haematology/BMT

Demand for transplantation and general and malignant haematology has grown steadily over recent decades. In 2020 there was a decline in transplant activity internationally due to the impact of the COVID-19 pandemic with recovery in subsequent years reaching near pre-pandemic levels in 2022. It is projected that 2023 transplant activity will reach or surpass 2019 (pre-pandemic) levels. Exceptions to the pandemic decline were allogeneic transplantation given that this is largely undertaken in patients with aggressive haematological malignancies and CAR-T therapy which is reserved for patients not in remission and whose therapy cannot be successfully postponed.

It is therefore anticipated that cellular therapy activity will continue to increase further due to continuously improving outcomes as a result of better supportive care, an increase in the range of treatment regimens available, the ability to deliver curative treatments to older patients (who bear the greatest burden of haematological cancer) and improved allogeneic donor availability resulting from improvements in HLA typing as well as the successful application of haploidentical family donors for patients lacking a conventional donor.

However, capacity to provide a timely service remains a challenge. This has resulted in increased waiting times for admission to the ward and delays in transplantation. To minimise the impact there are weekly planning meetings to review and triage patients on the waiting list. Although this has lessened the impact of the infrastructure deficiencies, it consumes inordinate amounts of senior clinician time and there are inevitable breakthrough relapses on the waiting list in some instances precluding transplantation and leading to premature death.

The introduction of a CAR-T programme has compounded the capacity issues. As indicated earlier, a BMT bed was sacrificed to make room for CAR-T patients with the intention that this would be mitigated by increased use of the ambulatory care model, reducing dependency on traditional inpatient beds. Whilst the ambulatory model has proved successful, there are limitations, chief of which is the requirement for patients to reside within one hour of the cellular therapy centre. Only 20% of patients treated on the UHW site have a local postcode so the majority of patients would need an accommodation option. Whilst the use of local hotel accommodation has been helpful, there is an additional requirement for patients to be accompanied whilst in residence to ensure that there is someone to arrange urgent transfer to hospital in the event that they become incapacitated. The net effect is continued lack of sufficient surge capacity despite the ambulatory model saving 748 bed days in calendar year 2020.

In addition to capacity constraints, the existing inpatient, ambulatory, day unit and outpatient facilities remain inadequate with regards to provision of hygiene facilities, triage, isolation and protection of patients from nosocomial (hospital-acquired) infection. This has resulted in unnecessary exposure of immunosuppressed patients to infection resulting in additional treatment, morbidity and mortality.

A new physical infrastructure, including an expanded ambulatory model of treatment delivery, will meet current and projected future demand, offer insulation against uncertainties in future demand whilst addressing health and safety deficiencies.

There is a pressing need to provide an appropriate JACIE-compliant environment for BMT and CART activity on the UHW site at CVUHB for the following reasons:

- International standards for cellular therapy services (transplantation and CAR-T) are defined by FACT-JACIE Standards. There is published evidence demonstrating that clinical outcomes are better in JACIE-accredited centres when compared with non-accredited centres. Indeed, outcomes also improve in centres preparing for JACIE accreditation demonstrating that the discipline involved in becoming "JACIE-

compliant" improves outcomes providing direct evidence that the adoption of quality standards improve clinical outcomes (Gratwohl et al, Haematologica 2014,908-915).

- Commissioning bodies in the UK have made JACIE accreditation a prerequisite for providing BMT and CAR-T services and WHSSC have introduced this criterion in their BMT Service Specification. Therefore, lack of JACIE accreditation would necessitate closure of the BMT programme with the attendant loss of revenue and loss of reputation for Cardiff and Vale UHB, Welsh Government and for Wales.
- The JACIE Inspectorate in 2013 declared the physical infrastructure of the adult service on the CVUHB site "shabby and well behind the curve" compared with other UK centres. Following the 2019 inspection the feedback was even more scathing with the facilities described as "the worst ever seen". Indeed, the Lead Inspector made it clear that had it not been for our excellent clinical outcomes that the programme would have been recommended for closure. The next JACIE inspection is due in 2025 and application for reinspection would be due in 2024. It is therefore imperative that there is meaningful progress by these deadlines.
- Due to the existing design deficiencies affecting inpatient, day unit and outpatient facilities which prevents adequate triage and isolation, more than 60 instances of risk of nosocomial infection directly attributable to the lack of adequate facilities were documented in 2019. By contrast, in 2020, when strict COVID-compliant pathways were enforced, there was a single incident of potential nosocomial infection proving that adequate facilities will protect patients and potentially save lives. Unfortunately, with activity again approaching pre-pandemic levels, the same levels of isolation and patient distancing are no longer possible, and patients are again being put at risk of nosocomial infection.
- The lack of sufficient capacity to treat patients in a timely manner has resulted in patients breaching agreed waiting times for BMT, which can increase the risk of relapse whilst on the BMT waiting list. To minimise this relapse risk patients are often given additional (but unnecessary) chemotherapy which in turn can increase toxicities and complications.

As a result of the above deficiencies, the physical infrastructure of the adult SWBMT Programme on the CVUHB site was severely criticised by the JACIE Inspectorate following the 2013 and 2019 inspections. These deficiencies were echoed by the HTA following onsite inspections in 2013, 2015 and 2017.

Following JACIE inspection in January 2013, the Lead Inspector in his informal feedback to the Programme Director indicated that the adult facilities on the CVUHB site were "shabby" and "well behind the curve" when compared to other UK transplant centres. More diplomatic language was used in the written report and accreditation was granted in December 2014 following corrective actions within the Programme's control and a joint written commitment by the Executive of CVUHB and WHSSC to support infrastructure improvement.

The service was re-inspected in 2019 whereby it was noted that not only had no progress been made to correct the deficiencies noted in 2013, but conditions had also deteriorated further such that the facilities were now described as "the worst ever seen." Indeed, the Lead Inspector made it clear to the Programme Director, the Executive Medical Director and

other members of the Executive that, had it not been for the excellent clinical outcomes, the programme would have been recommended for closure.

Loss of JACIE accreditation would have far-reaching consequences:

1. The SWBMT Programme would be the only major UK programme, the 15th largest of 53 UK and Irish transplant centres, (BSBMTCT 2021 report, 2019 pre-pandemic data) without JACIE accreditation and would be the first and only centre to have had JACIE accreditation withdrawn

2. The SWBMT Programme would need to cease activity since it is the policy of all UK BMT commissioners, including WHSSC, to procure services only from JACIE-accredited centres. This would lead to significant political and reputational loss for Wales, Welsh Government, CVUHB and the SWBMT Programme

3. Patients in Wales would need to be referred to BMT centres in England where transplant costs are typically ≥50% higher than in Wales. Benchmarked survival with the rest of the UK/Eire is similar, as exemplified in the BSBMTCT 2022 report covering the period 2016-2020, despite patients in Wales being older and with a greater proportion aged >60 (47% v 33%, P=0.0005), having significantly more comorbidities (74% v 51%, with 35% in Wales having highest comorbidity levels compared with 22% in the rest of the BSBMTCT, P=0.0005) and with more unrelated donor transplants being performed (81% v 63%, P=0.0005), likely due to Welsh siblings being less fit or available to act as donors. It is therefore unknown whether survival outcomes for these more unwell patients would be maintained were large numbers to be transplanted in England. Additionally, our more unwell Welsh patients would tolerate the rigors of travel less well and would have the disbenefit of not having the proximate support of family members. Finally, Welsh patients transplanted in England may not get the benefit of the comprehensive, award-winning prehabilitation programme that occurs in Cardiff, improving patient fitness prior to both transplantation and CAR-T therapy

4. In addition to the financial disbenefit to NHS Wales and the potential for a worse clinical outcome by referring patients to NHS England, such a move would contravene cancer standards which require patients to be treated as close to home as possible. The patient experience would be significantly worse since relatives would be able to visit less often and families would incur greater travel costs to visit patients in England.

2.7.3.2 JACIE Standards (8th Edition)

The initial 2013 JACIE inspection was against the 4th Edition Standards and the 2019 inspection against Edition 6.01. Accredited centres are required to meet new Standards as they are updated and the current JACIE Standards in operation are version 8.1, 2021. As with the 4th Edition, the SWBMT Programme continues to fall short of the following selected subset of Standards:

1. Standard B2.1. There shall be a designated inpatient unit of appropriate location and adequate space and design that minimises airborne microbial contamination.

2. Standard B2.2. There shall be a designated outpatient care area that protects the patient from transmission of infectious agents and allows, as necessary, for appropriate patient isolation; confidential examination and evaluation; and administration of intravenous fluids, medications, or blood products.

3. Standard B2.3. When the preparative regimen, cellular therapy product administration, or initial post-transplant care is provided in an ambulatory setting, there shall be a designated area with appropriate location and adequate space and design to minimise the risk of airborne microbial contamination.

4. Standard B2.14. The Clinical Programme shall be operated in a manner designed to minimise risks to the health and safety of employees, recipients, donors, visitors, and volunteers.

5. Standard C2.1.1. The designated area for collection shall be in an appropriate location of adequate space and design to minimize the risk of airborne microbial contamination.

6. Standard C2.1.2. The Apheresis Collection Facility shall be divided into defined areas of adequate size to prevent improper labelling, mix-ups, contamination, or cross-contamination of cellular therapy products.

7. Standard C2.1.2. There shall be a designated area with appropriate location and adequate space and design to minimise the risk of airborne microbial contamination.

8. Standard C2.1.4. There shall be suitable space for confidential donor examination and evaluation.

9. Standard C2.2. The Apheresis Collection Facility shall provide adequate lighting, ventilation, and access to sinks for handwashing and to toilets to prevent the introduction, transmission, or spread of communicable disease.

10. Standard C2.3. Apheresis Collection Facility parameters and environmental conditions shall be controlled to protect the safety and comfort of donors and personnel.

The current configuration of the inpatient, day unit, ambulatory, outpatient and apheresis facilities does not comply with the above Standards and deficiencies in the above were highlighted following the 2013 and 2019 JACIE inspections. It is therefore imperative than any plans for a new cellular therapy unit include all the component parts.

It should be noted that every year, particularly (but not restricted to) the winter months, numerous patients and accompanying visitors are exposed to airborne microbial infection on the wards, day unit and outpatient suites. These events result in the subsequent administration of prophylactic antimicrobial agents to potentially exposed patients resulting in unnecessary stress and cost. As indicated in Section 2.6.1.7 above, in 2019 alone there

were over 60 reported cases of patient exposure leading to potential nosocomial exposure across the various physical facilities.

2.7.3.3 Cardiff Cancer Research Hub

There are no dedicated cancer research beds at UHW and patients with solid cancers therefore have limited access to clinical trials that require specialist services that are not provided on the Velindre site. Furthermore, patients that are admitted whilst having cancer trial medications will access the hospital via the emergency department, medical assessment unit or as a direct transfer from VCC, if complications arise or medical support is required.

Over the last 18-36 months, medical and nursing teams from VCC and Cardiff & Vale have begun integrating services across the two sites and supporting patients with treatments that would not be suitable to be delivered at VCC. This change in practice has given an opportunity for the clinical teams to start to look at the wider opportunity to provide better access to more research studies, the type of facilities that will be needed to deliver high quality clinical and translational research for cancer patients, and to work with colleagues to look at the practical and governance related aspects of joint services.

The main barrier to further expansion of services in research and development is that without dedicated facilities in UHW, all complex, intermediate and high-risk clinical trials will not be able to be undertaken as patients will increasingly require a dedicated area with access to specialist services, including interventional radiology, or high dependency care beds. This leads to inequity of access to clinical trials for cancer patients in South Wales compared to those treated across the rest of UK. Many of these types of trials will be commercial (Pharma) trials, providing real opportunities for research income into Wales.

2.7.3.4 Complex Specialist Oncology

The current service supports patients in Cardiff and across South and Mid Wales to manage severe reactions and acute toxicity which can rarely have a fatal outcome. There areas where investment would enable the current arrangements to be strengthened and sustainable:

- Improved patient pathway(s) across the South East Wales region which provide a clear process for managing cancer patients with specialist complex oncology needs at a local (Cardiff population) and regional level (South Wales) as part of the overall commissioned pathway
- Provision of dedicated/sufficient beds which have the capability to safely manage the increase in the number of patients who have received:
  - Solid tumour immuno-oncology and advanced therapies delivered by Velindre Cancer Services
  - Complex therapies with much greater toxicities e.g., need oral therapies
- Increased levels of specialist oncology presence on site at UHW to provide oncology expertise for the management of patients who have received SACT treatments and solid tumour immune-oncology and advanced therapies with higher toxicity that

cannot be delivered at Velindre Cancer Centre and/or require patient transfer to UHW if they become acutely unwell

- Robust and rapid escalation pathways for patients receiving care at Velindre Cancer Centre who require enhanced and critical care services; with dedicated facilities in place at UHW and or partner University Health Boards. Reduced ability to deliver the full range of forecast solid tumour immuno-oncology and advanced therapies, NICE approved ATMPs and advanced therapies across South East Wales without the provision of a complex specialist oncology service to complement the regional acute oncology service resulting in poorer outcomes
- Potentially reduced patient experience if access to specialist multi-disciplinary isn't available when required to support high quality treatment and care
- Potential for longer length of stay for patients if initial treatment and management is not optimal, impacting on clinical outcomes
- Potential for Cardiff / UHW current capacity being exceeded as it manages patients from its own population and potentially from neighbouring health boards as well as those from South and Mid Wales

2.7.4 Activity

2.7.4.1 Haematology

The bed space for general haematological malignancy (GH) patients on B4 haematology currently comprises an allocation of 17 beds.

Patients occupying these beds are admitted for one of four main reasons:

1. New diagnosis of blood cancer
2. Elective admission for in-patient chemotherapy
3. Emergency admission of patients with complications of chemotherapy
4. Medically fit patients awaiting discharge planning

Along with all cancers, the incidence of blood cancers is projected to rise over the next 5 years plus the advent of more complex 'advanced therapy' treatments with new and more significant short and long-term toxicity due to infection, organ dysfunction etc will likely increase numbers of patients admitted under clause 1, 2 and 3 above.

Unfortunately, it is not always possible to accommodate all of the GH patients on B4. Reasons for this include requirement for isolation due to febrile episodes (B4 having only 2 isolation cubicles but without air handling or ensuite facilities), temporary bed closure due lack of staff to safely manage patients, and mainly lack of bed capacity.

A recent audit of the GH inpatient activity over the last 7 years is shown below:

Year	Total Patients on B4 under GH (average per day)	Total Patients in UHW under care of GH, including outliers (average per day)	Outliers (average per day)
2023	13.8	20.5	6.7
2022	16.6	25.5	8.9
2021	12.8	17.2	4.4
2020	13	15	2
2019	15.5	19.3	3.8
2018	14.3	18.6	4.3
2017	11	14.8	3.8

Table 5: General Haematology Outliers

This data show that in 2017 there were an average of 3.8 patients per day on outlying wards; in 2022 this figure rose 8.9 patients per day and so far for 2023 the figure is 6.7 patients per day. The negative impacts of managing patients on multiple outlying wards cannot be underestimated. These include lack of access to specialist haematology nursing, increased risk of hospital acquired infection (due to reduced vigilance) plus reduced efficiency for haematology ward medical staff where establishment of junior doctors is chronically depleted.

It is proposed that an allocation of 20 beds for GH is provided within this project, an increase of 3 from 17. This will resolve the problems described above.

2.7.4.2 BMT

In keeping with international trends, there has been a year-on-year increase in the number of BMT procedures performed. As shown in Figure 12, in the 5-year period 2006-2010, prior to the 2011 merger to form the SWBMT Programme, 322 adult transplant procedures were performed on the CVUHB site, increasing to 459 procedures (43% increase) in 2011-2015, immediately post-merger. In 2015-2019, the last pre-pandemic 5-year period, activity increased further to 510 procedures, an increase of 58% over pre-merger levels. As previously indicated, activity transiently fell in calendar year 2020 due to the effects of COVID-19, but with increases in each subsequent year such that 2023 activity levels are anticipated to reach or surpass 2019 pre-pandemic levels.

It is self-evident that increased activity within the same physical footprint would necessitate overcrowding which in turn would contravene JACIE Standards as summarised in Section 2.7.3.2 above. This predictably resulted in increased throughput and/or waiting at all stages along the treatment pathway from new patient referral (Figure 14), to queueing for inpatient admission (Figure 13) to increased attendances in the Haematology Day Centre where

allogeneic recipients (half of all adult transplant activity at UHW) attend once to twice weekly from discharge to day 100 post-transplant, and a minimum of weekly in the subsequent three months to month 6. Whilst prior to the COVID-19 pandemic there were robust shared-care arrangements in place with our referring hospitals, in the aftermath of COVID-19 many local hospitals were unable to provide COVID-compliant pathways for these "clinically extremely vulnerable" patients (as defined in the Green Book due to their immunocompromised state), resulting in all follow-ups being undertaken at CVUHB for the majority of patients. This has put additional strain on already stretched and insufficient resources, and which led to the shared-care arrangements in the first place.

As a consequence, e-Datix data show a rise in the number of patient-day delays in admission for chemotherapy and in inter-hospital transfers for patients requiring diagnosis or treatment of haematological malignancy or complications of treatment.

The Ambulatory Care Unit opened in 2019 and as early as 2020 led to the saving of 748 inpatient bed days (Section 2.7.3.1). Following recovery from the COVID-19 pandemic, throughput is now running at numbers predicted at its introduction. However, with more treatments being configured for delivery in AC, horizon scanning shows further growth in this department. One restriction, which will require an accommodation solution, is the requirement to be housed within 1 hour of the treatment centre, a significant constraint given that only 20% of patients transplanted on the UHW site have a local CVUHB post code, emphasising the truly tertiary nature of the BMT service.

The vision is to seek innovative ways with other partners (e.g., Cafod who have expressed interest in this venture) to provide accommodation such that at least 50% of patients receiving either BMT or CAR-T therapy could exercise the ambulatory option. Having the ability to "flex" via Ambulatory Care (Figure 11) would insulate against uncertain future demand and potentially obviate the need for an ever-increasing inpatient footprint as new therapies emerge.

In the aftermath of COVID-19, outpatient activity had to be tailored to maintain COVID-compliant spacing and this requirement continues. Whilst this initially led to a fall in activity due to the triaging of BMT indications in the early phase of the pandemic, to cope with a return in demand, more clinics had to be opened to maintain COVID-compliance. Whilst this has put added strain on consultant sessions, it has allowed the recovery of new patient attendances as shown in Figure 14. Data for 2022-2023 is complete only for 6 months (April-September 2022) so pro rata data for the entire year is shown for comparison purposes. Note that pro rata, new patient activity in 2022-2023 is predicted to outstrip previous years and if this is not able to be matched by inpatient capacity, waiting times for BMT are set to increase again emphasizing the need for facilities capable of coping with surge capacity demands.

Not counting the impact of COVID-19, Figure 12 shows that not only have BMT activity been increasing, so has been the complexity, with unrelated donor BMT accounting for 63% (85/135) of allogeneic activity in 2006-2010, rising to 70% (149/212) in 2011-2015, and increasing further to 78% (202/259) in 2015-2019. Latest data show that unrelated donor BMT currently comprise 80% of allogeneic activity.

To appreciate the significance and impact of this increased unrelated donor activity, one has to revisit the allogeneic patient pathway summarised in Figure 9. Whilst the patient is undergoing induction chemotherapy aimed at achieving remission, there needs to be parallel testing of siblings (where available and appropriate) followed by searching of the international unrelated donor registries when there is no suitable family donor. Given that only 20-30% of patients would find a donor within the family, it is unsurprising that most patients would require an unrelated volunteer. Indeed, internationally, both in North America and Europe, unrelated donor transplants overtook sibling transplants as early as 2006/07.

The challenge with unrelated donor transplantation is the planning logistics required to treat patients in a timely manner. Not only must there be testing of the patient and family in the first instance, but there must also subsequently be searching of the international donor registries, request and receipt of confirmatory donor samples, arrangement of donor medical assessments to confirm fitness to donate, and dovetailing of collection slots with preferred admission dates, considering patient readiness in the context of chemotherapy requirements and anticipated subsequent recovery times. Should there be patient- or donor-related delays, with the majority of patients depending on unrelated donors, one cannot easily reschedule others in the queue, since the constraints and challenges of timing apply equally to all unrelated donor recipients. This inevitably leads to a reduction in efficiency of bed use since patients cannot be easily advanced in the queue since admission dates are tied to available or agreed donation dates. Therefore, without sufficient surge capacity, patient waiting times will inevitably increase with increasing use of unrelated donors.

Without sufficient capacity for readmission, one of the greatest requirements of unrelated donor recipients given that this is the most complex of all transplant procedures, admission dates for other BMT patients on the waiting list could be jeopardized due to unavailability of beds or conversely, readmissions are delayed, contravening JACIE Standards.

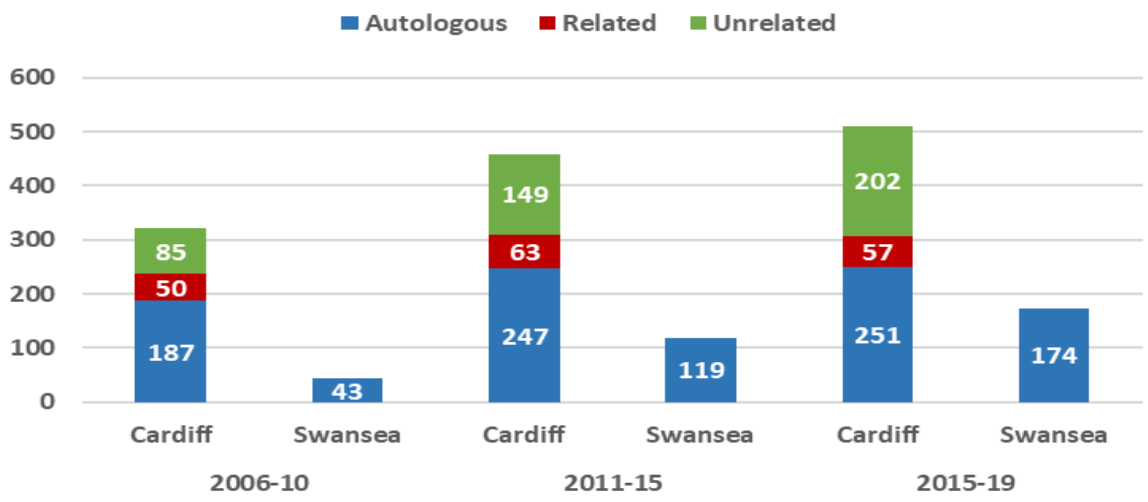


Figure 11: Adult BMT Activity by Donor Type, 2006-2019

This business case aims to deliver the activity for all adult patients in the SWBMT catchment area, irrespective of whether commissioned by WHSSC or via the clinical trial route, i.e.:

- Autologous haematopoietic stem cell transplantation (HSCT)
- Allogeneic HSCT
- Advanced Therapy Medicinal Products (ATMPs), including but not limited to CAR-T therapy
- Bispecific T-cell engager (BiTE) and related therapies
- Non-cellular therapies, primarily immunosuppression for bone marrow failure syndromes and treatment of paroxysmal nocturnal haemoglobinuria (PNH)
- Apheresis services including donor apheresis (i.e., cell collection) and therapeutic apheresis (therapeutic plasma exchange, red cell exchange, leukapheresis and extracorporeal phototherapy)

In addition, the service must cater for the treatment of general haematology patients undergoing treatment other than cellular therapy, including treatment of acute leukaemia, lymphoma, myeloma, bone marrow failure syndromes, bleeding disorders and inherited blood disorders.

The capacity must be sufficient to allow patients to be admitted within agreed timeframes with no more than 10% of patients waiting longer than agreed waiting times due to capacity constraints, rather than the current 45-50%. In addition, there must be sufficient capacity for readmissions as is required by JACIE Standards.

Table 6 below shows bed occupancy for HSCT recipients (primary BMT admissions and readmissions) over the period 2016/17 to 2021/22. CAR-T and non-cellular therapy bed occupancy is excluded. Note that the readmission activity is an underestimate since it captures only readmissions to CVUHB and not readmissions to local referring hospitals due to lack of capacity at CVUHB. It is estimated that readmissions to referring hospitals

account for an additional 30-50% of bed days and this should be accommodated at CVUHB according to JACIE Standards.

What is not shown is that readmissions in any given financial year include patients transplanted in up to 6 previous financial years, demonstrating the long-term commitment that is required to adequately care for these patients.

Parameter	2017/18	2018/19	2019/20	2020/21	2021/22
Primary (forward) BMT Bed Days	2395	2289	2249	1772	2305
Readmission Bed Days	1424	1666	1388	1165	983
Total Bed Days	**3819**	**3955**	**4637**	**2937**	**3288**

Table 6: Adult BMT Bed Occupancy 2016/17 to 2021/22

Figure 12 shows that waiting times have chronically exceeded agreed KPIs with the Commissioners. As previously explained, increasing the bed complement from 8 to 10 in 2017 (blue arrow) transiently reduced excess waiting times from its historic 50% to 30%. However, following the introduction of the CAR-T programme in 2019 and the sacrificing of a BMT bed, despite the concurrent opening of the Ambulatory Care Unit, excess waiting times have crept upwards and now affect around 40% of BMT patients, equating to 40-55 patients with defined KPIs per annum in recent years.

Adoption of the CAR-T service in 2019 has put additional pressure on beds and this has exacerbated waiting times for HSCT since CAR-T patients must be admitted as soon as they are ready given the nature of their underlying disease state, i.e., not in remission.

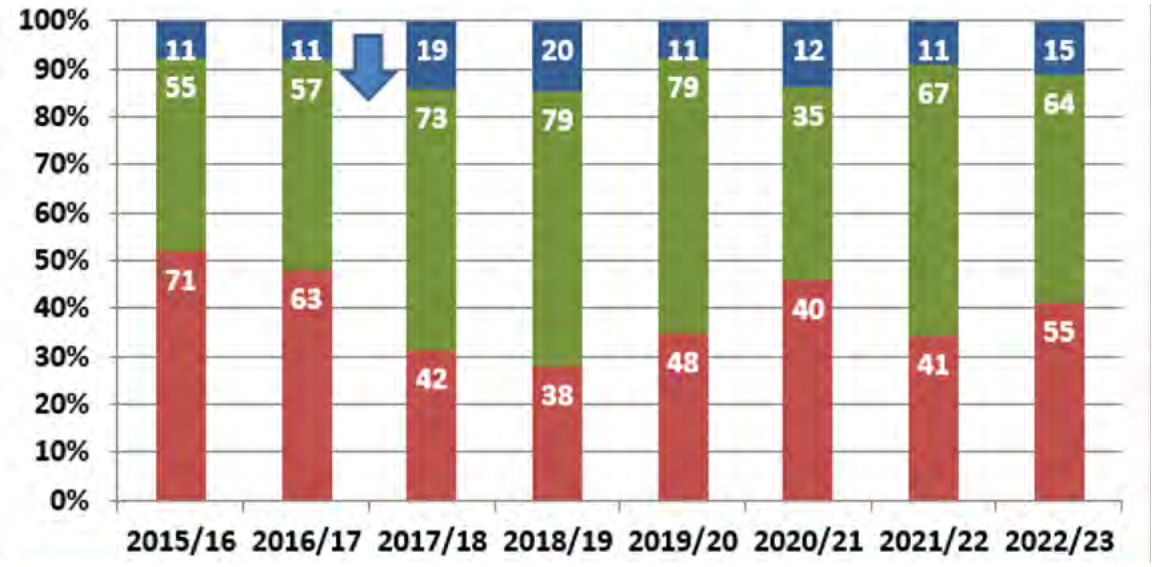


Figure 12: BMT Waiting Times 2015/16 to 2022/23

To reduce excess waiting times for BMT admission to no more than 10%, would require doubling of the current complement from 9 beds to 18 beds at a minimum, given that 100 adult transplants are currently performed annually on the CVUHB site and a mean of 46

patients have had excess waits over the past four financial years (down from 53.5 over the previous four financial years). It should also be noted that extra capacity is also required to accommodate the 11-15 patients transplanted annually, but for whom waiting times have not been established (e.g., patients with myelofibrosis, chronic myelomonocytic leukaemia and aplastic anaemia). Thus, typically a total of **58-60 patients** experience inordinate waiting times on the CVUHB site each year.

This latter group of patients has been used as a "buffer" to get defined waiting times down. However, it should be noted that despite the absence of defined maximum waiting times, they suffer significant symptoms whilst awaiting transplantation and risk catastrophic infection or bleeding (aplastic anaemia) or transformation to acute leukaemia (myelofibrosis and chronic myelomonocytic leukaemia). Therefore, prolonged waiting for this group of patients is not a benign influence.

To be able to readmit patients with complications without encroaching on general haematology beds as is currently the case, would require that the maximum measured readmission bed stay of 1666 bed days be increased by 30% (to 2166 bed days), equivalent to 6-7 beds at 85% occupancy to allow for surge capacity.

Therefore, the bed requirement for the BMT Programme needs to be a minimum of 18 forward beds and 6 readmission beds to adequately cope with current activity. Increasing use of the ambulatory model would allow the accommodation of existing commissioned activity for which there is no current capacity (e.g., autologous HSCT for multiple sclerosis) as well as potential new indications, without necessarily requiring a further increase in the inpatient footprint between this interim solution and completion of UHW2.

ATMP demand would be separately estimated and needs to be distinct from the BMT bed requirement given that CAR-T patients must be admitted with minimum delay given that current indications are for patients with malignancies not in remission and there is a significant risk of attrition during work-up, currently averaging 26% in the UK.

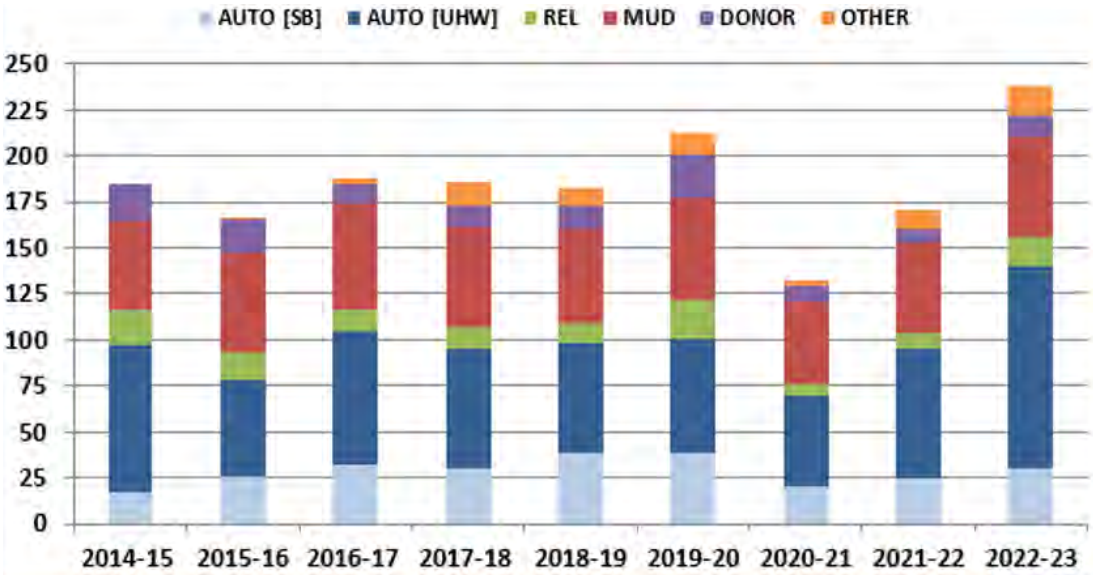


Figure 13: New Patient Activity by Type

[AUTO = autologous transplant (HSCT), REL = related donor HSCT, MUD = matched unrelated donor HSCT, Donor = sibling donor, SB = SBUHB, UHW = CVUHB, Other = non-cellular therapy consultation]

Figure 13 shows new patient activity by type. Note that, excluding donors, approximately 175 new patients were seen at CVUHB in 2019/20 prior to the COVID-19 pandemic. As previously discussed, activity in the early phases of the pandemic decreased in keeping with international and national triaging recommendations but has been increasing back to baseline levels. Data for 2022/23 is incomplete and is available for the first 6 months (April to September 2022), with the annual data shown representing a pro rata extrapolation of the first 6 months' data, equating to 180 patients – pre-pandemic levels.

Even with the typical attrition rate of approximately 20%, should there be minimum delays in admission due to sufficiency of capacity, approximately 140 patients could be treated at CVUHB per annum, an increase of 40% over pre-pandemic activity of 100 patients annually.

	Bed	Current patient			Next patient			Following patient		
		Admit	Detail	Disch	Admit	Detail	Disch	Admit	Detail	Disch
ALLO/IST – UHW	1	22 Feb	AML MUD	17 Mar	16 Mar	SAA MUD	14 Apr	14 Apr	AML MUD	12 May
	2	21 Feb	NHL SIB	17 Mar	21 Mar	ALL SIB	14 Apr	18 Apr	AML SIB	19 May
	3	03 Mar	MDS MUD	31 Mar	04 Apr	AML MUD	28 Apr			
	4	27 Feb	MM AUTO	14 Mar	15 Mar	MDS MUD	14 Apr			
	5	01 Mar	AML MUD	31 Mar	29 Mar	MPN SIB	21 Apr			
	6	07 Feb	MPN MUD	10 Mar	09 Mar	MPN MUD	07 Apr	11 Apr	ALL MUD	05 May
AUTO/CART – UHW	7	13 Mar	NHL CART	24 Mar	27 Mar	NHL CART	24 Apr			
	8	18 Nov	AML MUD	31 Mar	20 Mar	NHL CART	30 Mar	29 Mar	MM AUTO	14 Apr
	9	22 Feb	MM AUTO	10 Mar	20 Mar	MM AUTO	31 Mar	03 Apr	MM AUTO	21 Apr
	10	02 Mar	NHL AUTO	24 Mar	27 Mar	MM AUTO	13 Apr	11 Apr	NHL CART	15 May

Table 7: Bed state as of 02 March 2023

Table 7 shows the utilisation of the 9 BMT and 1 CAR-T bed and the impact of insufficient bed capacity on queueing for admission. Due to lack of capacity an inordinate amount of time is spent triaging patients to minimise the risk of relapse whilst on the waiting list for admission.

The above example relates to the planning (triaging) meeting of 02 March 2023. Several features are worthy of note:

- Beds can be solidly booked for up to four consecutive patients (patients with discharge dates shaded in red have patients booked to follow them following discharge)

- Although the planning meeting took place on 02 March 2023, the latest projected discharge was on 31 May 2023 (Patient not shown but following patient in Bed 10 due to be discharged on 15 May 2023)
- Patients with ward admission dates shaded in green started cellular therapy (BMT/CAR-T) earlier in Ambulatory Care, thereby minimising use of inpatient beds
- Patients are often deliberately overlapped to maintain patient flow (e.g., first and second patients in Beds 1, 5 and 6)
- Patients who stay longer than anticipated can potentially block other patients on the waiting list (e.g., long-stay unrelated donor recipient in Bed 8) who was admitted on 18 November 2022 and was still an inpatient on 02 March 2023 with a projected eventual discharge date of 31 March 2023. Also note the overlap with the following CAR-T patient. This transplant patient was eventually moved to a general haematology bed to make way for the CAR-T patient, encroaching on the ability of the general haematology team to undertake their own admissions.

What Table 7 amply demonstrates is the intense triaging that takes place on a weekly basis, planning for patients months in advance, juggling relapse risks and negotiating with referring teams to administer additional (unnecessary) chemotherapy in some instances to stave off the risk of relapse whilst on the waiting list. An adequate bed complement, with sufficient surge capacity, would reduce waiting times, obviate the need for "bridging" chemotherapy, and improve outcomes and patient experience

2.7.4.3 Cardiff Cancer Research Hub

Velindre's Early Phase Clinical Trial (EPCT) portfolio includes Phase1, Phase I/II and Phase II and includes drug, drug-radiotherapy and combination EPCTs including a mix of commercial and non-commercial studies. These attract grants from external sources such as the Experimental Cancer Medical Centre (ECMC) and the Wales Cancer Research Centre (WCRC), Third Sector (including Cancer Research UK) and research income generated from commercial companies (Pharma).

Over the last 5 years, on average each year:

- 5 new EPTs are opened (includes Phase I Phase I/II and some Phase II.)
- 120 patients are referred for EPTs, of which, 64 patients were suitable to be seen in clinic for trial discussions and of those 38 patients are consented and screened
- There are 760 EPT's patient visits; (associated with screening, consent, delivery of trial treatment and trial related tests and follow up)
- EPTs require different bed/chair hours e.g., least intensive EPT requires 3 hours per visit during first cycle of treatment, whilst the most intensive EPT requires 14 hours per visit bed hours during first cycle of treatment. The type of the trials that will be conducted at the CCRH will be intensive and likely to exceed 14 hours per visit
- A complex first into human trial can involve 55-60 patient management hours in the first four weeks of treatment, compared to standard care management which requires 2-3 hours

The solid tumour EPT/ATMP trial landscape has is changing, with more novel therapies being developed including immunotherapy, virotherapies and cellular therapies.

During the last two years, VCC have been approached to take on more complex EPTs. In Jan 2020 - Apr 2021, VCC submitted Expression of Interest (EOIs) for 35 EPTs, of these, 14 EOIs (40%) required patients to be dosed at UHW, allowing access to services such as critical care for safe patient management.

In the early part of 2023 VCC have been approached to take part in 2 complex Cellular therapy trials (Tumour Infiltrating Lymphocytes, TILs) which have been turned down due to lack of infrastructure for their delivery. The CCRH would provide the facility for delivering these therapies, as well as other therapies including tumour-specific precision virotherapies which have been developed in Cardiff University (by Professor Alan Parker), licenced, and will be ready for clinical trial delivery within the next 24 months.

To date, VCC has not yet conducted any CAR-T trials, although one Solid tumour CAR-T trial will potentially be conducted in UHW in the next 12 months within the Bone Marrow Transplant Unit.

It is expected that the majority of the CCRH trial portfolio will include Phase 1 and 1b EPCT, TILs, Bi-specifics and cancer vaccines with smaller numbers of CAR-T Trials, as well as complex Phase 3 trials and translational research. Delivery of this portfolio of cancer studies to Welsh patients will simply not be possible without the CCRH.

Haemato-oncology EPCTs and ATs

There has been a year-on-year growth in activity in EPTs for patients with haematological malignancies over the last 5-6 years including the breadth of subtypes of haematological cancers covered by EPTs, the numbers of open studies and the numbers of patients recruited. The haemato-oncology EPT portfolio has included a mix of Phase I, Ib and II studies, increasingly featuring first-in-human haematology trials. Currently the majority of these EPT studies are administered through the Clinical Research Facility at UHW (CVUHB) with higher risk ATMP trials conducted in BMTU

There is growing and excellent cross-site collaboration between haematology and solid tumour early phase researchers, best exemplified by the TC Biopharma adoptive T-cell study for patients with advanced solid tumours which had joint Principal Investigators (CVUHB and VCC), utilising haematology apheresis services at UHW and early phase units on both sites. There is an increasing focus of activity on haemato-oncology ATMP which will continue to grow as a proportion of total activity.

a. Baseline Data

EPT Baseline Data - based on current trial activity for solid tumour + haem-oncology (April 2018 -March 2021.) - Over the last 3 years on average per year 22 EPTs are open to recruitment with a further 22 EPTs in set up. Associated with this portfolio, on average per year, 55 patients are recruited to EPTs. It should be noted that COVID 19 had significantly this impacted research activity during this data period.

Current CAR-T trials - This is an emerging area, the BMT team are currently setting up 2 CAR-T trials: SOTIO, A First-in-Human, Phase 1/2, Dose Escalation Study of BOXR1030 T cells in subjects with Advanced GPC3-Positive Solid Tumours and Cartitude 6. The BMT team have CAR-T experience in terms of CAR-T standard treatments treating 29 patients over the last 4 years.

Translational Research - This is an emerging research area, across the 3 institutions, given the ambition for closer collaboration and research alignment with Cardiff University (CU) cancer scientists and NHS clinicians. This enables bringing forward discovery research from the laboratory through to the clinical area for patient benefit (bench to bedside) and patient blood and tissue samples informing the development of discovery research (bedside to bench. Whilst there is no historic recruitment data, however, there are some translational research exemplars such as TACTIC, SABRIT and COVID Immune and CONSCOP 2.

As part of the developing portfolio of translational research there are a number of key posts recently appointed and/or about to be appointed that, will be involved in developing translational research which will involve patients coming to the Hub for tumour biopsies and blood sampling.

These include 3 jointly funded Clinical Academic Posts and 5 Clinical Research Fellows with an ambition to further grow these types of posts.

Conducting more translational research, leads to research grant applications some of which will be successful in securing cancer research grants such as CRUK programme grants and importantly MRC NIHR, EME grants and associated funding. Some CRUK Programme grants secure research monies of a few million pounds over a 5-year period. Conducting more translational research will enable increased critical mass (clinical scientists and NHS researcher Clinicians) in the Cardiff cancer research community, which improves Cardiff's opportunity when applying to CRUK for a Cardiff CRUK Centre.

Complex Late Phase Trials - In addition, some late phase (phase II to III) cancer trials have complexities in patient management which require access to CVUHB services such interventional radiology, cardiology and surgery etc. Historically this has meant that Velindre has not been able to participate in these studies, which has not only reduced research access for patients but lost research income into Wales. The CCRH co-located with such services will have facilities to manage such samples and related patient monitoring required, thus increasing research opportunities for patients.

b. Horizon Scanning

ATMP Trials - Advanced Therapy Wales has reviewed the Cell and Gene Therapy Catapult ATMP Clinical Trials Database 2022 https://ct.catapult.org.uk/

There are a number of ATMPs that are coming forward into the trial setting. In total there are 178 trials, 70% of these are oncology ATMP broken down by Blood Cancers = 32 and Non Blood (Solid Tumour) Cancers = 38

Growth Assumption for EPT ATMP & Translational Research Recruitment - Within the CCRH Workforce Task and Finish Groups, teams set an ambition to double current recruitment i.e., 110 patients over the next 5-8 years (this will include EPTs ATMP trials and translational research). Some of this research will be academically locally led some commercial and non-commercial trials.

2.7.4.4 Complex Specialist Oncology

During the first quarter of 2021/22, an average of 323 immunotherapy regimes were authorised for treatment per month from over 60 types of regimen. Licensed drug indications continue to grow with usage in renal cell, melanoma, Lung, GI cancers, as well as Head and Neck.

Several further new indications are expected to be introduced in the current financial year, with overall spend on this category of drugs forecast to grow by 50% in 2021/22 compared to the prior year. It is expected rapid expansion of drug indications will continue for the next two years based on the potential new indications with the NICE evaluation programme. Immunotherapy is now used in combination with Chemotherapy and targeted agents routinely in different cancer sites. This is leading to further complexity when evaluating patient toxicity of treatment and its management.

Based on anticipated approvals for additional indications and new therapies under trial (currently over 1000 immunotherapy trials registered with clinicaltrials.gov.) This increase in trials and the conversion to BAU/routine treatment will undoubtedly continue at pace. Whilst precise modelling is difficult due to the many variables modelling has been undertaken across the UK which illustrates the significant increase expected over the coming years.

The figure below shows the forecast growth in immunotherapy treatment:

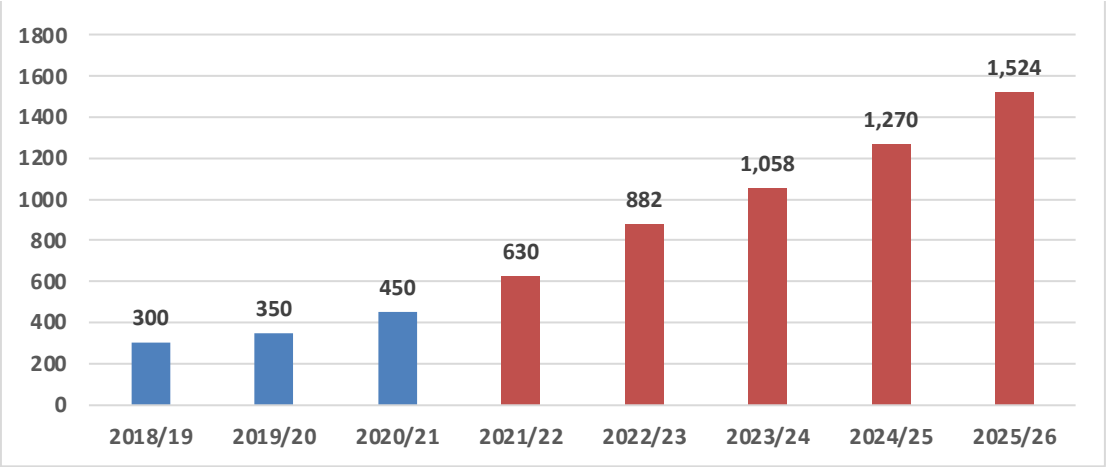


Figure 14: Forecast Immunotherapy Treatment Number Growth

References: Checkmate 067 Trial https://www.nejm.org/doi/full/10.1056/NEJMoa1910836 Keynote-021 Study https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(16)30498-3/fulltext#seccestitle150

The number of patients is modelled to grow by 40% in 2021/22 and 2022/23 and then by 20% p.a. over the next 3 years.

Forecasting Future Demand

The future predicted growth in immunotherapy activity is set out below:

	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
Patients Nos. Immunotherapy Treatment	450	630	882	1,058	1,270	1,524
Patients with severe toxicities (30%)	135	189	265	318	381	457

Table 8: Forecast demand for complex specialist oncology services at UHW resulting from Immunotherapies for solid tumours related toxicity

Given the current understanding of the current activity and difficulty in accurately forecasting new treatments and research an uncomplicated methodology has been used to develop a range of scenarios.

Planning assumptions

- Baseline position 2021/2022: 141 patients
- Average length of stay: 13 days

Patients admitted in 2021/2022: 141 Average length of stay: 13 days	Bed days	Beds required
Scenario 1: 30% with grades 3 and 4 require inpatient bed	549 bed days	2
Scenario 2: 40% with grades 3 and 4 require inpatient bed	733	2
Scenario 3: 50% with grades 3 and 4 require inpatient bed	916.5	3
Scenario 4: 70% with grades 3 and 4 require inpatient bed	1283	4

Table 9: Forecast beds required to support Complex Specialist Oncology service for patients receiving immunotherapy for solid tumour immunotherapies (excluding advanced therapies/AMTPs)

The forecast growth in activity identifies a range of 2 – 4 beds will be required to enable the complex specialist oncology service to be fully implemented at UHW.

2.8 Potential Business Scope and Key Service Requirements

As part of the development of this business case a range of service priorities were considered by both the clinical teams and the executive team of the Health Board. These discussions considered including acute oncology within the scope of the project. The clinical team developed a list of service priorities, including the benefits of delivering each of these within this project. Schedules of accommodation were developed for each of these priority areas.

Both the clinical benefits paper and summary schedules of accommodation can be seen within Appendix 5. Drawings were developed to indicate the possible location and scale of each of these priorities. These papers were presented to a meeting with the Chief Operating Officer, Medical Director and Director of Planning in order to agree what will be included within this strategic outline case. It has been agreed that the Health Board will submit this case to develop a facility for Haematology and BMT that ensures the Haematology service meets JACIE accreditation and to develop the Cardiff Cancer Research Hub (CCRH) and to include inpatient facilities for complex specialist oncology within the Haematology/BMT ward.

It was, therefore, concluded that whilst the development of the acute oncology service was important and a priority for the Health Board it should not be included as part of the scope of this business case and will be taken forward within its own dedicated project.

Other specific exclusions not considered within the scope are:

- Haematology services at UHL
- Laboratory Haematology which rests in Laboratory Medicine and the Clinical Diagnostics and Therapeutics Clinical Board
- Inherited Anaemias
- CAR-T therapy for solid tumour oncology

- New CAR-T or other ATMP indications for non-haematological conditions
- Early phase clinical trial activity
- Stem cell processing laboratory
- Teenage and Young Adult Cancer Service

Following the outcomes detailed above this section describes the potential scope for the project in relation to the spending objectives and business needs.

In line with Welsh Government guidance, the scope has been assessed against a continuum of need ranging from:

- A minimum – essential or core requirements/outcomes
- An intermediate – essential and desirable requirements/outcomes
- A maximum – essential, desirable and optional requirements/outcomes

	Core	Desirable	Optional
Potential Scope	Service included: Haematology/BMT Inpatients, UHW Haematology Day Centre, UHW Advanced Therapies, UHW	Service included: Haematology/BMT Inpatients, UHW Haematology Day Centre, UHW Advanced Therapies, UHW Cardiff Cancer Research Hub, UHW Complex Specialist Oncology Inpatients, UHW	Services included: Haematology/BMT Inpatients, UHW Haematology Day Centre, UHW Advanced Therapies, (UHW Cardiff Cancer Research Hub, UHW Complex Specialist Oncology Inpatients, UHW Haematology Outpatients, UHW Cardiff Haemophilia Centre, UHW Acute Oncology Unit
	Services excluded: Haematology Outpatients, UHW Cardiff Cancer Research Hub, UHW Cardiff Haemophilia Centre, UHW Complex Specialist Oncology Inpatients, UHW	Services excluded: Haematology Outpatients, UHW Cardiff Haemophilia Centre, UHW	

	Core	Desirable	Optional
Key Service Requirements	A facility that meets minimum statutory requirements with regard to environmental and care quality standards. Sized to meet current and projected future demand	A facility that meets minimum statutory requirements with regard to environmental and care quality standards. Sized to meet current and projected future demand	A facility that meets minimum statutory requirements with regard to environmental and care quality standards. Sized to meet current and projected future demand

Table 10: Potential Scope

2.9 Main Benefits Criteria

This section describes the main benefits associated with the implementation of the potential scope in relation to business needs.

Satisfying the potential scope for this investment will deliver the following high-level strategic and operational benefits.

Benefits are expressed in relation to the developed appraisal criteria that were derived from the spending objectives as follows:

- **CRB** - cash releasing benefits (e.g., avoided costs)
- **Non CRB** - non cash releasing benefits (e.g., staff time saved)
- **QB** - quantifiable benefits (e.g., achievement of targets)
- **Non QB** - non-quantifiable or qualitative benefits (e.g., improvement in staff morale)

Spending Objective	Stakeholder Group	Main Benefits
Objective 1: Quality and Safety of Services	Patients	Non QB - High quality patient care QB – Improvements in health and safety (reduced incidents and specifically relating to toxicity) QB - Patient outcome maximised through treatment early in the course of the disease. For example, patients with acute myeloid leukaemia (AML) transplanted in first remission have a cure rate of 65% falling to 40% when done in second remission. Thus, earlier treatment avoids the costs of re-treatment (due to relapse) and results in a better long-term outcome QB – Reduced length of stay for complex specialist oncology patients Non QB - Ensuring the model provides safe management of patients at higher clinical risk and who require complex specialist oncology services Non QB - Delivering research care in a safe and seamless way QB - Providing patients in Cardiff and potentially South East Wales with access to high quality and safe

Spending Objective	Stakeholder Group	Main Benefits
		solid tumour immunotherapies and immuno-oncology treatments QB - Significant improvement to the quality of care and expected patient outcomes (i.e., increase in curative treatments; improved 1 and 5 year survival rates) QB - High levels of safety which support increasing toxicity of treatments now and in future years i.e., reduced number of incidents relating to toxicity QB - Reduction of avoidable patient harm Non QB - Development of specialist toxicity management pathways with each organ specialist
	Staff	Non QB – Maintain continuity of services QB – Improvements in health and safety (reduced incidents) QB – Staff recruitment and retention will improve as investment in new facilities will help attract and retain high quality professional staff Non QB - Development of best practice clinical pathways with clinicians from the Health Board and Trust collaborating with on the management of complex patient toxicity
	Health Community	Non QB – High quality care given to all patients Non QB - Delivering high quality and research-led teaching at both undergraduate and postgraduate level, and to inspire others to pursue excellence in research, teaching and innovation QB - Producing high quality research measured by publications, impact, income, increased CU impact cases and Research Excellence Framework (REF) status Non QB - Improving research status and reputation for all partners involved Non QB - Supports the development of fundamental foundations (capacity/capability) to deliver advanced therapies/AMTPs
Objective 2: Provide a high quality physical environment	Patients	Non QB – Provide safe and appropriate environments of care for patients and improving the patient experience, with improved patient satisfaction (patients have repeatedly complained about the lack of ensuite facilities during informal feedback) QB - An increase in capacity with contiguous inpatient and daycase facilities forming an integrated unit will enhance patient flow and continuity of care with timely admission for therapy and reduced delays with documented increased risk of relapse Non QB – Maintaining appropriate privacy and dignity

Spending Objective	Stakeholder Group	Main Benefits
		Non QB - Providing a supported environment for the delivery of EPCTs including, those utilising Advanced Therapies (ATs)
	Staff	Non QB – Provide a safe and appropriate environment for staff and be a better place to work Non QB – Improved clinical morale gained from improved access to modern equipment, technologies and facilities
	Health Community	QB – Compliance with statutory standards, including JACIE accreditation and maintenance of the HTA licence QB – Compliance with NHS guidance/best practice including NICE and All Wales Medicines Strategy Group requirements Non QB – Improved environments to enable productivity gains QB –Effectively and efficiently deliver the wider the clinical model essential to the deliver the model for non-surgical tertiary cancer services in south east Wales as outlined in the Nuffield report. Non QB - Attract researchers to Cardiff to support the establishment of the Cardiff Cancer Research hub Non QB - Organisational reputation will be enhanced by providing high quality and safe care which supports the ability to provide new and novel treatments in South Wales
Objective 3: Access	Patients	Non QB – Provide suitable services and facilities sized to meet demand to ensure improved and optimised treatment pathways QB – Improved waiting times QB - Increasing research options for Welsh patients nearer to home QB – Improvements to patient aftercare: toxicity follow-ups provided for all patients with toxicity irrespective of tumour group QB - Improved survival and quality of life
	Staff	QB – Reduction in the non-availability of inpatient beds for Haematology/BMT patients
	Health Community	Non QB – Reduced pressures on other facilities and provides appropriate capacity for the population QB – Reduction in patients receiving extra ('holding') courses of chemotherapy (due to current waiting times). This will reduce patients' exposure to potential complications from unnecessary additional treatment Non QB - Providing opportunities for shared learning, training, education and career pathways to inspire, train and mentor future clinical and non-clinical cancer research leaders.

Spending Objective	Stakeholder Group	Main Benefits
		QB - Specialist oncology presence physically located within a UHW/secondary care setting to enhance multi-disciplinary working and knowledge transfer for better quality of care, outcomes and clinical and patient experience Non QB - Provision of capacity and capability to deliver immunotherapies and advanced therapies/ATMPs will assist in establishing Cardiff and Wales as a global player new/emerging market
Objective 4: Effective use of Resources	Patients	QB – Improved waiting times QB - Reduced the current waiting times for BMT
	Staff	Non CRB – Reduced delays and cancellations maximises use of staff
	Health Community	Non QB - Maximise use of existing accommodation to enable estate rationalisation and improved utilisation Non QB - Building research critical mass, expertise and infrastructure Non QB - Supports development of a robust and comprehensive database for cancer services (acute and complex patient cohort) QB - Improving income generation (commercial trials, industry investments, grant awards etc.) Non QB - Enhancing Cardiff/Wales research competitiveness at UK level and how Cardiff/Wales is perceived by key research funders Non CRB - Cost avoidance: if capacity and capability is not established patients may have to travel across the border for immunotherapies/ATMPs/advanced therapies and this will be more expensive CRB - Cost savings: there is a significant opportunity to delivery significant cost savings from reduced length of stay for patients with severe toxicity (grade 3 and 4)
Objective 5: Sustainability	Patients	Non QB – Services continue to be provided to meet patients' needs Non QB - Providing a pipeline of late phase trials and benefits for future cancer patients
	Staff	QB - Reduction in vacancy and turnover rates QB - Reduction in staff sickness rates Non QB - Improved job satisfaction
	Health Community	Non QB - Maximise flexibility of facilities Non QB - Better connecting academic researchers and clinical researchers Non QB - Facilitating both research development and delivery (NHS/Academia) QB - Increasing the scope and reach for UK research partnerships and collaborations

Spending Objective	Stakeholder Group	Main Benefits
		QB - Provision of capacity and capability to deliver ATMPs in Cardiff will make it/Wales a more attractive place for strategic partners to invest in (in terms of infrastructure and financial investments)

Table 11: Main Benefits

2.10 Main Risks

The main business and service risks associated with the potential scope for this project are shown below, together with their counter measures:

Risk	Counter Measures	Stage			
Service Risks		Design Development	Implementation	Operational	Termination
Insufficient revenue resources to support the new facilities	Service model will be developed to support the service within the current revenue resource envelope or reduced costs where more optimal environments enable this			✓	
Clinical quality – failure to ensure that clinical quality is reflected in the plans	Ensure appropriate review of plans during design development including clinical, infection prevention, clinical support and FM representatives	✓	✓	✓	✓
Changes in demand – the anticipate demand for services is greater or less than has been projected within the case	Robust activity and capacity analysis has been undertaken. Design will be generic with the ability to adapt to different usage	✓	✓	✓	✓
Constraints of existing service and infrastructure	Undertake appropriate surveys to establish any constraints	✓	✓		
Business Risks		Design Development	Implementation	Operational	Termination
Financial Viability – capital cost of works is unaffordable, tenders exceed budget	Monitoring of costs during business case development. Robust financial analysis utilising established benchmarked norms to establish project budget	✓	✓	✓	
Changes in strategic context/policy direction	Non-political and strategic factors have been considered in developing the proposals	✓	✓	✓	✓

Risk	Counter Measures	Stage			
Design changes that are over and above the contingency allowances	Health Board to monitor and manage changes throughout the project	✓	✓		
Life-cycle cost (building and engineering maintenance) exceeds budget	Estates and facilities input into revenue cost modelling during business case development and clarity of life cycle costs			✓	
External Risks		Design Development	Implementation	Operational	Termination
Failure to proceed – Contractor bankruptcy, development stalls due to lack of capital or failure to achieve business case approval	Appointment of established Contractor and liaison with Welsh Government to ensure available capital and approval of business case	✓	✓		

Table 12: Main Risks and their Counter Measures

2.11 Constraints

Identified below are the parameters within which the investment must be delivered which have been set at the outset of the project:

- The proposals must be consistent with the Health Board's *Shaping Our Future Wellbeing strategy* and long term *clinical services plan* for acute care, contributing to the Health Boards pursuit of a more sustainable future for services
- The scheme must allow full compliance with relevant statutory/mandatory standards and meet the requirements of the various clinical service pathways
- Physical works will need to be delivered in order to have the least possible impact on service provision
- Any plans must maintain revenue neutrality unless alternative/new funding streams are clearly identified
- Project must be delivered through funding from the All Wales Capital Programme

2.12 Dependencies

Identified below are dependencies that will be carefully monitored and and/or managed throughout the lifespan of the scheme to enable the delivery of the investment:

- Approval from Welsh Government and release of capital form the All Wales Capital Programme

Economic Case

3.0 THE ECONOMIC CASE

3.1 Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the SOC documents the wide range of options that have been considered in response to the potential scope identified within the strategic case.

3.2 Critical Success Factors

The Critical Success Factors (CSFs) for this project were taken from the WG guidance and endorsed by the Project Team and are as follows:

CSF1: Business Needs	How well the option satisfies the existing and future business needs of the organisation
CSF2: Strategic Fit	How well the option provides holistic fit and synergy with other key elements of national, regional and local strategies
CSF3: Benefits Optimisation	How well the option optimises the potential return on expenditure – business outcomes and benefits (qualitative and quantitative, direct and indirect to the organisation) – and assists in improving overall VFM (economy, efficiency and effectiveness)
CSF4: Potential Achievability	The organisation's ability to innovate, adapt, introduce, support and manage the required level of change, including the management of associated risks and the need for supporting skills (capacity and capability). Also, the organisation's ability to engender acceptance by staff
CSF5: Supply Side Capacity and Capability	The ability of the market place and potential suppliers to deliver the required services and deliverables
CSF6: Potential Affordability	The organisation's ability to fund the required level of expenditure – namely, the capital and revenue consequences associated with the proposed investment

Table 13: Critical Success Factors

These CSFs have been used alongside the spending objectives for the project to evaluate the long list of possible options.

3.3 The Long Listed Options

The long list of options was generated in accordance with best practice contained in the Infrastructure Investment Guidance. The evaluation was undertaken in accordance with how well each option met the spending objectives and CSFs.

This process resulted in options either being discounted or carried forward for further consideration in the short list.

The long list of options for this investment was generated within the following key categories of choice:

Scoping options – choices in terms of coverage (the what)

The choices for potential scope are driven by business needs and the strategic objectives at both national and local levels. In practice, these may range from business functionality to geographical, customer and organisational coverage. Key considerations at this stage are 'what's in?' 'what's out?' and service needs.

Service solution options – choices in terms of solution (the how)

The choices for potential solution are driven by new technologies, new services and new approaches and new ways of working, including business process re-engineering. In practice, these will range from services to how the estate of an organisation might be configured. Key considerations range from 'what ways are there to do it?' to 'what processes could we use?'

Service delivery options – choices in terms of delivery (the who)

The choices for service delivery are driven by the availability of service providers. In practice, these will range from within the organisation (in-house), to outsourcing, to use of the public sector as opposed to the private sector, or some combination of each category. The use of some form of public private sector partnership (PPP) may be relevant here.

Implementation options – choices in terms of the delivery timescale

The choices for implementation are driven by the ability of the supply side to produce the required products and services, VFM, affordability and service need. In practice, these will range from the phasing of the solution over time, to the modular, incremental introduction of services.

Funding options – choices in terms of financing and funding

The choices for financing the scheme (public versus private) and funding (central versus local) will be driven by the availability of capital and revenue, potential VFM, and the effectiveness or relevance/ appropriateness of funding sources.

3.3.1 Scoping Options

In accordance with the Treasury Green Book and Infrastructure Investment Guidance, the business as usual option has been considered as a benchmark for potential VFM.

An infinite number of options and permutations are possible; however, within the broad scope outlined in the strategic case, the following main options have been considered:

Option 1.0 Business As Usual (status quo)	Option 1.1 Core	Option 1.2 Desirable	Option 1.3 Optional
Existing haematology/BMT, cancer research and Complex Specialist Oncology services (i.e., no beds)	Haematology/BMT Inpatients, UHW Haematology Day Centre, UHW Advanced Therapies, UHW	Core Services plus: Cardiff Cancer Research Hub, UHW Complex Specialist Oncology, UHW	Core and Desirable Services plus: Haematology Outpatients, UHW Cardiff Haemophilia Centre, UHW Acute Oncology Unit, UHW

Table 14: Potential Scope

The table below summarises the assessment of each option against the spending objectives and CSFs:

Option:	1.0	1.1	1.2	1.3
Spending Objectives				
1: Quality and Safety of Services	X	✓	✓✓	✓✓
2: Provide a high-quality physical environment	X	✓✓	✓✓	✓✓
3: Access	X	✓	✓✓	✓
4: Effective use of Resources	✓	✓✓	✓✓	✓
5: Sustainability	X	✓	✓✓	✓✓
Critical Success Factors				
1: Business Needs	X	✓	✓✓	✓
2: Strategic Fit	X	✓	✓✓	X
3: Benefits Optimisation	X	✓	✓✓	✓
4: Potential Achievability	✓✓	✓✓	✓✓	X
5: Supply Side Capacity and Capability	n/a	✓✓	✓✓	✓✓
6: Potential Affordability	✓✓	✓✓	✓✓	✓
Summary	Discounted	Carried Forward	Preferred Way Forward	Discounted

Table 15: Summary Assessment of Scoping Options

Key: ✓✓ - fully achieves ✓ - partially achieves X - does not achieve

3.3.1.1 Option 1.0: Business as Usual

Description

The business as usual option includes retaining relevant haematology/BMT, cancer research and complex specialist oncology services (i.e., no beds) within their current locations with no changes to either services or the facilities from which they are provided

Advantages

- No capital investment required
- Patients and staff are familiar with existing arrangements

Disadvantages

- Does not improve the environmental quality of services
- Will not provide infrastructure to deliver complex specialist oncology and therefore will not meet Nuffield requirements
- Significant risk to the delivery of the nVCC model of care
- Does not enable the delivery of the Nuffield Trust recommendations or support the realisation of the identified benefits. Patients with solid cancer will have less access to cancer research and complex specialist care than haemato-oncology patients and other solid cancer patients in other UK centres (inequity of care)
- Missed opportunity to partner with Cardiff University to become a focus for translational cancer research excellence in Wales, capable of attracting inward investment from commercial partners and third sector
- Lack of the ability to conduct cutting edge cancer research (EPTs and ATMPs) disadvantages attracting an expert workforce to Wales
- Does not ensure future JACIE accreditation
- Does not provide the Health Board with bespoke R&D requirements, including providing sufficient overnight stays
- Does not enhance the research or innovation opportunities for Wales

3.3.1.2 Option 1.1: The 'Core' Scope

Description

The services included within the core scope are:

- Haematology/BMT Inpatients, UHW
- Haematology Day Centre, UHW
- Advanced Therapies, UHW

Advantages

- Improvements in the environmental quality of core services
- Should ensure future JACIE accreditation
- Reduced capital outlay required

Disadvantages

- Will not provide infrastructure to deliver complex specialist oncology in a sustainable manner or the Cardiff Cancer Research Hub and therefore will not meet Nuffield requirements
- Significant risk to the delivery of the nVCC model of care

- Does not enable the delivery of the Nuffield Trust recommendations or support the realisation of the identified benefits
- Patients with solid cancer will have less access to cancer research and complex specialist care than haemato-oncology patients and other solid cancer patients in other UK centres (inequity of care)
- Missed opportunity to partner with Cardiff University to become a focus for translational cancer research excellence in Wales, capable of attracting inward investment from commercial partners and third sector
- Lack of the ability to conduct cutting edge cancer research (EPTs and ATMPs) disadvantages attracting an expert workforce to Wales
- Does not provide the Health Board with bespoke R&D requirements, including providing sufficient overnight stays
- No improvements to the Haemophilia Centre, including optimising flows and safeguarding for children
- There would be no efficiencies with outpatients as this element of the service would not be co-located with other haematology services
- Does not provide complex specialist oncology beds within the appropriate area at UHW
- Does not enhance the research or innovation opportunities for Wales

3.3.1.3 Option 1.2: The 'Core and Desirable' Scope

Description

The services that are included are Core Services plus:

- Cardiff Cancer Research Hub, UHW
- Complex Specialist Oncology, UHW

Advantages

- Improvements in the environmental quality of core and desirable services
- Ensures compliance with JACIE accreditation
- Enables the delivery of the Nuffield Trust recommendations or support the realisation of the identified benefits
- Reduced capital outlay required
- Provides the Health Board with bespoke R&D requirements, including providing sufficient overnight stays
- Provides complex specialist oncology beds within the appropriate area at UHW
- Enhances research opportunities for patients from across South Wales
- Establishes a new partnership with Cardiff University and creates a focus for cancer research excellence to attract commercial and third sector funding into Wales
- Is advantages to attract an expert cancer workforce into Wales

Disadvantages

- No improvements to the Haemophilia Centre, including optimising flows and safeguarding for children
- There would be no efficiencies with outpatients as this element of the service would not be co-located with other haematology services

3.3.1.4 Option 1.3: The 'Core, Desirable and Optional'' Scope

Description

The services included are Core and Desirable Services plus:

- Haematology Outpatients, UHW
- Cardiff Haemophilia Centre, UHW
- Acute Oncology Unit, UHW

Advantages

- Improvement in the environmental quality of all haematology services at UHW
- Would ensure future JACIE accreditation
- Provides the Health Board with bespoke R&D requirements, including providing sufficient overnight stays
- provides complex specialist oncology beds within the appropriate area at UHW
- Enhances research and innovation opportunities

Disadvantages

- Requires significant capital investment and is potentially unaffordable
- Potentially unachievable as unlikely to be supported by WG

3.3.1.5 Overall conclusion: scoping options

Option 1.0: business as usual is unsustainable and fails to address safety and compliance issues within the haematology/BMT services at UHW and was discounted for further detailed analysis but will be retained as a baseline comparator.

Option 1.2 has been carried forward as the preferred choice for assessment within the next category.

3.3.2 Service Solution Options

This range of options considers potential solutions in relation to the preferred scope. The range of options that have been considered are:

Option 2. 0 Business As Usual	Option 2.1 Do Minimum	Option 2.2 Intermediate	Option 2.3 Maximum
Backlog maintenance is addressed	Backlog maintenance is addressed and refurbishment of the accommodation the services currently occupy	Backlog maintenance is addressed and refurbishment of other potentially available existing Health Board accommodation	New build

Table 16: Service Solution Options

The table below summarises the assessment of each option against the spending objectives and CSFs:

Option:	2.0	2.1	2.2	2.3
Spending Objectives				
1: Quality and Safety of Services	X	✓	✓✓	✓✓
2: Provide a high-quality physical environment	X	✓	✓	✓✓
3: Access	X	X	✓✓	✓✓
4: Effective use of Resources	✓	✓	✓✓	✓
5: Sustainability	X	X	✓	✓✓
Critical Success Factors				
1: Business Needs	X	X	✓✓	✓✓
2: Strategic Fit	X	X	✓✓	✓✓
3: Benefits Optimisation	X	X	✓✓	✓✓
4: Potential Achievability	✓	X	✓	✓✓
5: Supply Side Capacity and Capability	✓✓	✓✓	✓✓	✓✓
6: Potential Affordability	✓✓	✓✓	✓✓	✓✓
Summary	Discounted	Discounted	Carried Forward	Preferred Way Forward

Table 17: Summary Assessment of Service Solution Options

Key: ✓✓ - fully achieves ✓ - partially achieves X - does not achieve

3.3.2.1 Option 2.0: Backlog maintenance issues are addressed

Description

Only backlog maintenance issues are addressed

Advantages

- Reduced capital outlay required

Disadvantages

- No improvement in the quality of accommodation
- Significant disruption to existing services whilst work is carried out
- Unlikely to achieve JACIE accreditation
- No improvements to service capability/capacity which will reduce access to service along with lack of integration with day case service would create longer waits for clinically compromised patients negatively impacting JACIE access standards

3.3.2.2 Option 2.1: Do Minimum

Description

Backlog maintenance is addressed and refurbishment of the accommodation the services currently occupy

Advantages

- Limited improvements in the environment for patients, staff and visitors
- Limited improvements to service capability

Disadvantages

- Significant disruption to haematology/BMT services
- Some disruption to the wider site during construction
- Reduction in the number of BMT beds due to the need to increase ensuite provision to meet JACIE requirements
- Unlikely to meet all JACIE requirements as insufficient area within the existing haematology footprint to achieve all necessary improvements to facilities
- No improvements in service capacity

3.3.2.3 Option 2.2: Intermediate

Description

Backlog maintenance is addressed and refurbishment of existing potentially available Health Board accommodation

Advantages

- Improvements in the environment for patients, staff and visitors
- Improvements to service capability
- Provides sufficient capacity to meet future demand
- Will fully meet JACIE requirements
- Provides the opportunity to collocate close to critical care for critically ill patients

Disadvantages

- Disruption to the wider site during construction
- Potentially impacts on other Health Board services

3.3.2.4 Option 2.3: Do Maximum

Description

This option would provide the required accommodation within a new build facility on the UHW site.

Advantages

- Significant improvements in the environment for patients, staff and visitors
- Improvements to service capability
- Less disruption to patients
- Provides sufficient capacity to meet future demand
- Will fully meet JACIE requirements

Disadvantages

- Disruption to the wider site during construction
- Planning permission would be required

3.3.2.5 Overall conclusion: service solutions options

Options 2.0, and 2.1 have been discounted as they do not meet the spending objectives and critical success factors.

Option 2.3 has been carried forward as the preferred choice for assessment within the next category.

3.3.3 Service Delivery Options

This range of options considers the options for service delivery in relation to the preferred scope and potential solution.

The ranges of options that have been examined are:

Option 3.1	Option 3.2	Option 3.3
In-house	Strategic Partnership	Outsource

Table 18: Service Delivery Options

The table below summarises the assessment of each option against the spending objectives and CSFs:

Option:	3.1	3.2	3.3
Spending Objectives			
1: Quality and Safety of Services	✓✓	✓	✓
2: Provide a high-quality physical environment	✓✓	✓	✓
3: Access	✓✓	✓	✓
4: Effective use of Resources	✓✓	✓	X
5: Sustainability	✓✓	✓	✓
Critical Success Factors			
1: Business Needs	✓✓	✓	X
2: Strategic Fit	✓✓	✓	X
3: Benefits Optimisation	✓✓	✓	X
4: Potential Achievability	✓✓	X	X
5: Supply Side Capacity and Capability	✓✓	X	X
6: Potential Affordability	✓✓	✓	✓
Summary	Preferred Way Forward	Discounted	Discounted

Table 19: Summary Assessment of Service Delivery Options

Key: ✓✓ - fully achieves ✓ - partially achieves X - does not achieve

3.3.3.1 Option 3.1: In-house

Description

In-house delivery of proposed services and facilities by the Health Board.

Advantages

The main advantages are that:

- Retains the income stream for this work
- Retains control over the quality of the service
- Maintain care closer to home for patients
- Maintains clinical skills and experience the Health Board
- Maintains flexibility to accommodate required changes in service delivery
- Ensures seamless pathways for patients

Disadvantages

The main disadvantages are that:

- Risk remains with the Health Board
- Requirement to provide a suitable, fit for purpose environment
- Capital investment required

3.3.3.2 Option 3.2: Strategic Partnership

Description

This option describes the provision of services through a strategic partnership.

Advantages

The main advantages are that:

- No capital investment required
- Retains some control over the quality of services

Disadvantages

The main disadvantages are that:

- Potential increase in revenue cost
- Some loss of the income stream for this work
- Some loss of control over the quality of the service
- Patients may have to travel further for their care
- Finding a suitable partner who can provide the required services and capacity within the timescales
- Potential loss of clinical skills within the Health Board
- Patients will move between providers which could complicate the pathway and cause delays

3.3.3.3 Option 3.3: Outsource

Description

Outsource delivery of proposed services and facilities to another provider.

Advantages

The main advantages are that:

- No capital investment required

Disadvantages

The main disadvantages are that:

- Finding a suitable provider who can provide the required capacity within the timescales
- Reduced flexibility to accommodate required changes in service delivery and facilities
- Patients may have to travel further for their care
- Potential loss of clinical skills within the Health Board
- Patients will move between providers which could complicate the pathway and cause delays

3.3.3.4 Overall conclusion: service delivery options

Given this service is an essential NHS service the only practicable and acceptable service delivery option available is a wholly in-house NHS staffed solution, as it delivers all of the spending objectives and critical success factors. Therefore Option 3.1 has been carried forward as the preferred way forward.

3.3.4 Implementation Options

This range of options considers the choices for implementation in relation to the preferred scope, solution and method of service delivery.

Option 4.1	Option 4.2
Phased	Big Bang (single phase)

Table 20: Implementation Options

The table below summarises the assessment of each option against the spending objectives and CSFs:

Option:	4.1	4.2
Spending Objectives		
1: Quality and Safety of Services	✓✓	✓✓
2: Provide a high-quality physical environment	✓✓	✓✓
3: Access	✓✓	✓✓
4: Effective use of Resources	✓✓	✓
5: Sustainability	✓✓	✓✓
Critical Success Factors		
1: Business Needs	✓✓	✓✓
2: Strategic Fit	✓✓	✓✓
3: Benefits Optimisation	✓✓	✓✓
4: Potential Achievability	✓✓	X
5: Supply Side Capacity and Capability	✓✓	✓✓
6: Potential Affordability	✓✓	X
Summary	Preferred Way Forward	Discounted

Table 21: Summary Assessment of Implementation Options

Key: ✓✓ - fully achieves ✓ - partially achieves X - does not achieve

3.3.4.1 Option 4.1: Phased

Description

This option assumes that the implementation of the required services would be phased on an incremental basis in order to maintain the appropriate service capacity throughout the project.

Advantages

The main advantages are that:

- Delivers the preferred service solution option

Disadvantages

The main disadvantages are that

- Longer timescales
- Potentially higher costs and longer programme
- Could disrupt current services for longer

3.3.4.2 Option 4.2: 'Big Bang'

Description

This option assumes that all the required services could be delivered within one phase.

Advantages

The main advantages are:

- Shorter timescales
- Less disruption to existing services

Disadvantages

The main disadvantages are that

- Potentially higher costs as decant accommodation would be required
- Does not deliver the preferred service solution option

3.3.4.3 Overall conclusion: implementation options

Option 4.1 a phased solution is the only possible implementation option.

3.3.5 Funding Options

This range of options considers the choices for funding and financing in relation to the preferred scope, solution, method of service delivery and implementation. The options are as follows:

Option 5.1	Option 5.2
Public Funding	Private Funding

Table 22: Funding Options

3.3.5.1 Option 5.1: Public Funding

Description

The options for public funding are essentially to secure funding from WG through the capital programme.

Advantages

The main advantages are that:

- The Health Board can manage its assets and ongoing plans for estate rationalisation and development as part of a long-term financial model
- The Health Board can assure greater control of expenditure and cost through direct management of development activities
- The Health Board can retain existing assets for disposal when market conditions are more favourable

Disadvantages

The main disadvantages are that:

- The Health Board needs to secure funding from WG

Conclusion

It is considered that this is the more sensible and achievable option for the Project.

3.3.5.2 Option 5.2: Private Funding

Description

Under this option, the required services and facilities might be provided on a PPP basis from a single service provider or consortium made up of potential service providers on the private sector side.

The assets underpinning the provision of services would be an integral part of the service and indistinguishable within the resultant service charge. All elements of the service would be within the potential scope of the deal.

Relevant background

The Confederation of British Industry (CBI) has developed the following criteria for assessing the eligibility of public sector investment schemes against private funding arrangements (CBI Report: Private Skills in Public Service). The Project Team has assessed the potential for private finance using these criteria.

	High	Medium	Low
1. Output / service delivery driven	✓		
2. Substantial operating content within the project			✓
3. Significant scope for additional/alternative uses of the asset			✓
4.Scope for innovation in design			✓
5.Surplus assets intrinsic to transaction			✓
6.Long contract term available		✓	
7. Committed public sector management		✓	
8.Political sensitivities are manageable			✓
9. Risks primarily commercial in nature	✓		
10.Substantial deal			✓
11.Complete or stand-alone operations to allow maximum synergies		✓	
Note: none of these conditions will themselves guarantee success but they point to a particular direction and allow for a more informed decision			

Table 23: Assessment of favourable characteristics for a privately financed project

Advantages

The main advantages are that:

- Any commercial transaction can be tailored to reduce the Health Board's risk exposure
- The Health Board is not dependent upon securing monies from the WG Capital Programme
- The disposal of any existing assets could be factored into a commercial deal
- Ongoing maintenance and part-operation of the new facilities could be factored into the commercial deal

Disadvantages

The main disadvantages are that:

- Public Private Partnerships are becoming a rarer option
- There are significant timescales, costs and resources required to establish a commercial settlement
- The recurrent costs of PPP are much greater than a traditionally procured solution, as measured by the Unitary Payment
- The size and scope of the Project is unlikely to be attractive to private sector partners in the current macro-economic environment

Conclusion

In the context of this investment, it is considered that there is very limited likelihood of reaching a commercial settlement on private funding for the proposal. It is also very likely that the recurrent Unitary Payment would not be affordable within agreed investment profiles.

3.3.5.3 Overall Conclusion: Funding

Use of the CBI table above indicates that the deal would not be suitable for private finance because the risks are significantly greater than any perceived benefits.

3.4 The Long List: Options Framework

The framework options long list options findings are summarised below as per business case guidance:

Framework Options	Business As Usual	Do Minimum	Intermediate	Do Maximum
Potential Service Scope Options – as outlined in the strategic case	1.0 BAU: Existing Haematology/BMT, Cancer Research and Complex Specialist Oncology services (no beds)	1.1 Core Services: Haematology/BMT Inpatients, UHW Haematology/BMT Day Centre, UHW Advanced Therapies, UHW	1.2 Core Services plus: Cardiff Cancer Research Hub, UHW Complex Specialist Oncology, UHW	1.3 Core and Desirable Services plus: Haematology Outpatients, UHW Cardiff Haemophilia Centre, UHW Acute Oncology Unit, UHW
	Discounted	Carried Forward	Preferred Way Forward	Discounted
Potential Service Solution Options – in relation to the preferred scope	2.0 Backlog maintenance is addressed	2.1 Backlog maintenance is addressed and refurbishment of the accommodation the services currently occupy	2.2 Backlog maintenance is addressed and refurbishment of other potentially available existing Health Board accommodation	2.3 New build
	Discounted	Discounted	Carried Forward	Preferred Way Forward
Potential Service Delivery Options - in relation to preferred scope and solution	3.1 In-house		3.2 Strategic Partnership	3.3 Outsource
	Preferred Way Forward		Discounted	Discounted
Potential Implementation Options – in relation to preferred scope, solution and method of service delivery		4.1 Phased		4.2 Big Bang (single phase)
		Preferred Way Forward		Discounted
Potential Funding Options – in relation to preferred scope, solution, method of service delivery and implementation		5.1 Public Funding		5.2 Private Funding
		Preferred Way Forward		Discounted

Table 24: Options Framework

3.5 The Short Listed Options

The preferred and possible solutions identified in the table above have been carried forward into the short list for further appraisal and evaluation. All the options that were 'discounted' as impracticable have been excluded at this stage. Business As Usual was excluded from further detailed analysis but has been retained as the baseline comparator. Based on this hi-level non-financial analysis, the recommended short list for further appraisal as per business case guidance is as follows:

Framework Options	Option 0	Option 1	Option 2	Option 3
	Business As Usual	Do Minimum/ Less Ambitions	More Ambitious	Preferred Way Forward
Service Scope	1.0 Existing haematology/BMT, cancer research and Complex Specialist Oncology services (no beds)	1.1 Core Services: Haematology/BMT Inpatients, UHW Haematology/BMT Day Centre, UHW Advanced Therapies, UHW	1.2 Core Services plus: Cardiff Cancer Research Hub, UHW Complex Specialist Oncology, UHW	1.2 Core Services plus: Cardiff Cancer Research Hub, UHW Complex Specialist Oncology, UHW
Service Solution	2.0 Backlog maintenance is addressed	2.3 New Build	2.2 Backlog maintenance is addressed and refurbishment of existing Health Board accommodation	2.3 New Build
Service Delivery	3.1 In-house			
Implementation	N/A	4.1 Phased	4.1 Phased	4.1 Phased
Funding	5.1 Public Funding			

Table 25: Short List of Options

3.5.1 Summary Assessment of Short-Listed Options

Based on the table above the initial short list is:

- Option 0 – Business as usual (for comparative purposes)
- Option 1 – core services only at UHW, within a new build on the UHW site
- Option 2 – core and desirable services within Health Board refurbished accommodation. Within option 2 there are three possible physical solutions:
  - 2a – Provide the required accommodation for the preferred scope within a refurbished/remodelled Lakeside Wing
  - 2b - Provide the required accommodation within a refurbished/remodelled area on the ground floor of the main hospital adjacent to the existing haematology/BMT services, currently occupied by general outpatients and the Haemophilia Centre. Re-provide the displaced general outpatient department within a refurbished/remodelled Lakeside Wing and the displaced Haemophilia Centre within a refurbished Highly Contagious Infectious Diseases Unit (HCID) Unit
  - 2c – Provide the required accommodation within a refurbished/remodelled area on the seventh floor of the main hospital building
- Option 3 – core and desirable services within a new building on the UHW site Within this option there are two possible solutions:
  - Option 3a – core and desirable services provided within a traditionally built new build on the site of the current HCID Unit on the car park above the main hospital entrance
  - Option 3b – core and desirable services provided within a new modular building on the site of the current HCID Unit on the car park above the main hospital entrance

The short listed options, including sub-options (relating to location) have been further analysed against the spending objectives and critical success factors. The table below shows the outcome of this analysis:

Option:	0	1	2a	2b	2c	3a	3b
Spending Objectives							
1: Quality and Safety of Services	X	✓	X	✓✓	✓	✓✓	✓✓
2: Provide a high-quality physical environment	X	✓✓	✓✓	✓	X	✓✓	✓✓
3: Access	X	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
4: Effective use of Resources	✓	✓	X	✓✓	✓✓	✓	✓✓
5: Sustainability	X	✓	X	✓	X	✓	✓✓
Critical Success Factors							
1: Business Needs	X	✓	✓✓	✓✓	✓✓	✓✓	✓✓
2: Strategic Fit	X	✓	X	✓✓	✓	✓✓	✓✓
3: Benefits Optimisation	X	✓	✓✓	✓✓	✓✓	✓✓	✓✓
4: Potential Achievability	✓	✓✓	✓✓	✓	X	✓	✓✓
5: Supply Side Capacity and Capability	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	✓
6: Potential Affordability	✓✓	✓✓	✓	✓✓	✓	✓✓	✓✓
Summary	Discounted	Possible	Discounted	Possible	Discounted	Possible	Preferred Way Forward

Table 26: Short Listed Option Analysis

Key: ✓✓ - fully achieves ✓ - partially achieves X - does not achieve

On the basis of this analysis, the recommended short list for further appraisal within the OBC is as follows:

- Option 0 – Business as usual (for comparative purposes)
- Option 1 – core services only at UHW, within a new build on the UHW site
- Option 2b - Provide the required accommodation for core and desirable services within a refurbished/remodelled area on the ground floor of the main hospital adjacent to the existing haematology/BMT services, currently occupied by general outpatients and the Haemophilia Centre. Re-provide the displaced general outpatient department within a refurbished/remodelled Lakeside Wing and the displaced Haemophilia Centre within a refurbished HCID Unit
- Option 3a – core and desirable services provided within a traditionally built new build on the site of the current HCID Unit on the car park above the main hospital entrance
- Option 3b – core and desirable services provided within a new modular building on the site of the current HCID Unit on the car park above the main hospital entrance

Option 3b offers the following advantages over option 3a:

- Speed: One of the primary advantages of MMC in construction is the significantly reduced programme on-site through the use of prefabricated elements
- Lower assembly cost: By using fewer parts, decreasing the amount of labour required, and reducing the number of unique parts, MMC can significantly lower the cost of assembly
- Higher quality and sustainability: A highly automated approach can enhance quality and efficiency at each stage. There may be less waste generation in the construction phase, greater efficiency in site logistics, and a reduction in vehicle movements transporting materials to site
- Shorter assembly time: MMC shortens assembly time by utilising standard assembly practices such as vertical assembly and self-aligning parts. MMC also ensures that the transition from the design phase to the production phase is as smooth and rapid as possible
- Increased reliability: MMC increases reliability by lowering the number of parts, thereby decreasing the chance of failure
- Safety: By removing construction activities from the site and placing them in a controlled factory environment there is the possibility of a significant positive impact on safety

Option 2a and 2c have been discounted. Option 2a is not viable from a clinical perspective due to the distance of the Lakeside Wing to core support services such as ITU. Option 2c has been discounted as there is insufficient space to create the required accommodation to an acceptable standard.

For ease of reference these have been re-numbered as follows:

- Option 0 – Business as usual (for comparative purposes)
- Option 1 – core services only at UHW, within a new build on the UHW site
- Option 2 - Provide the required accommodation for core and desirable services within a refurbished/remodelled area on the ground floor of the main hospital adjacent to the existing haematology/BMT services, currently occupied by general outpatients and the Haemophilia Centre. Re-provide the displaced general outpatient department within a refurbished/remodelled Lakeside Wing and the displaced Haemophilia Centre within a refurbished HCID Unit (previously option 2b)
- Option 3 – core and desirable services provided within a traditionally built new build on the site of the current HCID Unit on the car park above the main hospital entrance (previously option 3a)
- Option 4 – core and desirable services provided within a new modular building on the site of the current HCID Unit on the car park above the main hospital entrance (previously option 3b)

Information regarding each of these shortlisted options can be found within the Estates Annex.

3.5.2 Economic Appraisal

An initial high level economic analysis has been undertaken in line with Green Book Treasury guidance on the costs and risks of the options outlined in this SoC. A number of theoretical benefits have been identified at SOC stage and will be calculated and refined as part of the outline business case process. They have not been quantifies for the SoC.

3.5.2.1 Assumptions

- An economic appraisal has been run for 60 years at a 2022/23 price base and with capital costs at 300 pubsec index
- Lifecycle costs have been estimated at standard levels and will be refined at OBC level
- A high level risk analysis has been undertaken to show operational risks of new and existing models and estate implementation of the new model
- R&D income has been assumed within the model to cover additional costs for option 2 to 4. This will be reviewed in more detail as part of the OBC
- A full benefits analysis will be undertaken at OBC
- A draft CIA model has been submitted with this SOC

3.5.2.2 *Capital Costs*

Capital costs have been included within the SOC as below based on QS calculations and with optimism bias.

Capital Costs	Option 0	Option 1	Option 2	Option 3	Option 4
Works Cost	750	29,334	42,682	36,401	40,508
Fees	122	4,796	6,979	5,952	1,904
Non-Works	194	2,414	2,081	2,463	2,413
Equipment	0	1,988	3,314	2,539	2,539
Planning contingency	107	3,853	5,506	4,735	4,736
Optimism Bias	0	6,116	17,720	7,516	6,976
Total Capital Costs at Approval Pubsec	1,173	48,502	78,281	59,605	59,076
VAT	210	8,603	13,852	10,559	11,383
Total Capital Costs at Approval Level	1,383	57,105	92,134	70,164	70,459
Pubsec Index at Approvals Level	292	300	300	300	300

Table 27: Capital Costs

The capital cost forms are included as Appendix 6, which show the costs excluding optimism bias.

3.5.2.3 *Revenue Costs*

Revenue costs have been calculated at a high level using draft workforce assessments and facility management costs based on square areas. Work with clinical and estates teams will refine these costs at OBC level.

Research and Development costs have been assumed at this stage to be covered by additional external income which has been included within the model for options 2, 3 and 4. A Strategic Investment Case for the Cardiff Cancer Research Hub is being developed by the partnership organisations (CVUHB, Cardiff University and Velindre UNHST) with the expectation of completion in September 2023. This work will be refined at OBC with a more detailed market analysis.

Revenue Costs	Option 0 £000	Option 1 £000	Option 2 £000	Option 3 £000	Option 4 £000
Facilities and Estates	301	1,435	2,486	1,854	1,854
HAEM BMT	30,313	32,284	32,284	32,284	32,284
CCRH			2,298	2,298	2,298
Specialist Complex Oncology			1,971	1,971	1,971
Revenue Costs in CIA	30,614	33,719	39,039	38,407	38,407
Net External Contribution			(2,298)	(2,298)	(2,298)
Cost within CIA	30,614	33,719	39,039	38,407	38,407

Table 28: Revenue Costs

3.5.2.4 Economic Outputs

The table below presents a summary of the key outputs of the economic appraisal based on the assumptions and inputs described above, expressed as Net Present Values (NPV). It shows discounted values for each option of:

- Costs (Capital, Revenue, Externalities and Risk), and
- Benefits (Standard NHS efficiencies)

The Net Present Social Value (NPSV) is established by comparing the incremental change of each development option compared to Option 0 (Business as Usual). The headline Benefit Cost Ratio (BCR) is the ratio of total incremental benefits (including cost reductions) over total incremental costs.

Economic Impact in NPV terms	Option 0 £000	Option 1 £000	Option 2 £000	Option 3 £000	Option 4 £000
Net Present Cost (NPC) of Costs					
Opportunity	0	0	0	0	0
Capital	1.4	52.6	91.9	72.1	72.4
Revenue	824.2	895.9	1018.9	1001.1	1004.3
Externalities	0	0	0	0	0
Risk	0	0	0	0	0
Total Costs NPC	**934.2**	**1,026.3**	**1202.4**	**1160.4**	**1167.0**
Net Present Value (NPV) of Benefits	0	0	0	0	0
NPV non-Cash releasing Benefits	0	0	0	0	0
NPV Societal	0	0	0	0	0
Net Contribution (Benefit)	0	0	53.1	51.1	53.1
Total Benefits NPV	**0**	**0**	**53.1**	**51.1**	**53.1**
Incremental Impact					

Economic Impact in NPV terms	Option 0 £000	Option 1 £000	Option 2 £000	Option 3 £000	Option 4 £000
Total Incremental Cost Increases (Capital)	0	(50.1)	(89.5)	(69.7)	(70.0)
Incremental Cost - Revenue	0	(71.8)	(194.8)	(176.9)	(180.2)
Incremental cost reduction – opportunity cost	0	0	0	0	0
Incremental cost reduction - revenue	0	0	0	0	0
Incremental cost reduction – net contribution	0	0	53.1	51.1	53.1
Incremental cost reduction - risk	0	29.9	16.1	18.9	17.4
Net Present Social Value (NPSV)	**0**	**(92.0)**	**(215.0)**	**(176.6)**	**(179.6)**
Benefit Cost Ratio		**3**	**4**	**1**	**2**
Economic Ranking of Options				**0.7%**	
BCR Switch Value				(0.002)	0.002

Table 29: Economic Appraisal of Options

A detailed assessment of benefits will be undertaken as part of the OBC appraisal but at this stage the economic analysis indicates that:

- Option 3 has the better benefits cost ratio before the more detailed analysis is undertaken but it is very close to Option 4 at this stage and sensitivity analysis would show that further work required on benefits should provide a clearer statement. The wider benefits and flexibility allowed from Option 4 as a modular build are such that this option may preferable

An output summary of the economic appraisal is included as Appendix 7.

3.5.2.5 Economic Sensitivity Testing

Sensitivity testing has been undertaken to assess the extent to which the key cost drivers would have to change differentially between options sufficiently to switch economic preference.

The table below shows the % changes that would be needed to either (a) initial capital costs or (b) the revenue cost of delivering activity and capacity requirements in 2032.

% Change Required to NPC or NPV elements	Option 3	Option 4
Incremental Cost Increase Capital	3.5%	(4.0%)
Incremental Cost Increase - revenue	1.4%	(1.4%)
Incremental cost increase - risks	0.0%	0.0%
Total Incremental Cost Change Needed	(2,466)	2,502

Table 30: Economic Sensitivity – Differential Change % required to Trigger Switch Value

This confirms that:

- Option 3 shows the better option before a full benefits analysis is undertaken but further work undertaken at OBC will provide a clearer statement. In particular, the wider benefits and flexibility of Option 4 as a modular build are relevant

3.5.2.6 Benefits to be developed for OBC

In preparation for the OBC a detailed analysis of quantifiable benefits will be undertaken to assess the relative impact of each of the options. The table below lists the potential benefits identified to date. This list will be refined and expanded where further opportunities are identified.

Potential Benefit	Realisable Benefit	Quantification Method
Improved Outcomes	Improved clinical outcomes	Patient by number of years by QUALYS
	Economic return on extended life	Patient by number of years by average salary
	Fewer Relapses and treatments - reduced treatments	Reduced number of readmissions
Increased Efficiency	Reduction in Length of stay due to effective triage on risk/infection control	Number of days estimated to be saved by average cost per day, transfers to other hospital areas?
	Reduced travelling for patients repatriated	Patients not transferred by estimated miles, incl NHS transport costs if possible
	Increased staff retention and recruitment	Reduction in staff agency and turnover costs and service resilience
	Increased staff efficiency through better designed facilities	Number of hours realised by average hourly rate
	Business opportunity in beds now not filled with haematology patients	Average cost by bed days saved
	Reduction on A&E attendances through direct access to local services	A&E attendance by number of future diversions
	Savings on costs of services commissioned elsewhere	identify cost to commissioner of patients no longer transferred
	Improved patient flows	Reduced length of stay
Cost savings	R&D opportunities	Estimate potential market

Potential Benefit	Realisable Benefit	Quantification Method
	Savings on costs of services commissioned elsewhere Staffing economies of scale	identify cost to commissioner of patients no longer transferred Cost of new structures
Wider Social Benefits	Impact of Net Zero Targets Travel Impact on patients and carers	Liaise with QS and estates Costed journeys and time saved

Table 31: Potential Benefits

It is anticipated that this work will confirm that option 3 and 4 are clearly preferred options whilst also providing a clear proposal which of those two options is the clear preferred option.

3.6 The Preferred Way Forward

The preferred way forward at this SOC stage is option 3 or option 4. Under both of these options the proposal will provide BMT and Haematology services to meet JACIE compliance. It will also ensure co-location with the Cardiff Cancer Research Hub (CCRH) and beds for Complex Specialist Oncology. This is an essential component to effectively and efficiently deliver the wider the clinical model which is essential to deliver the model for non-surgical tertiary cancer services in south east Wales as outlined in the Nuffield report.

Given the wider potential benefits and flexibility associated with Option 4 as a modular build, the financial case has considered the valuation and associated capital charges of this preferred option at SOC stage.

The following table shows the key changes in bed numbers

	Current	Planned
General Haematology	17	20
BMT	9	18
BMT (readmission)	0	6
CAR-T	1	6
Clinical Trials (Haematology)	0	4
R&D (Cardiff Cancer Research Hub)	0	
Complex Specialist Oncology	0	4
TOTAL	**27**	**58**

Table 32: Proposed Changes to Bed Numbers

Due to the limited footprint the massing of a new build development on the site of the current Highly Contagious Infectious Diseases Unit on the car park above the main hospital entrance at lower ground floor level would require between 5-8 floors to provide the required departmental services, plant and communication space for the range of priority options.

To facilitate this option, the new building will be on stilts for continued use of the drop-off area around the hospital entrance. Additionally, a new link bridge will be required to connect back to the existing hospital.

The total anticipated floor area is 7,704sqm, the full schedule of accommodation can be seen within Appendix 8.

Details of the preferred option are within the Estates Annex that accompanies this SOC.

Commercial Case

4.0 THE COMMERCIAL CASE

4.1 Introduction

This section of the SOC outlines the proposed procurement process in relation to the preferred option outlined in the economic case. It gives a very high level, preliminary view and detailed analysis will take place during the development of the OBC.

The preferred construction method is Modular Build, procured through a two-stage tendering process, via the Shared Business Services (SBS) or via an open tender option, this will be further explored in the OBC.

Dialogue with colleagues from the NHS Wales Shared Services Partnership – Specialist Estates Services has been undertaken to explore the benefits of the preferred procurement option.

4.2 Required Services

The scope of services required is for the project management, cost advice and the design and construction of a new build modular construction.

4.3 Potential for Risk Transfer

This section provides an initial assessment of how the associated risks might be apportioned between the Health Board and any main contractor. Detailed analysis of risks will be undertaken during the OBC stage.

The general principle is to ensure that risks should be passed to 'the party best able to manage them', subject to value for money (VFM). The table below outlines the potential allocation of risk:

Risk Category	Potential Allocation		
	Public	Modular Build Supply Chain Partner	Shared
Design Risk		✓	
Construction & Development Risk			✓
Transition & Implementation Risk			✓
Availability and Performance Risk			✓
Operating risk	✓		
Variability of Revenue Risks	✓		
Termination Risks	✓		
Technology & Obsolescence Risks			✓
Control Risks	✓		
Residual Value Risks	✓		
Financing Risks	✓		

Risk Category	Potential Allocation		
	Public	Modular Build Supply Chain Partner	Shared
Legislative Risks			✓
Other Project Risks			✓

Table 33: Potential Risk Allocations

4.4 Proposed Charging Mechanisms

The Health Board intends to make payments in respect of the proposed products and services as follows:

- Charging will be completed in accordance with the terms and conditions associated within the contract conditions or the SBS Framework terms and conditions
- The contract will be managed by Cardiff and Vale University Health Board under the NEC4 Option A Fixed Price Contract with Activity Schedule

4.5 Proposed Contract Lengths / Implementation Timescales

It is anticipated that the main building contract will run for approximately 14 months although the start date for this is dependent on the approvals process and securing support for the investment.

4.6 Proposed Key Contractual Clauses

Contractual Arrangements will be entered into with all parties using the NEC contract. For the Project Manager and Cost Advisor, the NEC 4 Professional Services Contract will be used, and for the Supplier, the NEC 4 Option A (Fixed Price with Activity Schedule) contract will be used.

Payments to the externally appointed team will be as prescribed in the individual NEC contracts, or in line with the framework practices and procedures.

4.7 Personnel Implications (including TUPE)

It is anticipated that the TUPE – Transfer of Undertakings (Protection of Employment) Regulations 1981 - will not apply to this investment.

4.8 Procurement Strategy

In deciding on the most appropriate procurement route, the following consideration have been made:

- The size and complexity of the works
- A cost effective procurement route
- Procurement which complies with UK Law
- The timescales and "as soon as" target date for delivery due to JACIE requirements
- The level of pre-works engagement with the contractor required under each procurement route
- The current status of the project with regard to design
- Potential future opportunities for the re-use or re-purpose of the facility procured

The diagram below shows a comparison between the Design for Life Framework and utilising a modular build partner:

Activity	Design for Life Framework		Modular Build Partner	
Design Quality / Compliance	Design team working for SCP partner. Design team interpreting Health Boards standards and required compliance with WHTM/WHBN/ local Health board policies; Provider designers work to this standard. Potential for HB preferred MEPH contractor engagement		Design team working for Modular Build partner. Design team interpreting Health Boards standards and required compliance with WHTM/WHBN/ local Health board policies; Provider designers work to this standard. Designers employed directly by Modulat Build no third party warranty or relationships. Potential for HB preferred MEPH contractor engagement	
Design Constraints / Impact on internal environment	Design coordination of building floor to floor heights, superstructure and substructure design, with engineering services and Health Board's preferred fit out unconstrained in terms of design and specification. Slab design and vibration response, acoustic performance etc all accommodated		Some defined vertical constraints. Internal fit out design is based on 2d component site fit out and therefore little impact / contraint on internal environment.	
Adaptability during design	Internal fit out is 'traditional' site work based and therefore changes to internal fit-out can be easily assimilated during design phase		Internal fit out is 'traditional' site work based and therefore changes to internal fit-out can be assimilated during design phase	
Adaptability during construction	Internal fit out is 'traditional' site work based and therefore changes to internal fit-out can be implemented during construction phase subject to contract provision for programme/cost agreement		Internal fit out is 'traditional' site work based and therefore changes to internal fit-out can be implemented during construction phase subject to contract provision for programme/cost agreement	
Procurement Risk	Framework provides skilled partner already pre-assessed. Partner well aware of the procurement requirements and processes associated with OBC/FBC delivery. SCP Partner workload may be excessive if successful in other tenders associated with wider NHS projects in Wales. If Option C used market testing needs to be considered for elements outside of the SCP skills, therefore potential for costs to be provided at "not to exceed", this can work for or against Clients. Restrictive market competition to framework providers only, may result in lack of innovation.		Two stage tender process. Ensuring early engaement with a skilled building resource. Specialists in the market that know capabilities of structures and honed building practices. Reduces pre-tender design timeframes. Restricts change ability once design agreed for any significant changes.	
Programme Risk	Design Programme stages 3/4 tailored to prioritise deliverables and Planning Submissions however market tested cost not available until stage 4 design complete and the market tested returns received, analysed and post tender clarifications resolved.		Design Programme Stage 3/4 led by provider including detailed planning. Programme to manufacture of 3D elements not confirmed at time of contract let.	
Cost Certainty	Option C Target Cost provides an element of cost certainty with the Scheule of Cost Components providing ancillary cost information. Risk of delay due to adverse weather during superstructure phase and longer period in site assembly/construction work also exposes works to stoppage due to helipad /other hospital operations. All construction options require traditional site civils works to create the substructure.		Detailed breakdown of costs through activity scheduless provide an element of cost certainty. Risk of delay due to advrse weathr, any disruption in fabrication of superstructure modules. Potential for stoppages and craning caused by helipad /other hospital operations. All construction options require traditional site civils works to create the substructure.	
Sustainability - Ability to adopt more sustainable construction materials/systems	Design unconstrained by system build can adopt highly sustainable construction strategy and materials - eg opportunity for CLT framing / superstructure. Structure can not be dismantled and reused elsewhere on or off site.		Steel framed 3D superstructure elements; all other components unconstrained. Structure can be dismanted and resued elesewhere on or off site.	

Figure 15: Procurement Comparison

Whilst there is very little to choose between the procurement options, the construction period on site and the disruption to an existing Hospital Site, which will be reduced with the modular construction, as much of the structure can be fabricated off site, supports Modular Build. In addition, the modular construction system offers flexibility and adaptability, enabling modules to be easily unbolted, removed, and relocated as needed.

In addition to the above elements, another significant benefit of modular construction systems is that no wall is weight-bearing. This characteristic provides the building with long-term flexibility, as it allows for the complete adaptation of the space into something else. Without the constraint of load-bearing walls, the interior layout can be easily reconfigured and modified according to evolving needs and preferences. This flexibility ensures that the building can be transformed or repurposed with relative ease, offering a sustainable and future-proof solution that can adapt to changing requirements over time.

The preferred procurement option is to deliver through a modular construction. The preferred option would be to procure via Shared Business Services (SBS). The SBS framework has options for both mini competition and direct award.

The framework states that “Participating Authorities have the ability to call off (Direct Award) without further competition” in certain circumstances which includes:

- Where the framework supplier has already carried out significant services “at risk” on behalf of the Authority in relation to the site to where the call off agreement will relate
- Where for reasons of urgency it is not reasonably practicable to award the call off agreement by way of mini competition

4.9 Accountancy Treatment

It is envisaged that the assets underpinning the delivery of service will be on the balance sheet of the Health Board.

Financial Case

5.0 THE FINANCIAL CASE

5.1 Introduction

The purpose of this section is to set out the indicative financial implications of the project and provide a high-level assessment of affordability. It should be noted the detailed analysis of the financial case will be undertaken as part of the OBC/FBC.

5.2 Capital Costs

A summary of the capital costs for the preferred way forward at this stage are as follows:

Capital Costs	Option 4 £m
Works Cost	40.508
Fees	1.904
Non-Works	2.413
Equipment	2.539
Planning contingency	4.736
VAT	10.420
VAT Recovery	(0.381)
Total Capital Cost/ Cost Forms	**62.139**

Table 34: Capital Costs for the Preferred Way Forward

The cost forms are included within Appendix 6.

5.3 Revenue Costs

The indicative revenue cost implications associated with the case are summarised below.

These should be considered alongside the multiple commissioning arrangements as described in Section 5.6.

Revenue Costs	Option 4 £m
Facilities and Estates	1.854
Haematology, BMT & CAR-T	32.284
CCRH	2.298
Specialist Complex Oncology	1.971
Revenue Costs in CIA	38.407
Net External Contribution	(2.298)
Cost within CIA	38.407

Table 35: Revenue Costs

Revenue cost estimates include:

- Estates and soft FM running costs
- BMT / CAR-T pay and non-pay, with reference to outline staffing requirements
- Indicative CAR-T product (ATMP) costs up to 80 patients, circa £16.250m
- Haematology and Specialist Complex Oncology bed day costs
- Service costs inherently include both direct and indirect support service implications, including, for example, therapies, pathology, pharmacy
- CCRH provisional workforce costs, although trials income is planned to manage this
- Remaining R&D clinical non-pay costs would be speculative subject to trial and are therefore excluded, with trials income also planned to manage such costs

The financial implications are high-level estimates at this stage and will be developed further as part of the OBC, and alongside the required commissioning planning processes.

5.3.1 Depreciation and Impairment

In line with other centrally funded capital schemes, the Health Board would anticipate that the non-cash implications of the scheme would be funded. That is, Welsh Government would provide funding to cover any additional depreciation costs or impairments arising from the scheme. Provisional impairment and depreciation estimates are reflected below:

	£m
Impairment	28.804
Depreciation – Building / Engineering	0.772 per annum
Depreciation - Equipment	0.609 per annum

Table 36: Depreciation and Impairment

Impairment is calculated based on advice from the District Valuer. The asset value post impairment has been depreciated over the estimated useful economic life (UEL) provided by the District Valuer. These estimates are provisional and will be revised as part of the OBC.

The following is a summary of the total impact of capital charges and depreciation by year

	2025/26 £m	2026/27 £m	2027/28 £m
DEL Impairment	0	0	0
AME Impairment	28.804	0	0
Total Impairment	28.804	0	0
Depreciation – Build	(0.003)	0.772	0.772
Depreciation - Equipment	0.000	0.609	0.609
Total Depreciation	(0.003)	1.381	1.381

Table 37: Impact of Capital Charges and Depreciation by Year

Depreciation continues per annum in line with UEL and the Health Board's usual accounting policy beyond 2027/28.

This business case assumes all capital charges and depreciation will be funded by WG in each of the years as per the above and on a recurring basis where relevant.

5.4 Impact on Income and Expenditure Account

The anticipated depreciation and indicative net revenue cost profile for the extent of the project and initial implementation is set out below:

	2025/26	2026/27	2027/28	2028/29	2029/30
	£m	£m	£m	£m	£m
Depreciation	- 0.003	1.381	1.381	1.381	1.381
Revenue Cost (Less Ext. Cont'n)		9.491	18.518	27.545	36.109

Table 38: Impact on Income and Expenditure Account

The revenue cost profile is yet to be confirmed subject to the detail around phased implementation aligned to both workforce and commissioning plans.

5.5 Impact on the Balance Sheet and Capital Spend Profile

All assets will be shown on the Health Board's balance sheet. The asset will be valued on completion and recorded on the balance sheet at that value. Subsequently it will be treated as per the Health Board's capital accounting policy.

The anticipated capital spend profile is set out below:

	2023/24 £m	2024/25 £m	2025/26 £m	2026/27 £m	2027/28 £m
Capital (Ex VAT) - DEL	0.390	7.190	44.520	0.000	0.000

Table 39: Capital Spend Profile

5.6 Funding Arrangements and Overall Affordability

The revenue consequences of the business case need to be considered in the context of multiple commissioning arrangements and income associated with trials.

BMT / CAR-T services are commissioned by WHSSC, with funding for AMTP developments currently supported by strategic WG allocation routed via LHBs. Investment to support a phased expansion of capacity to meet critical accreditation requirements and demand over the coming years will be met through successive Integrated Commissioning Plan (ICP) rounds. The allocation to LHBs would remain in line with 'Risk Share' arrangements, based on utilisation and/or pooling methodologies. This forms the largest consideration of the financial revenue case.

Current risk shares are set out below for information only

	CVUHB	SBUHB	CTMUHB	ABUHB	HDUHB	PTHB	BCUHB
SW BMT Programme	14.08%	14.18%	21.52%	31.33%	17.00%	1.89%	0.00%
AW ATMPs	15.83%	12.42%	14.20%	18.75%	12.29%	4.21%	22.29%

Table 40: Current Risk Shares

Specialist Complex Oncology beds are required to support the wider nVCC pathways in line with the Nuffield Trust recommendations. Given the nature of this cohort, consideration of funding via the WHSSC ICP process as part of specialised Blood and Cancer services is proposed. The Velindre Collective Commissioners Group will be asked to consider and endorse this recommendation. The responsible provider for this aspect of care will need to be determined and confirmed through the OBC/FBC, with consideration of Nuffield Trust's Report Recommendation 5, but also the practicalities of location and reporting protocols.

General Haematology is commissioned by LHBs and is subject to long standing 'Long Term Agreements (LTAs)'. Funding for the additional capacity will be agreed through the IMTP planning process, with contracts amended to reflect revised prices and activity baselines where required. Based on 2019/20 inpatient activity, respective Health Board utilisation is set out below for information:

	CVUHB	SBUHB	CTMUHB	ABUHB	HDUHB	PTHB	BCUHB
Haematology IP	47.45%	3.06%	16.63%	23.57%	8.47%	0.82%	0.00%

Table 41: UHB Inpatient Utilisation

Cancer Research is a key component to the development and sustainability of tertiary and specialist cancer services in Wales, and a core part of partnership working with Velindre and Cardiff University. Funding arrangements surrounding both the BMT/CAR-T trials beds and the Cardiff Cancer Research Hub (CCRH) are predicated on a 'cost neutral' model. Income from trials or other associated activities will support the revenue costs of the direct workforce and clinical non-pay. A discrete CCRH revenue business case will be taken forward through the partnership of CVUHB, VUNHST and CU.

One important consideration is the opportunity cost from a revenue perspective.

The current and future expansion of CAR-T indications in line with NICE appraisals would need to be implemented and services commissioned for the population. In the absence of capacity and accredited facilities within Wales, patients would require referral to other UK Centres at full price tariffs / pass-through costs for extensive stays. Growth in BMT demand would also need to be referred out of Wales at full price tariffs.

The affordability of the case is therefore summarised through the following funding streams:

	Commissioner	Funding Model
BMT	WHSSC	Successive WHSSC ICP Rounds
CAR-T	WHSSC	Successive WHSSC ICP Rounds
General Haematology	LHBs	LHB LTA Uplifts and local C&V Investment
Specialist Complex Oncology	Proposal for WHSSC on endorsement of VCCG	Successive WHSSC ICP Rounds, alongside nVCC
CCRH and R&D Beds	Tripartite C&V, VCC, CU	Discrete business case and income from trials

Table 42: Funding Streams

The commissioning arrangements will be finalised and confirmed at OBC/FBC stage, with consideration of WHSSC intentions regarding Specialist Haematology.

5.7 Project Bank Account

The Health Board can confirm that a Project Bank Account will be prepared at the appropriate stage as the project exceeds the Welsh Government value threshold for the mandatory use of Project Bank Accounts.

Management Case

6.0 THE MANAGEMENT CASE

6.1 Introduction

This section of the SOC addresses the "achievability" of the scheme and identifies how the project will be managed from its initiation to completion. Its purpose is to describe the arrangements that will be required to effectively govern and successfully manage the project and deliver it in accordance with best practice.

This section has been drafted based upon the lessons learnt from previous projects, incorporating proven arrangements, structures and processes to ensure the successful delivery of the project.

6.2 Project Management Arrangements

Robust project management arrangements are vital to ensure the implementation of the overall project and that effective control is maintained over the capital scheme.

For the Health Board to successfully deliver this project, it is vital that the following overall approach is taken for the organisation and management of the project:

- The Health Board will adopt the general principles of PRINCE 2 methodology in managing the activities and outputs of the project and will meet the requirements of the WHC (2018): 012; Infrastructure Investment Guidance; and subsequent guidance which may be issued during the projects' lifespan
- The project will use NHS Wales standard documentation and products where these are available, and will seek to benefit from experience and best practice from other NHS Wales projects
- Specialist professional and technical advisers will be employed for those activities where the necessary skills and experience are not otherwise available to the project team. The transfer of skills and knowledge from specialist advisers to the project team will be achieved wherever possible and appropriate

In managing the project, the Health Board aims to:

- Deliver the project on time and to budget
- Ensure effective and proactive lines of accountability and responsibility for the project deliverables, and
- Establish user involvement at all stages of the project

6.2.1 Outline Project Reporting Structure

The reporting organisation and the reporting structure for the whole of the project is shown as follows:

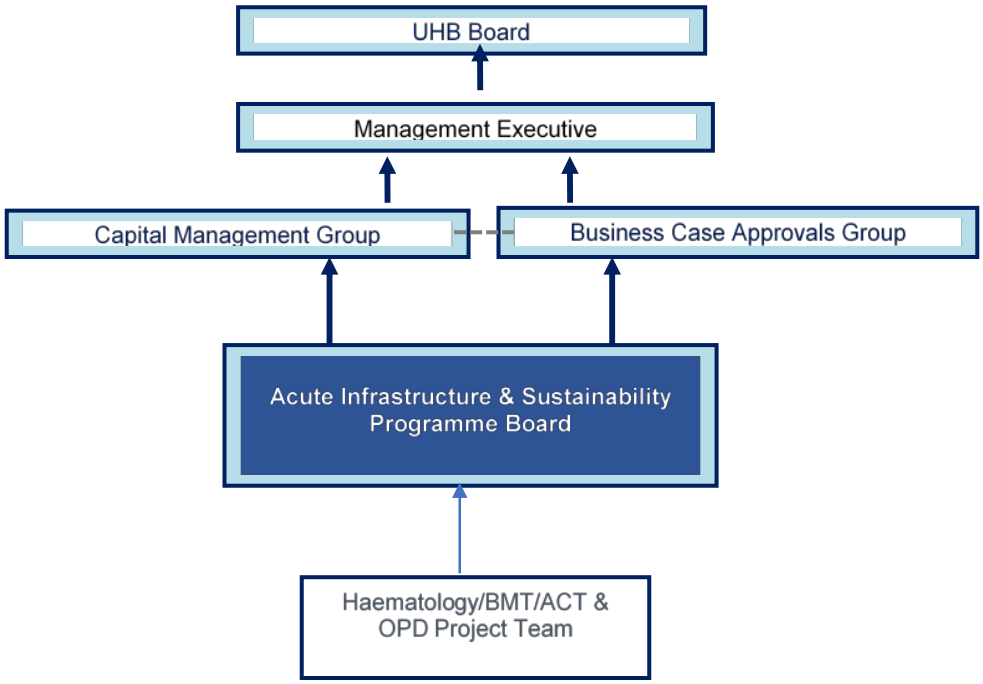


Figure 16: Outline Project Reporting Structure

6.2.2 Outline Project Roles and Responsibilities

The project roles and responsibilities are as follows:

6.2.2.1 Investment Decision Maker

In line with the NHS Wales Infrastructure Investment Guidance, it is recognised that there must be clarity on decision making authority and management arrangements.

The Investment Decision Maker is the Cardiff and Vale UHB Board. Their role is to:

- Ensure a viable and affordable business case exists and remains valid during the planning process
- Ensures that the appropriate level of business case is developed for submission to Welsh Government
- Maintain commitment to the project
- Authorise allocation of funds to the project
- Oversee project performance
- Ensure resolution of issues

6.2.2.2 *Senior Responsible Owner*

The Senior Responsible Owner (SRO) of this project is the Executive Director of Strategy and Planning, Abigail Harris. The SRO will monitor the development and progress of the programme and project at Executive Board level and will exercise executive responsibility for the capital aspects of the scheme including compliance with Financial Instructions and Standing Orders; will be responsible for responding to internal and external audit scrutiny and ensuring the appropriate interim reports are made to the Capital and Estates Division of Welsh Government in line with existing directives.

6.2.2.3 *Project Director*

The Director of Capital, Estates and Facilities, Geoff Walsh, will fulfil the role of Project Director for the project. The Project Director will have ultimate responsibility for the project and will ensure the project is focused, throughout its lifecycle on achieving the objectives and delivering the projected benefits. The Project Director will ensure that the project provides value for money and will act as the point of contact in all dealings with contractors, consultants and outside organisations involved in the construction process.

6.2.2.4 *Project Board*

The Acute Infrastructure and Sustainability Programme Board will act as the Project Board.

The Project Board will support the delivery of the project through:

- Ensuring that the project scope remains consistent with the strategic programme
- Providing formal approval at key stages to the project both in terms of business case development and formal submission to Welsh Government
- Providing the formal authority for committing resources to the project
- Ensuring that the scheme delivers appropriate value for money
- To provide regular reports on Programme Performance to Capital Management Group

6.2.2.5 *Project Team*

The purpose of the Project Team is to manage and co-ordinate, within the parameters set by the Project Board.

The Project Team will support the delivery of the project through:

- Taking actions to ensure all stages of the project are achieved within the identified timescales, reviewing progress on a regular basis
- Ensuring plans being developed fit within both the Capital Programme of the Health Board and the wider strategic service planning framework
- Developing and regularly reviewing the Project Risks Register and ensuring appropriate mitigation plans are developed
- Developing, agreeing and monitoring budgeting arrangements for project delivery
- Identifying and developing appropriate capital and revenue financing arrangements for the project ensuring both affordability and sustainability

- Every team member will have equal responsibility for identifying, at the earliest opportunity any major factors, risks or variances arising during the course of the project that may impact upon project delivery

6.2.2.6 Other Roles

The development of this project is supported by a range of corporate departments from within the Health Board including:

- Capital Planning
- Finance
- Strategic Clinical Engagement
- Workforce
- IM&T

6.3 Use of Specialist Advisors

Specialist advisors have been used in a timely and cost-effective manner in accordance with the Treasury Guidance: Use of Special Advisors:

Specialist Area	Adviser
Architects	BDP
Business Case Development	Adcuris Consulting Ltd
Cost Consultancy	Gleeds

Table 43: Specialist Advisors

6.4 Outline Project Programme

The dates detailed below highlight the proposed key milestones of the project:

Milestone Activity	Date
SOC Submission to WG	July 2023
OBC/FBC Submission to WG	April 2025
Design completion and commence construction	March 2025/July 2025
Construction completion	September 2026/ January 2027
Facility operational	September 2026/ January 2027

Table 44: Project Programme

NB: The design and construction periods differ depending upon the selected option at OBC with a modular construction providing a shorter timescale than a traditional build

6.5 Gateway Review Arrangements

Gateway Reviews undertaken across the health service have identified a range of common deficiencies within projects. These key areas have been reviewed under this project to ensure they were being managed as follows:

- Risk – A clearly structured risk management process has been put in place with regular review of the project risk register
- Roles and Responsibilities – A clear project structure exists for the management of this project with the Senior Responsible Officer and Project Director identified
- Skills and Resource – The Health Board is experienced and well-resourced and is supported by legal, financial and technical specialists
- Business Case - The need for a robust Business Case was identified at an early stage and has in part driven the project development
- Planning – A programme was developed early in the scheme development and has been a strong management tool in moving the project forward
- Stakeholder Issues – Stakeholder management has been a key focus in the projects development as it integrates various organisations
- Benefits – A clear benefits realisation plan has been developed and is embedded in the project processes
- Financial Issues – Finances have been robustly managed as the project has developed to ensure the project is affordable and value for money

The impact of the project has been scored against the risk potential assessment (RPA) model. A copy of the RPA form is attached as Appendix 9.

6.6 Recommendation

Cardiff and Vale UHB patients, staff and visitors would benefit substantially from the approval and financial support for this project. The proposed project will:

- Create an ambulatory model of treatment delivery for haematology/bone marrow transplant patients, which will meet both future service demand and address health and safety deficiencies and meets the requirements for JACIE accreditation
- Provide additional accommodation required to support advanced therapies
- Provide the required inpatient accommodation for complex specialist oncology patients
- Provide appropriate accommodation for the tripartite Cardiff Cancer Research Hub
- Provide an essential component to support the delivery of high quality cancer services across the region and support the achievement of the Nuffield Trust recommendations.

The timescale for the completion of the works will be dependent on the procurement route selected at OBC stage but is expected to be circa 18 months.

The Health Board would, therefore, recommend that WG give due consideration to the request for funding and approve the SOC enabling the scheme to progress to the OBC stage.

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	27/07/2023

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	06/06/2023	Approved

ACRONYMS	
nVCC	New Velindre Cancer Centre
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 **25/05/2023** – **18/07/2023.**

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

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

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	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 **25/05/2023** – **18/07/2023** as outlined in ***Appendix 1 of this report***.

Appendix 1

The following item was dealt with by Chairs Urgent Action:

1. DCWW Water Main Payment request – ASDA CONTRACT for the NVCC

The Trust Board were sent an email on the **06/06/2023** regarding the DCWW Water Main Payment request – ASDA Contract for the nVCC:

- To **APPROVE** £180,970.56+VAT (£217,164.67 including VAT), spend for the **Phase 1** water mains installation works

No objections to approval were received.

Independent Member, Martin Veale APPROVED this request and noted the Board discussions held on this matter, and that the supporting paper provided to the Board did not reference any details in regards to a possible remedy from DCWW as a result of their inaccurate information on the location of this pipe. A further update on any possible remedy (compensation) was requested to be provided once established.

Recommendation Approved by:

- Donna Mead, Chair
- Stephen Harries, Vice Chair
- Steve Ham, Chief Executive Officer
- Martin Veale, Independent Member
- Professor Andrew Westwell, Independent Member
- Sarah Morley, Executive Director of Orgaisational Development & Workforce

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 27 July 2023 to 28 September 2023

DATE OF MEETING	27 July 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	Matthew Bunce, Executive Director of Finance Cath O'Brien, ***(Appendix 1)*** Chief Operating Officer Gareth Hardacre – Director of People & OD and Employment Services ***(Appendix 2)***

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 ***(ref Appendix 1)***	08/06/2023	Endorsed
WBS Senior Management Team ***(ref Appendix 1)***	16/06/2023	Endorsed
NWSSP / NHS Wales Shared Services Partnership Committee ***(ref Appendix 2)***	20/07/2023	Approved

ACRONYMS	
BAT	Bottom and Top
BEs	Blood Establishments
EBP1	European Blood Pack 1
EBP2	European Blood Pack 2
EU	European Union
IBP1	International Blood Packs 1
IBP2	International Blood Packs 2
IMTP	Integrated Medium Term Plan
NHSBT	NHS Blood and Transplant

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 **27 July 2023 to 28 September 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. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendix 1-2** 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 July 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: 01/11/2023 End: 31/10/2027	£3,609,000
Appendix 2	NWSSP	TRAC Recruitment System	Start: 01/08/2023 End: 31/07/2026	£3,057,840

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 1-2 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.

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	Whole Blood Collection Systems and Ancillary Processing Systems (International Blood Packs 1)
DIVISION / HOST ORGANISATION	Welsh Blood Service
DATE PREPARED	23 May 2023
PREPARED BY	Huw Lovett (Interim Programme Manager) Rachel Evans (Senior Category Manager, NHS Wales Shared Services Partnership – Procurement Services)
SCHEME SPONSOR	Dr Tracey Rees (Chief Scientific Officer)

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Blood Collection systems are business critical consumables used for the collection and processing of blood and blood components. In 2007 a committee was set up to act on behalf of the European Blood Alliance - an association of blood establishments set up to promote best practice and improve performance through collaboration. The committee's remit was to facilitate the standardisation of blood collection and blood component production processes in line with the EU Blood Safety Directive, and to facilitate the transfer of blood packs between participating Member States.

In 2013 the first collaborative procurement between blood establishments (BEs) was undertaken with the resulting European Blood Pack 1 (EBP1) Framework Agreement being awarded to three suppliers (Macopharma, Haemonetics, Fresenius Kabi). In 2017 a replacement Framework Agreement named EBP2 was awarded. Once again this was a collaborative procurement exercise and the Framework Agreement was awarded to the three incumbent suppliers. WBS has utilised both Framework Agreements to award call-off contracts for blood collection systems.

The most recent call-off contract did have an end date of February 2022. However, due to the disruption caused by the COVID-19 pandemic and uncertainty over timelines for the enactment of EU-derived legislation requiring a major safety change in the plasticizer used to manufacture blood packs, all call-off contracts awarded under the EBP2 Framework were extended to 31st October 2023.

NHS Blood and Transplant (NHSBT) has recently led on a collaborative exercise to renew the third iteration of this Framework with WBS playing a significant role, not only during the planning and engagement phase prior to the procurement exercise, but also afterwards in the tender evaluation and validation of successful suppliers phase. Due to the inclusion of two members of the Asian Pacific Network (Australia and New Zealand) as beneficiaries alongside the existing three UK blood services and the Irish Blood Transfusion Service, the new Framework Agreement has been renamed International Blood Packs (IBP1).

The consumables supplied under the Framework can be broadly split into two main categories:

- Lot 1 - Whole Blood Collection Systems
- Lot 2 - Ancillary Blood Processing Systems

Macopharma and Fresenius can support the requirement for whole blood collection, and all three incumbent suppliers can support various elements of ancillary processing.

The other UK and Irish blood establishments utilise the existing EBP2 Framework Agreement and intend to continue doing so under the IBP1 Framework Agreement. It is therefore the intention of WBS to award a new call-off contract using the IBP1 Framework Agreement as the economies of scale provided through participation in this international agreement will ensure that the banded price available to WBS represents the best value.

It should be noted that the prices provided by each of the suppliers as part of the tender exercise will be fixed for the first 12 months of the new contract. However after this they will be subject to increase in accordance with an agreed price variation mechanism. As it is not known precisely when and by how much any future price increase will be applied the figures included in Section 7 (Financial Analysis) are based upon the prices provided at the time of tender.

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	01/11/2023
Expected End Date of Contract	31/10/2027
Contract Extension Options **(e.g. maximum term in 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 is business as usual and is covered from 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 (Decline)**
   - WBS call-off contract will end 31st October 2023 and WBS will be unable to continue to collect blood and process blood components, resulting in catastrophic reputational damage and potential patient harm.

2. **WBS to carry out its own procurement exercise for a replacement contract (Decline)**
   - Very unlikely that this could be achieved within the remaining lifetime of the current contract.
   - Increased costs due to WBS being unable to take advantage of economies of scale from being part of a collaborative procurement exercise.

3. **Award Call-off contract under new IBP1 Framework (preferred option)**
   - Ensures continuity of supply to enable whole blood collections to continue beyond October 2023
   - WBS will be aligned with the other participating blood services
   - Best value for money

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

- WBS will be able to continue buying primary and ancillary blood packs at a competitive price and will continue to benefit from the collaborative purchase power of the participating Blood Establishments.
- One of the items that WBS will have the option to purchase under Lot 1 is an alternative version of the Bottom and Top (BAT) pack currently used to collect and manufacture red blood cells and platelets. The alternative pack provides the ability to collect and process plasma, in addition to the other components, thereby providing more flexibility in terms of the combination of components that can be made from a single donation. This will be essential for the move towards collecting plasma for medicines – a key IMTP objective
- Participating in a collaborative Framework will allow WBS to continue to build relationships with other Blood Establishments at an international level.

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 be unable to continue whole blood collection after October 2023.	Import blood components under mutual aid agreement (at significant cost and reputational damage).
WBS will not have a contract in place for the supply of primary and ancillary blood packs.	Conduct an accelerated procurement exercise.
Significant increase in costs if WBS carries out a procurement exercise on its own due to weaker buying power and potential requirement for extensive validation.	None

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

The international Framework Agreement has been tendered by NHSBT in accordance with Public Contract Regulations (2015) with WBS listed as a named beneficiary. WBS intends to award a direct call-off contract to the top ranked supplier in each Lot.

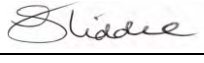
The overarching Framework Agreement has been awarded by NHSBT following Cabinet Office approval and no challenges to the award were received. Therefore, WBS are fully compliant in awarding call-off contract for each Lot to the top ranked supplier.

6.3 What is the approximate timeline for procurement?

A call-off contract award for WBS to take place in September 2023 with the new contract taking effect on 01st November 2023.

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 pp Head of Procurement
Signature:	
Date:	07/06/2023

Maximum expected whole life-cost relating to the award of contract	**Excluding VAT (£k)** £3m	**Including VAT (£k)** £3.6m
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

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
Primary blood packs (Lot 1)	£658	£658	£658	£658	£2,632	£3,158
Ancillary blood packs (Lot 2)	£94	£94	£94	£94	£376	£451
Overall Total	£752	£752	£752	£752	£3,008	£3,609

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	Project managed as a procurement project using PRINCE2 and Agile methodologies.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement rules, standing orders and standing financial instructions have been complied with. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	ALAN PROSSER
Signature:	
Service Area:	Welsh Blood Service
Date:	12/06/2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
WBS Capital and Procurement Planning Group	08.06.2023
Divisional Senior Management Team	14.06.2023
Executive Management Board	29.06.2023
Trust Board	

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	
HTW – Senior Management Team	

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	TRAC RECRUITMENT SYSTEM
DIVISION / HOST ORGANISATION	NWSSP
DATE PREPARED	4th July 2023
PREPARED BY	Kelly Skene, Assistant Director of Employment Services, NWSSP
SCHEME SPONSOR	Gareth Hardacre – Director of People & OD and Employment Services

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Once for Wales e-recruitment system (Trac) provides visibility of the full end-to-end recruitment process to all users allowing for the tracking of applicants, shortlisting, interview, and appointment stages. The flexibility of functionality provides use across Agenda for Change recruitment, medical recruitment, appointment to the temporary workforce, and more bespoke recruitment such as the Student Streamlining Process and Collaborative Bank with the ability to monitor and manage compliance with NHS Employment Check Standards. Built in e-functionality to process Disclosure and Barring Service (DBS) checks also enables Health Boards/Trusts the opportunity to process ad-hoc checks.

Since introducing Trac in 2016, applicants, appointing managers and NWSSP Recruitment teams are able to track the whole process through the activity dashboard. This enables monitoring and pro-active resolution of any delays in the process. Unique to Trac is the ability to monitor time taken from resignation to commencing a vacancy. Development work with the current supplier has enabled translation of the system to deliver a Welsh Language solution to ensure compliance with Welsh Language Measure Act 2011 & Welsh Language Standards 2018. This functionality is not currently available through other third-party providers. An API has also been implemented with NHS Jobs which allows seamless advertisement and management of NHS Wales vacancies.

The continuation of an automated system allows continued realisation of these benefits. Should an automated system not continue there would be an adverse impact on staffing budget, end

users and delivery of recurrent savings to Health Boards and Trusts based upon having an accurate and consistent solution to manage the recruitment process. TRAC is provided by Civica UK limited who acquired the specialist e-recruitment software provider Trac Systems Limited in December 2018. NHS Wales introduced TRAC in 2016 so it is an embedded system which is intrinsically linked to NHS Wales recruitment processes including recent changes following implementation of the Recruitment Modernisation Programme.						
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	01/08/2023
Expected End Date of Contract	31/07/2026
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**
	☐	☐
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	Business As Usual 'Do nothing'	No recruitment processing/monitoring system will be available for high volume recruitment in NHS Wales as this contract with Trac expires.
2	Undertake a full procurement exercise	Prohibitive increased cost and unlikely to find a comparable or improved system in the current marketplace that can provide at least the same service as is currently provided by Trac.
3	Award new Contract to Trac for 3 years at 2019 price.	Strategic fit, no price increase on 2019 prices and delivers continuity of service and continuing benefits to NHS Wales.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

Benefits

- Continued delivery of legislative requirements around pre-employment checks (DBS, Professional Registration, Home Office). An additional 10% contingency has been included to allow for additional eDBS checks should staff numbers increase in NHS Wales over the next three years.
- Continued delivery of 24/7 recruitment tracking and visibility
- Integration and inter-operability across processes within NWSSP with consistent links to other, dependent services via systems such as ESR (single data entry reduces duplication)
- Continued reporting across all aspects of the process
- Improved user experience with a focus on end user experience delivering automated and self-service, processes such as RPA.
- Improved user experience providing interactive dashboards for Recruitment Teams, managers, and applicants to inform 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)
- Continued communication to service users and strategic partners through built-in workflows
- Continued compliance with existing Key Performance Indicator's
- Employment services are able to forecast aspects of workload and appropriately redirect resource to meet service needs
- API with other service systems automating combining of datasets e.g. Electronic Staff Record (ESR) and NHS Jobs (bilingually).
- Continued standardised recruitment system across Wales helping to maintain a resilient workforce.
- Ensures provision of an equitable, bilingual, transparent recruitment platform
- Continued value for money maintaining costs from 2019 and fixing until 2026.
- 90% of the English NHS also use Trac.
- Ensures consistency of recruitment processes for future ESR delivery.

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 colspan="2"><table>
<tr><th>We won't be able to:</th><th>Implications:</th></tr>
<tr><td>Effectively monitor and process Recruitment for NHS Wales</td><td>Unable to meet service requirements</td></tr>
<tr><td>Develop real time reporting information</td><td>Limited information provided to key stakeholders to inform service change / service need or future workforce</td></tr>
<tr><td>Provide the same level of Data Quality Assurance</td><td>Risk to data capture resulting in limited quality assurance to key stakeholders</td></tr>
<tr><td>Provide full compliance with Welsh Language standards</td><td>End users, NWSSP, reduced compliance with Welsh Language legislation</td></tr>
<tr><td>Deliver DBS checks through one contract</td><td>A separate procurement exercise would need to be undertaken to enable electronic DBS checks to be processed. This would attract further costs.</td></tr>
<tr><td>Generate NWSSP process efficiencies</td><td>Additional time and money would be required to implement manual processes. Would lose the current RPA processes in place.</td></tr>
</table></td><td>Mitigation will take the form of using NHS Jobs only to manage the end-to-end recruitment process. NHS jobs is not currently set up to support high volume transactional recruitment for a whole country. Only small organisations have successfully managed their recruitment through NHS jobs. NHS Jobs has advised we do not use their system for a service as large as ours until they have completed significant development. This will not eliminate the risk, however, will mean there is a basic service provided which would be a backwards step to current service benefits.</td></tr>
</table>

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

1. Procurement Route

CCS framework RM6194 Back Office Software covers software required for a number of back-office systems including workforce and talent management solutions. Suppliers are able to provide a range of software and services under direct award via the Government eMarketplace, provided they are in scope of the Framework Schedules of RM6194. These include software licences, license renewals, support and maintenance of both new software and software that are already intrinsically linked to existing solutions. This has been validated as a compliant route to market following a thorough review of the framework schedules.

The CCS Marketplace was accessed and Civica TRAC is available as a direct call-off through the CCS eMarketplace. Civica have provided a pricing proposal based on the current solution used including the costs for electronic Disclosure and Barring Service (DBS) checks required by Health Boards and Trusts. These costs are the same as existing costs and are fixed for a 3 year period.

6.3 What is the approximate time line for procurement?

Contracting Stage	**Anticipated Date/Timescales**	**Responsibility**
Briefing Paper signed off	16th June 2023	Procurement
Issue tender document (eMarketplace call-off)	29th June 2023	Procurement

Approval of Ratification Paper	17th July 2023	Procurement
SSPC approval	20th July 2023	NWSSP Employment Services
Velindre Board approval	27th July 2023	NWSSP Employment Services
Contract Order Form completed	27th July 2023	Procurement
Contract commencement	1st August 2023	Supplier/NWSSP

Please note as this is a direct call-off from a CCS framework it does not require Welsh Government approval.

(WG Addendum to SFI's dated 7th November 2022)

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Jonathan Irvine
Signature:	
Date:	14/07/2023

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k) £2,548,200**	**Including VAT (£k) £3,057,840**
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: The cost of the DBS checks are met initially by NWSSP but are subsequently recharged to the recruiting organisations.

7. FINANCIAL ANALYSIS

The breakdown on annual costs is provided below:-

The contract value shown above, includes the anticipated cost of DBS checks which are recharged to Organisations.

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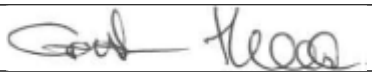
Item	Annual Cost	Comment
License fee	£108,000	Charged at £9000 per month
DBS Checks (All Wales)	£741,400	Based on an average annual cost over past 3 years with a contingency of an additional 10% to allow for additional numbers of NHS staff requiring DBS checks over the next three years.

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*N/A as current system*

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:	Gareth Hardacre
Signature:	
Service Area:	Director of People, Employment & OD
Date:	17/7/23

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	N/a
Divisional Senior Management Team	N/a
Executive Management Board	N/a

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	20 July 2023
HTW – Senior Management Team	N/a

TRUST BOARD

REVISIONS TO THE MODEL STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS FOR NHS TRUSTS

DATE OF MEETING	27/07/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The purpose of this report is to advise the Trust Board of the revisions to the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales following a review by the Welsh Government. The changes are: a) Introduction of the **Duty of Quality** and **Duty of Candour** reflecting the provisions of the **Health and Social Care (Quality and Engagement) Act 2020**;

	b) Update to reflect the change to the **Health and Care Quality Standards 2023**; c) Changes to the provisions with regard to a **Vice-Chair** of Trusts and changes to numbers of **Board Members**; d) Changes linked to the establishment of **Llais (Citizen Voice Body)** and the dissolution of the **Community Health Councils** and the Board of **Community Health Councils**; e) Temporary change to allow the Trust to hold its **Annual General Meeting** for 2023 by the end of September 2023 arising from the extended timeframe of Audit Wales audit programme of the Annual Accounts across NHS Wales.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts. Following Trust Board APPROVAL, these changes will be enacted with immediate effect and published on the Trust website.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Audit Committee	26/07/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Audit Committee **ENDORSED** the revisions to the Model Standing Orders, Reservations and Delegations of Powers for NHS Trusts, for adoption by the Trust Board.	

7 LEVELS OF ASSURANCE - N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1	Revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts

1. SITUATION

Velindre University National Health Service Trust is a statutory body that came into existence on 1st December 1993 under the Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838), as amended, "the Establishment Order".

Velindre University NHS Trust has a duty under Regulation 19(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990 to make Standing Orders for the regulation of their proceedings and business. It is important to note that the Trust is able to vary or suspend its own Standing Orders, providing that it is able to satisfy that it complies with the relevant regulations.

2. BACKGROUND

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales. All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

3. ASSESSMENT

Welsh Government has undertaken a review of the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales, and have undertaken the following revisions:

a) Introduced the **Duty of Quality** and **Duty of Candour** to reflect the provisions of the **Health and Social Care (Quality and Engagement) Act 2020**;

b) Updated to reflect the change to the **Health and Care Quality Standards 2023**;

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

d) Made changes linked to the establishment of **Llais (Citizen Voice Body)** and the dissolution of the **Community Health Councils** and the **Board of Community Health Councils**;

e) Made a temporary change to allow the Trust to hold its **Annual General Meeting for 2023** by the **end of September 2023**.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to **APPROVE** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the activity outlined in this report.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
	There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report.*
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case.

	Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is essential that the Trust complies with its standing orders.

6. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

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

Model Standing Orders

Reservation and Delegation of Powers

For NHS Trusts

Foreword

These Model Standing Orders are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. National Health Service Trusts ("NHS Trusts") in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs Trusts must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

They are designed to translate the statutory requirements set out in ***[delete as appropriate]*** [***For Velindre & WAST*** – the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024) as amended] [***For PHW*** – The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009 (2009/1385) as amended] into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of directors; a Scheme of decisions to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework **[Trust to insert title of relevant policy]**, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Trust's Board Secretary will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the Trust.
Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

Contents

Section A – Introduction

Statutory framework

i) ***[delete as appropriate]***
[***For Velindre*** – Velindre University National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838),** as amended, "the Establishment Order".]

[***For WAST*** – Welsh Ambulance Services National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st April 1998 under the **Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998 (S.I. 1998/678)**, "the Establishment Order".]

[***For PHW*** – The Public Health Wales National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st August 2009 under **The Public Health Wales National Health Service Trust (Establishment) Order 2009 (S.I. 2009/2058)**, "the Establishment Order".]

ii) The principal place of business of the Trust is – ***[insert address]***

iii) All business shall be conducted in the name of ***[Insert name]*** National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee.

iv) NHS Trusts are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

v) ***[delete as appropriate]***
[***For Velindre & WAST*** – **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024)**, as amended ("the Membership Regulations") set out the membership and procedural arrangements of the Trust.]

[***For PHW*** – Under powers set out in paragraph 4 of Schedule 3 to the NHS (Wales) Act 2006 the Welsh Ministers made **The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009 (S.I. 2009/1385),** as amended ("the Membership Regulations") which set out the membership and procedural arrangements for the Trust.]

vi) Sections 18 and 19 of and Schedule 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give directions about how they exercise those functions. NHS Trusts must act in accordance with those directions. The NHS Trust's main statutory functions are set out in their Establishment Order but additional functions may also be contained in other legislation, such as the NHS (Wales) Act 2006.

vii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1) (**the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers to think about the quality of health services when making decisions (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patents, when something may have gone wrong in their care (the Duty of Candour);
- The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

NHS Trusts will need ensure they comply with the provisions of the 2020 Act and the requirements of the ~~following~~ statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/nhs-duty-candour

~~vii)~~viii) The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

~~viii)~~ix) In exercising their powers NHS Trusts must be clear about the statutory basis for exercising such powers.

~~ix)~~x) In addition to directions the Welsh Ministers may from time to time issue guidance which NHS Trusts must take into account when exercising any function.

~~x)~~xi) NHS Trusts work closely with the seven Local Health Boards (LHBs) in Wales. The chief executive of the Trust is an associate member of the following joint-committees of the LHBs:

- The Welsh Health Specialised Services Committee, and
- The Emergency Ambulance Service Committee.

~~xi)~~xii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)** which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

~~xii)~~xiii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8 (W.08))** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8 (W.8))** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee ("EASC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution

and membership of the EASC including its procedures and administrative arrangements.

~~xiii)~~xiv) **The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012) (as amended) require the Trust to establish a Shared Services Committee and prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

~~xiv)~~xv) **The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014.**

~~xv)~~xvi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trust and, for the purposes of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

~~xvi)~~xvii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

~~xvii)~~xviii) The Welsh Language (Wales) Measure 2011 makes provision with regard to the development of standards of conduct relating to the Welsh Language. These standards replace the requirement for a Welsh Language Scheme previously provided for Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of NHS Trusts. The Trust will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

~~xviii)~~xix) Paragraph 18 of Schedule 3 to the NHS (Wales) Act 2006 provides for NHS Trusts to enter into arrangements for the carrying out, on such terms as considered appropriate, of any of its functions jointly with any Strategic Health Authority, Local Health Board or other NHS Trust, or any other body or individual.

~~xix)~~xx) NHS Trusts are also bound by any other statutes and legal provisions which govern the way they do business. The powers of NHS Trusts established under statute shall be exercised by NHS Trusts meeting in public session, except as otherwise provided by these SOs.

NHS framework

~~xx)~~xxi) In addition to the statutory requirements set out above, NHS Trusts must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

~~xxi)~~xxii) Adoption of the principles will better equip NHS Trusts to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

~~xxii)~~xxiii) The overarching NHS governance and accountability framework incorporates these SOs; the Scheme of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; ~~the '*Doing Well, Doing Better: Standards for Health Services in Wales*' (formally the Healthcare Standards) Framework~~the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

~~xxiii)~~xxiv) The Welsh Ministers, reflecting their constitutional obligations, and legal duties under the **Well-being of Future Generations (Wales) Act 2015 (2015/2)**, have stated that sustainable development should be the

central organising principle for the public sector and a core objective for the NHS in all it does.

[For Velindre and PHW]. The Trust is considered a public body under the Act.

[For WAST] The Welsh Ambulance Service NHS Trust is not, at present, considered a public body under the Act but is committed to achieving the Well-being Goals and the sustainable development principle.

~~xxiv)~~xxv) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of NHS Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

NHS Trust framework

~~xxv)~~xxvi) Schedule 2 provides details of the key documents that, together with these SOs, make up the NHS Trust's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

~~xxvi)~~xxvii) NHS Trusts will from time to time agree and approve policy statements which apply to the Trust's Board of directors and/or all or specific groups of staff employed by ***[insert name]*** National Health Service Trust and others. The decisions to approve these policies will be recorded and, where appropriate, will also be considered to be an integral part of the Trust's SOs and SFIs. *Details of the Trust's key policy statements are also included in Schedule 2.*

~~xxvii)~~xxviii) NHS Trusts shall ensure that an official is designated to undertake the role of the Board Secretary (the role of which is set out in paragraph xxxv) below).

~~xxviii)~~xxix) For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SO 1.1.2 refers.

Applying Standing Orders

~~xxix)~~xxx) The SOs of NHS Trusts (together with SFIs and the Values and Standards of Behaviour Framework **[Trust to insert title of relevant policy]**), will, as far as they are applicable, also apply to meetings of any formal Committees established by the Trust, including any sub-Committees and Advisory Groups. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.*

~~xxx)~~xxxi) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Board Secretary, who will ask the Audit Committee ***[or insert name of Committee established to consider audit matters]*** to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non-compliance to the Board Secretary as soon as they are aware of any circumstance that has not previously been reported.

~~xxxi)~~xxxii) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

~~xxxii)~~xxxiii) Although these SOs are subject to regular, annual review by the NHS Trust, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Board Secretary shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with ***[delete, as appropriate]*** [***For Velindre and WAST*** – regulation 19] [***For PHW*** – regulation 23] of the Membership Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;

- The proposed variation or amendment has been considered and approved by the Audit Committee ***[or insert name of Committee established to consider audit matters]*** and is the subject of a formal report to the Board; and

- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

~~xxxiii)~~xxxiv) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the Trust shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Board Secretary and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

~~xxxiv)~~xxxv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Board Secretary

~~xxxv)~~xxxvi) The role of the Board Secretary is crucial to the ongoing development and maintenance of a strong governance framework within NHS Trusts, and is a key source of advice and support to the NHS Trust Chair and other Board members. Independent of the Board, the Board Secretary acts as the guardian of good governance within NHS Trusts. The Board Secretary is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of NHS Trust business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the NHS Trust compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

As advisor to the Board, the *Board Secretary's* role does not affect the specific responsibilities of Board members for governing the organisation. The Board Secretary is directly accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

Further details on the role of the Board Secretary within ***[insert name]*** NHS

Trust, including details on how to contact them, is available at ***[insert signpost to relevant Trust documentation]***.

Section B – Standing Orders

1. THE TRUST

1.0.1 The Trust's principal role is to: ***[delete as appropriate]***

[***For Velindre*** –

(a) to own and manage Velindre Hospital, Velindre Road, Whitchurch, Cardiff CF4 7XL and associated hospitals and premises, and there to provide and manage hospital accommodation and services;

(b) to own and manage Welsh Blood Service Headquarters, Ely Valley Road, Talbot Green, Pontyclun CF72 9WB and associated premises, and there to provide and manage services relating to the collection, screening and processing of blood and its constituents and to the preparation and supply of blood, plasma and other blood products;

(c) services relating to prescribing and dispensing;

(d) to manage and provide Shared Services to the health service in Wales;

(e) to own or lease the premises associated with the provision of the services in paragraph (d), and

(f) to manage and administer the Wales Infected Blood Support Scheme in accordance with directions issued by the Welsh Ministers.

[***For WAST*** –

(a) to manage ambulance and associated transport services;

(b) to manage such other services (including communications and training) relating to the provision of care as can reasonably be carried out in conjunction with the management of ambulance and associated transport services from Ambulance Headquarters at:

(i) Vantage Point House, Ty Coch Way, Cwmbran, NP44 7HF
(ii) Ty Elwy, St Asaph Business Park, St Asaph, LL17 OLJ
(iii) Matrix One, Northern Boulevard, Swansea, SA6 8RE

~~(i) Caerleon House, Mamhilad Park Estate, Pontypool, NP4 0XF,~~
~~(ii) HM Stanley Hospital, St Asaph, LL17 0WA,~~
~~(iii) Cefn Coed Hospital, Cockett, Swansea, SA2 0GP, and~~
~~(iv) East Glamorgan General Hospital, Church Village, Pontypridd, CF38 1BS;~~

~~(b)~~(c) To own the premises associated with the provision of the services in paragraphs (a) and (b);

~~(c)~~(d) to perform the functions of the National Contact Point in Wales for the purposes of Directive 2011/24/EU as set out in regulations 3 to 6 of the National Health Service (Cross-Border Healthcare) Regulations 2013; and

~~(d)~~(e) to provide—

(i) information about health conditions and availability of health services; and

(ii) remote access health advisory, triage and referral services,

for the purposes of the health service in Wales.

[***For PHW*** –

(a) to provide to or in relation to the health service in Wales and manage a range of public health, health protection, healthcare improvement, health advisory, child protection and microbiological laboratory services and services relating to the surveillance, prevention and control of communicable diseases;

(b) to develop and maintain arrangements for making information about matters related to the protection and improvement of health in Wales available to the public in Wales, to undertake the provision and commission research into such matters and to contribute to the provision and development of training in such matters;

(c) to undertake the systemic collection, analysis and dissemination of information about the health of the people of Wales in particular including cancer incidence, mortality and survival, and prevalence of congenital anomalies; and

(d) to provide, manage, monitor, evaluate and conduct research into screening of health conditions and screening of health related matters.]

1.0.2 ***[delete as appropriate]***
[***For Velindre*** – The Trust was established by, and its functions are contained in, the **Velindre National Health Service Trust (Establishment) Order 1993** (S.I. 1993/2838), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

[***For WAST*** – The Trust was established by, and its functions are contained in, the **Welsh Ambulance Services National Health Service Trust (Establishment) Order 1998** (S.I. 1998/678), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

[***For PHW*** – The Trust was established by, and its functions are contained in, the **Public Health Wales National Health Service Trust (Establishment) Order 2009**. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

1.0.3 To fulfil this role, the Trust will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Trust

1.1.1 ***[delete as appropriate]***
[***For Velindre*** – The membership of the Trust shall comprise the Chair, vice-chair, 6 non-executive directors and ~~6~~5 executive directors.]

[***For WAST*** – The membership of the Trust shall comprise the Chair, vice-chair, , ~~6~~7 non-executive directors and ~~6~~5 executive directors.]

[***For PHW*** – The membership of the Trust shall comprise the Chair, vice-chair, 6 non-executive directors and ~~6~~5 executive directors.]

1.1.2 For the purposes of these SOs, the Trust Board of directors shall collectively to be known as “the Board” or “Board members”; the executive and non-executive directors (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively. The Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights.

1.1.3 The Minister for Health and Social Services shall appoint the Chair and non-officer members of the Trust.

1.1.4 The Trust will appoint a Committee whose members will be the Chair and non-executive directors of the Trust whose function will be to appoint the Chief Executive as a director of the Trust.

1.1.5 The Trust will appoint a Committee whose members will be the chair, the non-executive directors and the Chief Executive whose function will be to appoint the executive directors other than the Chief Executive.

Executive Directors

1.1.6 ***[delete as appropriate]***
[***For Velindre*** – A total of 6~~5~~, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance, a medical or dental practitioner (to be known as the Medical Director), a registered nurse or registered midwife (to be known as the Nurse Director) and 2~~1~~ others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

[***For WAST*** – A total of 6~~5~~, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance and 4~~3~~ others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

[***For PHW*** – A total of 6~~5~~, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance and 4~~3~~ others appointed by the Trust. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

Non-executive directors [to be known as Independent Members]

1.1.7 ***[delete as appropriate]***
[***For Velindre*** – A total of ~~6~~6 ~~-~~(excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services, which will include:

- A person appointed from Cardiff University.

[***For WAST*** – A total of 6~~7~~ (excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services.]

[***For PHW*** – A total of 6 (excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services, which will include:

- A person who holds a health related post in a university;
- A person with experience of local authorities in Wales;
- A person who is an employee or member of a voluntary sector organisation with experience of such organisations in Wales; and
- Three other independent members.]

1.1.8 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Membership Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice-Chair
- Non-Executive Directors

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the Trust is shared between more than one person because of their being appointed jointly to a post:

(i) Either or both persons may attend and take part in Board meetings;
(ii) If both are present at a meeting they shall cast one vote if they agree;
(iii) In the case of disagreement no vote shall be cast; and
(iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 ***[delete as appropriate]***
[for Velindre
The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.]

[for WAST

The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed**.** Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term**.**]

[for PHW
The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed but may not hold office as a non-executive director for a total period of more than 8 years**.** Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term.]

1.3.2 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.3 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.4 The Trust will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the Trust, its Board and responsibilities of individual members

Role

1.4.1 The principal role of the Trust is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through effective challenge and scrutiny of the Trust's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business, and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 NHS Trusts shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the Trust within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Board Secretary, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing chair resumes their duties or a new chair is appointed.

1.4.9 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They are the

appointed Accountable Officer for the Trust and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.10 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the Trust, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

(i) Schedule of matters reserved to the Board;
(ii) Scheme of delegation to committees and others; and
(iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 The Trust retains full responsibility for any functions delegated to others to carry out on its behalf. Where Trusts and Local Health Boards have a joint duty the Trust remains fully responsible for its part, and shall agree the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled

meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Board Secretary as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other Independent Members. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 [**Delete as appropriate**]
[**For Velindre –** The Trust shall delegate its Shared Services functions (that is, the provision and management of Shared Services to the health services in Wales) to the Shared Services Partnership Committee which they are required to establish and confer such functions on in accordance with the Shared Services Regulations.

Subject to Standing Order 2.2.2 the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2 (i), to Committees and others, setting any conditions and restrictions it considers necessary and in accordance with any directions or regulations given by the Welsh Ministers. These functions may be carried out:

(i) By a Committee, sub-Committee or officer of the Trust (or of another Trust); or
(ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
(iii) With one or more bodies including local authorities through a sub-Committee.]

[**For WAST & PHW –** The Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2 (i), to Committees and others, setting any conditions and restrictions it considers necessary and in accordance with any directions or regulations given by the Welsh Ministers. These functions may be carried out:

(iv) By a Committee, sub-Committee or officer of the Trust (or of another Trust); or
(v) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
(vi) With one or more bodies including local authorities through a sub-Committee.]

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees or sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 NHS Trust Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term "Committee"

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- sub-Committee

unless otherwise stated.

3.2 Sub-Committees

3.2.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.3 Committees established by the Trust

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds *[as appropriate]*;
- Remuneration and Terms of Service; and
- Mental Health Act requirements *[as appropriate]*.

3.3.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity;
- Maximise cohesion and integration across all aspects of governance and assurance.

3.3.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;

- Relationships and accountabilities with others (including the Board, its Committees and any Advisory Groups);
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.3.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

3.3.6 Executive Directors or other Trust officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated Trust officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.4 Other Committees

3.4.1 The Board may also establish other Committees to help the Trust in the conduct of its business.

3.5 Confidentiality

3.5.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.6 Reporting activity to the Board

3.6.1 The Board must ensure that the Chairs of all Committees operating on its

behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs, ~~and~~ Trusts and Special Health Authorities setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The Trust may and where directed by the Welsh Ministers must, appoint Advisory Groups to the Trust to provide advice to the Board in the exercise of its functions.

5.0.2 *Details of the Trust's Advisory Groups, their membership and terms of reference are set out in Schedule 4.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Advisory Groups established by the Trust

5.1.1 The Trust has established the following Advisory Group(s):

- Local Partnership Forum

[insert details as appropriate]

5.2 Terms of reference and operating arrangements

5.2.1 The Board must formally approve terms of reference and operating arrangements in respect of any Advisory Group it has established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the Board, its Committees and Advisory Groups) as well as other relevant local and national groups;
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.2.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements for the Trust's Advisory Groups are set out in Schedule 4.

5.2.3 The Board may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.3 Support to Advisory Groups

5.3.1 The Trust's Board Secretary, on behalf of the Chair, will ensure that Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the Trust Board and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see 5.7 and Schedule 4);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.4 Confidentiality

5.4.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.5 Advice and feedback

5.5.1 The Trust may specifically request advice and feedback from the Advisory Group(s) on any aspect of its business and they may also offer advice and feedback even if not specifically requested by the Trust. The Group(s) may provide advice to the Board:

- In written advice;
- In any other form specified by the Board

5.6 Reporting activity

5.6.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.6.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.6.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.7 The Local Partnership Forum (LPF)

Role

5.7.1 The LPF's role is to provide a formal mechanism where the Trust, as employer, and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

5.7.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.8 Relationship with the Board and others

5.8.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.8.2 The Board may determine that designated Board members or Trust staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or Trust staff, subject to the agreement of the Trust Chair.

5.8.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

5.8.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.8.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 4 for detailed Terms of Reference and Operating Arrangements.

6. WORKING IN PARTNERSHIP

6.0.1 The Trust shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the Trust through:

- The Trust's own structures and operating arrangements, e.g., Advisory Groups; and
- The involvement (at very local and community wide levels) in partnerships and community groups – such as Public Service Boards – of Board members and Trust officers with delegated authority to represent the Trust and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 ~~Community Health Councils (CHCs)~~The Citizen Voice Body for Health and Social Care, Wales (~~to be~~ known as Llais)

6.1.1 Part 4 of ~~T~~the **~~Community Health Councils (Constitution, Membership and Procedures) (Wales) Regulations 2010~~** ~~(S.I. 2010/288) and the~~

~~Community Health Councils (Establishment, Transfer of Functions and Abolition) (Wales) Order 2010~~ ~~(S.I. 2010/289)~~ **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on Trusts in relation to the engagement and involvement of ~~CHCs~~ Llais in its operations.

6.1.2 The 2020 Act places a statutory duty on the Trust to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide ~~Trusts~~NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

~~6.1.1~~6.1.3 The 2020 Act also places a statutory duty on the Trust to make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. The Trust must also have regard to the Code of Practice won access to premises when it comes into effect in June 2023.

~~6.1.2~~6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's functions, the Board shall work constructively with the Board of ~~Community Health Councils in Wales,~~Llais to ensure that regional offices of Llais~~CHCs across Wales~~ are involved, as appropriate, in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for changes in the way in which those services are provided; and
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- ~~Engaging and~~

~~and~~ formally consulting with ~~the Board of Community Health Councils~~Llais ~~and CHCs as appropriate~~ on any proposals for substantial development of the services it is responsible for, in line with the ~~. (For further details see~~ Guidance on Changes to Health Services in Wales 2023 ~~)~~.

The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

6.1.5 The Board shall ensure ~~that each relevant CHC~~Llais is provided with the information it needs on a timely basis to enable it to effectively discharge

its functions.

~~6.1.3~~

Relationship with the Board

6.1.6 The Board may determine that a designated ~~CHC~~ Llais representative (s) ~~members~~ shall be invited to attend Board meetings.

~~6.1.4~~ 6.1.7 The Board shall ensure ~~may make~~ arrangements are in place for ~~to hold~~ regular meetings between Trust officers and representatives of Llais. ~~the Board of Community Health Councils and CHCs, as appropriate.~~

~~6.1.5~~6.1.7 The Board's Chair shall put in place arrangements to meet with the ~~Board of Community Health Councils~~ Chair or Deputy Chair and/or representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The Trust's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The Trust, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested and required) and in electronic formats;
- Requesting that attendees notify the Trust of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language

Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the Trust's citizens and other stakeholders, including any views expressed formally to the Trust, e.g., through ~~CHCs~~Llais.

7.2 Annual Plan of Board Business

7.2.1 The Board Secretary, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the Trust to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisations website.

Annual General Meeting (AGM)

7.2.5 The Trust must hold an AGM in public no later than the 31 July each year. [Note : this will be no later than 30 September in 2023 to take account of the timetable for audit and laying of the Accounts by Audit Wales.] At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the Trust's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the ~~LHB~~ Trust are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of

the annual accounts and funds held on trust accounts, and may also include presentation of other reports of interest to citizens and others.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Board Secretary, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the Trust. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Board Secretary, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least 10 calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be

impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Board Secretary, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the Trust's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The Trust shall encourage attendance at its formal Board meetings by the public and members of the press as well as Trust officers or

representatives from organisations who have an interest in Trust business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Board Secretary where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

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

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Board Secretary, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers

appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Trust, (whether directly or through the activities of bodies such as LlaisCHC and the Trust's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the Trust will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Board Secretary. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 **[Delete as appropriate]**
[***For Velindre:*** At least one-third of all Board members, at least one of whom is an Executive Director and one is an Independent Members, must be present to allow any formal business to take place at a Board meeting.]

[***For WAST:*** At least one-third of all Board members, at least one of whom is an Executive Director and one is an Independent Members, must be present to allow any formal business to take place at a Board meeting.]

[***For PHW:*** At least one-third of all Board members, at least one of whom is an Executive Director and two are Independent Members, must be present to allow any formal business to take place at a Board meeting.]

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own

right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Board Secretary will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion

becomes the basis on which the further amendments are considered, i.e.., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

7.5.24 In determining every question at a meeting the Board members must take

account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the Trust's citizens and stakeholders. Such views will usually be presented to the Board through the Chair*(s)* of the Trust's Advisory Group*(s)* and the ~~CHC~~ Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the Trust's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulations 2018, and the Trust's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members together with members of any Committee or Advisory Group established by or on behalf of the Board and Trust officials must respect the confidentiality of all matters considered by the Trust in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework **[Trust to insert title of relevant policy]** or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the Trust that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Trust, including Board members, Trust officers and others, as appropriate. The framework adopted by the Board framework **[Trust to insert title of relevant policy]** will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect, or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework **[Trust to insert title of relevant policy]** and their statutory duties under the Membership Regulations. Board members must notify the Chair and Board Secretary of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Board Secretary will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Board Secretary. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Board Secretary will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Board Secretary, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Board Secretary will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Board Secretary must take reasonable steps to ensure that the citizens served by the Trust are made aware of, and have access to view the Trust's Register of Interests. This may include publication on the Trust's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the Trust's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Board Secretary, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the Trust and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Board Secretary before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

(i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

(ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

(iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

(iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Board Secretary when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a Trust Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Board Secretary.

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Board Secretary, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of Trust officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework **[Trust to insert title of relevant policy]** approved by the Board prohibits Board members and Trust officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or Trust officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Trust Board member or officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Board Secretary as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the

[2] The term gift refers also to any reward or benefit.

contact on both sides and whether it is a contact that is likely to benefit the Trust;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Trust; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework [~~LHB~~ Trust **to insert title of relevant policy**] and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Board Secretary, on behalf of the Chair, will maintain a register of

Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to Trust officers working within their Directorates.

8.7.2 Every Board member and Trust officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Board Secretary, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and Trust officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the Trust;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Board Secretary will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Trust to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the adequacy of the Trust's arrangements for dealing with offers of gifts, hospitality and sponsorship.

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[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.02. Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

9.1.1 The Board Secretary shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the Trust, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Board Secretary.

10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance and the effective management of the organisation's risks in pursuance of

its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the Trust.

10.0.4 Whilst the Trust is not a member of WHSSC or EASC the Chief Executive does attend the Committees as an Associate Member. Assurances in respect of the functions discharged by WHSSC and EASC shall achieved by the reports of the respective Joint Committee Chair, and reported back by the Chief Executive.

10.0.5 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the Trust shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the

Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Board Development Programme, as part of an overall Organisation Development framework; and
- the Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Trust's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the Trust implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee or other appropriate bodies.

10.3.4 The Trust shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of citizens and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their partners.

11.0.3 The Board shall also facilitate effective scrutiny of the Trust's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the Trust, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 The Board Secretary shall arrange for a appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.

12.0.2 These SOs shall be reviewed annually by the Audit Committee [or equivalent], which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Board Secretary

The Board Secretary will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit[4] Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify **[Trust to insert details]** of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

[4] Trust to insert title for the committee that carries out these functions.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[5]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are: **[Trust to insert details]**
3	FULL	GENERAL	Approve the Trusts Governance Framework
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

[5] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Board Secretary on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the Trust's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the Trust's Values and Standards of Behaviour framework. **[Trust to insert title of relevant policy]**
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Board Secretary
11	FULL	STRATEGY & PLANNING	Determine the Trust's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and

			care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)
13	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015 **[NOT APPLICABLE TO WAST)**
14	FULL	STRATEGY & PLANNING	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
15	FULL	STRATEGY & PLANNING	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
16	FULL	OPERATING ARRANGEMENTS	Approve the Trust's framework and strategy for performance management.
17	FULL	STRATEGY & PLANNING	Approve the Trust's framework and strategy for risk management and assurance.
18	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
19	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
20	FULL	STRATEGY & PLANNING	Approve the Trusts patient, public, staff, partnership and stakeholder engagement and co-production strategies.

21	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.
22	NO – Remuneration and Terms of Service Committee (For Chief Executive Committee to consist of Chair and non-Officer Members, for all other Officer members as above and to include Chief Executive)	ORGANISATION STRUCTURE & STAFFING	Appointment of the Chief Executive and Executive Directors (officer members of the Board)
23	NO – Remuneration and Terms of Service Committee (see above)	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Board Secretary

24	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
28	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
29	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
30	FULL	ORGANISATION STRUCTURE &	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups

		STAFFING	
31	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board
32	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property
33	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
34	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers

35	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Trust
36	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the ~~LHB's~~ Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
37	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
38	FULL	PERFORMANCE & ASSURANCE	Approve the Trust's audit and assurance arrangements
39	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
40	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate.
41	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales, etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
42	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
43	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
44	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Trusts performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.

45	FULL	REPORTING	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
46	FULL	REPORTING	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		[individual Trust to insert details, in accordance with statutory and Assembly Government requirements
	VICE CHAIR		[individual Trust to insert details, in accordance with statutory and Assembly Government requirements
	CHAMPION/ NOMINATED LEAD		[individual Trust to insert details, in accordance with statutory and Assembly Government requirements

DELEGATION OF POWERS TO COMMITTEES AND OTHERS[6]

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined:

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others, including [individual Trust to insert details]

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

The Board has delegated a range of its powers to the following Committees and others:

- **[Trusts to insert details]**

- **[Trusts to insert details]**

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees.

[6] As defined in Standing Orders.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, set out in **[insert details]**, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

DELEGATED MATTER	RESPONSIBLE OFFICER(S)
[Trusts to determine]	**[Trusts to determine]**

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

Trust framework

The Trust's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs*** *(see Schedule 2.1 below)*
- ***Values and Standards of Behaviour Framework***
- ***Risk and Assurance Framework***
- ***Key policy documents [Trust to insert details]***

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by:

[Trust to insert details]

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR NHS TRUSTS

[NHS Trust SFIs to be inserted]

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

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

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

[Trust to insert details, including detailed terms of reference and operating arrangements for each Committee]

Schedule 4

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

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

[Trust to insert details, including detailed terms of reference and operating arrangements for each Advisory Group – as a minimum to include the Local Partnership Forum]

Local Partnership Forum Advisory Group

Terms of Reference and Operating Arrangements

1. Role and Purpose

The NHS Trust Local Partnership Forum (LPF) is the formal mechanism where NHS Wales's employers and trade unions/professional bodies (hereafter referred to as staff organisations) work together to improve health services for the people of Wales. It is the forum where key stakeholders will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues.

At the earliest opportunity, Trust members will engage with staff organisations in the key discussions within the Trust at the Board, LPF and Locality/Divisional levels.

All LPF members are full and equal members of the forum and collectively share responsibility for the decisions made.

The LPF will provide the formal mechanism for consultation, negotiation and communication between the staff organisations and management. The TUC principles of partnership will apply. These principles are attached at Appendix 1.

The purpose of the LPF will be to:

- Establish a regular and formal dialogue between the Trust's Executive Directors and staff organisations on matters relating to workforce and health service issues.
- Enable employers and staff organisations to put forward issues affecting the workforce.
- Provide opportunities for staff organisations and managers to input into organisation service development plans at an early stage.
- Consider the implications on staff of service reviews and identify and seek to agree new ways of working.
- Consider the implications for staff of NHS reorganisations at a national or local level and to work in partnership to achieve mutually successful implementation.

- Appraise and discuss in partnership the financial performance of the organisation on a regular basis.

- Appraise and discuss in partnership the Trust services and activity and its implications.

- Provide opportunities to identify and seek to agree quality issues, including clinical governance, particularly where such issues have implications for staff.

- Communicate to the partners the key decisions taken by the Board and senior management.

- Consider national developments in NHS Wales Workforce and Organisational Strategy and the implications for the Trust including matters of service re-profiling.

- Negotiate on matters subject to local determination.

- Ensure staff organisation representatives are afforded reasonable paid time off to undertake trade union duties

- To develop in partnership appropriate facilities arrangements using A4C Facilities Agreement as a minimum standard.

In addition the LPF can establish LPF sub groups to establish ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas. Where these sub groups are developed they must report to the Trust LPF.

2. General Principles

The Trust and LPF accepts that partnerships help the workforce and management work through challenges and to grow and strengthen their organisations. Relationships are built on trust and confidence and demonstrate a real commitment to work together.

The principles of true partnership working between staff organisations and Management are as follows:

- Staff organisations and management show joint commitment to the success of the organisation with a positive and constructive approach
- They recognise the legitimacy of other partners and their interests and treat all parties with trust and mutual respect
- They demonstrate commitment to employment security for workers and flexible ways of working
- They share success – rewards must be felt to be fair

- They practice open and transparent communication – sharing information widely with openness, honesty and transparency
- They must bring effective representation of the views and interests of the workforce
- They must demonstrate a commitment to work with and learn from each other

All LPF members must:

- be prepared to engage with and contribute fully to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- comply with their terms and conditions of appointment;
- equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- promote the work of the LPF within the professional discipline they represent.

A Code of Conduct is attached as Appendix 2.

3. Membership

All members of the LPF are full and equal members and share responsibility for the decisions of the LPF. The NHS organisation shall agree the overall size and composition of the LPF in consultation with those staff organisations the Trust recognises for collective bargaining. The Trade Union member of the Board will be expected to attend the LPF in an ex-officio capacity. As a minimum, the membership of the LPF shall comprise:

Management Representatives

Management will normally consist of the following members of management representatives.

- Chief Executive
- Finance Director
- General Managers/Divisional Managers (as locally identified)
- Director of Workforce and OD
- Workforce and OD staff (as locally identified)

Other Executive Directors and others may also be members or may be co-opted dependent upon the agenda.

Staff Representatives

The Board recognises those staff organisations listed in Appendix 3 for the

representation of members who are employed by the Trust.

Staff representatives must be employed by the Trust and accredited by their respective staff organisations for the purposes of bargaining. If a representative ceases to be employed by the Trust or ceases to be a member of a nominating staff organisation then they will automatically cease to be a member of the LPF. Full time officers of the staff organisations may attend meetings subject to prior notification and agreement.

Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF.

Quorum

Every effort will be made by all parties to maintain a stable membership. There should be 50% attendance of both parties for the meeting to be quorate.

If the meeting is not quorate no decisions can be made but information may be exchanged. Where joint chairs agree extraordinary meeting may be scheduled within 7 calendar days' notice.

Consistent attendance and commitment to participate in discussions is essential. Where a member of the LPF does not attend on 3 consecutive occasions, the Joint Secretaries will write to the LPF member and bring the response to the next meeting for further consideration and possible removal.

4. Officers

The Staff Organisation Chair, Vice Chair and Secretary will be elected from the LPF annually. Best practice requires these three officers to come from different staff organisations.

Chairs

The Management and Staff Organisation Chairs will chair the LPF. This will be done on a rotational basis. In the absence of the Chair(s) the Vice Chair(s) will act as Chair. The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the LPF in a timely manner with all the necessary information and advice being made available to LPF members to inform the debate and ultimate resolutions

Joint Secretaries

Each side of the LPF should appoint/elect its own Joint Secretary. The Management and Staff Organisation Secretary will be responsible for the

preparation of the agendas and minutes of the meetings held, and for obtaining the agreement of the Management and Staff Organisation Chairs.

The Director of Workforce and OD will act as Management Secretary and will be responsible for the maintenance of the constitution of the LPF membership, the circulation of agenda and minutes and notification of meetings.

5. Sub Committees

When is considered appropriate, the LPF can decide to appoint a subcommittee, to hold detailed discussion on a particular issue(s). Nominated representatives to sub committees will communicate and report regularly to the LPF.

6. Management of Meetings

Meetings will be held bi-monthly but this may be changed to reflect the need of either staff organisations or management.

The business of the meeting shall be restricted to matters pertaining to LPF issues and should include local operational issues. Trust wide strategic issues and issues that have ~~LHB/~~Trust wide implications shall be referred to the Welsh Partnership Forum via the Board.

The minutes shall normally be distributed 10 days after the meeting and no later than 7 days prior to meeting. Items for the agenda and supporting papers should be notified to the Management Secretary as early as possible, and in the event at least two weeks in advance of the meeting.

The LPF has the capacity to co-opt others onto the LPF or its sub groups as deemed necessary by agreement.

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid ‘put downs’ of views or points made by colleagues
- Respect a colleague’s point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No ‘side-meetings’ to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as 'staff organisations' within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

TRUST BOARD

NHS WALES SHARED SERVICES – AMENDMENT OF STANDING ORDERS AND SCHEDULE OF DELEGATION

DATE OF MEETING	27 July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Andy Butler, Director of Finance & Corporate Services - NWSSP
PRESENTED BY	Matt Bunce, Executive Director of Finance & Informatics
EXECUTIVE SPONSOR APPROVED	Matt Bunce, Executive Director of Finance & Informatics

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Shared Services Partnership Committee	20/07/2023	ENDORSED FOR APPROVAL

ACRONYMS	
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

1.1 Changes are required to the NWSSP Standing Orders to reflect the following:

- The introduction of the Duty of Quality and the Duty of Candour;
- The establishment of Llais;
- The establishment of the Welsh Energy Group (WEG) and the Welsh Energy Operational Group (WEOG)
- Some required changes to the Scheme of Delegation; and
- The annual approval of the Audit Committee and Welsh Risk Pool Committee Terms of Reference by the Partnership Committee.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The specific changes relate to:

- The introduction of the Duty of Quality and the Duty of Candour (paragraph XI, page 8);
- The establishment of Llais (paragraph 6.2, page 31)
- The establishment of the Welsh Energy Group (WEG) and the Welsh Energy Operational Group (WEOG) (paragraph 4.1, page 23 and Annex 4, page 94, and pages 100-106)
- Increase in the revenue and capital budgetary delegation financial limits for the Deputy Director of Finance & Corporate Services from £10k to £25k (Section 5, page 71)
- Removal of the capital budgetary delegation financial limits for non-finance staff and replacement of Senior Finance Staff with Heads of Finance (Section 5 page 71)
- Additional wording included to explain the definition of an All-Wales contract (Section 5 page 71)
- Additional wording to include the allowed exceptions to the need to obtain prior approval from Welsh Government (Section 5 Page 74)
- Increase the individual authorisation limits to £150k for Welsh Infected Blood Support Services payments for the Managing Director, Director of Finance & Corporate Services and the Director of Planning, Performance, and Informatics. For the Managing Director and the Chair jointly, increase the limit to payments above £150k (page 72)
- Increase in the authorisation limit for both the Managing Director and Director of Finance & Corporate Services for Intra-NHS Invoices and Payments (included but not limited to Pharmacy rebates, NWSSP distribution) from £750k to £1m (page 72).
- The update to the Welsh Risk Pool Committee Terms of Reference where no significant changes have been made but which require annual approval and sign-off by the Partnership Committee (page 78)

- The update to the Audit Committee Terms of Reference where no significant changes have been made but which require annual approval and sign-off by the Partnership Committee (page 84)

The wording for the Duties of Quality and Candour are taken from the Model Standing Orders issued by Welsh Government. The items for the WEG and the WEOG are the inclusion of the Terms of Reference for both, which were approved at the March 2023 SSPC. The Audit Committee Terms of Reference were reviewed and endorsed at the Audit Committee meeting held on 11 July 2023. The WRP Committee Terms of Reference are due to be reviewed and endorsed at the Committee meeting held on 19 July.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 The Board APPROVE the amended Standing Orders incorporating the Scheme of Delegation.

Annexe 4

STANDING ORDERS FOR THE OPERATION OF THE SHARED SERVICES PARTNERSHIP COMMITTEE

This Annexe forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Standing Orders

Reservation and Delegation of Powers

For the

Shared Services Partnership Committee

Originally Introduced June 2015
(updated July 2023)

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12(3) of the National Health Services (Wales) Act 2006. Velindre University NHS Trust (Velindre) must agree Standing Orders (SOs) for the regulation of the Shared Services Partnership Committee's (the SSPC) proceedings and business. These SSPC SOs form an Annexe to Velindre's own SOs and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Velindre University NHS Trust Shared Services (Wales) Regulations 2012 (2012/1261

(W.156)) and Velindre's Standing Order 3 into day-to-day operating practice. Together with the adoption of a scheme of decisions reserved to the SSPC; a scheme of delegation to NHS Wales Shared Services Partnership officers and others; and in conjunction with Velindre University NHS Trust Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the SSPC.

These documents, together with the NWSSP Memorandum of Co-operation dated **[June 2012]** made between the seven Health Boards and three Trusts and two Special Health Authorities within NHS Wales, that defines the obligations of the 12 NHS bodies (the Partners) to participate in the SSPC and to take collective responsibility for the delivery of the services, a Hosting Agreement dated **[June 2012]** between the Partners that provides for the terms on which Velindre will host the NHS Wales Shared Services Partnership (NWSSP) and the Interface Agreement between the Chief Executive of Velindre (as the Accountable Officer for the organisation) and the Managing Director of NWSSP (as the Accountable Officer for NWSSP) dated **[June 2012]** that defines the respective roles of the two Accountable Officers, form the basis upon which the SSPC governance and accountability framework is developed. Together with the adoption of a Standards of Behaviour Framework, this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All SSPC members, NWSSP staff and Velindre staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Head of Finance and Business Development, NWSSP (acting Board Secretary for the SSPC) will be able to provide further advice and guidance on any aspect of the SOs or the wider governance arrangements for the SSPC. Further information on governance in the NHS in Wales may be accessed at: http://www.wales.nhs.uk/governance-emanual/standing-orders

TABLE OF CONTENTS

Section: A – Introduction

Statutory Framework

i) Velindre University National Health Service Trust (Velindre) is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (1993/2838)** (the Establishment Order).

ii) The Velindre University NHS Trust Shared Services Partnership Committee (to be known as the SSPC for operational purposes) was established under the **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 (2012/1261 (W.156))** (the Shared Services Regulations). The Shared Services Regulations define Shared Services at regulation 2 and the functions of the SSPC at regulation 4. The SSPC functions are subject to variations to those functions agreed from time to time by the SSPC**.** The SSPC is hosted by Velindre on behalf of each of the seven Health Boards, three Trusts and two Special Health Authorities within NHS Wales (the Partners).

iii) The principal place of business of the SSPC is:

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

iv) All business shall be conducted in the name of the NHS Wales Shared Services Partnership on behalf of the Partners.

v) Velindre is a corporate body and its functions must be carried out in accordance with its statutory powers and duties. Velindre's statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006 (c.42)** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006 (c.41)** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation, which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

vi) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (1990/2024)**, as amended (the Membership

Regulations) set out the membership and procedural arrangements of the Trust.

vii) Sections 18 and 19 of Annexe 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give Directions about how they exercise those functions. Trusts must act in accordance with those Directions. Velindre's statutory functions are set out in its Establishment Order but many functions are also contained in other legislation such as the NHS (Wales) Act 2006.

viii) However, in some cases, the relevant function may be contained in other legislation. In exercising its powers, Velindre must be clear about the statutory basis for exercising such powers.

ix) Under powers in paragraph 4(1)(f) of Annexe 3 to the NHS (Wales) Act 2006 the Minister has made the Shared Services Regulations which set out the constitution and membership arrangements of the Shared Services Partnership Committee. Certain provisions of the Membership Regulations will also apply to the operations of the SSPC, as appropriate.

x) In addition to Directions, the Welsh Ministers may from time-to-time issue guidance relating to the activities of the SSPC, which the Partners must take into account when exercising any function.

xi) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers think about the quality of health services when making decisions (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creations of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

Local Health Boards will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The guidance outlines the responsibilities of Local Health Board when commissioning services for their population. NWSSP shall ensure they consider these responsibilities in the discharge of their duties.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/nhs-duty-candour

xii) Velindre shall issue an indemnity to the NWSSP Chair, on behalf of the Partners.

NHS Framework

xiii) In addition to the statutory requirements set out above, the SSPC, on behalf of each of the Partners, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Minister's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon theWelsh Government's s' Citizen Centred Governance Principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xiv) Adoption of the principles will better equip the SSPC to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xv) The overarching NHS governance and accountability framework within which the SSPC must work incorporates Velindre's SOs; Annexes of Powers reserved for the Board and Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the Health and Care Quality Standards 2023, , the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xvi) The Welsh Ministers, reflecting their constitutional obligations, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the restructured NHS in all it does.

xvii) Full, up to date details of the other requirements that fall within the NHS

framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at:
http://www.wales.nhs.uk/governance-emanual/standing-orders

Directions or guidance on specific aspects of Trusts' business are also issued in hard copy, usually under cover of a Ministerial letter.

Shared Services Partnership Committee Framework

xviii) The specific governance and accountability arrangements established for the SSPC are set out within the following documents (which is not an exhaustive list):

- these SSPC SOs and Annexe 1: Scheme of Powers reserved for the SSPC and Delegation to others;
- the Velindre University NHS Trust SFIs;
- a Memorandum of Co-operation that defines the obligations of the Partners to participate in the SSPC and to take collective responsibility for the delivery of the services defining the respective roles of the Partners;
- a Hosting Agreement between the Partners that provides for the terms on which Velindre will host NWSSP;
- an Interface Agreement between the Chief Executive of Velindre (as the Accountable Officer for the organisation) and the Managing Director of Shared Services (as the Accountable Officer for NWSSP) that defines the respective roles of the two Accountable Officers; and
- an Accountability Agreement between the Chair of the SSPC and the Managing Director of Shared Services (as the Accountable Officer for NWSSP).

xix) Annexe 2 to these SOs provides details of the key documents that, together with these SOs, make up the SSPC's governance and accountability framework. These documents must be read in conjunction with these SSPC SOs.

xx) The SSPC may from time to time, subject to the prior approval of Velindre's Board, agree operating procedures which apply to SSPC members and/or members of NWSSP staff and others. The decisions to approve these operating procedures will be recorded in an appropriate SSPC minute and, where appropriate, will also be considered to be an integral part of these SSPC SOs and SFIs. Details of the SSPC's key operating procedures are also included in Annexe 2 of these SOs.

Applying Shared Services Standing Orders

xxi) These SSPC SOs (together with the Velindre University NHS Trust SFIs

and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any Sub-Committees established by the SSPC, including any Advisory Groups. These SSPC SOs may be amended or adapted for the Sub-Committees or Advisory Groups as appropriate, with the approval of the SSPC. Further details on Sub-Committees and Advisory Groups may be found in Annexes 3 and 4 of these NWSSP, respectively.

Full details of any non-compliance with these SSPC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Head of Finance and Business Development, who will ask the Velindre Audit Committee to formally consider the matter and make proposals to the SSPC on any action to be taken. All SSPC members and SSPC officers have a duty to report any non-compliance to the Head of Finance and Business Development as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with SSPC SOs is a disciplinary matter.**

Variation and amendment of SSPC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the SSPC determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the SSPC, advised by the Head of Finance and Business Development, shall submit a formal report to the Velindre Trust Board, setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the SSPC members are in favour of the amendment; or
- In the event that agreement cannot be reached, the Velindre Trust Board determine that the amendment should be approved.

Interpretation

xxiii) During any SSPC meeting where there is doubt as to the applicability or interpretation of the SSPC SOs, the Chair of the SSPC shall have the final say, provided that their decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Board Secretary support function.

xxiv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SSPC SOs, when interpreting any term or provision covered by legislation.

Relationship with Velindre University NHS Trust Standing Orders

xxv) These SSPC SOs form an Annexe to Velindre's own SOs and shall have effect as if incorporated within them.

The Role of the Board Secretary Support Function

xxvi) The role of the Board Secretary support function is crucial to the ongoing development and maintenance of a strong governance framework within the SSPC and is a key source of advice and support to the Chair and SSPC members. Independent of the SSPC, the Board Secretary support function will act as the guardian of good governance within the SSPC and shall ensure that the functions outlined below are delivered:

- providing advice to the SSPC as a whole and to individual Committee members on all aspects of governance;
- facilitating the effective conduct of SSPC business through meetings of the SSPC, its Sub-Committees and Advisory Groups;
- ensuring that SSPC members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- ensuring that in all its dealings, the SSPC acts fairly, with integrity, and without prejudice or discrimination;
- contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- monitoring the SSPC's compliance with the law, Shared Services SOs and the framework set by Velindre and Welsh Ministers.

xxvii) As advisor to the SSPC, the Board Secretary support function role does not affect the specific responsibilities of SSPC members for governing the Committee's operations. The Board Secretary Support role is directly accountable for the conduct of their role to the Chair of the SSPC and reports to the Managing Director of NWSSP on a regular basis.

Section B – Shared Services Partnership Committee Standing Orders

1. THE SHARED SERVICES PARTNERSHIP COMMITTEE (SSPC)

1.1 Purpose, Role, Responsibilities and Delegated Functions

1.1.1 The SSPC has been established for the purpose of exercising Velindre's functions in relation to NWSSP, including the setting of policy and strategy and the management and provision of Shared Services to Health Boards and Trusts in Wales.

1.1.2 The purpose of the SSPC is to:

- set the policy and strategy for NWSSP;
- monitor the delivery of Shared Services, through the Managing Director of NWSSP;
- seek to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners;
- ensure the efficient and effective leadership direction and control of NWSSP; and
- ensure a strong focus on delivering savings that can be re-invested in direct patient care.

1.1.3 The role of the SSPC is to:

- take into account NHS Wales organisations' plans and objectives when considering the strategy of NWSSP;
- encourage and support the aims and objectives of NWSSP;
- identify synergies between each of the Shared Services and ensure that future strategies incorporate synergistic opportunities;
- foster and encourage partnership working between all key stakeholders and staff;
- oversee the identification and sharing of financial benefits to NHS Wales' organisations on a fair basis that minimises administrative costs and financial transactional arrangements;
- seek to identify potential opportunities for further collaboration across the wider public sector;
- consider implications for Shared Services in relation to any reviews / reports undertaken by internal auditors, external auditors, and regulators, including Healthcare Inspectorate Wales; and
- seek assurance, through the Managing Director of NWSSP, on the adequacy and robustness of systems, processes, procedures, and

risk management, staffing issues and that risks and benefits are shared on an equitable basis in relation to Shared Services.

1.1.4 The responsibilities of the SSPC are to:

- produce an Integrated Medium-Term Plan, including the balanced Medium-Term Financial Plan for agreement by the Committee, following the publication of the individual Health Board, Trust, and Special Health Authority Integrated Medium-Term Plans;
- agree, on an annual basis, Service Improvement Plans (prepared by the Managing Director of NWSSP) for the delivery by services;
- be accountable for the development and agreement of policies and strategies in relation to Shared Services and for monitoring the performance and delivery of agreed targets for Shared Services through the Managing Director of NWSSP;
- take the lead in overseeing the effective and efficient use of the resources of Shared Services;
- benchmark the performance of Shared Services against the best in class;
- consider extended-scope opportunities for Shared Services;
- monitor compliance of best practice within Shared Services with NHS Wales recommended best practice;
- oversee the identification and delivery of "invest to save" opportunities;
- explore future Shared Services organisational delivery models across the NHS and the broader public sector*; and*
- embed NWSSP's strategic objectives and priorities through the conduct of its business and in so doing and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations (Wales) Act 2015, the Welsh Government Guidance on Ethical Procurement and the Code of Practice on Ethical Employment in Supply Chains.

1.1.5 The SSPC must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each Health Board, Trust, and Special Health Authority, shall be bound by the decisions of the SSPC in the exercise of its roles. In the event that the SSPC is unable to reach unanimous agreement in relation to the funding levels to be provided by each Health Board, Trust, and Special Health Authority, then this matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the SSPC shall lead and scrutinise the operations, functions and decision making of the NWSSP Senior Leadership Group (SLG) undertaken at the direction of the SSPC.

1.1.7 The SSPC shall work with all its Partners and stakeholders in the best interests of its population across Wales.

1.2 Membership of the SSPC

1.2.1 The membership of the SSPC shall be 14 voting members, comprising:

- the Chair (appointed by the SSPC in accordance with the Chair Selection Process at Annexe 5 to these SOs):
- the Chief Executives of each of the Health Boards, Trusts, and Special Health Authority (or their nominated representatives); and
- the Managing Director of NWSSP, who has been designated as the Accountable Officer for Shared Services.

1.2.2 *Vice Chair* – The SSPC shall appoint a Vice Chair from one of the Chief Executives (or their nominated representative) SSPC members. A Vice Chair cannot be appointed if the current Chair is employed by the same Partner organisation.

1.2.3 *Nominated Representatives* – Nominated deputies for Chief Executives should be an Executive Director of the same organisation and will formally contribute to the quorum and have delegated voting rights.

1.2.4 *Co-opted Members* – The SSPC may also co-opt additional independent 'external' members from outside NHS Wales to provide specialist skills, knowledge, and expertise. Co-opted members will not be entitled to vote.

1.2.5 *Attendees* – The NWSSP Director of Finance and Corporate Services / Director of Planning, Performance, and Information, NWSSP Director of People & Organisational Development (or nominated representative) and the Medical Director may attend the SSPC meetings but will not be entitled to vote. Other NWSSP Service Directors / Heads of Service may only attend SSPC meetings, as and when invited.

1.2.6 *Use of the Term Independent Member* - For the purposes of these SPC SOs, use of the term 'Independent Member' refers to the non-officer members of a Health Board or the independent members of a Trust, or Special Health Authority.

1.3 Member and Staff Responsibilities and Accountability

1.3.1 The SSPC will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the SSPC.

1.3.2 All members must comply with the terms of their appointment to the

SSPC. They must equip themselves to fulfil the breadth of their responsibilities on the SSPC by participating in relevant personal and organisational development programmes, engaging fully in the activities of the SSPC and promoting understanding of its work.

The Chair

1.3.3 The Chair of the SSPC must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the health service across Wales.

1.3.4 The Chair is responsible for the effective operation of the SSPC:

- chairing SSPC meetings;
- establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all SSPC business is conducted in accordance with these SSPC SOs; and
- developing positive and professional relationships amongst the SSPC's membership and between the SSPC and each Health Board, Trust and Special Health Authority's Board.

1.3.5 The Chair shall work in close harmony with the Chief Executives of each of the Health Board, Trust and Special Health Authority (or their nominated representatives) and supported by the Head of Finance and Business Development, shall ensure that key and appropriate issues are discussed by the SSPC in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.6 The Chair is accountable to the SSPC in relation to the delivery of the functions exercised by the SSPC on its behalf and, through Velindre's Chair, as the hosting organisation, for the conduct of business in accordance with the defined governance and operating framework.

The Vice Chair

1.3.7 The Vice Chair shall deputise for the Chair in their absence for any reason and will do so until either the existing Chair resumes their duties, or a new Chair is appointed.

1.3.8 The Vice Chair is accountable to the Chair for their performance as Vice Chair.

Managing Director of NWSSP and the Chief Executive of Velindre

1.3.9 **Managing Director of NWSSP** – The Managing Director of NWSSP, as

head of the Senior Leadership Group, reports to the Chair and is responsible for the overall performance of NWSSP. The Managing Director of NWSSP is the designated Accountable Officer for NWSSP (see 1.3.11 below). The Managing Director of NWSSP is accountable to the SSPC in relation to those functions delegated to them by the SSPC. The Managing Director of NWSSP is also accountable to the Chief Executive of Velindre University NHS Trust in respect of the hosting arrangements supporting the operation of NWSSP.

1.3.10 **Chief Executive of Velindre** – The Chief Executive of Velindre University NHS Trust is responsible for the overall performance of the executive functions of the Trust and is the designated Accountable Officer for the Trust (see 1.3.11 below). As the host organisation, the Chief Executive (and the Velindre Trust Board) has a legitimate interest in the activities of NWSSP and has certain statutory responsibilities as the legal entity hosting NWSSP.

1.3.11 **Accountable Officers** – The Managing Director of NWSSP (as the Accountable Officer for NWSSP) and the Chief Executive of Velindre (as the Accountable Officer for the Trust) shall be responsible for meeting all the responsibilities of their roles, as set out in their respective Accountable Officer Memoranda. Both Accountable Officers shall co-operate with each other so as to ensure that full accountability for the activities of the NWSSP and Velindre is afforded to the Welsh Ministers whilst minimising duplication.

Senior Leadership Group (SLG)

1.3.12 The Managing Director of NWSSP will lead a SLG to deliver the SSPC's annual Business Plan. The SLG will be determined by the Managing Director of NWSSP.

1.4 Appointment and tenure of Shared Services Partnership Committee (SSPC) members

1.4.1 The ***Chair*** is appointed by the SSPC in accordance with the appointment process outlined in Annexe 5 and shall be appointed for a period specified by the SSPC, but for no longer than 4 years in any one term. The Chair can be reappointed but may not serve as the Chair of the SSPC for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term. Through the appointment process, the SSPC must satisfy itself that the person appointed has the necessary skills and experience to perform the duties. In accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012, the first chair of the Committee would be appointed by Velindre for a period of

six months.

1.4.2 The ***Vice Chair*** is appointed by the SSPC from its Chief Executive (or their nominated representatives) members and shall be appointed for a period specified by the SSPC, but for no longer than 4 years in any one term. The Vice Chair may not serve as the Vice Chair of the SSPC for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in term.

1.4.3 The appointment and removal process for the Chair and Vice Chair shall be determined by the SSPC. In making these appointments, the SSPC must ensure:

- a balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the SSPC;
- that wherever possible, the overall membership of the SSPC reflects the diversity of the population;
- potential conflicts of interest are kept to a minimum;
- the Vice Chair is not employed by the same Partner organisation as the Chair; and
- that the person has the necessary skills and experience to perform the duties of the chair.

1.5 Termination of Appointment of SSPC Chair and Vice Chair

1.5.1 The Committee may remove the SSPC Chair or Vice Chair by the process outlined in Annexe 5 to these SOs if it determines:

- It is not in the interests of the SSPC; or
- It is not conducive to good management of the SSPC

for that Chair or Vice Chair to continue to hold office.

1.5.2 All SSPC members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they are applicable, and as specified in the relevant Regulations. Any member must inform the SSPC Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office.

1.5.3 The SSPC will require its Chair and members to confirm their continued eligibility on an annual basis in writing.

1.6 Appointment of NWSSP Staff

1.6.1 NWSSP staff shall be appointed by Velindre. The appointments process shall be in line with the workforce policies and procedures of Velindre and any directions made by the Welsh Ministers.

1.7 Responsibilities and Relationships with each Health Board, Trust and Special Health Authority's Board, Velindre University NHS Trust as the Host and Others

1.7.1 The SSPC is not a separate legal entity from each of the Health Boards, Trusts, and Special Health Authorities. It shall report to each Health Board, Trust, and Special Health Authority Board on its activities, to which it is formally accountable in respect of the exercise of the Shared Services functions carried out on their behalf. Velindre's Trust Board will not be responsible or accountable for exercising Velindre's functions in relation to NWSSP, including the setting of policy and strategy and the management and provision of Shared Services to Health Board, Trust, and Special Health Authority. Velindre's Board, as the host organisation, shall be responsible for ensuring that NWSSP staff act in accordance with the administrative policies and procedures agreed between Velindre and the SSPC.

1.7.2 Each Health Board, Trust and Special Health Authority shall determine the arrangements for any meetings with the Managing Director of NWSSP and their organisation through the SSPC.

1.7.3 The Health Board, Trust, and Special Health Authority Chairs, through the lead Chair, shall put in place arrangements to meet with the SSPC Chair on a regular basis to discuss the SSPC's activities and operation.

2 RESERVATION AND DELEGATION OF SHARED SERVICES FUNCTIONS

Within the framework agreed by Velindre, and set out within these SSPC SOs, and subject to any directions that may be given by the Welsh Ministers, the SSPC may make arrangements for certain functions to be carried out on its behalf so that the day-to-day business of the SSPC may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the SSPC must set out clearly the terms and conditions upon which any delegation is being made.

The SSPC's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i Scheme of matters reserved to the SSPC;
ii Scheme of Delegation to Sub-Committees of the SSPC and others; and

iii Scheme of Delegation, including financial limits, to Velindre NWSSP officers and non-NWSSP officers

all of which must be formally agreed by Velindre and adopted by the SSPC.

The SSPC retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's Action on Urgent Matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the SSPC need to be taken between scheduled meetings, and it is not practicable to call a meeting of the SSPC. In these circumstances, the SSPC Chair and the Managing Director of NWSSP may deal with the matter on behalf of the SSPC - after first consulting with at least one other Health Board, Trust, or Special Health Authority Chief Executive (or their representative). The Head of Finance and Business Development must ensure that any such action is formally recorded and reported to the next meeting of the SSPC for consideration and ratification.

2.2 Delegation to Sub-Committees and Others

2.2.1 The SSPC shall agree the delegation of any of their functions to Sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions agreed by Velindre.

2.2.2 The SSPC shall agree and formally approve the delegation of specific powers to be exercised by Sub-Committees which it has formally constituted or to others.

2.3 Delegation to Officers

2.3.1 The SSPC will delegate certain functions to the Managing Director of NWSSP. For these aspects, the Managing Director of NWSSP, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other Velindre officers to undertake the remaining functions. The Managing Director of NWSSP will still be accountable to the SSPC for all functions delegated to them, irrespective of any further delegation to other Velindre officers.

2.3.2 This must be considered and approved by the SSPC (subject to any amendment agreed during the discussion) and agreed by Velindre. The Managing Director of NWSSP may periodically propose amendment to the Scheme of Delegation and any such amendments must also be

considered and approved by the SSPC and agreed by Velindre.

2.3.3 Individual members of the NWSSP SLG are in turn responsible for delegation within their own teams in accordance with the framework established by the Managing Director of NWSSP and agreed by the SSPC and Velindre.

3 SUB-COMMITTEES

In accordance with SSPC Standing Order 4.0.3, the SSPC may and, where directed by Velindre must, appoint Sub-Committees of the SSPC either to undertake specific functions on the SSPC's behalf or to provide advice and assurance to others (whether directly to the SSPC, or on behalf of the SSPC). Velindre's NWSSP officers should not normally be appointed as Sub-Committee Chairs. NWSSP officers may only be appointed to serve as members on any committee, where that committee does not have the function of holding that officer to account.

These may consist wholly or partly of SSPC members or of persons who are not SSPC members.

3.1 Sub-Committees Established by the SSPC

The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or utilise Velindre's Committee arrangements to assist it in discharging its governance responsibilities. The SSPC shall ensure its Sub-Committee structure meets the needs of Velindre University NHS Trust, as the host organisation, and also the needs of its Partners. As a minimum, it shall ensure arrangements are in place to cover the following aspects of SSPC business:

- Audit

3.1.1 The SSPC may make arrangements to receive and provide assurance to others through the establishment and operation of its own Sub-Committees or by placing responsibility with Velindre, as the host. Where responsibility is placed with Velindre, the arrangement shall be detailed within the Hosting Agreement between the SSPC and Velindre as the host organisation and/or the Interface Agreement between the Managing Director of NWSSP (as the Accountable Officer for NWSSP) and Velindre's Chief Executive (as Accountable Officer for the Trust).

The SSPC has the following Sub-Committees:

- Velindre Audit Committee for SSPC
- Welsh Risk Pool Committee

Full details of the Sub-Committee structure established by the SSPC, including detailed Terms of Reference for each of these Sub-Committees, are set out in Annexe 3 of these SSPC SOs.

3.1.2 Each Sub-Committee established by or on behalf of the SSPC must have its own Terms of Reference and operating arrangements, which must be formally approved by the SSPC and agreed by Velindre. These must establish its governance and ways of working, setting out, as a minimum:

- the scope of its work (including its purpose and any delegated powers and authority);
- membership and quorum;
- meeting arrangements;
- relationships and accountabilities with others;
- any budget and financial responsibility, where appropriate;
- secretariat and other support;
- training, development, and performance; and
- reporting and assurance arrangements.

3.1.3 In doing so, the SSPC shall specify which aspects of these SSPC SOs are not applicable to the operation of the Sub-Committee, keeping any such aspects to the minimum necessary.

3.1.4 The membership of any such Sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the SSPC, subject to any specific requirements or directions agreed by Velindre. Depending on the Sub-Committee's defined role and remit, membership may be drawn from the SSPC or Velindre staff (subject to the conditions set in NWSSP Standing Order 3.1.5) or others.

3.1.5 Velindre's NWSSP officers should not normally be appointed as Sub-Committee Chairs, nor should they be appointed to serve as members on any committee set up to review the exercise of functions delegated to NWSSP officers. Designated NWSSP Directors or Heads of Services or other NWSSP officers shall, however, be in attendance at such Sub-Committees, as appropriate.

3.2 **Other Groups**

3.2.1 The SSPC may also establish other groups to help it in the conduct of its business.

3.3 **Reporting Activity to the Shared Services Partnership Committee**

3.3.1 The SSPC must ensure that the Chairs of all Sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the SSPC on their activities. Sub-Committee Chairs' shall bring to the SSPC's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

3.3.2 Each Sub-Committee shall also submit an annual report to the SSPC through the Chair within 3 months of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

4 EXPERT PANEL AND OTHER ADVISORY GROUPS

4.1.1 The SSPC may appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the SSPC, including detailed terms of reference are set out in Annexe 4 of these Shared Services SOs.

4.1 Expert Panels and Advisory Groups Established by the SSPC

- Evidence Based Procurement Board
- Welsh Energy Group (WEG) and Welsh Energy Operating Group (WEOG)

4.2 Confidentiality

4.2.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

4.3 Reporting Activity

4.3.1 The SSPC shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the SSPC on their activities. Expert Panel or Advisory Group Chairs shall bring to the SSPC's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.3.2 Any Expert Panel or Advisory Group shall also submit an annual report to the SSPC through the Chair within 1 month of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

4.3.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

4.4 Terms of Reference and Operating Arrangements

4.4.1 The SSPC and the Velindre Board must formally approve terms of reference and operating arrangements in respect of any. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development, and performance; and
- Reporting and assurance arrangements.

4.4.2 In doing so, the SSPC shall specify which aspects of these SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

4.4.3 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the SSPC, subject to any specific requirements or directions agreed by Velindre.

4.4.4 The SSPC may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the SSPC approves such action.

4.5 The Local Partnership Forum (LPF)

4.5.1 The LPF's role is to provide a formal mechanism where the SSPC, as employer, and trade unions/professional bodies representing NWSSP's employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the NWSSP – achieved through a regular and timely process of consultation, negotiation, and communication. In doing so, the LPF must effectively represent the views and interests of the NWSSP workforce.

4.5.2 It is the forum where the NWSSP and staff organisations will engage with each other to inform, debate, and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

4.5.3 NWSSP may specifically request advice and feedback from the LPF on any aspect of its business, and the LPF may also offer advice and feedback even if not specifically requested by NWSSP. The LPF may provide advice to the SSPC:

- In written advice; or
- In any other form specified by the Board.

4.6 Terms of Reference and Operating Arrangements

4.6.1 The SSPC must formally approve terms of reference and operating arrangements for the LPF. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountability and terms and conditions of office);
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the Board, its Committees and Advisory Groups, and other relevant local and national groups);
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support; and
- Reporting and assurance arrangements.

4.6.2 In doing so, the SSPC shall specify which aspects of these SOs are not applicable to the operation of the LPF, keeping any such aspects to the minimum necessary. The LPF will also operate in accordance with the TUC six principles of partnership working.

4.6.3 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/ Directorates/ Service areas; and/or
- Detailed discussion in relation to a specific issue(s).

4.7 Membership

4.7.1 NWSSP shall agree the overall size and composition of the LPF in consultation with those staff organisations it recognises for collective bargaining. As a minimum, the membership of the LPF shall comprise:

- Management Representatives;
- Managing Director;
- Director of Finance & Corporate Services; and
- Director of People and Organisational Development.

together with the following:

- General Managers/Divisional Managers; and
- People and Organisational Development staff

4.7.2 The Trust may determine that other Executive Directors or others may act as members or be co-opted to the LPF.

Staff Representatives

4.7.3 The maximum number of staff representatives shall be *agreed by the LPF* comprising representation from those staff organisations recognised by NWSSP.

In attendance

4.7.4 The Trade Union member of the Board shall attend LPF meetings in an ex officio capacity.

4.7.5 The LPF may determine that full time officers from those staff organisations recognised by the Trust shall be invited to attend LPF meetings.

4.8 Member Responsibilities and Accountability

Joint Chairs

4.8.1 The LPF shall have two Chairs, on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

4.8.2 The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff

Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework; and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the SSPC.

4.8.3 The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of NWSSP's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

4.8.4 The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by NWSSP.

Joint Vice Chairs

4.8.5 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

4.8.6 Each Vice Chair shall deputise for their Chair in that Chair's absence for any reason and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

4.8.7 The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

4.8.8 All members of the LPF are full and equal members and collectively share responsibility for its decisions.

4.8.9 All members must:

- Be prepared to engage with and contribute to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the LPF within the professional disciplinethey

represent.

4.9 Appointment and Terms of Office

4.9.1 Management representative members shall be determined by the SSPC.

4.9.2 Staff representatives shall be determined by the staff organisations recognised by the NWSSP, subject to the following conditions:

- Staff representatives must be employed by **NWSSP** and accredited by their respective trade union; and
- A member's tenure of appointment will cease in the event that they are no longer employed by **NWSSP** or cease to be a member of their nominating trade union.

4.9.3 The *Management Representative Chair* shall be appointed by the LPF.

4.9.4 The *Staff Representative Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representative members. The *Staff Representative Chair's* term of office shall be for one (1) year.

4.9.5 The *Management Representative Vice Chair* shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

4.9.6 The *Staff Representative Vice Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Vice Chair's* term of office shall be for one (1) year.

4.9.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

4.10 Removal, Suspension and Replacement of Members

4.10.1 If an LPF member fails to attend three consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

(a) The absence was due to a reasonable cause; and

(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

4.10.2 If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

4.10.3 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

4.10.4 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4.11 Relationship with the SSPC and others

4.11.1 The LPF's main link with the SSPC is through the Managerial members of the LPF.

4.11.2 The Senior Leadership Group may determine that designated SLG members or NWSSP staff shall attend LPF meetings. The LPF's Chair may also request the attendance of SLG members or NWSSP staff, subject to the agreement of the Chair.

4.11.3 The SLG shall determine the arrangements for any joint meetings between the SLG and the LPF's staff representative members.

4.11.4 The Managing Director shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

4.11.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

4.12 Support to the LPF

4.12.1 The LPF's work shall be supported by two designated Secretaries, one of whom shall support the staff representative members and one shall support the management representative members.

4.12.2 The Director of People and Organisational Development will act as Management Representative Secretary and will be responsible for the

maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

4.12.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representatives. The Staff Representative Secretary's term of office shall be for two (2) years.

4.12.4 Both Secretaries shall work closely with the NWSSP Head of Finance and Business Development who is responsible for the overall planning and co-ordination of the programme of SLG and Committee business, including that of its Advisory Groups.

5 WORKING IN PARTNERSHIP

5.1.1 The SSPC shall work constructively in partnership with others to plan and secure the delivery of the best possible healthcare for its citizens, in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

5.1.2 The Chair shall ensure that the SSPC has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the NWSSP through:

- NWSSP's own structures and operating arrangements, e.g., Advisory Groups;

5.1.3 The SLG shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6 MEETINGS

6.1 Putting Citizens first

6.1.1 The SSPC's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The SSPC, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- active communication of forthcoming business and activities;
- the selection of accessible, suitable venues for meetings;

- the availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read and in electronic formats;
- requesting that attendees notify the Committee Secretariat of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g. arranging British Sign Language (BSL) interpretation at meetings; and

where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh, in accordance with legislative requirements, e.g. Equality Act 2010 (Statutory Duties) (Wales) Regulations, Welsh Language (Health Sector) Regulations and Standards; as well as NWSSP's Communication Strategy and Velindre's Welsh Language Scheme.

6.1.2 The SSPC Chair will ensure that, in determining the matters to be considered by the SSPC, full account is taken of the views and interests of all citizens served by the SSPC on behalf of each Health Boards, Trust and Special Health Authority, including any views expressed formally. The Chair will ensure that, in determining the matters to be considered by the Committee, full account is taken of the views and interests of the Committee's stakeholders, including any views expressed formally to the Committee, e.g. through Llais.

6.2 Working with Llais

6.2.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) places a range of duties on LHBs and Trusts in relation to the engagement and involvement of Llais in their operations.

6.2.2 The 2020 Act places a statutory duty on LHBs and Trusts to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.2.3 The 2020 Act also places a statutory duty on LHBs and Trusts to make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. LHBs

and Trusts must also have regard to the Code of Practice on access to premises when it comes into effect in June 2023.

6.2.4 The LHBs, NHS Trusts and the SSPC will ensure it is clear who will assume responsibility for engaging and co-operating with Llais when planning and commissioning services.

6.2.5 The SSPC shall ensure arrangements are in place to engage and co-operate with representatives of Llais as appropriate.

6.3 Annual Plan of Committee Business

6.3.1 The Committee Secretariat, on behalf of the SSPC Chair, shall produce an annual Business Plan of Committee business. This plan will include proposals on meeting dates, venues, and coverage of business activity during the year. The Business Plan shall also set out any standing items that shall appear on every SSPC agenda.

6.3.2 The Business Plan shall set out the arrangements in place to enable the SSPC to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing SSPC members to contribute in either English or Welsh languages, where appropriate.

6.3.3 The Business Plan shall also incorporate formal SSPC meetings, regular Committee development sessions and, where appropriate, and the planned activities of Sub-Committees, Expert Panel and Advisory Groups.

6.3.4 The SSPC shall agree the Business Plan for the forthcoming year by the end of March.

6.4 Calling Meetings

6.4.1 In addition to the planned meetings agreed by the SSPC, the SSPC Chair may call a meeting of the SSPC at any time. An individual SSPC member may request that the SSPC Chair call a meeting, provided that in at least one third of the whole number of Committee members supports such a request.

6.4.2 If the Chair does not call a meeting within seven days after receiving such a request from SSPC members, then those SSPC members may themselves call a meeting.

6.5 Preparing for Meetings

Setting the agenda

6.5.1 The SSPC Chair, in consultation with the Committee Secretariat and Managing Director of NWSSP, will set the agenda. In doing so, they will take account of the planned activity set in the annual cycle of SSPC business; any standing items agreed by the SSPC; any applicable items received from Sub-Committees and other groups as well as the priorities facing the SSPC. The SSPC Chair must ensure that all relevant matters are brought before the SSPC on a timely basis.

6.5.2 Any SSPC member may request that a matter is placed on the agenda by writing to the SSPC Chair, copied to the Committee Secretariat, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of SSPC business.

Notifying and equipping SSPC members

6.5.3 SSPC members should be sent an agenda and a complete set of supporting papers at least 10 calendar days before a formal SSPC meeting. This information may be provided to SSPC members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided after this time, provided that the SSPC Chair is satisfied that the SSPC's ability to consider the issues contained within the paper would not be impaired.

6.5.4 No papers should be included for decision by the SSPC unless the SSPC Chair is satisfied (subject to advice from the Committee Secretariat, as appropriate) that the information contained within it is sufficient to enable the SSPC to take a reasonable decision. Equality Integrated Impact Assessments (EqIIAs) shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the SSPC, and the outcome of that EqIIA shall be included within the report to the SSPC, to enable the SSPC to make an informed decision.

6.5.5 In the event that at least half of the SSPC members do not receive the agenda and papers for the meeting as set out above, the SSPC Chair must consider whether or not the SSPC would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the SSPC Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.5.6 In the case of a meeting called by SSPC members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.5.7 Except for meetings called in accordance with SSPC Standing Order 6.4, at least 10 calendar days before each meeting of the SSPC a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- at the SSPC's principal sites;
- on the SSPC's website, together with the papers supporting the public part of the agenda; as well as
- through other methods of communication as set out in the SSPC's communication strategy.

6.5.8 When providing notification of the forthcoming meeting, the SSPC shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g. as Braille, large print, easy read, etc.

6.6 Conducting Shared Services Partnership Committee Meetings

Admission of the public, the press and other observers

6.6.1 The SSPC shall encourage attendance at its formal SSPC meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the SSPC. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility such as an induction loop system.

6.6.2 The SSPC shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g. business that relates to a confidential matter affecting a NWSSP officer, a patient, or a procurement contract. In such cases, the Chair (advised by the NWSSP Head of Finance and Business Development, where appropriate) shall Annexe these issues accordingly and requires that any observers withdraw from the meeting. In doing so, the SSPC shall resolve:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the

confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

6.6.3 In these circumstances, when the SSPC is not meeting in public session, it shall operate in private session, formally reporting any decisions taken to the next meeting of the SSPC in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a SSPC meeting held in public session.

6.6.4 The NWSSP Head of Finance and Business Development, on behalf of the SSPC Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.6.5 In encouraging entry to formal SSPC meetings from members of the public and others, the SSPC shall make clear that attendees are welcomed as observers. The SSPC Chair shall take all necessary steps to ensure that the SSPC's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting. In doing so, the SSPC shall resolve:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the SSPC to reconvene the meeting and to complete business without the presence of the public".

6.6.6 Unless the SSPC has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the SSPC, its Sub-Committees, Expert Panel or Advisory Groups

6.6.7 The SSPC shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the SSPC, its Sub-Committees, expert panel, or Advisory Groups, and may change, alter, or vary these terms and conditions as it considers appropriate. In doing so, the SSPC will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the SSPC (whether directly or through the activities of bodies such as Llais) and to demonstrate openness and transparency in the conduct of business.

Chairing SSPC Meetings

6.6.8 The Chair of the SSPC will preside at any meeting of the SSPC unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent, then no formal business shall take place.

6.6.9 The Chair must ensure that the meeting is handled in a manner that enables the SSPC to reach effective decisions on the matters before it. This includes ensuring that SSPC members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the SSPC must have access to appropriate advice on the conduct of the meeting through the attendance of the Head of Finance and Business Development. The Chair has the final say on any matter relating to the conduct of SSPC business.

Quorum

6.6.10 At least 6 voting members, at least 4 of whom are Health Board, Trust, or Special Health Authority Chief Executives (or their nominated representatives) and one is either the Chair or the Vice Chair, must be present to allow any formal business to take place at an SSPC meeting. If the Managing Director of NWSSP is not present, then no formal business should be transacted unless there is, in attendance, a properly authorised deputy for the Managing Director.

6.6.11 If a Health Board, Trust, or Special Health Authority Chief Executive (or their nominated representative) or the Managing Director of NWSSP is unable to attend a SSPC meeting, then a nominated deputy may attend in their absence which should be an Executive Director of the same organisation and will formally contribute to the quorum and have delegated voting rights, provided that the Chair has agreed the nomination before the meeting.

6.6.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e. any decisions to be made. Any SSPC member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.6.13 In the normal course of SSPC business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a SSPC member may put forward a motion proposing that a formal review of that service area is undertaken. The Board Secretary support role will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the SSPC unless moved by a SSPC member and seconded by another SSPC member (including the SSPC Chair).

6.6.14 **Proposing a formal notice of Motion –** Any SSPC member wishing to propose a motion must notify the SSPC Chair in writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the SSPC Chair has determined that the proposed motion is relevant to the SSPC's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the SSPC Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.6.15 The SSPC Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of SSPC business.

6.6.16 **Amendments -** Any SSPC member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the SSPC alongside the motion.

6.6.17 If there are a number of proposed amendments to the Motion, each amendment will be considered in turn, and if passed, the amended Motion becomes the basis on which the further amendments are considered, i.e. the substantive motion.

6.6.18 **Motions under discussion –** When a motion is under discussion, any SSPC member may propose that:

- the motion be amended;
- the meeting should be adjourned;
- the discussion should be adjourned and the meeting proceed to the next item of business;
- a SSPC member may not be heard further;
- the SSPC decides upon the motion before them;

- an ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.6.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.6.20 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconded and the SSPC Chair.

6.6.21 **Motion to rescind a resolution –** The SSPC may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months unless the motion is supported by the (simple) majority of SSPC members.

6.6.22 A motion that has been decided upon by the SSPC cannot be proposed again within six months except by the SSPC Chair, unless the motion relates to the receipt of a report or the recommendations of a Sub-Committee/Managing Director of NWSSP to which a matter has been referred.

Voting

6.6.23 The SSPC Chair will determine whether SSPC members' decisions should be expressed orally, through a show of hands, or by secret ballot or by recorded vote. The SSPC Chair must require a secret ballot if the majority of voting SSPC members request it. Where voting on any question is conducted, a record shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the minutes shall record the name of the individual and the way in which they voted.

6.6.24 In determining every question at a meeting, the SSPC members must take account, where relevant, of the views expressed and representations made by individuals who represent the interests of citizens in Wales. Such views may be presented to the SSPC through the Chairs of any Expert Panel, Advisory Group and/or the Llais representative(s).

6.6.25 Except for decisions related to the overall funding contribution from each of the Health Boards, Trusts, or Special Health Authority, the SSPC will make decisions subject to a 2/3 majority of voting. In no circumstances may an absent SSPC member (or their nominated deputy) vote by proxy. Absence is defined as being absent at the time of the vote.

6.7 Record of Proceedings

6.7.1 A record of the proceedings of formal SSPC meetings (and any other meetings of the SSPC where the SSPC members determine) shall be drawn up as 'minutes'. These minutes shall include a record of SSPC member attendance (including the SSPC Chair) together with apologies for absence and shall be submitted for agreement at the next meeting of the SSPC, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.7.2 Agreed minutes shall be circulated in accordance with SSPC members' wishes, and, where providing a record of a formal SSPC meeting shall be made available to the public on the NWSSP website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g. Data Protection Act, the SSPC's Communication Strategy and Velindre's Welsh Language Scheme.

6.8 Confidentiality

6.8.1 All SSPC members, together with members of any Sub-Committee, Expert Panel or Advisory Group established by or on behalf of the SSPC and SSPC members and/or Health Board/Trust/Special Health Authority officials must respect the confidentiality of all matters considered by the SSPC in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the SSPC Chair or relevant Sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g. in contracts of employment, within the Standards of Behaviour Framework or legislation such as the Freedom of Information Act 2000, etc.

7 VALUES AND STANDARDS OF BEHAVIOUR

The SSPC must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour Framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the SSPC, including SSPC members, Velindre NWSSP officers and others, as appropriate. The Framework adopted by the SSPC will form part of these SOs.

7.1 Declaring and Recording Shared Services Partnership Committee Members' Interests

7.1.1 **Declaration of interests –** It is a requirement that all SSPC members should declare any personal or business interests they may have which may affect, or be perceived to affect, the conduct of their role as a SSPC member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the SSPC's business. SSPC members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. SSPC members must notify the SSPC of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as SSPC members.

7.1.2 SSPC members must also declare any interests held by family members or persons or bodies with which they are connected. The NWSSP Head of Finance and Business Development will provide advice to the SSPC Chair and the SSPC on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g. the Values and Standards of Behaviour Framework. If individual SSPC members are in any doubt about what may be considered as an interest, they should seek advice from the NWSSP Head of Finance and Business Development. However, the onus regarding declaration will reside with the individual SSPC member.

7.1.3 **Register of interests –** The Managing Director of NWSSP, through the NWSSP Head of Finance and Business Development, will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all SSPC members. The register will include details of all Directorships and other relevant and material interests which have been declared by SSPC members.

7.1.4 The register will be held by the NWSSP Head of Finance and Business Development, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by SSPC members. The NWSSP Head of Finance and Business Development will also arrange an annual review of the register, through which SSPC members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the SSPC's commitment to openness and transparency, the NWSSP Head of Finance and Business Development must take reasonable steps to ensure that citizens served by the SSPC are made aware of and have access to view the Register of Interests. This will include publication on the NWSSP website.

7.1.6 **Publication of declared interests in Annual Review –** SSPC members' directorships of companies or positions in other organisations likely or

possibly seeking to do business with the NHS shall be published in each Shared Services' Annual Review.

7.2 Dealing with Members' interests during Shared Services Partnership Committee meetings

7.2.1 The SSPC Chair, advised by the NWSSP Head of Finance and Business Development, must ensure that the SSPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual board members must demonstrate, through their actions, that their contribution to the SSPC's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the SSPC and as a member of the Board of a Health Board, Trust, or Special Health Authority.

7.2.2 Where individual SSPC members identify an interest in relation to any aspect of SSPC business set out in the SSPC's meeting agenda, that member must declare an interest at the start of the SSPC meeting. SSPC members should seek advice from the SSPC Chair, through the NWSSP Head of Finance and Business Development before the start of the SSPC 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 SSPCs minutes.

7.2.3 It is the responsibility of the SSPC Chair, on behalf of the SSPC, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i the declaration is formally noted and recorded, but that the SSPC member should participate fully in the SSPC's discussion and decision, including voting
ii the declaration is formally noted and recorded, and the SSPC member participates fully in the SSPC's discussion, but takes no part in the SSPC's decision;
iii the declaration is formally noted and recorded, and the SSPC member takes no part in the SSPC discussion or decision;
iv the declaration is formally noted and recorded, and the SSPC member is excluded for that part of the meeting when the matter is being discussed. A SSPC member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the SSPC.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a SSPC member is compatible with an identified conflict of interest.

7.2.5 Where the SSPC Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the SSPC.

7.2.6 In all cases the decision of the SSPC Chair (or the Vice Chair in the case of an interest declared by the SSPC Chair) is binding on all SSPC members. The SSPC Chair should take advice from the NWSSP Head of Finance and Business Development when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a SSPC member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the SSPC including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The SSPC may determine that the SSPC member concerned shall be excluded from that part of the meeting.

7.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests, and these definitions always apply when determining whether a member has an interest. These SSPC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a SSPC meeting, an individual SSPC member may establish a clear conflict of interest between their role as a SSPC member and that of their professional role outside of the SSPC. In any such circumstance, the SSPC shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the NWSSP Head of Finance and Business Development.

7.3 Dealing with Officers' Interests

7.3.1 The SSPC must ensure that the NWSSP Head of Finance and Business Development, on behalf of the Managing Director of NWSSP, establishes and maintains a system for the declaration, recording and handling of

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other

NWSSP officers' interests in accordance with the Standards of Behaviour Framework.

7.4 Reviewing How Interests are Handled

7.4.1 The SSPC's Audit Committee will review and report to the Health Boards, Trusts, and Special Health Authority upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with Offers of Gifts[2] and Hospitality

7.5.1 The Committee will adopt the Values and Standards of Behaviour Framework Policy of Velindre University NHS Trust, which prohibits SSPC members and NWSSP officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits, or hospitality must never be solicited. Any SSPC member or NWSSP officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a SSPC member or NWSSP officer. Compliance with the Velindre University NHS Trust Standards of Behaviour Framework is mandatory for all Trust employees.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the NWSSP Head of Finance and Business Development as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case, accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the SSPC;

[2] The term gift refers also to any reward or benefit

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel, or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, sporting, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the SSPC; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures, or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Register of Gifts and Hospitality

7.6.1 The NWSSP Head of Finance and Business Development, on behalf of the SSPC Chair, will maintain a Register of Gifts and Hospitality to record offers of gifts and hospitality made to SSPC members. NWSSP Director of Finance and Corporate Services together with Heads of Service, will adopt the Velindre University NHS Trust Policy on Gifts and Hospitality in relation to NWSSP officers working within their areas.

7.6.2 Every SSPC member and NWSSP officer has a personal responsibility to volunteer information in relation to offers of gifts and hospitality made in their capacity as SSPC members, including those offers that have been refused. The NWSSP Head of Finance and Business Development, on behalf of the SSPC Chair and Managing Director of NWSSP, will ensure the incidence and patterns of offers and receipt of gifts and hospitality is kept under active review, taking appropriate action where necessary.

7.6.3 When determining what should be included in the register, NWSSP Officers must apply the principles as set out in the Velindre University NHS Trust Policy on gifts and hospitality.

7.6.4 SSPC members and NWSSP officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the SSPC;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.6.5 The NWSSP Head of Finance and Business Development will arrange for a full report of all offers of Gifts and Hospitality recorded by the SSPC to be submitted to Velindre's Audit Committee at least annually. The Audit Committee will then review and report to the SSPC and the Velindre Trust Board upon the adequacy of the SSPC's arrangements for dealing with offers of gifts and hospitality.

7.6.6 Detailed arrangements for the handling of gifts and hospitality are set out within the Velindre University NHS Trust Standards of Behaviour Framework and its policy on Gifts and Hospitality.

8 SIGNING AND SEALING DOCUMENTS

The Common Seal of NWSSP's host is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

Where the Velindre Trust Board has decided that a NWSSP document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised Independent Member) and the Chief Executive (or another authorised individual) both of whom witness the seal.

8.1 Register of Sealing

8.1.1 The NWSSP Head of Finance and Business Development shall keep a register that records the sealing of every NWSSP document. Each entry must be signed by the person who approved and authorised the document and who witnessed the seal. A report of all sealing shall be presented to the SSPC at least biennially.

8.2 Signature of Documents

8.2.1 Where a signature is required for any document connected with legal proceedings involving the NWSSP, it shall normally be signed by the Managing Director, except where the SSPC has been otherwise directed to allow or require another person to provide a signature.

8.2.2 The Managing Director or nominated officers may be authorised by the SSPC to sign on behalf of the NWSSP any agreement or other document (not required to be executed as a deed) where the subject matter has been approved by the SSPC.

8.3 Custody of Seal

8.3.1 The Common Seal of NWSSP's host is kept securely by the Board Secretary.at Velindre University NHS Trust.

9 GAINING ASSURANCE ON THE CONDUCT OF SHARED SERVICES PARTNERSHIP COMMITTEE BUSINESS

The SSPC shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to Velindre on the conduct of SSPC business, its governance, and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

The SSPC shall ensure that its assurance arrangements are operating effectively, advised by Velindre's Audit Committee.

9.1 The Role of Internal Audit in Providing Independent Internal assurance

9.1.1 The SSPC shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

9.1.2 The SSPC shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the SSPC. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Audit Committee facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and

- Ensure that the Head of Internal Audit reports periodically to the SSPC on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

9.2 Reviewing the Performance of the Shared Services Partnership Committee, its Sub-Committees, Expert Panel and Advisory Groups

9.2.1 The SSPC shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Sub-Committees, Expert Panel, and any other Advisory Groups. Where appropriate, the SSPC may determine that such evaluation may be independently facilitated.

9.2.2 Each Sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the SSPC through the Chair within 1 month of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

9.2.3 The SSPC shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Committee Development Programme, as part of an overall Organisation Development framework; and
- inform its Partners through its annual report of its alignment with the Assembly Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

9.3 External Assurance

9.3.1 The SSPC shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on its operations, e.g. Audit Wales and Healthcare Inspectorate Wales.

9.3.2 The SSPC may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the SSPC itself may commission specifically for that purpose.

9.3.3 The SSPC shall keep under review and ensure that, where appropriate, the SSPC implements any recommendations relevant to its business

made by the Welsh Government Audit and Risk Assurance Committee, the Public Accounts Committee, or other appropriate bodies.

9.3.4 The SSPC shall provide the Auditor General for Wales with assistance, information, and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities under section 145 of and paragraph 17 to Annexe 8 to the Government of Wales Act 2006 (C.42).

10 DEMONSTRATING ACCOUNTABILITY

10.1.1 Taking account of the arrangements set out within these SSPC SOs, the SSPC shall demonstrate to its Partners, citizens, and other stakeholders and to Velindre, as host, a clear framework of accountability within which it:

- conducts its business internally;
- works collaboratively with NHS colleagues, partners, service providers and others; and
- responds to the views and representations made by those who represent the interests of the citizens it serves and its own NWSSP officers.

10.1.2 The SSPC shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report of the SSPC.

10.1.3 The SSPC shall also facilitate effective scrutiny of NWSSP's operations through the publication of regular reports on activity and performance, including publication of an Annual Review document providing a summary of annual performance.

10.1.4 The SSPC shall ensure that within the NWSSP staff, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

11 SUPPORT FOR THE SHARED SERVICES PARTNERSHIP COMMITTEE

11.1.1 The NWSSP Head of Finance and Business Development, on behalf of the SSPC Chair, will ensure that the SSPC is properly equipped to carry out its role by:

- overseeing the process of nomination and appointment to the SSPC;
- co-ordinating and facilitating appropriate induction and organisational development activity;

- ensuring the provision of governance advice and support to the SSPC Chair on the conduct of its business and its relationship with its partners, Velindre, as the host and others;
- ensuring the provision of secretariat support for SSPC meetings;
- ensuring that the SSPC receives the information it needs on a timely basis;
- ensuring strong links to communities/groups;
- ensuring an effective relationship between the SSPC and Velindre as its host; and
- facilitating effective reporting to each Health Board, Trust, and Special Health Authority

thereby enabling each Health Board, Trust, and Special Health Authority's Board to gain assurance on the conduct of business carried out by SSPC on their behalf.

12 REVIEW OF STANDING ORDERS

12.1.1 These SSPC SOs shall be reviewed annually by the SSPC, which shall report any proposed amendments to the Velindre Trust Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SSPC SOs, including the Equality Integrated Impact Assessment.

Annexe 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annexe forms part of, and shall have effect as if incorporated in the Shared Services Partnership Committee Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

As set out in Standing Order 2, the SSPC - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day-to-day business of the NWSSP may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The SSPC may delegate functions to:

i A Committee, e.g., Audit Committee;
ii A Sub-Committee,
iii A Joint-Committee or Joint Sub-Committee, e.g., with other Health Boards established to take forward matters relating to specialist services; and
iv Officers of NWSSP (who may, subject to the SSPC's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the SSPC is notified of any matters that may affect the operation and/or reputation of NWSSP.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Annexe of matters reserved to SSPC;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officer.

all of which form part of the SSPC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The SSPC will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the SSPC unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs.
- The SSPC must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management.
- Any decision made to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility.
- The SSPC must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development.
- The SSPC must take appropriate action to assure itself that all matters delegated are effectively carried out.
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes.
- Except where explicitly set out, the SSPC retains the right to decide upon any matter for which it has responsibility, even if that matter has been delegated to others.
- The SSPC may delegate authority to act, but retains overall responsibility and accountability.
- When delegating powers, the SSPC will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Shared Services Partnership Committee (SSPC)

The SSPC will formally agree, review and, where appropriate revise Annexes of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Managing Director

The Managing Director will propose a Scheme of Delegation to officers, setting out the functions they will perform personally, and which functions will be delegated to other officers. The SSPC must formally agree this scheme.

In preparing the scheme of delegation to officers, the Managing Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Managing Director may re-assume any of the powers they have delegated to others at any time.

Board Secretary Governance Support/The NWSSP Head of Finance and Business Development

The Board Secretary Governance Support/the NWSSP Head of Finance and Business Development will support the SSPC in its handling of reservations and delegations by ensuring that:

- A proposed Annexe of matters reserved for decision by the SSPC is presented to the SSPC for its formal agreement;
- Effective arrangements are in place for the delegation of NWSSP's functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the SSPC, Audit Committee and Velindre University NHS Trust Board for revision and approval, as appropriate.

The Velindre University NHS Trust Audit Committee for NWSSP

The Velindre University NHS Trust Audit Committee for NWSSP will provide assurance to the SSPC and Velindre University NHS Trust Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Velindre University NHS Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary providing governance support to the SSPC of their concern, as soon as possible, so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the SSPC has set out alternative arrangements.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within NWSSP. The Scheme is to be used in conjunction with the system of control and other established procedures within NWSSP.

SECTION 1

ANNEXE OF MATTERS RESERVED TO THE SSPC[3]

SSPC		AREA	DECISIONS RESERVED TO THE SSPC
1	FULL	GENERAL	The SSPC may determine any matter for which it has statutory or delegated authority, in accordance with NWSSP SOs.
2	FULL	GENERAL	The SSPC must determine any matter that will be reserved to the whole SSPC in accordance with statutory and Welsh Government guidance.
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the SSPC, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges.
4	FULL	OPERATING ARRANGEMENTS	Approve, vary, and amend: ▪ NWSSP SOs ; ▪ NWSSP SFIs; ▪ Annexe of matters reserved to the SSPC; ▪ Scheme of delegation to SSPC others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

[3] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements

5	FULL	OPERATING ARRANGEMENTS	Approve the SSPC Values and Standards of Behaviour Framework, including NWSSP's mission statement.
6	FULL	OPERATING ARRANGEMENTS	Approve the SSPC framework for performance management, risk, and assurance.
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the SSPC determines it so based upon its contribution/impact on the achievement of the SSPC's aims, objectives and priorities.
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Managing Director in accordance with NWSSP Standing Order requirements.
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with NWSSP SOs.
10	FULL	OPERATING ARRANGEMENTS	Approve procedures for dealing with complaints and incidents.
11	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with NWSSP SFIs.
12	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write-off of losses or making of special payments above the limits of delegation to the Managing Director and officers.
13	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the NWSSP.
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline, and dismissal of the Management Team and any other SLG level appointments, e.g., the Committee Secretary.

15	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive, and determine action in response to the declaration of NWSSP members' interests, in accordance with advice received, e.g. from Audit Committee.
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the NWSSP's top level organisation structure and SSPC policies.
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss SSPC sub-Committees, including any joint sub-Committees directly accountable to the SSPC.
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the SSPC.
17	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the SSPC on outside bodies and groups.
18	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the SSPC.
19	FULL	STRATEGY & PLANNING	Determine the SSPCs strategic aims, objectives, and priorities.
20	FULL	STRATEGY & PLANNING	Approve the SSPCs Integrated Medium Term Plan, including the balanced Medium Term Financial Plan.
21	FULL	STRATEGY & PLANNING	Approve the SSPCs Risk Management Strategy, including risk appetite, risk tolerance levels and treatment plans and managing risks in relation to public confidence.
22	FULL	STRATEGY & PLANNING	Approve the SSPCs citizen engagement and involvement strategy, including communication.

23	FULL	STRATEGY & PLANNING	Approve the SSPCs Committee's partnership and stakeholder engagement and involvement strategies.
24	FULL	STRATEGY & PLANNING	Approve NWSSP's key strategies and programmes related to: ▪ People and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans) ▪ Primary Care ▪ Communications & Engagement
25	FULL	STRATEGY & PLANNING	Approve the SSPCs budget and financial framework (including overall distribution of year end surplus/deficits including risk sharing agreements.
26	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Managing Director set out in the NWSSP SFIs.
27	FULL	PERFORMANCE & ASSURANCE	Approve the SSPC's audit and assurance arrangements.
28	FULL	PERFORMANCE & ASSURANCE	Receive reports from the SSPC's NWSSP Directors on progress and performance in the delivery of the SSPC's strategic aims, objectives and priorities and approve action required, including improvement plans.

29	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the SSPC's Sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans.
30	FULL	PERFORMANCE & ASSURANCE	Receive reports on the SSPC's performance produced by external regulators and inspectors (including, e.g., Audit Wales, HIW, etc) that raise issue or concerns impacting on the NWSSP's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of SSPC sub-Committees (as appropriate).
31	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the SSPC's Head of Internal Audit and approve action required, including improvement plans.
32	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the SSPC's external auditor and approve action required, including improvement plans.
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the SSPC's performance against the Health and Care Standards for Wales and approve action required, including improvement plans.
34	FULL	PERFORMANCE & ASSURANCE	Approval of the Risk and Assurance Framework.
35	FULL	REPORTING	Approve the SSPC's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners, and stakeholders and nationally to the Welsh Government.
36	FULL	REPORTING	Receive, approve, and ensure the publication of SSPC reports, including its Annual Report.

SECTION 2

ANNEXE OF DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Under Standing Order Section 2 it provides that the SSPC may delegate powers to SSPC Committees, Sub-Committees, and others. In doing so, the SSPC has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others;

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

Subject to Clauses within the Trust Standing Orders and to such directions as may be given by the Welsh Government, the SSPC may appoint ad-hoc committees of the NWSSP, whose membership can be wholly or partly of the Chairman and Directors of the NWSSP, or persons who are not Directors of the NWSSP.

A committee appointed under this regulation may subject to such directions as may be given by the Welsh Government or the SSPC appoint ad hoc Sub-Committees consisting wholly or partly of members of the committee (whether or not they are Directors of NWSSP) or wholly of persons who are not members of the committee (whether or not they include Directors of the NWSSP).

The Standing Orders, with appropriate alterations, apply to a committee or Sub-Committee and to a committee or Sub-Committee as they apply to the SSPC and apply to a member of such committee or sub-committee (whether or not they are a Director of the NWSSP) as it applies to a Director of the NWSSP.

The SSPC may make, vary and revoke Standing Orders relating to the quorum, proceedings, and place of meetings of a committee or Sub-Committee but, this shall be carried out in accordance with the identified procedures laid down for these changes as outlined in these Standing Orders.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee Terms of Reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the SSPC's Scheme of Delegation to Committees.

The SSPC has delegated a range of its powers to the following Sub-Committees and others:

- Welsh Risk Pool Committee
- Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Summary of matters delegated to Sub-Committees:

Sub-Committee: Welsh Risk Pool Committee **Delegated Matters:**
The Sub-Committee will: 1. To approve the payment and reimbursement of claims and impose penalties in accordance with the WRPS Claims Reimbursement Procedure. 2. To enact the risk sharing arrangements as agreed by the NWSSP. 3. To receive and consider the annual statements of account. 4. To receive and consider the annual assessment reports and to approve recommendations for any necessary action. 5. To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action. 6. To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately. 7. To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk. 8. To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All-Wales basis. 9. To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.

Sub-Committee: Velindre University NHS Trust Audit Committee for NWSSP **Delegated Matters:**
The Committee will: 1. Approve any variation to, review annually and monitor compliance with Standing Orders and Standing Financial Instructions. 2. Review and report to the SSPC upon the adequacy of the arrangements for declaring, registering, and handling interests at least annually. 3. Receive a full report of all offers of Gifts and Hospitality recorded by the NWSSP and review the adequacy of NWSSP's arrangements for dealing with offers of gifts and hospitality. 4. Advise the Velindre Trust Board on the adequacy that its assurance arrangements are operating effectively. 5. Review and approve Internal Audit Strategy, Charter, operational plan, programme of work. 6. Review effectiveness of internal audit. 7. Review policies and procedures in respect of fraud and bribery set out in the Welsh Government Directions and to receive the Counter Fraud Annual Report and Plan. 8. Approve write-off of losses or making of special payments within delegated limits determined by the Welsh Ministers. 9. Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities. 10. Review the assurance gained through the development of a Risk and Assurance Framework and to consider gaps in control and gaps in assurance and report results to the Board. 11. Review the adequacy of all risk and control related disclosure statements, including the Annual Governance Statement. 12. Receive quarterly assurance of Post Payment Verification (PPV) reports.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the NWSSP's Scheme of Delegation to Committees.

SECTION 3

ANNEXE OF SCHEME OF DELEGATION TO NWSSP DIRECTORS AND OFFICERS

The SSPC SOs, alongside the Trust SOs and the SFIs specify certain key responsibilities of the Chief Executive Velindre University NHS Trust, the Managing Director of NWSSP, Directors, Heads of Service and other officers. The Chief Executive and Managing Director of NWSSP Job Descriptions, together with their Accountable Officer Memorandums set out their specific responsibilities, and the individual job descriptions determined for Directors and Heads of Service level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the Annexe of additional delegations below and the associated financial delegations set out in the Velindre Trust SFIs form the basis of the Scheme of Delegation to Officers.

Standing Orders – List of Delegated Matters

SO REF	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
GENERAL			
	Non-compliance and variation of Standing Orders Final interpretation of Standing Orders Responsibility for providing advice to the Board on all aspects of governance/committee services	Head of Finance and Business Development Chair Head of Finance and Business Development	Board Secretary Support
CHAIR'S ACTION ON URGENT MATTERS			
SO 2.1	Use of Chair's Action and onward reporting to	Chair & Managing Director	Board Secretary Support
DELEGATION TO OFFICERS			
SO 2.3.1	Compilation of Scheme of Delegation for functions	Managing Director	Head of Finance and Business

	delegated to Managing Director for consideration and approval by the SSPC		Development
SO 2.3.1	Delegation of functions within Directorates/departments/localities in line with the framework established by the Managing Director and agreed by the SSPC	Directors	Directors
WORKING IN PARTNERSHIP			
SO 5.0.2	Identification and engagement with all key partners and regular review of effectiveness	Chair	Deputy Director of Finance and Corporate Services
MEETINGS			
SO 6.2	Development of the Annual Plan of SSPC Business	Chair/Managing Director	Head of Finance and Business Development
SO 6.3	Call meetings of the SSPC	Chair/Managing Director	Head of Finance and Business Development
SO 6.4	Preparation of SSPC meetings	Chair/Managing Director	
SO 6.5	Report decisions made & review NWSSP business conducted in private session	Chair	Head of Finance and Business Development
SO 6.5	Chair SSPC meetings & associated responsibilities	Chair	Head of Finance and Business Development
SO 6.6	A record of proceedings of SSPC meetings	Chair (Vice Chair in Chair's absence)	Chair (Vice Chair in Chair's absence) / Head of Finance and Business Development

VALUES AND STANDARDS OF BEHAVIOUR			
SO 7.1	Establishment, maintenance, and annual review of a Register of Interests declared by all SSPC members	Managing Director	Head of Finance and Business Development
SO 7.6	Establishment, maintenance and annual review of a Register of Gifts and Hospitality in respect of SSPC business for all SSPC members	Chair	Head of Finance and Business Development
SO 7.6	Establishment maintenance and annual review of a Register of Gifts and Hospitality for NWSSP Officers	Managing Director/Directors	Head of Finance and Business Development
SIGNING AND SEALING DOCUMENTS			
SO 8.1	Establishment, maintenance, and bi-annual reporting of a Register of Sealings undertaken by the Velindre NHS Trust Board for NWSSP business	Managing Director	Head of Finance and Business Development

This scheme only relates to matters delegated by the Velindre Board and the SSPC to the Managing Director and Directors, together with certain other specific matters referred to in SFIs. Each Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annexe of Additional Delegations

Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Managing Director of NWSSP/ NWSSP Director of Finance	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Trust Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Financial policies & procedures
Engagement of staff within funded establishment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Managing Director of Shared Services	Nominated deputy	In absence of Director of Shared Services
Staff re-grading and awarding of incremental points	NWSSP Director of P&OD	Yes	Written authority to suitably qualified HR staff
Approval of overtime	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of compassionate leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures

Approval of leave without pay	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Managing Director of NWSSP NWSSP Directors	 No Yes	 Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Managing Director NWSSP/ NWSSP Director of W&OD	No	
Approval of relocation costs	NWSSP Director of W&OD	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • NWSSP Directors • Other staff	Managing Director of NWSSP NWSSP Finance Director	 No No	
Approval of redundancy, early retirement, and ill-health retirement	Managing Director of NWSSP	Yes	Authorisation matrix. HR policies & procedures
Dismissal of staff	Managing Director of NWSSP and NWSSP Director of P&OD	Yes	Authorisation matrix. HR policies & procedures
Approval to procure goods and services within budget	NWSSP Directors / Heads of Service	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Managing Director of NWSSP	Nominated deputy	In absence of the Managing Director of NWSSP
Approval to commission services from other NHS bodies	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures

Approval to commission services from voluntary sector	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission services from private and independent providers	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Management and Control of Stocks	NWSSP Director (Head of Procurement Services)/ NWSSP Director of Finance	Yes	Authorisation matrix
Work in relation to counter fraud and corruption	Trust Director of Finance/ NWSSP Director of Finance	Yes	Authorisation matrix Fraud & Corruption policies and procedures
Authorisation of sponsorship	Managing Director of NWSSP	No	Sponsorship policies & procedures
Approval of research projects	Managing Director of NWSSP	Yes	Research policies & procedures
Management of complaints	NWSSP Director of Finance	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	NWSSP Directors / Trust Board Secretary	Yes	Communication policies & procedures
Approval for use of charitable funds	Trust Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose of equipment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation (except for personal effects)	Managing Director of NWSSP	No	Within authorised limits set by WG.

Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	 Trust Small Claims Panel Managing Director of NWSSP Approval by WG	 No No No No	
Approval of clinical negligence and personal injury claims	Managing Director of NWSSP / NWSSP Director of Finance	Yes	Authorisation matrix and within limits set by WAG.
Approval of capital expenditure	Managing Director of NWSSP/ NWSSP Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	NWSSP Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Managing Director of NWSSP	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Managing Director of NWSSP& NWSSP Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Heads of Service.

This scheme only relates to matters delegated by the SSPC to the Managing Director of NWSSP and the NWSSP Directors and Heads of Service, together with certain other specific matters referred to in SFIs. Each NWSSP Director and Head of Service is responsible for delegation within their department. They shall produce a Scheme of Delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

SECTION 4

ANNEXE OF DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Velindre University NHS Trust Standing Financial Instructions detail the requirements for Budgetary Control, including:

5.1 Budget Setting
5.2 Budgetary Delegation
5.3 Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Income and Expenditure budgetary responsibility for the NHS Wales Shared Services Partnership has been delegated to the Managing Director of NWSSP.

The Managing Director of NWSSP and other NWSSP Directors will, in turn, delegate budgetary responsibility to other Heads of Service and managers. The detailed Annexe of this second-tier delegation will be reviewed, revised and reapproved on an annual basis by the Managing Director of NWSSP and the Senior Leadership Group as part of the annual Financial Strategy and Budget Setting process. Within the budgetary delegation there are delegated powers of budget virement:

- between Divisions must be approved by the Managing Director of NWSSP.
- between budgets within the same Division must be approved by the relevant Director / Heads of Service.
- between staff and non-staff within the same budget must be approved by the Budget Holder.

These delegated powers of virement, from the Managing Director of NWSSP to Heads of Service and Budget Holders, assume that the NWSSP is achieving its financial targets and can be revised, in year, by the Managing Director of NWSSP in the light of adverse financial performance. Budget virements within Divisions can be authorised by the Head of Service and Director of Finance up to the limit of £60,000.

SECTION 5

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF BUDGETARY DELEGATION

Financial Limits (All Values exclude VAT)	Revenue	Capital	All Wales Contracts**
	£000	£000	£000
Velindre:			
Trust Board	No Limit	No Limit	No Limit
Charitable Funds Committee	0	0	0
NWSSP (excluding all Wales Procurement Contracts):			
Managing Director and NWSSP Chair	200	1m	1m
Managing Director of NWSSP	100	500	500
Director of Finance and Corporate Services	80	100	100
Director of People and Organisational Development	50	50	N/A
Director of Planning, Performance and Informatics	50	50	N/A
Service Directors/Heads of Services (within own area)	25	0	N/A
Service Directors/Heads of Service's Nominee (within Agreed area)	10	0	N/A
Heads of Function (within own area)	7.5	0	N/A
Deputy Director of Finance and Corporate Services	25	25	N/A
Heads of Finance	10	10	N/A
Delegated Budget Holders (within own area) Level 1	5	0	N/A
Delegated Budget Holders (within own area) Level 2	1	0	N/A
Notes:			
***Represents contracts where expenditure is directly incurred by NWSSP in respect of All Wales Contracts where the expenditure is either recharged to NHS Wales organisations or the expenditure is incurred for goods/services that will be directly consumed by NHS Wales organisations.*			

Welsh Infected Blood Support Services Limits

Scheme Designation	Payments to Claimants (£)
Managing Director/NWSSP Chair	Over 150k
Managing Director	Up to 150k
Director of Finance and Corporate Services	Up to 150k
Director of Planning, Performance, and Informatics	Up to 150k
Head of Function (WIBSS Manager)	Up to 10k

Corporate Areas

Scheme Designation	Area	Limits (£)
Managing Director/Director of Finance and Corporate Services	ESR Recharges	Up to £1m
Managing Director/Director of Finance and Corporate Services	Intra-NHS Invoices and Payments (included but not limited to Pharmacy rebates, NWSSP distribution)	Up to £1m

Legal & Risk and Welsh Risk Pool Services Limits

Scheme Designation	Reimbursement of claims and redress cases following WRPC approval (£)	WRP Managed Claims (£)	
		(£)	(actions)
NWSSP Chair	Over 2m	Over 2m	
Managing Director of NWSSP	Up to 2m	Up to 2m	
Director of Finance and Corporate Services	Up to 1m	Up to 1m	
Director of Legal and Risk Services and Welsh Risk Pool	Up to 500k	Up to 500k	Agree settlement and make admissions
Deputy Director of Legal & Risk and Welsh Risk Pool	Up to £250k	Up to £250k	Agree settlement and make admissions
Deputy Director of Finance and Corporate Services	Up to 250k	Up to £250k	
Head of Safety and Learning	Up to 100k	£20k	
Note:			
All cases submitted for reimbursement are reviewed by a Learning Advisory Panel and the Welsh Risk Pool Committee prior to approval. Approval of Lessons Learned in cases where payments will exceed £1m are delegated by Welsh Government to the Welsh Risk Pool Committee. Payments above £1m are approved by Welsh Government prior to the Welsh Risk Pool Committee. Claims above £2m will be signed by the Managing Director of NWSSP and NWSSP Chair.			

Procurement Services Limits

Scheme Designation	Contracts for and on behalf of NHS Wales (£)*	NWSSP Stock Requisitions and Invoices (£)	NWSSP Stock Write offs (£)
Trust Board			
Chair and Managing Director / Director of Finance & Corporate Services			
Managing Director of NWSSP and NWSSP Chair	Over 1m	Over 2m	Over 50k
Managing Director of NWSSP	Up to 1m	Up to 100k	Up to 50k
Director of Finance and Corporate Services NWSSP	Up to 750k	Up to 60k	Up to 25k
Director of Procurement Services	Up to 750k	Up to 50k	Up to 25k
Assistant Directors of Procurement		Up to £25k	Up to £10k
Senior Manager Procurement Services (Logistics)		Up to 25k	Up to 10k
Regional Supply Chain Manager			Up to 5k
Warehouse Manager (Bridgend/Denbigh) / Storage and Distribution Manager (IP5)			Up to 1k
Assistant Warehouse Manager (Bridgend/Denbigh) / Shift Manager (IP5)			Up to 1k
Note:			
**Contracts for and on behalf of NHS Wales > £1m require prior approval from Welsh Government with the exception of those contracts specified in SFI 11.6.4*			

Existing Liabilities Scheme Limits

Scheme Designation	Damages Limit (£)
Welsh Government	1M and over
Managing Director and NWSSP Chair	Up to 1M
Managing Director	Up to 500k
Director of Finance & Corporate Services	Up to 500k
Director of Legal and Risk Services and Welsh Risk Pool	Up to 500k
Deputy Director of Finance & Corporate Services	Up to 100k
Deputy Director of Legal and Risk Services and Welsh Risk Pool	Up to 100k
Head of Function - GMPI Team Leader	Up to 50k
Note:	
Claims and payments will be made by NWSSP and approved in line with the above scheme of delegation. Any value of damages decisions greater than £1 million will require written Welsh Government approval. All other value of claims decisions below £1million will be approved in line with the Scheme of Delegation.	

Annexe 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs

Shared Services Partnership Committee Framework

The SSPC's governance and accountability framework comprises these SSPC SOs, incorporating Annexes of Powers reserved for the SSPC and Delegation to others, together with the following documents agreed by the SSPC.

These documents must be read in conjunction with the SSPC SOs and will have the same effect as if the details within them were incorporated within the SSPC SOs themselves:

- Standing Financial Instructions (SFIs);
- Values and Standards of Behaviour Framework;
- Risk and Assurance Framework;
- SSPC Annual Plan of Committee Business;
- Welsh Language Scheme;
- Complaints Management Protocol;
- Annual Governance Statement; and
- Annual Review,

These documents may be accessed by viewing NWSSP's website (www.nwssp.wales.nhs.uk/opendoc/326169).

NHS Wales Framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at http://www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of SSPC business are also issued in hard copy, usually under cover of a Ministerial Letter.

Annexe 3

SHARED SERVICES PARTNERSHIP COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. *Welsh Risk Pool Committee - Terms of Reference*

2. *Velindre University NHS Trust Audit Committee For NHS Wales Shared Service Partnership - Terms of Reference*

1. Welsh Risk Pool Committee Terms of Reference

1. Background

The Welsh Risk Pool (WRP) was established in 1996 when responsibility for meeting the cost of negligence claims was transferred to NHS Wales. Management of redress matters was transferred to the responsibility of the WRP from 1st April 2018. Management of General Medical Practice Indemnity (GMPI) cases was introduced on 1st April 2019 with the introduction of the National Health Service Clinical Negligence Scheme Wales Regulations 2019.

The WRP is managed by NHS Wales Shared Services Partnership (NWSSP) and decisions are made by a committee which is formed of representatives from NHS Wales and Welsh Government.

The aim of the WRP budget management is to align the financial governance relating to claims and redress cases with the corporate and quality governance agenda.

The WRP has responsibility for reimbursement of claims, redress cases, GMPI matters, property & equipment losses and special payments. Excess levels to be borne by health bodies apply in some cases. It is also required to have effective processes for ensuring that NHS Wales learns from events to limit the risk of recurrence and improve the quality and safety for both patients and staff.

In line with Standing Orders the NWSSP Committee (NWSSPC) has resolved to establish a sub- committee to be known as the Welsh Risk Pool Committee (WRPC). The WRPC is a sub- committee of the NWSSPC and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Membership

The membership of the WRPC shall be determined by the NWSSPC, taking account of the balance of skills and expertise necessary to deliver the WRPC's remit and subject to any specific requirements or directions made by Welsh Government.

The WRPC comprises of representation from senior NHS professionals from Trusts, Local Health Boards, Legal & Risk Services (L&RS) and Welsh Government. WRPC health body representatives are not in attendance on behalf of their individual organisation but are representing their professional or peer group.

Membership includes:

Chair: Chair of NHS Wales Shared Services Partnership Committee

Members: Managing Director NWSSP (Accountable Officer for WRP)
Director Legal & Risk Services NWSSP Deputy Director Legal & Risk Services NWSSP
Director of Finance & Corporate Services NWSSP Medical Director, NWSSP
NHS Wales Health Body Chair (1)

NHS Wales Health Body Chief Executive (1)
NHS Wales Health Body Medical Director (1)
NHS Wales Health Body Director of Nursing (1)
NHS Wales Health Body Director of Finance (1)
NHS Wales Health Body Director of Therapies & Health Science (1)
NHS Wales Health Body Audit Committee Chair (1)
NHS Wales Health Body Board Secretary (1)

NHS Wales Health Body Director of Primary Care (1)
Welsh Government (2)
NHS Wales Health Body Digital Services (1)

In attendance:

NWSSP – WRP Finance Business Partner

NWSSP - WRP Head of Safety and Learning

NWSSP – L&RS Head of Healthcare Litigation

WRP Operations Team
WRP Safety and Learning Team

Other individuals may be involved at the discretion of the Chair (e.g., representatives from National Speciality Advisory Groups as appropriate). The WRPC shall appoint a Vice Chair from the agreed membership. The Vice Chair shall deputise for the Chair in their absence for any reason.

In the event that a member of the WRPC is unable to attend a meeting they are required to seek a suitable representative to attend on their behalf.

Committee Secretariat is provided by the WRP Operations Team who will ensure that records are maintained in line with NWSSP process. The agenda and reports will be shared at least five working days before the meeting.

3. Dealing with Members' interests during meetings

The Chair, advised by the Committee Secretariat, must ensure that the WRPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual members must demonstrate, through their actions, that their contribution to the WRPC's decision making is based upon the best interests of the NHS in Wales.

Where individual members identify an interest in relation to any aspect of business set out in the meeting agenda, that member must declare an interest at the start of the meeting. Members should seek advice from the Chair, through the Committee Secretariat 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 minutes. It is responsibility of the Chair, on behalf of the Committee, to determine the action to be taken in response to the declaration of interest, this can include excluding the member, where they have a direct or indirect financial interest or participating fully in the discussion but taking no part in the WRPC decision.

4. Quorum

A quorum shall be the Chair or Vice Chair and at least 4 other representatives, 2 of which must be representatives from health bodies.

5. Frequency of Meetings

Meetings will be held at least 6 times per year, with additional meetings held if considered necessary.

6. Authority

The Accountable Officer for WRP is authorised to carry out any activity within the terms of reference and the scheme of delegation.

To advise the Accountable Officer, WRPC business items are subject to discussion and decisions based on consensus. Where deemed appropriate items may be referred to the NWSSPC.

The WRPC may, establish subgroups or task and finish groups as appropriate to address specific issues and to carry out on its behalf specific aspects of business.

The National Learning Advisory Panel is established as a sub-committee of the WRPC.

7. Responsibilities of the WRPC

It is important that there is clarity between the role of the WRPC and that of the NWSSPC. The NWSSPC has overall responsibility for overseeing the governance arrangements within WRP and in support of this function the minutes of the WRPC will be forwarded for information and assurance including the highlighting of matters of significance. WRP can by exception, report directly to the NWSSPC on specific matters of concern as agreed by consensus.

The role of the WRPC is to:

a. Receive assurance on the management of delegations for areas of responsibility detailed within this Terms of Reference and to report regularly to the NWSSPC on performance;

b. Undertake actions reserved specifically for the WRPC;

c. To provide advice and guidance to the Accountable Officer on reimbursement decisions; and

d. To support and promote a learning culture within NHS Wales.

8. WRPS areas of responsibility

The main areas of responsibility for which the Operations Team, supported by NWSSP Finance will be held to account by the WRPC are:

- To present key financial and performance information.
- To develop an effective and efficient process including guidance for the management of reimbursement to NHS Wales health bodies.
- To ensure that there are effective processes for the forecasting of resource requirements over the short and medium term and that there is sufficient capacity to meet obligations.
- To ensure that the transactions of the WRP are fully recorded and that financial accounts are produced in accordance with the timetable set by the Welsh Government.
- To undertake regular assessments of the Putting Things Right arrangements throughout NHS Wales.
- To undertake regular assessments of the arrangements for the management of GMPI claims by NHS Wales.
- To undertake assessments of clinical services where there is a recognised litigation profile.
- To develop processes for learning from events and cascading information to all NHS Wales health bodies including undertaking

detailed reviews of cases and identifying trends which arise.

- To undertake project work as required by the WRPC.
- To coordinate a National Learning Advisory Panel for the scrutiny of cases presented to each WRPC to provide assurance across NHS Wales that appropriate action has been taken to reduce the risk of recurrence.
- To operate a process for the handling of enquiries and responding to enquiries in relation to indemnity and reimbursement matters.

9. WRPC reserved matters

- To approve the reimbursement of cases and impose penalties in accordance with the WRP Reimbursement Procedures.
- To enact the risk sharing arrangements as agreed by the NWSSPC.
- To receive and consider the annual statements of account.
- To receive and consider the periodic assessment reports and to approve recommendations for any necessary action.
- To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately.
- To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk.
- To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All-Wales basis.
- To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action.
- To commission the Once for Wales Concerns Management System on behalf of health bodies in NHS Wales.

10. Reporting Arrangements

Minutes shall be taken at each meeting and circulated to all members of the WRPC and to the NWSSPC for information.

Risk sharing arrangements will be proposed by the WRPC and approved by the NWSSPC.

Regular financial reports on the risk sharing arrangements, forecasting future resource needs will be presented to the NWSSPC and Welsh Government as required.

11. Audit Arrangements

The WRP will be subject to audit by both internal and external auditors. The external auditors of Velindre University NHS Trust will ensure that there is overall audit coverage of case management across NHS Wales.

12. Associated documents

- All-Wales Policy on Indemnity and Insurance
- Scope of the Risk Pooling Arrangements
- WRP Reimbursement Procedures
- Terms of Reference for the National Learning Advisory Panel

13. Review Arrangements

These Terms of Reference will be reviewed every two years and approved by the WRPC and ratified by the NWSSPC.

a. Date of next review: September 2025

Key Contact: Jonathan Webb Head of Safety and Learning Jonathan.Webb@wales.nhs.uk

2. Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership - Terms of Reference

1. BACKGROUND

1.1 In May 2012, all Health Boards and Trusts approved the Standing Orders for Shared Services Partnership Committee. Section 4.0.3 of the Standing Orders (as amended 1 March 2019) states:

"The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or ***utilise Velindre's Committee arrangements*** *to assist in discharging its governance responsibilities."*

These Terms of Reference set out the arrangements for utilising the Velindre University NHS Trust Audit Committee to support the discharge of those relevant functions in relation to NHS Wales Shared Services Partnership (NWSSP).

ORGANISATIONAL STRUCTURE

Velindre University NHS Trust has an interest in NWSSP on two levels:

a) The internal governance of NWSSP in relation to the host relationship; and
b) As a member of NWSSP Committee in relation to the running of national systems and services.

The governance and issues relating to the hosting of NWSSP dealt with in **(a)** will be incorporated into the standard business of the existing Velindre University NHS Trust Audit Committee, with a specific focus on alternating Trust Audit Committee business. The assurance for the business dealt with in **(a)** will be to the Velindre University NHS Trust Board. The Chair of NWSSP Audit Committee should receive copies of the meeting papers and will be invited to attend, should there be anything on the agenda which has implications for the Shared Services Partnership Committee (SSPC).

Issues relating to NWSSP nationally run systems and services **(b)** will be fed into a separate Velindre University NHS Trust Audit Committee for NWSSP operating within its own work cycle. The assurance for the business dealt with in **(b)** will be to NWSSP Chair and the NWSSP Audit Committee, via the communication routes, detailed below.

The arrangements for **(a)** above, will not be considered further within these Terms of Reference, as it is for Velindre University NHS Trust Audit Committee to determine the relevant assurance required in relation to the host relationship.

2. INTRODUCTION

2.1 Velindre University NHS 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*".

2.2 In line with Standing Orders and NWSSP's scheme of delegation, the SSPC shall nominate, annually, a Committee to be known as the Velindre University NHS Trust Audit Committee for NWSSP. The detailed Terms of Reference and Operating Arrangements in respect of this Committee are set out below.

2.3 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.

3 PURPOSE

3.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the SSPC and the Accountable Officer on whether effective arrangements are in place - through the design and operation of NWSSP's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the organisation's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Velindre University NHS Trust Board and SSPC as to where and how its system of assurance may be strengthened and developed further.

4 DELEGATED POWERS AND AUTHORITY

4.1 With regard to its role in providing advice to both Velindre University NHS Trust Board and the SSPC, the Audit Committee will comment specifically upon:

- The adequacy of NWSSP'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, designed to support the public disclosure statements that flow from the assurance processes (including the Annual Governance Statement) and providing reasonable assurance on:

    - NWSSP's ability to achieve its objectives;
    - Compliance with relevant regulatory requirements, standards, quality and service delivery requirements, 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 NWSSP safeguards and protects all of its assets, including its people.

- NWSSP's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- The planned activity and results of Internal Audit, External Audit, and the Local Counter Fraud Specialist (including Strategies, Annual Work Plans and Annual Reports);
- The adequacy of executive and management's response to issues identified by audit, inspection, and other assurance activity, via monitoring of NWSSP's Audit Action Plan;
- Proposals for accessing Internal Audit service (where appropriate);
- Anti-fraud policies, whistle-blowing processes, and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the SSPC or the Accountable Officer may seek advice.

4.2 The Audit Committee will support the SSPC 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 SSPC;

- 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.

4.3 In carrying out this work, the Audit 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 directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.4 This will be evidenced through the Audit 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 Audit Committee to review and form an opinion on:

- The ***comprehensiveness*** of assurances in meeting the SSPC and the Accountable Officer's assurance needs across the whole of the organisation's activities; and
- The ***reliability and integrity*** of these assurances.

4.5 To achieve this, the Audit 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 SSPC and the Accountable Officer through the Audit 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 SSPC and the Accountable Officer through the Audit 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 SSPC and the Accountable Officer or through the effective completion of Audit Recommendations and the Audit Committee's review of the development and drafting of the Annual Governance Statement;

- The work carried out by key sources of external assurance, in particular, but not limited to the SSPC'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 SSPC and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, together with the risks of failing to comply;
- The systems for financial reporting to the SSPC, including those of budgetary control, are effective; and
- The results of audit and assurance work specific to the organisation and the implications of the findings of wider audit and assurance activity relevant to the SSPC'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 Audit Committee will follow and implement the Audit Committee for Shared Services Annual Work Plan and will be evidenced through meeting papers, formal minutes, and highlight reports to the SSPC, Velindre University NHS Trust Board and annually, via the Annual Governance Statement, to the Velindre University NHS Trust's Chief Executive.

Authority

4.6 The Audit Committee is authorised by the SSPC to investigate or to have investigated any activity within its Terms of Reference. In doing so, the Audit Committee shall have the right to inspect any books, records, or documents of NWSSP, relevant to the Audit 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 co-operate with any reasonable request made by the Audit Committee); and
- Any other Committee, Sub Committee or Group set up by the SSPC to assist it in the delivery of its functions.

4.7 The Audit Committee is authorised by the SSPC to obtain external 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 SSPC's procurement, budgetary and other requirements.

Access

4.8 The Head of Internal Audit and the Audit Manager of External Audit 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.

4.9 The Audit 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.

4.10 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

4.11 The Audit Committee may, subject to the approval of the SSPC, establish Sub Committees or Task and Finish Groups to carry out on its behalf specific aspects of Committee business. Currently, there are no Sub Committees of the Audit Committee.

5 MEMBERSHIP

Members

5.1 A minimum of three members, comprising:

Chair	Independent member of the Board
Members	Two other independent members of the Velindre University NHS Trust Board. The Audit 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

5.2 In attendance:

NWSSP Managing Director, as Accountable Officer
NWSSP Chair
NWSSP Director of Finance & Corporate Services
NWSSP Director of Audit & Assurance
NWSSP Head of Internal Audit
NWSSP Audit Manager
NWSSP Head of Finance and Business Development
NWSSP Corporate Services Manager
NWSSP Local Counter Fraud Specialist
Representative of Velindre University NHS Trust
Representative of the Auditor General for Wales
Other Executive Directors will attend as required by the Committee Chair

By invitation the Committee Chair may invite:

- any other Partnership 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.

The Velindre University NHS Trust Chief Executive Officer should be invited to attend, where appropriate, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Secretariat

Secretary — As determined by the Accountable Officer

Member Appointments

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

5.4 Members shall be appointed to hold office for a period of four years. Members may be re-appointed, up to a maximum of their term of office. During this time a member may resign or be removed by the Velindre University NHS Trust Board.

5.5 Audit Committee members' Terms and Conditions of Appointment, (including any remuneration and reimbursement) are determined on appointment by the Minister for Health and Social Services.

Support to Audit Committee Members

5.6 The NWSSP Head of Finance and Business Development and NWSSP Corporate Services Manager, on behalf of the Audit Committee Chair, shall:

- Arrange the provision of advice and support to Audit Committee members on any aspect related to the conduct of their role;
- Ensure that Committee agenda and supporting papers are issued five working days in advance of the meeting taking place; and
- Ensure the provision of a programme of organisational development for Audit Committee members as part of the Trust's overall Organisational Development programme developed by the Velindre University NHS Trust Executive Director of Workforce & Organisational Development.

6 AUDIT COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

6.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Audit Committee deems necessary, consistent with NWSSP's Annual Plan of Business. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary.

Withdrawal of Individuals in Attendance

6.3 The Audit 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.

7 RELATIONSHIP & ACCOUNTABILITIES WITH THE TRUST BOARD & SSPC DELEGATED TO THE AUDIT COMMITTEE

7.1 Although the Velindre University NHS Trust Board, with the SSPC and its Sub Committees, has delegated authority to the Audit Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Audit Committee is directly accountable to the Velindre University NHS Trust Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Audit Committee, through its Chair and members, shall work closely with NWSSP and its other sub-Committees to provide advice and assurance to the SSPC by taking into account:

- Joint planning and co-ordination of the SSPC 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 NWSSP's overall risk and assurance arrangements. This will primarily be achieved through the discussions held at the SSPC, annually, at the end of the financial year.

7.4 The Audit Committee will consider the assurance provided through the work of the SSPC's other Committees and sub-Committees to meet its responsibilities for advising the SSPC on the adequacy of the organisation's overall system of assurance by receipt of their annual work plans.

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

8 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Audit Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board, SSPC and the Accountable Officer on the Audit Committee's activities. This

includes verbal updates on activity and the submission of Committee minutes, and written highlight reports throughout the year;

- Bring to the Velindre University NHS Trust Board, SSPC and the Accountable Officer's specific attention any significant matters under consideration by the Audit Committee; and
- Ensure appropriate escalation arrangements are in place to alert the SSPC Chair, Managing Director (and Accountable Officer) or Chairs of other relevant Committees, of any urgent/critical matters that may affect the operation and/or reputation of the organisation.

8.2 The Audit Committee shall provide a written Annual Report to the SSPC 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 Audit Committee's self-assessment and evaluation.

8.3 The Velindre Trust Board and SSPC may also require the Audit Committee Chair to report upon the Audit Committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g. where the Audit Committee's assurance role relates to a joint or shared responsibility.

8.4 The NWSSP Head of Finance and Business Development and Corporate Services Manager, on behalf of the Partnership, shall oversee a process of regular and rigorous self-assessment and evaluation of the Audit 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.

9 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

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

10 REVIEW

10.1 These Terms of Reference and operating arrangements shall be reviewed annually by the Audit Committee with reference to the SSPC and Velindre University NHS Trust Board.

Annexe 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. Evidence Based Procurement Board (EBPB)
2. Welsh Energy Group (WEG) and Welsh Energy Operational Group (WEOG)

1. Terms of Reference of the Evidence Based Procurement Board (EBPB) of the NHS Wales Shared Services Partnership (NWSSP) (August 2018)

1. Aims and Objectives

The Board shall be known as the 'Evidence Based Procurement Board' (EBPB) and will consist of professionals from across various disciplines within NHS Wales and appropriate research bodies, making recommendations and guidance for implementation by the Welsh NHS**.**

The EBPB advises, promotes, develops and implements value and evidence-based procurement of medical technologies for NHS Wales. The group will assist with rationalisation and standardisation in line with Prudent healthcare principles, underpinned with the "*Once for Wales*" philosophy, and will assess whether NHS Wales should discard devices/technologies if they are deemed inappropriate or wasteful.

The EBPB will produce advice and guidance to support planning and decision making in Local Health Boards and Trusts.

The EBPB shall provide advice, guidance and recommendations to the Shared Services Committee and the WG Efficiency Healthcare Value & Improvement Group.

The EBPB will support NHS Wales core values through the assessment of quality and safety elements of medical technologies; using this to provide high value evidence-based care whilst reducing harm. In addition, through the rationalisation and standardisation programme, the EBPB will enable reduced variation and waste. It also specifically supports the 2018 report "*A Healthier Wales: our Plan for Health and Social Care*" principles of "Higher value" (better outcomes, better experience at reduced cost, less variation, and no harm) and "Evidence driven" (the use of research, knowledge and information to understand what works).

In line with the emphasis of "Value" in "*A Healthier Wales*", the EBPB will play a key role in assisting the delivery of the Value Based Health Care agenda across the NHS in Wales.

It is acknowledged that there will be some areas that will be of mutual interest to Health Technology Wales (HTW) and these will be addressed through discussion with appropriate representatives.

2. MEMBERSHIP

Membership will be endorsed by Welsh Government and made up of senior

professionals from NHS Wales and academia. The EBPB will consist of both voting and non-voting members. Membership is as follows;

- Chair - Medical Director/Assistant MD
- NWSSP Director (SRO)
- Finance Director
- Health Economist
- Director of SMTL
- Health Technology Wales
- Procurement Services
- Deputy Executive Nurse Director
- Secondary Care Clinician
- National Clinical Lead for Prudent & Value Based Care/Primary Care Senior Clinician
- Value Based Care/National Lead VBP
- Academic Clinician
- Academia
- NWSSP MD

Non-voting members may be invited to attend as and when appropriate;

- Individuals co-opted for advice on specialist category areas, including Clinical networks and clinicians locally.
- Nominated experts from Evidence Research Group

Secretariat

- NHS Wales Shared Services Partnership – Procurement Services
- NHS Wales staff may request to attend as observers by writing in advance to the Chair.

Deputies

In the event of a voting member not being in attendance, an agreed named deputy should attend. The EBPB will approve deputies for all voting members of the group, (Chair excluded). A Vice Chair will be appointed in accordance with *Point 4.*

3. OFFICERS

The Chair will normally be a Medical Director/ Assistant Medical Director, appointed by the EBPB and approved by Welsh Government whose term of office shall normally be between 1-5 years. They will be eligible for re-appointment for an additional term of office, but the total period cannot exceed 10 years.
A Vice-Chair will be elected from the voting members. The Vice Chair or in their

absence, another voting member may preside over meetings in the absence of the Chair.

4. MEETINGS

The EBPB will meet a minimum of 4 times per year, and roles and responsibilities of members should be readily available to any relevant party on request.

5. DECLARATION OF INTEREST

Members MUST declare, in advance any financial and/or personal interests, to any related matter that is subject of consideration. Any declarations made and/or actions taken will be noted in the minutes.

6. VOTING

Any issues/questions should be resolved by consensus. Only voting members will have voting rights. Deputies will be eligible to vote. The Chair will not normally vote on matters however in the case of equality of votes, the Chair or person presiding as Chair will have the casting vote. Members with a conflict of interest in a specific Topic, including members who have had a significant role in the preparation of the submissions being considered, will not cast a vote for that Topic.

7. QUORUM

Quorum will be 50% of voting members.

8. VALIDITY OF PROCEEDINGS/MEMBERSHIP VACANCIES

Validity of proceedings of the EBPB is not affected by a vacancy or defect in the appointment of a member of deputy. Membership of the EBPB shall end if;

- Members resign by giving notice in writing to the Chair of the EBPB
- Absenteeism from 3 consecutive ordinary meetings; unless the EBPB is satisfied that absence is due to reasonable cause
- Ceases to belong to the body they represent
- Term of office expires

9. EVIDENCE REVIEW GROUP (ERG)

The ERG is a standing committee which reports to the EBPB. Staff from SMTL and ProcS form the core membership who will undertake the day-to-day workload for the ERG.

The ERG will also include experts in Health Economics and Human Factors from

Swansea University as and when required.

The ERG will liaise with other researchers and analysts as and when required, including partnering with HTW staff.

Expert Membership - The ERG will recruit expert members as and when required to provide clinical and domain-specific advice and expertise. Expert members may include Clinical experts from NHS Wales and Welsh Government National Special Advisory Groups (NSAGs).

10. POWERS OF THE EBPB

- The EBPB may require the Evidence Review Group (ERG) to convene meetings of expert advisors.
- The work and meetings of the ERG and expert advisors should be reported to the EBPB.
- The ERG should operate in an advisory role to the EBPB.
- The EBPB may seek independent advice as and when appropriate.
- The EBPB may commission external bodies to evaluate evidence in relation to products.
- The EBPB and ERG will incur the minimum necessary expenditure to enable their work to be carried out. These expenses will be considered and administered by NWSSP Shared Services Procurement Services.
- Nominated experts from the ERG may be required to attend meetings of the EBPB.

11. GOVERNANCE AND ACCOUNTABILITY

The EBPB is accountable to the NWSSP committee and will utilise NWSSP's governance structures.

12. ROLES AND RESPONSIBILITIES

- Support the rationalisation and standardisation agenda in line with prudent Healthcare principles.
- Review evaluations and evidence assessments of medical technologies.
- Develop a work programme determined by Health Boards/Trusts, Welsh Risk Pool, and other stakeholders.
- Provide advice to stakeholders regarding new or innovative products for use across NHS Wales in consultation with HTW.
- Liaise with Academia on the EBPB work programme, including product development initiatives where appropriate.
- Participate in horizon scanning with other agencies such as HTW and advise on the potential impact for the NHS.

- Provide advice on clinical pathways/treatments where devices and consumables are part of the clinical process, complimenting and supporting the work of NICE.
- Receive for consideration into the work programme topics referred by WG and other key stakeholders. This will include liaison with HTW's Front Door Group.
- Liaise and engage with professional peers.
- Produce an Annual report for review by NHS Wales and Shared Services Partnership Committee.
- Consider NICE guidance and Do Not Do recommendations when developing the work programme.
- Develop mechanisms to audit adoption of the EBPB advice.

13. GROUP STRUCTURE & METHODS

A separate document is available detailing the structure and working methodology of the EBPB and other structures.

Welsh Energy Group (WEG)

Welsh Energy Operational Group (WEOG)

Terms of Reference

Scope

The energy requirements of the NHS in Wales have a combined value in excess of £134m per annum. The overall portfolio comprises of over five hundred sites each requiring a supply of Gas, Electricity, Fuel Oils and/or Biomass Fuel.

Given the exceptional energy prices and volatility in the energy markets, an All Wales Directors of Finance (AWDoFs) Task & Finish Group was established in 2023 to progress a review, consider options and make recommendations in regard to the governance of energy procurement for NHS Wales. The outcome of this was the recommendation for the following groups to be formed:

- Wales Energy Group (WEG) - with delegated authority to agree national purchasing decisions & report to the NHS Wales Shared Services Partnership Committee (SSPC)

- Wales Energy Operational Group (WEOG) as a sub-group to the WEG – for operational management issues

This document's purpose is to define the Terms of Reference (ToR) for both of the above groups.

WEG

The WEG shall establish a strategy for the procurement of gas and electricity which will define basket choices from the Crown Commercial Services (CCS) framework options available to NHS Wales. The strategy shall have the aim of balancing risk limitation with cost certainty to the NHS Wales energy budget. Group members will be provided with monthly energy market analysis from CCS, in order to develop expertise of group members and aid informed decision making. The group will meet quarterly – with the option to increase frequency as market volatility dictates. The WEG shall also act as the All-Wales Programme Review Board regarding the renewal, extension and ratification of Gas and Electricity contracts made on an All-Wales Basis.

WEOG

The WEOG shall establish a common model to supplier management and best working practices across all NHS Wales utility contracts. Group members will be provided with monthly energy market analysis and insight from CCS, in order to keep members well-informed of market conditions. The group will meet monthly – with the option to increase or decrease the frequency if required.

Structure

WEG

The group will consist of Directors of Finance representatives from each of the Health Boards, Special Health Authorities, NWSSP and Trusts, or their deputies who will act with the delegated authority of their respective organisation to contribute to the collective decisions of the Group. The group will also include representation from NWSSP Procurement Services and NWSSP Finance.

WEOG

The group will consist of representatives from each of the Health Boards, Special Health Authorities, NWSSP and Trusts, made up of colleagues from various departments such as (but not limited to) Estates, Facilities and Finance. Representatives should have the delegated authority of their respective organisations to contribute to the decisions relevant to the scope of the Group. The group will also include representation from NWSSP Procurement Services.

Membership

WEG

It is suggested that the Group consist of the following members as a minimum;

- Chair of the Group
- Vice Chair of the Group
- Health Board/ Special Health Authority /NWSSP/ Trust Directors of Finance representatives or deputies with the delegated authority of their respective organisation to contribute to the decisions of the Group
- Representative(s) from NWSSP Procurement Services and NWSSP Finance.

The Group shall Co-opt an Account Manager or Market Analyst of the framework provider (CCS) for each meeting of the WEG to provide market intelligence.

It may be necessary for separate Task & Finish group(s) to be established in order to undertake specifically defined programmes of work with clear objectives and timescales. In such instances, the WEG will determine the remit and membership of such groups and the resultant groups will report progress and deliverables to the WEG and WEOG where appropriate.

Quorum – The minimum group representation required to make any decision shall be the Chair of the Group (or the Vice Chair), the Head of Sourcing from NWSSP Procurement Services (or a deputy nominated by the same) and sufficient additional members so that there are no less than seven member organisations represented at the meeting.

WEOG

It is suggested that the Group consist of the following members as a minimum;

- Chair of the Group
- Vice Chair of the Group
- Organisation representatives from various departments such as (but not limited to) Estates, Facilities, and Finance as appropriate
- Representative(s) from NWSSP Procurement Services and NWSSP Finance.

The Group shall Co-opt an Account Manager of the framework provider (CCS) for each meeting of the WEOG to provide market intelligence and discuss matters arising in relation to the Gas and Electricity contracts. Additionally, the group shall Co-opt a commodity supplier representative on a bi-monthly basis to facilitate account management discussions.

It may be necessary for separate Task & Finish group(s) to be established in order to undertake specifically defined programmes of work with clear objectives and timescales. In such instances, the WEG will determine the remit and membership of such groups and the resultant groups will report progress and deliverables to the WEOG and WEG where appropriate.

Quorum – The minimum group representation required to make any decision shall be the Chair of the Group (or the Vice Chair), the Head of Sourcing from NWSSP Procurement Services (or a deputy nominated by the same) and sufficient additional members so that there are no less than seven member organisations represented at the meeting.

Role of the Groups

WEG

- To ensure a consistent approach to the procurement / sourcing of Gas and Electricity throughout all aspects of the NHS in Wales.
- To input into the development of a strategic procurement model for Gas and Electricity contracts within NHS Wales.
- To provide a platform for the framework provider to share utility market intelligence with all Health Boards, Special Health Authorities, NWSSP and Trusts within NHS Wales.
- To develop, agree and manage the Purchasing Strategy for the All-Wales Gas and Electricity contracts having received market intelligence and actual price/contract performance, and agree in a timely manner national purchasing decisions (i.e. basket choice).
- To monitor contract performance with the WEOG representative/s providing an update of performance of the Gas and Electricity contracts.
- To monitor NHS Wales Gas and Electricity forecasts as provided by the supplier and supply regular financial forecasts to all member NHS organisations.
- To nominate NHS Wales member(s) as required for participation in the suppliers

External Risk Management (ERM) group
- To ensure that the Terms of Reference for the WEG/WEOG are reviewed each year .

WEOG

- To ensure a consistent approach to the contract management of the supply of all utilities (including but not limited to Gas, Electricity, Fuel Oils, and Biomass) throughout all aspects of the NHS in Wales.
- To allow all parties to discuss their respective levels of satisfaction in respect of those Services provided via all Contracts managed by the WEOG and to agree any action necessary to address areas of dissatisfaction.
- To monitor and discuss the performance of supplier(s) against the terms of the All-Wales Utilities contracts and (where necessary) agree a strategy for enforcing said contractual terms, including (but not limited to) the use of performance improvement notices, financial penalties and termination of contracts.
- To support the role of the Local Estates and Energy leads by enabling a collaborative approach to contract management.
- To agree and monitor Key Performance Indicators for All Wales Utilities contracts.
- To consider any changes required to the supply of utilities in line with national policies and strategies as they change and develop.
- To provide an update of performance of Gas and Electricity contracts to WEG, by nominated person/s.
- To nominate NHS Wales member(s) as required for participation in the suppliers Operational Improvement Group (OPIG)
- To ensure that the Terms of Reference for the WEG/WEOG are reviewed annually

Market Analysis

WEG

The framework provider will provide a market overview prior to the development of a Purchasing Strategy by WEG. The framework provider will not influence the development of the strategy and decisions will be verbally agreed by NHS Wales WEG attendees.

The Purchasing Strategy will decide basket(s) for NHS Wales to join, and should multiple baskets be selected, define meter level criteria for basket participation.

The framework provider shall provide monthly/quarterly/annual market and basket analysis as required by NHS Wales, which will be distributed to the WEG and WEOG by NWSSP Procurement Services.

WEOG

The framework provider shall provide monthly/quarterly/annual market and basket

analysis as required by NHS Wales, which will be distributed to the WEG and WEOG by NWSSP PS.

Authority and Accountability

NWSSP Procurement Services has the authority to conduct market engagement activity, on behalf of all Health Boards, Special Health Authorities, NWSSP and Trusts, in NHS Wales, from the governance divested in NHS Wales Shared Services Partnership.

The WEG is under the authority of NHS Wales Shared Services Partnership Committee and therefore will be required to submit an update/highlight report to each meeting of the NHS Wales Shared Services Partnership Committee as instructed.

WEG

All decisions made by the WEG should ideally be via the consensus of all member organisations in attendance at the relevant WEG meeting. In the event that consensus cannot be reached, a decision will be made by means of a vote whereby each member organisation will have a single equal vote and a decision based on the view of the majority. NWSSP Procurement Services will have no vote. In the event of a tied result, the Chair of the Group will have the casting vote.

The WEG is a sub-Committee of the Shared Services Partnership Committee. The All-Wales Directors of Finance Group will be responsible for nominating a Chair and Vice Chair for the WEG from within NHS Wales once every two years or as necessitated due to the resignation of the previous Chair. The Shared Services Partnership Committee will be responsible for appointing the Chair and Vice Chair. Individuals will not be restricted from undertaking these roles for longer than two years provided that the Shared Services Partnership Committee approve, and All-Wales Directors of Finance Group is in favour of their continued tenure

WEOG

All decisions made by the WEOG should ideally be via the consensus of all member organisations in attendance at the relevant WEOG meeting. In the event that consensus cannot be reached, a decision will be made by means of a vote whereby each member organisation will have a single equal vote and a decision based on the view of the majority. NWSSP Procurement Services will have no vote. In the event of a tied result, the Chair of the Group will have the casting vote.

The WEG will be responsible for appointing a Chair for the WEOG from within NHS Wales once every two years or as necessitated due to the resignation of the previous Chair. The WEG will also appoint a Vice Chair. Individuals will not be restricted from undertaking these roles for longer than two years provided that the WEG is in favour of their continued tenure.

The WEOG shall also have the authority to agree the award and renewal of supply agreements for other utilities contracts (Fuel Oils and/or Biomass) on behalf of the

Health Boards, Special Health Authorities, NWSSP and Trusts, in NHS Wales.

Performance Monitoring and Financial Forecasting

The framework provider shall be required to produce quarterly reports outlining the overall performance of trading on behalf of NHS Wales. This will include analysis of the traded periods in comparison to the average market price for each tradable period and information provided by the Department for Energy Security and Net-Zero. This report shall evidence the overall pricing activity carried out in relation to the pure energy components of each contract only. Whilst the Group will acknowledge the impact of transmission, transportation, and other industry pass through costs, no accountability will be borne by the group in this respect. This report will be provided at each quarterly meeting of the WEG and will be distributed onwards to WEOG members by NWSSP Procurement Services.

The framework provider shall also be required to produce an annual report each financial year providing a forecast of out-turn costs for each NHS Wales organisation for that financial year. By request, they will also be required to provide forecasts of utilities costs for future years as may be required to meet IMTP planning requirements.

Frequency of meetings

The WEG shall meet on a quarterly basis as a minimum. The Group will, at its discretion, agree intermediate meetings if these are deemed to be warranted. The WEOG shall initially meet on a monthly basis and at its discretion, may amend the frequency of the meetings and agree intermediate meetings if required.

Content of meetings

Each of the WEG meetings will consist of the following activities.

- Brief internal pre meeting to enable discussion for NHS members prior to main meeting forum (The framework provider will not be at the pre meeting) .

- Approve the minutes of the previous WEG meeting and review agreed actions.
- Review of the energy market activity, trends and factors which influence commodity pricing (to be provided by the framework provider).
- WEG member to provide feedback from the suppliers External Risk Management (ERM)
- Review of the performance of the WEG Purchasing(baskets) as executed by the framework provider
- Review of Gas and Electricity supplier(s) performance, including any agreed KPIs and improvement actions – with summary to be provided by nominated person/s from WEOG.
- Framework provider's report of any change to pass-through costs to enable member organisations to project total energy costs.
- Updates on specific projects and activity of any separate Task & Finish group(s).

Each of the WEOG meetings will consist of the following activities.

- Brief pre internal meeting to enable discussion for NHS members prior to main meeting forum with framework provider and supplier(s) present. (The framework provider will not be at the pre meeting)
- Approve the minutes of the previous WEOG meeting and review agreed actions.
- Review of framework providers summary market report on those factors currently affecting utility pricing.
- Supplier risk (framework provider to highlight any risk of note)
- Review of supplier performance, including any agreed KPIs and improvement actions.
- Supplier's presentation of any information requested by the Group, for example billing, Complaints etc
- Framework provider's report of any change to pass-through costs to enable member organisations to project total energy costs.
- Any potential new/deleted sites affecting volumes to be flagged
- Updates on specific projects and activity of any separate Task & Finish group(s).
- WEOG member to provide feedback on the CCS Operational Improvement Group

While it is acknowledged that the WEOG will focus on Gas and Electricity contracts, the Group's meeting agenda will also include review of other Utility contracts, such as Fuel Oils and Biomass, at least once per annum. The inclusion of such contracts as part of the agenda will be notified to the Group in advance. This will enable additional personnel as may be required to be co-opted into the Group for those specific meetings where other Utility contracts will be discussed.

Annexe 5

Process for the Selection, Appointment and Termination of the Chair of the SSPC

This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs

The Shared Services Partnership Committee (SSPC) has the responsibility for appointing the Chair of the SSPC. Whist the appointment is not a Ministerial appointment the planned process will take account of the appointment principles outlined in the "Governance Code on Public Appointments" which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments.

MAIN BODY

In line with the Governance Code on Public Appointments to Public Bodies 2016 the principles of public appointments are summarised below:

A. **Ministerial responsibility** - The ultimate responsibility for appointments and thus the selection of those appointed rests with Ministers who are accountable to Parliament for their decisions and actions. Welsh Ministers are accountable to Welsh Government.

B. **Selflessness** - Ministers when making appointments should act solely in terms of the public interest.

C. **Integrity** - Ministers when making appointments must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

D. **Merit** - All public appointments should be governed by the principle of appointment on merit. This means providing Ministers with a choice of high-quality candidates, drawn from a strong, diverse field, whose skills, experiences and qualities have been judged to meet the needs of the public body or statutory office in question.

E. **Openness** - Processes for making public appointments should be open and transparent.

F. **Diversity** - Public appointments should reflect the diversity of the society in which we live, and appointments should be made taking account of the need to appoint boards which include a balance of skills and backgrounds.

The essential features of the process will include the following:

- A panel must be set up to oversee the appointments process;
- The panel must be chaired by an independent assessor;
- An agreed selection process, selection criteria and publicity strategy for a successful appointment;
- A panel report must be prepared, signed by the chair of the appointment panel; and
- The appointment of the successful candidate must be publicised.

It is important that all public appointees uphold the standards of conduct set out in the Committee on Standards in Public Life's Seven Principles of Public Life. The panel must satisfy itself that all candidates for appointment can meet these standards and have no conflicts of interest that would call into question their ability to perform the role.

The selection panel will comprise of the following members:

- 3 members of the SSPC; and
- NWSSP Director of Workforce and Organisational Development

The appointment process is managed by the NWSSP Director of People and Organisational Development.

A suite of supporting documentation has been developed to support the process.

The job **advertisement.** It is proposed that, in line with the practice adopted by Welsh Government for all other public appoints this post is advertised on Job Wales which is the Western Mail and Daily Post on-line publication.

The candidate application **form**. The content and format very closely mirrors the application form currently used by the Welsh Government for Ministerial Public Appointments.

A **briefing pack** for candidates. This includes details of the role profile and person specification.

Governance and Risk Issues

Whist the appointment is not a Ministerial appointment, the planned process will take account of the appointment principles outlined in the "Governance Code on

Public Appointments" which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments.

The appointment documentation and processes has been reviewed and agreed by the Director of Governance & Corporate Services/Board Secretary at Cwm Taf Morgannwg UHB who was a member of the SSPC; and has also been provided to the Director of Corporate Governance/Board Secretary at Velindre University NHS Trust to ensure that the appointment aligns to Velindre's governance requirements.

The selection process will be repeated following each maximum term of office for the Chair of the SSPC, or when the Chair resigns, or following removal of the Chair by termination.

Reappointment and Tenure

The SSPC SOs form part of the Velindre University NHS Trust Standing Orders, which must take account of the provisions of the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and the disapplication of these Regulations with regard to the tenure of the Chair and Vice Chair.

Suspension and Termination

Should the circumstances laid down in the draft regulations at 9.(1), 9.(3), 9.(5) or 10.(1) emerge, and the removal (i.e. suspension or termination) of the Chair is deemed necessary, the Committee will agree the reasons for the decision to do so and formally submit these reasons to a panel constituted as that described for the selection process above.

The panel will then make a recommendation to Velindre University NHS Trust to suspend or remove the Chair. Velindre University NHS Trust will then take the necessary action and subsequently provide the Welsh Ministers with the reasons agreed as per section 9.(2) (termination) or 10.(2) (suspension) of the Regulations.

TRUST BOARD

Approval of Velindre University NHS Trust Business Continuity and Emergency Planning Policy (PP06) [V3.0]

DATE OF MEETING	27/07/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Laurie Thomas, Head of Validation & Risk Management
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
VUNHST Business Continuity and Emergency Preparedness Group	17/03/2023	ENDORSED FOR APPROVAL
EMB	02/05/2023	ENDORSED FOR APPROVAL
Strategic Development Committee	06/07/2023	ENDORSED FOR APPROVAL

ACRONYMS	
BCMS	Business Continuity Management System
AEO	Accountable Emergency Officer (AEO)
CCA	Civil Contingencies Act 2004
BIA	Business Impact Assessment
MTPD	Maximum Tolerable Period of Disruption
RTO	Recovery Time Objective
IRP	Incident Response Plan
EPRR	Emergency Preparedness Response and Resilience
PDCA	Plan Do Check Act (model)

1. SITUATION/BACKGROUND

1.1 The Trust Policy for Business Continuity and Emergency Planning (PP06) is due for review and has been updated to reflect existing operational requirements and aligned to current NHS and Government Guidance.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached Policy provides the overarching framework within which the Trust Business Continuity Management System (BCMS) is established to ensure that the organisation can continue to deliver the core services and products in the event of any disruptive incidents so far as is reasonably practicable.

2.2 The document has been reviewed and amended against current NHS and government guidance.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Effective management of and response to disruptive incidents is essential to ensure the Trust can continue to deliver its core services.
RELATED HEALTHCARE STANDARD	Safe Care
	• Governance, Leadership & Accountability • Effective Healthcare
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	• The Trust Business Continuity & Emergency Preparedness Policy [PP06] has an associated EIA.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust has statutory and mandatory duties regarding having appropriate emergency procedures in place.
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 VUNHST Board are asked to **Approve** the Policy.

APPENDICES	**YES - (Please Include Appendix Title in Box Below)**
	Approval of Velindre University NHS Trust Business Continuity and Emergency Planning Policy [PP06]

Ref: PP 06

Velindre University NHS Trust
Business Continuity and Emergency Planning Policy

Executive Sponsor & Function: Chief Operating Officer

Document Author: Head of Validation & Risk Management

Approved by: Executive Management Board

Approval Date: 27/07/2023

Date of Equality Impact Assessment: 17th April 2018 – under review

Equality Impact Assessment Outcome: Endorsed for Approval.

Review Date: July 2026

Version: 3.0

Velindre University NHS Trust
Business Continuity and Emergency Planning Policy

CONTENTS

1. Introduction

1.1 The Velindre University NHS Trust (VUNHST) Business Continuity and Emergency Planning Policy provides the framework within which the Trust Business Continuity Management System (BCMS) is established to ensure that the organisation can continue to deliver the core services and products in the event of any disruptive incidents so far as is reasonably practicable.

VUNHST provides specialist services to the people of Wales. The operational delivery of products and services is managed through Velindre Cancer Centre (VCC) and the Welsh Blood Service (WBS).

1.2 The Trust hosts the following organisations on behalf of other bodies;

- Health Technology Wales (HTW)
- NHS Wales Shared Services Partnership (NWSSP)

Further information on the above organisations is available by clicking on the following link: https:/velindre.nhs.wales

1.3 The capability of the Trust to continue delivery of its products and services during a disruptive incident or emergency remains a key priority and the Trust is required to ensure it has in place, appropriate, acceptable, and effective arrangements and plans to protect its products and services.

1.4 The Policy provides the strategic framework and sets out the scope and governance of the Business Continuity and Emergency Planning arrangements within the Trust.

1.5 The VUNHST Business Continuity and Emergency planning system is based upon the industry wide guidance and specifically that contained in the International Organisation for Standardisation ISO Security and resilience – Business Continuity Management Systems – requirements.

2. Definitions

2.1 A glossary of terms is available from your Divisional Business Continuity and Emergency Planning leads.

3. Scope of Policy

3.1 The scope of this Policy covers all staff, functions and premises that are required to deliver and maintain services to the public and service users. The Trust are committed to embedding a culture that will ensure staff and management are engaged and proactively manage business continuity within the organisation.

3.2 This Policy extends its application to the Trust Hosted Organisations, with the expectation that hosted services have their own local procedures embedded within their services.

3.3 Furthermore, this Policy extends to ensure supply chains and contractors associated to the delivery of core services have appropriate contingency arrangements in place to enable resilience to be achieved and avoid potential points of failure.

4. Aim and Objectives

The aim of the Policy is to ensure that the core services and functions provided by the Trust are protected so far as is reasonably practicable, through the application and management of robust business continuity arrangements.

4.1 The Trust will adopt a risk-based approach to its BCMS, ensuring business continuity plans are in place and are coherent and accessible to support response to an incident. Where possible the Trust will endeavor to adopt a standard approach across the Trust, however there may be instances where specific divisional or departmental plans and approaches are required. In these circumstances, divisional / departmental procedures will be developed, implemented, tested, and exercised to provide assurance of business continuity and emergency planning arrangements to support delivery of core products and services.

4.2 Ensures robust escalation arrangements within the Trust that are embedded across all employees and stakeholders through awareness communications enabling a Trust wide preparedness and capability to respond to a disruptive incident 24 hours a day, 7 days a week.

4.3 The reputation and integrity of the Trust for the benefit of the public and service users is protected at all times.

4.4 Business Continuity and Emergency Plans will be regularly reviewed for accuracy and available to provide guidance and support during disruptive incident and a response structure to those responsible for managing a crisis. Hard copy plans will be accessible in the event of Digital or Power failure.

4.5 The Trust will ensure that there is a Strategic (Executive) and Tactical (Divisional) 'On Call' arrangement in place to support the capability to respond to any incident, emergency, or crisis where a contingency has not been already identified'.

5. Responsibilities

Strategic (Gold)

5.1 The Trust Chief Executive owns the Business Continuity and Emergency Planning Policy.

5.2 The Chief Executive is accountable and responsible for ensuring the Trust is prepared for emergency situations including Business Continuity incidents. This role is identified by the NHS EPRR Framework and Core Standards 2015 as the **Accountable Emergency Officer (AEO).**

5.3 The Chief Executive can delegate the responsibility of AEO to an appropriate Trust Officer.

5.4 The VUNHST Chief Operating Officer is the delegated AEO for BCM and EPRR for the Trust. They will have executive authority and responsibility for ensuring that the Trust complies with legal and Policy requirements. They will provide assurance to the Board that strategies, systems, training, policies, and procedures are in place to ensure an appropriate response for the Trust in the event of an incident. Additionally, to promote continual improvement of the VUNHST BCMS.

5.5 The AEO will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain public protection and maximise the NHS response.

5.6 The AEO will provide assurance to the Board that the Trust is meeting its obligations with respect to EPRR and relevant statutory duties under the Civil Contingencies Act 2004 (CCA) and the NHS Act 2006 (as amended). This will include assurance that the Trust has allocated sufficient experienced and qualified resource to meet these requirements.

5.7 The AEO in consultation with the nominated Business Continuity leads and Service Managers will identify the appropriate external stakeholders and interested parties who may need to be aware of the Trust Business Continuity and Emergency Planning arrangements.

5.8 The AEO in conjunction with Divisional leads will ensure the completion and timely submission of the Health Emergency Planning Annual Report.

Tactical / Operational (Silver/Bronze)

5.9 Each Division shall nominate a Business Continuity and Emergency Planning Lead who will be responsible for the development and delivery of the Trust BCM arrangements under the direction of the AEO. The lead in conjunction with the respective Heads of Departments within each Division will:

- Review and develop the BCMS in line with industry best practice and the needs of the Trust.
- Monitor standards and compliance of the system.
- Undertake a Business Impact Assessment (BIA) for their service areas within each Division to ensure service prioritised activities are identified. The BIA will confirm the Maximum Tolerable Period of Disruption (MTPD) i.e., the length of time that services can tolerate a disruption, the Recovery Time Objective (RTO) i.e., the point in time following an incident at which each of the key services would need to be resumed and, finally, quantify the resource and dependencies required to maintain the essential activities including people, premises, equipment, IT, and other stakeholders.
- Develop, review and test Divisional Business Continuity Management Plans and Procedures on an annual basis or as determined appropriate for their service area

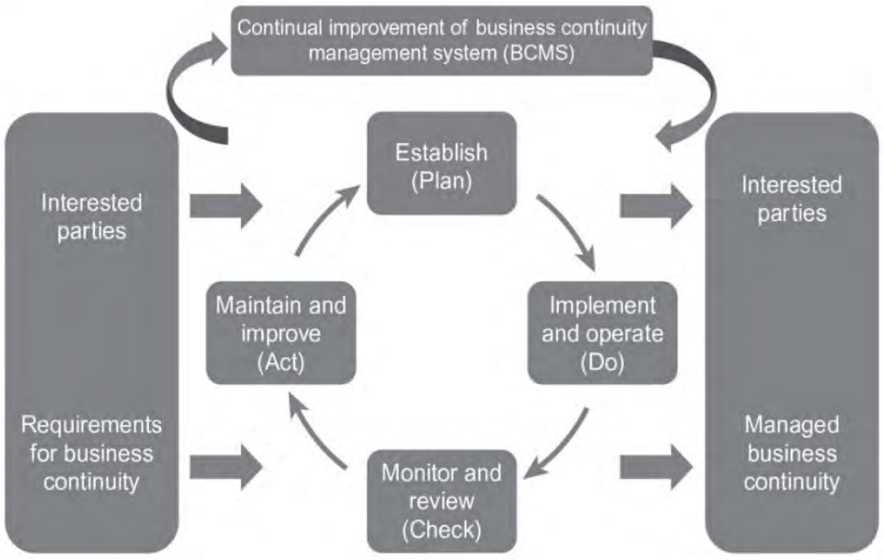
based on available guidance. (Where possible the Trust will endeavour to avoid duplication of effort to ensure a standard approach is taken to Business Continuity and Emergency Planning).

- Undertake a Training Needs Analysis for Business Continuity within their service area.
- Attend relevant Trust Business Continuity & Emergency Preparedness groups as required.
- Provide training, support and guidance to managers ensuring that staff and other appropriate, relevant stakeholders such as contractors and suppliers will be made aware of the Trust's BCM arrangements as defined by the AEO and service managers.
- Engagement with any relevant audit and review requirements.
- Continued multi agency working and engagement.
- Contribute and engage in the Welsh Government and the health Emergency Preparedness Resilience and Response network including the requirement to submit a Health Emergency Planning Annual Report.

6. Business Continuity Management System (BCMS) Lifecycle

The Trust and its Divisions will adopt the cycle of activity illustrated in Figure 1.

Figure 1- Plan Do, Check and Act Model



(Source: ISO 22301:2012)

6.1 Plan (Establish)

Establish business continuity Policy, outlining the scope/ understanding of the BCMS i.e. objectives, targets, controls, processes and procedures relevant to improving

business continuity in order to deliver results that align the organisation's overall policies and objectives.

The scope of BCMS links the potential impact of a disruptive event on the organisation's activities, functions, services, supply chain and relationships with external stakeholders.

6.2 **Do (Implement and Operate)**

Implement and operate this Business Continuity Policy, controls, processes and procedures. All staff will be required to read and understand the Business Continuity Plans relevant to their areas, along with those that can affect all areas i.e. Fire, Severe Weather, Power Outage etc.

Hard copies of all Business Continuity Plan Action Cards will be filed within folders in specific locations and within various departments to enable staff quick and easy access during a disruptive event. All staff will be aware of the locations of these folders.

The VUNHST Incident Response Plan (IRP) provides further guidance on varying levels of incident response the Trust may be required to respond to and can be found within the senior management/leadership and executive on-call packs.

6.3 **Check (Monitor and review)**

Monitor, review and exercise/ test performances against Business Continuity Policy and objectives, report any results to management for review, and determine and authorised actions for remediation and improvement.

6.4 **Act (Maintain and improve)**

Maintain and improve the Business Continuity Policy and Plans by taking corrective action, based on the results of management review, and reappraising the scope of the Policy and corresponding business continuity objectives. Debriefs will be produced following actual disruptive events, and all lessons identified will be reviewed and considered for inclusion within the process.

Note, Business Impact Assessments and Business Continuity Plans shall be updated if:

- There are any changes to the organisation, including major restructures
- Changes to methods of delivery
- Changes to the operating environment (new markets etc.)
- Changes to key staff
- Following recommendations from exercise and testing or debriefs post live incidents

6.5 **Business Continuity & Emergency Preparedness Exercises**

It is a requirement to validate incident response plans through exercises and testing arrangements to ensure they are fit for purpose. Exercise and tests should be carried out at pre agreed frequency and or to meet the requirements set within relevant

legislation or core standards. Exercises will provide opportunities for responding staff to rehearse plans and maintain a level of competence, confidence and aid training.

7. Equality Impact Assessment Statement

7.1 This Policy has been screened for relevance to equality. No potential negative impact has been identified.

8. Governance

8.1 This Policy will be approved by the relevant Board Committee a minimum of every 3 years subject to changes in legislation, guidelines and Divisional arrangements.

8.2 The Policy has been endorsed by the Trust Business Continuity & Emergency Preparedness Group to ensure alignment with each of the Divisional arrangements.

8.3 The Trust will commit to providing resource as and when required to participate in internal and external delivered exercise, testing and training.

8.4 The Trust Business Continuity Steering Group will submit highlight reports to relevant Executive and Committee meetings for oversight. The Trust will participate in any internal and external assurance frameworks or reports that relate to Business Continuity and Emergency preparedness, Resilience & Response i.e. Welsh Government Emergency Preparedness Annual Report.

8.5 Disciplinary action under the terms of the Trusts Disciplinary Procedures will be taken against any employee, regardless of status, who shows wilful disregard for the Policy and associated working practices.

9. Main relevant Legislation and Standards

- Civil Contingencies Act 2004
- BS ISO Security and resilience – Business continuity management systems – requirements 22301:2019
- BCI Good Practice Guidelines 2018 Global Edition
- NHS & Welsh Government guidance (i.e., NHS Emergency Preparedness Resilience & Response core standard & framework, NHS Business Continuity Guidance)

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	18 May 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising – Duty of Quality

Following a formal presentation to the Committee in March, a verbal update was provided demonstrating good progress in identifying the quality measures in each division and mapping the Quality Management Systems already in place within NWSSP. Staff have been briefed on the requirements and implications and discussions have taken place with Welsh Government and Delivery Unit colleagues on how the self-assessment, which is primarily clinically focused, can best be adapted to accurately portray the activities undertaken within NWSSP. A further formal update will be provided in September.

The Committee NOTED the update.

Deep Dive – Welsh Risk Pool

The Committee were provided an overview of the many and various activities undertaken by the Risk Pool.

One of the key aims of the Risk Pool is to ensure that NHS Wales organisations learn and share lessons from claims that are received. Learning from Events reports were introduced in 2018 and scrutiny is undertaken by a Learning Advisory Panel. A number of Safety and Learning networks help to share good practice and support is provided to Health Bodies to conduct complex investigations where specialisms and/or independence will add value. Investigations are supported not only by specialists from within NHS Wales, but from across the UK to ensure that advice being provided is of the highest calibre.

The Committee NOTED the update.

Chair's Report

The Chair updated the Committee on her attendance at recent meetings, both within NWSSP and externally.

The Committee NOTED the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The very positive outcome of the five-yearly External Quality Assessment of the Audit and Assurance Service.
- The recent visit of the NWSSP Senior Leadership Group to North Wales where they visited a number of sites including the Laundry and Stores and presented awards to staff who had been successful in the Staff Awards process that concluded in January of this year.
- The recent visit to India by NWSSP members including the Medical Director and colleagues from Health Boards and Welsh Government which has led to the potential recruitment of 58 nurses and on-going conversations with a further 20 Doctors.

The Committee NOTED the update.

Items Requiring SSPC Approval/Endorsement

Citizen Voice Body SLA - LLAIS

The Committee were presented with the draft SLA to govern the services provided to LLAIS by NWSSP. Further work is required on the SLA and the accompanying Memorandum of Understanding (MOU) and so while there was AGREEMENT IN PRINCIPLE on the documentation provided, the final SLA and MOU will need to be brought back to the Committee for formal approval.

Service Level Agreements

The overarching Service Level Agreement and the supporting schedules for 2023/24, which cover the core services provided to all NHS Wales bodies by NWSSP, were APPROVED by the Committee.

Primary Care Workforce Intelligence System

A summary of the Business Case for the Workforce Intelligence System for Primary Care was presented. This pulls together a number of separate systems into one system covering the following:

- Compliant registration of practicing clinicians to meet the NHS regulations via the Performers List & Pharmacy Database;
- The capture and reporting of the primary and community service workforce data and information respectively including the compliance registration for the Scheme of General Medical Practice Indemnity (GMPI) of substantive

and Locum workforce; and
- Capture and publication of declarations of interest enabling open and transparent assessment of conflict of interest.

The proposal requires capital funding in Year One but thereafter will deliver savings against current costs.

The Committee APPROVED the paper subject to confirmation of Welsh Government funding and sight of the Full Business Case.

Items for Noting

Internal Audit – External Quality Assessment

The 5-year external quality assessment of Internal Audit was undertaken by the Chartered Institute of Public Finance & Accountancy over recent months and resulted in the highest possible rating being awarded to the service that is operated by NWSSP. There were no areas of either partial or non-compliance noted with the standards.

The Committee NOTED the paper.

Laundry Services Update

The business case to build two new laundries and to significantly refurbish a third laundry has been put on hold due to a lack of available capital funding. Alternative plans are therefore being developed to ensure that the laundry service meet the appropriate environmental and legal regulations, but within a much-reduced financial envelope. These have been produced but at present Welsh Government are still unable to confirm any capital funding for the laundry service.

The Committee NOTED the paper.

Finance, Performance, People, Programme and Governance Updates

Finance –The final (unaudited) position for 2022/23 was a surplus of £12k with £2m re-distributed to Health bodies and Welsh Government. The Welsh Risk Pool position was as forecast in the IMTP, and all allocated capital funding was spent. The value of stock amounted to £24m and reflected several valuation adjustments that had been made in accordance with the relevant Accounting Standards. The adjustments had been approved by and funded by Welsh Government.

People & OD Update – Sickness absence rates remain low, and there has been an increase in Statutory and Mandatory Training compliance to 91%. PADR completion is almost at green. Staff turnover is relatively high, but this is largely due to starters and leavers in the Single Lead Employer Division.

Performance – In-month performance was generally on target with an improvement seen in Recruitment service time to hire. Report turnaround within

Audit and Assurance continues to be behind target but is largely outside the direct control of NWSSP. With regards to recruitment the review of, and subsequent clearance of historic cases, is continuing to adversely affect performance in the short-term but will deliver a longer-term benefit. The Payroll Call Handling Team have achieved their targets for the last three months, which represents a significant turnaround in performance.

IMTP Q4 Progress Report - Progress has been made towards achieving our IMTP objectives that form part of our 3-year rolling plan, with 45% on track for delivery as part of those longer-term programmes of work. 36% of our total objectives were successfully achieved, as planned, in year across our divisions.

Project Management Office Update – The new Case Management System, the Patient Medical Records Accommodation and the TrAMS Projects remain red-rated. All other projects are on track.

Corporate Risk Register – Two of the previously reported seven red-rated risks covering energy costs and industrial action, have been down-graded to amber. A number of COVID-specific risks have also been removed from the Register.

Draft Annual Governance Statement – This was provided for comment at this stage and will come back to the July Committee prior to final approval at the Audit Committee.

The Committee NOTED the above Reports.

Papers for Information

The following items were provided for information only:

- Audit Wales Plan
- 2023/24 Internal Audit Plan
- Audit Committee Assurance Report;
- 2022/23 Annual Complaints Report
- Finance Monitoring Returns (Months 12 and 1).
- 2023/24 Forward Plan.

AOB

It was agreed that the planned Committee Development Session scheduled for 9 June would be postponed in recognition of the pressures on NHS Wales colleagues at the current time. The session planned for November will however still go ahead.

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	20 July 2023

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	Emergency Ambulance Services Committee
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	16 May 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link:
https://easc.nhs.wales/the-committee/meetings-and-papers/may-2023/

The following were warmly welcomed to the meeting

- Nerissa Vaughan, Interim Director of Strategy for Swansea Bay UHB (for the first time)
- Carol Shillabeer in her new role as Acting CEO for Betsi Cadwaladr UHB
- Hayley Thomas in her new role as Interim CEO at Powys Teaching HB
- Fflur Jones, from Audit Wales observing the meeting and
- Steve Ham, returning from a period of absence.

The minutes of the EASC meeting held on 14 March 2023 were approved.

PERFORMANCE REPORT

A new Performance Report and supporting dashboard was received which included the Ambulance Service Indicators and the EASC Action Plan.

Noted that:

- Ambulance Service Indicators were published monthly and information was available back to 2016 https://easc.nhs.wales/asi/
- The return of 111 calls back to the 999 service had increased to 19% during January to March
- There had been a 12% increase in incidents
- The overall red performance had deteriorated and this had also been seen in the longest waits in the amber category
- Ambulance Handover delays in 2022, were 178% higher than 2019.
- Handover over 4 hours had deteriorated significantly from Feb 23 to Mar 23.
- Progress was being made in relation to reducing handover delays of over 4 hours, particularly in Cardiff and Vale UHB and more recently improvements had been made in the Cwm Taf Morgannwg UHB area
- The Integrated Commissioning Action Plan (ICAP) meetings were providing an important opportunity for health boards and WAST teams to work together to improve overall performance. Future local ICAPs would capture trajectories on handover improvements

- There was an aim by the end of the current Welsh Senedd (Parliament) term to have no delays of over one hour.

Discussion took place and Members welcomed the new dashboard which allowed more local analysis of the data available and felt it was a big improvement on previous iterations.

Members noted that:

- There continued to be significant variation on a month by month basis
- The EASC IMTP referred to total hours lost, as opposed to the trajectory to meet the aim of no delays of over one hour (Ministerial target), and the need to consider the narrative of actual numbers versus percentages – this would be clarified in the next version of the report
- The EASC Team would be developing a specific dashboard to report on the commitments made in the IMTP in order to closely monitor any progress being made.
- March had been a very difficult month for performance but it was expected that improvements would be seen in April and May
- WAST had increased the UHP (units of hours produced); had completed the roster reviews; reduced sickness absence levels and combined with the impact of the additional 100WTE on performance would be closely monitored and reported to the Committee.

Stephen Harrhy gave an overview of the current ongoing actions across all health boards in Wales highlighting the importance of maintaining the trajectories already committed to and mindful of the work needed to improve and prepare for the seasonal variations, especially over the winter months.

QUALITY AND SAFETY REPORT

The revised quality report in light of the requirements of the Duty of Candour and Duty of Quality was received.

Noted that:

- The timescales to respond to complainants within 28 days was challenging across Wales
- The themes of complaints received referred predominantly to delayed responses and were also linked to performance
- A review of responses to red incidents had been completed and discussions taking place in relation to delivering improvements
- The Commissioning Intentions had for a number of years referred to 'call to door times' and it was hoped that data would soon be available for members on this matter
- The mode of arrival at the emergency department (ED) (patients making their own way when no ambulance was available) was also being reported.

Members responded by:

- Welcoming the new Quality Dashboard and the information presented
- Raising concerns about the potential inequity (for patients) in relation to the mode of arrival at EDs and the impact of being able to access the right pathways quickly
- Agreeing to further develop the report by offering lines of enquiry to be added to the dashboard.

Future reporting would include an atlas of variation for ambulance demand, however the report identified opportunities across the system to support improvement.

FOCUS ON – COMMITTEE EFFECTIVENESS

The Chair introduced the Focus on Committee Effectiveness, the annual opportunity to discuss the processes and work of the Joint Committee itself. A presentation was shared which showed the information from the survey circulated with the reports under the key headings:

- Composition and Establishment
- Effective functioning of the Joint Committee
- Compliance with the law and regulations governing the NHS
- Assurance
- Other issues
- Administrative arrangements
- Questions for consideration and discussion
- Effective functioning – individual members.

Noted that:

- The EASC is a decision-making committee (2/3 majority required) and health boards are bound by the decision of the Committee; if unable to agree on any matter it would be escalated to the Welsh Government and ultimately to the Ministers
- To be quorate, four health boards need to be present and in all meetings during 2022-23 this requirement was met
- Members were asked if they felt that there was effective challenge at meetings and were again invited to contact the Chair at any time if they had concerns
- In terms of monitoring performance across the system, the ongoing changes, supported by the weekly / monthly dashboard sent to all members and HB teams, provided a better balance of approach during the year which aligned with information from WAST on performance, units of hours produced, sickness absence, post production lost hours etc
- there were limitations on the performance information that could be shared at the Committee (due to StatsWales and legal rules) this meant that the latest information was not shared in public and this may mean more “in committee” sessions would need to be arranged although the Chair had some reservations about this approach; more discussions were planned with StatsWales with an aim to resolve the issue
- all health boards presented the confirmed minutes to Board meetings and the work of the committee was discussed across NHS Wales and was also linked to the work in relation to the Six Goals for Urgent and Emergency Care Programme
- one member of the committee had not attended any meetings in the last year and one associate member had not attended a meeting for at least 4 years.

During the session it was agreed to:

- Develop a short presentation with key information for new members
- Meet twice a year in person and work with WHSSC to try and get the best dates / times of year for this
- Continue to provide the Chair’s Summary as soon as possible after meetings
- Receive feedback on the formal engagement process related to the EMRTS Service Review (Air Ambulance) and the response from the public, which included wider views on other services, at a future meeting

- Look at wider benchmarking for ambulance services
- Consider using patient and or staff stories from provider organisations
- Continue to use Teams Live until the decision is made about the EMRTS Service Review and then record a Teams meeting and make the recording public as the Members felt this allows for better discussion
- Continue with the agenda and reports being sent out 7 days prior to meetings (as opposed to the 10 days within the Standing Orders) and report to Audit and Risk Committee
- Continue with the EASC Team chairing the sub group meetings (which is not in line with the Standing Orders but there is only one independent member – the Chair of EASC) and report to Audit and Risk Committee
- Continue providing similar reports as now, Members felt these were about right, not too long or too short but would keep under constant review
- Review the Committee's risk appetite during the summer
- Send out the Declaration of Interest form for all members and members of the EASC sub groups
- Continue to develop the Forward Look and Annual Business Plan to effectively capture all of the business required.

Members felt it was a useful session to consider the effectiveness and a helpful discussion was held. The view of the Committee was that it was working well and that their overall assessment was positive. In summarising the discussion, the Chair thanked Members for their ideas, comments and suggestions and reiterated that he would welcome any further comments or suggestions to improve the work of the Committee at any time.

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

The update report on the EMRTS Service Review was received.

Noted that:
- Support from health boards had been provided for some sessions
- The approach taken had aimed to build trust and confidence in the process and in the independence of the Chief Ambulance Services Commissioner, which had been mostly achieved
- Cooperation with key local stakeholders had been achieved
- Continued to hear concerns related to the original Service Development Proposal and the impact on the air bases in mid and north Wales
- The last face to face engagement session would take place in Newtown on 5 June 2023.

Members thanked the team for the ongoing work and highlighted
- the importance of the next phase of the work
- the new approach being taken by Llais and the 'Guidance on changes to health services' released by the Welsh Government on 5 May 2023.

Members noted:
- the next phase of the work would involve detailed analysis of data and would develop options for consideration

- meetings would continue until 5 June, including with senior staff at Llais
- A comprehensive update would be provided at the next meeting, including key themes heard from meeting with the public across Wales.

It was noted that the public had commented many times that they were very grateful to be heard.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received.

Members noted

- The ongoing roll out of the Cymru High Acuity Response Units (CHARU), where good progress was being made and training planned, a further 100 staff had been identified as required and some recruitment would be needed to balance the overall establishment
- The improvement to the sickness absence trajectory
- The achievement of the 'consult and close' where the rate had improved from 15% to 17%
- Ongoing work related to the exposure to diesel fumes whilst queueing outside EDs, in winter for heating and summer for air conditioning. This had been monitored by an external organisation and was found to be within the safe legal limit but remained unpleasant for staff and patients (and impacted some EDs as well)
- The use of 'Penthrox' for pain relief which could also now be used by the Community First Responders (CFRs); this was judged to be an important issue to improve the patient experience (Penthrox was a recently licensed drug for wider use).

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received.
Noted that:

- important to get the balance right between red and amber performance and not attaining one at the expense of the other
- important to have the right balance of rapid response (CHARU) with the ability to be flexible for deployment
- single and double person responses would be tracked in relation to meeting improved performance
- remote clinical support, if correctly applied, would lead to reduced conveyance to hospital and linked to the clinical assessment of 999 calls and to support this a baseline review by the EASC Team working in collaboration with WAST will be undertaken and the Terms of Reference were received
- In relation to the EASC IMTP constructive discussion had taken place with Welsh Government officials. Central funding had been found for the 100wte this year and potential to taper as efficiencies and improvements take effect
- WAST suggested the potential to discuss further with Members in relation to the 100WTE and the funding arrangements including whether different roles could be considered or utilised and moving from conveyance to safely treating in communities

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received.

This included:

- Commissioning Framework
- Integrated Commissioning Action Plans (ICAP)
- Integrated Medium Term Plan
- Commissioning Intentions 2022-23

Noted that:

- Work had commenced on the Non-Emergency Patient Transport Service (NEPTS) Quality and Delivery Framework which had been planned for Q1 and Q2, anticipated to have the final version ready by Q3
- Significant progress had been made by NEPTS on the expectations of the original business case and there was now an opportunity to consider the strategic future
- The refresh for the Emergency Medical Retrieval and Transfer Service (EMRTS) was planned to take place in Q4 and launch in the new financial year of 2024
- The ICAP meetings were working well; a new approach had been adopted (meeting less frequently, now monthly) bringing teams together to improve service delivery. Update ICAPs would be developed by the end of May
- An Internal Audit Report (on the ICAP process) Ambulance Handover Improvement Plan Arrangements had been undertaken and had received a "substantial assurance" rating. One recommendation had been made to capture risks and the meeting template had already been amended to do this
- The EASC IMTP had been submitted (with the requested changes) at the end of March and had been subject to some challenge in the collective review process

One issue was raised in relation to the NEPT service and its eligibility criteria which would need to be resolved in order to improve the service and meet local requirements of service, this would be discussed again at the NEPTS Delivery Assurance Group.

The Chair congratulated all involved for the excellent Internal Audit Report on the ICAP process which appeared to be working well to the benefit of all parties.

EASC FINANCIAL PERFORMANCE REPORT MONTH 12 2022/23

The EASC Financial Performance Report at month 12 in 2022/23 was received.

Noted that:

- There was an underspend at year end of £341k.
- The dispute in relation to £186,000 non-recurrent funding not paid by one health board had been resolved
- The National Collaborative Commissioning Unit position, with the Sexual Assault Referral Unit and the Six Goals for Urgent and Emergency Care Programme had a £821k surplus; Members noted that WHSSC meeting had confirmed a £1.1m surplus. Work was underway to finalise funding for the 100wte with the EASC Team, WAST and Welsh Government.

EASC SUB-GROUPS CONFIRMED MINUTES

Approved: EASC Management Group – 15 February 2023

EASC GOVERNANCE

The report on EASC Governance was received.

Highlighted the following key areas:

- EASC Risk Register
- EASC Assurance Framework
- EASC Draft Annual Governance Statement
- EASC Draft Annual Report 2022 – 2023
- EASC Draft Audit Enquiries Letter 2022-23
- EASC Management Group Annual Report 2022 -2023
- EASC Key Organisational Contacts
- Welsh Language Commissioner – Final Report and Decision Notice

Noted that:

- The Risk Register had five red risks in total, three scoring the highest level at 25. Additional information had been included and related to the ongoing system pressures and the impact on patients and the increasing risk of harm. It had been agreed to discuss the Members Risk Appetite at a future meeting.
- The EASC Assurance Framework had been updated in line with the changes above to the risk register
- The EASC Draft Annual Governance Statement was presented although the Committee was not required to have one, it was good governance. The AGS would also be presented to the Audit and Risk Committee at CTM for inclusion with the host body approach
- The EASC Draft Annual Report 2022 – 2023 provided an overview of the work of the work of the Committee over the last year. The attendance of members and their nominated deputies had been good at Committee meetings with all meetings being quorate (at least 4 health boards present).
  One EASC Member had not attended any meetings of the Committee and one Associate Member had not attended any meetings over the last three years.
- The EASC Draft Audit Enquiries Letter 2022-23 required by Audit Wales was presented which reflected similar information from WHSSC. There were no concerns identified to report and none were raised.
- The EASC Management Group Annual Report 2022 -2023 captured the work of the EASC Management Group over the last year. Generally, attendance was volatile and poor, which was a worse position than for the previous year. Members were asked to review their representatives for the Group
- The latest EASC Key Organisational Contacts report was presented and Members asked to review their organisational representatives at EASC and its sub groups
- The Welsh Language Commissioner – Final Report and Decision Notice. The Commissioner found that EASC had failed to comply with Standard 39 and therefore had failed to ensure that every Welsh Language page on the website was fully functional and therefore treated the Welsh Language less favourably than the English language on the website. Also, a failure to comply with Standard 60 and failed to promote the use of the Welsh version of the EASC Website by providing service of inferior quality to the service on the English version of the website

  The EASC Team would now take steps to ensure that content cannot be published on one site without the other and provide written evidence that enforcement action has been completed. In apologizing to the Committee, Gwenan Roberts reported that the following actions had been taken.

More robust training had been provided to members of the EASC Team to ensure the ability to add to the websites at any time. Work was also underway with the CTM Welsh Language team and a meeting had already taken place with staff from Digital Health and Care Wales to seek a software solution to this matter.

There were now three months to comply and ensure that this would not recur.

FORWARD LOOK AND ANNUAL BUSINESS PLAN

The Forward Look and Annual Business Plan was received and approved.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance
- Handover delays (and the development of handover improvement plans in HBs with trajectories) and the impact on WAST
- The ongoing formal engagement process for the EMRTS Service Review, face to face meetings will end on 5 June.

Matters requiring Board level consideration

- To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours
- Opportunity for health boards to take part in the public engagement process related to the potential changes to EMRTS Cymru working in partnership with the Wales Air Ambulance Charity.

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	18 July 2023			

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 16 MAY 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 16 May 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings
The minutes of the meetings held on the 14 March 2023 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. WHSSC Specialised Services Strategy
Members received a report and presentation presenting the final draft of the Specialised Services Commissioning Strategy for approval.

Members **noted** that following the Joint Committee workshop to discuss the strategy on 17 April the document had been updated to reflect the feedback received from the Joint Committee and Welsh Government.

Members (1) **Approved** the final draft of the Specialised Services Commissioning Strategy; and (2) **Supported** the decision to undertake further detailed work on the development of a set of meaningful success measures for the strategic objectives, with a timescale of September 2023 for completion.

4. WHSSC & HB Shared Pathway Saving Target – Milestones on Governance System & Process
Members **received** a presentation on the outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target, which had been requested by the Committee following approval of the Integrated Commissioning Plan (ICP) 2023-2024 on 13 February 2023.

Members **noted** that WHSSC had applied a programme management approach to establishing a mechanism to monitor savings and efficiencies and had developed Project Initiation Document (PID) outlining that a Programme Board be established comprising of representatives from each Health Board (HB). The PID had been shared with the Management Group in readiness for detailed discussion on 23 March 2023.

Members **noted** that an update on progress would be provided as a standing item on the agenda of future Joint Committee meetings.

Members **noted** the presentation.

5. Chair's Report

Members received the Chair's Report and **noted**:

- **Chair's Action** - The Chair's Action taken on 9 May 2023 to extend the tenure of Professor Ceri Phillips, Independent Member (IM), WHSSC from 31 May 2023 until 30 June 2023,
- **WHSSC Independent Member (IM) Recruitment** - that a recruitment process for the third WHSSC IM position will open in May 2023,
- **Welsh Government (WG) Review of National Commissioning Functions** - further to the Minister for Health & Social Services's announcement concerning a review of national commissioning functions a facilitated discussion with Joint Committee members took place on 14 March 2023 to coincide with the EASC and WHSSC meetings scheduled for that day; and
- Key meetings attended.

Members (1) **Noted** the report, (2) **Ratified** the Chair's action taken on 9 May 2023 to extend the tenure of Professor Ceri Phillips, Independent Member (IM), WHSSC from 31 May 2023 until 30 June 2023.

6. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- **Single Commissioner for Mental Health -** Further to the Joint Committee meeting on 10 January 2023, when six of the seven HBs on the Joint Committee supported a recommendation to WG that WHSSC should be the single commissioner for secure Mental Health service in Wales, on 20 March 2023 WHSSC received confirmation from WG that they accepted the recommendation. A letter has been issued to Welsh Government requesting funding for project management support for the associated programme of work,
- **Sacral Nerve Stimulation (SNS) for faecal incontinence in South Wales -** WHSSC has received a request from the Chair of the NHS Wales Health Collaborative Executive Group (CEG) formally requesting that WHSSC take on the commissioning of Sacral Nerve Stimulation (SNS) for faecal incontinence in South Wales. The

WHSSC Team will undertake an evidence review of the procedure and an estimation of demand and budget impact to feed into the WHSSC Integrated Commissioning Plan. A report outlining the process and timeline, will be brought to the July Joint Committee,

- **Spinal Operational Delivery Network (ODN) -** Following highlighting the delay reported in the March 2023 meeting the Implementation Board have confirmed that the plan is for the ODN to go live in September 2023,
- **Thoracic Surgical Centre Update -** Following further detailed capital planning work undertaken by SBUHB as the host provider of the future single Thoracic Surgical Centre a briefing has been received with a more detailed timeline for the delivery of the scheme. At the Project Board meeting in November 2022 an initial indicative timeline was reported that the Centre will be operational during 2026; and
- **All Wales IPFR Policy Review**
  The final draft of the All Wales Individual Patient Funding Panel (IPFR) Policy will be presented to the Joint Committee in July 2023. It has not been possible to complete the work in time for the May committee meeting due to the availability of the KC to consider the draft which has now been agreed by WHSSC and stakeholders.

Members **noted** the report.

7. Review of Specialised Commissioning in Haematology: Acute Myeloid Leukaemia (AML), Acute Lymphoblastic Leukaemia (ALL) and High Risk Myelodysplasia

Members received a report outlining the main findings and proposals of the report on Acute Myeloid Leukaemia (AML), Acute Lymphoblastic Leukaemia (ALL) and High Risk Myelodysplasia (HRM) from the review of specialised commissioning in haematology.

Members (1) **Noted** the findings of the specialised haematology review in relation to the opportunities, risks and challenges for the Acute Myeloid Leukaemia (AML), Acute Lymphoblastic Leukaemia (ALL) and High Risk Myelodysplasia (HRM) service in Wales, (2) **Considered** the options proposed for how specialised commissioning under WHSSC could address the opportunities, risks and challenges in the AML, ALL and HRM service to provide an equitable, high quality and sustainable service for patients in Wales; and (3) **Approved** option 4, the phased implementation of option 1 (all Wales MDT) and option 3 (network service model for Wales), as the preferred option.

8. Review of Specialised Commissioning in Haematology: Allogeneic Haematopoietic Stem Cell Transplantation, Salvage Therapy in Non-Hodgkin's Lymphoma and Secondary Immunodeficiency

Members received a report outlining the main findings and proposals of the review of specialised commissioning in haematology for Allogenic Haematopoietic Stem Cell Transplantation (AHSCT), salvage therapy for high grade Non-Hodgkin's Lymphoma (HG NHL) and Secondary Immunodeficiency in haematology patients.

Members (1) **Noted** the findings of the specialised haematology review in relation to the management of AHSCT, salvage therapy for HG NHL and treatment for secondary immunodeficiency in haematology patients,
(2) **Noted** the options proposed for how specialised commissioning under WHSSC may address the opportunities, risks and challenges in these service; and (3) **Approved** the following specific recommendations:

- Management of AHSCT:
  - Commissioning responsibility for long term follow up (post 100 days) by the specialist AHSCT team is transferred from HBs to WHSSC,
- Salvage therapy for HG NHL:
  - Current commissioning arrangements are retained,
  - The role of central commissioning is re-evaluated once an agreed national pathway for HG NHL is in place,
- Secondary immunodeficiency:
  - Current commissioning arrangements are retained; and
  - Consideration is given to undertaking work at an all Wales level to evaluate the feasibility of a national sub-cutaneous immunoglobulin therapy service for patients with secondary immunodeficiency.

9. Review of Specialised Commissioning in Haematology: Thrombotic Thrombocytopenic Purpura

Members received a report outlining the main findings and proposals of the review of specialised commissioning in haematology for Thrombotic Thrombocytopenic Purpura (TTP).

Members (1) **Noted** the current model of service delivery for TTP across Wales and the risks to equitable access to best treatment, (2) **Approved** the transfer of commissioning responsibility for TTP from Health Boards to WHSSC; and (3) **Approved** the proposed preferred option to commission TTP for the population of south Wales from a designated comprehensive TTP centre in NHS England.

10. Cochlear and Bone Conduction Hearing Implant (BCHI) Engagement & Next Steps

Members received a report outlining the targeted engagement process undertaken regarding Cochlear and BCHI services for people in South East

Wales, South West Wales and South Powys, the findings from that process and the proposed next steps.

Members (1) **Noted** the process that has been followed both in respect of a) the temporary urgent service change for Cochlear services and b) the requirements against the guidance for changes to NHS services in Wales, (2) **Noted** and **Considered** the feedback received from patients, staff and stakeholders with respect commissioning intent, (3) **Approved** the preferred commissioning model of a single implantable device hub for both children and adults with an outreach support model, (4) **Supported** the next steps specifically the undertaking of a designated provider process; followed by a period of formal consultation, (5) **Noted** the process that has been enabled to seek patient and stakeholder views in line with the requirements against the guidance for changes to NHS services in Wales; and (6) **Agreed** to take the outcome and proposed next steps through Health Boards for consideration.

11. Performance Management Framework

Members received a report presenting the draft WHSSC Performance Management Framework approach which subject to approval will be embedded into WHSSC's business as usual processes, and shared with provider organisations, for transparency and awareness.

Members (1) **Noted** the report, (2) **Approved** the proposed approach for an updated WHSSC Performance Management Framework; and
(3) **supported** the proposed implementation arrangements.

12. Development of the Integrated Commissioning Plan 2024-2027

Members received a report outlining the high level process for the development of the WHSSC Integrated Commissioning Plan (ICP) for 2024-2027.

Members (1) **Noted** the report, (2) **Considered** and **Approved** the timeline; and (3) **Received assurance** on the process.

13. Annual Governance Statement 2022-2023

Members received a report presenting the Annual Governance Statement (AGS) 2022-23 for approval.

Members (1) **Noted** the final report, (2) **Noted** that the draft Annual governance Statement was presented to the Integrated Governance Committee on the 18 May 2023 for assurance, (3) **Noted** that the WHSSC Annual governance Statement 2022-2023 will be presented at the CTMUHB Audit & Risk Committee Meeting on 21 June 2023, (4) **Noted** that the WHSSC Annual Governance Statement 2022-2023 will be included in the CTMUHB Annual report submission to Welsh Government and Audit Wales in June 2023, recognising that it has been reviewed and

agreed by the relevant sub committees of the Joint Committee; (5) **Noted** that the final documents will be submitted to the CTMUHB Audit & Risk Committee in July 2023 for recommendation for CTMUHB Board Approval on 27 July 2023; and (6) **Noted** that the final Annual Governance Statement will be included in the Annual Report presented at the CTMUHB Annual General Meeting in September 2023.

14. Sub Committee Annual Reports

Members received a report presenting the Sub-Committee Annual Reports for 2022-2023.

Members **noted** the Sub-Committee Annual Reports for 2022-23.

15. Sub Committee Terms of Reference

Members received a report presenting the updated Terms of Reference (ToR) for the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC), and the Welsh Kidney Network (WKN) for approval.

Members (1) **Noted** that the Welsh Kidney Network (WKN) Terms of Reference were discussed and approved at the WKN Board Meeting on 4 April 2023, (2) **Noted** that the Integrated Governance Committee (IGC), the Quality & Patient Safety Committee (QPSC) Terms of Reference were discussed and approved at sub-committee meetings on 18 April 2023, (3) **Noted** that the MG ToR were discussed at the MG meeting on 27 April 2023 and no changes were proposed; and (4) **Approved** the revised Terms of Reference (ToR) for the IGC, the QPSC and the WKN.

16. Performance & Activity Report Month 11 2022-2023

Members received a report highlighting the scale of the decrease in activity levels during the peak COVID-19 period, and outlining signs of recovery in specialised services activity. The activity decreases were shown in the context of the potential risk regarding patient harms and of the loss of value from nationally agreed financial block contract arrangements.

Members **noted** the report.

17. Financial Performance Report – Month 12 2022-2023

Members received the financial performance report setting out the financial position for WHSSC for month 12 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The year-end financial position reported at Month 12 for WHSSC was an underspend of (£10.939m). The under spend predominantly relates to releasable reserves of (£18m) arising from 2021/22 as a result of WHSSC

assisting Health Boards to manage resources over financial years on a planned basis, as HBs could not absorb underspends above their own forecasts, and to ensure the most effective use of system resources.

Members **noted** the current financial position and forecast year-end position.

18. South Wales Trauma Network Delivery Assurance Group (Quarter 3 Report)

Members received a report providing a summary of the Quarter 3 2022/23 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members **noted** the full South Wales Major Trauma Network (SWTN) Delivery Assurance Group (DAG) report.

19. Corporate Governance Matters

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members **noted** the report.

20. Other reports

Members also **noted** update reports from the following joint Sub-committees:

- Audit and Risk Committee (ARC),
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel,
- Integrated Governance Committee (IGC),
- Quality & Patient Safety Committee (QPSC; and
- Welsh Kidney Network (WKN).

21. Any Other Business

- Members noted a Joint Committee development session will be held on 11 September 2023.

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	27th July 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR DISCUSSION

ACRONYMS	
DHCR	Digital Health Care Record
SACT	Systemic Anti-Cancer Therapy
BSL	British Sign Language

1. PURPOSE

This paper is 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 13th July 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 FROM THE MEETING HELD ON 13th JULY 2023

3.1.1 *Triangulated themes*

The Committee commended the considerable progress that has been made over the last year as demonstrated through the suite of annual reports considered. Enhanced assurance processes have started to be put in place across a number of areas over the last year and improvements made so that the Trust can meet the required national and legislative standards. It was recognised that this should positively impact on patients and donors.

Some cross cutting themes were identified as:

- Digital capability
- Quality and experience focus
- Despite workforce constraints in areas- recognition of staff resilience and dedication to ensuring the best services for patients.

The Committee identified there was a variance in the range of written presentation styles in respect of the reports and it was agreed that a Trust Annual Report template would be developed for use for the 2023 – 2024 report.

3.1 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 July 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-13072023/

3.2 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** The Committee heard details of the continuing work around the refresh of the Trust Assurance Framework (TAF) risks and were advised that whilst the refresh should have been ready for the July Committee, this work would be now be completed for the Committee's September governance cycle. It was agreed that IM's would receive the completed TAF as soon as completed in late July. The Risk Register Report covered the 13 risks that meet the threshold for Committee and Board reporting. Following discussion at Executive Management Board it was agreed that the risk management assurance level is currently a level 2. It was identified that the action plans in place for the risks reported to Trust Board and Committees are addressing the root cause. Committee members identified that there remain a number of risks which have been open for a significant period of time without any risk reduction and targeted action to address this was requested. A verbal deep dive was provided in respect of two risks: o Risk 3001: Workforce Risk o Risk 3042: Laboratory Information Management System (LIMS). The Committee requested that future deep dive outcomes are covered within the risk paper rather than verbally.

	The Committee were advised that risks 3011 and 3092, which relate to the DHCR implementation, are expected to be closed within the next few days. • **Finance Report: Month 2 - Period up to 31st May 2023 (M2)** The Committee received the Finance Report which outlines a balanced financial position for the period to the end of May 2023 and the year end forecast is a breakeven position based on the assumption that all planned additional income is received, saving targets achieved, and financial risks appropriately mitigated throughout the year. A risk around capital within the new Velindre Cancer Centre project was highlighted due to additional project management costs arising from the changing timelines although it is likely that these additional costs will be funded. Attention was brought to the risk around the Digital Health Care Record system which at month 2 was identified as a medium risk but is now significantly reduced and reporting as low. The Committee were advised that since the report was published, confirmation has been received that protection of all provider income will continue for another year. • **Quality, Safety & Performance Report** The Committee were advised that the first Halcyon machine in radiotherapy has now been successfully implemented, which is a step towards addressing the risks caused due to the fragility of the radiotherapy LINAC fleet and were advised how the new software is improving data intelligence and providing the opportunity to have greater performance scrutiny. The Committee were also advised of the actions being taken to ensure SACT treatments can be provided within the required timescales as well as being able to implement the required additional services. .
ASSURE	**The following Annual Reports were Approved by the Committee:** • **Trust Clinical Audit Annual Report (2021-2023)** The Clinical Audit Annual Report, provided an overview of the clinical audit activity and programme of work on clinical effectiveness,

undertaken at Velindre Cancer Centre and the Welsh Blood Service and covering a 2-year period from April 2021 to the end of March 2023. No report was submitted for the year 2021/22 as per strategic business continuity decisions taken during the COVID-19 pandemic.

Two achievements were highlighted: implementation of a digital clinical audit system (AMaT) to support effective audit management and tracking and a 'reasonable assurance' internal audit rating.

- **Infection Prevention & Control Annual Report (2022 – 2023)**
  The Infection Prevention & Control Annual Report provided a comprehensive overview of the Trust's infection prevention and control outcomes and improvements for the year. Key achievements included the Trust being the first NHS Body in Wales to achieve Aseptic Non-Touch Technique (ANTT) accreditation – gold achieved, 40% reduction in healthcare acquired clostridium difficile, no cases of MRSA Bacteraemia since November 2013.

- **Medical Devices Annual Report (2022-2023)**

- **Information Governance Annual Report**
  The significant enhancement of Trust assurance mechanisms and Information Governance improvements made during the year was commended.

- **Sustainability Annual Report (including decarbonisation) (2022-2023)**
  The Committee noted the maintenance of ISO14001 (environmental systems) with no non-conformities.

- **Safeguarding & Vulnerable Adults Management Group Annual Report (2022-2023)**

All Annual Reports approved will be translated into Welsh and published on the Trust's website.

The following annual reports were **ENDORSED** for Trust Board approval. The full suite of reports is included within the Trust Board papers:

- **Performance Annual Report (2022 – 2023)**
  The Committee noted the Performance Annual Report which will form part of the suite of reports that come together to form the

overarching Trust Annual Report and were advised that positive feedback had been received from Audit Wales..

- **Putting Things Right Annual Report (2022 – 2023)**
  The Committee commended the significant improvement work that has been undertaken across the organisation to ensure the Trust meets its Putting Things Right responsibilities.

- **Patient & Donor Experience Annual Report (2022 – 2023)**
  The Committee were advised that a one-page summary poster of highlights would be provided and published for all staff to hear what our patients and donors have said over the last year and what actions the Trust is taking to further enhance the experience.

- **Local Partnership Forum Annual Report (2022 – 2023)**

- **Annual Equality, Diversity & Inclusion Report (2022 – 2023)**

- **Gender Pay Gap Annual Report (2022 – 2023)**

- **Welsh Language Annual Report (2022 – 2023)**
  The Committee noted the work being undertaken to enhance translation and that one formal investigation has been commissioned relating to how the Trust answers the telephone.

- **Business Continuity & Emergency Planning Annual Report (2022 – 2023)**

- **Professional Registration / Revalidation Report (2022 – 2023)**

The following reports were noted by the Committee:

- **Health Technology Wales (HTW) Annual Report (2022 – 2023)**

- **Estates Annual Report (2022 – 2023)**

- **People Strategy Annual Report (2022 – 2023)**

	Integrated Medium Term Plan (IMTP) Quarter 1 Report The Committee were advised that the 15 actions for Welsh Blood Service were all on target to be delivered or had plans in place to facilitate this. From the 22 actions for Velindre Cancer Service, 18 were on course to be delivered, with the remaining connected to the new Velindre Cancer Centre and to be managed by other committees.
INFORM	• **Staff Story** The Committee received a staff story video from Michelle Fowler, Organisational Development Manager, Equalities, Diversity & Inclusion, who shared her workplace challenges as a member of the deaf community. New to the NHS, Michelle spoke positively about her experiences since joining Velindre, but outlined the challenges she continues to experience. Michelle highlighted the lack of priority around ensuring that BSL interpreters are booked in good time to support various workshops, conferences and other events and felt that much improvement is needed in this area. The Committee conveyed its sincere thanks to Michelle for sharing her story and experiences that provides the Trust with an opportunity to significantly improve its inclusivity.
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 13th July 2023.

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 6th July 2023.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Velindre Oncology Academy** The Velindre Oncology Academy paper was presented to the Committee. It was confirmed the uplift of the pay award needs to be included within the costings, originally the costings included the original pay award prior to the uplift being agreed. Hannah Russon, Project Lead was thanked for all her hard work and contribution for the Velindre Oncology Academy. It was confirmed the Integrated Medium Term Plan will include the Velindre Oncology Academy. The financial business case wasn't included within the papers at this Committee, but it was confirmed it will be included within the Trust Board papers. The Strategic development Committee **Endorsed** and supported the principle of the Velindre Oncology Academy and the selection of Option 3, to recommend for Trust Board approval in July. **Replacement of a third Linac at VCC** The Replacement of a third Linac at VCC paper was delivered to the Committee. It was explained originally the scope was to replace two Linac machines at Velindre Cancer Centre within phase one. Following further demand and capacity planning for the service, the Strategic Development Committee as asked to endorse the replacement of the third Linac at Velindre Cancer Centre. This allows the service to be further operationally ready for the new Velindre Cancer Centre as well as giving scope to train staff earlier. It was confirmed the additional costs will be funded by Welsh Government. Agreement to replace the 3rd LINAC will be followed by the appropriate assurance of budgets and financial approvals. The Strategic Development Committee **Endorsed for Board Approval** the Replacement of a 3rd Linac at VCC paper.
ASSURE	There were no items identified to assure the Trust Board.

INFORM	**Trust Integrated Medium Term Plan** The Trust Integrated Medium Term Plan is still waiting approval from Welsh Government. Whilst awaiting approval for our most recent plan, there is a requirement to commence the process for updating our plan for 2024/25 – 2026/27. Although Welsh Government planning guidance is not expected to be issued until October 2023 it is assumed that the IMTP will need to be approved by the Velindre University NHS Trust Board no later than the 31st January 2024. The Strategic Development Committee **noted** the Trust Integrated Medium Term Plan Paper. **Quality Management System Development** The Quality Management System Development paper was delivered to the Strategic Development Committee. The Strategic Development Committee **Noted** the Quality Management System Development paper. **Organisational Values and Culture** This report summarises progress to date and sets out a timeline for concluding the Culture and Values workstream by 31 March 2024.The timeline has been previously agreed at Executive Management Board. It was recognised that we need to involve patients, public and a broad range of stakeholders within the engagement. It was also suggested to show how many people have been involved in the engagement process and how we have engaged with Llias and staff. It was suggested the development of a culture and dashboard data set should sit within the quality dashboard to ensure it aligns with the quality work that is currently being undertaken. The Strategic Development Committee **noted** the timeline and deadlines within the Organisational Values and Culture paper. **Trust Assurance Framework** Previous discussions have been held within the Strategic Development Committee regarding the refresh of the strategic risks. Sessions have been held with the Leadership Teams but further sessions will need to be arranged. The Strategic Development Committee **Noted** the verbal update for the Trust Assurance Framework. **Velindre University NHS Trust Business Continuity and Emergency Planning Policy**

	The Velindre University NHS Trust Business Continuity and Emergency Planning Policy was **endorsed** for Trust Board Approval.
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	27th July 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
nVCC	New Velindre Cancer Centre
FBC	Full Business Case
WG	Welsh Government

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 20th April 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Trust Board.
ADVISE	**TCS Programme Finance Report** The TCS Programme Finance Report was discussed as follows: • A query was raised regarding the statement *"The final costs for the Project at this time were £0.178m"* and clarity on the term *"final costs"* was sought. The Sub-Committee were advised that this referred to the internal procurement project costs up until closure of the contract and that these funds will be reimbursed. • A query was raised around the statement that the Implementation Project will not be reported by the TCS Project and clarity sought on the intended reporting process. It was agreed that this would be further reviewed and clarity would be provided in due course. • Two similar entries within Appendix 2 (TCS Programme Funding for 2022-23) were highlighted. These were clarified as follows: o Trust revenue funding £0.060M *Funds for the recruitment of a Project Manager given the concerns raised regarding high-risk outreach project.* o Trust revenue funding from reserves £0.063M *£30K funded from Trust reserves since the TCS programme was established, £33K one-off judicial review legal fees over and above available capital funding.* The Sub-Committee **noted** the TCS Programme Finance Report.
ASSURE	There were no items identified to assure the Trust Board.
INFORM	**Communications & Engagement** The Sub-Committee received and **noted** the Communications & Engagement update. The Sub-Committee's attention was brought to the recently held

	Spring Jamboree which had proven to be a successful event. It was attended by over 40 families from the local community, 12 patients and their children, and 104 staff members. **Programme Director's Report** The Programme Director's Report was received and discussed as follows: • The Sub-Committee's attention was brought to the paragraph *"The FBC was considered at all commissioner Board meeting in March, with approval subsequently being achieved at three of the five meetings. The remaining two commissioners did not feel at this stage they could currently confirm their financial support for the nVCC FBC and have requested further engagement".* As a point of clarity it was noted that this should state "*…approval subsequently being achieved by four of the six meetings*" and that the remaining two commissioners supported the strategic direction and management case but could not approve the financial case on affordability grounds. • The Project Status table was queried as it was noted that Project 3a shows a 'green' rating for all elements with an overall status of 'amber'. It was agreed that this appeared to be an anomaly and would be reviewed. • Attention was brought to the section entitled "Project 6 Service Delivery, Transformation & Transition" in which it is stated that *"transition planning has also been raised by the WG Scrutiny process as of critical importance…".* Members wished to clarify that concerns around this have been previously flagged by this Sub-Committee. The Sub-Committee **noted** the Programme Director's Report.
APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	27th July 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, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 19th June 2023.

1.2 Key highlights from the meeting are reported in section 2.

1.3 Trust Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
ADVISE	There were no items identified to advise to Trust Board.
ASSURE	**Programme Director's Report** The Programme Director's Report was received and discussed as follows: • Within Project 6: Service Delivery, Transformation and Transition states "has been deferred a few months given the delays in the nVCC programme". It was confirmed the timings are vague, but it would be helpful to have clarity around the timeline. The Sub-Committee were assured there is a lot of work happening regarding the service delivery, transformation and transition. Following financial close we will be in a good position to formally launch as an internal project. • It was confirmed the Sub-Committee will still receive reports from Projects 1 to 6 to make up that programme of work. • It was confirmed there has been no change in the governance and approvals arrangements. • A paper will be circulated to the Sub-Committee showing the clear scope demonstrating what projects or pieces of work are sat where and who's accountable for them. Showing the governance for each of these pieces of work ensuring there are no gaps. This is to provide clarification to the Sub-Committee and will feed up into Trust Board for information and assurance. The Sub-Committee **noted** the Programme Director's Report.
INFORM	**Communications & Engagement** The Sub-Committee received and **noted** the Communications & Engagement update.
APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE Private Remuneration Committee

DATE OF MEETING	27.07.2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Emma Barnes-Lewis, Business Support Officer
PRESENTED BY	Prof Donna Mead OBE, Velindre University NHS Trust Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce
REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Private Remuneration Committee on 28.06.2023.

1.2 Key highlights from the meeting are reported in section 2.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There are no items for escalation to the Trust Board.
ADVISE	There are no items for advising the Trust Board.
ASSURE	There are no items for assurance for the Trust Board.
INFORM	• Proposal to Archive the Anonymous Communications Policy was **ENDORSED** by the Committee. • A Case for Redundancy was **APPROVED** by the Committee. • The National A4C Pay Awards was **NOTED** by the Committee. • An Anonymous Communication Received was **NOTED** by the Committee.
APPENDICES	N/A.

3. The Board is requested to **NOTE** the contents of the report and actions being taken.

TRUST BOARD

CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	27/07/2023
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	Steve Ham, Chief Executive Officer
REPORT PURPOSE	FOR NOTING

ACRONYMS	
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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 8th June 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 Charitable Funds Committee held on the 08 June 2023:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**FUNDRAISING** The Charitable Funds Committee **NOTED** some exciting developments within the Charity: • Patron Rhod Gilbert is now able to support a schedule of planned fundraising events, including a concert in the Millennium Centre in October 2023. • Overseas bike ride in France to coincide with the World Cup will be led by Velindre Charity President Jonathan Davies – 'Jiffy'. **FINANCIAL POSITION** The Charitable Funds Committee **NOTED** the financial performance of the Charity for the period ending 31st March 2023, and the current position and performance of the Charity's investment portfolio. **Income Performance:** • Total income financial year ending 2022/2023 circa £4.76 million, an increase of £1.78million on a plan of £3 million. The increase is primarily due to a legacy of circa £1.6million. • May 2023 year to date income is set to come in at circa £550,000 for donations and legacies and in addition there have been legacies notified to the Trust of circa £1,150,000. • Expenditure saw a reduction in 2022/2023 of circa £1.89 million, largely due to the delays due to staff vacancies reducing spend for the project. Fund balances have grown by roughly £3.06m to around £9.74 million, £6 million of which is classified in unrestricted funds. • As at end of financial year, the investment portfolio has seen shrinkages of circa 6.11% on the 2022 closing balances. In this financial year it is expected to see some recovery on fund balances on the investment portfolio. **Balance Sheet** • The Charity is currently holding significant cash balances circa £2.4 million.

	• **Forward Look:** • Based on forecast commitments for 2023/2024 of £6.42 million, the target reserve for the Trust will be approximately £2.14 million. • Income for 2023/2024 has been forecast at £2.847m in line with the Annual Plan and will be monitored throughout the financial year. **BUSINESS CASE AND EXPENDITURE PROPOSALS** The Charitable Funds Committee **APPROVED two** Business Case and Expenditure proposals: **1. Advanced Radiotherapy Fund Business Case Moondance Bid Match Funding** The Charitable Funds Committee **AGREED** to **APPROVE** the Business Case for £1.5 million for the period of 5 years to match fund the Moondance contribution. **2. Lung Cancer PhD Clinical Research Fellow Business Case** A PhD post included in the integrated research and development bid approved by Charitable Funds Committee January 2023 This represented the matched funding from the Stepping Stones Lung Cancer Research Sub Fund for the funding previously agreed in the original bid from the unrestricted funds. The PhD title is to explore primary and secondary lung cancer existence using tissue and circulating tumour DNA biomarkers. The Charitable Funds Committee **AGREED** to **APPROVE** the Business Case from the Stepping Stones Research Sub Fund of £82,688. **NODDFA BUSINESS CASE** The Charitable Funds Committee were informed that the Velindre Cancer Service Senior Leadership Team are considering the final iteration of the Business Case. The Charitable Funds Committee **AGREED** that the Noddfa Business Case would be circulated to Committee members for Out of Committee consideration in due course.
ASSURE	There were no items required to report for assurance to the Trust Board.
INFORM	**DELEGATED FINANCIAL LIMIT REVIEW** The Charitable Funds Committee **DISCUSSED** the review of delegated financial limits. The current position is that all expenditure over £5,000 needs

	to go to the Charitable Funds Committee by Business Case and anything under £5,000 can be approved by the Chief Executive. Consideration is being given to increasing the limit for the Chief Executive and Director of Finance to £25,000. The Committee **AGREED** several principles contained in the paper but requested further information before approval. The note will be brought to the September 2023 Charitable Funds Committee. **CHAIRS URGENT ACTION** The Charitable Funds Committee **CONSIDERED** and **RATIFIED** the Chairs urgent action taken on the 16/05/2023 and 04/05/2023: • Fundraising Proposal Overseas Bike Ride 2024 • Fundraising activity for QUICKDNA Project • Rhod Gilbert 2023 Fundraising Proposal

3. RECOMMENDATION

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