Public Trust Board

Thu 28 September 2023, 10:00 - 14:00

Velindre University NHS Trust Headquarters, Nantgarw

Agenda

10:00 - 10:10
10 min

1. STANDARD BUSINESS

1.1. Apologies

Professor Donna Mead OBE, Chair

1.2. In Attendance

Professor Donna Mead OBE, Chair

1.3. Declarations of Interest

Professor Donna Mead OBE, Chair

1.4. Minutes from the Public Trust Board meeting held on 27th July 2023

Professor Donna Mead OBE, Chair

1.4.0 Draft Public Trust Board Minutes 27.07.2023 v2SHapproved.pdf (18 pages)

1.5. Action Log

Professor Donna Mead OBE, Chair

1.5.0 PUBLIC TRUST BOARD ACTION LOG v1.pdf (1 pages)

1.6. Matters Arising

Professor Donna Mead OBE, Chair

10:10 - 10:25
15 min

2. KEY REPORTS

2.1. Chair's report

Professor Donna Mead OBE, Chair

2.1.0 Chair's Update September 2023 DM.pdf (5 pages)

2.2. Vice Chair's report

Stephen Harries, Vice Chair

2.2.0 Vice Chair Update Sept 2023.pdf (3 pages)

2.3. Chief Executive's report

Steve Ham, Chief Executive

2.3.0 Chief Executive's Report September 2023 vfinal.pdf (4 pages)
2.3.0a Appendix 1 - Letter JP to SH - following End Year JET 1.pdf (3 pages)

10:25 - 11:40
75 min

3. QUALITY, SAFETY & PERFORMANCE

3.1. VUNHST Risk Register

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 3.1.0 TRUST RISK REGISTER -TB - 28.09.2023- vfinal.pdf (8 pages)
- 3.1.0a Appendix 1 - DATIX REPORTS - V01 - 19.09.2023.pdf (4 pages)
- 3.1.0b Appendix 2 - DATIX REPORTS - V01 - 19.09.2023.pdf (2 pages)

3.2. Trust Assurance Framework

Lauren Fear, Director of Corporate Governance & Chief of Staff

**Oral update.

3.3. Performance Management Framework (July 2023)

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

- 3.3.0 TRUST BOARD 28.09.23 JULY PMF Performance Report FINAL version 008.pdf (69 pages)

3.4. Financial Report (July 2023)

Matthew Bunce, Executive Director of Finance

- 3.4.0 Month 4 Finance Report Cover Paper - Trust Board.pdf (9 pages)
- 3.4.0a M4 VELINDRE NHS TRUST FINANCIAL POSITION TO JULY 2023 - TRUST BOARD.pdf (23 pages)

3.5. Sickness Absence Key Performance Indicator

Sarah Morley, Executive Director of Organisational Development & Workforce

- 3.5.0 Sickness Key Performance Indicator - final.pdf (9 pages)

3.6. Public Quality, Safety & Performance Committee Highlight Report (14/09/2023)

Vicky Morris, Independent Member and Chair of Quality, Safety & Performance Committee

- 3.6.0 Public Quality Safety Performance Committee Highlight Report 14.09.23.pdf (11 pages)

3.7. Public Audit Committee Highlight Report (26/07/2023)

Martin Veale, Independent Member and Chair of Audit Committee

- 3.7.0 Audit Committee Part A Public Highlight Report 28 September 2023-LF-MV.pdf (4 pages)

11:40 - 13:05
85 min

4. PRESENTATIONS

4.1. Integrated Radiotherapy Solution (IRS)

Led by Tony Millin, Head of Radiotherapy Physics, supported by:

- Helen Payne, Radiotherapy Service Manager
- Dr Tom Rackley, Consultant Oncologist
- Kathy Ikin, Head of Radiation Services

- 4.1.0 Implementation of IRS.pdf (24 pages)

4.2. LUNCH MEET AND GREET WITH THE IRS TEAM

13:05 - 13:05
0 min

5. PLANNING AND STRATEGIC DEVELOPMENT - NO ITEMS

13:05 - 13:35
30 min

6. CONSENT ITEMS

6.1. CONSENT FOR APPROVAL

Professor Donna Mead OBE, Chair

6.1.1. Health & Safety Management Annual Report

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

- 6.1.1a H&S Annual Report Appendix 1.pdf (25 pages)
- 6.1.1 Trust Board Annual Health and Safety Report - Cover Paper.pdf (5 pages)

6.1.2. Quality Impact Assessment Tool

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

- 6.1.2 Quality impact assessment.pdf (12 pages)

6.1.3. Lease for Approval

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.1.3 NWSSP Lease Approval .pdf (6 pages)
- 6.1.3a Toast Heads of Terms.pdf (1 pages)

6.2. CONSENT FOR NOTING

Professor Donna Mead OBE, Chair

6.2.1. Public Strategic Development Committee Highlight Report (05/09/2023)

Stephen Harries, Vice Chair and Chair of Strategic Development Committee

- 6.2.1 Public - Highlight Report SDC 12.09.2023 -v2SHapproved.pdf (5 pages)

6.2.2. Public Welsh Health Specialised Services (WHSSC) Committee briefing (18/07/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.2 JC Briefing (Public) 18 July 2023.pdf (7 pages)

6.2.3. Emergency Ambulance Services (EASC) briefing (18/07/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.3 Chair's EASC Summary from 18 July 2023.pdf (9 pages)

6.2.4. NHS Wales Shared Services Partnership Committee Assurance Report

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.4 SSPC Assurance Report 20 July 2023.pdf (4 pages)

6.2.5. NHS Wales Shared Services Partnership Audit Committee Highlight Report

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.5 NWSSP Audit Committee Assurance Report.pdf (4 pages)

6.2.6. Approved Policies Update

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.6 TRUST WIDE POLICIES UPDATE_ September 2023 v1.pdf (3 pages)
- 6.2.6a TRUST ENVIRONMENTAL POLICY.pdf (12 pages)
- 6.2.6b WASTE MANAGEMENT POLICY.pdf (7 pages)

6.2.7. Trust Seal Approval Report (May-September 2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.7 Trust Seal Report June-September 2023 v1.pdf (3 pages)

6.2.8. Wales Infected Blood Support Scheme (WIBBS) Annual Report 2022-23

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.8 WIBBS cover paper.pdf (2 pages)
- 6.2.8a WIBSS Annual Report V4.pdf (25 pages)
- 6.2.8b WIBSS Annual Report 2022 2023- Cy.pdf (25 pages)

13:35 - 13:35
0 min

7. ANY OTHER BUSINESS

Professor Donna Mead OBE, Chair

Prior approval required by Chair

13:35 - 13:35
0 min

8. DATE OF NEXT MEETING

Thursday, 30th November 2023

13:35 - 13:35
0 min

9. CLOSE

The Board is asked to adopt the following resolution: That representatives of the press and other members of the public be excluded form 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)

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

PRESENT	
Stephen Harries	Vice Chair (Chair)
Steve Ham	Chief Executive
Vicky Morris	Independent Member
Professor Andrew Westwell	Independent Member
Gareth Jones	Independent Member
Martin Veale	Independent Member
Matthew Bunce	Executive Director of Finance
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
Cath O'Brien MBE	Chief Operating Officer
ATTENDEES	
Lauren Fear	Director of Corporate Governance and Chief of Staff

1.0.0	PRESENTATIONS	ACTION LEAD
1.1.0	**Health Technology Wales Annual Report (2022-2023)** The Board received a presentation of the 2022-2023 Health Technology Wales Annual Report, describing work undertaken during 2022-23 by Health Technology Wales, to improve health and social care in Wales. Professor Peter Groves provided an overview of the following: • The core responsibilities of Health Technology Wales; to provide a nationally coordinated approach to identify, appraise and adopt medical technologies across Wales. • The additional, broader role of Health Technology Wales as a well-established international Health Technology Organisation (one of 6 such Organisations) and promotion of Research. • The publication of a significant number (10) pieces of guidance over the course of the year, covering a wide range of topics, noting that the ability to do so relies heavily on input from clinical experts, patients and members of the public alike. • The impact of guidance published and potential benefit of adopting a particular technology to patients, when promoting the adoption of guidance. • An overview of key findings of 2022-2023 Adoption Audit, due for imminent publication. • Highlights from the last 5 years in addition to suggestions for future development, in alignment with the 6 Ministerial Priorities. Peter Groves indicated that publication of all guidance on the Health Technology Wales website is supplemented by a significant number of topic	

	exploration reports, providing high level evidence summaries of topics of merit that do not qualify for full appraisal. Professor Andrew Westwell queried how whether Health Technology Wales explores the economic resource implications of introducing a new technology or process into the NHS. Peter Groves indicated that this very much lies within the remit of the Organisation and an in-house team of Health Economists support analysis of cost and economic implications of any guidance considered for adoption. Professor Peter Groves thanked the Trust for the continuing support and the Trust Board commended the work undertaken over the year, **NOTING** the Annual Report.	
2.0.0	**STANDARD BUSINESS**	
	Stephen Harries, Acting Chair opened the meeting and welcomed those in attendance, advising that he would chair today's meeting on behalf of Professor Donna Mead OBE, due to Professor Mead being unwell. The Board that this was the first occasion since her appointment that Professor Mead had not chaired a Public Board meeting. It was noted that a recording of today's meeting would subsequently be made available on the Trust website.	
2.1.0	**Apologies noted:** • Professor Donna Mead OBE, Velindre University NHS Trust Chair • Stephen Allen, Regional Director, Llais Cymru • Dr Jacinta Abraham, Executive Medical Director • Kyle Page, Business Support Manager *(Secretariat)*	
2.2.0	**In Attendance** The Vice Chair extended a warm welcome to the following attendees in support of specific agenda items: • Professor Peter Groves, Chair of Health Technology Wales *(for item 1.1.0)* • Steve Wyndham, Audit Manager, Audit Wales *(for item 4.1.0)* • Emma Rees, Deputy Head of Internal Audit, NHS Wales Shared Services Partnership *(for item 4.2.0)* • Simon Cookson, Director, Audit & Assurance Services, NHS Wales Shared Services Partnership *(for item 4.2.0)* • Jade Coleman, Quality, Safety & Assurance Manager *(for item 8.1.0)* • Zoe Gibson, Interim Head of Quality, Safety & Assurance *(for item 8.2.0)* • Professor Mererid Evans, Consultant Clinical Oncologist *(for item 9.4.0)* • Dr Edwin Massey, Medical Director Welsh Blood Service *(deputising for Dr Jacinta Abraham)* • Hannah Russon, Project Lead, Velindre Oncology Academy *(for item 9.2.0)* • David Cogan, Patient Representative	
2.3.0	**Declarations of Interest** There were no declarations of interest to **note** in respect of today's agenda.	
2.4.0	**Minutes from the Public Trust Board meeting held on 25th May 2023**	

	The Trust Board **APPROVED** the minutes from the meeting held on 25th May 2023 as an accurate and true reflection of proceedings.	
2.5.0	**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**. The target date (28th September 2023) for the remaining open action, ***(3.3.0 – Explore an appropriate internal Trust target for sickness absence levels and provide a proposal to a future Trust Board)*** was confirmed as correct following a query raised by Gareth Jones.	
2.6.0	**Matters Arising** There were no matters arising which were not included on the action log or meeting agenda.	
3.0.0	**Accountability Report and Annual Accounts 2022-2023**	
3.1.0	**Cover Paper for Accountability Report and Annual Accounts 2022-2023** (Items included in the cover paper were addressed separately below).	
3.1.1	**Accountability Report 2022-2023** Martin Veale noted that a number of drafting issues of the Accountability Report identified in yesterday's Audit Committee had been rectified prior to Trust Board, advising that a minimal number of additional elements would be included prior to publication on the 31st July 2023. Martin Veale advised that the Audit Committee was content to **ENDORSE** the version of the Accountability Report sighted at today's Trust Board, however matters relating to further detail within the Directors' report and information governance disclosure status will be amended prior to final publication. In providing an overview of the report, Lauren Fear advised that the Accountability Report comprises the following: • Corporate Governance Report. • Financial Accountability Report. • Remuneration of Staff Report. • Senedd Cymru Accountability and Audit Report. **Corporate Governance** – The report provided an overview of the Trust's Governance Framework, mainly referencing the reduced impact of the pandemic over the period, in addition to highlighting learning from the pandemic in terms of ways of working. The report also detailed the Trust's responsibilities and approach in relation to hosting obligations. Two notable changes had occurred over the course of the year; the permanent appointment of Stephen Harries as the Trust's Vice Chair (April 2022) and the revision of the portfolio for Strategic Transformation & Digital to support the inclusion of the Executive Director role (February 2023). **Financial Accountability** – The significant impact resulting from the current economic climate, the pandemic, industrial action and cost of living crisis on the NHS as a whole was recognised. Notwithstanding, the Trust had	

	successfully met its three financial targets set by Welsh Government and this achievement was commended by the Board. The Trust Board **NOTED** the content of and **APPROVED** the Accountability Report 2022-23, noting minor final amendments.	
3.1.2	**Velindre University NHS Trust Final Accounts 2022-2023** The Trust Board: • **NOTED** the content of the Annual Accounts for 2022-23, including the letter of representation and Trust Response to Audit Wales regarding Trust Governance and Management Arrangements. • **APPROVED** the Annual Accounts for 2022-23.	
3.1.3	**Appendix 1 – Letter of Representation 2022-2023** **See recommendation for item 3.1.2*	
3.1.4	**Appendix 2 – Trust Response to Audit Wales Regarding Trust Governance & Management Arrangements** **See recommendation for item 3.1.2*	
3.2.0	**Annual Performance Report 2022-2023** Vicky Morris provided an overview of the internal governance route and explicit national requirements for the Annual Performance Report, advising that the 13th July 2023 Quality, Safety & Performance Committee was content to **ENDORSE** the report. In presenting the report, Carl James highlighted the following: • Continued impact of the pandemic, increased demand, cost of living implications on patient / donor travel. • Sustained high quality, safety and experience of services across both divisions. • Progress made in relation to the Trust performance scorecard, particularly in terms of safety, infection prevention and control, access and waiting times. • Financial management and continued growth of the organisation in terms of training and digital. • Continued delivery of services within current financial constraints and implementation of new equipment in exceptionally challenging circumstances across both divisions. • The significant amount of work undertaken within Radiation Services, enabling the implementation of the first Linac; this will be addressed specifically at the September Trust Board meeting. Nicola Williams advised that a more detailed explanation of patient experience figures would follow via the Annual Patient & Donor Experience Report later in the meeting. Gareth Jones requested a final review of the format of the document before submission. The Trust Board **APPROVED** the Trust Annual Performance Report for 2022-23.	

4.0.0	**Audit Wales & Internal Audit**	
4.1.0	**Audit Wales ISA 260 Report 2022-2023** Martin Veale advised that the Audit Wales ISA 260 Report had been received at and **ENDORSED** by the July 26th Audit Committee and that it was Audit Wales' intention to issue an unqualified audit opinion on the Trust's accounts for the period (to be issued on the 31st July 2023). In presenting the report, Steve Wyndham referred to a number of areas of outstanding work (completion of internal file review arrangements and obtaining responses to outstanding document requests regarding their IT audit work). Steve Wyndham also referenced difficulties experienced in completing the audit, noting staffing capacity as a major issue. A number of adjustments had been made to the financial statements following any issues identified as a result of the audit, none of which result in significant material impact on the position of the Trust. A summary of corrections made had been included in the report and Martin Veale suggested including narrative to assure the public audience that the adjustments had resulted in no impact. However, as the report had been formally finalised, it was agreed that this would be noted in the minutes of the meeting. The Trust Board: • **REVIEWED** and **APPROVED** the report. • **AUTHORISED** the Chair and Chief Executive Officer to sign the Letter of Representation contained within the Audit Report.	
4.2.0	**NWSSP Audit & Assurance Services – Head of Internal Audit Opinion and Annual Report 2022-2023** Martin Veale advised that the report had been considered at the July 26th Audit Committee, which provided the Board with overall reasonable assurance that arrangements to secure governance, risk management and internal control are suitably designed and applied effectively. It was noted that elements of the report are also replicated in the Trust's Accountability Report. In presenting the report, Simon Cookson highlighted the following additional points: • The position of overall **reasonable assurance** had been based on 3 substantial, 10 reasonable and 1 limited assurance report, in addition three other elements of advisory support. • The inclusion of reporting of national audits within the report (via NHS Wales Shared Services Partnership and Digital Health & Care Wales) providing input to the final version; all indicated positive outcomes. • The programme of work in place relating to the development of the nVCC, recognising changes in timelines, is also reflected within the report, deferring a number of elements into the 2023-24 plan. Simon Cookson thanked the Board for the support provided over the course of the year. The Trust Board **NOTED** the content of the 2022-23 Head of Internal Audit Opinion and Annual Report 2022-2023.	

5.0.0	**KEY REPORTS**	
5.1.0	**Chair's Report** In presenting the update on behalf of the Trust's Chair, the Vice Chair highlighted the following: • The Chair's attendance at the Welsh Blood Service Donor Awards, which took place at Llandrindod Wells during May 2023; this was the first ceremony to take place following the pandemic and the Chair was in attendance to present the awards in person. • The Trust's support of Armed Forces Week and associated programme of events. • Attendance at the National Service of Thanksgiving to celebrate the 75th anniversary of the NHS in Wales. • Attendance at the RCN Nurse of the Year Awards during June 2023; the Trust had sponsored the Nurse of the Year Award (which was presented to the winner by Nicola Williams) and last year's winner (Diane Rees, winner of the Healthcare Support Worker of the Year Award) was given the opportunity to attend due to the absence of a ceremony caused by the pandemic. • The Chair's appraisal with the Minister during July 2023 received positive feedback, recognising the scale of change taking place within the Trust. Professor Andrew Westwell noted his attendance at a subsequent Welsh Blood Service Donor Award ceremony, with a number of future ceremonies planned to address the backlog and enable a return to the pre-pandemic position. The Trust Board **NOTED** the content of the Update Report.	
5.2.0	**Vice Chair's Report** The Vice Chair's update was not discussed in detail. No questions were raised and The Trust Board **NOTED** its contents.	
5.3.0	**Chief Executive's Report** In presenting the update, the Chief Executive highlighted the following: • The appointment of a new Trust Head of Innovation, Jennet Holmes; a significant post for the Trust. It is anticipated that her experience to date, including working with Innovation Leads across Wales in a variety of sectors, will continue to drive innovation, engagement and collaboration opportunities across the Trust. The Trust Board **NOTED** the content of the update Report.	
5.4.0	**Research & Innovation Board Champion Report** In presenting the Board Champion Report, Professor Andrew Westwell highlighted the following: • A Research & Innovation Champion has now been implemented in all Trusts / Health Boards within Wales, who now meet regularly as a peer group. • The purpose of the Research & Innovation Board Champion Role is to	

	raise awareness and secure priority of Research on the Board agenda within Health Boards and Trusts. • There is significant evidence to support the benefits of research activity within organisations, such as delivery of better standards of care and improved patient experience and a higher level of recruitment retention. A number of selected research achievements had been included for noting. The Trust Board **NOTED** the content of the Research & Innovation Board Champion Report.	
6.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
6.1.0	**VUNHST Risk Register** The report informed the Board of the status of reportable risks in line with renewed risk appetite levels and progress against the Risk Framework. Lauren Fear highlighted the following: • The assurance level rating for the Risk Register had been rated at Level 1 to date since the introduction of the new reporting format; it had been suggested at Executive Management Board to raise this to Level 2 due to improvements made to the quality of the action plans. Level 3 has yet to be reached due to the significant length of time of a number of open risks. • The current cycle of review will focus on addressing the length of time high scoring risks have been open versus the lack of movement to reduce the risks to target level. • An in-depth review of two risks was undertaken at the 13th July 2023 Quality, Safety & Performance Committee; it was advised that this will remain a regular item. • In discussing raising the assurance level from 2 to 3, the 26th July Audit Committee suggested the use of a target risk score date and associated path to achieve this; this will be worked through with risk owners in readiness for the next reporting cycle. • The Audit Committee had identified one risk not published on the Trust website. • Following discussions in the May 2023 Strategic Development Committee in relation to the Trust Assurance Framework, a refresh of risks was anticipated by July 2023. However, this had not been achieved due to other commitments and will be completed by the September cycle. The use of the assurance rating and associated governance processes was welcomed. Stephen Harries queried the low compliance rate in relation to the Introduction to Risk training and the feasibility of the completion of this within 6 months. Lauren Fear advised that this was in fact ahead of schedule and continues to be monitored on a regular basis. 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. • **NOTED** the on-going developments of the Trust's risk framework.	
6.2.0	**Performance Management Framework (May 2023)**	

In presenting the Trust Performance Management Framework Report, Carl James highlighted the following:

- The continued evolution of the Framework and Trust approach.
- Improved link between organisational requirements (e.g. quality, diversity, Welsh Language requirements, sustainability) service delivery and facilitation of this by the Trust's support services (digital, estates, workforce).
- Requirement for the Board to focus on the most important elements (due to the significant number of measures within the Framework).
- Emerging challenges in terms of service delivery.

Velindre Cancer Service:

- Cath O'Brien indicated increased pressures in relation to SACT delivery against target. A significant amount of work is underway to identify and address impeding factors. It had been identified that PICC (Peripherally Inserted Central Catheter) lines have seen a 20% increase and immediate action has been undertaken to extend current service provision in addition to onboarding of external ideas and sharing of information from Cardiff & Vale University Health Board to further streamline the service. Current areas of focus are streamlining of systems and processes, capacity and flexible use of staff and support of the service from elsewhere.

Nicola Williams advised that the Trust's Integrated Quality & Safety Group is currently developing proposed quality measures for the organisation as part of the Trust's Duty of Quality requirements, with a priority plan anticipated by the end of the summer.

Gareth Jones queried the 'paused' performance status of the percentage of Outpatients seen within 30 minutes of the scheduled time, therefore not achieving the target. Cath O'Brien explained that this data had been collected manually and continues to be worked through and the timeline for this would be confirmed outside of the meeting.

Vicky Morris questioned the overall use of Level 6 (outcomes realised in full) assurance rating for such a wide-ranging report due to the large number of areas and concerns within, suggesting populating individual key areas of the report with assurance levels.

Welsh Blood Service:

- Further reduction of Platelet wastage during May 2023 for the second month in a row.
- Welsh Bone Marrow Registry has continued to see challenges in terms of recruitment, however, there is some early evidence of post-pandemic recovery.

Workforce:

- Sarah Morley highlighted good performance in terms of Core Skills and Training Framework compliance (87%).
- 72% compliance with Personal Appraisal Development Reviews (PADRs) carried out by Managers.
- Continued reduction in rolling average of absence levels – 5.64% reported 20th July, noting a decrease in long-term absence. It was noted that the 3.54% target is a Welsh Government target which is currently still under review and an update would be provided at the September Trust Board.

	Gareth Jones requested an update on the Trust's position following previous discussions in relation to pressures within the organisation and resource requirements / best use of staff. Cath O'Brien advised that an exercise to review all major areas of work and transformation programmes had been undertaken, scoping out workforce requirements for each individual programme. Completion of this work is anticipated in October 2023. **Estates:** • Carl James indicated continued reduction in carbon emissions and improved waste recycling. • No RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable incidents of workforce for the period. • Improvement in statutory mandatory training compliance. It was recognised that further improvement is required. The Trust Board **NOTED** the content of the report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 3.	
6.3.0	**Financial Report (May 2023)** In presenting the report outlining the financial position for the period ended (month 2) May 2023, Matthew Bunce highlighted the following performance in relation to the standard performance indicators: • An expected revenue outturn forecast of breakeven. • Capital expenditure remained within the Capital Resource Limit. • The Public Sector Payment Performance Target was met, at upwards of 98%. • Delivery of savings target remains on track, with areas of concern being addressed via the appropriate routes. It was advised that alternative measures would be accessible to cover the shortfall (e.g. use of recurrent savings) failing delivery of all savings schemes. • Positive current position for the Trust. Gareth Jones highlighted the Digital Health Care Record Risk (likelihood – medium) and potential loss of £2m income should the issue not be rectified and the potential for reclaiming the amount. Matthew Bunce advised that the risk has since been downgraded following significant improvement in the position, with a view to resolution. The Trust Board **NOTED** the content of the May 2023 financial report and in particular, the yearend financial performance which at this stage is reporting a breakeven position.	
7.0.0	**The Trust Board paused for lunch**	
8.0.0	**ANNUAL REPORTS 2022-2023**	
8.1.0	**Annual Patient / Donor Experience Report 2022-2023** Vicky Morris noted that Nicola Williams had facilitated the sighting of all annual reports at the July Quality, Safety & Performance Committee, acknowledging the commitment and timescales all Leads had worked to, to ensure the requirement had been met, in addition to subsequent consideration at Trust Board.	

	In presenting the Annual Patient / Donor experience report, Jade Coleman highlighted the following key areas: • The discrepancy between percentages in the report and Trust Annual Report is due to percentages in the Annual Patient/Donor Experience report representing overall patient / donor satisfaction scores, whereas percentages in the Annual Performance Report represent patients who have responded that their experience was 9 out of 10 or higher. • Positive feedback in the main, with VCS reporting 93% of patients experiencing excellent service and 98% of donors (WBS) reporting complete satisfaction with their overall experience. • Steady reduction in the number of concerns being raised, supporting the reported high satisfaction scores. Improvements continue in areas where concerns are raised. • Development of 'always on' reporting metrics to aid continued improvements and real time investigation of concerns, required following the introduction of the Duty of Candour. Metrics will be presented via a dashboard, with anticipated go-live of 1st August 2023. • Development of a 'one page' donor experience poster following feedback from the Quality, Safety and Performance Committee, circulation of which is anticipated shortly. • The use of CIVICA has much improved collection of feedback and visible encouragement of this via 'you said…we did' boards continues. Active use of feedback will facilitate changes within services and information regarding how to raise a concern will be made visible in all patient and donor facing areas. Vicky Morris requested the inclusion of specific outcomes in future reporting, where a reduction in complaints in specific areas / departments had been evidenced as a result of learning and applied improvements. David Cogan raised the following questions: • Whether it was recognised that despite high percentage scores, the number of responses is relatively low. • How more patients can be encouraged to provide feedback. • Whether information from a higher level of feedback would be broken down to identify whether it was received from patients or their families. Nicola Williams advised that efforts to increase the number of patients providing feedback is a priority and is being undertaken with departmental managers. Additionally, the CIVICA system allows significant drill-down of information and it was advised that the majority of feedback is received from patients. Survey questions will also be updated as part of a national scheme. Martin Veale queried whether an alternative reporting route for staff concerns was in place. Sarah Morley indicated that the 'work in confidence' platform and exit interviews are currently used for this purpose and that it is also the intention to reinstate the staff survey from September 2023. The Trust Board **APPROVED** the 2022-23 Trust Patient / Donor Experience Annual Report. Following approval, the report will be translated into Welsh and published on the Trust website.	
8.2.0	**Putting Things Right Annual Report 2022-2023**	

	Nicola Williams advised the Board that this is the first iteration of the report to include Claims, Inquests, Redress (previously reported at Private Trust Board) for transparency. The report provided an overview of Trust-wide concerns activity for the period, including issues relating to performance, concern analysis, key themes and trends, learning and resulting continuous improvement. Zoe Gibson highlighted the following key items: • Demonstration of the Trust's ongoing commitment and focus on actively listening to patients, donors and families and active engagement should issues arise; this is key to facilitating improvements and allowing the Trust to identify areas of learning and achieving Trust requirements under the Duty of Candour. • Key points of focus for the future include implementation of the Health & Care Quality Standards, extensive review of existing policies and procedures, optimisation of compliment reporting and development and implementation of a Quality Management System to inform the Trust's quality approach. Nicola Williams added that this year's more structured approach (via the Integrated Quality & Safety Group) had considered how activity / issues during 2022-23 could inform the Trust's safety priorities, safe care collaborative priorities and clinical audit plan. In terms of concerns management, Nicola Williams also advised that feedback received from the Public Service Ombudsman had indicated that the investigation process is robust and feedback is transparent. The Trust Board **APPROVED** the 2022-23 Putting Things Right Annual Report 2022-23, recognising the increase in assurance level following the July Quality, Safety & Performance Committee. Following approval, the report will be translated into Welsh and published on the Trust website.	
8.3.0	**Local Partnership Forum Annual Report 2022-2023** In presenting the Local Partnership Annual Report, Sarah Morley highlighted the following key items: • Continued Trust commitment to working with Trade Union colleagues, achieved by forging clear and transparent relationships. • Recognition that the Trust does not possess the desired strength of Trade Union representation in order to fulfil its obligations under partnership working. • Development of a Partnership Working Action Plan, where the Trust is working with Trade Union Colleagues to actively strengthen partnership working across the organisation. No comments or questions were raised and the Trust Board **NOTED** the content of the Local Partnership Forum Annual Report 2022-23.	
8.4.0	**Equality, Diversity & Inclusion Annual Report 2022-2023** The report outlined the demographics as an organisation under each of the 9 protected characteristics under the Equality Act 2010, reported by all public sector Organisations on an annual basis. Hilary Williams had previously requested a comparison within each section between the organisation's demographics and the demographics of the	

	population served by the Trust. Sarah Morley advised that as the Trust provides both regional and national services, the national demographic had been included in the report as a comparison. Martin Veale raised the following: • Suggestion of using 'south east Wales' specific data (potentially sourced from Local Authorities) as opposed to national data. Dr Edwin Massey indicated that as the Trust has a number of staff from outside of the region, this therefore may not be the appropriate option. • Validity of comparative data included in the Gender Reassignment section of the report and ambiguity between 'gender reassignment' and 'gender identity'. • Use of the terms 'sex' and 'gender' in the same section. • Elimination of pay gaps – gaining a wider picture of pay gaps across other categories outside of gender (ethnicity, disability, etc) to identify possible issues within the Trust. Sarah Morley advised that racial pay gaps would be considered as part of the Workforce Race Equality Standard, to be introduced later in the year. The Trust Board **APPROVED** the Equality, Diversity & Inclusion Annual Report.	
8.5.0	**Gender Pay Gap Annual Report 2022-2023** The Gender Pay Gap Annual report is required to report on mean, median and bonus gender pay gaps. Sarah Morley highlighted the following key items: • The Trust's mean gender pay gap remains at 13%, presenting a concern for the core organisation and requires continued improvement. • The agreement of six long term actions following the previous Gender Pay Gap Report, which will remain the key focus to further reduce the gender pay gap and how these will be achieved. No questions or comments were raised and the Trust Board **APPROVED** the Gender Pay Gap Annual Report.	
8.6.0	**Welsh Language Annual Report 2022-2023** The report detailed the Trust's activity, progress and compliance with the Welsh Language Standards over the period. Sarah Morley highlighted the following key items: • Recognition that the Trust currently does not meet the standards within the organisation both in terms of service delivery and internal processes. • Establishment of working groups within both Divisions to address relevant elements of the Welsh Language Standards. • The challenges of implementing changes, for example the requirement for staff to answer the telephone in Welsh and support basic initial conversation before transfer of the patient to a competent Welsh speaker. • Welsh Language Commissioner's investigation – It is understood that the Trust has yet to reach 100% compliance with the Standards; however it is anticipated that this will be achieved over time and is being actively pursued as an organisation.	

	Gareth Jones advised of his recent attendance at a webinar with the Welsh Language Commissioner, who appeared realistic but ambitious about the Trust's achievements. It is the expectation that the Trust will seek to overcome current challenges in this area and demonstrate how meeting the Standards will be achieved as soon as possible to avoid further scrutiny. Vicky Morris queried the level of assurance in the report and it was agreed to amend this prior to publication. Carl James questioned whether it would be of benefit to include Welsh language training in the remuneration within job descriptions where Welsh is deemed essential. Sarah Morley advised that while such strategic conversations were not underway at a national level within the NHS, the organisation could potentially stipulate in job advertisements that while it is possible to appoint a non-Welsh speaking individual, it would be a mandatory requirement of the post that they learn the relevant level of Welsh. The Trust Board **APPROVED** the Welsh Language Annual Report 2022-23 prior to publication.	
8.7.0	**Professional Regulation / Revalidation Assurance Report 2022-2023** The report provided a summary of professional registration / revalidation lapses or breaches over the period. Nicola Williams highlighted the following: • One NMC lapsed registration during November 2022; an employee had failed to revalidate by the required timescale due to being off work at the time. • One instance of use of another NMC registrant's details to authorise revalidation; this was investigated and reported via the appropriate routes. In both cases, neither employee practised without a live registration. The Trust Board **APPROVED** the Professional Regulation / Revalidation Assurance Report 2022-23.	
9.0.0	**PLANNING & STRATEGIC DEVELOPMENT**	
9.1.0	**Approval of replacing a 3rd (Linear Accelerator) Linac @ VCC** In presenting the paper, Cath O' Brien re-iterated the ongoing fragility of the Linac fleet, with LA7 having remained non-operational in recent months. In addition to the commencement and acceleration of the initial (LA6) Linac replacement and planning and agreement of a second (LA5) Linac replacement, the Trust seeks to replace a third Linac, on the understanding that fragility would be much improved. Additionally, this would enable continuity of service, as end-of-life notifications have been received for two other Linacs (LA1 and LA3). Preliminary discussions have been undertaken with Welsh Government to assess capital funding and contract arrangements and their ability to meet the request; the necessary provision has also been included in the nVCC Full Business Case.	

	Cath O'Brien confirmed that this is a movement within the existing contract as opposed to an addition. The Trust Board **APPROVED** the recommendation to replace a third Linac at VCC.	
9.2.0	**Velindre Oncology Academy** Nicola Williams provided a brief overview of the proposal to develop a Velindre Oncology Academy and its potential impact, advising that the Full Business Case (including commercial and financial elements) would be presented at the Private Trust Board meeting. Hannah Russon, Project Lead, highlighted the following key items: • The undertaking of a benchmarking exercise in conjunction with similar UK Academies / Schools (to identify funding requirements and to support the intention that the Academy should eventually become self-funding). • Engagement with all professional groups within the cancer centre in relation to Stakeholders. • Undertaking of a scoping exercise of the current existing education resource within the cancer centre, identifying inequities in education provision and resource across professional groups. • Increased digital capability to deliver courses outside our own area. • Benefits to the organisation in relation to recruitment and retention, development of an agile workforce and ultimately, beneficial to patient outcomes. • Identification of gaps in the market in terms of courses. • Recognition for the organisation. Nicola Williams reiterated that there is a robust case for developing an Academy, which would not only service the Trust, but NHS Wales and beyond. Three options had been considered at the July Strategic Development Committee, resulting in the endorsement of option 3 for Board approval *(Establishment of a full Velindre Oncology Academy in line with the best in the UK)*. Hilary Jones queried whether there was sufficient capacity to achieve the delivery plan and Nicola Williams advised that this would be feasible provided the requirements of the Full Business Case are met. The Trust Board **APPROVED** in principle the proposal to develop a Velindre Oncology Academy, pending receipt of the Full Business Case.	
9.3.0	**Framework Scheme of Delegation for Major Capital Programmes** Matthew Bunce advised that the paper set out the proposed Framework Scheme of delegation for major capital programmes. It was noted that the Trust continues to progress through significant strategic levels of change due to its transformation programme, with several major capital programmes either currently in progress or approaching the final stages of full business case approval. The Framework had been developed following an internal audit report issued in December 2022 in relation to the nVCC contract management and non-compliance issues. Following discussion with two Local Health Boards which had encountered similar issues, shared learning has been applied	

	within the Framework to enable the Trust to address issues in relation to contract management of such capital programmes. Additionally, a review by the Trust's Audit Committee had also been undertaken and it was advised that all resulting recommendations had been included within the Framework. Matthew Bunce provided the Board with a detailed overview of the approach taken to the development of the Framework, noting a number of policies and procedures with which the Framework should be used in conjunction. It was suggested that the inclusion of further narrative in relation to the reporting of governance routes in relation to contract management for each major capital project would provide additional clarity and assurance. Following detailed discussion, the Trust Board: • **DISCUSSED / REVIEWED** the proposed approach to the development of model Scheme of Delegation and Governance Framework for Major Capital Projects and Programmes; • **APPROVED** the approach and application of the model Scheme of Delegation and Governance Framework for Major Capital Projects and Programmes to all Major Capital Schemes; • **APPROVED** the Integrated Radiotherapy Solution (IRS) Programme Scheme of Delegation and Governance Framework.	
9.4.0	**Bone Marrow Transplant – Strategic Outline Case (SOC)** Carl James provided an overview of the Strategic Outline Case (SOC), noting that Cardiff & Vale University Health Board is currently developing a Strategic Outline Case (SOC), for the delivery of bone marrow transplant services across South Wales, seeking investment from Welsh Government (capital) in addition to other partners (revenue). This is to include Velindre University NHS Trust and the Trust had been invited to input two additional elements into the SOC (Cardiff Cancer Research Hub and a footprint for specialist Oncology care provision – see below). *Cardiff Cancer Research Hub* - The 2020 Nuffield recommendations suggested that the Trust should work in conjunction with Cardiff & Vale University Health Board and Cardiff University to develop a Cancer Research Hub to enable delivery of novel treatments and research sampling (based on the University Hospital Wales site). Work continues in this regard. *Footprint* – This includes 8 chairs, 8 beds, vaccine preparation room (for the delivery of novel treatment) and 4 complex specialist Oncology beds to allow for treatment of toxicities. This will enable collaborative working with Haematology colleagues and learning, in addition to a combined workforce with Haematology to enable future delivery of such treatments to Velindre patients. The Board was requested to support the SOC, and in doing so, providing a letter of support for the submission of the SOC by Cardiff & Vale University Health Board to Welsh Government. <u>Although no financial commitments are currently being sought</u>, it was recognised that estimated costs would be £60m (capital) and £4.1m (revenue). Andrew Westwell queried the specialist staff required to staff this unit. Mererid Evans advised that several staff members have been funded to undertake training in the delivery of future therapies. However, it was acknowledged that employing a number of new staff would be required over	

	the next two years, with a number or early appointments funded by the Charity. Gareth Jones queried Heads of Terms and operational / legal requirements from all organisations involved and it was advised that this is currently being worked through. The Trust Board: • **NOTED** 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. • **NOTED** 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. • **NOTED** that no financial commitments are being sought at this stage. • **APPROVED** 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.	
10.0.0	**CONSENT ITEMS**	
10.1.0	**CONSENT FOR APPROVAL**	
10.1.1	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chair's urgent action taken between the **25/05/2023** – **18/07/2023** as outlined in ***Appendix 1.***	
10.1.2	**Commitment of Expenditure Exceeding Chief Executive's Limit** The Trust Board **AUTHORISED** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices and **AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.	
10.1.3	**Variation to Standing Orders Velindre University NHS Trust** *This item was removed from the consent agenda* at Lauren Fear's request, to allow for further discussion. The report advised the Trust Board of revisions to the NHS Wales Model Standing Orders, following a review by Welsh Government. Lauren Fear advised that the document would be re-circulated for clarity, to include further amendments following Audit Committee. The Trust Board **APPROVED** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts (noting the amendments raised during Audit Committee).	**LF**
10.1.4	**Variation to NHS Wales Shared Services Partnership Standing Orders** The Trust Board **APPROVED** the amended Standing Orders, incorporating the Scheme of Delegation.	
10.1.5	**Velindre University NHS Trust Business Continuity and Emergency Planning Policy (PP06)**	

	The Trust Board **APPROVED** the Velindre University NHS Trust Business Continuity and Emergency Planning Policy (PP06).	
10.2.0	**CONSENT FOR NOTING**	
10.2.1	**NHS Wales Shared Services Partnership (NWSSP) Committee - Assurance Report (18/05/2023)** The Trust Board **NOTED** the contents of the Assurance Report dated 18th May 2023, setting out the key matters including achievements and progress considered by the NHS Wales Shared Services Partnership Committee.	
10.2.2	**Emergency Ambulance Services Joint Committee (EASC) Briefing (16/05/2023)** The Trust Board **NOTED** the contents of the Public briefing dated 16th May 2023.	
10.2.3	**Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing (16/05/2023)** The Trust Board **NOTED** the contents of the Public briefing dated 16th May 2023, setting out the key areas of consideration, aiming to ensure everyone is kept up to date with activity in Welsh Health Specialised Services.	
10.2.4	**Public Quality, Safety & Performance Committee Highlight Report (13/07/2023)** The Trust Board **NOTED** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 13th July 2023.	
10.2.5	**Public Strategic Development Committee Highlight Report (06/07/2023)** The Trust Board **NOTED** the content of the report.	
10.2.6	**Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report (20/04/2023 and 19/06/2023)** The Trust Board **NOTED** the content of the reports and actions being taken.	
10.2.7	**Remuneration Committee Highlight Report (28/06/2023)** The Trust Board **NOTED** the content of the report and actions being taken.	
10.2.8	**Public Charitable Funds Committee Highlight Report (08/06/2023)** The Trust Board **NOTED** the content of the report.	
11.0.0	**ANY OTHER BUSINESS** The Chair had not received prior notice of any other business.	
12.0.0	**DATE and TIME OF THE NEXT MEETING**	

	The next meeting of the Public Trust Board will take place on Thursday 28th September 2023.	
13.0.0	**CLOSE**	

VELINDRE UNIVERSITY NHS TRUST
PUBLIC TRUST BOARD MEETING 27th JULY 2023
ACTION LOG

ACTIONS ARISING FROM 25/05/2023					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
ACTIONS ARISING FROM 25/05/2023					
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**	**Update 21/09/2023 –** This item is included on the September agenda for discussion.	**CLOSED**
ACTIONS ARISING FROM 27/07/2023					
8.6.0	Amend level of assurance in Welsh Language Annual Report prior to publication on the Trust website.	Executive Director of Organisational Development and Workforce	**28/09/2023**	**Update 21/09/2023 –** This was amended prior to publication.	**CLOSED**
10.1.3	Variation to Standing Orders Velindre University NHS Trust to be re-circulated to Board members with further amendments following Audit Committee.	Director of Corporate Governance & Chief of Staff	**28/09/2023**	**Update 13/09/2023 –** Addressed in final version and circulated to Trust Board members.	**CLOSED**

TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING	28/09/2023

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:

- WBS Donor Awards Ceremony 12th July 2023
- Velindre University NHS Trust Charity
- Jury Duty
- Veggies for Velindre visit
- Welsh NHS Confederation Annual Conference 12th September 2023
- Tripartite Deed of Association
- Walk for Hope 10th September 2023
- Velindre University NHS Trust Employee Excellence Awards 29th September 2023

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 WBS Donor Awards 12th July 2023

Another WBS Donor Awards ceremony was held at the Parkway Hotel, Cwmbran. Donors were celebrated for their 50th, 75th and 100th whole blood donations alongside platelet and bone marrow donors.

The Trust's Independent Board Member, Professor Andrew Westwell, was in attendance as our guest speaker.

A second ceremony was held at Bargoed Farm, Aberaeron, on September 13th 2023. The Trust's Independent Board Member, Vicky Morris, was in attendance. Donor award ceremonies are taking place quite frequently at the moment. They were not held during the pandemic and there are many donors in the system who have yet to receive their awards.

2.2 Velindre University NHS Trust Charity

The Chair and Chief Executive Officer met with Jonathan Davies, President of the Charity during August, to discuss the strategic direction of the charity and upcoming events. The opportunity was taken to than our President for his unstinting support for the charity.

2.3 Jury Duty

The Chair undertook two weeks of Jury Duty in Swansea during August 2023. Stephen Harries, Vice Chair, acted as Chair for the period.

2.4 Veggies for Velindre Visit

'Veggies for Velindre' were inspired by 14 year old Seren and her 12 year old brother Morgan, who acquired an allotment near their home in Treherbert and used this to grow and sell a wide range of vegetables. All funds raised will be donated to the Charity in aid of children's resources. Seren and Morgan have also delivered presentations in two local schools, inspiring wider involvement. Their former and current schools are following in their footsteps, having established their own allotments to grow their own vegetables in aid of Velindre. The Chair recently paid a visit to the two young ambassadors to express her thanks and to encourage the youngsters.

2.5 Welsh NHS Confederation Annual Conference 12th September 2023

This year's Welsh NHS Confederations flagship event took place at the All Nations Centre, Cardiff, on the 12th September 2023, following a conference reception and dinner held at the Hilton Hotel, Cardiff, the previous evening. The Chair and a number of Board members were also in attendance. The conference provided the opportunity to participate in interactive workshops, in addition to networking with other delegates, exhibitors and industry experts, covering a wide range of areas.

2.6 Tripartite Deed of Association

A meeting of the Chair, Chief Executive and other Trust Senior Colleagues took place on the 25th September 2023 with the University of Wales Trinity St David colleagues, for the formal signing of the Tripartite Deed of Association between the Trust and University. The Tripartite Deed of Association will enable the establishment of the Trust's 'Velindre Oncology Academy', in addition to facilitating the formal accreditation of courses delivered via the Academy.

2.7 Walk For Hope

The Chair participated in the 'Walk of Hope' on Sunday 10th 2023, which took place at Dare Valley Country Park. All monies raised from the event will go directly to Velindre Cancer Centre's specialist nurses to continue with the support of patients and their families.

Participating in the walk for hope was a valuable experience as the Chair was able to meet several families whose loved ones had been cared for or were still being cared for at Velindre. It was reassuring and uplifting to listen to their incredible endorsements of the care their loved ones had received at Velindre and there were a number of young people participating.

The event was extremely well organised by Tracey Davies, a Velindre Ambassador. There were excellent arrangements for the safety and comfort of participants and these arrangements were meticulously carried out throughout. The event was a success and participants are keen for it to be repeated.

2.9 Velindre University NHS Trust Employee Excellence Awards 29th September 2023

The 2023 Trust Employee Excellence Awards will take place on Friday 29th September across both Velindre divisions, followed by the Trust's Annual General Meeting. Following a record number of nominations, the Awards present an exciting opportunity to celebrate individual colleagues and teams who have made a difference to experiences and outcomes for donors, patients, families and colleagues. Rewarding colleagues and teams will boost morale, improve profiles and open doors to new opportunities.

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	28/09/2023

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.

During August and September, I covered as Acting Chair on 3 occasions during the Chair's absence on Jury Service and on Annual Leave.

Consultant Oncologist Interviews and Appointments

On 9 August 2023 I chaired Interview Panels for two Consultant Medical Oncologist posts, one for "Skin/AOS" and one for "Urology". I am pleased to welcome the successful candidates, Dr Helen Fitzgerald (Urology) and Dr Allie Shipp (Skin/AOS) to these roles in the Trust and congratulate them on their appointment

Our first Assistant Practitioner

On 4 August 2023, I attended a small event at the Cancer Centre Outpatients department to celebrate the occasion of Becky Bowie completing her Assistant Practitioner education. Becky is the Trust's first Assistant Practitioner (Band 4 nursing support worker), and the team wanted to mark this special occasion. I know that the Board will join with me in congratulating Becky on this excellent achievement.

Wellbeing Champion Visit

In my role as Wellbeing Champion, on 7 August 2023 I met with colleagues from WBS and OD, and our recently appointed Clinical Psychologist (Annette Leponis), to visit the recent staff Wellbeing initiatives there. In addition to refurbished dedicated space within the building, these initiatives include improvements in the grounds, in particular additional "picnic" benches, improvements to paths and routes around the site, and even a bee-hive (sadly, no honey quite yet!)

Trust Board & Committees

During the period, I have attended the following Board Meetings/Sessions:

- Extraordinary Trust Board – 9 August 2023 (I Chaired this meeting on behalf of the Chair)
- Board Briefing Session – 13 September 2023

I have (or will have) Chaired the following Committee and Sub-committee meetings:

- TCS Scrutiny Sub-Committee, Public and Private Meetings – 21 September 2023
- Strategic Development Committee, Public and Private Meetings – 5 September 2023

I have attended the following Committee meetings:

- QSP Committee, Public and Private Meetings – 14 September 2023

External Meetings

On 8 August 2023 I attended a Meeting of Chairs of Health Boards and Trusts, on behalf of the Trust Chair.

On 20 September 2023 I attended a Meeting of Vice-Chairs of Health Boards and Trusts.

Internal Meetings

I have scheduled 1-1 monthly meetings with the Director of Strategic Transformation, Planning & Digital, and with the Chief Operating Officer (COO). I receive monthly updates on Information Governance (IG) matters from the Head of IG (and meet with the Director of Finance and the Head of IG as necessary to discuss).

Staff Wellbeing

On 26 September 2023 I will be meeting with the Director of OD & Workforce, and the Head of Organisational Development to receive an update on, and discuss, Staff Wellbeing issues. Topics to be discussed will included potential future Board Briefing/Development topics, and the production and presentation of the Annual Report to the Board.

I have a standing invitation to the Trust's Healthy and Engaged Steering Group and receive the papers for review.

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	28/09/2023

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 Kyle Page, Business Support Manager
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:

- Intervention Status and Integrated Medium Term Plan
- Joint Executive Team Meeting (JET)
- Working Together staff sessions
- Quality & Safety Systems

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Intervention Status and Integrated Medium Term Plan

The Trust's intervention status has been confirmed as the minimal level of "routine arrangements" for 2023-2024. In addition, the Trust's Integrated Medium Term has been approved by Welsh Government.

2.2 Joint Executive Team Meeting

Following the Joint Executive Team Meeting on the 19th May 2023, to discuss the Trust's end of year position across a number of key areas, formal feedback has now been received from Welsh Government officials. Please refer to *appendix 1* for further information. The actions are being coordinated via Executive Management Board.

2.2 Working Together staff sessions

There are ten sessions organised over the coming months, across divisions and corporate services in the Trust, to provide an opportunity for staff to get together

for discussion with the Executive Board and Senior Leadership Team members to discuss what it feels like to work for the Trust today. The approach is part of the Building our Future Together organisational change approach, which the Trust Board signed off in March 2023. This will then become a regular way of engaging with staff across the Trust and the key themes, and action taken as a result, will be fed back through the Building our Future Together reporting, starting in November 2023.

2.3 Quality & Safety Systems

The Chief Executive would like to update the Board on recent discussions at the NHS Leadership Board following the tragedies that occurred in the neonatal unit of the Countess of Chester Hospital. In summary it was agreed that even in advance of more formal review and Inquiry, we should all take stock and assure ourselves that the mechanisms that we have in place to support quality and safety governance are robust and well implemented across our organisations. The Director General Health and Social Services/ NHS Wales Chief Executive has summarised these discussions in a letter which will be shared with Trust Board members. This includes a request for all NHS Wales organisations to complete a self-assessment against the “Framework for Speaking up Safely in NHS Wales”. The Chief Executive will update the Board at the next meeting following this assessment being progressed through Executive Management Board.

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	Not required

COMPLETED	
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.

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Steve Ham
Chief Executive
Velindre NHS Trust
Corporate Headquarters
Unit 2, Charnwood Court
Parc Nantgarw
Nantgarw
Cardiff
CF15 7QZ

25 August 2023

Dear Steve

Joint Executive Team Meeting 2022-2023

Firstly, I would like to offer my apologies for the delay in sending this letter after the Joint Executive Team meeting in May.

Thank you for attending the meeting on 19 May with your Executive Team to discuss your organisation's end of year position across several key areas. Thank you also for providing the papers beforehand to aid the discussion, these form an important part of the official record for the meeting.

You set out the organisational context, highlighting how you are working to balance your strategic cultural and structural ambitions to deliver service development and transformation - with quality as a central thread. You also described how you are building on these ambitions through the 'Destination 2033' strategy and how you are engaging staff and stakeholders through 'Building our Future Together' approach to organisational design. You acknowledged this work is evolving and we would be interested to revisit progress at future discussions.

Following the national launch of the new duty of quality and duty of candour in April, you confirmed you had held a Trust-wide briefing on the new duties, which had been well-attended and further sessions will be held on a quarterly basis, as well as considering training for staff to maintain engagement. Development of the Trust's new quality management system and quality dashboard was continuing, with a Board development session planned for June to help ensure ownership can be embedded across the organisation.

Parc Cathays • Cathays Park
Caerdydd • Cardiff
CF10 3NQ

Ffôn • Tel 0300 0251182
Judith.Paget001@gov.wales

Gwefan • website: www.gov.wales

It was encouraging to hear how the Trust's integrated quality and safety operational group has helped inform the definition of your quality priorities and your clinical audit plan, and how you are also using this group to draw in learning from across NHS Wales. You also explained work had commenced around value-based healthcare, with a particular focus on PROMs. You were also making progress against the five Safe Care Collaborative projects, and you had recently launched your nursing strategy.

You also described how, as part of being seen as an attractive employer, several proof-of-concept courses have been set up through the establishment of the Velindre Oncology Academy and work was taking place with University of Wales Trinity St Davids to seek accreditation, with a view to developing an NHS Wales-wide training offer. It was pleasing to hear that progress has been made on the patient donor experience and that the CIVICA patient experience system has now been embedded. You reported that there were nine nationally reportable incidents during the year and reviews were undertaken to ensure they do not occur again.

You reported there has been a sustained delivery of cancer services over the last 12 months, despite considerable variation in tumour sites and the flow of patients from health boards, as well as the increasing number of new treatment options. It was noted there have been particular challenges related to SACT delivery in quarters 1 and 2 of 2022/23 and increased demand and complexity, particularly in radiotherapy services. The replacement of the first LINAC, implementation of the DHCR and new RRTT targets had also been key challenges in 2022/23.

Despite these challenges, it was encouraging to hear about the innovative ways of working you have been exploring, including the MDT for immuno oncology, your support for the Genomic Partnership Wales programme and plans to expand use of virtually assessed patient (VAP) clinics. You also described collaborative working with CVUHB to develop a clinical model for a complex specialist oncology service, which could potentially be applied on a regional basis. The Integrated Radiotherapy Solution (IRS) project is expected to provide increased granularity to highlight where improvements can be made at different stages of the pathway. You acknowledged that while you have begun work around AI and machine learning, there is more you could do to exploit the opportunities these emerging technologies could offer, so we would encourage you to link in with Mike Emery as part of the proposed AI Commission for NHS Wales.

On the blood service, you reported another strong year of delivery, supported by effective collaboration and mutual aid with other UK nations, in response to variations in demand. Your slides provided detail against key metrics, and the new CIVICA platform is providing valuable real time feedback which has already started to be acted upon. Challenges have included increased venue costs and limited availability of venues for collection sites, as well as the ongoing issue of platelet supply. You described ongoing work with health boards to reduce variation in platelet demand, your collaboration with PHW and Welsh Government to introduce new hepatitis B testing, and the encouraging progress with the blood health plan which has attracted interest from other blood services. We would also be interested to hear more about the plasma fractionation of medicines programme as plans are developed.

On research, development and innovation, you described key projects as part of your portfolio of research studies in cancer and mentioned that the cancer centre's research strategy is being implemented, with a focus on improving access for patients and staff to participate in research studies. You also described opportunities to develop research potential within the blood service. It was encouraging to hear that funding has been secured

to help finance the Cardiff Cancer Research Hub investment strategy and we would be interested to hear how this work develops. We encouraged you to consider how you can build research capacity into your system, bringing in a wider range of professionals and the development of healthcare fellowships, supported by the grant funding made available through your integrated research bid. We also discussed the opportunity for the Trust to put forward a member of staff to support an NMC scoping exercise around regulation of advanced practice.

On workforce and organisational development, sickness absence remained challenging including absence related to anxiety, stress and depression. The Trust is taking a multi-faceted approach, and a team psychologist has been appointed which has been pivotal in outlining the approach moving forward. Compliance for PADR and statutory and mandatory training remained high, the pay progression policy is now fully implemented, and a large piece of work has been undertaken around recruitment and retention to provide additional information and resources to ensure you are able to attract the right applicants.

In terms of finance, I was encouraged to note that, subject to audit, you had met the three key financial targets for revenue break-even; capital expenditure; and public sector payment performance (PSPP). You had also been able to submit a balanced IMTP, though this was based on a number of assumptions, with key risks around £3m and opportunities of around £2.5m, which the Finance team will work through with you.

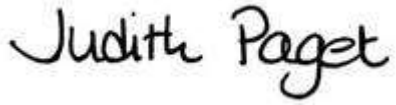
Your future priorities were discussed in detail, supported by your slides, and I would appreciate being kept informed of progress, particularly in relation to planning for the transition to the new cancer centre. You described some examples of how you are working to ensure your service models address health inequalities, though you acknowledged there is perhaps more that could be done and in the context of the anti-racist Wales action plan, by working with your partners to improve equity of access to services (and research studies) and outcomes for all the communities you serve and place these values at the heart of everything you do.

In summary, while recognising the very challenging issues everyone has faced recently, you have managed to maintain essential services over the last year. As an organisation you recognise the importance of focussing on staff well-being and support where they can thrive and are continuing to build and improve upon a high-quality service, and there is room to build on cultural aspects.

You described the changes you have made to your strategic approach to risk management, risk appetite and reporting. You presented a snapshot of the Trust Assurance Framework, showing your long-term strategic risks, which was due to be considered at your July Trust Board meeting.

It is encouraging to see the passion and enthusiasm shown by your leadership team and I would like to take this opportunity to thank you and all your staff once again for their commitment on delivering such high-quality care for patients and their families.

Yours sincerely



Judith Paget CBE

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	28.09.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

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

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

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board – Run	31.08.2023
Quality, Safety and Performance Committee	14.09.2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The current position of the Risk Register was discussed and noted. In depth discussion took place in respect of risks 2465 and 2501 at the Executive Management Board. Following triangulation of information in respect of digital risk the Quality, Safety and Performance Committee were assured regarding the digital risk and the relation to legacy systems.	

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
3	Deep Dive Template

1. SITUATION

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

2. BACKGROUND

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

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 11 risks to report to Board and Committee on Datix 14, this includes 9 risks with a current score over 15 and 1 risk with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Risk Register

- The risk register detail in Appendix 1 is for consideration by the Trust Board.
- In respect of TCS risks; some are reported with expired review date, this is due to there being no governance cycle in August. Following the project meeting is risk will be updated on Datix.
- 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.
- The Quality, Safety and Performance Committee and the Audit Committee requested the inclusion of a date by which the target rating will be received. Where information has been available this has been included manually for submission to the Trust Board on 28.09.2023. A decision has been made to include the target date as a substantive field on Datix, which will be reportable to Trust Board and Committees.

4.2 Risk In Depth Review

The Executive Management Board discussed two risks, which have been open the longest to ensure effective plans ked to discuss risks open the longest, with a focus on the effectiveness of the action plans in place.

The Risks on the register which have been open the longest are:

2465

- Risk open 662 days
- Risk regarding email traffic

The Head of Information Governance joined Executive Management Board to discuss the risk. The root cause of the risk was clarified as the management of communications in respect of patient information and the mechanisms in place to manage the risk appropriately.

It was agreed in the Executive Management Board meeting that the owner of the risk should be the Director of Velindre Cancer Services, as the risk is specific to cancer services and mechanisms in place.

Since the meeting took place the risk has been fully reviewed; resulting in a changed title, risk owner confirmed and an updated action plan and date to reach the target risk grading. There was no change to the current risk grading, however an internal audit is underway to address the underlying causes, with a completion date of 09.10.2023.

2501

- Risk was open for 592 days.
- Risk is regarding inflation rates.

The risk has been reassessed, resulting in a reduction of the current risk rating. The review was signed off at the Project Board on 13.09.2023. Following sign off, the changes will now be reflected on Datix.

Following discussion at the Quality Safety and Performance Committee it was agreed to share the template use to collate information and facilitate discussion in respect of risk deep dives going forwards.

4.3 Digital Risks

In consideration of risks at the July Quality, Safety and Performance Committee there was a request to reflect on risks relating to digital systems. Following review of the risks it was reported to the September Committee that there are no evident trends in digital risks and individual risks related to digital development are unique to each system.

In response to this, the September Quality, Safety and Performance Committee raised a question to whether the multiple digital risks were primarily a result of legacy systems or the workarounds and impact to the service as a result. It was agreed that a detailed presentation on digital risks would be shared at the

Committee in November 2023 and an update will then be included in the November Trust Board paper.

4.4 Next Steps in Engagement and Embedding

- 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.
- Regular reminders are shared in communications across the Trust to remind staff to complete the Introduction to Risk Training.
- As of 29th August 2023 an Introduction to Risk training has a completion rate of 66.8% across VCS, WBS and Corporate.

Compliance Area	Compliance Rate
Corporate	67.88%
Research Development and Innovation	67.3%
Transforming Cancer Services	54.1%
Velindre Cancer Centre	62.99%
Welsh Blood Service	73.91%

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.

- As we approach the six month initial completion deadline work will be undertaken with managers to ensure completion of level one training.

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.

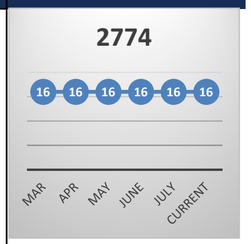
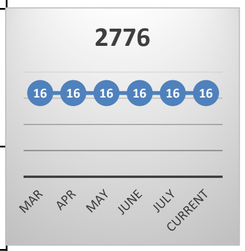
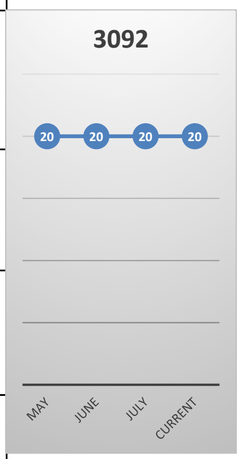
6. RISKS

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	

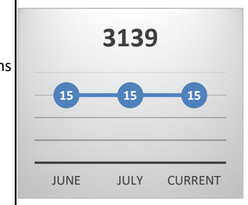
APPENDIX 1

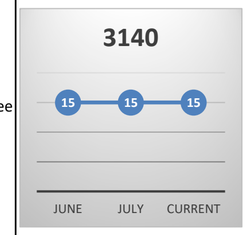
Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

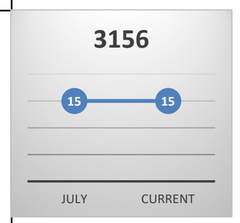
RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, 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

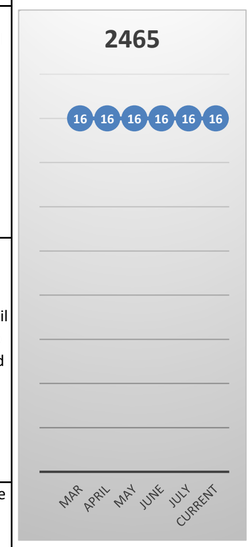
ID	Risk Title - New	Risk (in brief)	Risk Type	Opened	Amount of Days Open	Division	RR - Current Controls	Rating (initial)	Rating (current)	Rating (Target)	Date to Reach Target Rating	Review Date	Action Plan On target Overdue Complete		Risk Rating Trend
2774	There is a risk to Quality and Safety as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	Data entry/transcription errors introduced during overly complex manual workaround processes could potentially lead to issue of incorrect test results and clinical advice, which could impact patient safety. 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. Staff are required to check multiple spreadsheets to decide which tests need to be done. In an on call situation, a single member of staff is required to manually check information in multiple places. There are longer-term plans to implement a new system. Once implemented, the replacement system would mitigate this risk.	Quality	27/10/2022	312	Welsh Blood Service	Staff diligence - multiple manual checking stages prior to issue of results and associated clinical advice. Minimal updates progressed within constraints of the existing IT system.	20	20	4	31/03/2025	14/02/2023	31/07/2024	Complete actions for replacement LIMS - see risk 2776	
												29/09/2023	Tender for replacement IT System (Q2)		
												31/12/2025	Implement replacement IT System (Q3)		
2776	There is a risk to performance and service sustainability as a result of significantly limited IT expertise to support the ongoing use of outdated, legacy systems, leading to inability to provide core operational services.	Inability to provide core services could lead to patient harm for those requiring acute urgent services and reputational damage. Inability to enhance and develop new transplant services to meet business needs and/or other factors such as changes to external regulatory requirements. Transplant services are reliant on in-house developed IT applications 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. There are longer-term plans to implement a new system. Once implemented, the replacement system would mitigate this risk.	Performance and Service Sustainability	27/10/2022	312	Welsh Blood Service	Working group to manage prioritisation of a 'backlog' of urgent development work needed to maintain the system, and prevent critical failure. Minimal updates progressed within constraint of system and available IT Subject Matter Expert resource. In the event of IT system failure, a business continuity agreement is in place. Core transplant services would be referred to NHS England.	16	16	4	31/03/2025	14/02/2023	28/04/2023	Secure Funding for replacement LIMS	
												29/09/2023	Tender for replacement for IT System		
												31/12/2025	Implement replacement for IT System		
												01/09/2023	Review Risk Assessment		
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.	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.	Multipl Risk Domains	27/04/2023	130	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	20	20	8		31/07/2023	31/05/2023	Risk needs reviewing	
												07/06/2023	Risk needs reviewing		
												31/07/2023	use of WPAS		
												23/06/2023	Query why Chemocare is still part of this risk		

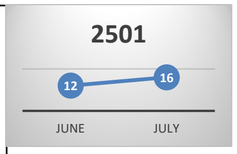
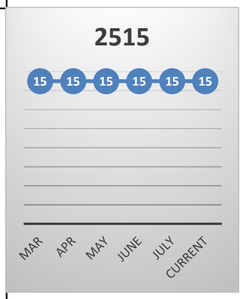
3139	Clearance Limitations There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	There is a risk that the NRW Licence puts limitations on clearance resulting in delays to construction	Performance and Service Sustainability	21/06/2023	75	Transforming Cancer 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	12	15	6	15/09/2023	04/08/2023	04/08/2023	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
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.	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	75	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	12	15	6	16/10/2023	04/08/2023	04/08/2023	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
3156	Transfer of new Equipment There is a risk that delay to opening of the nVCC will lead to the necessity of transferring new equipment which has been procured in the interim leading to greater operational disruption, prolonged commissioning period and costs.	There is a risk that delay to opening of the nVCC will lead to the necessity of transferring new equipment which has been procured in the interim leading to greater operational disruption, prolonged commissioning period and costs.		17/07/2023	49	Transforming Cancer Services	1) Determine impact and seek WG support for revised cash flow - ongoing	10	15	10		04/08/2023	No Action Plan	No Action Plan
2465	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	Safety	05/11/2021	668	Velindre Cancer Centre	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	16	16	4	31/03/2024	29/12/2023	09/10/2023 30/06/2023 29/09/2023	Head of Information Governance (HOIG) has commenced the internal audit, as of 01.09.2023. Following areas have been interviewed: SACT Bookings SACT Preparation SACT Helpline Consultant Oncologist Following activity planned for week email etiquette to be developed as part of hybrid working tool kit and shared widely. To be closed pending All Wales email policy. Associated SOPS will need to be developed to reflect this updated policy. Development will be lead from a Trust level by Head of IG. Timelines - imminent. Reporting will be via QSMG and via EMB IB to undertake an audit into the use of email within the medical directorate and SACT booking meetings continuing to be undertaken. Progress delayed due to demands from COVID inquiry. completion date updated

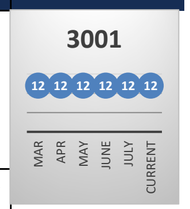




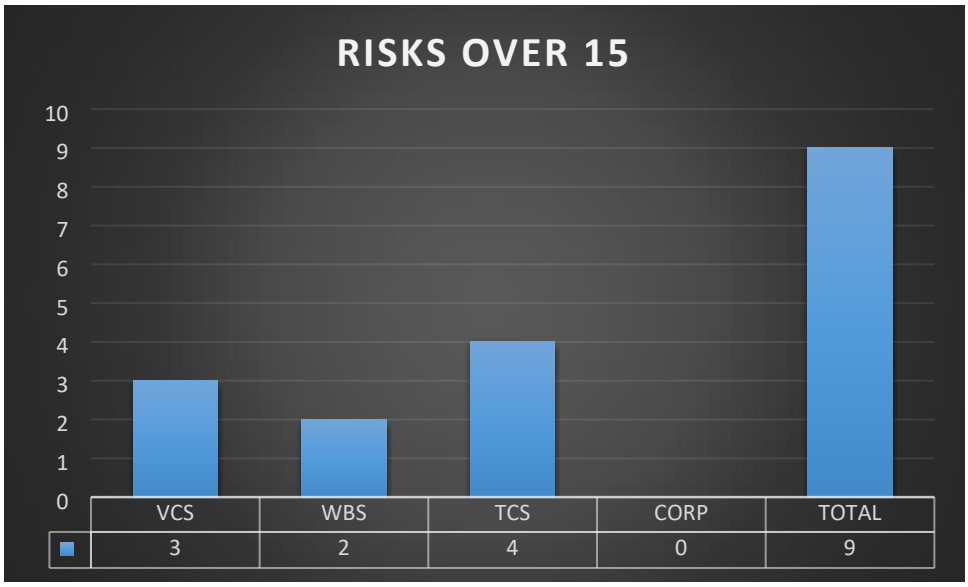




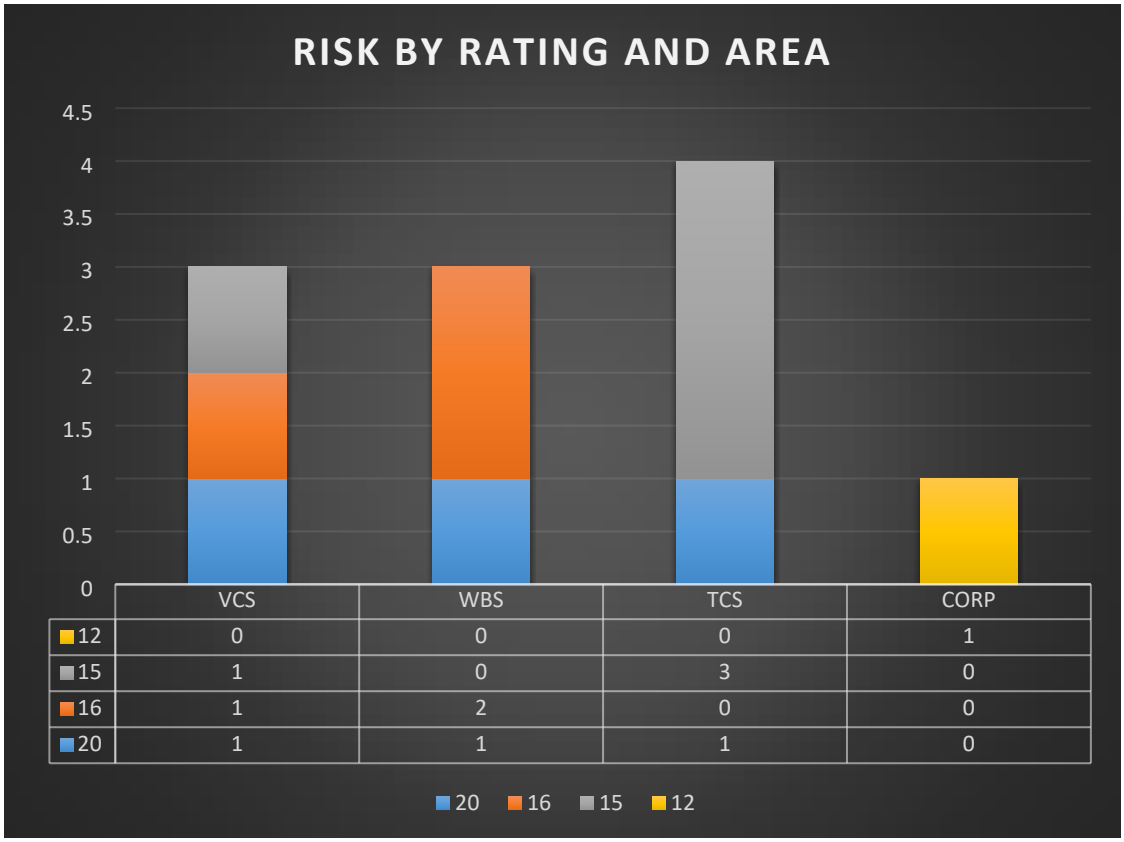
2501	Inflation - There is a risk that increased rates of inflation before financial close lead to the costs of the project exceeding the affordability envelope.	There is a risk that increased rates of inflation before financial close lead to the costs of the project exceeding the affordability envelope	Financial Sustainability	14/01/2022	598	Transforming Cancer Services	1. Discuss with Welsh Government. Increased CAPEX approved. Complete 2. Monitor inflation inline with the financial index. Ongoing	20	16	12		28/07/2023	No Action Plan	No Action Plan	
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.	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. 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.	Performance and Service Sustainability	09/02/2022	572	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 Oncologist in Urology is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. A locum Consultant Clinical Oncologist was appointed in 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. 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 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 September 2023	20	15	15		30/09/2023	30/09/2023	Brachy Workforce	
													14/03/2023	The risk review is overdue	
													28/03/2023	A SMART Action Plan needs to be developed	
													31/07/2023	Insufficient brachy MPE	

ID	Risk Title - New	Risk (in brief)	Risk Type	Opened	Amount of Days Open	Division	RR - Current Controls	Rating (initial)	Rating (current)	Rating (Target)	Expected Date to Reach Target Rating	Review date	Action Plan On target Overdue Complete		Risk Rating Trend
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	Safety	09/12/2022	269	Corporate Services	People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	16	12	9	30/12/2026	31/12/2023	31/03/2024	Divisions/Departments should have proactive stress risk assessments	
													09/12/2022	Formal arrangements not in place for the Healthy and Engaged Steering Group to evaluate wellbeing interventions	
													21/03/2023	This risk needs a SMART action plan	
													22/12/2023	Systemic factors that impact on levels of workforce stress to be described and associated actions plans developed	
													31/03/2024	Develop management training in managing stress	

Data Graphs


RISKS OVER 15
10
9
8
7
6
5
4
3
2
1
0
VCS
WBS
TCS
CORP
TOTAL
3
2
4
0
9


SAFETY RISK RATING 12
1.2
1
0.8
0.6
0.4
0.2
0
VCS
WBS
TCS
CORP
TOTAL
Series1
0
0
0
1
1



	VCS	WBS	TCS	CORP
12	0	0	0	1
15	1	0	3	0
16	1	2	0	0
20	1	1	1	0

Trust Board

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT AND SUPPORTING ANALYSIS FOR JULY 2023/24

Date of meeting	28/09/23
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	**Peter Gorin, Head of Strategic Planning and Performance Rachel Hennessy, Head of Operational Services and Delivery, Sarah Richards, Interim General Services Manager**
PRESENTED BY	**Cath O'Brien, Chief Operating Officer, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance**
APPROVED BY	**Carl James, Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**1. VELINDRE NHST PERFORMANCE MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD TO JULY 2023/24** 1.1 This paper reports on the performance of our Trust for the month of July 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 overview, in Section 2, draws attention to key areas of performance across the organisation as a whole, highlighting the interconnection between many of these areas 1.3 The Performance Management Framework (PMF) Scorecards, in Section 3, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care. 1.4 Each KPI is supported by data, in Appendices 1 to 3, that explain 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. 1.5 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. 1.6 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 Appendices 1 to 3.** • **The new style PMF Performance reports continue to be developed by the PMF Project Group, with a number of potential new measures currently under consideration.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	**16 August 2023**
VCS SLT / Performance Review	**18 August 2023**
Executive Management Board – Run	**31 August 2023**
Quality Safety and Performance Committee	**14 September 2023**
Summary and outcome of previous governance discussions **The report has been considered and endorsed at the VCS and WBS Performance Review meetings, EMB 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	**Select Current Level of Assurance**

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 FOR JULY 2023

The following paragraphs provide an overview of our Trust-wide performance against key performance metrics through to the end of July 2023 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2.1 Cancer Centre Services Overview

There has been significant improvement in SACT since the last reporting period with compliance for July for 21-day time-to-treatment performance target increasing from 90% to 94%. Challenges remain with nursing and pharmacy workforce capacity and a recruitment and resource plan is under development to meet the revised forecasts.

Targets were met for Pressure Ulcers, Falls, SEPSIS, Hospital Acquired Thrombosis (HAT), Occupational Therapy and Speech and Language Therapy waiting times. Staffing remains a challenge within the dietetics department due to vacancies and in physiotherapy services, impacting on waiting time. In dietetics, we have recruited locums to cover the gaps but start date was delayed to administrative issues associated with DBS checks. Physiotherapy staffing issues relate to pressures due to a combination of annual leave and training requirements on WPAS for a member of staff only recently returning to work following a period of maternity leave.

There were eight Delayed Transfers of Care in July. Delays were related to bed capacity challenges that are being experienced across the wider healthcare system which impacts the ability of Velindre Cancer Centre to discharge patients without delay. Velindre Cancer Centre Nurse leads are active members of the All Wales Pathways of Care Delays (PoCD) National Group who are looking at delayed discharges. Discussions continue to take place with Health Boards and Community teams to progress delays. "*Pathways of Care All Wales*" have scheduled visits at Velindre Cancer Centre to provide additional training on the Six Goals of Emergency Care to provide further support in facilitating patient discharge.

Radiotherapy capacity continues to be a challenge due to requests for rescans/replans, late delineation, and linac capacity. Current staffing vacancies and extended periods of annual leave across all Directorates associated with the summer period is impacting on the capacity available to undertake delineation planning in a timely manner. Requests for rescans/replans are due to changes in patients' condition, meaning that do not meeting the clinical specification for the treatment plan which is reviewed on a case by case basis. Due to the fragility of the machinery periods of downtime are being experienced. In order to maintain service delivery for patients, extended working days and weekend working are in place. There are a number of patient delays being experienced in Urgent Symptoms Controlled pathways and Scheduled Elective radiotherapy pathways – each of these patients has been fully reviewed (ie the fuill data has been fully validated) . The data for the Elective delay radiotherapy pathways are still in the process of validation. Any patients waiting longer than 28 days (previous JCCO target) have had a clinical harm review undertaken and no harm deemed to have occurred.

We are still experiencing some data quality issues related to the implementation of the DH&CR which continues to cause significant administrative challenges across Velindre Cancer Centre. The Medical Records team continue to make significant progress against the backlog of unprocessed documents through the support of additional resource and ensure that these are enacted in time for the resultant activity. As the system use continues to bed in, a review of use has been undertaken to draw feedback from system users. The DH&CR Operational Group, through a series of resource impact assessments, identified the additional resources needed to meet the requirements associated with the new system. This paper was presented to the DH&CR Project Board and the ongoing resource requirements are now being considered by the senior team and finance colleagues.

To further mitigate the data quality issues that have been experienced, a revised staff training plan, that greater meets the needs of individual users or groups in relation to their specific role, was developed by the IT Applications Support Team and Operational Services and is to be presented to the DH&CR Operational Group in August for review and approval.

2.2 Welsh Blood Service Overview

WBS have continued to perform well during July and all clinical demand was met.

Quality incident investigations closed within 30 days remains well above target (90%) at 96%. There were no reportable events submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in July. One report was submitted to Human Tissue Authority (HTA) regarding a positive blood culture from a stem cell donation after 3 days incubation. The HTA were notified as there is an increased risk to the patient. All relevant processes were followed, and the issue was picked up via routine monitoring. Following an investigation there was no risk to the patient.

Donor satisfaction continues to stay above the 95% target and has remained at 97% in July. 7,488 donors were registered at donation clinics with no formal concerns raised during July and only 4 informal concerns (0.05%) reported during this period which is a decrease from June. One of the informal concerns was managed outside of the required timeline as the service was unable to reach the donor by telephone within 2 days. An email was issued to the donor following attempts to contact by telephone.

Reference Serology performance improved on last month but did not meet target in July. The ongoing training activities of junior members of staff contributed to prolonged turnaround times of non-urgent requests. Training and development of two of the four junior members of staff will be completed between July and November 2023 and performance levels are expected to continue to improve during this period.

All clinical demand for platelets was met representing a strong performance against this metric. Platelet wastage just missed target in July after meeting target for the last three months. This is mainly attributed to a reduction in average weekly demand for the month.

Collection productivity has improved in July but is slightly below 1.25% target at 1.18%. Contributory factors influencing the performance include short term staff sickness and staff vacancies.

Performance for new bone marrow volunteers improved for July but remained below target. The summer months are typically lower due to the reduced blood donor clinics in educational establishments. In addition, the blood supply was under pressure during July, and the targeting of blood groups took place with regular donors being called, which negatively impacted on the number of new donors called to clinic. Work is ongoing to understand how we can address this by considerably increasing swab recruitment. We are currently analyzing the data from previous swab recruitment campaigns to inform the way forward. 519 eligible donors attended blood sessions with a 26% conversion rate.

The total number of collections in July was 6 (comprising of 4 Peripheral Blood Stem Cell and 2 Peripheral Blood Lymphocyte collections). The total cell provision for the service was 9 (6 collected and 3 imported for a Welsh patient). The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80). 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 and will be managed under WBS Futures.

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 employ 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 work programmes 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 5.71% to July 2023 still above the Welsh Government Target of 3.54%. Trust wide PADRs this month has a marginal increase to 74% lower than the 85% target, whereas Statutory and Mandatory training remains above target at 88% and has been consecutively on target for the whole year to July 2023. Details of interventions can be found in the SPC's for these metrics and corresponding action plans.

The Workforce Race Equality KPI's are not going to be available to us until at least June next year as they are dependent on the national implementation of the Workforce Race Equality Standard (WRES).

2.4 Nursing and Quality

The Trust's Quality & Safety Framework continues to be developed by the Integrated Quality & Safety Governance Group at its monthly meetings. The Divisions are also developing a range of Service level Quality and Safety metrics to be included within the Performance Management Framework and these potential measures are given in Appendix 4

A new KPI measuring compliance against the World Health Organisation's 5 moments of hand hygiene best practice continues to meet target compliance of 100%.

2.5 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (97%) and 'Your Velindre experience?' (91%) 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

Performance largely stable, with a slight improvement on performance in June 2023.

Rolling 12-month number of significant IT business continues remains stable at 10, a significant improvement on reported performance earlier in the year. Progress continues to be made in terms of removing legacy IT infrastructure and improving the resilience across both the WBS and VCC sites. This work will continue through 2023/24

Resolution timescales for service requests and incidents logged with the Digital Service Desk improved slightly in July 2023, but remains under the 85% target for both indicators. The Digital Services Desk is now back up to full capacity, and the new Digital Operations Manager has been tasked with developing a service improvement plan, with the aim of instigating processes to ensure targets are achieved by the end of this financial year. Progress has also been made with the recruitment of 2nd and 3rd line support, with two new starters commencing work in September 2023. This should help improve the overall responsiveness of the team.

Reporting arrangements for two remaining (2) indicators are still being developed, delayed due to recruitment challenges and capacity:

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role – this role has now been filled, with the new member of staff due to commence work in September 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. Delivery of routine reporting has been delayed due to competing priorities within the team.

2.7 Estates Infrastructure and Sustainability

The period through to July has realised high levels of compliance for PPM and reactive tasks which are currently listed as green. Recruitment has stalled, with no appointable candidates available for selection for the three advertised posts. Posts have been re-advertised with candidates assessed early September. Two H&S posts are progressing through the recruitment process with a view to get to advert during September. 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, minor improvements are witnessed month on month. 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.
June Patient manual handling figures for WBS appear to have dropped from 90% to 45% was confirmed as an error.

2.8 Finance

The overall position against the profiled revenue budget to the end of July 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 revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

The approved Capital Expenditure Limit (CEL) as at July 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 July'23 of £10.333m and is forecasting to remain within the CEL of £24.416m. A risk to delivery of the Capital programme exists where Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close., however this risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m.

During July '23 the Trust (core) achieved a compliance level of **98.%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.4%** as at the end of month 3, and a Trust position (including hosted) of **98.1%** compared to the target of 95%.

At this stage the Trust is currently planning to fully achieve the savings target of £1.8m during 2023-24. During July replacement savings plans were identified to support several schemes that had turned Red.

The expected underlying surplus to be carried into 2024-25 has reduced from £0.391m to £0.086m as underlying recurrent cost pressures are now forecast to exceed recurrent savings schemes.

On the 31st July the Trust received a letter from Judith Paget (NHS Wales Chief Executive) which provided a view on the overall financial position of Welsh NHS organizations for 2023/24. In response to the financial challenges set out by Health Boards in 2023/24 the Trust has been asked to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the Trust considered options at the extraordinary Board meeting on the 09th of August and have submitted several financial improvement options to WG on the 11th of August to support the NHS Wales Deficit.

3. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION VELINDRE NHST PERFORMANCE SCORECARDS FOR JULY 2023

3.1 The following QSF Scorecard tables show the current performance of VCS and WBS Divisions and Trust-wide services against a range of National mandatory and local stretch targets, highlighting variances in performance. The scorecards incorporate hyperlinks to supporting KPI data, enabling switching between the high-level positions to detailed analysis provided in Appendices 1 to 3, as below.

3.2 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.

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework

Welsh Blood Service

Trust Board Scorecard as at July (Month 04) 2023/24

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 04 (July 2023)			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	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	87%	85%	88%	✓	↑	WOD.19
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	→	KPV.02
	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	1	✗	→	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	2	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	2	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	100%	✓	→	KPV.08
	Number of National VCS Serious Untoward Incidents recorded with Welsh Government	National	Monthly	0	0	0	✓	→	KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	1	✗	↓	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	15	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	99.9 C/m3	85.3 C/m3	✓	→	EST.06

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 04 (July 2023)			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	8	✗	🡻	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	105%	✓	🡻	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%	✓	🡹	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	119%	✓	🡹	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	12%	✗	🡹	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	6	✗	🡻	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54%	5.71%	✗	🡻	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	74%	✗	🡹🡻	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	97%	✓	🡺	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓	🡹	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	🡺	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	NIL	✓	🡺	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	29% 47%	80% 100%	21% 52%	✗	🡺	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	National	Monthly	6% 50%	80% 100%	2% 68%	✗	🡺	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	National	Monthly	94% 100%	80% 100%	100% 100%	✓	🡹	KPV.16

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 04 (July 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	National	Monthly	27% 32%	80% 100%	73% 76%	✗	→	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	94%	✗	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	↑	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	97%	✓	→	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%				KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.004m)	✓	→	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	N/A	£10.333m	£10.333m	✓	→	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.58m	£0.75m	✗	→	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£0.172m	£0.69m	✓	↑	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	→	FIN.60
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.80
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	TBA	TBA	TBA	✓	→	WOD.81

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

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?	
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

SAFETY

KPI Indicator KPV.02

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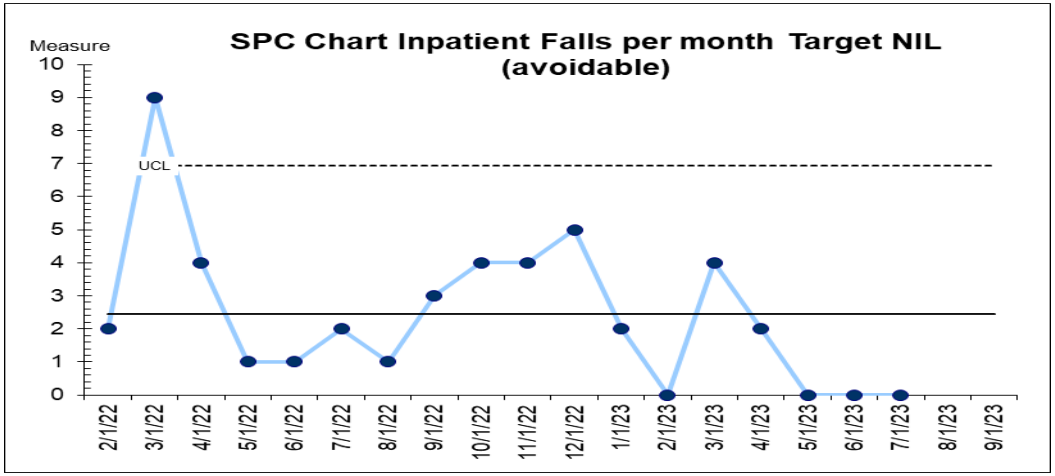
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Jul 23
Actual Number	1	1	2	1	3	4	4	5	2	0	4	2	0	3	5
Avoidable Falls	1	0	2	0	1	2	2	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 over the last 15 months, with a 'special cause' variation of 9 falls in March.

Performance

No avoidable falls in July 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.01

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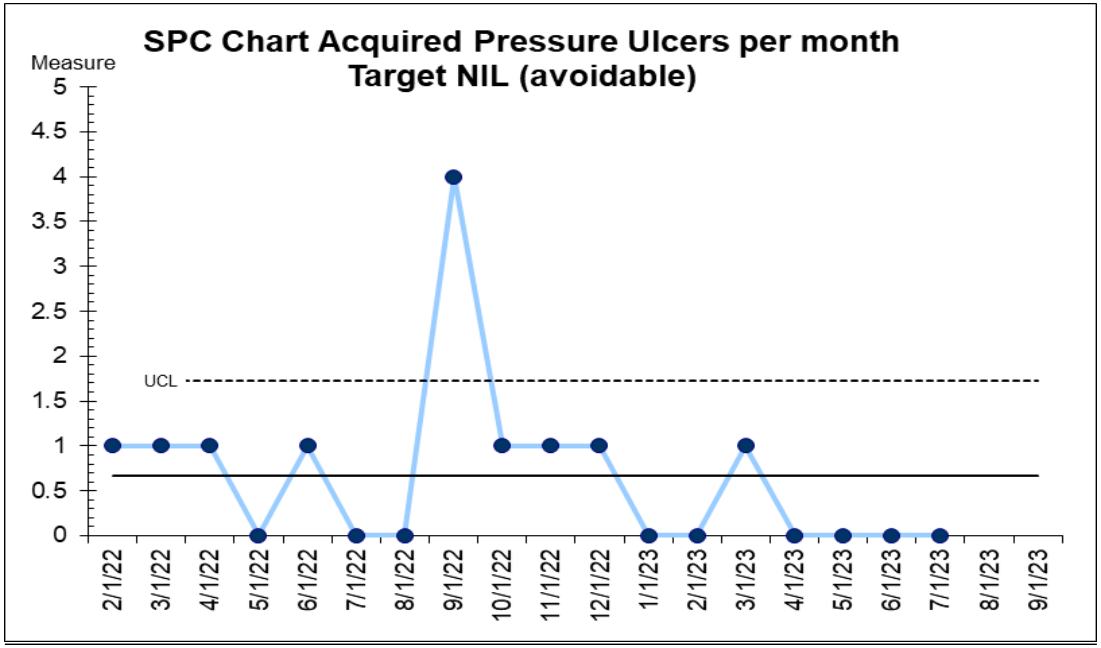
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Jul 23
Actual Number	0	1	0	0	4	1	1	1	0	0	1	0	0	0	2
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 July 2023.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator WOD.19

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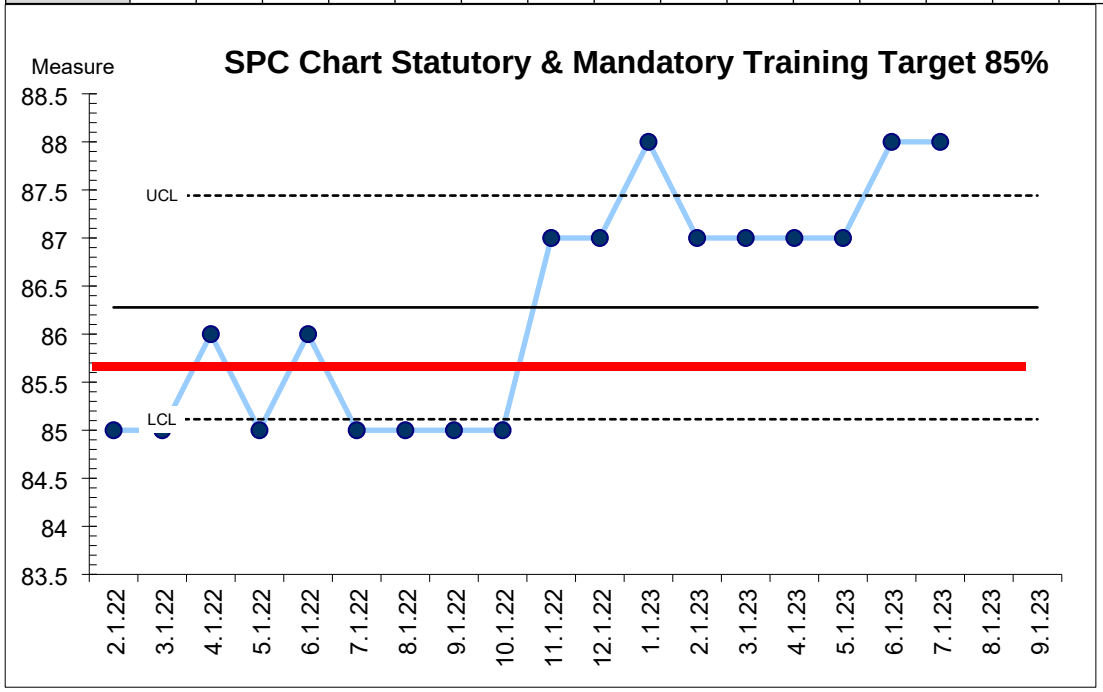
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	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	July 23
Actual %	85	86	85	85	85	85	87	87	88	87	87	87	87	88	88
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 KPV.07

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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	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	Jun 23	Jul 23
Hospital Acquired Thromboses	0	0	1	0	0	0	0	0	0	0	2	1	0	0	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

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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	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	Jul 23
C.diff	0	0	0	0	0	0	0	1	1	0	0	0	0	0	2
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
MSSA	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
E.coli	0	0	1	0	0	0	0	1	3	1	0	1	0	0	1
Klebsiella	0	0	0	0	0	0	0	0	1	0	0	1	1	0	2
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	1	4	1	0	1	1	0	0

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

KPI Indicator KPV.08

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Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by (VCS WBS) Department

Target: 100%

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	My 22	Jun22	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
VCS Hand Hygiene														100 %	100 %
WBS Hand Hygiene														100 %	99.2 %
Trust Hand Hygiene														100 %	99.5 %
IPC Validation														100 %	100 %
Target l00%	0	0	0	0	0	0	0	0	0	0	0	0	0	100 %	100 %

Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by Department based on 20 weekly hand hygiene observations over the month

Plus Infection Prevention Control Team Validation Audits % compliance

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:
• Weekly validation audit by IPCT		IPC

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.60

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Number of National VCS Serious Untoward Incidents(SUIs) recorded with Welsh Government in a calendar month

Target: NIL

SLT Lead:

Current Performance against Target or Standard

	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	June 23	July 23
Actual															
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

[SUI data to be input]

Performance

Assessment of current performance, set out key points:

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

KPI Indicator KPI.30

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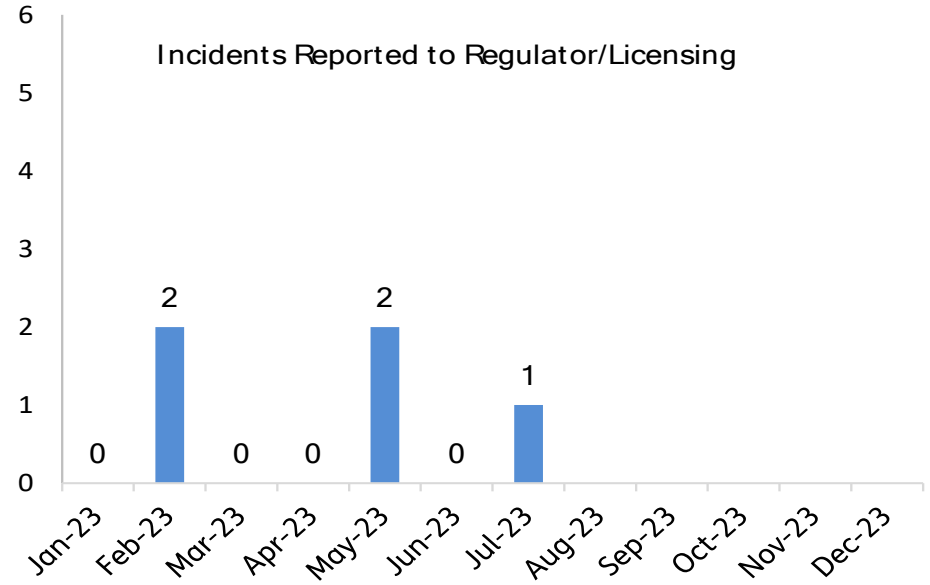
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	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	June 23	July 23
Actual	0	0	1	1	0	0	0	2	0	2	0	0	2	0	1
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Performance

Assessment of current performance, set out key points:

There were no reportable events submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in July and both reports submitted in May have now been closed to the satisfaction of regulators.

In July, one report was submitted to HTA (Human Tissue Authority) regarding a positive blood culture from a stem cell donation after 3 days incubation, post collection. The HTA were notified as there is an increased risk to the recipient. All relevant processes have been followed and the issue was picked up via routine monitoring. Following investigation there was no risk to the recipient as there was contamination detected in the product which indicated an issue with the sampling.

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 and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & safety Hub	Progress is monitored via monthly reporting into the WBS Integrated Quality & Safety Hub.	Peter Richardson

Expected Performance gain - immediate

N/A

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Actions have been introduced as outcome of root cause analysis of these incidents.		

Expected Performance gain – longer-term

N/A

Risks to future performance

N/A

KPI Indicator H&S.55

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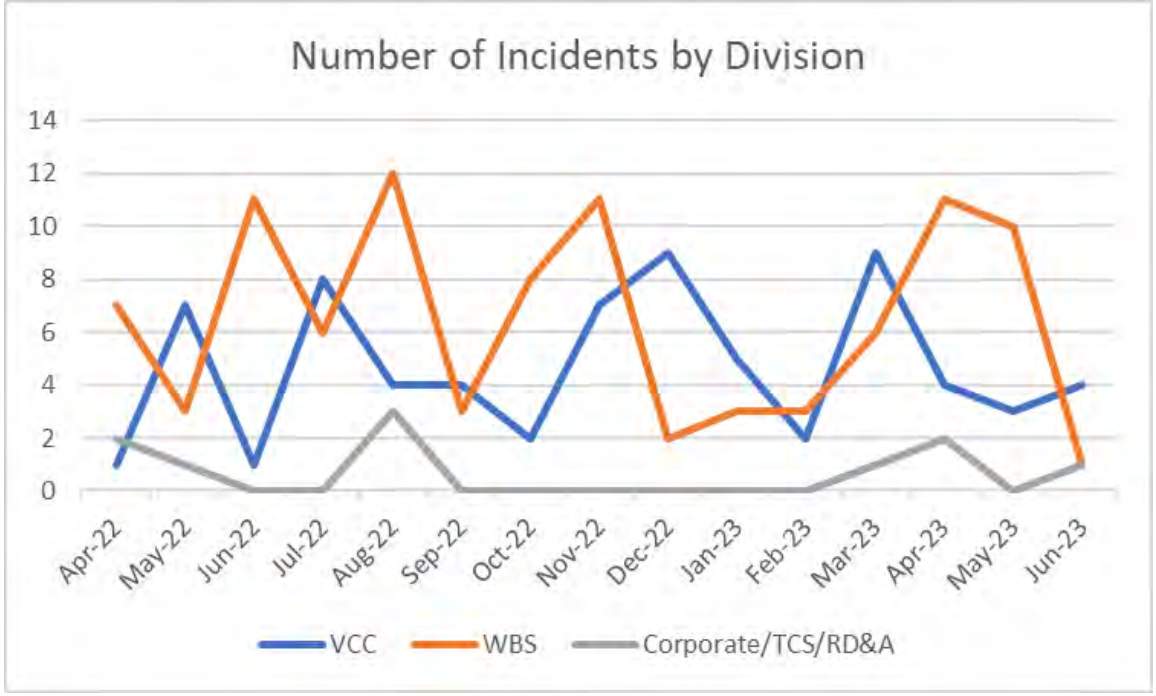
Graph title - Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division

Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

	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	June 23	Jul 23
VCC	1	7	1	8	4	4	2	7	9	5	2	9	4	3	4	6
WBS	7	3	11	6	12	3	8	11	2	3	3	6	2	10	1	9
Corporate	1	1	0	0	2	0	0	0	0	0	0	0	2	0	1	0



Performance - remains stable

Behavioural issues displayed by patient – considering issue of Behaviour Contract

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

VCS – 6 incidents Staff incident – 3 accidents • fall in the car park observed by member of staff no further action. • Staff attacked by dog, no injury sustained. Reported via 101 • Patient exposed to hazardous substance. Additional training identified Inappropriate Behaviour - 1 incident • Patient family member continually being aggressive toward staff and patients Infrastructure – 1 Incident • Staff driving incorrect way down a one way system presenting risk to pedestrians. Department Managers informed, situation being monitored by security Equipment Devices /Manual handling – 1 Incident • New wheelchairs deployed, with locking system which is counter to provision of responsive service. Discussion with the porters had surrounding use of this equipment **WBS** – 9 Incidents Accident Injury – 6 accidents • Road Traffic accident ford Ka crashed into collection lorry • Vehicle damaged while parked in Singleton Hospital • Staff member lost balance getting out of a chair. Fell and bumped head – Under investigation • Staff Member bumped head reaching for their bag – No further action required • Staff member bumped head while plugging device into an electrical socket – No further action required • Staff member cut finger on sharp edge while cleaning cabinet – SOP in place to prevent future occurance Infrastructure – 1 incident • Tree adjacent to car park at Talbot Green collapsed striking a staff members car. Inappropriate Behaviour - 2 Incident • Donor spoke aggressively to a Contact Centre Adviser not the first incident – management review ongoing • The second incident involved a donor that was turned away from donating for travel reasons. Threw pen at CCA and left session.	

KPI Indicator EST.06

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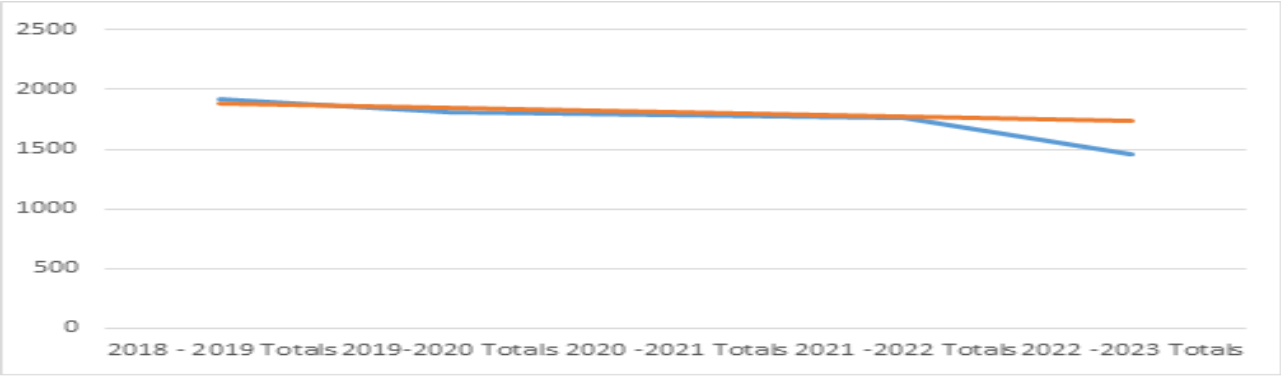
% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline

Target: -16% by 2025

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	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	Jun 23	July 23
Actual Number	134.31	97.97	103.01	95.85	102.66	122.08	172.82	155.55	212.01	179.31	187.06	130.20	111.83	86.13	85.33
Target (-3% from previous year emissions)	179.7298	113.2977	110.6551	104.4917	104.8802	133.9711	190.288	201.7611	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858



We are currently 'on track' (blue line) to meet the Target of -16% Carbon Footprint/Emissions (Orange line) Statutory Regulations reduction by 2025 against 2018/19 baseline – measure carbon parts per million by volume

Performance

Assessment of current performance, set out key points:

- Carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.
- VCC Gas data for June / July is currently under review, therefore the carbon figure for June & July may be updated in due course.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Deacrbonisation Action Plan • Site Based Sustainability Implementation Plan	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – immediate

Ongoing communication and engagement with staff to reduce consumption.

Amendments to the BMS across all sites for better controls.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Continuing monitoring • Improvement to monitoring energy through the BMS	XX/XX/XX XX/XX/XX	AN Other 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

-

EFFECTIVENESS

KPI Indicator KPV.05

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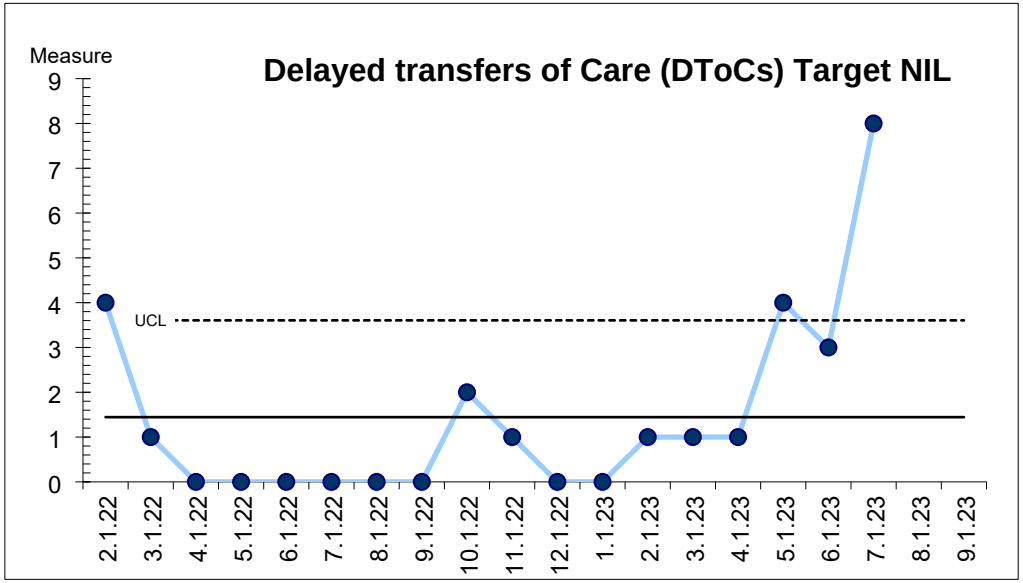
Number of Delayed Transfers of Care (DToC) Should we change this to the new WG descriptor i.e. Pathways of Care Delays (PoCD)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	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	Jul 23
Actual %	0	0	0	0	0	2	1	0	0	1	1	1	4	3	8
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC Chart shows 'special cause' or exceptional variations in May and July for pathways of care delays.

Performance

Assessment of current performance, set out key points:

There were 8 DToC reported in July 2023.

Social DToC

Patient 1: Awaiting fast track discharge home with a delay of 3 days.

Patient 2: Awaiting fast track discharge home with a delay of 5 days.

Patient 3: Awaiting package of care allocation with a delay of 8 days.

Repatriation DToC

Patient 1: Awaiting repatriation to local hospital with a delay of 2 days.

Patient 2: Awaiting repatriation to local hospital with a delay of 5 days.

Patient 3: Awaiting repatriation to local hospital with a delay of 1 day.

Patient 4: Awaiting repatriation to local hospital with a delay of 8 days.

Patient 5: The patient was initially planned for discharge home, however the patient required ongoing therapies input and therefore was repatriated to their local hospital for convalescence.

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 NHS Exec PoCD group, BI have provided assistance and data is now being uploaded nationally as required. Individual patient discussions are taking place daily with HB and community teams to progress any delays. It is acknowledge that there are bed pressures across the whole system which impacts on patient discharge/transfer. Pathways of Care All Wales leads are visiting VCC to provide additional training on the Six Goals of Emergency Care to further support and facilitate patient discharge.		**Matthew Walters Operational Senior Nurse** **Matthew Walters Operational Senior Nurse**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

	Actions: what we are doing to improve Membership of all Wales POCD group, opportunity to discuss with HB colleagues and review national data including VUNHST data identifying themes and patterns.	**Timescale:**	**Lead:** **Matthew Walters** **Operational Senior Nurse**
	Expected Performance gain – longer-term		
	Risks to future performance		
	Set out risks which could affect future performance		

KPI Indicator KPI.04

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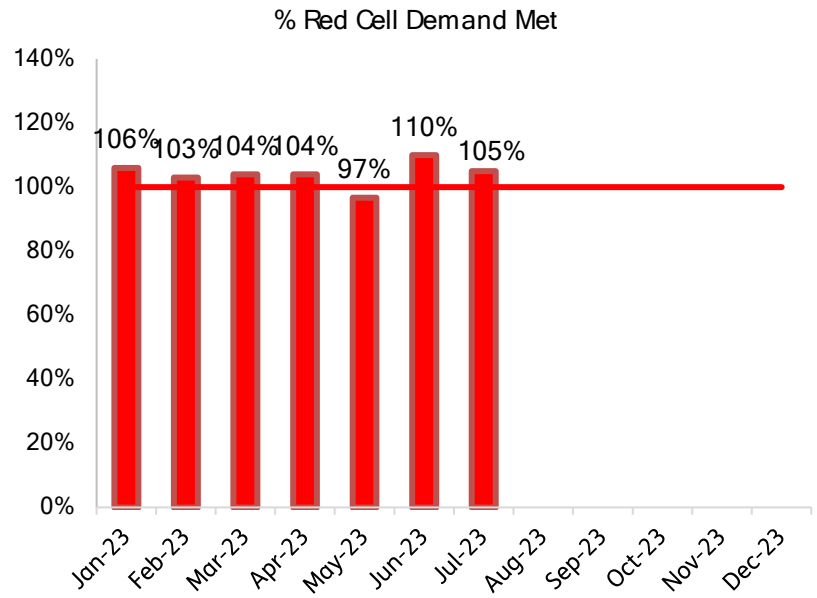
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	102	100	107	112	105	115	115	94	106	103	104	104	97	110	105
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

Blood collected in July exceeded the demand.

The average weekly demand in July was slightly higher than June (from 1376 to 1433 units per week).

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.

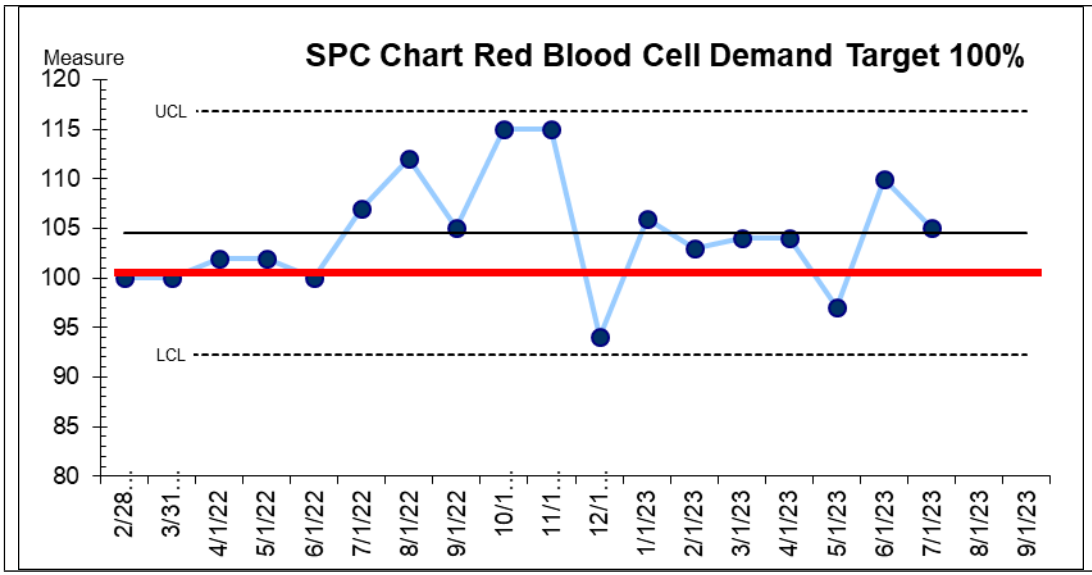
Service Improvement Actions – tactical (12 months +)

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.
N/A



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

KPI Indicator KPI.26

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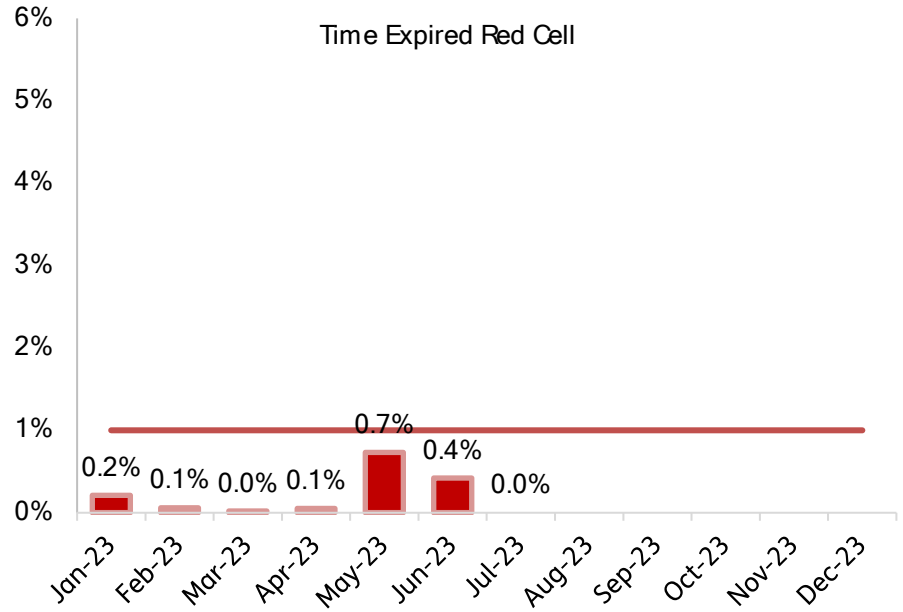
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	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	0.42	0
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance

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

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

Balanced stocks for each blood group are managed through the daily Resilience meetings where priorities are set as needed. This supports the recovery of specific blood groups when they are at lower level but also minimises excess collections to minimise wastage.

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.

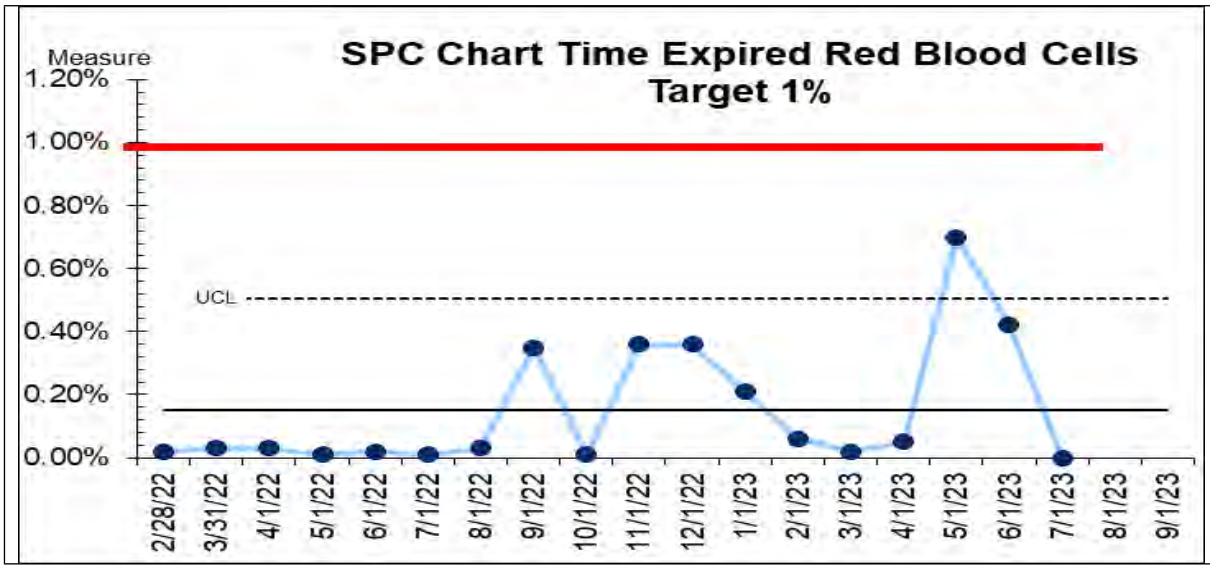
Service Improvement Actions – tactical (12 months +)

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.



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 0.15% remains well within the maximum 1%

KPI Indicator KPI.05

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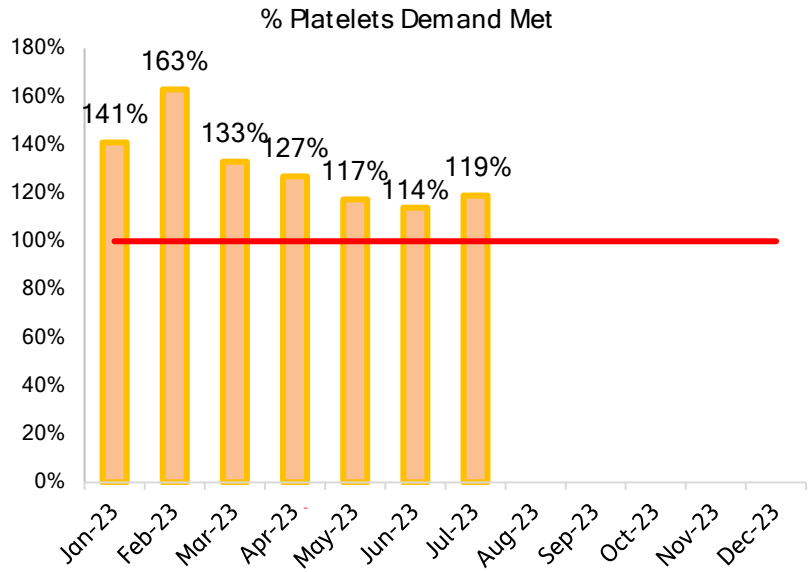
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	July 23
Actual %	125	128	145	164	132	126	139	145	141	168	133	127	117	114	119
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



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.

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 in July was 150 units per week on average. This is lower than June's average demand of 166 units per week.

Service Improvement Actions – Immediate (0 to 3 months)

Daily monitoring of platelet stock position and assessment of likely demand in the upcoming days. Controlled adjustments in production of pooled platelets to better align overall stock holding to daily demand.	**Lead:** Tracey Rees Daily - BAU **Timescale:** Ongoing – Business As Usual

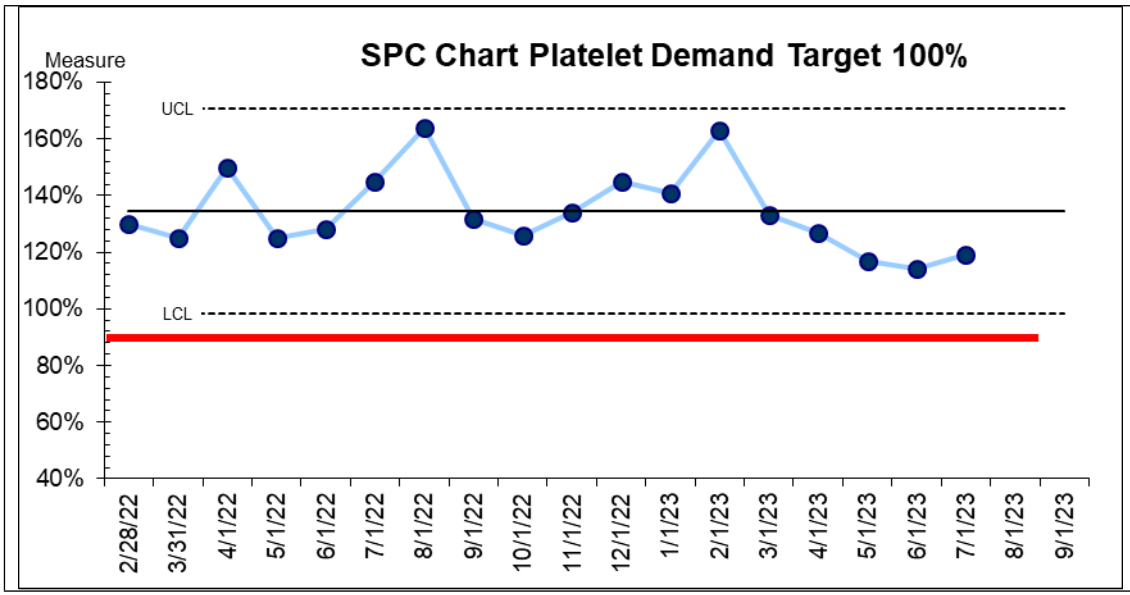
Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs. Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve A focus on balance of apheresis versus pooled platelets and timing of apheresis clinics will be conducted as part of the WBS futures programme under Laboratory Modernisation work. Consideration of a digital tool to enable prediction/requirement for platelet production will also be included.	**Timescale:** Dec 2023 **Lead:** Tracey Rees

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.



SPC Chart Analysis
The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 132% consistently exceeding the 100% target.

KPI Indicator KPI.25

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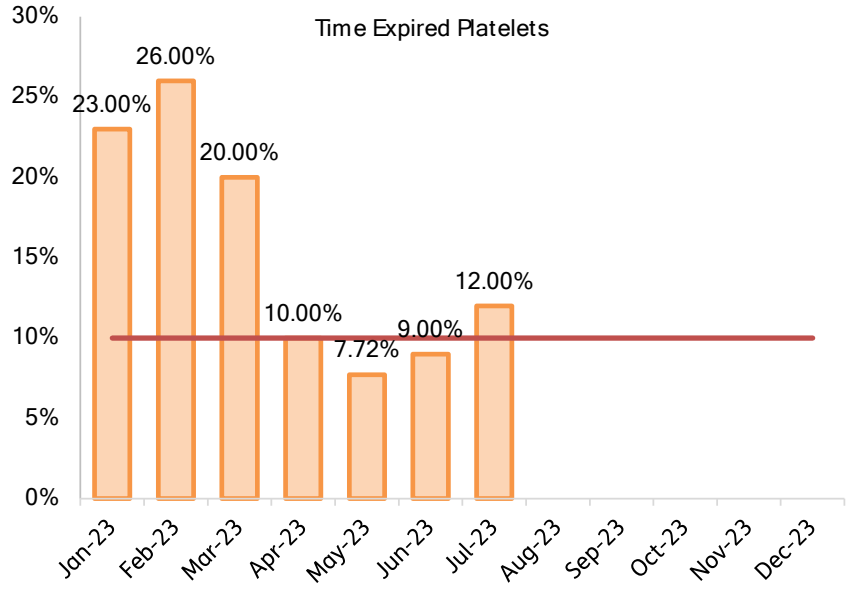
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	15	23	19	30	25	14	15	27	23	25	20	10	8	9	12
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:

July performance slightly breached target, with contributory factors attributed to:

- Reduction in average weekly demand for the month
- Collection model for apheresis platelets is not aligned to 7-day expiry – this is being reviewed under WBS Futures. *Essentially the appointment capacity on a Wed is too big for what we need sometimes and is not always easy to switch on and off. We normally manipulate it by altering the pooled platelets but on one instance last month we had 40 just from apheresis when we only needed a total of 30. Even in these instances we still need to make some pools to make sure we have the group mix correct and to ensure we sufficient stock within expiry dates.*
- Excess apheresis production against target on 19th July. There were 40 apheresis platelets in process against a total target of 30 platelets. Due to expiry dates production could not be reduced later in the week.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Lead:** Tracey Rees
a. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings.	**Timescale:** Daily (BAU)
b. Pooled platelet reductions have been implemented and are being reviewed as a measured approach to the declining demand trend.	
c. A Platelet Strategy is being developed. This will sit under WBS Futures under the Lab Services Modernisation Programme.	Timelines to be confirmed as part of WBS Futures
d. Develop a forecasting tool to inform decisions around pooled platelet manufacture. This action has been delayed due to insufficient capacity within the Business Intelligence Team.	

Expected Performance gain – immediate.
Controlled platelet production leading to reduced wastage

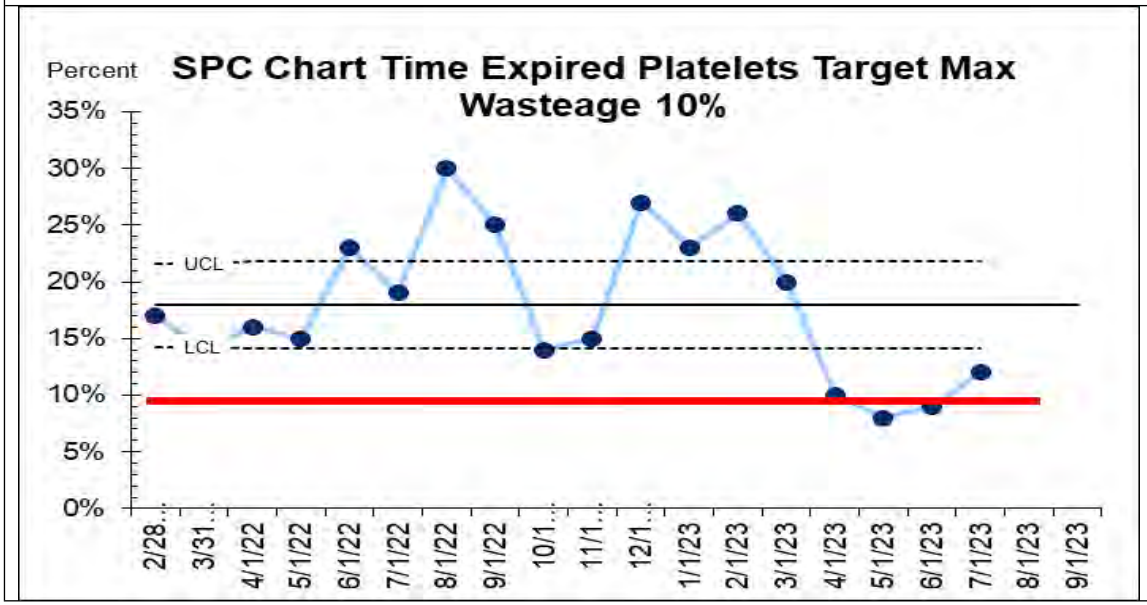
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
Reviewing the clinic collection plan for Apheresis to ensure the clinic times are optimised to reflect changes to 7-day platelet expiry. Embedding the demand planning tools for platelets into routine practice.	Qtr 3&4 onwards **Lead:** Jayne Davey/Tracey Rees

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.13

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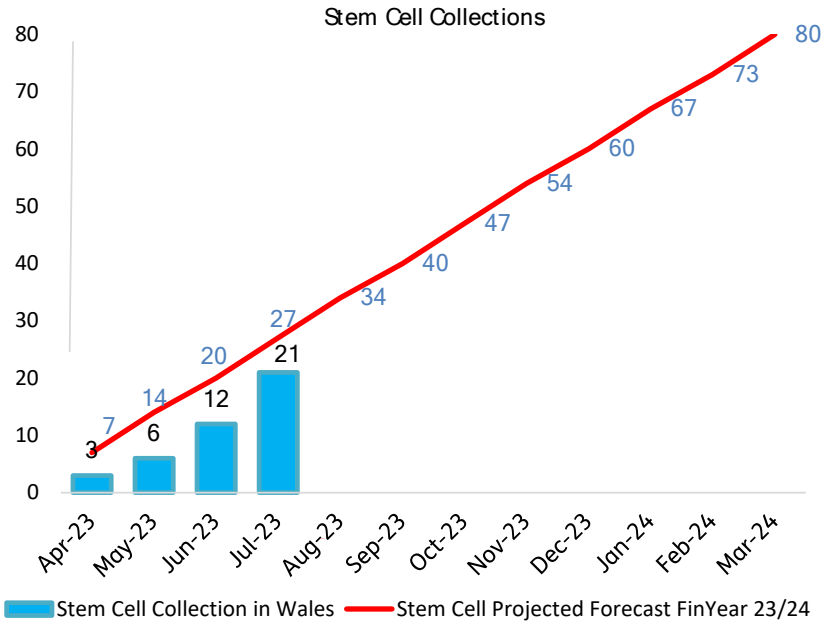
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Cumulative Actual	2	8	8	12	14	14	15	19	23	26	32	3	6	12	18
Cumulative Target p/a	14	21	28	35	42	49	56	63	70	77	84	7	14	20	27



Performance

The total cell provision for the service was 9 with 6 collections (4 Peripheral Blood Stem Cell, 2 Peripheral Blood Lymphocyte) and 3 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.

The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80).

NB: The Projected Forecast detail does not include stem cells collection sourced globally for patients in Wales.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve

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. This will form part of the WBS futures programme

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:
Q3

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 WOD.37

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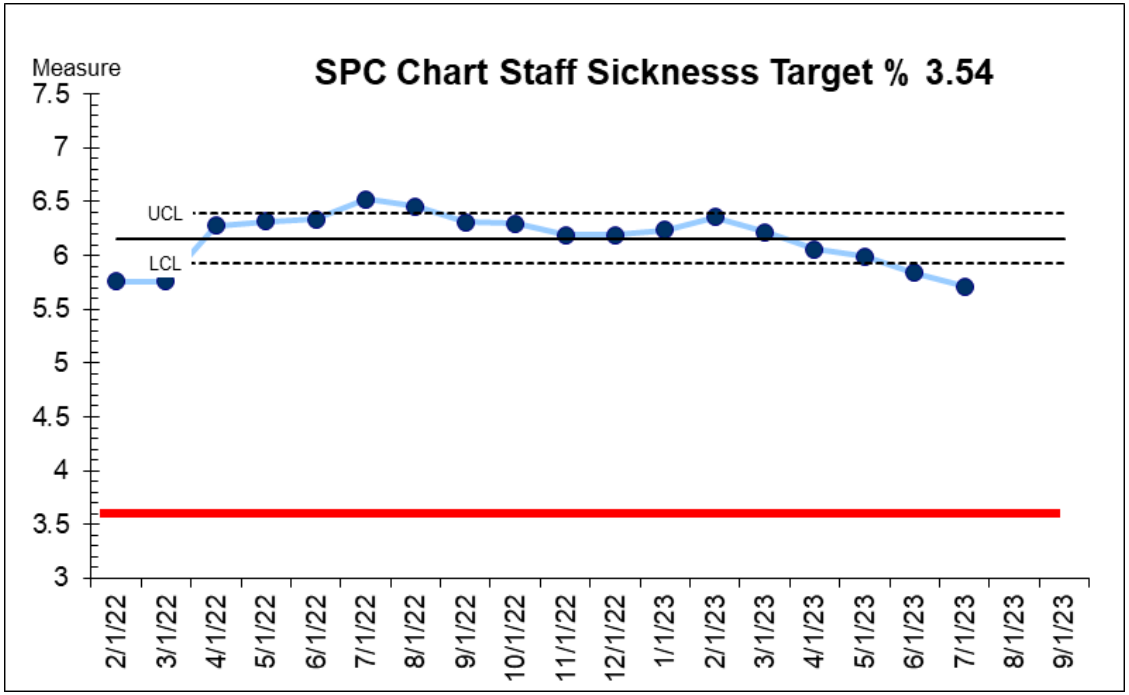
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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	July 23
Actual %	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	5.84	5.71
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

There is a slight decline in sickness following the winter months and as the People and Relationship Team continue to support managers in the application of the sickness policy. Corporate Services has significantly reduced their rolling 12 months from 5.37 to 2.85 in the year to date.

Short-term absence remains relatively low across the Trust.

Focused management on resolving long-term absence has seen in month figured reduce from 4.97% to 2.91% in the past 6 months. This continued reduction should see the overall rolling target reduce also.

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 (Closed)	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 actions are being taken over the coming 12 months • Staff wellbeing support survey • Developing a Menopause friendly culture	30/04/2024	Head of OD

	• 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 WOD.36

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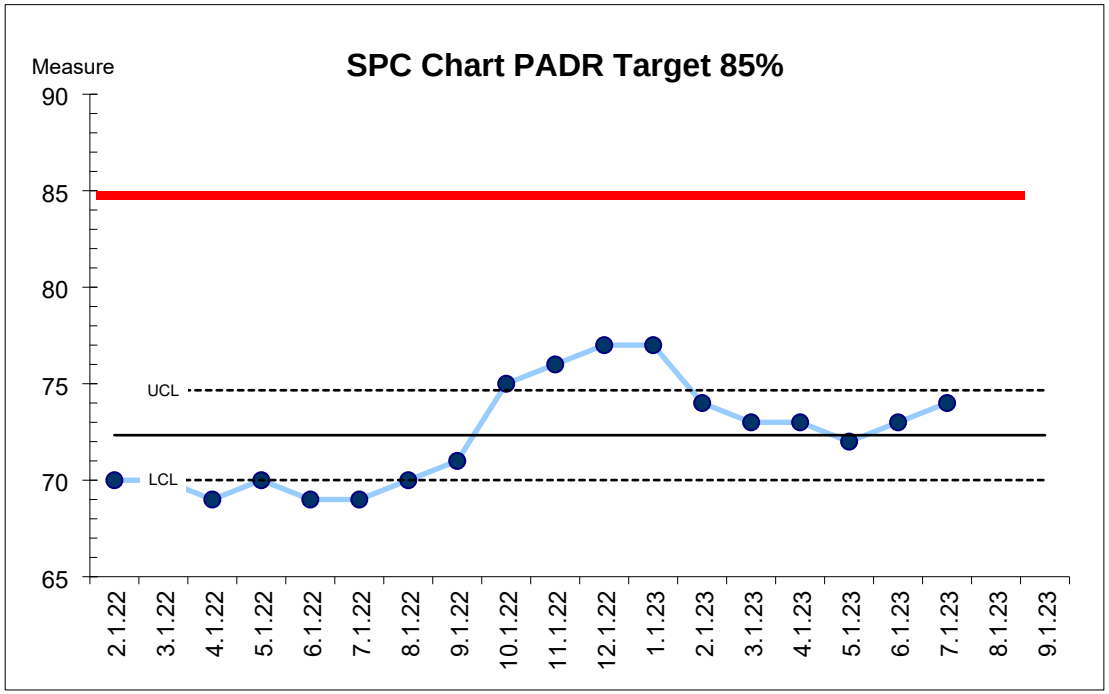
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	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	July 23
Actual %	70	69	69	70	71	75	76	77	77	74	73	73	72	73	74
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 this remains significantly below the Welsh Government target. Transforming Cancer Services remains the biggest cause for concern reporting 8 months consecutively below 50%

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

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

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% 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

VCC	May 22	Jun 22	Jul22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23
Would you recommend us? %				89	89	88	nda	nda	93	96	95	95	98	96	97
Your Velindre Experience? %							nda	nda	84	86	82	82	68	71	91
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

Assessment of current performance, set out key points:

There are 2 surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience' The Your Velindre experience uses 0-10 in the question about rating VCC, whereas 'Would you recommend us?' used Very good, good etc. The majority of surveys completed in VCC is the 'Would you recommend us?' one. The 97% in June was due to 78 survey responses to the VCC 'Would you recommend us? CIVICA survey.

42 patients responded to "Your Velindre Experience" CIVICA survey. Of these 42 responses, 30 responded 9/10 and 10/10 with 4 patients scoring 2 or below. Review of the responses showed 2 respondents sometimes or never felt listened to, 1 reported sometimes or never understood what was happening with their care, and 11 respondents said they waited a bit or much too long. However, 31 respondents felt they waited less or about right, and 37 people felt they were always listened to, 39 they usually or always felt cared for.

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		
• Q+S team to review the difference in positive percentages for both surveys		

Expected Performance gain – immediate

Patient Experience and Concerns manager in post since February 2023.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

KPI Indicator KPI.09

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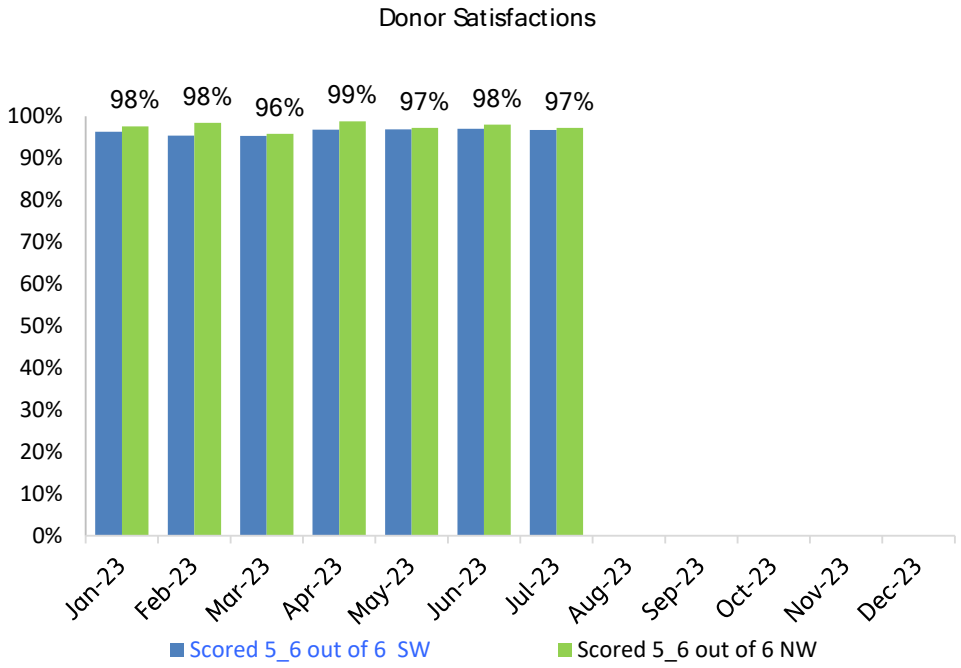
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	96	97	96	97	97	96	96	95	97	97	95	97	97	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 96.8%, Donor Satisfaction exceeded target for July. In total there were 1,288 respondents to the donor survey, 195 from North Wales (scoring satisfaction at 97.2%), and 1,012 from South or West Wales (scoring satisfaction at 96.7%).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Findings are reported 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 KPV.12

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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	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	June 23	Jul 23
Actual %			100	100	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 consistently been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Patient Experience and Concerns manager in post since February 2023

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.03

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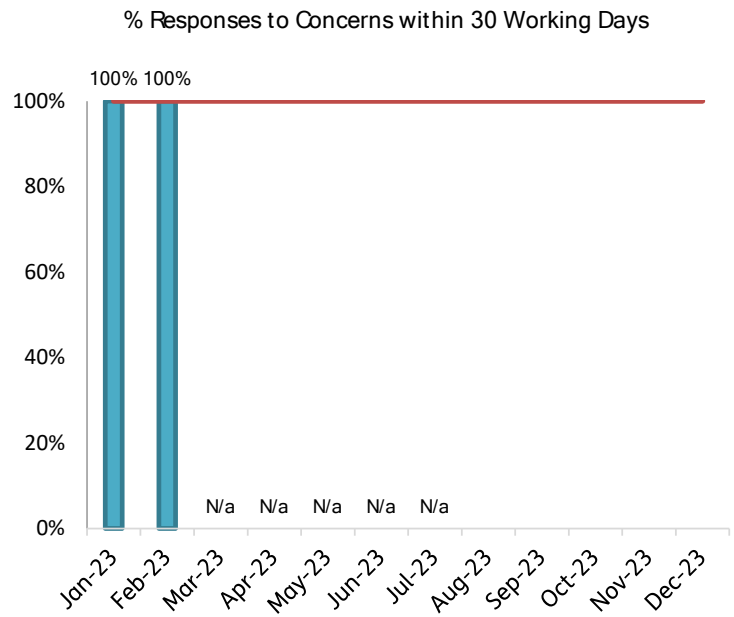
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	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	June 23	July 23
Actual %	n/a	100	100	n/a	n/a	100	100	N/A	100	100	N/A	N/A	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 July 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. – Work closer with relevant departments to ensure proactive and thorough investigations and learning outcomes. – 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.

TIMELINESS

KPI Indicator KPV.14

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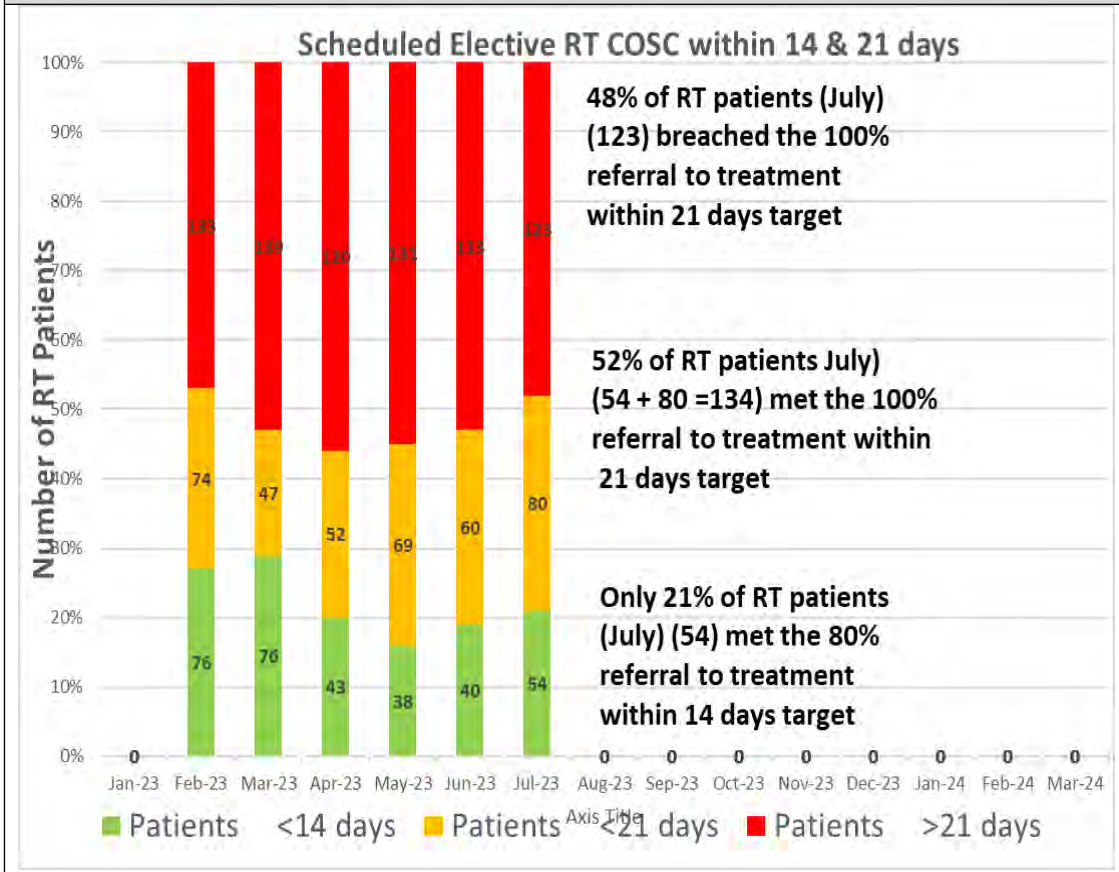
Elective Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)

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 well over 6 month's 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 WG categorisation. Validation resources currently insufficient to address range of issues identified.

Number of referrals	257	
treated within 14 days of referral (80% target)	54	21%
treated within 21 days of referral (100% target)	134	52%

Service Improvement Actions – Immediate (0 to 3 months)

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

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 time to radiotherapy timings

Risks to future performance

Set out risks which could affect future performance

Linac replacement programme which has commenced

KPI Indicator KPV.15

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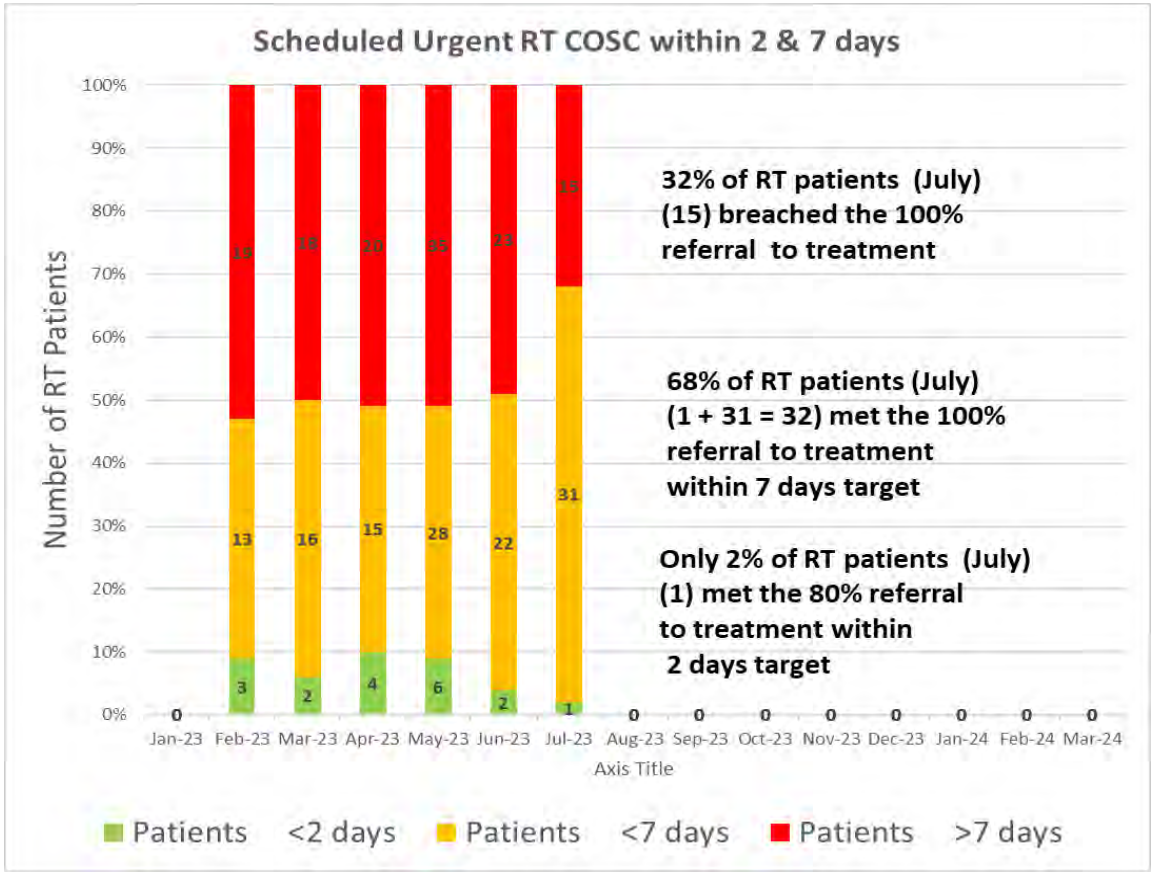
Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	
Target: 80% within 2 Days and 100% within 7 days (COSC)	**SLT Lead: Head of Radiation Services / Clinical Director**

Current Performance against Target or Standard



SPC Chart Analysis

The SPC chart analysis is not possible until we have well over 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	47	
treated within 2 days of referral (80% target)	1	2%
treated within 7 days of referral (100% target)	32	68%

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

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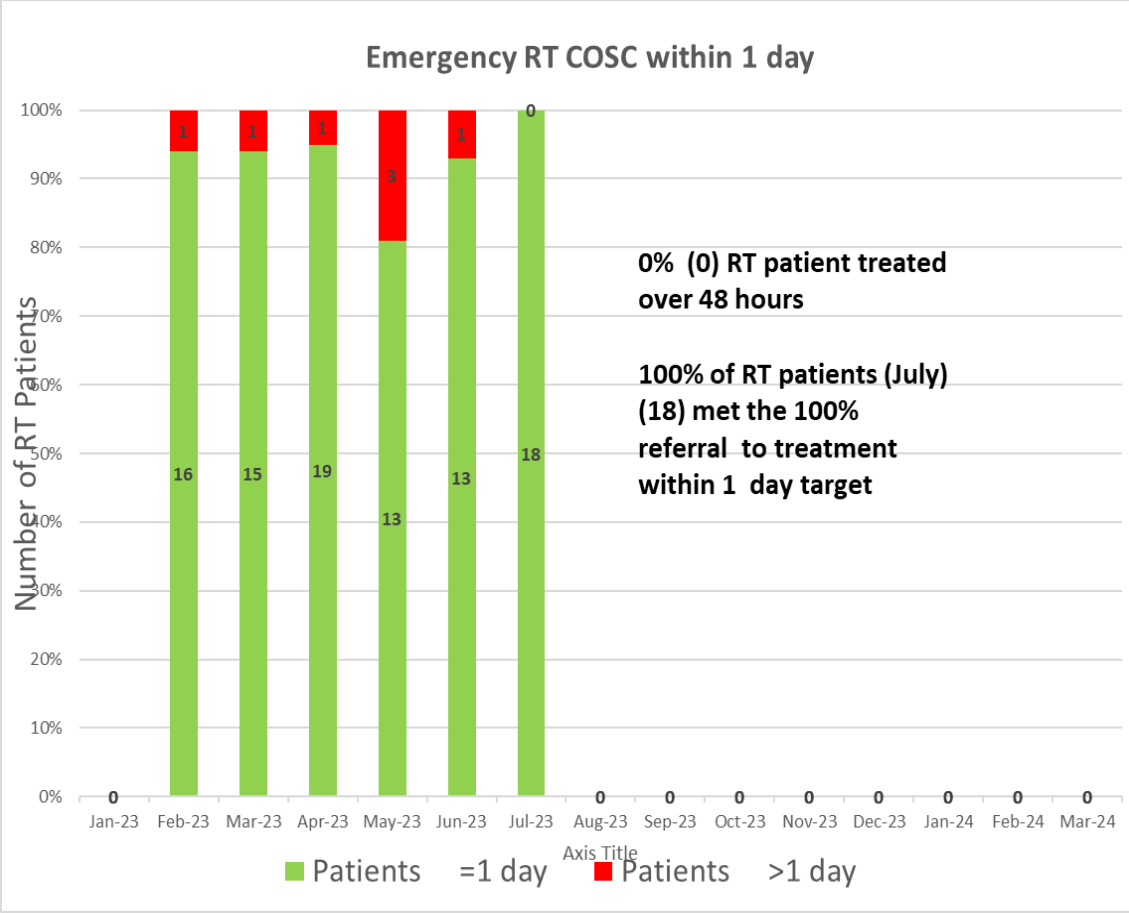
Emergency Radiotherapy Patients Treated Within 1 Day (COSC)	
Target: 100%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



SPC Chart Analysis

The SPC chart analysis is not possible until we well over 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	18	
% treated within 24 hours of referral	18	100%
% treated within 48hours of referral		

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

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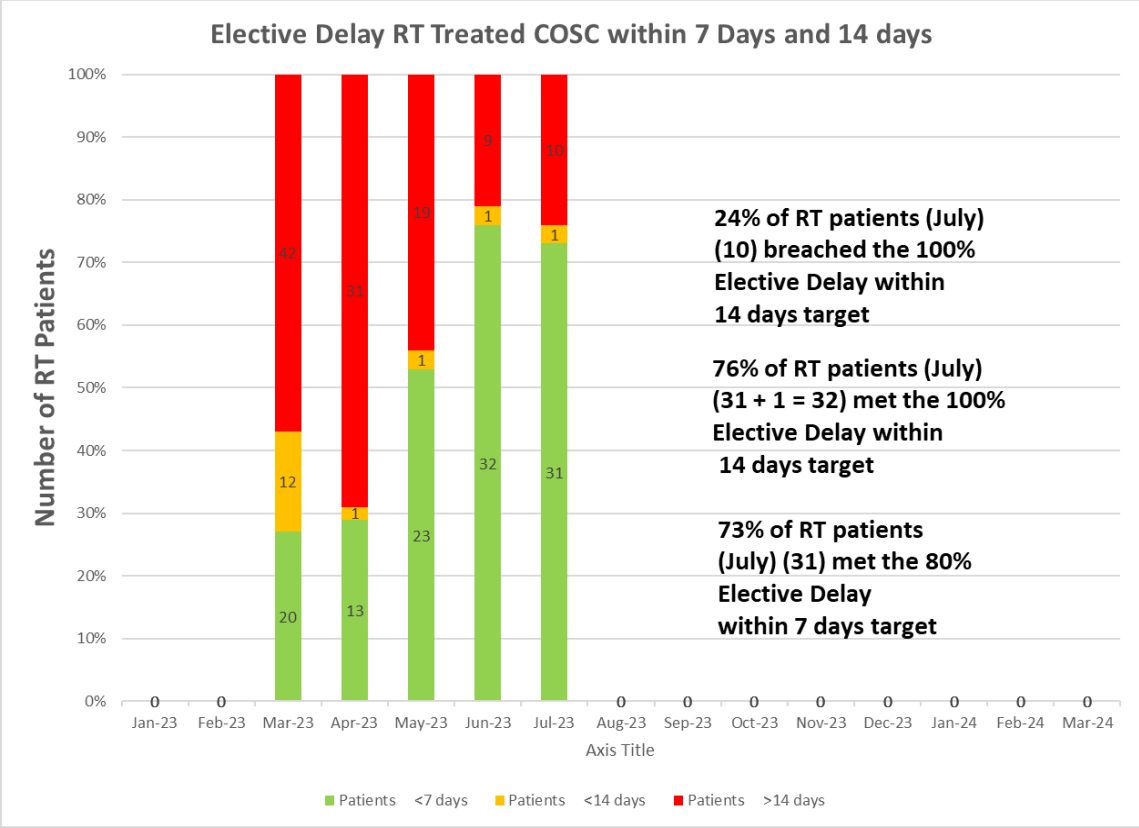
Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**

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 well over 6 month's 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	42	
treated within 7 days of referral (80% target)	31	73%
treated within 14 days of referral (100% target)	32	76%

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

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Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	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	June 23	Jul 23
Actual %	61	59	66	77	89	96	98	96	97	98	98	93	90	90	94
Target 98%	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**
More than 21 days	**146**	**147**				**14**	**6**	**12**	**9**	**9**	**8**	**26**	**40**	**40**	**25**
Within 21 days	**375**	**355**				**341**	**354**	**322**	**336**	**388**	**409**	**343**	**354**	**378**	**279**

The number of patients scheduled to begin non-emergency SACT treatment in July 2023 was 404.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,186	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	2486	2463	2572	2297	2455	2162	2557
2023/24 Attendances	2,220	2,545	2,622	2,483								

Performance

Of 404 new patients started patients started, 25 patients waited over 21 days = performance of 94%. Target Not Achieved

Intent /Days -	22-28	29-35	36-42	43 da1ys +
Non-emergency (21-day target)	24	0	1	0

20 patients breached due to joint nursing and pharmacy capacity

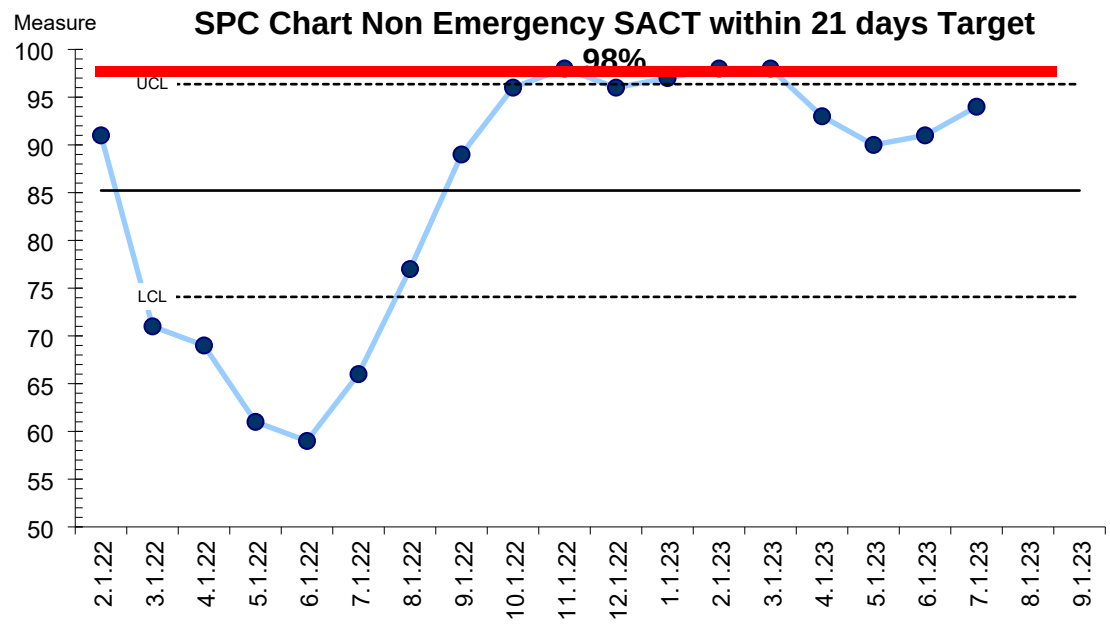
1 x patient breached as they were awaiting a PET scan

1x patient breached because ChemoCare was altered by one of the Clinical Team. This meant that the booking team was unaware of the need to schedule. The Chemocare team are linking with the staff involved to improve their knowledge of chemocare & avoid any repetition.

1 X patient did not appear on scheduling list – this is being investigated by the Chemocare team & CIS

1 x pt – booking requests misinterpreted the booking request.

1 booked alongside RT



SPC Chart Analysis

The chart shows normal variation over the last 10 months after a significant period of improvement. However, current performance falls short of 95% target.

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. -	**complete**	BT
Review and confirm resource requirements of PICC service	**complete**	MW
Continue to progress SACT nurse and booking review recommendations.	~~**31/07/23**~~ **Timescale updated to 01/1023**	BT
Review "allocation" field in ChemoCare to mitigate risk of user error		

Expected Performance gain – immediate

No patients to breach due to incorrect allocation of treatment location.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Re-determine the impact of continued growth in demand across SACT teams	**01/09/23**	BT/WJ
• Determine additional staff resources/ recruitment plan to meet revised forecasts across all staffing groups (nursing, pharmacy and booking teams)		BT
• Engage with HB partner to deliver on VCC strategy to deliver care closer to home	**01/11/23**	

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
- Overall capacity of aseptic services across SE Wales

KPI Indicator KPV.21

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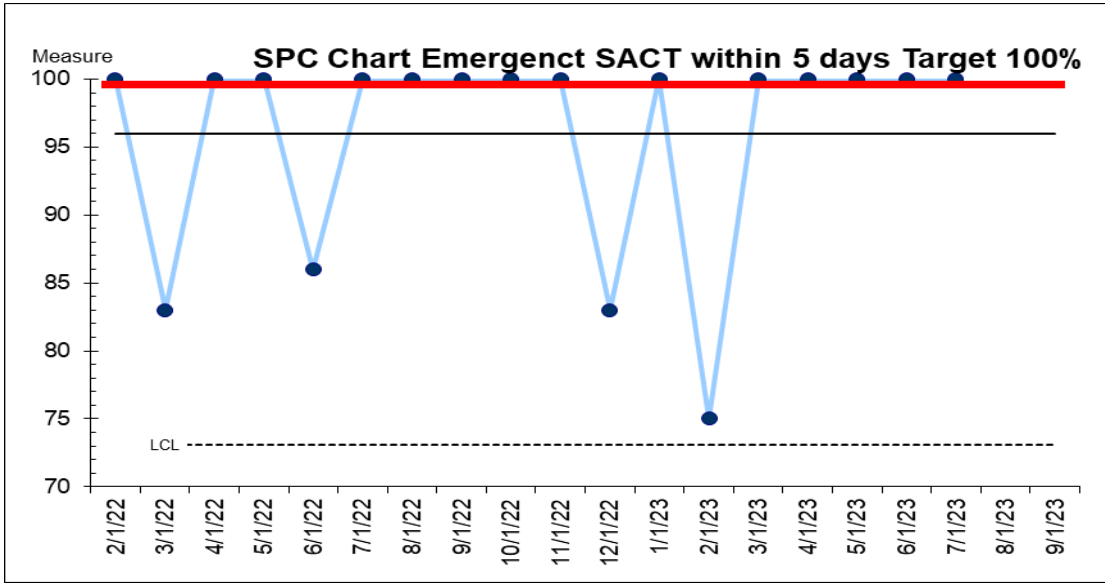
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	My 22	Jun 22	Jul22	Au22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23
Actual %	100	86	100	100	100	100	100	83	100	75	100	100	100	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	0	2	0	0	0	0	0	1	0	1	0	0	0	0	0
Within 5 days	9	7			0	5	6	5	8	3		5	0	12	10



SPC Chart Analysis

The SPC chart shows a fluctuating process starting to stabilize with average 95 % against the 100% target, however note small numbers involved.

Performance

10 patients referred for emergency SACT treatment were scheduled to begin treatment in July 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 +)

		Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPI.18

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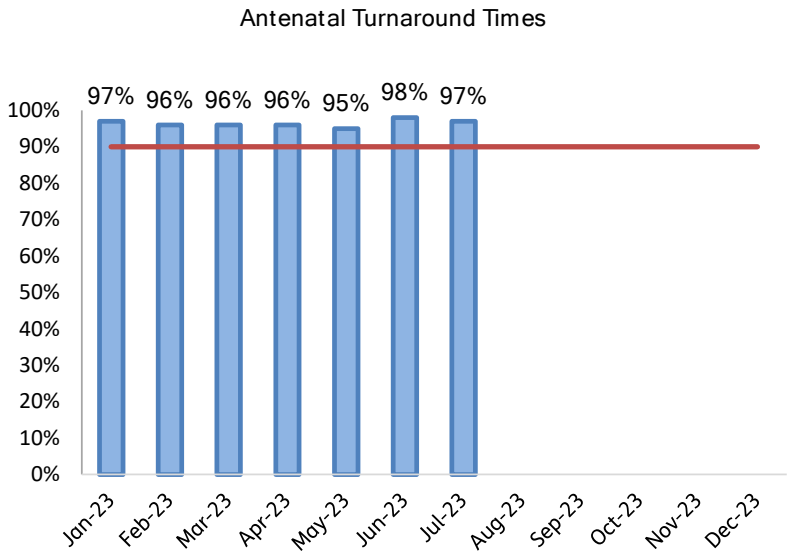
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	96	95	96	97	97	98	96	87	97	96	96	96	95	98	97
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 97% the turnaround time performance for routine Antenatal tests continued to exceed target in July 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.

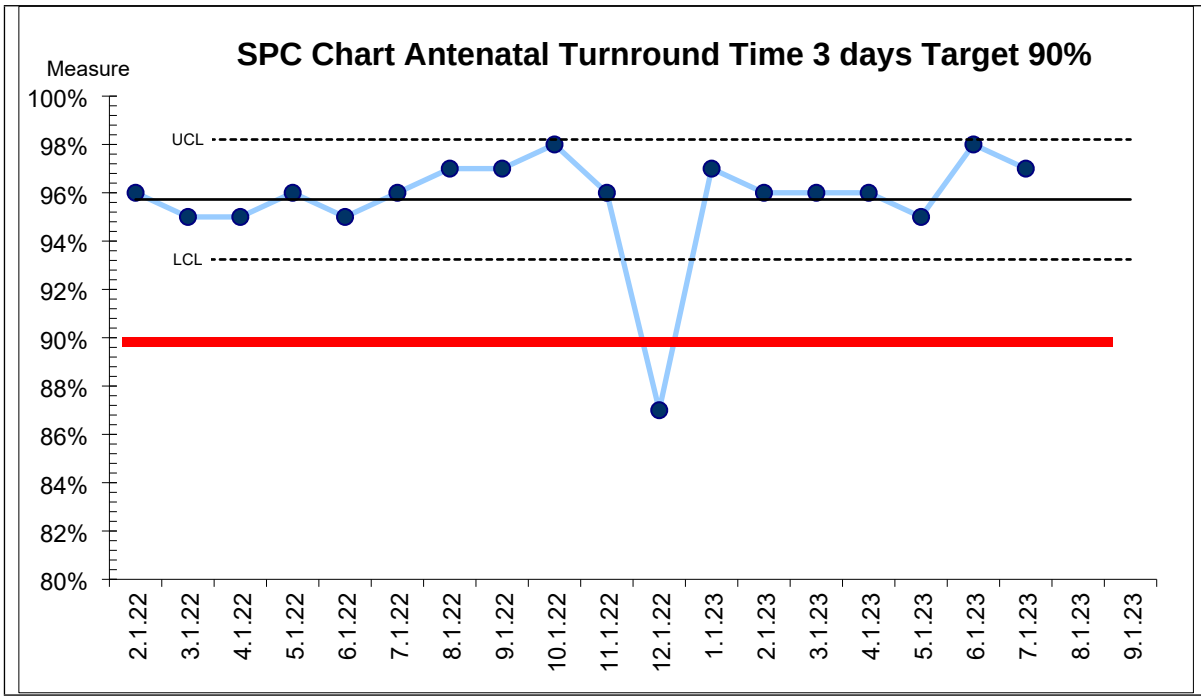
Service Improvement Actions – tactical (12 months +)

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 92% exceeds the 90% target.

KPI Indicator KPI.17

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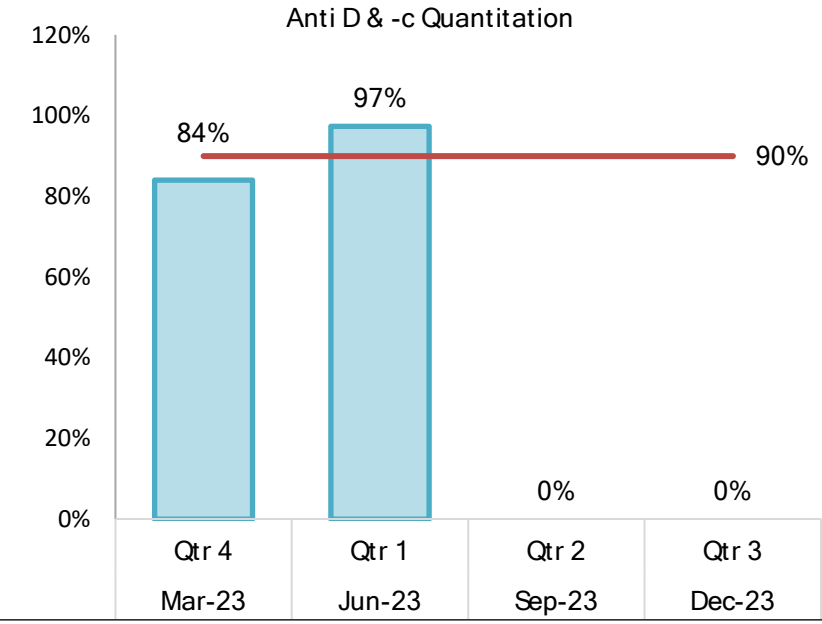
% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	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	June 23	July 23
Actual %	99	83	99	96	99	99	96	97	96	60	92	97	98	97	
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	



Performance

On Target. Excellent performance March through to June despite the increase in anti-D referrals and training commitment on the auto analysers concerned.

Service Improvement Actions – Immediate (0 to 3 months)

N/A	**Timescale:**	**Lead:**

Expected Performance gain - immediate.

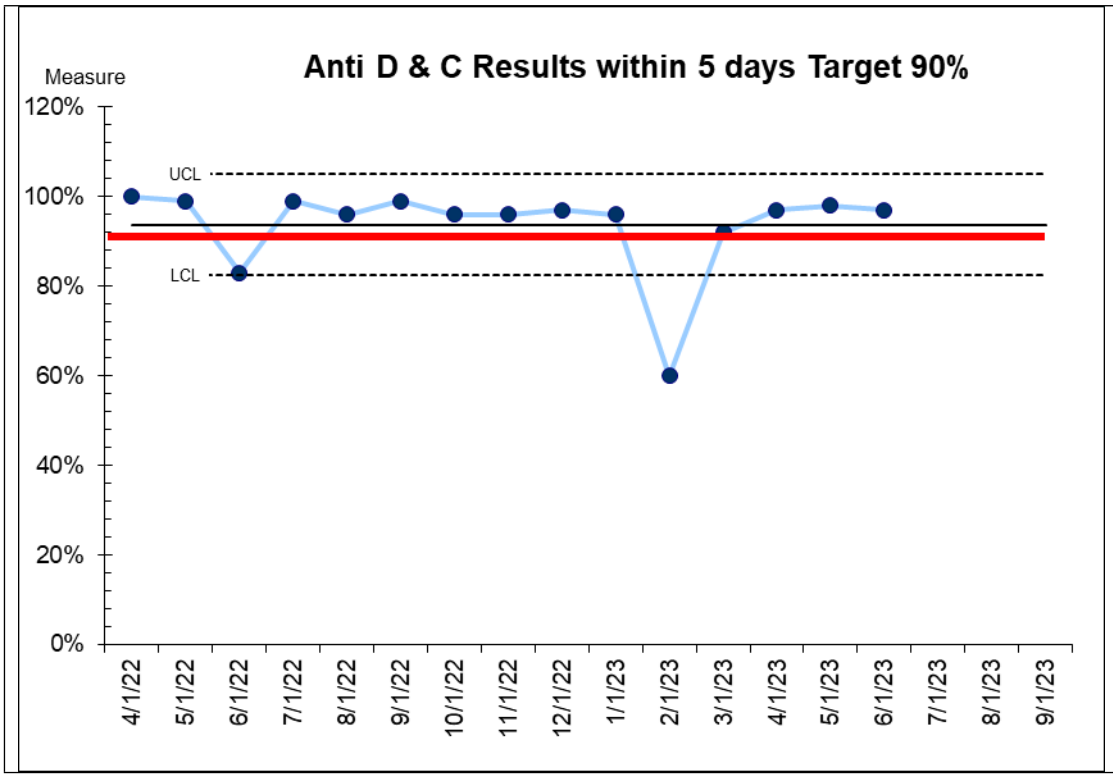
Service Improvement Actions – tactical (12 months +)

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.

EFFICIENT

KPI Indicator FIN.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

Current Performance against Target or Standard

Performance

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	2	4								
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at July 23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(14.656)	(14.656)	0.000	(40.175)	(40.175)	0.000
RD&I	(0.359)	(0.359)	(0.000)	0.091	0.091	0.000
WBS	(7.417)	(7.418)	(0.000)	(21.503)	(21.503)	0.000
Sub-Total Divisions	**(22.432)**	**(22.433)**	**0.000**	**(61.587)**	**(61.587)**	**0.000**
Corporate Services Directorates	**(4.231)**	**(4.207)**	**0.024**	**(12.311)**	**(12.311)**	**0.000**
Delegated Budget Position	**(26.663)**	**(26.640)**	**0.023**	**(73.897)**	**(73.897)**	**0.000**
TCS	(0.272)	(0.292)	0.020	(0.744)	(0.744)	0.000
Health Technology Wales	(0.054)	(0.054)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	26.990	26.990	0.000	74.758	74.758	0.000
Trust Position	0.000	0.004	0.004	0.000	0.000	0.000

In response to the letter received from Judith Paget the Trust considered options at the extraordinary Board meeting on the 09th August and submitted the following financial improvement options to WG on the 11th August.

The overall position against the profiled revenue budget to the end of June 2023 is an underspend of £0.00m 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 revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

On the 31st July the Trust received a letter from Judith Paget (NHS Wales Chief Executive) which provided a view on the overall financial position of Welsh NHS organisations for 2023/24. In response to the financial challenges set out by Health Boards in 2023/24 the Trust has been asked to support the delivery of a reduction in the overall NHS Wales deficit.

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

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	0.436	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	1.250	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 4 there is a reduction of c£0.436m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	TBC	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.686**	

Risks to future performance

Set out risks which could affect future performance

- Further Non Delivery of recurrent savings plans
- Whilst improving 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.73

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Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast

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(Cum)	27.8	1.389m	1.637m	5.646m	**10.333m**								
Target £24.416m CEL		1.389m	1.637m	5.646m	10.333m								

Capital Position as at July 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M4 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	7.522	0.000	3.374	10.896	0.000
nVCC - Project costs	0.000	0.938	0.000	(0.938)	1.843	(1.843)
Integrated Radiotherapy Solutions (IRS)	10.326	1.806	0.000	8.520	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	10.266	0.000	12.467	24.576	(1.843)
Discretionary Capital	1.683	0.067	0.000	1.616	1.683	0.000
Total	24.416	10.333	0.000	14.083	26.259	(1.843)

The approved Capital Expenditure Limit (CEL) as at June 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.733m**, and Discretionary funding of **£1.683m.**

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m as at the end of June.

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022/23.

The allocation of the discretionary programme for 2022/23 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m has been ring-fenced to support the nVCC enabling works and project costs with expectation that this funding will be reimbursed from additional funding requested from WG for the nVCC enabling works.

Performance to date

The actual expenditure to July 2023 on the All-Wales Capital Programme schemes was £10.266m, this is broken down between spend on the nVCC enabling works £7.522m, nVCC Project Costs £0.938. and the IRS £1.806m.

Spend to date on Discretionary Capital is currently £0.067m.

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:** XX/XX/XX	**Lead:** AN Other
	Expected Performance gain - immediate		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
	Expected Performance gain – longer-term		
	Risks to future performance		
	Set out risks which could affect future performance • NVCC not securing the additional funding request from WG of c£1.8m for project support costs.		

KPI Indicator FIN.72

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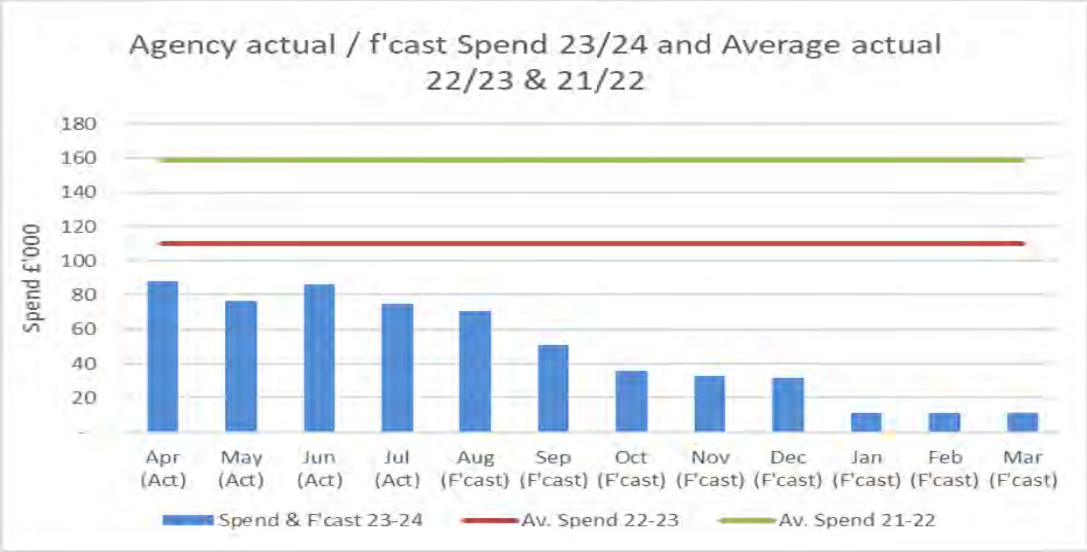
Usage of Overtime Bank and Agency Staff within Budget

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	86	75								
Target (per IMTP) £0.543M Forecast		115	115	115	58	50	50	16	16	0	0	0	0



Performance

The spend on agency for July'23 was **£0.075m,** which gives a cumulative year to date spend of £0.325m and a current forecast outturn spend of circa **£0.580m** (£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.74

Return to Top

Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	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	0.080m	**0.069m**								
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

Performance

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%).

Following an in depth assessment of savings schemes in July, several schemes have turned red. The impacted schemes relate to workforce and the supply chain with replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has reduced the underlying position to be carried into 2024-25 from £0.391m to a latest position of £0.086m.

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 have again been 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. Whilst we don't expect delivery this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain.

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
Trust Position													
Capital & Revenue Invoices	95	98	98	99	98								
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

During July '23 the Trust (core) achieved a compliance level of **98.2%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.4%** as at the end of month 4, and a Trust position (including hosted) of **98.1%** compared to the target of 95%

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

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	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	July 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	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	July 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	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	July 23
Actual %															
Target TBA%															

The Workforce Race Equality KPI's are not going to be available to us until at least June next year as they are dependent on the national implementation of the Workforce Race Equality Standard (WRES).

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	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	July 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 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
-

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST JULY (M4)

DATE OF MEETING	28/09/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of July 2023.
RECOMMENDATION / ACTIONS	**Trust Board** is asked **NOTE** the contents of the July 2023 financial report and in particular the yearend financial performance which at this stage is reporting a **breakeven** position.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board - Run	31/08/2023
Quality, Safety and Performance Committee	14/09/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The finance paper was noted at EMB Run on the 31st August and QSP on 14th September.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed. N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the* ***"How to Guide for Reporting to Trust Board and Committees"*** N/A

APPENDICES	
	Trust Finance Report - July 2023
Appendix 1	TCS Finance Report – July 2023 (to follow)

1. SITUATION/ BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of July 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	0.002	0.004	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	4.477	10.330	26.259
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.2%	98.4%	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 July'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.

NHS Wales Financial Pressures

On the 31st July the Trust received a letter from NHS Wales Chief Executive Judith Paget, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services in view of the overall financial position of Welsh NHS organisations in 2023/24. In response to the financial pressures faced by the system, the Trust has been asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the following options were considered to contribute to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.436	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 4 there is a reduction of c£0.436m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	TBC	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.686**	

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 revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

2.3 Savings

At this stage the Trust is currently planning to fully achieve the savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status.

Delivery of service re-design and supportive structures continues to be a challenge due to the high level of vacancies and sickness with the Trust.

The Procurement supply chain saving schemes have again been affected by procurement team capacity constraints and current market conditions during 2023/24.

2.4 PSPP Performance

PSPP performance for the whole Trust is currently 98.1% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently achieving a target of 98.4% as at the end of July.

2.5 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 £0.134m.

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 for 2023-24. The latest position is that the contract performance income is improving however this is reliant on forecast activity levels from Commissioners for Velindre Cancer Services. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The activity levels and Commissioner demand for services will be closely monitored over the coming months.This risk will be managed through the Trust's budgetary control procedures.

2.6 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.

A review of reserves and commitments is currently underway in response to the letter received from Judith Paget with a request to support the overall NHS Wales Deficit.

2.7 Financial Risks

The financial risks for 2023/24 rated high or medium are as follows:

<u>DHCR – Risk 1.500m / Likelihood – Medium</u>

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 being fully captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team have reviewed the situation and put in place plans to address the issues. However, if these plans do not resolve the data capture issue there is a risk that c£1.500m income related to unrecorded activity could be lost.

There are several potential opportunities that are described in the report which could be utilised to support any risks should they crystallise.

2.8 Capital

All Wales Programme

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m as at the end of July.

Other than the nVCC Project 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.

The allocation of the discretionary programme for 2022/23 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB in August.

At this stage the discretionary programme is expected to deliver to budget.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

<table>
<tr><td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:
Choose an item</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>Choose an item</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Yes -select the relevant domain/domains from the list below. Please select all that apply
Safe ☐
Timely ☐
Effective ☐
Equitable ☐
Efficient ☐
Patient Centred ☐</td></tr>
<tr><td></td></tr>
<tr><td>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:</td><td>Choose an item</td></tr>
</table>

For more information: *https://www.gov.wales/socio-economic-duty-overview*	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a financial position of **£0.004m** for July'23 which is in line with the IMTP
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A

WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
	N/A
All risks must be evidenced and consistent with those recorded in Datix	

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 JULY 2023/24

TRUST BOARD
28/09/2023

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.

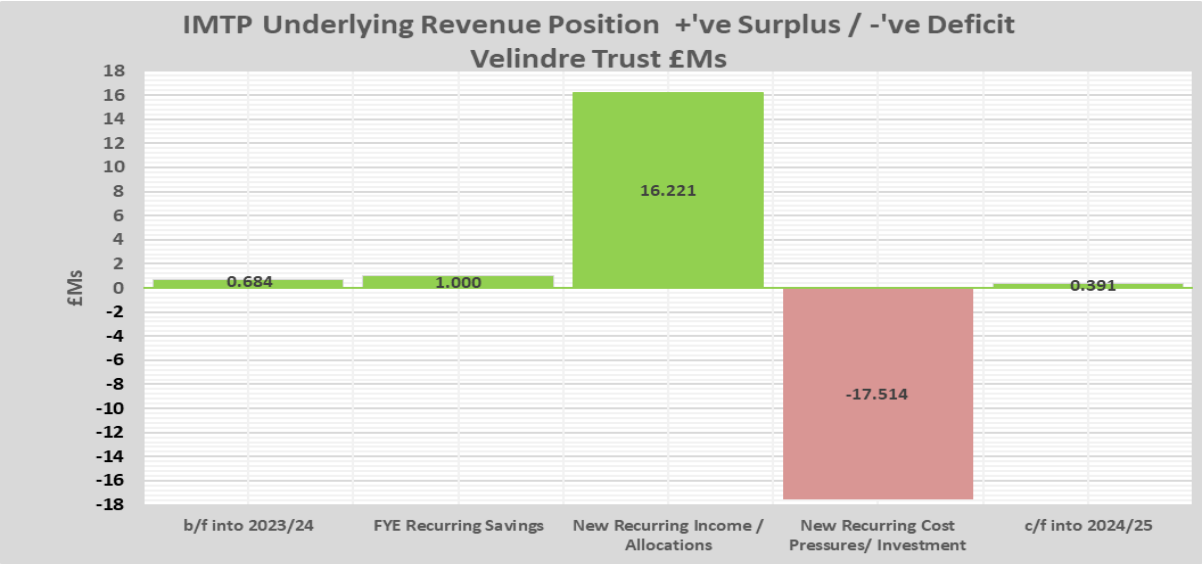
- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

- 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	0.002	0.004	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	4.477	10.330	26.259
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.2%	98.4%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.041)	(0.012)	0.000

Revenue

The Trust has reported a **£0.002m** in-month underspend position for July'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 July 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 July'23 of £10.333m 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**

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m.

PSPP

During July '23 the Trust (core) achieved a compliance level of **98.2%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **98.4%** as at the end of month 4, and a Trust position (including hosted) of **98.1%** compared to the target of 95%.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status.

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	(61.761)	(62.317)	0.556	(191.458)	(191.458)	0.000
Pay	28.905	28.698	0.207	82.774	82.774	0.000
Non Pay	34.029	34.788	(0.759)	108.684	108.684	0.000
Total	**1.173**	**1.169**	**0.004**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of July 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 revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

4.1 Revenue Position Highlights / Key Issues

NHS Wales Financial Pressures

On the 31st July the Trust received a letter from NHS Wales Chief Executive Judith Paget, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services in view of the overall financial position of Welsh NHS organisations in 2023/24. In response to the financial pressures faced by the system, the Trust has been asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the Trust has reviewed its cost control mechanisms and implemented Enhanced Monitoring arrangements which are intended to ensure savings delivery to meet the Trust's financial plan, oversee cost control mechanisms and assess choices / options and impacts of further cost saving opportunities. Following a review of the financial plan and savings position, an extraordinary Board meeting on the 09th August considered the further options for Velindre to contribute towards reducing the financial pressures in the system. The following financial improvement options were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.436	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 4 there is a reduction of c£0.436m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	TBC	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.686**	

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 expected underlying surplus to be carried into 2024-25 has reduced from £0.391m to £0.086m following the inability to enact several savings schemes, which results in underlying recurrent cost pressures forecast exceeding the recurrent savings schemes.

The ability to carry forward a surplus into 2024-25 will still depend on energy cost volatility, and the Trusts capacity to fund or mitigate current and potential new cost pressures which may emerge over the course of the year.

Income Highlights / Key Issues

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24. The latest position is that the contract performance income is improving however this is reliant on forecast activity levels from Commissioners for Velindre Cancer Services. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The activity levels and Commissioner demand for services will be closely monitored over the coming months. The final funding flows agreement included income protection measures for Velindre Cancer Services, which were not included within the Trust's Medium Term Financial Plan.

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

At this stage the Trust is expecting to receive full funding from WG for the recurrent impact of the 1.5% (c£1.2m) and 5% (c£3.5m) consolidated pay award which was processed in July.

The Trust has now received full funding for the one off recovery pay award which was paid in June.

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.

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.

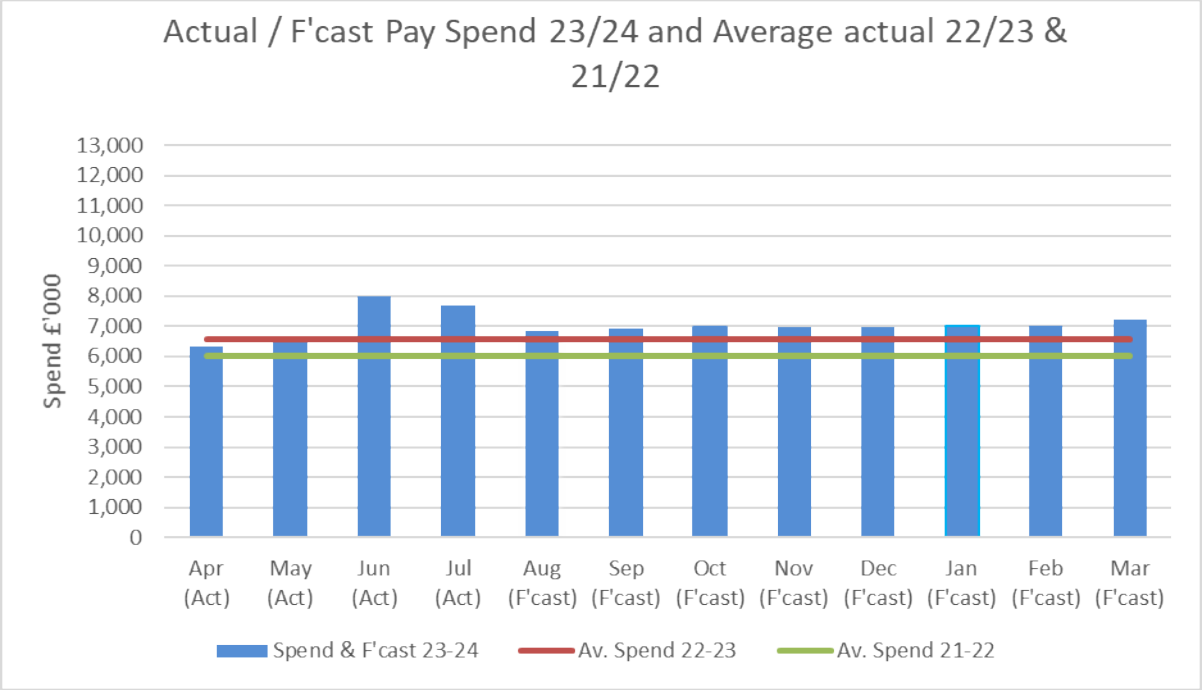
Non Pay Key Issues

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.

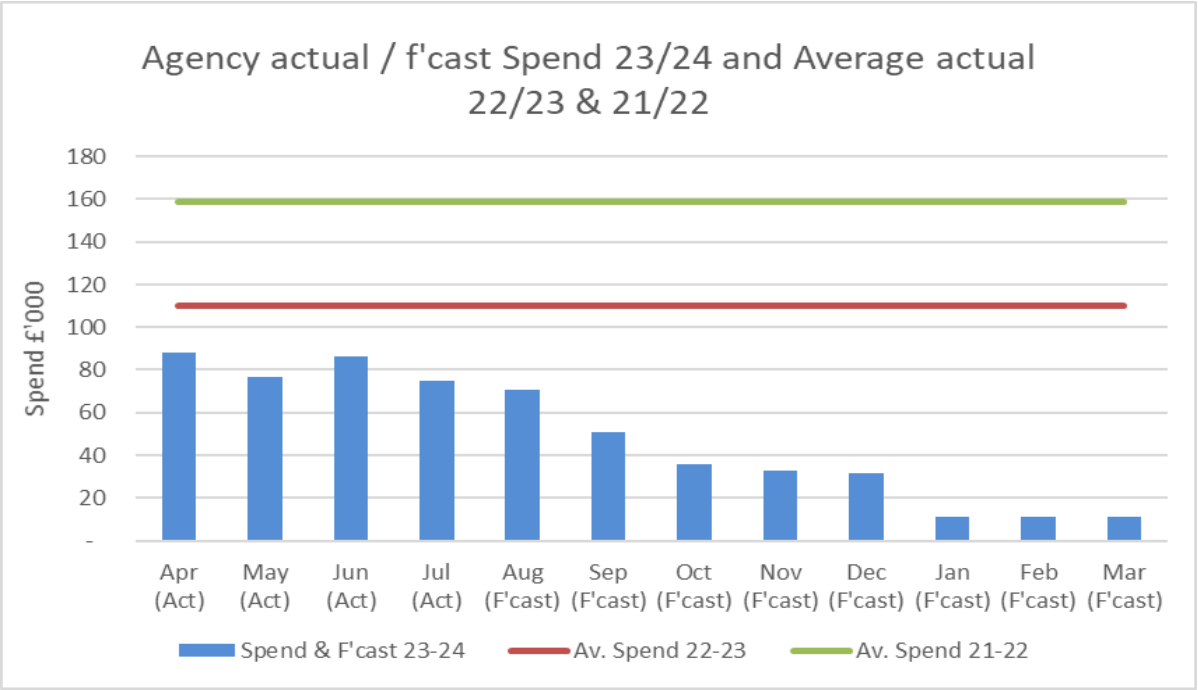
The Trust reserves and previously agreed unallocated investment funding is currently under review following the letter received from Judith Paget with a request to support the overall NHS Wales Deficit. The budget for the reserves is held in month 12 and will be released into the position to match agreed spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

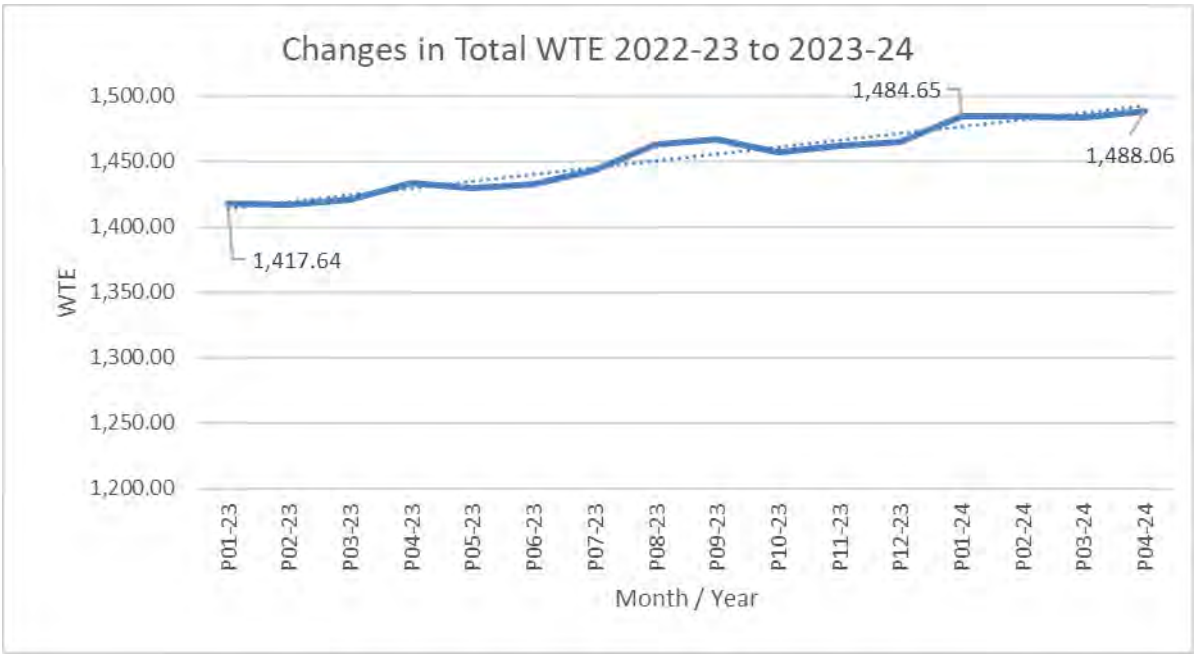
Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. At this stage of the year we are still expecting to transition the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following 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.



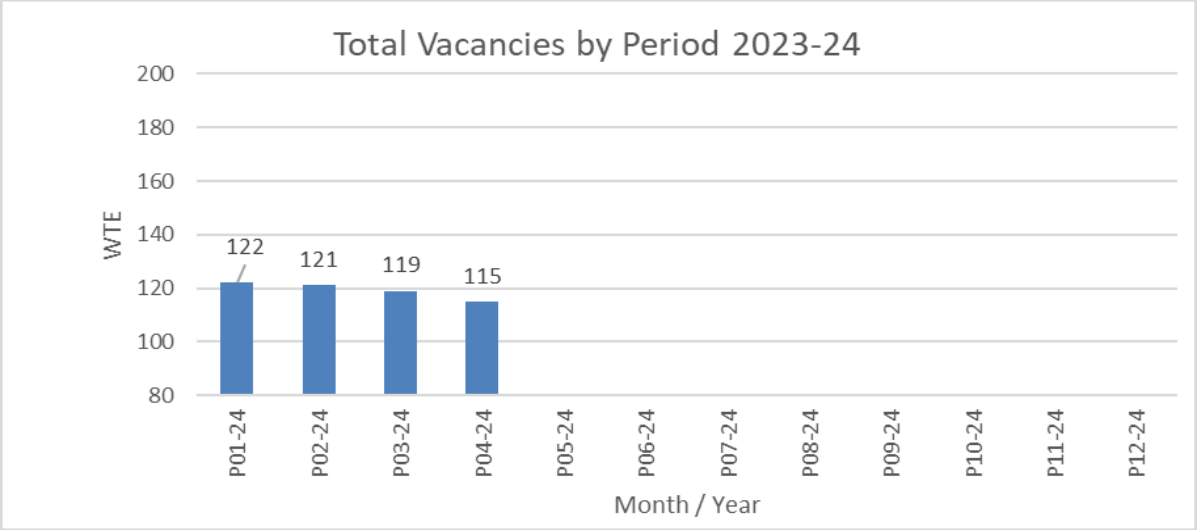
*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% consolidated pay award backdated to April 2023.



The spend on agency for July'23 was **£0.075m,** which gives a cumulative year to date spend of £0.325m and a current forecast outturn spend of circa **£0.580m** (£1.323m 2022/23).


Changes in Total WTE 2022-23 to 2023-24
1,500.00
1,450.00
1,400.00
1,350.00
1,300.00
1,250.00
1,200.00
WTE
1,484.65
1,488.06
1,417.64
P01-23
P02-23
P03-23
P04-23
P05-23
P06-23
P07-23
P08-23
P09-23
P10-23
P11-23
P12-23
P01-24
P02-24
P03-24
P04-24
Month / Year

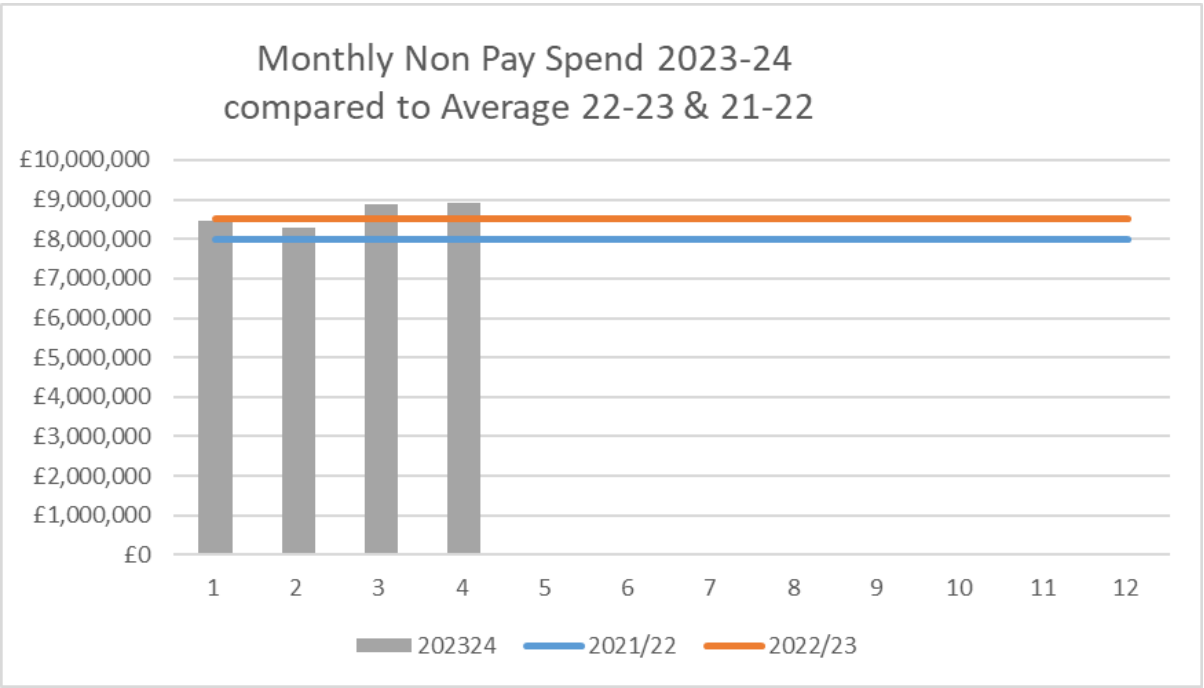

Changes in Actual WTE 2022-23 to 2023-24
By Division
900
800
700
600
500
400
300
200
100
0
WTE
821.48
815.28
779.85
411.39
405.077
402.577
160.03
182.05
185.44
40.45
50.93
47.8
23.41
20.7
VCC WTE
Corp WTE
R&D WTE
TCS WTE
WBS WTE
HTW WTE
Month / Year



The total Trust vacancies as at June 2023 is 119wte, VCC (76wte), WBS (25wte), Corporate (9wte), R&D (3wte), TCS (0wte) and HTW (2wte).

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 £8.6m per month which is a slight increase from the previous whole year average. Largest movement is in drug spend which has increased by £1.4m ytd, or £0.3m average per month when compared with the previous year's spend for the same period. Energy costs have decreased by £0.146m ytd.



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 would be extricating themselves from many of the Covid response costs. Therefore, WG have only committed to cover the financial costs of certain 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 funded to the Trust based on actual spend 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 July 23 being £0.134m, which is a reduction of £0.106m from the £0.240m requested as part of the IMTP. However, whilst unlikely 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

Committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.5m for 2022-23. The income funding for this additional capacity flows via performance related LTA contracting income from Commissioners and is dependent upon activity levels. The LTAs approved by LHBs in June 2023 included a level of income protection for the Trust. Recognising the financial pressures faced by the system in NHS Wales, the Trust Board made a decision in August to concede the income protection arrangements in order to contribute to the reduction of the planned deficit. This will need to be formally communicated with Commissioners and transacted following updated LTAs in September.

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24. The latest position is that the contract performance income is improving however this is reliant on forecast activity levels from Commissioners for Velindre Cancer Services. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The activity levels and Commissioner demand for services will be closely monitored over the coming months.

Whilst the gap in funding continues to reduce 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%).

Following an in depth assessment of savings schemes in July, several schemes have been assessed as non-deliverable and RAG rated red. The impacted schemes relate to workforce and the supply chain with non-recurrent replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has reduced the underlying position to be carried into 2024-25 from £0.391m to a latest position of £0.086m.

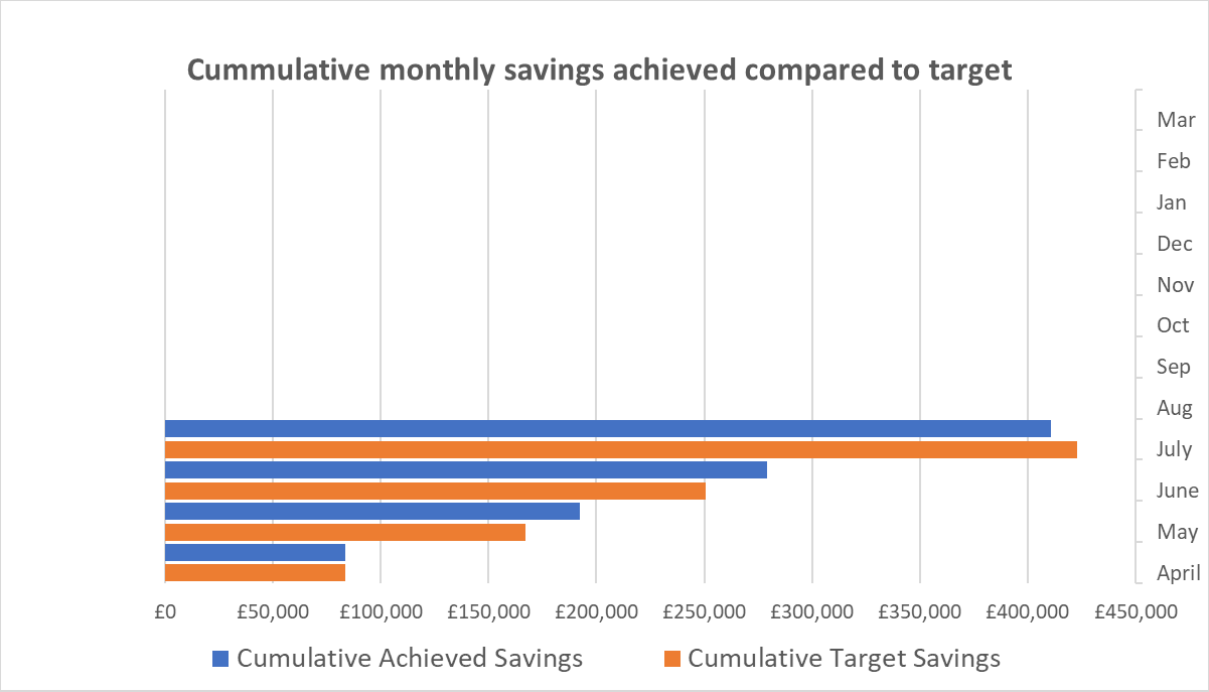
Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness.

The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Whilst we don't expect delivery this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain.

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.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**950**	**211**	**237**	**26**	**950**	**0**
			112%		**100%**	
WBS TOTAL SAVINGS	**700**	**162**	**124**	**(38)**	**700**	**0**
			77%		**100%**	
CORPORATE TOTAL SAVINGS	**150**	**50**	**50**	**0**	**150**	**0**
			100%		**100%**	
TRUST TOTAL SAVINGS IDENTIFIED	**1,800**	**423**	**411**	**(12)**	**1,800**	**0**
			97%		**100%**	

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							
Establishment Control (N/R) (Corporate)	Green	75	25	25	0	75	0
Procurement Supply Chain (R) (WBS)	Red	100	11	0	(11)	0	(100)
Collection Team Costs Reduction (R) (WBS)	Green	10	3	3	0	10	0
Collection Team Costs Reduction (NR) (WBS)	Green	8	3	3	0	8	0
Establishment Control (R) (WBS)	Green	60	20	20	0	60	0
Reduced use of Nitrogen (R) (WBS)	Red	55	6	0	(6)	0	(55)
Reduced Research Investment (R) (WBS)	Green	25	8	0	(8)	25	0
Stock Management (NR) (WBS)	Green	125	42	42	0	125	0
Reduced Transport Maintenance (NR) (WBS)	Amber	30	3	0	(3)	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	Amber	137	15	0	(15)	137	0
Service Workforce Re-design (R) (VCS)	Red	50	6	0	(6)	0	(50)
Establishment Control (NR) (VCS)	Green	175	19	45	26	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	Amber	150	17	17	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	42	42	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	17	17	0	50	0
Procurement Supply Chain (R) (VCS)	Red	100	11	0	(11)	0	(100)
Total Saving Schemes		**1,275**	248	213	(35)	970	(305)
Income Generation							
Bank Interest (R) (Corporate)	Green	75	25	25	0	75	0
Sale of Plasma (R) (WBS)	Green	150	50	50	0	150	0
Expand SACT Delivery (R) (VCS)	Green	200	67	67	0	200	0
Private Patient Income (R) (VCS)	Green	50	17	17	0	50	0
Private Patient Income (N/R) (VCS)	Green	50	17	17	0	50	0
NEW Medicines at Home (N/R) (VCS)	Green		0	17	17	150	150
NEW Sale of Plasma (NR) (WBS)	Green		0	6	6	155	155
Total Income Generation		**525**	175	198	23	830	305
TRUST TOTAL SAVINGS		**1,800**	**422**	**411**	**(12)**	**1,800**	**0**
				97%		**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.

As highlighted earlier a review of reserves and commitments is currently underway in response to the letter received from Judith Paget with a request to support the overall NHS Wales Deficit.

6. End of Year Forecast / Risk & Opportunities Assessment

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2023-24, however following actions taken by the Trust the majority of these risks have either been managed or mitigated for 2023/24.

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The remaining key financial risks & opportunities highlighted to Welsh Government are provided below

Risks

DHCR activity data income risk – *Risk £1.500m / 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 being fully captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team have reviewed the situation and

put in place plans to address the issues. However, if these plans do not resolve the data capture issue there is a risk that c£1.500m income related to unrecorded activity could be lost.

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 2024/25 – *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.

Opportunities

There are several potential opportunities which are in addition to those contributions that have been identified and shared with WG to support the delivery of a reduction in the NHS Wales deficit which could be utilised to support any risks should they crystallise. These include:

Recovery and Planned Care Capacity- *Opportunity / Likelihood - Medium*

An income generation opportunity will arise if the forecast activity performance continues to increase throughout the year. A continued increase in activity levels could mean that the Trust's investment in Covid Capacity and backlog infrastructure can be covered on a non-recurrent basis for 2023/24.

In addition, the Trust continues to review the service model that has been implemented to support backlog activity and where possible reduce or mitigate costs.

Vacancy Turnover – (Low)

There is a potential non-recurrent cost saving opportunity if the Trust cannot recruit to posts over and above the vacancy factor, which is held by the Divisions and Corporate Services.

Contract Currency Review – (low)

An opportunity may develop from a review of the Time Driven Activity Based Costing Model for contract currencies where Service Developments or changes have impacted the underlying cost base.

Finance continues to work with the service to understand changes to contract currencies which would be put to our commissioners as business case for change control.

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 @ M4 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	7.522	0.000	3.374	10.896	0.000
nVCC - Project costs	0.000	0.938	0.000	(0.938)	1.843	(1.843)
Integrated Radiotherapy Solutions (IRS)	10.326	1.806	0.000	8.520	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	10.266	0.000	12.467	24.576	(1.843)
Discretionary Capital	1.683	0.067	0.000	1.616	1.683	0.000
Total	24.416	10.333	0.000	14.083	26.259	(1.843)

The approved Capital Expenditure Limit (CEL) as at June 2023 is **£24.416m**. This represents all Wales Capital funding of **£22.733m**, and Discretionary funding of **£1.683m.**

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£1.8m as at the end of June.

The discretionary allocation of £1.683m represents an increase of 16% on the £1.454m provided during 2022/23.

The allocation of the discretionary programme for 2022/23 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m has been ringfenced to support the nVCC enabling works and project costs with expectation that this funding will be reimbursed from additional funding requested from WG for the nVCC enabling works.

Performance to date

The actual expenditure to July 2023 on the All-Wales Capital Programme schemes was £10.266m, this is broken down between spend on the nVCC enabling works £7.522m, nVCC Project Costs £0.938. and the IRS £1.806m.

Spend to date on Discretionary Capital is currently £0.067m.

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. The financial year cashflows for the IRS and IRS Satellite projects require re-profiling due to delays in the nVCC project and RSC project. This is currently being worked on. The TCS nVCC cash flows will also be revised due to the n VCC project delays for inclusion in the final FBC. The schemes included within the IMTP are provided below:

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 in NHS Financial Statements is known as the Statement of Financial Position (SoFP). It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

The statement shows the Trust's assets and liabilities. As part of the Trust SFIs there is a mandatory requirement to report movement in working capital.

	Opening Balance Beginning of Apr 23	Closing Balance End of Jul-23	Movement from 1st April Jul-23	Forecast Closing Balance End of Mar 24
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	170.418	181.304	10.886	181.304
Intangible assets	11.194	11.262	0.068	11.262
Trade and other receivables	1,111.634	1,111.822	0.188	1,111.822
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,293.246	1,304.388	11.142	1,304.388
Current Assets				
Inventories	34.070	34.035	(0.035)	34.035
Trade and other receivables	565.641	551.807	(13.834)	536.482
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	31.136	11.936	(19.200)	27.261
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	630.847	597.778	(33.069)	597.778
TOTAL ASSETS	1,924.093	1,902.166	(21.927)	1,902.166
Current Liabilities				
Trade and other payables	(226.254)	(208.206)	18.048	(208.206)
Borrowings	(1.123)	0.00	1.123	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(392.525)	(432.194)	(39.669)	(432.194)
Current Liabilities sub total	(619.902)	(640.400)	(20.498)	(640.400)
NET ASSETS LESS CURRENT LIABILITIES	1,304.191	1,261.766	(42.425)	1,261.766
Non-Current Liabilities				
Trade and other payables	(3.092)	(7.336)	(4.244)	(7.336)
Borrowings	(2.421)	0.00	2.421	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,113.507)	(1,069.027)	44.480	(1,069.027)
Non-Current Liabilities sub total	(1,119.020)	(1,076.363)	42.66	(1,076.363)
TOTAL ASSETS EMPLOYED	185.171	185.403	0.232	185.403
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	34.708	34.833	0.125	34.833
PDC	131.461	131.047	(0.414)	131.047
Retained earnings	19.002	19.523	0.521	19.523
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	185.171	185.403	0.232	185.403

9. CASH FLOW (Includes Hosted Organisations)

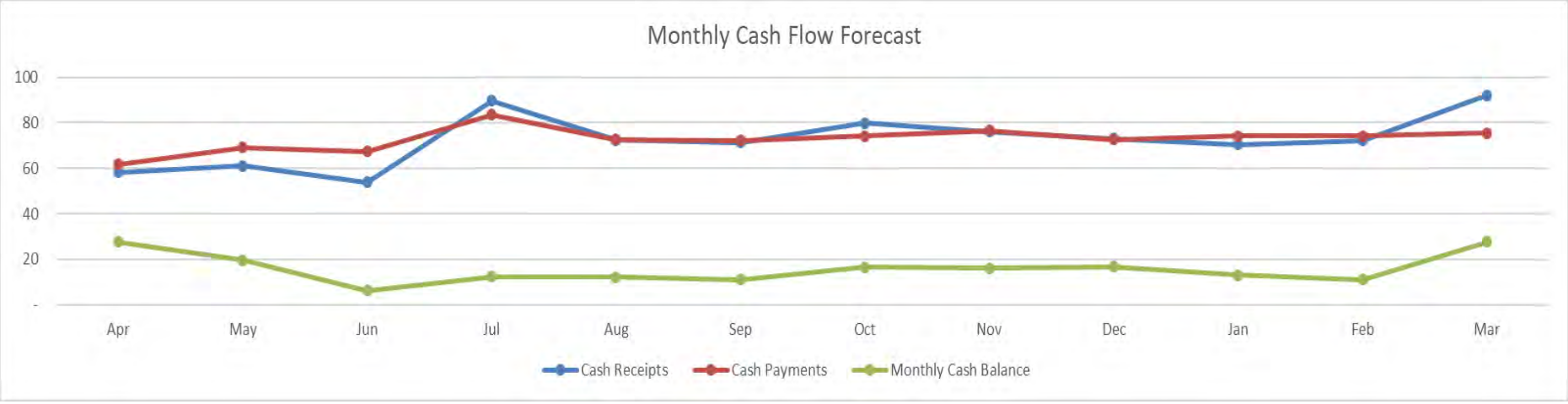
The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of 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	37.581	38.378	41.097	40.905	41.974	41.674	46.542	42.597	41.697	42.597	42.297	41.335	498.673
2	WG Income	14.460	18.799	9.707	42.966	24.263	23.215	24.832	27.325	25.325	21.486	23.525	24.800	280.703
3	Short Term Loans													0.000
4	PDC				0.000								16.404	16.404
5	Interest Receivable	0.149	0.162	0.143	0.126	0.100	0.100	0.100	0.100	0.100	0.100	0.100	0.100	1.380
6	Sale of Assets													0.000
7	Other	6.156	3.753	2.953	5.651	6.150	6.250	8.265	6.150	6.050	6.350	6.250	9.325	73.302
8	TOTAL RECEIPTS	**58.346**	**61.092**	**53.900**	**89.648**	**72.487**	**71.239**	**79.739**	**76.172**	**73.172**	**70.533**	**72.172**	**91.964**	**870.463**
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	38.993	34.802	33.238	33.366	33.419	33.424	33.432	33.464	33.476	33.636	407.771
10	Non pay items	28.883	33.947	26.186	46.813	37.325	36.425	37.253	39.583	37.798	38.746	38.524	38.023	439.507
11	Short Term Loan Repayment											0.000		0.000
12	PDC Repayment													0.000
14	Capital Payment	1.122	0.394	2.160	1.949	2.170	2.490	3.591	3.477	1.328	1.987	2.202	3.775	26.645
15	Other items													0.000
16	TOTAL PAYMENTS	**61.807**	**69.062**	**67.339**	**83.564**	**72.733**	**72.281**	**74.263**	**76.484**	**72.558**	**74.197**	**74.202**	**75.434**	**873.923**
17	Net cash inflow/outflow	(3.461)	(7.970)	(13.438)	6.085	(0.246)	(1.042)	5.476	(0.312)	0.614	(3.664)	(2.031)	16.529	
18	Balance b/f	31.136	27.675	19.705	6.266	12.351	12.105	11.063	16.539	16.227	16.841	13.177	11.146	
19	Balance c/f	27.675	19.705	6.266	12.351	12.105	11.063	16.539	16.227	16.841	13.177	11.146	27.676	



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	(10.486)	(10.487)	(0.000)	(37.761)	(37.761)	0.000
RD&I	(0.273)	(0.273)	(0.000)	0.091	0.091	0.000
WBS	(5.292)	(5.292)	(0.000)	(20.226)	(20.226)	0.000
Sub-Total Divisions	**(16.052)**	**(16.052)**	**0.000**	**(57.896)**	**(57.896)**	**0.000**
Corporate Services Directorates	**(3.061)**	**(3.059)**	**0.002**	**(11.670)**	**(11.670)**	**0.000**
Delegated Budget Position	**(19.113)**	**(19.111)**	**0.002**	**(69.566)**	**(69.566)**	**0.000**
TCS	(0.186)	(0.186)	(0.000)	(0.638)	(0.638)	0.000
Health Technology Wales	(0.025)	(0.025)	(0.000)	(0.025)	(0.025)	0.000
Trust Income / Reserves	19.323	19.323	(0.000)	70.229	70.229	0.000
Trust Position	0.000	0.002	0.002	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	**23.064**	**23.470**	**0.406**	**71.893**	**71.893**	**0.000**
Expenditure						
Staff	**16.942**	**16.851**	**0.091**	**48.267**	**48.267**	**0.000**
Non Staff	**20.778**	**21.275**	**(0.497)**	**63.801**	**63.801**	**0.000**
Sub Total	**37.720**	**38.126**	**(0.406)**	**112.068**	**112.068**	**0.000**
Total	**(14.656)**	**(14.656)**	(0.000)	**(40.175)**	**(40.175)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of July 2023 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 4 represents a surplus of **£0.406m**. Overachievement on Private Patients drugs due to both activity and the VAT savings from delivery of SACT homecare is offsetting the divisional management savings target.

VCS have reported a year to date underspend of **£0.091m** against staff. The division continues to have high levels of vacancies, sickness, and maternity leave across several services, this along with recruitment challenges, is largely offsetting both the vacancy savings target and the

requirement to support posts appointed into without funding agreement i.e. Advanced recruitment and Capacity investments.

Non-Staff Expenditure at Month 4 was **£(0.497)m** overspent which is a result of increased activity pressures which can be linked to contract performance and in areas such as 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	**8.621**	**8.663**	**0.042**	**26.554**	**26.554**	**0.000**
Expenditure						
Staff	**6.359**	**6.308**	**0.050**	**18.361**	**18.361**	**0.000**
Non Staff	**9.680**	**9.772**	**(0.092)**	**29.696**	**29.696**	**0.000**
Sub Total	**16.039**	**16.081**	**(0.042)**	**48.057**	**48.057**	**0.000**
Total	**(7.417)**	**(7.418)**	0.000	**(21.503)**	**(21.503)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of July 2023 was **Breakeven** with an outturn forecast position of **Breakeven** currently expected.

Income overachievement of **£0.042m** to month 4. 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, however the year to date target is currently underachieving by c35%.

Staff reported a **£0.050m** underspend to July. 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.

Discussions ongoing within WBS SMT to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff reported an overspend of **£(0.092)m** to July. Energy price rises expected to be funded centrally by the Trust as agreed at the IMTP planning stage, along with venue hire costs pressures previously funded by WHSSC, are being offset by reduced spend from lower activity.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**0.809**	**1.164**	**0.355**	**1.973**	**1.973**	**0.000**
Expenditure						
Staff	**3.883**	**3.821**	**0.062**	**11.245**	**11.245**	**0.000**
Non Staff	**1.157**	**1.550**	**(0.393)**	**3.039**	**3.039**	**0.000**
Sub Total	**5.040**	**5.371**	**(0.331)**	**14.284**	**14.284**	**0.000**
Total	**(4.231)**	**(4.207)**	0.024	**(12.311)**	**(12.311)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of July 2023 was an underspend of **£0.024m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust continues to significantly benefit from receiving greater returns on cash being held in the bank due to the rise in interest rates.

For staff the expectation is that vacancies within the division will help offset the cost of 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 ageing 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	**0.658**	**0.671**	**0.013**	**3.229**	**3.229**	**0.000**
Expenditure						
Staff	**0.945**	**0.943**	**0.002**	**2.876**	**2.876**	**0.000**
Non Staff	**0.072**	**0.087**	**(0.015)**	**0.262**	**0.262**	**0.000**
Sub Total	**1.017**	**1.030**	**(0.013)**	**3.137**	**3.137**	**0.000**
Total	**(0.359)**	**(0.359)**	0.000	**0.091**	**0.091**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of July 2023 was **breakeven** with a current forecast outturn position of **breakeven**.

Trials Income fluctuations expected throughout the year

Small Pay underspend due to vacancies.

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**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.266**	**0.264**	**0.002**	**0.730**	**0.730**	**0.000**
Non Staff	**0.006**	**0.028**	**(0.022)**	**0.015**	**0.015**	**0.000**
Sub Total	**0.272**	**0.292**	**(0.020)**	**0.744**	**0.744**	**0.000**
Total	**(0.272)**	**(0.292)**	(0.020)	**(0.744)**	**(0.744)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of July 2023 is breakeven with a forecasted outturn position of **Breakeven.**

The TCS report is including Escrow interest within the overall financial envelope which is not yet reflected within the budgets and will be used to mitigate the current overspend.

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	**0.506**	**0.506**	**0.000**	**1.677**	**1.677**	**0.000**
Expenditure						
Staff	**0.510**	**0.509**	**0.000**	**1.545**	**1.545**	**0.000**
Non Staff	**0.051**	**0.051**	**0.000**	**0.248**	**0.248**	**0.000**
Sub Total	**0.561**	**0.560**	**0.000**	**1.794**	**1.794**	**0.000**
Total	**(0.054)**	**(0.054)**	(0.000)	**(0.117)**	**(0.117)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of July 2023 was **breakeven,** with a forecasted outturn position of **breakeven.**

HTW is funded directly by WG.

TRUST BOARD

Sickness Absence Key Performance Indicator

DATE OF MEETING	28th September 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	Amanda Jenkins, Head of Workforce
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	This paper considers the current KPI for sickness absence of 3.54% within Velindre University NHS Trust and benchmarks this against the current labour market in health and social care to demonstrate this is not an achievable measure for the interim given this information. The paper does not seek to replace the Welsh Government target however it looks to consider if an additional internal KPI, that is more realistic, should be used when assessing the performance of the divisions in respect of sickness absence management.

RECOMMENDATION / ACTIONS	Board is asked to **Approve** an internal sickness target of 4.7%, as a stepping stone towards improvement, while Welsh Government are considering targets nationally.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	(31/08/2023)
Quality Safety and Performance Committee	(14/09/2023)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS *Endorsed for approval*	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

APPENDICES	
N/A	

1. SITUATION

Welsh Government sets a tier one target in respect of sickness absence for each organisation within NHS Wales and performance against this target is reported within the Trust on a monthly basis. The Trust's current sickness absence target is 3.54% and was set by Welsh Government more than ten years ago. The landscape of the labour market has significantly changed since this target was set therefore this paper will present more recent benchmarking and provide an analysis to support the local implementation of a more sustainable internal target within the Trust.

This Target will not replace the expectation from Welsh Government but aid as a stepping stone for the organisation to better understand if improvements are being made towards the tier one target within the current employment landscape.

2. BACKGROUND

UK Labour Market

The Office of National Statistics produce an annual dataset on sickness absence within the current UK labour market, providing us with key benchmarking as an organisation in comparison to the national average sickness rates.

The sickness rates recorded by the ONS is proportional to the total hours lost because of sickness or injury divided by total hours multiplied by 100 within a year starting on 01st January and ending on 31st December.

The following information shows annual sickness absence rates from the ONS dataset:

Year	*Sickness Rate in the UK Labour Market*	*Sickness Rate in Health and Social Care*
2022	2.6%	4.2%
2021	2.2%	3.4%
2020	1.8%	3.0%
2019	1.9%	2.9%
2018	2.0%	No data
2017	1.9%	No data

While the UK labour market has seen marginal increases in sickness absence rates it is important to take note that COVID-19 has had significant impact on the data due to government policies on furlough and the wider ability to work from home. In comparison in the Health and Social Care Sector where these schemes are less viable due to service needs, the UK has seen a more marked growth in sickness absence rate.

NHS Wales Sickness Absence

Information on sickness absence rates are provided to Welsh Government via NHS Wales Shared Services Partnership (NWSSP) with an annual data set

equivalent to that of the ONS being produced for each NHS Wales organisation by Stats Wales.

The following information shows the annual sickness rates from the Stats Wales data set sorted by 2022 performance.

Organisation	***2022***	***2021***	***2020***	***2019***	***2018***	***2017***
Welsh Ambulance Services NHS Trust	10.01%	9.7%	7.0%	7.2%	7.4%	6.8%
Swansea Bay University LHB	8.0%	7.3%	7.4%	6.1%	.	.
Cwm Taf Morgannwg University LHB	7.6%	7.2%	7.0%	6.1%	.	.
Cardiff & Vale University LHB	7.2%	6.6%	6.0%	5.4%	5.2%	5.0%
Aneurin Bevan University LHB	6.9%	6.1%	6.1%	5.6%	5.3%	5.2%
All Wales	**6.9%**	**6.3%**	**6.0%**	**5.5%**	**5.3%**	**5.1%**
Betsi Cadwaladr University LHB	6.6%	6.0%	5.5%	5.3%	5.0%	4.9%
Hywel Dda University LHB	6.6%	5.7%	5.2%	5.1%	4.9%	4.9%
Velindre University NHS Trust[1]	**6.3%**	**4.3%**	**3.7%**	**4.2%**	**4.1%**	**3.9%**
Powys Teaching LHB	6.1%	5.3%	4.9%	4.7%	4.6%	4.6%
Public Health Wales NHS Trust	4.6%	4.1%	3.5%	3.8%	4.0%	4.0%
NHS Wales Shared Services Partnership	3.1%	2.9%	.	.	.	.
Digital Health and Care Wales	2.9%	2.4%	.	.	.	.
Health Education and Improvement Wales	2.2%	2.2%	2.0%	2.6%	1.7%	.

When considering the data across NHS Wales there is a clear and significant increase in sickness absence rates across all health organisations post the COVID-19 pandemic.

[1] *The data for Velindre University NHS Trust includes NWSSP staff until June 2021*

Cancer and Blood Services

As well as considering our position within the wider NHS Wales system it is important to provide a comparative analysis against other Cancer and Blood Services within the UK, where their sickness absence data has been publicly reported.

The following data represents the most recent public reports on rolling sickness absence for December 2022. As demonstrated above in the NHS Wales figure Velindre University NHS Trust was reporting 6.3% at this time.

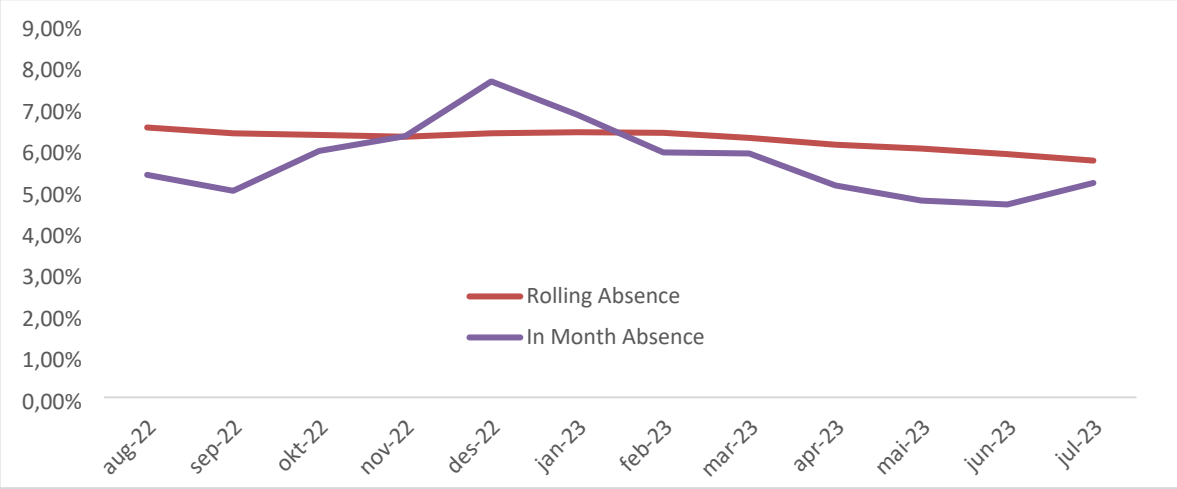
Organisation	*Reporting Month*	*Sickness Absence Rate*	*Sickness Absence Target*
The Christie NHS Foundation Trust	December 2022	6.22%	3.4%
The Clatterbridge Cancer Centre NHS Foundation Trust	December 2022	5.9%	4%
The Royal Marsden NHS Foundation Trust	December 2022	4.5%	3%
NHS Blood and Transplant	December 2022	5.79%	4%

Prior to 2022 the average sickness absence rate from 2017 to 2021 for the Trust was 4.04% however the benchmarking data presented within this report, clearly demonstrates that the growth in sickness absence for the Trust is not unprecedented across the wider health system.

It is clear that Velindre University NHS Trust needs to consider this wider picture in coming to a conclusion as to a realistic internal target for sickness absence.

3. SUMMARY OF MATTERS FOR CONSIDERATION

Current Sickness Absence Analysis (July 2023)



The graph above demonstrates the rolling sickness absence rate as of July 2023 and shows the 0.66% decline in rolling absence since December 2022. Given the Trust is continuing its efforts to effectively manage staff absence and proactively support wellbeing it is anticipated this position will continue to improve across the service.

It would be realistic to predict in the coming year based on the current sickness trends the Trust's sickness absence rate will reduce.

Based on this anticipated decline in sickness absence as cases are managed within the Trust and considering the benchmarking data across the sector, it would be reasonable to set an internal target of 4.7% to be reviewed in September 2024.

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*	03 - Workforce Planning
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 ☒ Not effectively managing sickness absence will have a significant impact on the availability of skilled and developed people to deliver services in a safe, timely, effective, equitable, efficient manner that is centred around the patient or donor.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required

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
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial resources are impacted by the level of absence across all staff groups in the Trust.
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
	Policies that relate to absence management are subject to individual EQIA processes
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	

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	28th September 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	

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 14th September 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 14th SEPTEMBER 2023

3.1 Triangulated themes

The following themes emerged from the meeting:

- Digital capability and impact on clinical delivery, patient / donor safety and risk.

3.2 Further Information

Board members who are not members of the Committee and require further detail are able to access the agenda and papers for the September 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-14092023/

3.3 Summary of Committee Highlights

The following areas were highlighted for reporting to the Trust Board by the Committee:

ALERT / ESCALATE	• **Equality Impact Assessments** The Committee were unable to endorse/approve several Trust policies as the Equality Impact Assessment process had not been completed. The Committee requested that a review of the Equality Impact Assessment processes is undertaken to ensure that these are all fully completed in advance of any policies being provided to the Committee for endorsement / approval.
ADVISE	• **Fuller Inquiry Action Plan (Body Storage) – Interim Progress Report** The Committee received the Fuller Inquiry Action Plan and noted the progress made towards meeting the recommendations in the report. All but five recommendations (76.2%) had been completed and 5 remain outstanding. All outstanding are due to be completed by December 2023. The Committee **APPROVED** that all remaining actions can move across to the Quality & Safety Tracker for continued monitoring. The Chair of the Committee identified that the level 6 assurance level applied to the paper could not reflect the position given that not all recommendations had been concluded and no audit undertaken to evidence sustained implementation. The Committee were advised that two refresher "seven levels of assurance" training sessions are being arranged for Trust officers who require further training. This will be completed by the end of November 2023. • **Trust Risk Register and Trust Assurance Framework** The Committee received an update on the Risk paper following the discussions at the July meeting and subsequent further discussion at Audit Committee, where it was requested that due-by dates to reach the target risk score be included in the report. These dates have now been included, where possible, and this will now be included as a field in DATIX to appear as a column in future reporting. The Committee were advised that deep dives were focused on the two longest open risks: the use of email for clinical processes and inflation for the new Velindre Cancer Centre programme, the latter of which is reducing along with the proximity to financial close.

	In terms of Digital risks which had been highlighted as a key theme of triangulated risks during the July cycle, it was noted that some progress towards addressing these risks has been made and a detailed presentation around the progress of all Digital-related risks will be brought to the November meeting. Trust Assurance Framework:-Following a strategic risk refresh, a paper was presented which outlined which Committee would provide oversight on these strategic risks and highlighted the wording review. The paper outlined that two strategic risks were reportable to this Committee – service capacity and patient outcomes – which had been endorsed by the Strategic Development Committee at their meeting on 5th September 2023. It was agreed, however, after discussion, that the Quality, Safety and Performance Committee should also have oversight of the Workforce Supply and Shape risk due to its potential impact on patients and donors and reflected in the Committee's Terms of Reference. The chair expressed her concerns that the Committee had still not seen the actual refreshed Trust Assurance Framework (TAF) (Strategic objectives aligned with the risks against delivery, with actions and assurances against each area) and asked for confirmation that the Trust Board in September and the Audit Committee at the beginning of October would be receiving the full TAF. This assurance was given. • **Workforce Supply and Shape & Associated Finance Risks** The Committee received the report, the purpose of which is to provide an update on the key strategic integrated actions the Trust is taking to address the challenges of the supply and shape of the workforce, to ensure the mitigation of risks and to understand how actions are impacting on performance. Various existing and upcoming challenges were highlighted, along with wellbeing interventions implemented to address these. The Committee were advised that as the BMA are due to ballot on strike action, a forthcoming period of Industrial Action is highly likely and partnership working with Trade Unions is challenging. Performance data was highlighted, showing a declining trend in sickness absence – currently at 5.7% and workforce feedback via exit strategies, staff surveys and pulse surveys indicate that staff are suffering from fatigue.

	The Committee heard that key areas of recruitment have been undertaken over the past few months and a move towards international recruitment has been made. The Committee requested that future papers outline performance indicators in order to clearly demonstrate the pace of key actions within the strategy, what has and has not been achieved as expected and any improvement outcomes and to ensure that levels of assurance are included. The two key financial risks were outlined: the first around the significant investment made to provide additional capacity during COVID to deal with the increased demand on the service. This was initially funded by Welsh Government during the pandemic, however this funding ceased during this financial year. The Committee were advised that based on the current forecast and trajectory to the end of the year in terms of activity performance, the financial risk initially flagged at potentially £1.5M is currently at £500K and anticipated to disappear completely during this financial year. The second financial risk under continual review is vacancy rate and sickness and absence levels and the impact on variable pay – essentially agency costs – although this is reducing as a result of successful recruitment efforts. • **Finance Report for the period ended 31st July 2023 (M4)** The Committee received the Finance Report which demonstrates that the revenue position is on track to deliver. A significant number of ongoing financial risks exist across the financial landscape and NHS Wales, although the Trust has a balanced Integrated Medium-Term Plan which was recently approved by the Minister and the trajectory remains to be balanced by the end of the year. It was noted that for this month a year forecast deficit has been flagged, this was to ensure that Welsh Government are clearly sighted on the additional funding requested in relation to the new Velindre Cancer Centre project management costs. Welsh Government are aware that these costs have moved on and have requested an update which will be submitted this week. The Committees attention was drawn to the information around the NHS Wales financial pressures which, agreed by the Board, demonstrates the measures to be taken by the Trust in terms of contributing to the all-Wales financial challenge – specifically foregoing contract income protection which will release £1.2M benefit to Health Board colleagues,

and the reduction in prices around energy and improvement in our forecast.

- **Highlight Report from the Trust Estates Assurance Group**

The Committee received the report, noting in particular the items for alert/escalation in respect of health & safety/fire safety training compliance figures and inflated utilities costs. Attention was drawn also to the issues around staffing levels as it was noted that significant recruitment challenges remain, largely due to the higher salaries offered for the same or similar roles in non-NHS organisations.

- **Integrated Quality & Safety Group Report**

The Integrated Quality & Safety Group Report covering the period May-July 2023 was discussed in detail.

The report included the current status of the Quality & Safety Tracker and the Committee were advised of the further work planned (due to the current gaps in the tracker) so that the Committee can, from the next meeting, begin to receive the required level of assurance from the tracker.

The Committee were advised that the Duty of Quality "always on reporting" had commenced on the Trust website with patient and donor experience information. The development of the Trust's Quality Management Systems is underway and significant work has been undertaken to agree the additional quality metrics.

- **Trust Infection Prevention Management Group Highlight Report**

The highlight report from the Infection Prevention and Control Management Board meeting held on 17th August 2023. The Committee Endorsed

- IPC 00 – Framework Policy for Infection Prevention and Control and
- Endorsed that IPC 11 – Transport of Specimens would remain extant until November 2023 when the review of the policy will be completed.
- IPC Policy 09 – Infection Prevention and Control in the Built environment is removed as a Trust policy as the requirements are now covered adequately as a chapter in the National Infection Prevention and Control Manual (IPC 05).

There were five matters for alerting to the Committee contained within the report and there was work underway to address each of them:

	• Compliance with uniform standards in clinical areas – escalation to responsible managers and Divisional Senior Teams has taken place. • VCC Flooring in Radiotherapy – will be repaired / replaced by the 27th November 2023. • Repeated positive Legionella water samples in Welsh Blood, risk mitigation in place through flushing and filters and a long-term solution to replace piping is being planned. • Infection Prevention & Control Training Compliance – robust escalation to managers taken place and a recovery plan is in place. • New Cancer Centre- resolution has been reached on a number of Infection Prevention and Control design matters that had been escalated and a plan in place to address those that remain outstanding. In addition, there had been fungal environmental deviations in the aseptic unit at Velindre Cancer Centre Pharmacy Department identified through monitoring systems. Risk reduction action has been taken including regular fogging with Hydrogen Peroxide. All present, at the Infection Control meeting including the Infection Control Doctor, were assured in respect of actions taken at the time to reduce risk, ongoing actions and functioning of the Unit.
ASSURE	• **Value Based Healthcare Report** The Committee received the Value Based Healthcare Report, a bi-annual update to reflect the work undertaken over the past eight months and forms part of the Trust's Building Our Future Together programme and should not be seen as an isolated piece of work. The Committee noted that Welsh Government funded two specific projects for the Trust in the Value Based Healthcare monies that were available in the last financial year: o Preoperative Anaemia Pathway, led by Welsh Blood Service which is already showing improvements across Wales in terms of use of blood, and o Value Intelligence Centre, essentially the staffing infrastructure (i.e. additional Business Intelligence, Digital and Project Management staff, backfilling clinical inputs into value based healthcare improvements) to drive forward the value based healthcare agenda. • **Information Governance Assurance Report** The Committee received the report which highlights compliance with Information Governance legislation and standards, details actions to

improve management of associated risks, reporting of incidents and actions from lessons learned. The report focuses on three of the four Information Governance domains: NHS Wales Information Governance Toolkit, Information Management and Information Security.

- **Welsh Blood Service Quality, Safety & Performance Report**

An overall positive comprehensive WBS Quality & Safety Report covering a six- month period February 2023 to July 2023 was discussed. The report included positive donor experience outcomes and good compliance with investigations.

Three SABRE (Serious Adverse Blood Reactions and Events) incidents were reported during the period. All had been fully investigated and no harm occurred.

The Duty of Candour had not been triggered during this period.

- **Quality, Safety & Performance Report**

The Committee received a comprehensive Trust-wide report covering the month of July 2023 and highlighting some of the current challenges. Fragility of the workforce was noted as a common theme, although it was understood that this had been exacerbated due to the high number of annual leave days taken during the summer period.

- Radiotherapy capacity continues to present challenges and although largely affected by LINAC capacity, late delineation and repeat scan requests staff are working extended days and weekends in order to mitigate the impact of summer annual leave.

- Issues experienced by the wider healthcare system around delayed transfers of care were also highlighted. Velindre nurse leads are active members of the All Wales Pathways of Care Delays (Po CD) National Group who are working to manage this.

- Validation work is still underway to ensure all patients are being appropriately managed during the transfer to Digital Health and Care Record (DHCR). Clinical Harm Reviews have been carried out for the small number of patients who have waited slightly longer than the target times, concluding that no patient harm has occurred in these cases.

- Continued improved performance in Systemic Anti-Cancer Therapy (SACT) was noted.

In terms of the national concerns around the use of Reinforced Autoclaved Aerated Concrete (RAAC) the Committee were given assurance that, following an initial assessment, no RAAC had been identified. The final report to confirm this is expected to be received at the end of this month.

- **Sickness Absence Key Performance Indicator**

The Committee reviewed the paper which considers the current Welsh Government-set Key Performance Indicator (KPI) for sickness absence of 3.54% and looks to consider whether an additional, more realistic, internal KPI (4.7%) should be used when assessing the performance of the divisions in respect of sickness absence management. The paper benchmarks the KPI figure against the current labour market and sickness absence rates amongst health and social care and summarises that the 3.54% figure is not an achievable measure.

The Quality, Safety and Performance Committee **APPROVED** an internal sickness target of 4.7%, as a steppingstone towards improvement, while Welsh Government are considering targets nationally.

- **Quality and Safety 2023-24 Quarter 1 Report**

The Quality & Safety Quarter 1 report provided an overall positive overview of delivery against the Trust's responsibilities in relation to key elements of Quality & Safety for the period 01/04/2023 - 30/06/2023 and for the first time includes safeguarding and infection prevention & control data. The Committee were advised that:

- Good compliance with Putting Things Right in line with complaints had been achieved, with 100% compliance on timescales.
- There were no new Ombudsman cases referred to the Trust.
- There were no National Reportable Incidents in quarter 1 in line with Putting Things Right, although 3 IRMER incidents had been reported.
- One moderate incident was reported in quarter 1, however the Duty of Candour was not triggered until quarter 2 and as such will be included in the next report.

- **The Medical Examiner Service and Velindre University NHS Trust**

The Committee received the six-monthly report which provided an update regarding the implementation of the Medical Examiner Service (MES) and the wider work of mortality and morbidity within Velindre

	Cancer Centre. Statutory requirements around the MES continue to be met, with progress being made in the formal reviews of mortality and morbidity, with work now anticipated to gather pace following the recent appointment of a Mortality and Improvement Facilitator. An issue on the accuracy of death data recorded within Velindre's Welsh Patient Administration System (WPAS) since the implementation of the Digital Health & Care Record was highlighted. This is urgently being investigated and inpatient data is not affected. A contingency has been put in place for the affected 30-day mortality data to be checked and validated before publishing. • **Annual Medical Education Governance Report** This report is the second annual report for medical education governance for the Trust and details the activities and performance for the reporting period August 2022 to August 2023 for both WBS and VCC. The report provides assurance that the Trust is meeting its commissioning and GMC requirements for Medical Education. Many of the emerging themes received from the recent GMC survey around burnout of trainees, time for training, etc. are reflective of many of the pressures currently experienced throughout the service. An action group has been established to work with trainees, gain an understanding of the issues and put mitigations in place to address them.
INFORM	• **Welsh Blood Service Donor Story** A video donor story had been provided to the Committee that outlined the recommencement post-COVID of the Donor Awards and the importance that these events have in retaining donors. The video outlined the experiences of a number of donors and how much they get from giving blood. • **Freedom of Information Requests Report** The Committee received a brief report providing answers to question previously raised, offering more detail around the quarter-by-quarter view of compliance and the types of Freedom of Information requests received by the Trust. • **Health & Safety Annual Report** The Committee received an overview of the report which covered the period 1st April 2022-31st March 2023.

	The Health and Safety Annual Report was **ENDORSED** for Trust Board approval. • **Surgical Materials Testing Laboratory (SMTL) Annual Report** The report, presented for the first time at this Committee, provided an overview of the key aspects of the SMTL service for NHS Wales, the significance of medical device testing and the quality management system employed to provide assurance on laboratory output. • **Medical Examiner Service (MES) Annual Report** The Committee received the first Medical Examiner Service (MES) report which provided an overview of implementation of the MES and work undertaken in preparation for anticipated statutory status in early 2024. • **Quality Impact Assessment Tool** The new National Quality Impact Assessment tool was **ENDORSED** for onward Board approval. • **Medicines Management Assurance Report** The Committee received the report which provided assurance that the roles and responsibilities of the Medicines Management Group are being executed in line with accepted current best practices.
APPENDICES	N/A

3 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 14th September 2023.

TRUST BOARD

AUDIT COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	28/09/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Martin Veale, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 26 July 2023.

Key highlights from the meeting are reported in Section 2.

The Board is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Audit Committee held on the 26 July 2023:

ALERT / ESCALATE	**2022/23 INTERNAL AUDIT ANNUAL REPORT & HEAD OF INTERNAL AUDIT OPINION** The Committee noted the positive report which gave a **REASONABLE ASSURANCE** rating for the year, based on three substantial, ten reasonable, and one limited assurance reports. **AUDIT WALES ISA 260 REPORT** The Committee noted Audit Wales' end of audit ISA 260 report, which gave an **UNQUALIFIED OPINION** on the Trust's annual accounts for 2022/23. There were no uncorrected misstatements, and none of the corrected misstatements had any impact on the Trust's outturn position. **ACCOUNTABILITY REPORT & ANNUAL ACCOUNTS 2022/23** The Accountability Report and Annual Accounts for 2022/23, including the Letter of Representation and the Trust's response to Audit Wales regarding Trust governance and management arrangements were noted by the Committee. The Accountability Report 2022/23 was **ENDORSED** by the Committee subject to minor recommended changes, to be taken to the July Trust Board for approval. The Annual Accounts for 2022/23 were **ENDORSED** by the Committee to be taken to July Trust Board for approval. Following Board approval an unqualified opinion would be issued, and the Annual Accounts for 2022/23 would then be submitted for sign-off by the Auditor General for Wales by 31 July 2023.
ADVISE	**AUDIT WALES FINAL AUDIT PLAN** The Committee noted that this audit plan was received very late in the day and should normally be received before the annual audit has commenced. The plan sets out materiality levels, the timetable, and the audit fee: a 4.2% increase in the performance audit fee and a 15% increase in the estimated financial audit fee. **AUDIT ACTION TRACKER** The Committee was pleased with the progress shown in the Audit Action Tracker. It **APPROVED** the closure of 24 Internal and six External actions, noted the two Internal and two External overdue actions and **APPROVED** the extension to completion dates for these. **VARIATION TO STANDING ORDERS VELINDRE UNIVERSITY NHS TRUST** The Committee **ENDORSED** the report for Board approval subject to minor changes. **TRUST ASSURANCE FRAMEWORK** The Committee expressed disappointment that there was not a Trust Assurance Framework (TAF) item on this agenda. The Committee received an oral update on the ongoing work to the TAF template and were informed that work will be completed with the owners on the new template to bring back to Strategic Development Committee and September 2023 Trust Board.

ASSURE	**INTERNAL AUDIT PROGRESS UPDATE** The Committee **APPROVED** the following changes to the 2023/24 Audit Plan: • Integrated Radiotherapy Solution (IRS): The Implementation Review will be undertaken as the capital assurance review, and audit and management have identified the governance assurance and risk programme to go in its place. • New Cancer Centre: Five nVCC audits were deferred from last year into the 2023/24 audit programme. However, it has been identified that there are external parties doing work in two of these areas that would duplicate what was planned. Consequently, audits on the Design and Change Management, and Procurement Reviews will be cancelled. **VUNHST CLINICAL AUDIT ANNUAL REPORT 2021-2023** The Committee noted the report covering the past two years and its integrated approach, including the audit outputs from both Velindre Cancer Service and the Welsh Blood Service. The report demonstrates the diversity and the range of the clinical audits that are currently in place. The report had an overall reasonable assurance rating with five actions identified. All the outputs of this annual report have informed the development of the Trust Clinical Audit Plan that has been developed for 2023/2024. **TRUST RISK REGISTER** The Committee expressed concerns around the length of time some risks are outstanding with no indication of a target date to mitigate the risk, and were told that this would be added as part of the ongoing development of the register. The Committee noted that QSP Committee has discussed the cumulative risk of the separate digital systems, the challenges in BI and the manual resource of clinical staff to manage information. It was agreed that, where in depth discussions are taking place on specific risks at QSP Committee, Audit Committee should be invited to those sessions. **GOVERNANCE ASSURANCE & RISK GOVERNANCE, ASSURANCE & RISK PROGRAMME OF WORK.** The Committee received an oral update on the ongoing work to the 21 projects under this programme. **FINANCIAL CONTROL PROCEDURE UPDATE** The Committee **APPROVED** a change to FCP 1 – Budgetary Control procedure, which was an action in relation to the recommendation from Internal Audit.
INFORM	**INTERNAL AUDIT REPORTS** The Committee received the following internal audit reports: • Follow Up of Previous Recommendations - Reasonable Assurance • Trust Priorities – Reasonable Assurance **OTHER BUSINESS:** The Committee also received written reports under the following agenda items: • Audit Position Update; • Public Sector Readiness for Net Zero Carbon by 2030 - Management Responses; • Counter Fraud Progress Report Quarter 1 23/24; • Private Patient Service Review; • Private Patient Service Debt Position;

	• Losses and Special Payments Report; • Procurement Compliance Report; and • Audit Committee Cycle of Business.
APPENDICES	**NONE**

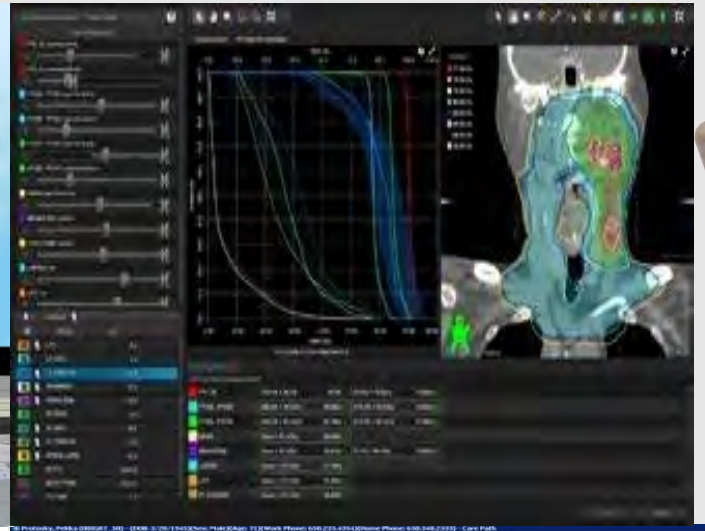
3. RECOMMENDATION

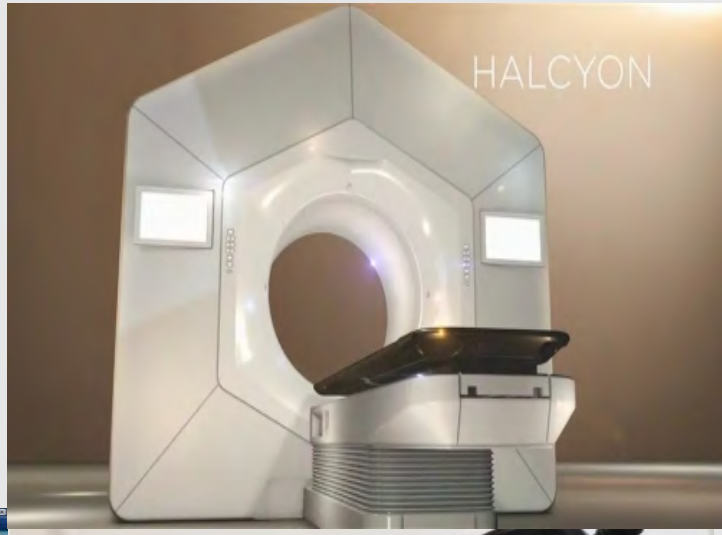
The Trust Board is asked to **NOTE** the contents of this report.

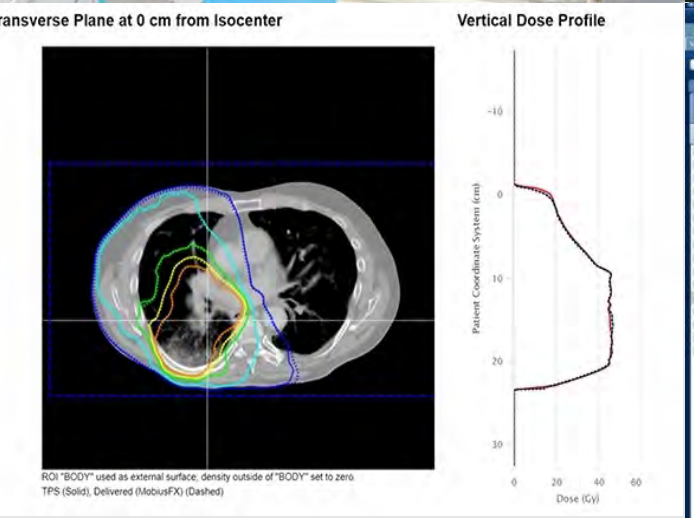
Radiation Services – Board Development Session

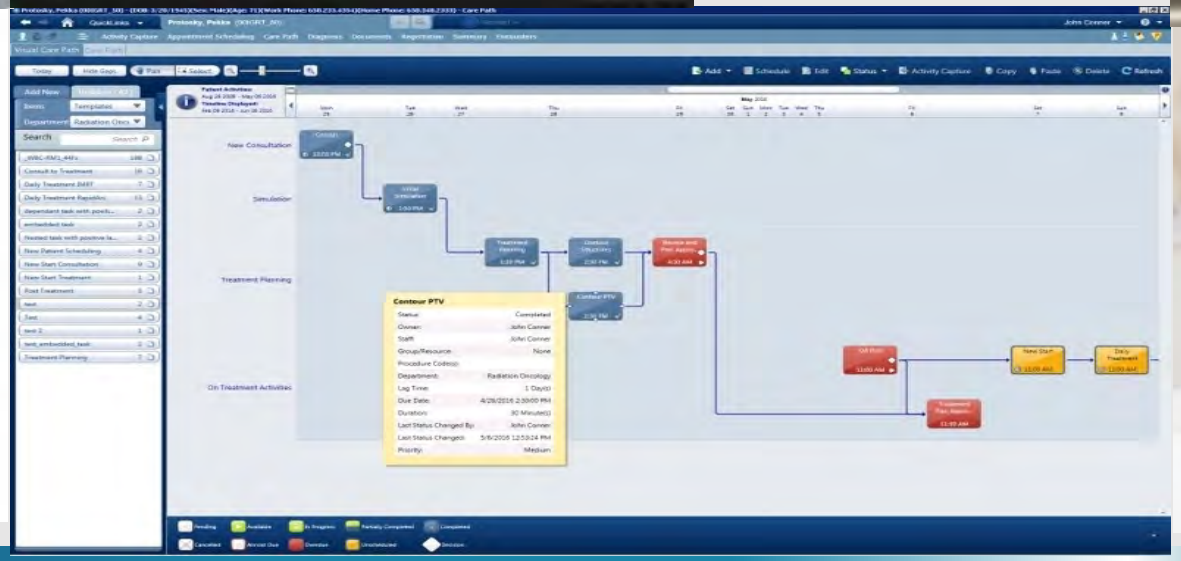
Autumn 2023

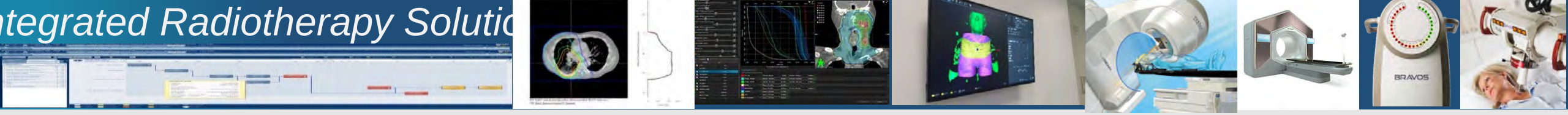
The Integrated Radiotherapy Solution





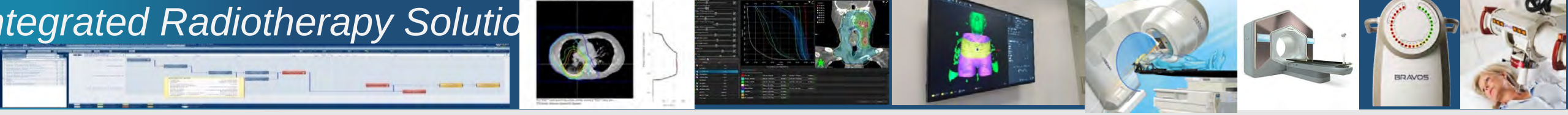






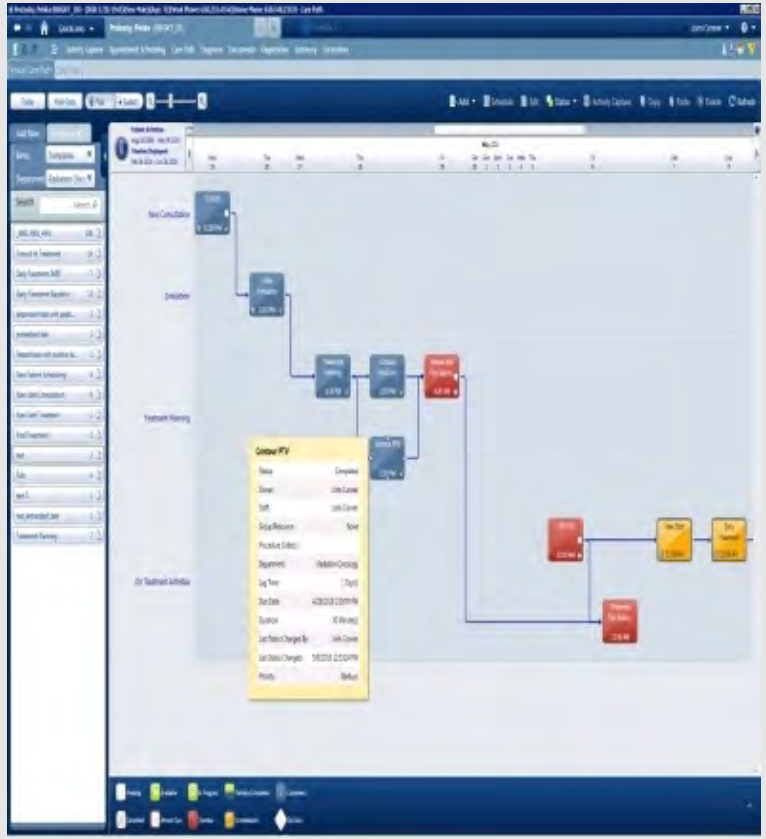
What we are trying to communicate

- The features of the IRS
- That the IRS represents a major implementation programme resulting in a resilient, efficient system delivering radiotherapy of the highest quality for all patients meeting anticipated demand for at least the next 10 years.
- That the magnitude of the project to implement the IRS is greater than any attempted previously at Velindre or beyond with multiple internal and external dependencies.
- And to deliver RT successfully in the future we must implement the IRS **safely**, **efficiently** and **completely**



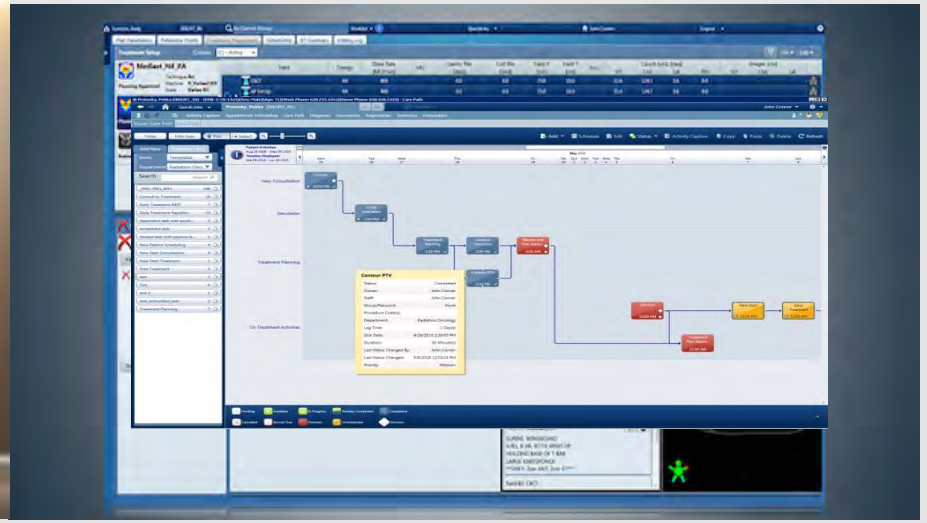
What is the IRS

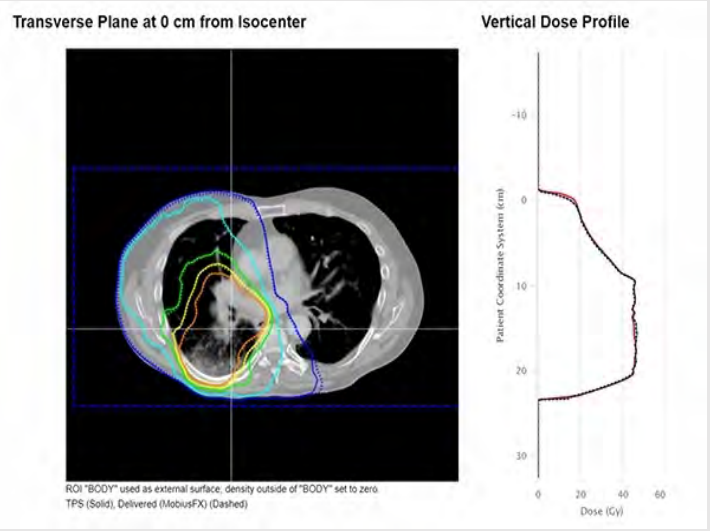
- Radiotherapy is a complex process involving imaging, treatment planning, delivery, follow up and dosimetry.
- The systems in use at VCC are significantly more complex than any other centre and more complex than they need to be.
- The **Integrated Radiotherapy Solution** has been procured to simplify this situation by integrating systems as much as possible to improve treatment quality, efficiency, and patient and staff experience.



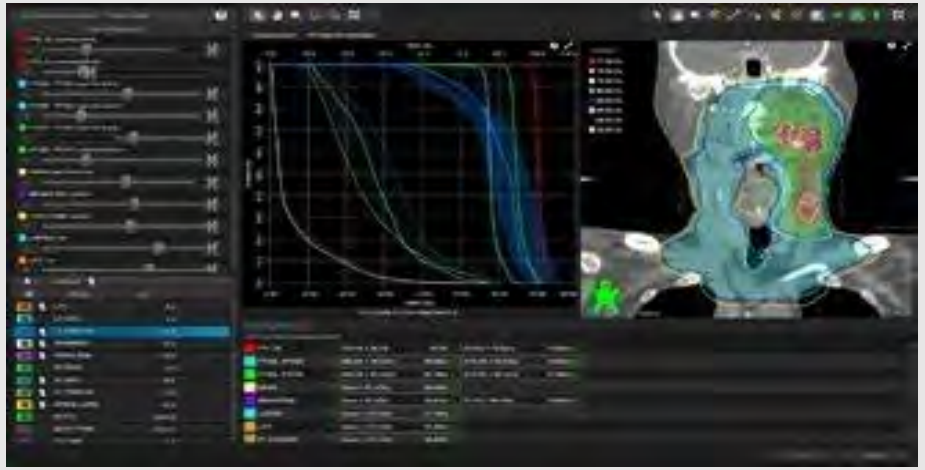
The IRS includes

Oncology Information System



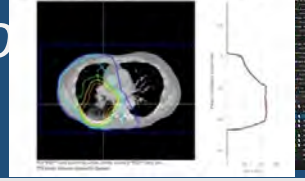
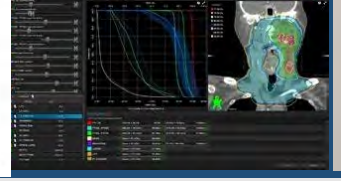


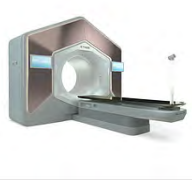
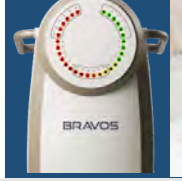
Treatment Devices



Patient Dosimetry System

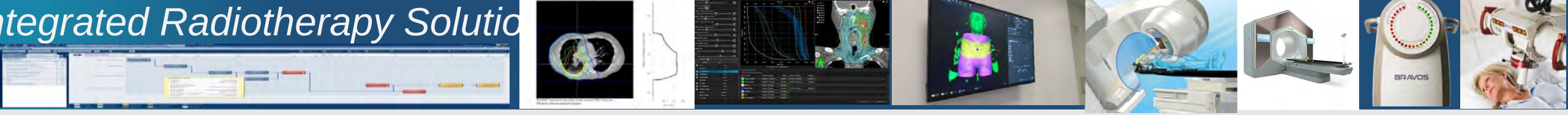
Treatment Planning System

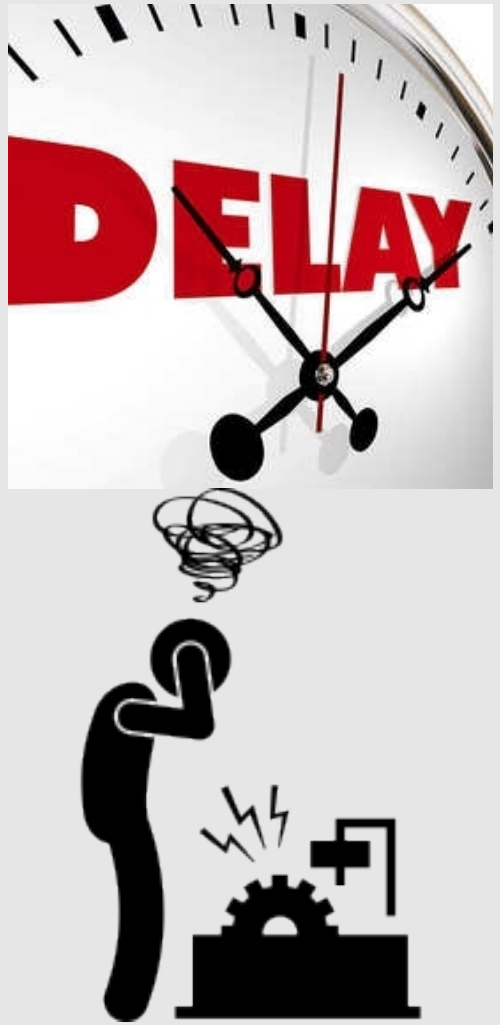
The Current Situation

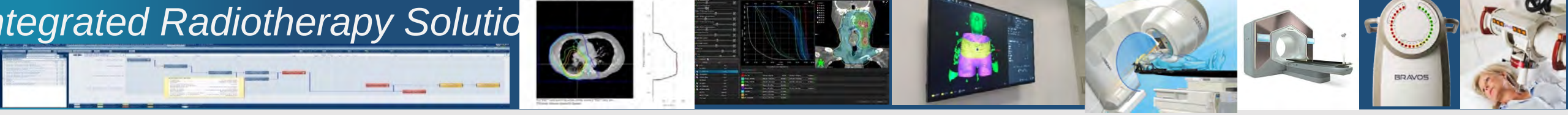
- The first phase of the implementation project has begun and is running to planned timescales.
- However, there are a number of unforeseen complications that will affect the timescale for some time.
- The current fleet of treatment machines is ageing and several of them are being used longer than initially planned. Currently all of them will be beyond or at their End of Life (EoL) by 2026. Two of the machines will reach their End of Life data (after extension on 01/05/2024)
- Unexpected unavailability of the existing fleet due to breakdowns has been greater than previously experienced exacerbated by mandated safety critical upgrades.
- Demand on the service has increased due to an increase in patient numbers and complexity of treatment.



Current Situation (cont)

- Although the quality of RT delivered at VCC compares favourably to other RT centres, the systems currently used to deliver RT significantly fall short of those at the end point of IRS Implementation.
- We need the IRS to refresh the fleet, improve our systems and continue to develop our treatment delivery processes in terms of quality and efficiency.
- However, there is a significant strain on the service caused by
  - delays to dependent projects from those used in the planning assumptions during the IRS procurement.
  - An ageing fleet
  - Post Covid practices increasing fraction time
  - CANISC Replacement
  - Training requirements of the new system
  - inefficiencies inherent with moving to a new system.

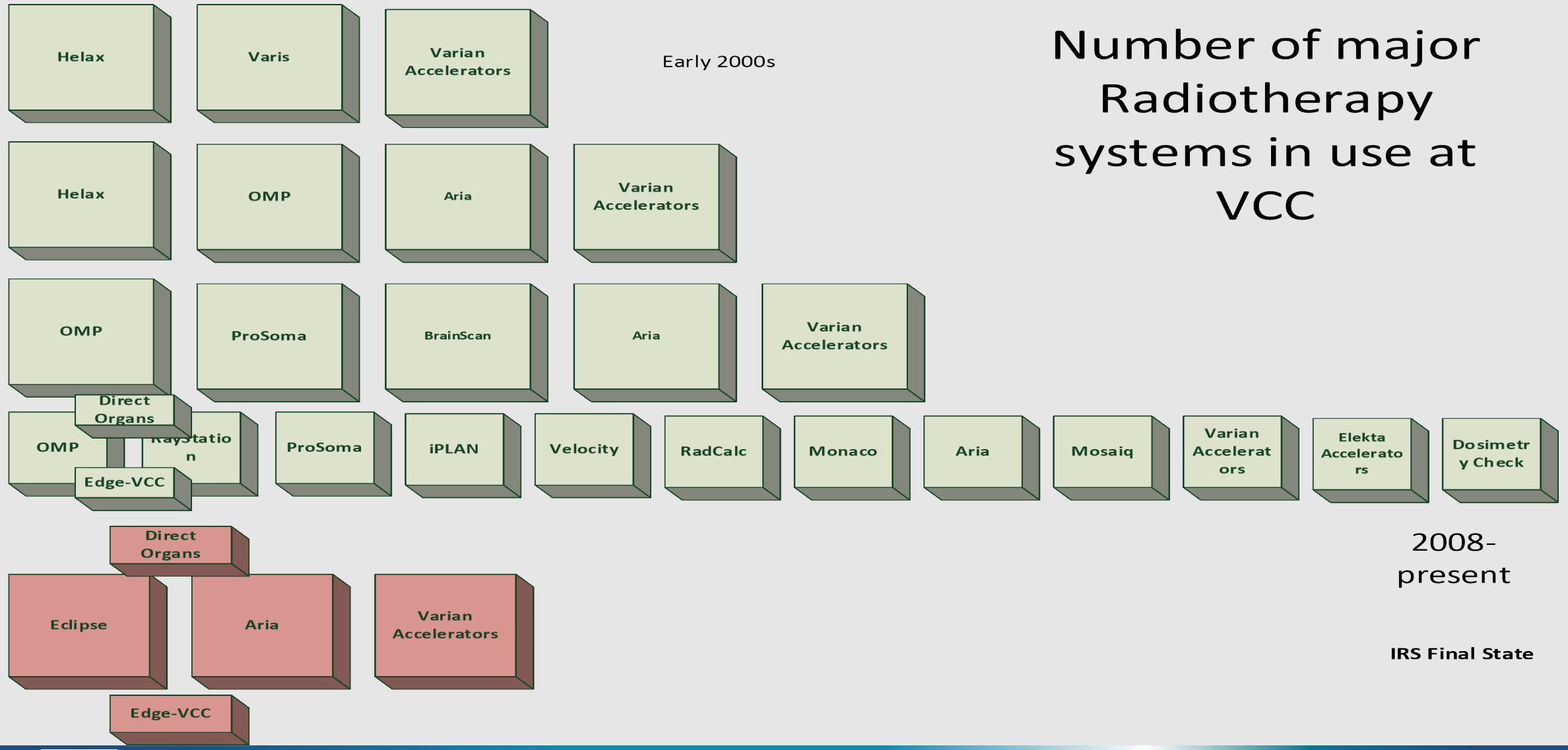


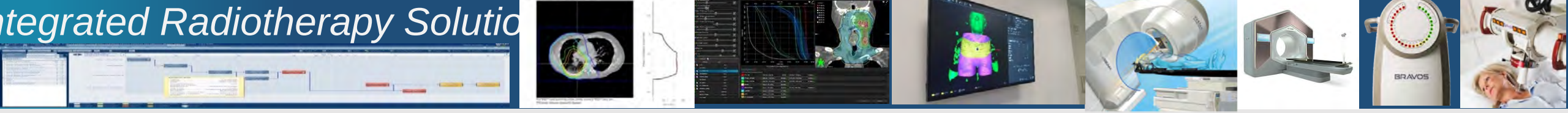


Why do we need an IRS?

- One generation of treatment machine ago (10+ years ago)
  - VCC made the decision to move from an all Varian treatment machine centre with 3rd party systems to a mixed Elekta / Varian centre with an increasing number of 3rd party systems.
    - A situation avoided by 95%+ of radiotherapy centres.
    - This was predominantly a financially driven decision.
- This led to a major impact on the department as
  - The number of systems required to run the service increased considerably.
  - Transferring patients from machine to machine became significantly difficult, requiring significant resources to completely re-plan the treatment involving all 3 disciplines.

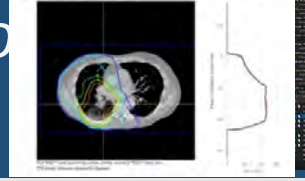
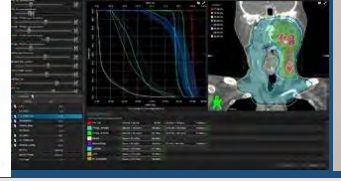
Number of major Radiotherapy systems in use at VCC

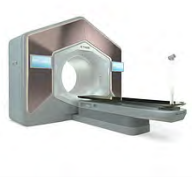
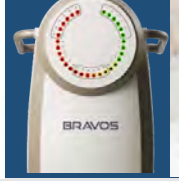




Why do we need an IRS? (cont)

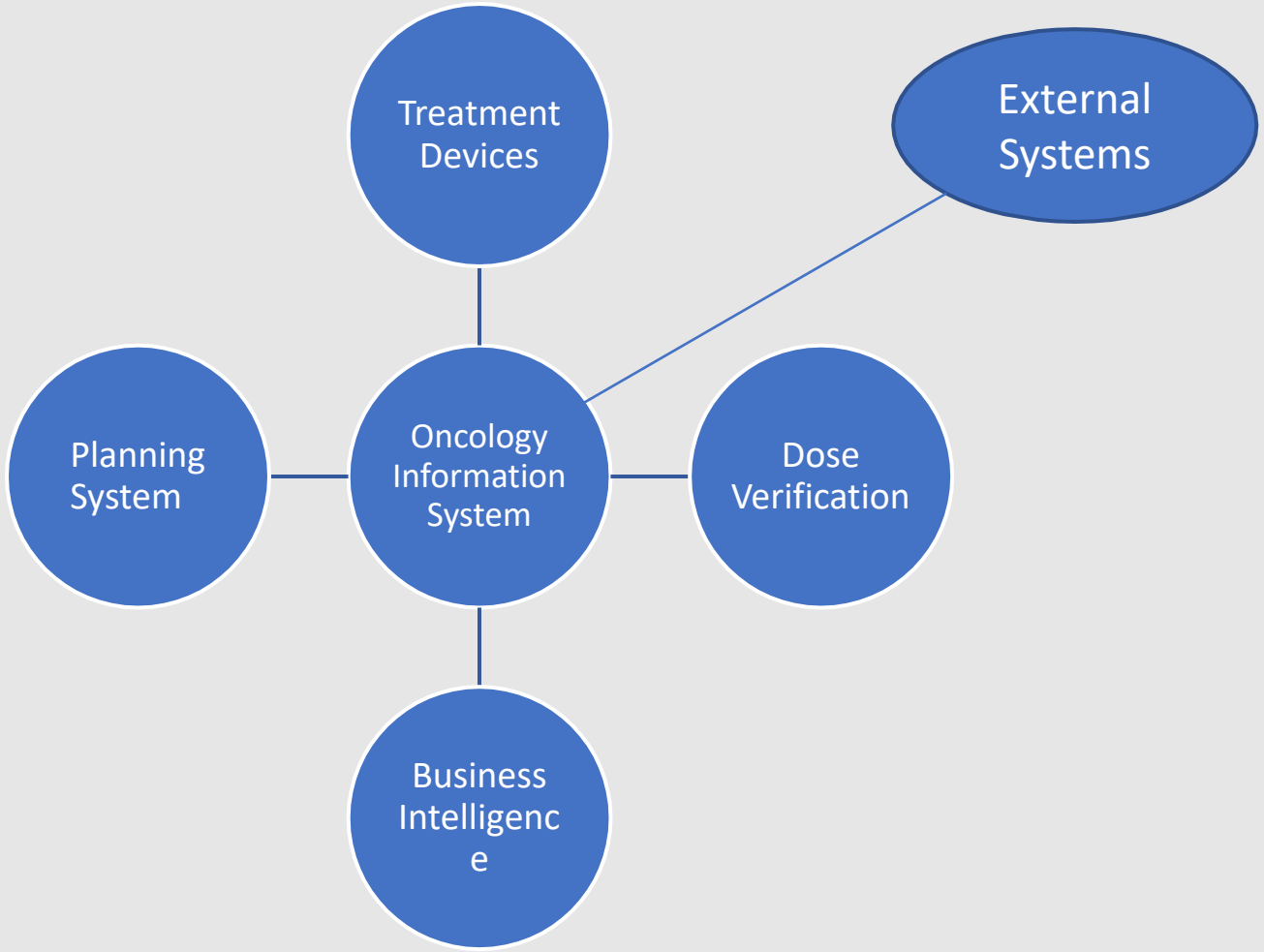
- It quickly became apparent that
  - Working in a mixed vendor environment required more resource and inefficient than first thought.
  - A further change was required to maintain some advanced technique delivery e.g. SRS.
  - There would be significant benefits in moving to a principal provider for RT equipment.
  - Managing workflow and data transfers alongside CANISC was problematic and resulted in many inefficiencies
- Consequently
  - Cases were developed to implement a phased move from 2 vendors + 3rd party providers to a principal provider to improve the situation.
- But
  - Progress on this was delayed due to the requirement to align this with other organisational developments.

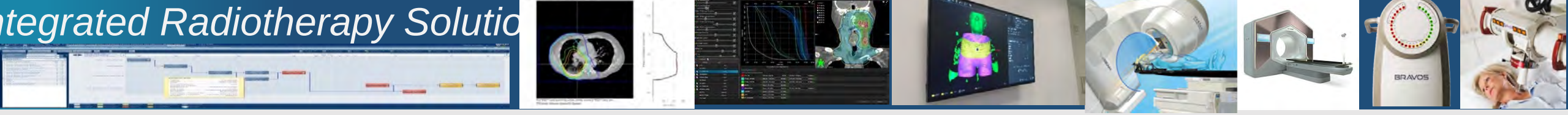




IRS Concept

- 1 OIS not 2
- Workflow managed by the OIS not two systems that don't talk to each other
- 1 TPS to avoid transfer of data and allow propagation of information and authorisation
- Process information available to the service
- Integrated dose validation



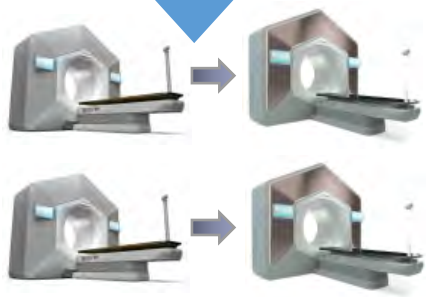


The Principal Provider Project

- Sometime around 2015, the principal provider project started with a view to it procuring equipment for nVCC and RSU.
- Due to the complexities in mapping out the requirements of the solution., requiring in depth analyses of possible solutions a decision was made in 2019 to purchase a complete Integrated Radiotherapy Solution from a single provider via competitive dialogue.
- This has the advantage of ensuring integration between all components and transferring some of the risk of delivery from the Trust to the successful vendor.
- This IRS project was subsequently decoupled from the TCS project due to the anticipation that many of the machines at VCC would require replacing before nVCC opened. The project is now operationally owned and delivered by Radiation Services.
- The procurement was started in 2020 and despite a few bumps in the road a contract was awarded to Varian with the contract signed at the end of 2022.

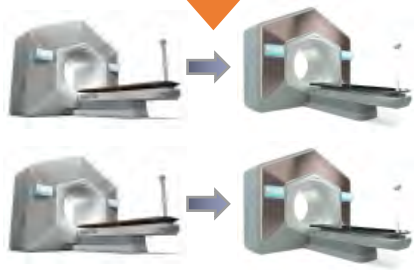
varian SOLUTION OVERVIEW A PHASED APPROACH

PHASE 1
(Current VCC)



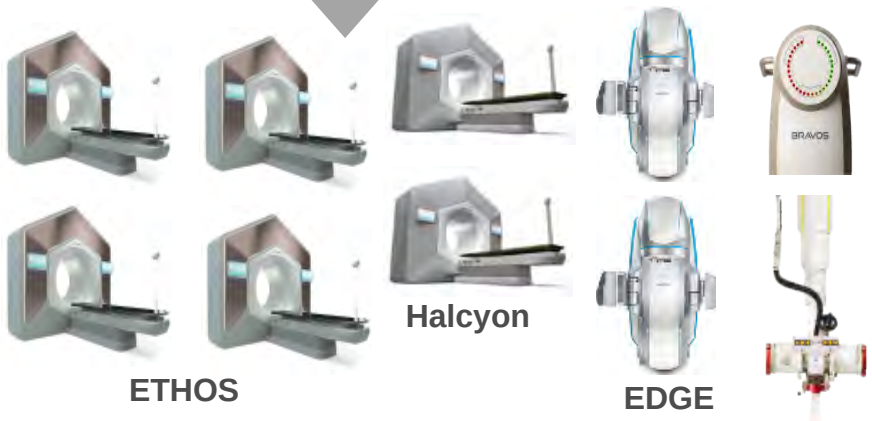
Halcyon ETHOS

PHASE 2
(Satellite Radiotherapy Unit)



Halcyon ETHOS

PHASE 3
New VCC (nVCC)



ETHOS Halcyon EDGE

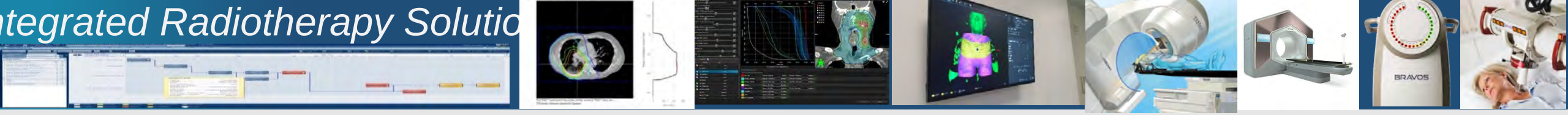
Eclipse

Velocity

inSightive

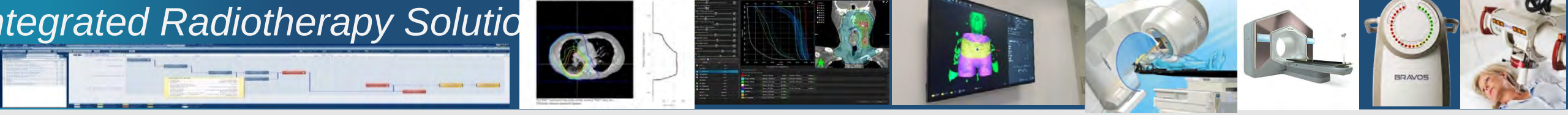
Also included:

AI-Rad Companion - ePeer Review - ARIA Oncology Information System - IDENTIFY SGRT - Patient ID - Adv. IGRT, Mobius (Independent Dose Calculation & Patient QA)



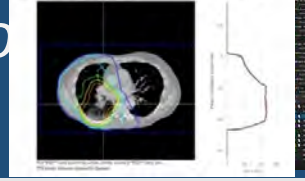
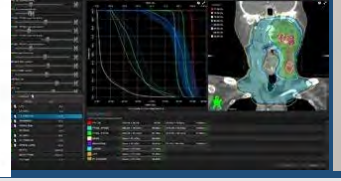
The IRS Solution

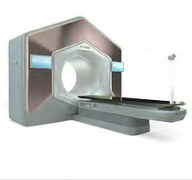
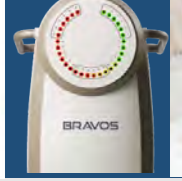
- As well as the hardware and software described in the previous slide it also includes
  - A co-produced model between the Trust and Varian for service and maintenance.
  - Commitment from Varian to aid in training and development of solutions.
  - A contractual requirement for benefits to be realised in the Trust with withheld payments to Varian should these not be reached.
  - A guaranteed Research and Development grant (c £166k pa) from Varian to the trust to perform R&D projects



Implementation

- We are performing the implementation in the background of
  - Increased downtime of existing fleet
  - Increase in demand due to increase in complexity and numbers
  - More challenging waiting time targets
  - Requirement to contribute to nVCC and SRU projects (unresourced)
  - Imminent end of life notices on two Elekta machines (01/05/2024) and the other two before may 2026

Implementation

- In order to obtain full benefits of the system all parts of the proposed solution must be implemented.
- Varian are the biggest RT vendor in the world with about 70% of market share
  - Velindre IRS is their biggest ever order in terms of scope.
  - The wholesale transfer from multiple systems to Varian systems on this scale has not been done before.
  - Therefore, this is likely to be the biggest RT implementation project ever performed.
- A major staff resource is required to perform the implementation requiring senior, experienced staff to lead. It is difficult to recruit senior staff from elsewhere.

IRS Implementation

Advancing Site Specific Radiotherapy

- Developments
- Imaging
- Motion Management
- SGRT
- SRS

Capacity & Phasing

- Capacity Analysis
- Machine Replacement
- Ongoing Replacement Scheme and Phasing

Comms & Engagement

- Comms Strategy

Contract Management, Benefits Realisation and Finance

- Benefits Realisation
- Contract Management
- Finance

Digital

- ARIA Upgrades
- Business Intelligence
- Data Migration
- DHCW Working Relationship
- Interfaces
- Noona
- Off Site Data Centre

Eclipse (TPS)

- Development Impacts
- Eclipse
- Ethos Conversion /Adaptive Process

Machine Clinical Commissioning

- Clinical Commissioning Linac 6
- Independent Dose Checking

Project Governance

- Decision Log
- Highlight Reports
- Housekeeping
- Lessons Learnt
- Risk Management
- Terms of Reference

Research, Development & Innovation

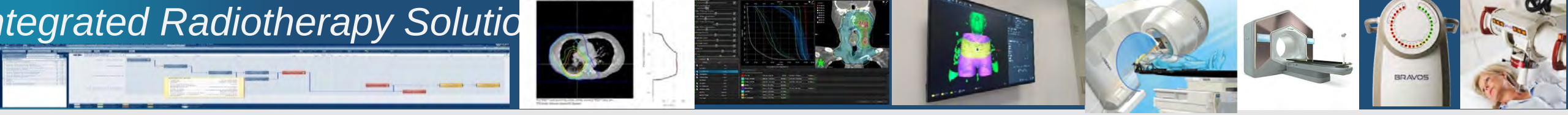
Joint Varian / VCC Research Commitee

Workflow (Referral to treatment)

- Carepaths
- Patient ID

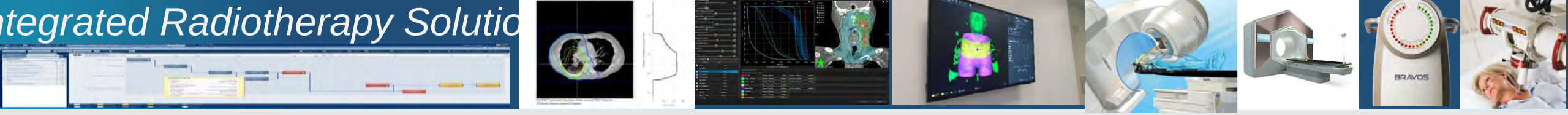
Workforce, OD, Training and Role Redesign

- Human Resources
- Recruitment
- Staff Management
- Training



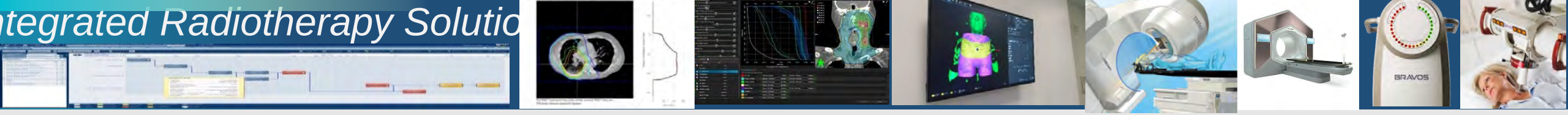
Patient Benefits

- When we implement successfully we will have the most efficient RT system available, leading to reduced waiting times.
- There will be a step change in treatment quality as a consequence of improved on-set imaging allowing best in class adaptions. This will reduce toxicity and achieve efficient treatment times.
- Online access to appointment times and online Patient Report Outcome Measures / Patient Reported Experience Measures
- We will be able to better target the cancer and avoid sensitive tissue avoiding costly interventions later in the treatment journey.



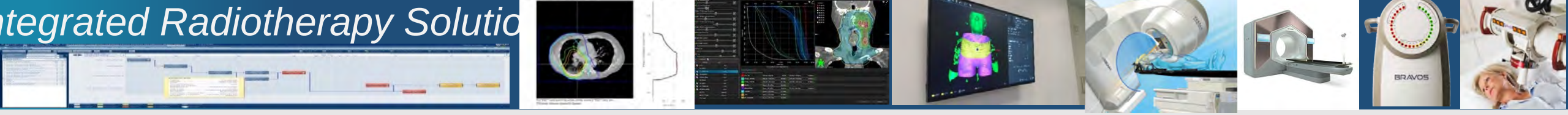
Staff Benefits

- Improved job satisfaction of working in a cutting edge department.
- Less time on sending data around the department and duplication of data entry enabling more time to be spent on what matters.
- Increased attraction as a good place to work.
- Increased opportunities for Research and Development
- Every member of staff involved in radiotherapy will be affected. For some it may completely change the way they work and what they do.



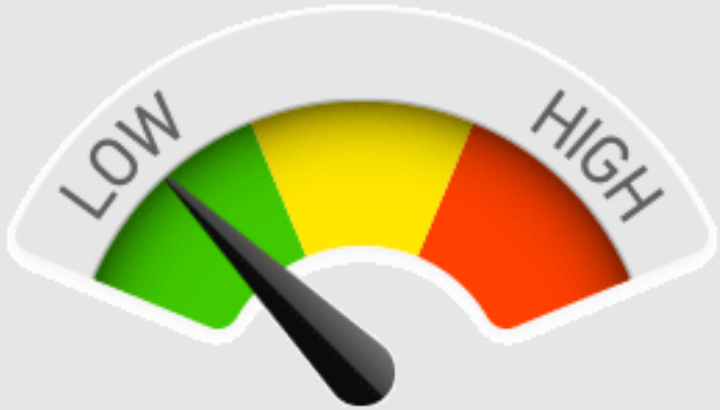
Challenges

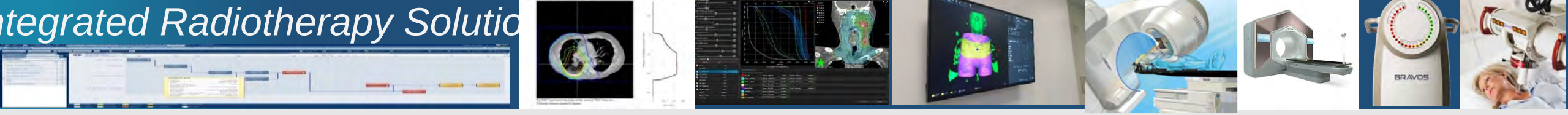
- We need to do all of this whilst maintaining a high quality service.
- The requirement to balance safe implementation against other priorities such as Varian's contractual requirements and other Velindre projects.
- Resources are scarce and departure of key staff can have a very significant impact. The current incremental structure makes appointing experienced staff from other organisations very difficult.
- Changes in work practices to fully utilise the new systems will be a big ask for the whole service.
- Time for training 300+ staff on all elements of the system as they are implemented
- Every member of staff involved in radiotherapy will be affected. For some it may completely change the way they work and what they do



Risks

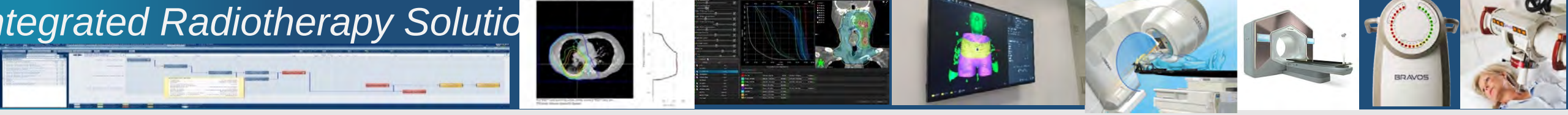
- Immense change with plenty of crossover / dual running of new and legacy systems.
- If we don’t get the training right there are significant implications
- Solutions are already required for a drop in capacity, further delays in other programmes could have major implications
- Staff wellbeing, resources
- We are dependent on Varian, DHCW for many tasks



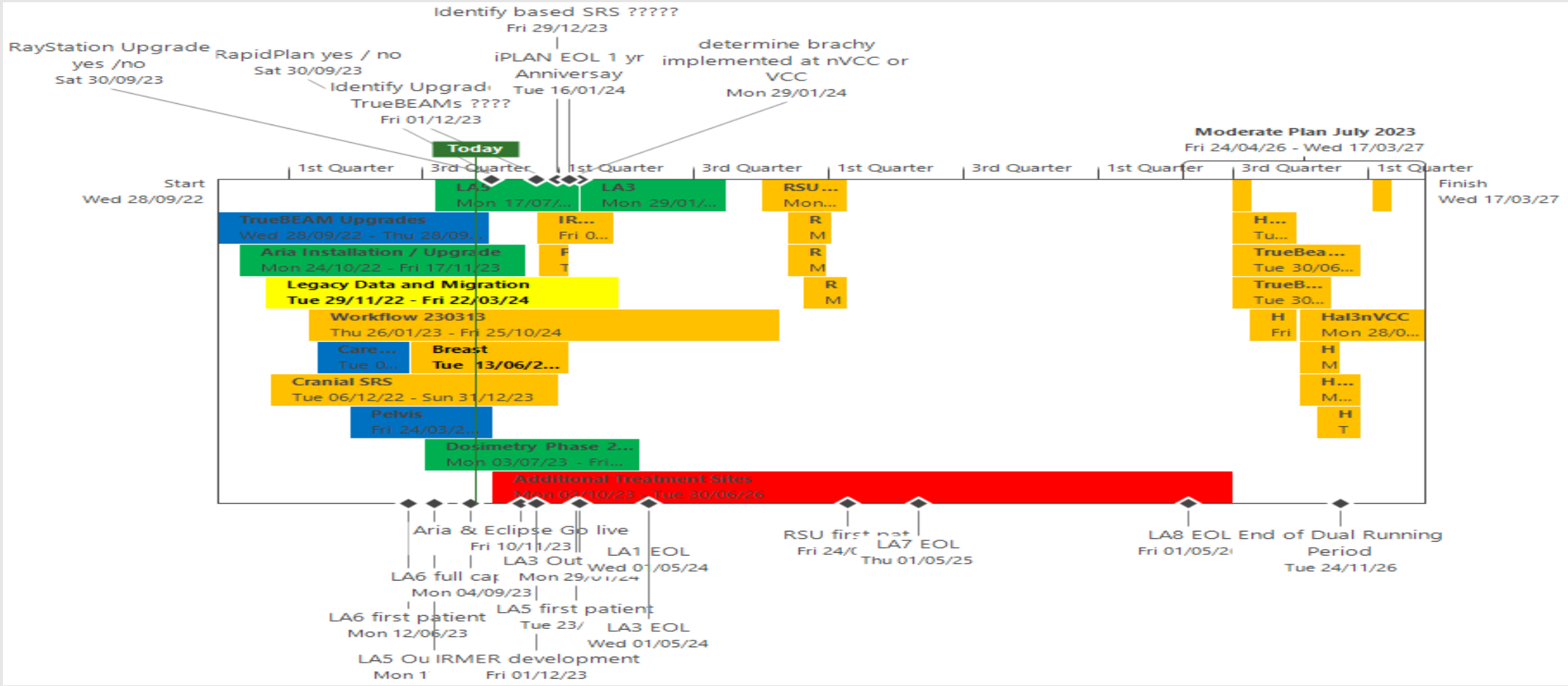


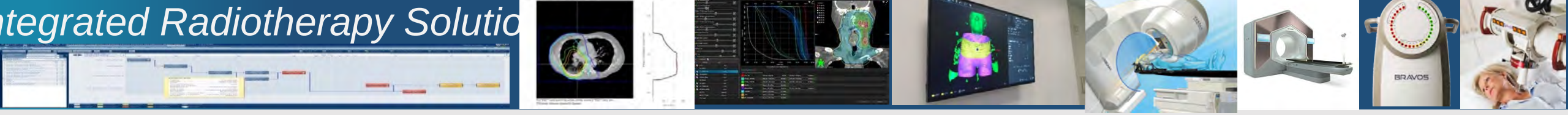
How is it going so far?

- First patient treated on 12th June 2023 as planned.
- TPS beam model successfully validated as planned
- First iteration of new workflow system live on 12th June 2023 as planned
- New fault / issue reporting system implemented (although with some issues)



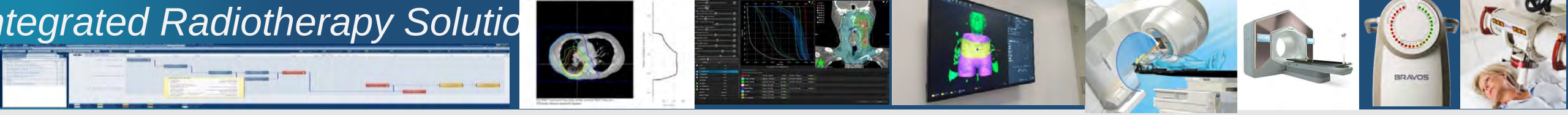
What Next


Identify based SRS ?????
Fri 29/12/23
RayStation Upgrade yes /no
Sat 30/09/23
RapidPlan yes / no
Sat 30/09/23
Identify Upgrad
TrueBEAMs ????
Fri 01/12/23
iPLAN EOL 1 yr Anniversay
Tue 16/01/24
determine brachy implemented at nVCC or VCC
Mon 29/01/24
Today
Moderate Plan July 2023
Fri 24/04/26 - Wed 17/03/27
1st Quarter
3rd Quarter
1st Quarter
3rd Quarter
1st Quarter
3rd Quarter
1st Quarter
3rd Quarter
1st Quarter
Start
Wed 28/09/22
Finish
Wed 17/03/27
LA5
Mon 17/07/...
LA3
Mon 29/01/...
RSU ...
Mon...
TrueBEAM Upgrades
Wed 28/09/22 - Thu 28/09...
IR...
Fri 0...
Aria Installation / Upgrade
Mon 24/10/22 - Fri 17/11/23
Legacy Data and Migration
Tue 29/11/22 - Fri 22/03/24
Workflow 230313
Thu 26/01/23 - Fri 25/10/24
Care...
Tue 0...
Breast
Tue 13/06/2...
Cranial SRS
Tue 06/12/22 - Sun 31/12/23
Pelvis
Fri 24/03/2...
Dosimetry Phase 2...
Mon 03/07/23 - Fri...
Additional Treatment Sites
Mon 02/10/23 - Tue 30/06/26
TrueBea...
Tue 30/06...
TrueB...
Tue 30...
Hal3nVCC
Mon 28/0...
Aria & Eclipse Go live
Fri 10/11/23
LA3 Out
Mon 29/01/24
LA1 EOL
Wed 01/05/24
LA6 full cap
Mon 04/09/23
LA6 first patient
Mon 12/06/23
LA5 first patient
Tue 23/
LA3 EOL
Wed 01/05/24
LA5 Ou
Mon 1
IRMER development
Fri 01/12/23
RSU first pat
Fri 24/0
LA7 EOL
Thu 01/05/25
LA8 EOL
Fri 01/05/2
End of Dual Running Period
Tue 24/11/26



What do we need for success?

- The organisation needs to maintain focus on the end goal.
- Improved engagement with patients, staff and other stakeholders.
- Retain / recruit staff.
- Swift decision making to account for changes to stay on track. There is little contingency available to maintain service capacity and failure to react to changes will have a significant impact on patients and staff.
- Any changes such as delays in other projects and / or new initiatives must be planned whilst maintaining the focus on the end point of the IRS.
- An appreciation that capacity is not about how many machines we have but capacity throughout the treatment pathway.
- We are going to have to make some compromises and prioritise some tasks. New demands are likely to have an effect on what we can do. Therefore there is a requirement for collective responsibility and accountability at all levels to ensure difficult choices are made with a concentration on patient and service benefit.



Conclusions

- We should not underestimate the magnitude of this task.
- Neither should we forget the benefits that can be achieved in the medium to long term.
- We have a very strong team across all disciplines, who need to be supported and enabled.

Velindre NHS Trust Health and Safety Annual Report 2022-2023

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Canolfan Ganser Felindre
Velindre Cancer Centre

Purpose of the report:

Annual quality management review to ensure continuing suitability, adequacy and effectiveness of the quality management systems and alignment with the strategic direction of the organisation.

Prepared by:

Jason Hoskins, Assistant Director of Estates

Ceri Pell, H&S Adviser

Matthew Bellamy, H&S Adviser

Reporting Period:

Financial Year 2022/2023

Report date:

July 2023

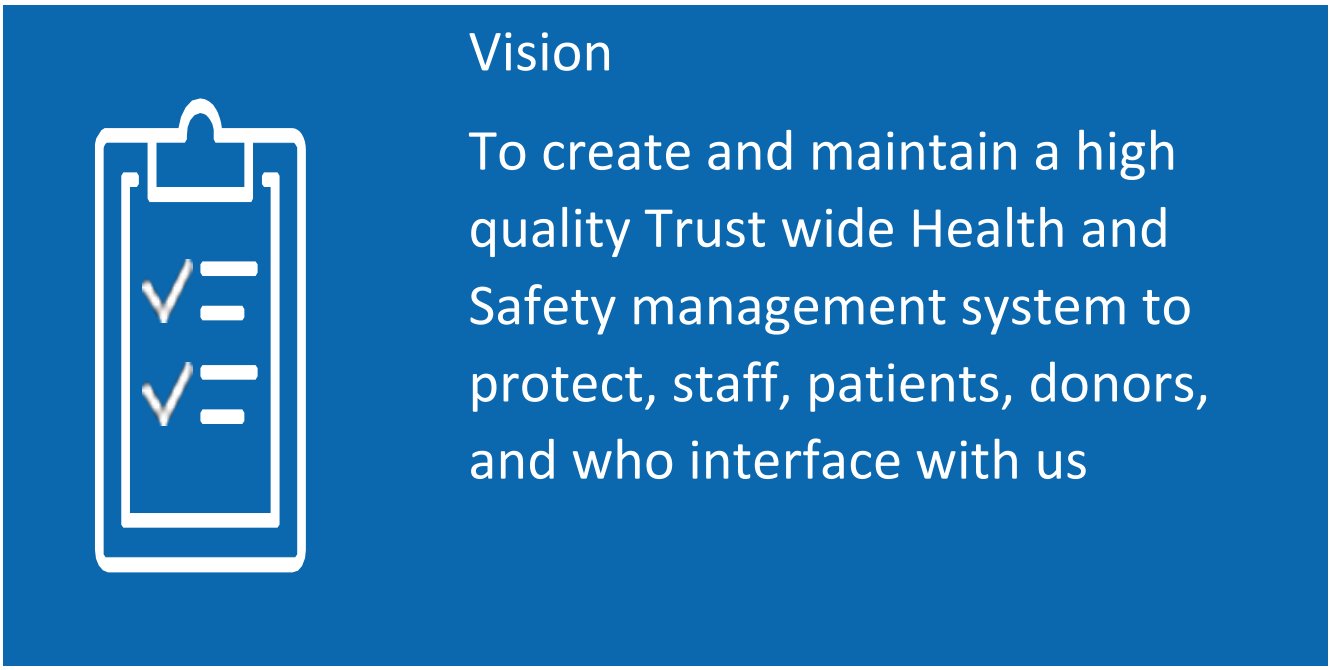
Contents

1 Introduction

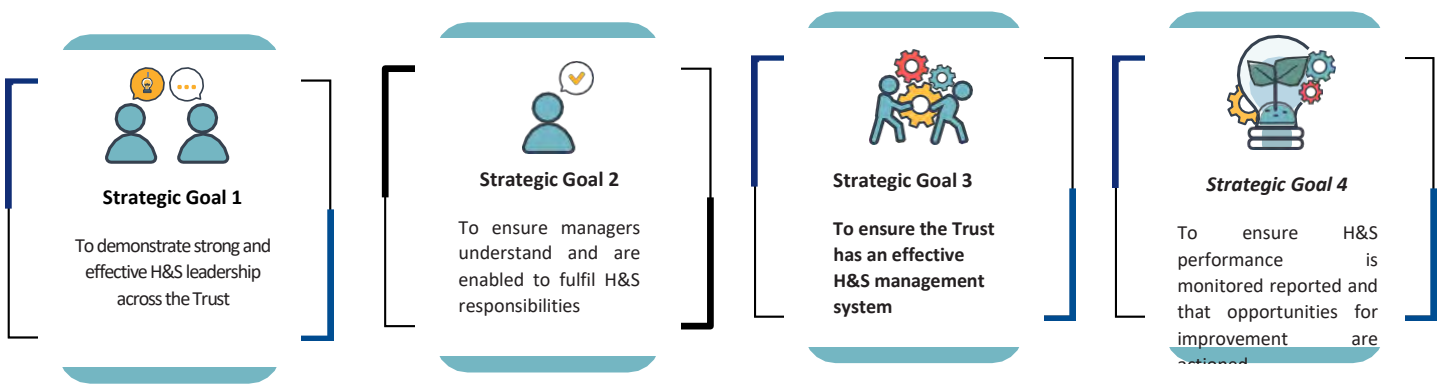
This Health and Safety annual report has been produced to provide an overview of the management of Health and Safety within Velindre University NHS Trust for the period 1st April 2022 – 31st March 2023.

1.1 Our Vision & Strategic Goals

The Trust has developed a strategy to include a vision and 4 strategic goals, to support improving and enhancement of the H&S culture within the Trust



Trust Strategic Goals 2022-2023



2. Executive Summary

The Trust received no prosecutions or Improvement Notices from any of the enforcing agencies of the HSE, or Fire & Rescue Service during 2022/23. This status has now been maintained for many years and is a direct result of the 'good Safety Culture' and the high standards throughout the Trust for health & safety compliance.

The Trust Incident Reporting is a significant part of this culture and continues to remain strong during the past year as a well-established part of the Trust and its values.

The increasing incident reporting culture remains strong and continues to improve with a measured increase in reporting across the many Trust departments. The Trust reported 140 incidents during the year which was an increase of 11% on the 12,847 Incidents reported during 2022/2023

There were several issues identified and improvements made across the Trust's H&S, Fire management systems during the financial year, which are highlighted within the report. During the year there were only 4 RIDDOR reportable accidents reported to the HSE which is a reduction on the previous year

This equates to a 10% increase in relation to the previous year. Root cause analysis investigations have been completed.

RIDDOR numbers remain low which again confirms the resilience of the Trust safety management systems. Root cause analysis investigations are completed in all cases and the learning is built back into the relevant processes & procedures.

Other main reporting categories consisted struck by object moving/stationary, slip/trip/fall incidents. Although there are no trends the above categories remain in the highest recorded and will be monitored going forward.

There have also been a number of instances of violence and aggression toward staff, which are in the main verbal. All such instances are assessed and there have been occasion where the Trust has issued Behavioural Agreements.

3 Health and Safety Management

3.1 Health and Safety governance was upheld through the course of the year through a framework of Health, Safety and Fire meetings at both divisional and Trust level. The Trust Health Safety and Fire Board consists of senior managers and reports to the Executive Management Board. Divisional Health Safety and Fire meeting was established at Velindre Cancer Centre and Welsh Blood Service, with Estates related matters discussed within the Estates Management Group. These forums bring together management level representatives from departments to monitor and actively engage in health and safety planning and management. Meetings are supported by a monthly Health, Safety and Fire subgroup who provides operational support to the Health and Safety Lead for the division.

3.2 The Velindre Cancer Centre, Welsh Blood Service and Trust meetings for 2022/23 are scheduled quarterly and monthly and dates are in the diary. Additional meetings have been added to the cycle of business to support the Health and Safety Agenda building on works achieved in the previous year, meeting include;

- VCC Operational & Delivery Health Safety and Fire Group
- WBS Health Safety & Fire Group

Table 1 – Health and Safety governance – meeting schedule

Health and Safety Governance	Chair	Agreed Frequency	Number of meetings held 2021/22
Trust Health Safety and Fire Board	Director of Strategic Transformation, Planning & Digital, Corporate Services	Quarterly	3
VCC Health and Management Group	Operations Manager	Quarterly	2
VCC Operational & Delivery Health Safety and Fire Group	Operations manager	Monthly	10
WBS Estates and Facilities management Group (Cynefin Group)	Interim General Services Manager	Quarterly	4
WBS Health Safety & Fire Group	Interim General Services Manager	Quarterly	1

Table 2 – Health and Safety Groups providing specialist advice and governance

Health and Safety Strategic Groups	Chair	Agreed Frequency	Actual
Electrical Safety Group	Head of Estates	6 monthly	2
Water Safety Group	Head of Estates	3 monthly	4
Ventilation Group	Assistant Director of Estates, Environment & Capital Development, Corporate Services	3 monthly	4
Medical Gas Group	Chief Pharmacist	3 monthly	4

3.3 Additional resource requirements have been discussed during quarter 4, which will be progressed through next financial year.

3.4 The Health and Safety Advisors for both Velindre Cancer Centre and Welsh Blood Service commenced studying for the NEBOSH Diploma in Health and Safety Management. WBS Advisor has completed the training.

Table 3 – Health and Safety resource

Department	Resource
Trust	Trust Health and Safety Manager
VCC	Health and Safety Advisor
WBS	Health Safety and Environment Manager

4 Health and Safety Priority Improvement Plan

4.1 The Trust Priority Improvement Plan has been the core document used through the year to develop and implement Health and Safety.

4.2 There has been sustained progress with the development and implementation of the Plan. The Trust Health, Safety and Fire Board have been provided with updates on progress to enable monitoring. The Priority Improvement Plan was reviewed and refreshed supporting the adoption of the 7 Levels of Assurance Framework with Divisional plans produced to support focus across all levels.

The plan translated the strategic vision and goals into actions to be delivered by the Trust.

5 Health and Safety Related Policies

5.1 Eight Policy reviews are scheduled in the next reporting period 2023/2024

Table 4 – Policies reviewed or in date

Reference no	Policy Title
QS18	Health Safety and Welfare policy
QS14	Safer Manual Handling
QS15	Management of Violence and Aggression
QS26	Safe use of Display Screen Equipment
QS09	Management of Latex and Latex Allergy
QS24	Medical Devices and Equipment Policy
QS30	Lone Working Policy
QS33	Control of Substances Hazardous to Health
QS36	Workplace Equipment Policy

6 Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division

Table 5 – Number of incidents by division by month

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
VCC	1	7	1	8	4	4	2	7	9	5	2	9	**59**
WBS	7	3	11	6	12	3	8	11	2	3	3	6	**75**
Corporate Division	1	1	0	0	2	0	0	0	0	0	0	2	**6**
Total	9	11	12	14	18	7	10	18	11	8	12	15	**140**

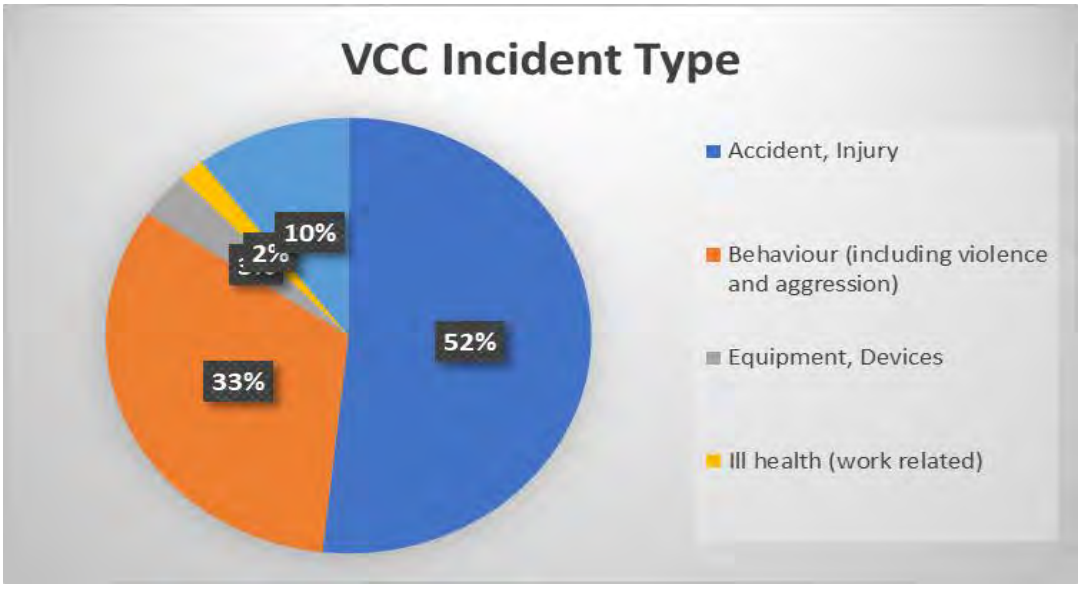
6.1 Table 4 details the number of incidents which occurred in each month and were recorded on the Datix system. Incidents are investigated, additional control measures are implemented when required and lessons learned are shared.

6.2 Incidents are monitored by the Trust and Divisional Health, Safety and Fire meetings and by the Estates Management Group. The manager responsible for the area/activity where the incident occurred is responsible for allocating a manager to investigate. Investigation training organised by Quality and Safety has been rolled out to a cohort of managers across the Trust to enhance the quality of incident investigations. Further support for incident investigation and recording on the Once for Wales Datix system is provided by the Health and Safety team.

Current trend analysis of the incidents experienced suggest that levels and types recorded do not require further investigation or training. However, where issues are identified addition training and support has been put in place. This trend analysis also identified the requirement to conduct a Training Needs Analysis exercise, which was concluded in quarter 3, and identified the need to expand training to meet the needs of the Trust.

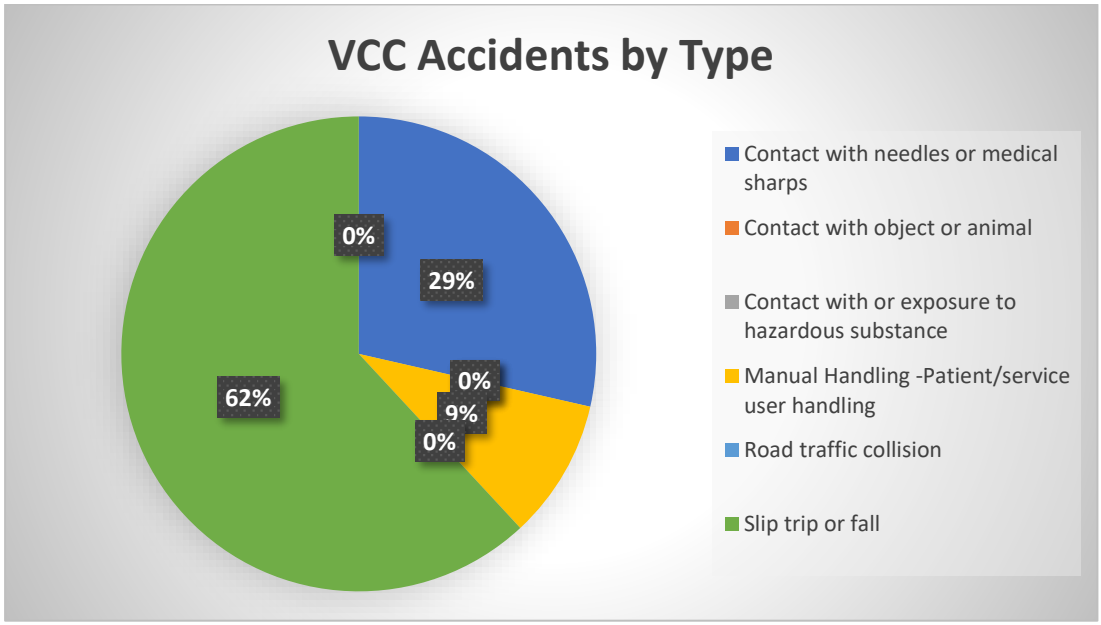
6.3 Chart 1 shows the percentage of incidents by type in VCC. The Accident/Injury coding has the largest percentage of incidents and contains the highest number of subtypes related to health and safety.

Chart 1 – VCC incidents by type (%)



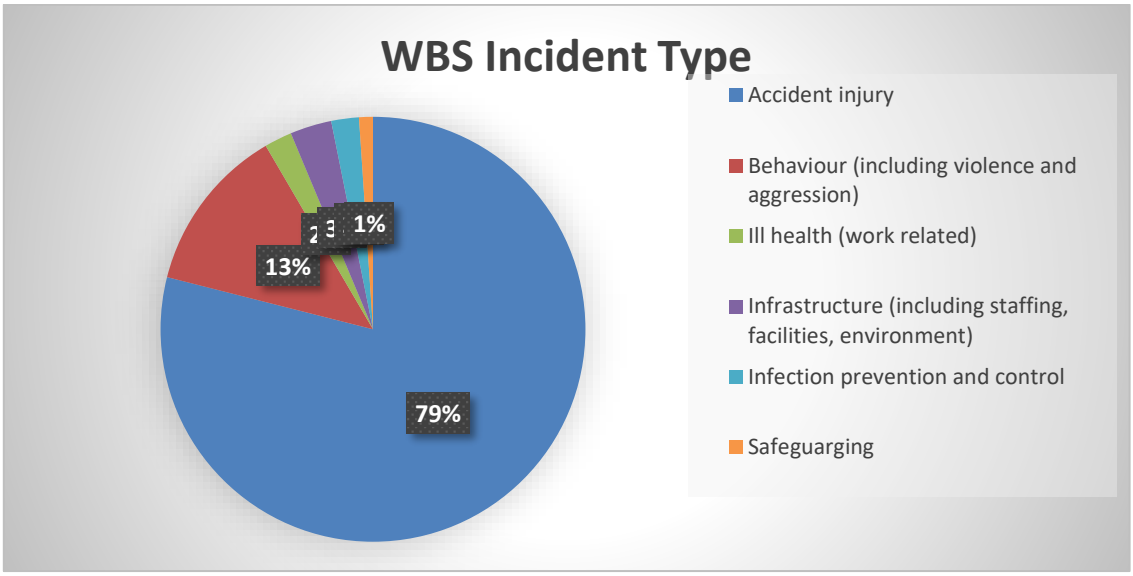
6.4 Chart 2 provides further details of the accident/incident coding. A further breakdown of sharps incidents and information about actions to address these incidents is contained in section 8. Accident numbers and types are such that there is no apparent trend identified that warrants any focus.

Chart 2 – VCC accidents by subtype (%)



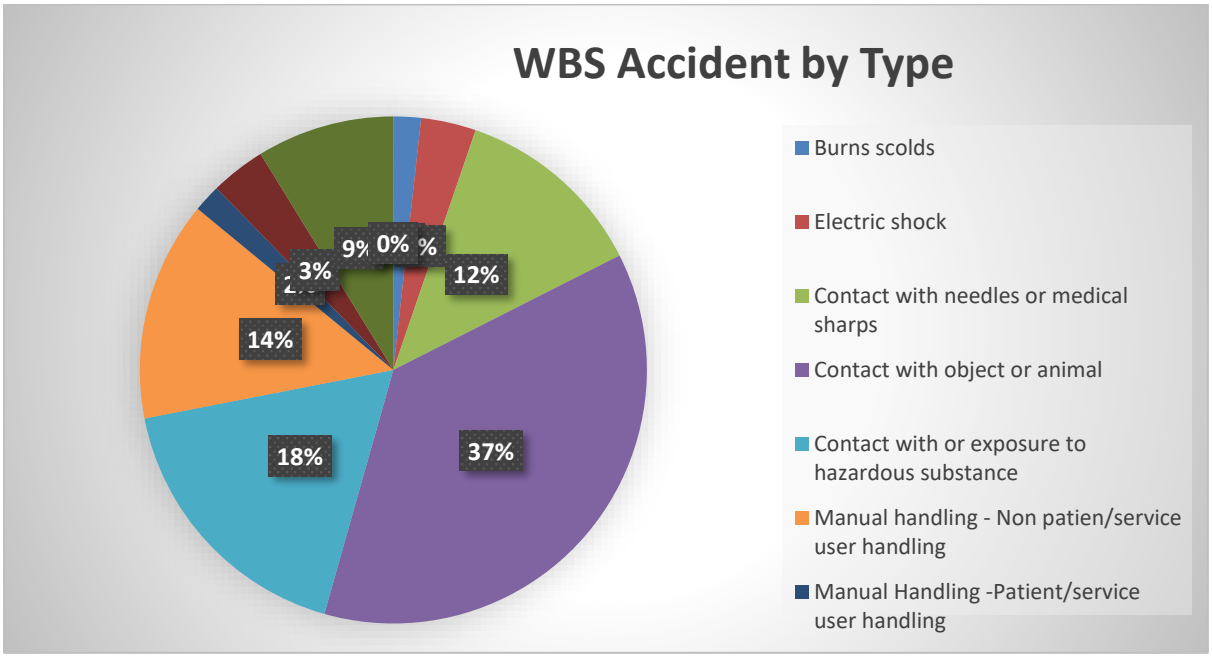
6.5 At WBS Accident/injury is the highest incident type which reflects the pattern in previous years and the high number of incident subtypes contained within this Datix OFW code. Accident numbers and types are such that there is no apparent trend identified that warrants any focus. Although it is evident that Accident injury accounts for most incidents.

Chart 3 – WBS Incidents by type



6.6 Chart 4 provides further details of the accident/incident coding section 8. Accident numbers and types are such that there is no apparent trend identified that warrants any focus, but contact with objects are the highest reported number of incidents

Chart 4 Accidents by subtype



6.7 There have been a number of incidents during the reporting period involving the collection teams when setting up collection venues. These have been recorded under accident, contact with object or manual handling incident categories. An ongoing investigation has ben under way involving a group of all necessary areas including safety, collections managers and transport. The Health and Safety adviser has met with the team to observe the problem and discuss. This is a complex problem and has been resolved initially by providing the team with additional equipment and exploring companies that can provide roll cages that are of the correct size to meet the requirements of the equipment vehicles. Further work will be undertaken to look at ordering new roll cages and we will continue to work with the teams over the next financial year.

6.8 WBS has seen a number of improvements during the reporting period to the outside space that will benefit staff health and wellbeing.

Improvements were made to the safety of the walk way around the WBS site. This followed on from the work to replace the rotten unsafe wooden steps with paved steps. Improvements in 2022/23 included resurface the pathway and replacing rotten picnic benches with new safer benches made from recycled plastic. The walk and the benches are used regularly by staff during breaks helping with their mental health and wellbeing and reduce stress levels by allowing them to get away from the stresses of the workplace and enjoy the grounds of the WBS site.

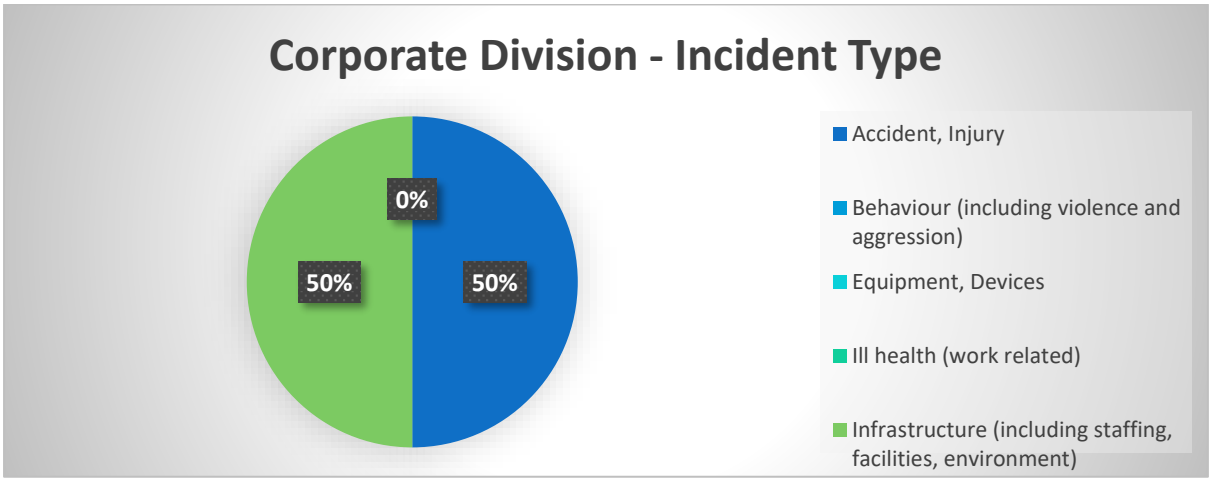
The improved path and seating area allow staff to spend their breaks enjoying the outside space helping relieve stress and anxiety. The pathway around sit allows staff to walk in their breaks helping with health.

6.9 The list below outlines learning and actions stemming from accident that occurred at VCC through the reporting period. All will be compiled into a document and communicated through the H&S forums. Slips trips and falls were identified as the most frequent accident type recorded.

Lessons Learnt	Improvement Plan
• Regular Internal and external site inspections	• Actions reported through the Health, Safety & Fire Divisional Meeting
• Modifications made to external walkways and pedestrian thoroughfares.	• Regular monitoring of pedestrian routes and behaviours
• Implementation of emergency lifting training	• Enhanced lighting during autumn and winter
• Incident Investigation Template for non-in-patient Falls	• Share lessons learnt across VCC site
• Robust reporting for workplace inspection actions	• Continue to promote the reporting of slips trips and falls on datix.
• Enhanced monitoring of internal floors and walkways	• Implement STF checklist to manage and prioritise risk
• Review of the workplace inspection audits	• Digital solutions for completing self-audits

6.10 There were only four incidents recorded in Corporate Division – thermal comfort, a road traffic incident, theft of earthing cables at Velindre Cancer Centre and one sharps incident.

Chart 5 Corporate Division Incidents by type



6 **Reporting of Incidents Diseases and Dangerous Occupancies Regulations 2012 (RIDDOR)**

6.1 There were four incidents reported to the Health and Safety Executive during 2022-2023. Three occurred at Velindre Cancer Centre and one instance was reported within the Corporate Directorate. The Health and Safety Executive took no further action on either occasion. An overview of RIDDOR incidents are included in Table 5 below.

Table 6 Incidents Reported Under RIDDOR

Date	Reporting type	Reporting Department
02/06/2022	Specified Injury	SACT
01/08/2022	> 7day absence	Estates
10/11/2022	> 7day absence	Integrated Care
14/11/2022	Specified Injury	Integrated Care

6.2 The list below outlines learning and actions stemming from investigation of the RIDDOR incidents that occurred through the reporting period. All will be compiled into a document and communicated through the H&S forums.

Lessons Learnt	**Improvement Plan**
• All incidents to be reported within the RIDDOR time frame.	• Improve communication across sites between Managers and H&S leads
• Raise awareness on RIDDOR report requirements	• Develop RIDDOR guidance for managers
• Review all incidents within 48 hours for RIDDOR reporting	• All RIDDOR incidents to be centrally reported by the H&S leads

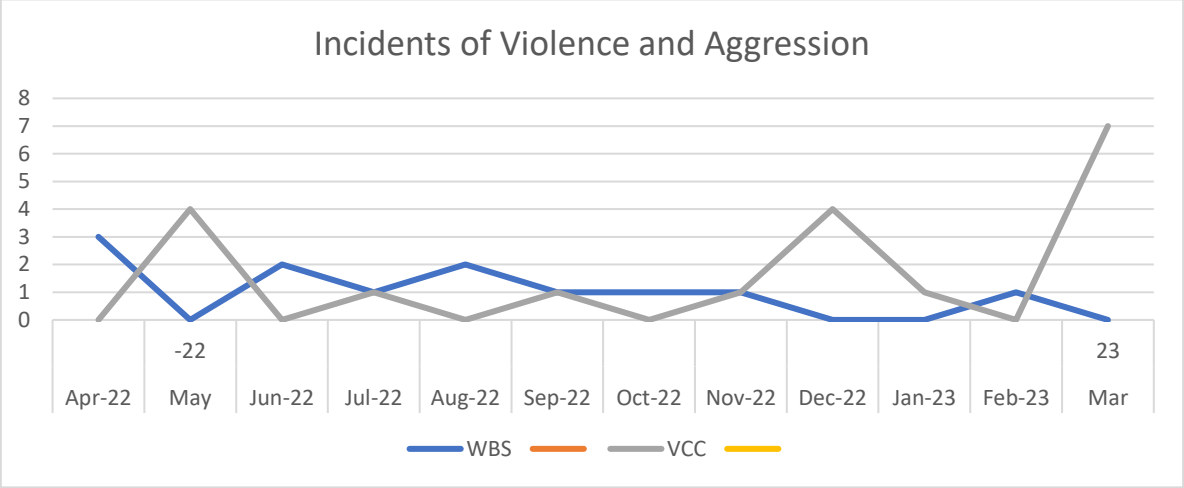
7 Violence and Aggression

7.1 Incidents of violence and aggression although remain at a relatively low level across the Trust it is the second highest reported incident in both VCC & WBS. Incidents reported within Inpatient settings have identified additional training needs delivered under the All Wales Passport. Case management support was provided by the Trust Health and Safety Manager, the SLA with Cardiff and Vale has been assessed and is not required at this time. This activity is currently being delivered by the H&S Advisor at VCC.

7.2 The Trust has escalated an incident which resulted a letter and Behaviour Agreement issued to the individual concerned.

7.3 At Welsh Blood Services cases of verbal aggression by donors often relate to frustration around being turned away from donating due to medical or travel reasons. An SOP is in place for repeated/serious incidents. Each incident is reviewed on a case by case basis by a group of Safety, Collections and Donor Contact Centre managers. The Collection Team will receive focused bespoke training during the next financial year to ensure that the teams have the necessary skills to deal with these types of incidents.

Chart 6 and Table 6 – Incidents of Violence and aggression at VCC and WBS by month



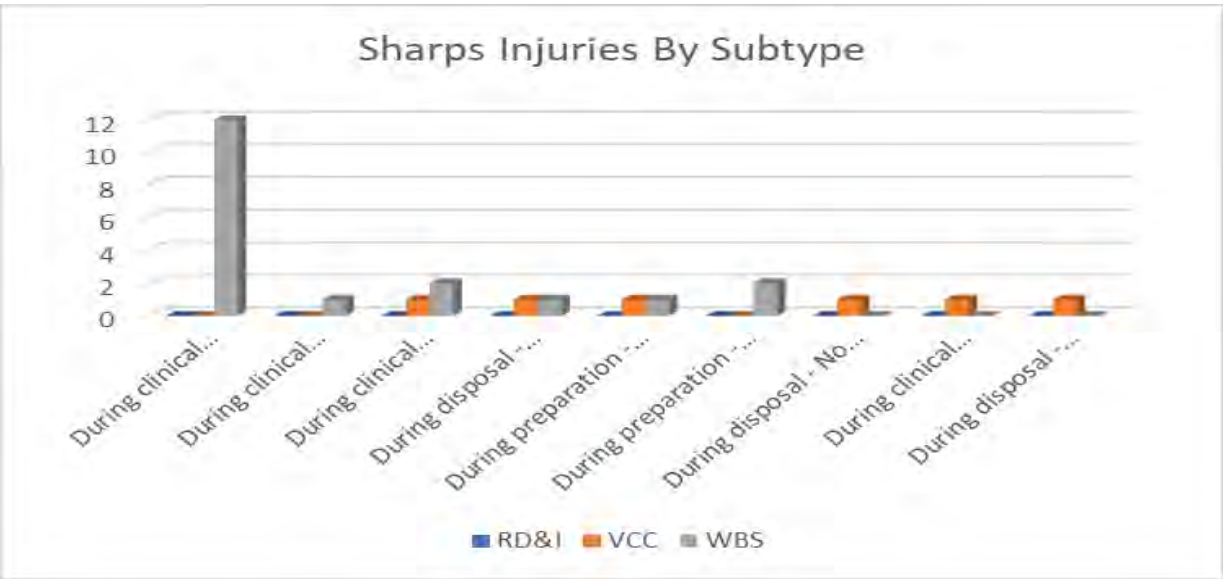
7.4 The list below outlines learning and actions stemming from investigation of incidents related to Violence and Aggression incidents that occurred through the reporting period. All will be compiled into a document and communicated through the H&S forums.

Lessons Learnt	**Improvement Plan**
• All incidents of violence and aggression to be reported on the datix OfW system	• Ensure lessons learnt are communicated back to the staff and departments.
• Promote zero tolerance amongst staff and managers – taking action against every incident	• Continue to support areas with reporting and investigating incidents
• Review risks associated with individuals' roles to ensure the right training received	• Establish links with local police teams and identify SPOC within South Wales Police
• Implement an investigation tool, leading to improvement and consistency of V&A investigations	• Develop additional training needs for inpatient areas.
• Training needs analysis undertaken for Module C under the All Wales Passport and Information Scheme	• Joint working with the Quality & Safety Team to develop procedures in caring for patients who lack capacity.
• Patient supervision policy enhanced to include wandering, confused patients.	• Review current alarms systems and procedures (staff attack alarms)
• Revise individual and departmental lone worker risk assessments	• Review community lone worker risks, develop and implement safe systems of work

- Actively promote the NHS Anti-violence Collaborative agreement 'Obligatory Response to violence in Healthcare'
- Velindre representation at the Anti Violence Collaborative meetings to promote effective and efficient communication and the exchange of information

8 Sharps injuries

Chart 7 Sharps Injuries by Subtype



8.1 In all cases the referral process to Occupational Health has been followed. Infection Protection and Control are working with Health and Safety to review non-safety sharps risk assessments, and to review of areas ordering non safety to identify any gaps. Where appropriate the 'Focused Review' function is used on Datix to enhance investigations and guidance is provided to departments to support investigations to ensure causes are identified and lessons learned.

Overall sharps injuries are generally low in number with no obvious trends that require address.

9 Recording of risks

9.1 All Divisions are recording risks on Datix Version 14. All Health and Safety risks rated above 12 were reported to divisional Health, Safety and Fire meetings and to the Trust Health Safety and Fire Board for scrutiny.

9.2 The adequacy of Health and Safety risk assessments is captured as part of the departmental HSG65 audits. This is an ongoing process.

9.3 Additional risk assessment training to support the process was delivered during 2022-2023. This was delivered by the in house H&S Team at VCC. WBS formerly review Risk Assessment as part of FMEA SOP's.

10 Health and Safety Statutory and Mandatory Training Compliance

10.1 Health and safety training requirements are identified by training needs analysis. This exercise was undertaken during 2022/23 by The Education and Development Department which has informed and updated Trust Training needs. This exercise has impacted overall figures as further training needs were identified highlighting increased training requirements. In

November 2022 there where a total of 7128 assignments and 7452 in February 2023, this is an increase of 324. Table 8 shows the training compliance for individual courses for the Trust as a whole. The majority of courses are provided on-line through the ESR system with two moving and handling courses (inanimate loads and people handling) provided face to face in line with the requirements of the All Wales Passport Scheme.

10.2 Compliance on most courses has risen steadily during the year but remains below the 85% target set by the Welsh Government. Multiple channels are used to communicate with managers and staff to enable increased compliance including monitoring at Trust and divisional health and safety meetings, escalation to senior management meetings, auditing of compliance during departmental HSG65 audits and contact with individual managers.

Table 7 – Trust wide compliance with Health and Safety statutory and mandatory training by month

	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
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%

Table 8 - Health and Safety statutory and mandatory training compliance by division by month

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Corporate Division	74%	76%	76%	72%	73%	74%	75%	76%	77%	78%	81%	82%
RD&I	82%	78%	80%	79%	78%	81%	82%	83%	78%	73%	74%	74%
TCS	75%	73%	71%	73%	71%	75%	76%	76%	74%	70%	77%	77%
VCC	78%	78%	79%	76%	76%	76%	77%	78%	76%	75%	75%	75%
WBS	82%	83%	87%	85%	85%	86%	87%	90%	92%	91%	93%	93%
Trust Compliance	79%	79%	81%	78%	79%	79%	80%	81.20%	80%	79%	80%	80%

11 Manual Handling Training

11.1 There are three levels of manual handling training provided to staff across the Trust, the syllabus for which is defined in the All Wales Manual Handling Passport Scheme which is adopted by all NHS Trusts and Health Boards in Wales. The requirement for each course is identified by Training Needs Analysis

- Module A – available on-line
- Inanimate Load – face to face training
- Patient Handling – face to face training

11.2 The training compliance in some divisions is below the target level of 85% set by the Welsh Government.

11.3 Training compliance is monitored at divisional Health Safety and Fire meetings/ Cynefin Group, at the Joint Estates Management Group meeting and at the Trust Health, Safety and Fire Board. Health and Safety training compliance has also been escalated to Senior

Management meetings within the divisions. Compliance is also discussed during the HSG65 Health and Safety Audit.

11.4 Module A – compliance is monitored, and managers continue to be reminded to ensure that staff complete mandatory training. Arrangements are in place to enable access to IT to enable completion of the training.

11.5 Inanimate Load Training – Courses have been run in house, further courses have been delivered through internal resource via H&S Advisor and ED & Dev Trainer. Velindre Cancer Centre and Corporate Division take up is not always to capacity due to operational staff pressures.

11.6 A number of staff at Velindre Cancer Centre have been trained as Manual Handling Workplace Assessors and have been supporting staff with assessment of competency. An initiative to monitor arrangements is under development.

11.7 People Handling – the Service Level Agreement with Cardiff and Vale University Health Board remains in place and offers places on training course to supplement in house training. The provision of in-house training has received positive feedback. People handling training at WBS will continue to be delivered by the Clinical Training Team to the Collection Teams with compliance figures exceeding target.

11.8 Further discussions are continuing with operational departments and support services to identify any / more flexible solutions that enable higher numbers of staff to attend the training courses available.

11.9 The list below outlines learning and actions stemming from investigation of the RIDDOR incidents that occurred through the reporting period. All will be compiled into a document and communicated through the H&S forums.

Lessons Learnt	**Improvement Plan**
• Advise and implement Manual Handling risk assessment templates (TILE)	• Improve and develop user friendly templates
• Complete hazard analysis tasks for all manual handling activities	• Review corporate risk assessment policies for adherence to guidance
• Additional staff to gain IOSH accredited train the trainer course for continuity planning	• Lapsed accreditation due to COVID to be re-instated
• Clear protocols for equipment hire including Bariatric	• Circulate and publish equipment hiring process for 24/7 requirements
• Joint working between Nursing, H&S and physiotherapy	• Set up regular meetings to include Education & Development to ensure best practice and consistency with neighbouring HB's in Wales
• Provide clear advice on equipment available via the NHS supply chain	• Implement equipment trialled in departments throughout the Trust

12 Additional training

12.1 There have been several additional training courses run to promote the Health & Safety function across the trust. The Trust H&S Manager and H&S Advisors and Compliance Manager have supported the delivery of training and will continue to identify and respond to the needs of the organisation.

12.2 A continual focus in training has been promoted to improve behaviour and attitudes towards Health & Safety Training and Compliance. The message to all staff at every level within the organisation have include:

Table 10 – Additional Health and safety Training Delivered 2022/23

Training Course	Benefactor
First Aid Training	31 staff across the Trust have gained the Emergency First Aid at Work certificate.
Electrical Safety Training	Both Estates and Operational Services Teams have completed the new on-line Electrical Safety Training on ESR
Risk Assessment workshops	3-hour practical workshops were run at VCC to improve consistency of risk assessment documentation and templates
Investigations workshops	3-hour practical workshops were run at VCC to improve consistency of investigation reports
Spill Management Training	Face to face spill kit training has been re-introduced since the pandemic
Medical Gas Training	Face to face Medical Gas Training delivered annually and to all new starters
Emergency Lifting (Hoverjack)	Emergency lifting incorporated in Patient Handling training and Cascade trainers within Integrated Care and Therapies Departments
Asbestos Awareness	All estates staff

13 DSE Assessments

13.1 A number of face-to-face DSE assessments have been completed whereby the ESR online training module has identified further interventions. The DSE policy has been revised to reflect the Home Working Policy and the Extraordinary Ad hoc Home Working policy and Procedures for Managers and Staff.

13.2 The list below outlines learning and actions stemming from DSE assessments carried out through the reporting period. All will be compiled into a document and communicated through the H&S forums.

Lessons Learnt	Improvement Plan
• Improved focus on individual and departmental risks	• Timely referral to Occupational Health where identified
• Enhance DSE assessor provision on all sites	• Library of equipment for individuals to trial
• Improved access to equipment identified on assessment	• Develop Training programme for departmental assessors
• Enhanced reporting through the governance structure on the ESR training module	• Develop joint working plan with the Physiotherapy team

14 COVID 19

14.1 Whilst other Welsh NHS sites and premises reduced there COVID measures in line with Welsh Government (WG) guidance, the COVID Cell at VCC and Welsh Blood took a more cautious, step-by-step approach in their reduction of safety measures. Initiatives and actions identified in support of managing covid include;

- A risk assessment guidance template was devised to assist individual departments in recording their risks on the Datix v14 system.
- 64 COVID Risk Assessments were completed and uploaded on to Datix.
- Staff rapid assessment templates were developed to investigate all staff cases of COVID for the purpose of regulatory reporting and identify patterns and trends.
- Audits of fit tester competency were undertaken at VCC and an additional IP&C fit tester put forward for the Fit2Fit accreditation scheme endorsed by BSIF and the HSE.
- Staff absence indicators scrutinised at each COVID Cell meeting.
- COVID checklists added to the Contractor Control Policy
- Jan 2023 - Terms of Reference of COVID response cell updated to include all respiratory illnesses. – COVID surgery drop-in sessions continued
- March 2023 – WBS and Trust identified through risk assessment the impact on Staff, Doners and Visitors and a decision was made to remove the mandatory wearing of face coverings.
- April 2023 – The requirement for face coverings was stepped down in the Cancer Centre except for the inpatient ward and SACT areas.

15.0 HSG65 Audits

15.1 The HSG65 audit implementation was trialled in three areas across Velindre in 2022/23 and the gaps identified prompted a shift in focus to provide training and guidance to managers to enhance the work needed against the key areas being audited.

1. Leadership
2. Procedures
3. Risk Assessments
4. Training
5. Workplace inspections
6. DSE
7. Inanimate Load Training
8. Patient Manual Handling
9. Sharps compliance
10. CoSHH
11. Skin Care
12. Violence and Aggression
13. First Aid
14. Control of Contractors
15. Equipment Safety
16. Workplace Environment
17. Incident Reporting and Investigation
18. Fire Safety
19. COVID 19

15.2 There has been significant improvement in the above key areas in the last year and HSG65 monitoring will continue in 2023/24.

15.3 HSG65 templates have been revised to sit within the Nursing and Quality Audits (Tendable). The system will enhance the reporting and actions created through the divisional governance structures.

16 Progress against Health and Safety Strategic Goals 2020 -2023

16.1 There has been good progress against the Health and Safety Strategic Goals with further action schedules until the end of the period (2023) for which these goals have been set.

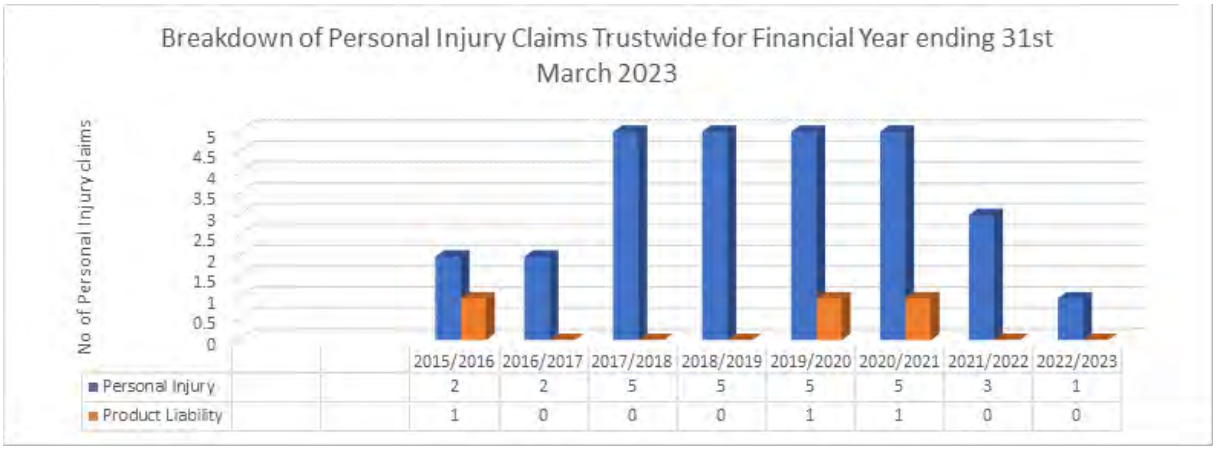
Table 11 – Progress with Health and Safety Strategic Goals 2020-2023

	Topic area	Strategic Goal	Progress	Timescale
1	Leadership	To demonstrate strong and effective health and safety leadership across the Trust	IOSH Training for Executives Identified. Training provider established. Training to be scheduled	Q1/Q2 2023
2	Mangers	To develop Health and Safety training course for managers	Development and roll out of VUNHST specific course for managers. Supported by managers information on staff intranet. IOSH	Q1 Q2 2023

			Managing Safely Licenses purchased training ongoing	
3	Management System	To ensure that the Trust has an effective health and safety management system across all divisions	Development of Division Priority Improvement Plans complete. Progress monitored through the Year	Q4
4	Monitoring	To ensure that health and safety performance is monitored and reported and that opportunities for continual improvement are actioned.	Monitoring of Trust Health Safety and Fire KPI'S, and Priority Improvement Plans by Trust H&S Fire Board	Q1,Q2,Q3,Q4 2023

17 Health and Safety Related Personal Injury Claims

Table 12 – Personal Injury Claims 2015-2023



17.1 During the reporting period: 2 Personal Injury claims were closed in relation to slip, trip and falls, following settlement of the cases, with 1 case being reimbursed by the Welsh Risk Pool.

18 Fire Safety

18.1 The Trust fire safety policy [PP01] was reviewed and updated in September 2022 taking into consideration the findings of relevant assessments, audits and inspections.

18.2 Welsh Government funded capital works were concluded during the reporting period, to improve fire stopping, fire doors, emergency lighting and a full validation of the fire alarm "cause & effect" at the Cancer Centre has been carried out with identified remedial action carried out.

18.3 To support improved management of compartmentation and fire-stopping, VUNHST Estates have developed and adopted a *Permit to Drill* whereby contractors and others identify where they need to work, they are made aware of the compartmentation and fire-stopping in their work locations and identify if they need to disturb compartmentation/fire-stopping and how they will make good.

18.4 The Estates department also commissioned inspections of the fire and fire/smoke dampers on the key sites. These inspections have identified and number of issues [including dampers with poor access] and defects which need to be addressed. An action plan is in place and work being delivered to rectify known issues.

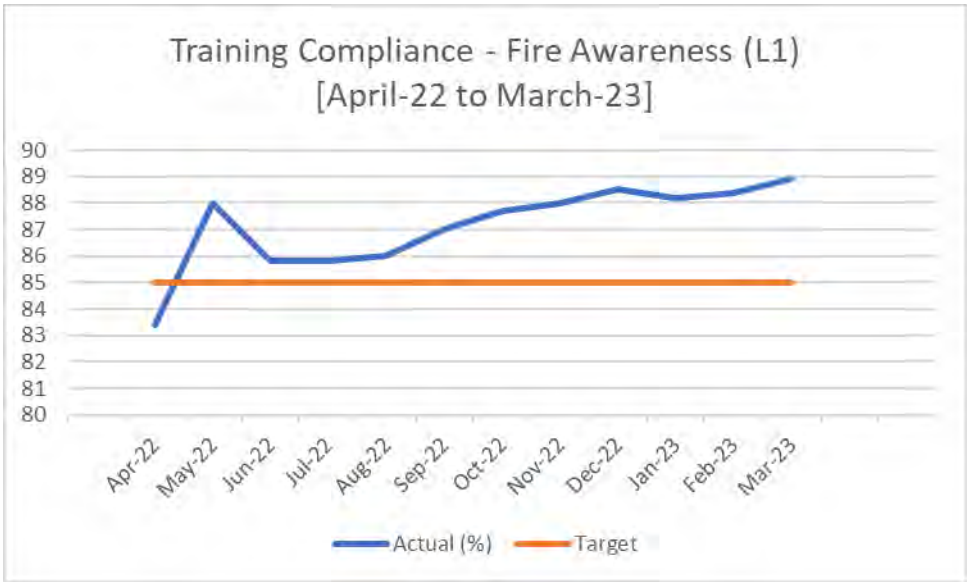
18.5 Following completion of the 2021/22 annual fire safety, fire risk assessments were reviewed to reflect findings and, where necessary, assessments have also been reviewed following any material changes to buildings and/or occupancy as required under the Fire Safety Order. The 2022/23 annual audit has also been completed and submitted to NWSSP – SES [in accordance with SESN 23-01.

18.6 Neither NWSSP-SES nor NWSSP Internal Audit undertook audits during this financial year and no sites were inspected by local fire and rescue services.

18.7 Although fire risk assessments are completed and issued to risk owners, how fire risks are recorded, communicated [taking into consideration the Trust's Risk Management Procedure] and assurance of resolution need to be improved.

18.8 In the last financial year, the compliance for basic fire awareness training has continued to improve and remains above the Trust's benchmark of 85%:

Table 13 – Fire Safety Compliance Training - Basic



18.9 Compliance for level 2 [Clinical] fire training continues to fluctuate and remains below the Trust's benchmark but there is an upward trend. The Trust AP [Fire] continues to work with departments to address this issue.

Table 14 -Fire safety Training Compliance – Clinical

18.10 As with other Statutory and Mandatory training, fire safety training compliance continues to be influenced by service needs and identified barriers include service pressures [including staff sickness/absence], change to hybrid working [so staff may not be able to access training in the traditional way] and lack of training space / available rooms.

18.11 Although some drills and exercises have taken place, both VCC and WBS have not met their statutory obligations to support all staff to participate in a drill or exercise at least once over the financial year.

18.12 The AP [Fire] is actively involved in task & finish groups looking at evacuation arrangements under the broader EPRR banner and it is anticipated that the issue of drills and exercises will be addressed.

18.13 Work is underway to develop a more robust, resilient strategy for the delivery of fire safety training which supports divisions and departments to achieve and maintain expected training compliance. Divisional strategies and schedules are being developed for emergency exercises and evacuation drills to include fire scenarios.

18.14 The Trust experienced one fire incident which occurred at VCC on 11th October 2022; the cause of the fire was failure of a light fitting in an office [Zone 01 / Rm 06] which generated smoke and activated the fire detector in the unoccupied room resulting in activation of the fire alarm. Recorded incidents and unwanted fire alarm activations are listed in table 15 below.

Table 15 – Fire safety Incidents

Site	Fire	UWFS
Velindre Cancer Centre	1	10

The incident also resulted in attendance of the South Wales Fire and Rescue Service and required evacuation of patients and others in the affected zone. Emergency evacuation procedures and emergency response worked well and the fire and recuse service did not undertake any further investigation or further action beyond their initial attendance.

18.15 There were 10 recorded unnecessary fire alarm activations, all occurring at VCC over the last financial year as demonstrated in Table 16.

Table 16 – Fire safety Incidents

Item	Value	%
Other environmental effect		50
Alarm activated by patient public		10
Accidental Damage		30
System fault/design		10
Total	10	100

As identified, 5 incidents were caused by changes to the "environment" [heat, dust, etc.] within the affected area and 3 incidents resulted from accidental contact / activation of either a fire alarm call point or fire detector.

All of the incidents were investigated and, where appropriate lessons learnt have been shared; examples include:

- Consideration of changing state [operating criteria of device] of detectors in areas susceptible to increases in temperature during periods of heatwaves;
- Better education of staff around use of aerosols in small rooms / rooms with low ventilation.
- Providing lift covers to fire alarm call points in high traffic areas.

Incidents did not affect the performance rating for the site, the threshold for improvement is set at 12 activations over 12 months; however, the Trust still has a duty to manage its fire alarm systems including the reduction of unnecessary activations.

1816 A number of unnecessary fire alarm activations occurred at WBS headquarters; however these were not formally recorded on DATIX or the NWSSP-SES Fire & UwFS Incident Reporting System with incidents being reported on DATIX moving forward to demonstrate due-diligence.

One significant "near-miss" occurred on 10th March involving over-heating of an electrical distribution board on the WBS HQ site. The incident was proactively managed by VUNHST Estates department with support from WBS and prompted full inspection of other distribution boards on site and longer-term development of planned preventative inspection and maintenance regimes.

Ensure that fire alarm activations at WBS HQ are formally recorded and reported to demonstrate due diligence with regard to management of the fire alarm system.

19 Conclusion

19.1 The Annual Report includes information on the reporting framework, trends, incidents, training, and the audit of management processes, demonstrating the continued work of the Health Safety and Fire Board Meeting over the year 2022/23.

19.2 Health and Safety continues to embed within the portfolio of the Director of Strategic Transformation, Planning and Digital, and the opportunity has been taken in 2022/23 to review the structures and reporting mechanisms outlined in this report, to ensure continual improvement in the management of Health and Safety within the Trust.

TRUST BOARD

Annual Health and Safety Report - 2022 / 2023

DATE OF MEETING	28th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Jason Hoskins, Assistant Director of Capital Planning, Estates and Environmental Development
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The Trust is required to produce an annual report in relation to Health and Safety performance across the Trust (see appendix 1).
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **APPROVE** the Trust Annual Health and Safety Report for 2022 / 2023

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Health Safety and Fire Management Board	16th May 2023
VCC Cynefin HS&F Group	31st July 2023
WBS Cynefin Group	29th June 2023
Executive Management Board	31st August 2023
Quality, Safety & Performance committee	14th September 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS: The Annual Health and Safety Report was noted by the groups listed above.	

7 LEVELS OF ASSURANCE – NOT APLLICABLE

APPENDICES	
Appendix 1	Health and Safety Annual Report – 2022 / 2023

1. SITUATION

It is a recommendation from the Trust internal audit function, as part of the Trust assurance process, that an annual report is submitted to the Trust Board in relation to the management of Health and Safety across the organisation. This paper has been prepared to provide the Trust Board, following endorsement by the Trust Quality, Safety and Performance Committee, with the annual Health and Safety report from the Trust Health Safety and Fire Board for the financial year 2022 / 2023.

2. BACKGROUND

This Trust Annual Health and Safety report has been produced to provide an overview of the management and performance of Health and Safety across Velindre University NHS Trust for the period 1st April 2022 – 31st March 2023.

3. ASSESSMENT

The Trust received no prosecutions or Improvement Notices from any of the enforcing agencies of the HSE, or Fire & Rescue Service during 2022 / 2023. This status has now been maintained for many years and is a direct result of the '*good Safety Culture*' and the high standards throughout the Trust for health & safety compliance.

The Trust Incident Reporting process is a significant part of this culture and continues to remain strong during the past year as a well-established part of the Trust and its values.

The increasing incident reporting culture remains strong and continues to improve with a measured increase in reporting across the many Trust departments.

There were several issues improvements made across the Trust's Health and Safety and Fire management systems during the financial year. These are highlighted within the Annual report (Appendix 1). During the year there were only 4 RIDDOR reportable accidents reported to the HSE. This is a reduction on the previous year.

There have, however, been a number of instances of violence and aggression toward staff, which are in the main verbal. All such instances are assessed and there have been occasions where the Trust has issued Behavioural Agreements.

RIDDOR numbers remain low which again confirms the resilience of the Trust safety management systems.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to:

- **APPROVE** the Trust Annual Health and Safety Report for 2022 / 2023

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*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒
	The Annual Health and Safety Report for 2022 / 2023 is a factual report based upon recorded performance during that timeframe. The Trust has established robust management systems and processes to support the management and reporting of Health and Safety across the Trust.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	The Annual Health and Safety Report for 2022 / 2023 is a factual report based upon recorded performance during that timeframe and therefore there is no requirement for a socio economic duty assessment.

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
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 are no equality impact considerations in relation to the Trust Annual Health and Safety report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	There are no additional legal considerations in relation to the Trust Annual Health and Safety report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
	The Annual Health and Safety Report for 2022 / 2023 is a factual report based upon recorded performance during that timeframe. Any 'live' / current Health and Safety risks which are identified 'in-year' are recorded on the Trust Health & Safety Risk Register.
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD

QUALITY IMPACT ASSESSMENT TOOL

DATE OF MEETING	28th September 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	Nicola Williams, Executive Director Nursing, AHP & Health Science
PRESENTED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The national (NHS Wales) beta (trial) Quality Impact Assessment was provided to NHS bodies on the 4th August 2023 earlier than anticipated to support NHS Wales with required financial proposals. The tool is designed to support NHS bodies in meeting their Duty of Quality responsibilities to ensure that quality is considered as part of all strategic decision making. The Quality Impact Assessment is designed around the NHS Wales Health & Care Quality Standards (2023) and covers the six domains of quality and the six enablers.

RECOMMENDATION / ACTIONS	Trust Board are asked to **APPROVE** the use of the national beta version of the Quality Impact Assessment Tool for all strategic decisions at Divisional, Executive and Board level and to request hosted bodies to also adopt the tool.

GOVERNANCE ROUTE	
Executive Management Board Quality, Safety & Performance Committee	14/08/2023 14/09/2023
ENDORSED for onward approval. ***APPROVED*** to be used with immediate effect for financial savings plans.	

7 LEVELS OF ASSURANCE	
N/A as a proposal for implementation – currently Trust has no quality impact assessment process	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 0 - Enthusiasm, no robust plan

APPENDICES	
1.	Beta version of the National Quality Impact Assessment Tool
2.	Supporting Information
3.	Quality Impact Assessment process

1. SITUATION / BACKGROUND

NHS bodies in England have, for many years used Quality Impact Assessments when major strategic changes are being considered / proposed. This has not, been mandated in Wales, although a few Health Boards in Wales have adopted over recent years the use of a Quality Impact Assessment Tool to support strategic decision making.

The Duty of Quality (Wales Quality & Engagement Act 2020) requires Ministers and NHS Bodies to demonstrate that Quality has been considered as part of all strategic decision making. A national Tool has been developed as a suggested tool but use of this is not mandated currently. If organisations have pre-existing arrangements / processes that meet the requirements of the Duty of Quality these can be used.

Velindre University NHS Trust does not currently have a Quality Impact Assessment Tool.

2. ASSESSMENT

The beta (not final draft) version of the national Quality Impact Assessment Tool is attached in ***Appendix 1***. In addition, there is supportive guidance (***Appendix 2***) and process flow chart (***Appendix 3***).

The supportive guidance refers to a proportionate process depending on the size, risk and complexity of the decision and for Clinical sign off.

It is proposed, in the absence of an alternative tool, that the Trust adopts the use of this beta Quality Impact Assessment Tool with immediate effect for all strategic decision making by Divisional Senior Management / Leadership Teams, Executive Management Board, Transforming Cancer Services Team and Trust Board. The completed tool is to be brought along with the proposal to the relevant decision-making group and the Corporate Governance Team will be responsible for recording such decisions.

As the responsible body for the Duty of Quality includes hosting and well as hosted organisations it is proposed that NWSSP and Health Technology Wales are asked to adopt the use of the Quality Impact Assessment Tool to support their strategic decision making and to include an overview of this in reporting through to the Trust Quality, Safety & Performance Committee.

If approved an electronic mechanism for completing and capturing the Quality Impact Assessments will need to be developed as this will assist with the Trust in collating reports and the annual quality report to publicly demonstrate how the Duty of Quality has been enacted.

3. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to:

- ***APPROVE*** the adoption of the beta version of the National Quality Impact Assessment Tool with immediate effect for all strategic decision making at a divisional and corporate / board level for onward Board approval.
- ***APPROVE*** the need to develop an electronic mechanism for completing and capturing use of the tool and outcomes.
- ***APPROVE*** the proposal to request hosted organisations adopt the tool for all strategic decision making.

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	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The undertaking of Quality Impact Assessments will impact on all 6 quality domains
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Proposal will not require this assessment
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
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Undertaking Quality Impact Assessments will not have a direct financial implication
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
	N/A is respect of proposal to undertake Quality Impact Assessments using a nationally agreed tool
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	It is a legal requirement to consider quality as part of all strategic decision making

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
All risks must be evidenced and consistent with those recorded in Datix	
There is a risk of non-compliance with Duty of Quality legislative requirements if the national Quality Impact Assessment tool is not endorsed / approved as the Trust does not have an alternative tool in place.	

Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	
QIA completed by / on date	Insert name/s and designation and date
QIA agreed by / on date	Insert name/s and designation and date *<e.g. Directorate manager>*

Part 2a: Clinical review and sign off of QIA

Reflecting the **proportionate** nature of the QIA to the proposal, each QIA should be reviewed and agreed by clinician(s) at an appropriate level (i.e. a more significant proposal should be subject to more senior clinical review and sign-off)

QIA clinically agreed by / on date	Insert name/s and designation and date *<e.g. Head of nursing / head of midwifery / clinical director>*

Part 2b: Executive clinical review and sign off of QIA if required

Reflecting the **proportionate** nature of the QIA to the proposal, each QIA should be reviewed and agreed by clinician(s) at an appropriate level (i.e. a more significant proposal should be subject to more senior clinical review and sign-off)

Clinical Executive 1 sign off / date	Insert name/s and designation and date *<e.g. Executive director of nursing / executive director of therapies and health sciences / executive medical director>*
Clinical Executive 2 sign off / date	Insert name/s and designation and date *<e.g. Executive director of nursing / executive director of therapies and health sciences / executive medical director>*
Clinical Executive 3 sign off / date	Insert name/s and designation and date *<e.g. Executive director of nursing / executive director of therapies and health sciences / executive medical director>*

Part 3: Outline of the proposal / decision to be made

1. Broadly outline what is being proposed and the decision that needs to be made
2. Why is the proposal / decision needed?
3. What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities)
4. Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected
5. How have you engaged with the people affected? If you have not yet engaged, what are your plans?
6. What are the main benefits of this proposal / decision?
7. i) What are the main risks of implementing this proposal / decision? ii) What are the main risks of not implementing it?
8. How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?
9. Is the proposal / decision planned to be temporary or permanent?

Part 4: Quality Impact Assessment

- This assessment tool should be completed for all strategic decisions.
- The response should be **proportionate** to reflect the significance, scale, risk, impact on delivery of strategic objectives and drivers of the proposal being made.
- Consider how the proposal / decision impacts on each of the Health and Care Quality Standards.

Health and Care Quality Standards	Briefly outline how the proposal / decision impacts on each of the Health and Care Quality Standards What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact?	Identify if the overall impact of the proposal / decision is **positive, neutral or negative**
Safe		
Timely		
Effective		
Efficient		
Equitable		
Person-centred		
Leadership		
Workforce		
Culture		

Health and Care Quality Standards	Briefly outline how the proposal / decision impacts on each of the Health and Care Quality Standards What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact?	Identify if the overall impact of the proposal / decision is **positive, neutral or negative**
Information		
Learning, improvement and research		
Whole systems approach		

Part 5: Summary of the Quality Impact Assessment

Based on the assessment in Section 2, what are the key messages, risks and recommendations for the clinical review and sign-off process?
What are the proposed monitoring arrangements and frequency of QIA Review?

Quality-driven decision-making
Quality Impact Assessment

Supporting information

Introduction

The duty of quality requires quality-driven decision-making for all strategic decisions. In discharging the duty of quality, NHS organisations are required to take into account the Health and Care Quality Standards when making decisions about healthcare services.

A Quality Impact Assessment (QIA) is a mechanism for considering and capturing the impact of proposals / decisions on the Quality of our healthcare system, to inform strategic decision-making. Key to the success of the implementation of a Quality Impact Assessment across healthcare in Wales is that it must be proportionate, have clinical sign-off, and feed into existing corporate processes rather than creating new ones. Organisations must be able to evidence that their strategic decisions have been made through a Quality lens.

The purpose of the QIA can therefore be described as:

- To inform strategic quality-driven decision-making
- To identify and assess the effect or influence of a proposal on the quality and safety of the healthcare system, in line with the Health and Care Quality Standards
- To ensure that we identify any actions needed to reduce risks where quality or safety could be negatively affected, and to ensure these risks and mitigations feed into existing corporate monitoring processes
- To provide assurance of quality-driven decision-making, together with audit trail.

This QIA tool is directly linked to the Duty of Quality and Health and Care Quality Standards that we have here in Wales. All strategic decisions should go through this process.

Using the tool

The suggested process for undertaking and agreeing the Quality Impact Assessment, and the beta QIA tool, are embedded below.

The QIA tool should be completed to support any proposal for a strategic decision to be made and be presented with the proposal to the appropriate decision-making forum.

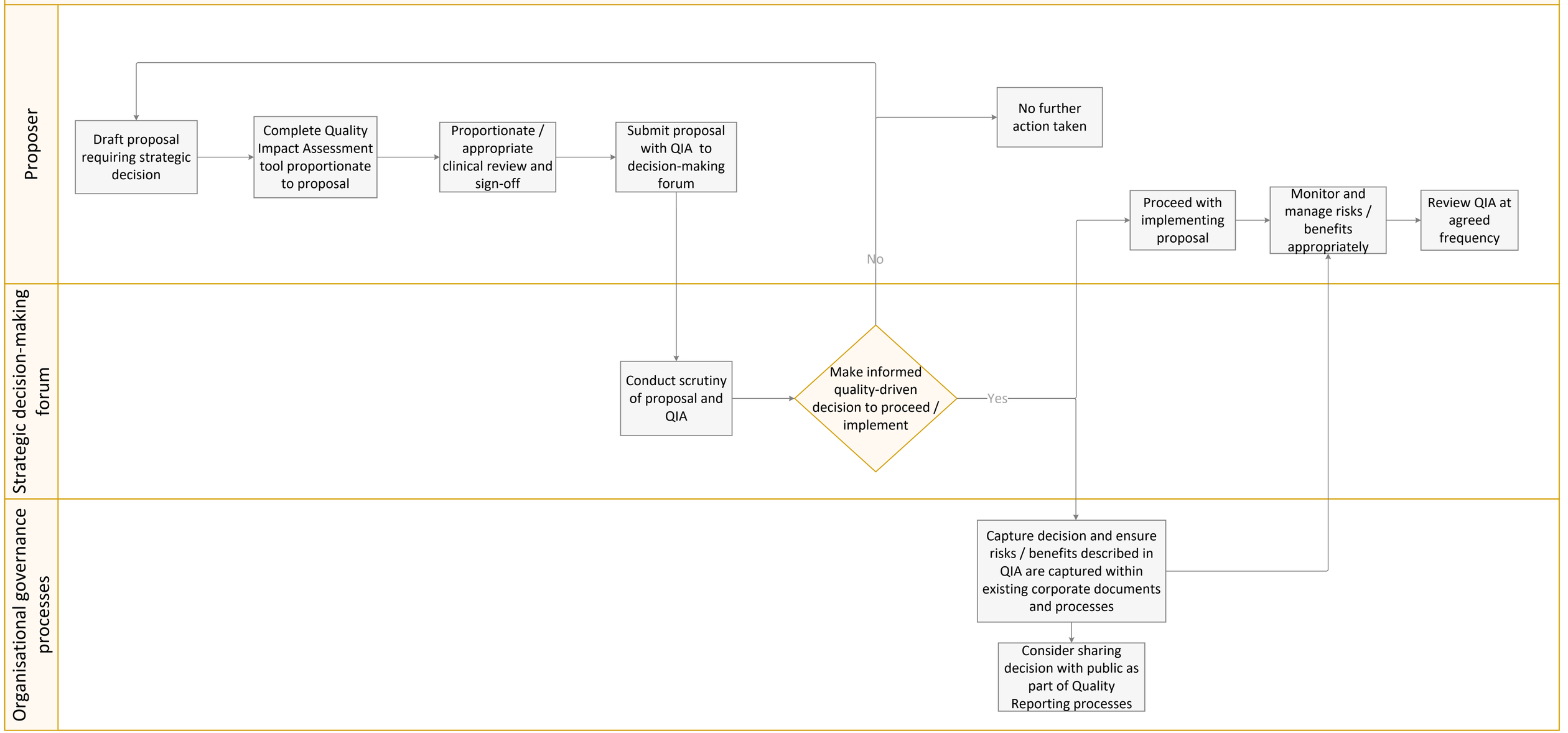
As mentioned above, the detail required to populate the QIA tool should be **proportionate** to the scale, risk, impact on delivery of strategic objectives, drivers and financial implications of the proposal and decision to be made. The more significant the decision to be made, the more detail required in the QIA.

All QIAs **must** be reviewed and signed-off by a clinician. Again, the significance of the decision should determine the seniority of the clinician who would need to review and authorise the QIA before it is presented to the decision-making forum.

If the decision makers agree that the proposal should proceed, then risks and benefits that are identified through the QIA process should feed into existing corporate monitoring processes.

[A final version of the QIA tool and formal supporting guidance will be issued in the future.]

Quality Impact Assessment process



TRUST BOARD

MATRIX HOUSE – RENEWAL OF LEASE WITH TOAST (MAIL ORDER) LIMITED

DATE OF MEETING	28 September 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?	YES
PREPARED BY	PETER STEPHENSON, HEAD OF FINANCE & BUSINESS DEVELOPMENT, NWSSP
PRESENTED BY	
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	Toast (Mail Order) Limited are a private sector company that has been a long-standing tenant in Matrix House, pre-dating the acquisition of this building by NWSSP in March 2022. Their current five-year lease expires at the end of September and a new lease has been agreed with them which will need to be signed by the Trust, and which therefore requires prior Trust Board approval.

RECOMMENDATION / ACTIONS	**The Trust Board is asked to approve the renewal of the lease with Toast (Mail Order) Limited.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS This paper has not been through other governance discussions as there has been no need. It relates solely to the renewal of a lease with a private tenant in Matrix House. The reason for requiring Trust Board approval is due to the lease needing to be formally signed by the Trust.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the* ***"How to Guide for Reporting to Trust Board and Committees"***

APPENDICES	
Appendix 1	Heads of Terms

1. SITUATION

This paper is prepared to seek the approval of the Trust Board for the signing of a (renewal) lease with Toast (Mail Order) Limited.

2. BACKGROUND

NWSSP purchased Matrix House on the 31st of March 2022, and took over the lease arrangements for the sub-letting of parts of the building to a number of tenants. This included Toast (Mail Order) Limited who had an existing five-year lease which expires at the end of September 2023. The lease has been re-negotiated on broadly similar terms and provides for rental income of just under £57k per annum and a service charge capped at £23k.

3. ASSESSMENT

The lease with Toast (Mail Order) Limited will need to be signed by the Trust as the legal entity. In accordance with the Standing Orders, this must first be approved by the Trust Board.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The lease provides for income to the NHS from the private sector and is for an existing tenant. Approval is needed for the Trust to formally sign the lease on behalf of NWSSP.

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** N/a
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ N/a
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	**Choose an item** This paper has been produced for the sole purpose of gaining approval for the signing of the lease with a private sector tenant in accordance with Standing Orders.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	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	**Choose an item**
	Source of Funding: Other (please explain) Please explain if 'other' source of funding selected: This arrangement relates to the receipt of income rather than the commitment of expenditure. **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	N/a for reasons given above.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Choose an item
	Click or tap here to enter text
	The signing of the lease has legal implications for the landlord and tenant. However, Legal and Risk have helped to draw up the lease document which is a renewal of an existing lease.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*N/a*
WHAT IS THE CURRENT RISK SCORE	N/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*N/a*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/a
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	N/a
All risks must be evidenced and consistent with those recorded in Datix	

HEADS OF TERMS
Part 3rd Floor
Matrix House

31 March 2023

Property	Matrix House
Demise	Part 3rd Floor Matrix House
Landlord	Velindre University NHS Trust Unit 2 Charnwood Court Parc Nantgarw Nantgarw Cardiff CF15 7QZ
Tenant	TOAST (Mail Order) Limited
Lease Details	5 year lease renewal by reference to an existing lease between Jarrington Properties Limited and TOAST (Mail Order) Limited dated 13 September 2018 (which was also a renewal lease, relating to the original lease dated 30 November 2009). Lease to commence 29 September 2023.
Rent	£56,956 per annum
Service Charge Cap	£23,000 per annum subject to annual RPI increases.
Timing	Target lease completion – As soon as possible.
Landlord's Solicitors	Sarah Clewett NWSSP Legal & Risk Services 4th Floor Companies House Crown Way Cardiff CF14 3UB Phone: 02920 905461 E-mail: sarah.clewett@wales.nhs.uk
Tenant's Solicitors	In house c/o Clare York yorc@Toa.st
Conditions	Subject to Contract

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	28/09/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Commercially Sensitive
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 Public: Strategic Development Committee held on 12th September 2023.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Blood Establishment Computer Systems (BECS): Verbal Formative Discussion** The Blood Establishment Computer System (BECS) contract ends in 2024. Several different factors are currently being worked through with Welsh Blood Service. This will be brought through Executive Management Board in the first instance then back through Strategic Development Committee in November showing the options which are currently being finalised. The Strategic Development Committee **noted** the Blood Establishment Computer Systems verbal formative discussion. **Quality Management System** Discussions to date in respect of the Quality Management System approach which had concluded that the Trusts long term Quality Management System will be 'Quality as an Organisational Design'. This approach included external procurement of support to the design and implementation. It was recognised that this approach would take five years from commencement to achieve the intended outcomes. However, subsequent discussions have identified that due to the financial outlay required to embark on this programme and the current NHS Wales financial situation that procurement of this would need to be paused at present. It had been agreed that in the short term the Trust needed to develop a Quality Management system that will be cognisant with the Quality as an organisational design work and meet the national requirements. It was agreed that the Hywel Dda University Health Board approach would be adopted. The presentation has been developed based on the Hywel Dda Quality Management system approach to outline the proposed aspects of the Trust's Quality Management System. Monthly dedicated Executive Management Board time has been agreed to develop the Quality Management System further. It was confirmed that Hywel Dda Quality Management system meets the Trusts requirements which have also been mapped across from the principles set within the board development sessions. The Strategic Development Committee **noted** the Quality Management System. **Talbot Green Infrastructure Programme Business Case and Outline Business Case: Direction of Travel** The Talbot Green Infrastructure Programme is overseeing development of the Outline Business Case for Phase 1 (sustainable infrastructure) of works proposed for the headquarters of the Welsh Blood Service in Talbot Green.

In light of finalised decant costs and clarity around requirements for space utilisation for the Welsh Blood Services Laboratories, a Feasibility Report has been completed exploring whether phase 1 (sustainable infrastructure) and phase 2 (Laboratory Modernisation) can be integrated. This would consolidate all elements of construction into one programme of work, preventing abortive costs and maximising benefits to the Welsh Blood Service as well as avoiding duplicating decant costs for both phases.

The Strategic Development Committee were updated on the endorsement made by the Executive Management Board of the decision of the Talbot Green Infrastructure Programme Board to integrate Phases 1 and 2 into one Outline Business Case for Welsh Government.

It was confirmed phase 1 has been completed.

The Strategic Development Committee **noted** the Talbot Green Infrastructure Programme Business Case and Outline Business Case: Direction of Travel paper.

Trust Assurance Framework

A review of the Trust Assurance Framework, including a refresh of the Trust's Principal Strategic Risks has been undertaken and was presented to the Strategic Development Committee. The Strategic Development Committee were asked to endorse for Board approval, the revised Strategic Risks detailed in this report, including any final articulation to facilitate effective operationalisation. It was decided to endorse all Strategic risks except the following two risks:

- Digital Transformation – failure to embrace new technology
- Patient, donor and community engagement

Both of these Strategic risks need to be reviewed prior to going to Trust Board.

The other six Strategic risks were approved.

The Strategic Development Committee **endorsed** the revised Strategic Risks for Board approval. The Strategic Development Committee reviewed the Strategic Risk Refresh and approved for submission through the Trust governance cycle.

Environmental Policy & Waste Management Policy Update

The Strategic Development Committee **endorsed** the following policies:

- Environmental Policy
- Waste Management Policy

ASSURE	**Integrated Medium Term Plan: Developing Our Approach** It is anticipated that the Trust will be required to submit a Trust Board approved Integrated Medium Term Plan for 2024 / 25 – 2026 / 27 to the Welsh Government by 31st March 2024. To facilitate the development of the Integrated Medium Term Plan for 2024 / 25 – 2026 / 27, and to meet the requirements of the Welsh Government planning guidance, there needs to be agreement in terms of the Trust-wide Integrated Medium Term Plan planning process and approach. In parallel, it is important that a number of opportunities are taken at this stage to improve the overall process for developing the Integrated Medium Term Plan. A discussion took place regarding including the current financial situation the NHS is in, this will be reflected when developing the Integrated Medium Term Plan further. The Strategic Development Committee **noted** the Integrated Medium Term Plan: developing our approach.
INFORM	**Cardiff Cancer Research Hub: Progress Update** The Cardiff Cancer Research Hub presentation was delivered to the Strategic Development Committee. It was highlighted that 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, which will meet both future service demand and address health and safety deficiencies and meets the requirements for JACIE (Europe's official accreditation body in the field of haematopoietic stem cell transplantation and cellular therapy) accreditation • The provision of additional capacity to support advanced cell therapies • The provision of additional capacity to support the Cardiff Cancer Research Hub • The provision of additional capacity to support the required level of provision for complex specialist oncology patients Key guiding principles have also been agreed: • An equal share of risk and reward among partners (although contributions from partners will likely not be the same/ partners will bring different elements to the partnership). • The flexibility to draw upon the relevant strengths of each organisation • A clear brand for the Hub, with each organisation moving towards a shared identity • A set period of time in order to meet pre-defined objectives i.e. protected time to prove the concept • An independent Board member and a scientific advisory panel to bring in necessary external governance challenge and advice

	Across the three organisations (Cardiff and Vale University Health Board, Velindre University NHS Trust and Cardiff University) there have been great engagement. Our forecast for capacity broadly aligns with those well-established centres across the UK. It was highlighted the fundraising team need to know what is being requested and what the implications will be for the charity. It was confirmed further discussions will be held with the fundraising team. The Strategic Development Committee were assured there is a Memorandum of Understanding in place across all three organisations. The Strategic Development Committee **noted** the Cardiff Cancer Research Hub paper. **Based Healthcare Programme of Work** The Value Based Healthcare Programme received funding from Welsh Government to progress two key Value Based Healthcare initiatives across the Trust as follows: • Preoperative Anaemia Pathway Project with the Welsh Blood Service • Value Intelligence Centre at the Trust The Strategic Development Committee were provided with the report that gives an overview of the development of the Value Intelligence Centre as part of the Value Based Healthcare programme of work over the past eight months. Strategic Development Committee **noted** the continued development of the Value Based Healthcare Programme including: • Phase 1 completion and Executive Summary in Appendix 1 • Phase 2 extension of third-party support until October 2023 to continue the development of the Value Intelligence Centre • The development of a Velindre Food Strategy with Welsh Government support. **R&I Highlight Report** The Strategic Development Committee **noted** the RD&I Highlight Report.
APPENDICES	**NOT APPLICABLE**

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 18 JULY 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 18 July 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 16 May 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. NHSE Funding Growth / Impact on Providers

Members **received** a presentation on the variation in growth and specialised services across the UK.

Members **noted** that work had been undertaken to analyse the variation in growth relating to specialised services across the different NHS sectors. The Joint Committee had requested that the work be undertaken to gain a benchmark of how Welsh services performed in comparison with those in England, Scotland and Northern Ireland.

Members **noted** the presentation.

4. Chair's Report

Members received the Chair's Report and **noted**:

- **Chair's Action** - The Chair's Action taken on 14 June 2023 to appoint Carolyn Donoghue, Independent Member (IM) at CTMUHB, as a WHSSC IM for an initial term of 2 years from 1 July 2023 until 30 June 2025, in accordance with the Welsh Health Specialised Services Committee (Wales) Regulations 2009 and the WHSSC Standing Orders (SOs); and
- **Key meetings attended**

Members (1) **Noted** the report; and (2) **Ratified** the Chair's action taken on 14 June 2023 to appoint Carolyn Donoghue, Independent Member (IM) at CTMUHB, as a WHSSC IM for an initial 2 year term from 1 July 2023 until 30 June 2025.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** the following updates:

- **Hosting Agreement with CTMUHB – Statutory Duty of Candour and the Duty of Quality -** Cwm Taf Morgannwg (CTMUHB), acting as Host Health Board (HB), requires WHSSC to use its reasonable endeavours to comply with this legislation in its activities where appropriate. WHSSC have written to CTMUHB to confirm we are aware of our duties and to advise that we will report on compliance with the duties within the Annual Governance Statement (AGS),
- **Memorandum of Understanding (MoU) with BCUHB -** WHSSC and Betsi Cadwaladr UHB (BCUHB) have developed a joint Memorandum of Understanding (MoU) to set out the arrangements for the management of contracts and commissioning for the population of North Wales from English providers. The MoU clearly describes the arrangements and responsibilities if a serious quality concern or risk materialises. The MoU has been signed by both parties and is operational with immediate effect,
- **Requests for WHSSC to Commission New Services – WHSSC has received requests to commission new services for NHS Wales**
    - Sacral Nerve Stimulation (SNS) for faecal incontinence in South Wales; and
    - Neurophysiology

  The workload associated with the adoption of new services during 2023-24 will be absorbed into the existing WHSSC Team capacity. A review of the longer-term workload impact, including the potential commissioning of Hepato-Pancreao- biliary (HPB) Surgery Services will be undertaken and will inform the 2024-25 ICP,
- **Fertility Update - WHSSC Policy development: - CP37 Pre-implantation Genetic Testing-Monogenic Disorders, Commissioning Policy - CP38, Specialist Fertility Services: Assisted Reproductive Medicine, Commissioning Policy -** The WHSSC team have been in discussion with Llais, regarding issues raised during the stakeholder engagement exercise on the above policies. In response to feedback, WHSSC will revise its Policy for Policies, and a paper describing the proposed approach is on the agenda for the July JC meeting. There is ongoing dialogue regarding the individual policies (CP37 and CP38) and a key issue to be resolved is the sequencing on any requirement for public consultation for policies, deemed to represent a significant service change which may have a budget impact, and therefore, require

incorporation into the WHSSC prioritisation and ICP approval processes.

- **Neonatal Cot Configuration Project -** At the March 2023 meeting the JC requested that the WHSSC Director of Planning sought advice from the NHS Wales Directors of Planning (DoPs) Executive Peer Group on the best approach to the strategic planning for the second phase of the neonatal cot review, to ensure that the review fully addresses the interdependencies with non-WHSSC commissioned services such as maternity, and the Clinical Services Plans of Health Boards (HBs). A positive discussion was held with the DoPs in May where it was agreed that WHSSC should lead this planning, and that the DoPs should be involved in the design of Phase 2. This has been followed up with a factual briefing to the DoPs on Phase 1.

Members **noted** the report.

6. Future Commissioning of the Wales Neurophysiology Service

Members received a report outlining the process and timeline of the work that will be undertaken for WHSSC to return to commissioning Neurophysiology services in Wales.

Members noted that the NHS Wales Health Collaborative Executive Group (CEG) has formally requested that WHSSC return to commissioning Neurophysiology services in Wales.

Members (1) **Noted** the report, **(2) Approved** the request for WHSSC to return to commissioning neurophysiology services from April 2024 onwards; and (3) **Supported** the proposed next steps and the work that will be undertaken to take this forward.

7. Sacral Nerve Stimulation (SNS) for Faecal and Urinary Incontinence in South Wales

Members received a report outlining the process and timeline of the work for WHSSC to take on the commissioning of Sacral Nerve Stimulation (SNS) for faecal incontinence and urinary incontinence in South Wales,

Members noted that the NHS Wales Health Collaborative Executive Group (CEG) has formally requested that WHSSC take on the commissioning of Sacral Nerve Stimulation (SNS) for faecal incontinence and urinary incontinence in South Wales.

Members (1) **Noted** the report, (2) **Approved** the request for WHSSC to commission Sacral Nerve Stimulation (SNS); and (3) **Support** the proposed process and timeline of the work that will be undertaken to take this forward.

8. Update on Welsh Kidney Network (WKN) Governance Review

Members received a report presenting an update on the Welsh Kidney Network (WKN) Governance Review.

Members **noted** the update on the Welsh Kidney Network (WKN) governance review.

9. WHSSC Policy for Policies Review

Members received a report which considered the implications of issues raised during the WHSSC stakeholder consultation on Clinical Commissioning Policies CP37 (Pre-implantation Genetic Testing) and CP38 (Specialist Fertility Services: Assisted Reproductive Medicine) in relation to the WHSSC 'Policy for Policies' and wider policy development in NHS Wales.

Members (1) **Noted** the report; and (2) **Supported** the proposed next steps.

10. IPFR Engagement Update – All Wales Policy

A recommendation was made and approved that this item not be discussed.

11. Appointment Process for the Individual Patient Funding Request (IPFR) Panel

A recommendation was made and approved that this item not be discussed.

12. Corporate Risk Assurance Framework (CRAF)

Members received a report presenting WHSSC's updated Corporate Risk Assurance Framework (CRAF) and outline the risks scoring 15 or above on the commissioning teams and directorate risk registers.

Members noted that as at 30 June 2023 there were 17 risks on the CRAF, 13 commissioning risks and 4 organisational risks.

Members (1) **Noted** the updated Corporate Risk Assurance Framework (CRAF) and changes to the risks outlined in this report as at 30 June 2023, (2) **Approved** the CRAF as at 30 June 2023, (3) **Noted** that the CRAF is presented to each Integrated Governance Committee, Quality & Patient Safety Committee, CTMUHB Audit & Risk Committee and the Risk Scrutiny Group (RSG) meetings; and (4) **Noted** that a desktop Risk Benchmarking exercise has been undertaken and the results were considered at the Integrated Governance Committee (IGC) meeting on 13 June 2023.

13. Annual Committee Effectiveness Self-Assessment Results 2022-2023

Members received a report presenting an update to the Joint Committee on the actions from the annual Committee Effectiveness Self-Assessment undertaken in 2021-2022 and to present the results of the annual committee effectiveness self-assessment 2022-2023.

Members **(1) Noted** the completed actions made against the Annual Committee Effectiveness Survey 2021-2022 action plan, (2) **Noted** the results from the Annual Committee Effectiveness Survey for 2022-2023, (3) **Noted** that an update on the survey findings was presented to the Integrated Governance Committee (IGC) Committee on the 13 June 2023, (4) **Noted** that the feedback will contribute to the development of a Joint Committee Development plan to map out a forward plan of development activities for the Joint Committee and its sub committees for 2023-2024; and (5) **Noted** the additional sources of assurance considered to obtain a broad view of the Committee's effectiveness.

14. WHSSC Annual Report 2022-2023

Members noted that the document will be sent to all members via email after the meeting for comment and subject to any further amendments for virtual approval. The document will be brought back to the September meeting under the corporate governance report to confirm approval.

Members **noted** the verbal update.

15. Declarations of Interest, Gifts, Hospitality and Sponsorship 2022-2023

Members received a report presenting an update on detail of the Declarations of Interest (DOI), Gifts, Hospitality and Sponsorship activities for the financial year 2022-2023.

Members (1) Noted the Declarations of Interest Register for 2022-2023, (2) **Noted** the Gifts, Hospitality and Sponsorship register for 2022-2023, **(3) Noted** that the Registers were presented and discussed at the Integrated Governance Committee meeting on 13 June 2023; and

(4) **Received assurance** regarding the WHSSC Declarations of Interest (DOI), Gifts, Hospitality and Sponsorship process.

16. Performance & Activity Report Month 1 2023-2024

Members received a report providing a summary of the performance of WHSSC's commissioned services. Further detail including splits by resident Health Board (HB) was provided in an accompanying Power BI Dashboard report.

Members **noted** the report.

17. Financial Performance Report – Month 2 2023-2024

Members received the financial performance report setting out the financial position for WHSSC for month 2 2023-2024. The financial

position was reported against the 2023-2024 baselines following approval of the 2023-2026 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2023.

The year to date financial position reported at Month 2 for WHSSC an underspend of (£0.021m) and a break even forecast year-end position.

Members **noted** the contents of the report including the year to date financial position and forecast year-end position.

18. Financial Assurance Report

Members received a verbal update advising that the report would be discussed in the in committee session.

Members **noted** the verbal update.

19. South Wales Neonatal Transport Delivery Assurance Group Update Report

Members received a report providing a summary of the South Wales Neonatal Transport Delivery Assurance Group (DAG) Annual Report for 1 April 2022 – 31 March 2023.

Members (1) **Noted** the report; and (2) **Received assurance** that the Neonatal Transport service delivery and outcomes were being scrutinised by the Delivery Assurance Group (DAG).

20. Major Trauma Network Delivery Assurance Group Quarter 4 Update Report

Members received a report providing a summary of the Quarter 4 2022-23 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members **noted** the South Wales Major Trauma Network (SMMTN) Delivery Assurance Group (DAG) Report.

21. All Wales PET Programme Progress Report

Members receive a report providing an update on the progress made by the All Wales Positron Emission Tomography (PET) Programme.

Members **noted** the progress made by the All Wales Positron Emission Tomography (PET) Programme and its associate projects and workstreams. The risk related to the availability of capital fundng was noted.

22. Efficiency and Recommissioning Programme Update

Members received a report providing an update on the Efficiency and Recommissioning programme enabled to realise the 1% savings requested by Joint Committee when signing off the 2023-24 Integrated Commissioning Plan (ICP).

Members **noted** the report and the progress made.

23. 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.

24. 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).

25. Any Other Business

- **Retirement of WHSSC Director of Finance** – members noted that it was Stuart Davies' last Joint Committee meeting following announcing his retirement. Members thanked him for his stalwart contribution and commitment to developing specialised commissioning in Wales and wished him every success in future.

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	18 July 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/july-2023/

- The minutes of the EASC meeting held on 16 May 2023 were approved.

PERFORMANCE REPORT

The Performance Report was received which included the Ambulance Service Indicators and the EASC Action Plan. In presenting the report, Ross Whitehead highlighted a number of key areas.

Members noted that:

- The latest Ambulance Service Indicators (ASIs) https://easc.nhs.wales/asi/ would be published on Thursday 20 July, reporting the June position
- 999 call volumes were 8% lower than in May 2022
- 4% reduction in incidents
- Hear and treat rates continued to improve
- See and treat rate back to the historical norm
- Improvements in response times – all on an improving trajectory as well as for those patients waiting the longest in the red and amber categories, although there was still a long way to go before the performance would be considered satisfactory (but in the right direction)
- An increase in the number of patients conveyed to hospital compared to the same period last year – this needed to be analysed further and would be presented to the EASC Management Group
- Improvement in handover delays and the number of patient waiting over 4 hours has reduced, in some areas this has been eradicated while others, though showing signs of improvement, required continued attention
- EASC Action Plan was being updated and, although it was no longer required to be submitted monthly, would be used at the Integrated Quality, Planning and Delivery meetings with Welsh Government.

Discussion took place and Members raised the issue of variation both across Wales but also within health boards. Members welcomed the dashboard approach in providing clarity and sought assurance that the data was being validated, particularly in relation to red release. Members noted that the weekly dashboard was constantly under review and enhancements would continue where members identified additional requirements.

Members discussed the impact of reducing handover delays and the expectation that this would affect performance although this had not yet been seen with performance in red consistently at the mid 50% level.

Jason Killens was asked to forecast where and when improvements would be seen and whether the assumptions made in the IMTP would be realised. Further discussion took place in relation to variation and Members noted good performance improvement in some areas whereas others were stubbornly at unacceptable levels. Further improvements were anticipated with the roll out of the Cymru High Acuity Response Units (CHARUs) and the improved utilisation of the ambulance fleet.

Stephen Harrhy raised the role of the Community First Responders, particularly in rural areas and also the variation in conveyance rates across health boards which would be important areas for the deployment of Advanced Paramedic Practitioners (APPs) in trying to avoid conveyance. Jason Killens explained that additional CFRs had been recruited & trained.

It was agreed that additional work would be required to retrospectively analyse the data from the electronic patient clinical record (ePCR) and other sources to correctly categorise the work; this would be included in the next report and would have the alternative services identified.

Members noted:

- Modelling suggested 4% of WAST activity could be dealt with in the Same Day Emergency Care (SDEC) units; this was currently at 0.2%
- The aim to make more use of video consultation, and to use to best effect
- The development of directories of services in health boards and the importance of ensuring access for WAST staff
- For lower acuity chest pain patients and some care homes analyse the data for potential opportunities to create services and track through actions (real time access)
- The importance of driving out variation in an environment of improving performance.

The version of data presented to the Committee was raised in view of the requirement for StatsWales to publish the Ambulance Service Indicators before any publication of the information. Ross Whitehead explained that ongoing meetings were taking place with the aim to resolve the issue and be agile as commissioners of the ambulance service. The aim would be to try and make progress in some areas with a view to ensuring the Committee had the most current information. Members noted that the Office of National Statistics (ONS) had been tasked to produce cross UK measures for health, which in view of the four different operating models was a complex request.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received.

In presenting the report, Ross Whitehead highlighted the presentation of the revised quality report in light of the requirements of the Duty of Candour and Duty of Quality.

Noted that:

- 25 ongoing investigations under the Joint Framework in May
- Work continuing to identify key themes in meetings with WAST and health boards

- The Welsh Risk Pool were supporting the work and seeking improvement opportunities for the tracking and reporting of joint investigations
- Reduction in the number of patients waiting over 12 hours in the community, although still a large number, the trajectory was one of improvement
- Improvement in the compliance of the clinical indicators within the Ambulance Service Indicators
- A technical error had been identified within the STEMI bundle and this would be rectified back to June 2020
- The published levels for the return of spontaneous circulation (ROSC) was 20% (the highest level achieved)
- The latest information was not available in respect of patients arriving as 'walk ins' but in the triage category one. This would be rectified as it was agreed this was an important metric for patient safety. Joint work was underway with the NHS Wales Delivery Unit (NHS Executive) to analyse those self-presenting and included stroke patients (high level of patients presenting at emergency departments).

Members responded asking about:
- learning from the North East Ambulance Service review and the potential to undertake a gap analysis to secure any insight or learning – noted that the EASC Team currently analysing the review and would report to EASC Management Group on any findings
- other reviews of ambulance services and noted that the EASC Team constantly scan for any ambulance service reviews and consider any learning. This would again be reported initially via EASC Management Group. Jason Killens also confirmed that WAST routinely undertake a gap analysis approach to any significant report on ambulance services.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received. This included:
- Integrated Medium Term Plan 2023-26
- Current EASC Integrated Medium Term Plan (IMTP) Tracker
- Non-Emergency Patient Transport Services (NEPTS) Strategic Direction
- Integrated Commissioning Action Plans (ICAPs)

Members noted that:
- Work had commenced on reviewing the Non-Emergency Patient Transport Services Commissioning Framework as per the agreed commissioning cycle
- The work to develop a longer-term strategy for NEPTS following the completion of the business case and adapting to the ongoing changes within the service. The final report would be presented at a future meeting
- In relation to the EASC IMTP Tracker some of the performance ambitions had been achieved including:
  - longest red – 95th percentile 30 minutes by the end of Quarter 1 – this had been achieved and it was suggested to review Quarter 2 ambition to <18 minutes
  - longest amber – 95th percentile 8 hours by the end of Quarter 1; this had been achieved and suggested revising the Quarter 2 ambition to 4.5 hours and Quarter 3 to 3.5 hours.

Agreed to: Revise the performance ambitions as outlined above

FOCUS ON – EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS) SERVICE REVIEW

Stephen Harrhy gave an overview of the work to date and introduced Lee Leyshon, Deputy Director of Communications and Engagement to deliver the presentation on the emerging themes.

Noted:

- Discussed the factors for developing options for the service and the weightings as previous used for EMRTS developments
- In relation to the EMRT Service:
  - General support and appreciation
  - Local bases mean local services for the people who live near
  - Some consider it a 'fast ambulance'
  - Understanding of a problem to fix
  - Important about effectiveness of working with other services and agencies
  - Implications for hours of operation, for air and road, with staffing implication
  - The small mutual aid implications
- In terms of wider issues and the original service development proposal:
  - Another rural loss – like banks, dentists, GP practices, post offices etc
  - Lack of understanding of 'unmet need'
  - The rationale for the original base locations; the coastal locations and the importance of rapid response vehicles RRVs
  - That the critical care staff would want to treat as many patients as possible
  - The impact of the weather on services
- In reference to the Wales Air Ambulance Charity:
  - Potential reputational damage with a risk to funding
  - Perception of cost saving
  - Accepted the findings of the original Service Development Review
- For rural and coastal areas the following issues were regularly raised:
  - Remote and lone working in high risk occupations
  - Seasonal population variations
  - Impact of rural geography, road infrastructure and topography
  - Mobile phone coverage
  - Patient road transfer experiences and outcomes
  - Impact of climate change affecting access
- Public perception that services prioritised in urban areas when using services per head of population and the respective needs were different in rural and urban areas
- Response times was a major concern, of increased response times, losing the 'golden hour' and the impact of adverse weather. The proximity to emergency department in urban areas was raised regularly
- Data was an area of focus regularly raised in sessions including:
  - The initial data period involving the Covid period
  - The significance of the average response times
  - Using historical and forecasting data
  - Seasonal and population variation and projected demographics for rural areas
  - Understanding the under-utilisation data
- In terms of the factors and weightings:
  - Regular questions related to cost saving perception
  - Cross over between the factors suggested

- Importance of defining the factors
- That clinical skills and sustainability needed a higher score and a reduction to the value for money weighting.

- With regard to the engagement process:
  - Understood a complex matter
  - Questionnaire available at all sessions and online
  - Increased and regular communications
  - Commissioner trusted and the public confidence in the approach
  - Responses received included 'balanced, fair, comprehensive and diligent'; not a 'fait accompli'
- Suggestions received included:
  - Same bases different hours; all bases 24/7; base investments; all 4 into one base
  - Variations on the issues above with RRV usage
  - Make either (or both) Welshpool and Caernarfon 24/7 instead of Cardiff
  - More RRVs to be available
  - Move the South Wales bases
  - That WAST provide similar critical care skilled staff
  - Make more incremental changes from aviation contract
  - Opportunities to work with Fire and Rescue
- Broader system issues included appreciation of the scale and landscape, the vulnerabilities and the context of other services
- Concerns about WAST in out of area; handover delays, triaging of 999 calls and recruitment of staff
- For health boards – primary and secondary care in terms of loss of access to services; sustainability of services (local) and how people can have a say (want to be involved)
- For public services – need to be more integrated; recognise local service loss and its impact; involve the local populations more and more raise more awareness
- For policy and decision makers – understand the current pressures; reliance on charitable donations; road infrastructure important and involving the public in decision making.

Members raised the following:

- Thanked the CASC and the EASC Team for their thorough exemplar process; lots of learning for the system on the strength of the approach
- The timescales for the independent analysis, keen to ensure the collective perspective considered
- Sharing the data, modelling and information received from the engagement process
- The importance of the next phase.

Stephen Harrhy explained the next phase of work in terms of sharing data, learning from the approach and responding to the concerns by formally reporting at the next meeting to provide the facts for the Committee to consider. Further modelling would be available for members to scrutinise at the next meeting.

Members noted that there was a strength of feeling in the locality of the Welshpool and Caernarfon bases in their desire to maintain the status quo.

Areas for further consideration would include:

- Making the best use of resources (mindful of the very different levels of utilisation of the current service)
- Whether the EMRT Service is too specialised and what opportunities could exist for different patient groups
- How rural areas receive health care and the issues with time sensitive requirements

- The options for a new base and whether this could be delivered by the Charity in terms of infrastructure – some assurance for the next phase
- Adapting the approach in light of the comments received and amending the weightings on clinical skills and value for money
- Options for closer working between WAST and EMRTS
- The wider picture – local areas primarily mentioned bases; Stakeholder Reference Groups across health board areas did not have major concerns if the service would be improved for all of the population, and in particular providing more ability to deliver to patients in the unmet need category.

Stephen Harrhy explained that further work was required in order to make a recommendation to Members and that Members in turn would make a fully informed decision no earlier than the meeting in November. Members noted the risk of reputational damage to the Charity and the potential impact on donations. Members agreed the importance of making the best use of the commissioning allocation for EMRTS and WAST.

A factual report including data and the independent analysis of the responses received would be provided at the September meeting.

It was reiterated that it was too early to make a recommendation to EASC and no decision had been made.

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. Lee Leyshon presented the report and gave an overview of work to date in the phased approach.

Noted:
- Suggestions to slightly amend the weightings
- Plans for next report at the September meeting
- Continuation of the approach including planning of Phase 2 and maintaining work with the All Wales Communications and Engagement leads in health boards and trusts; and planning & informatics colleagues.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received. In presenting the report, Jason Killens highlighted:

- The use of the Clinical Safety Plan - WAST were at escalation level 2 (4 is the maximum) and in May 2023, WAST spent 1% of the time at Clinical Safety Plan (CSP) level 3b (the third highest level). The levels of escalation and CSP were significantly lower than those seen in the depths of winter, which was reflected in the lower levels of patient cancellations and “no sends”
- Red Performance and the continued roll out of the Cymru High Acuity Resource Units (CHARU), about half had been commenced and more staff are being recruited, trained and deployed with an aim to build on the roster rota work and ensure the right fleet mix across Wales. This would improve red performance and the already seen increase in the return of spontaneous circulation (ROSC) rate.

- Ambulance production levels against the plan for the latest four months at 97% against the ambition of 95%
- The progress made by health boards in reducing handover delays at emergency departments and the consequential impact on the ambulance service
- The numbers of patients conveyed at 41% into EDs in May 2023 (27% in December 2022, with the Clinical Safety Plan affecting this)
- The Non-Emergency Patient Transport Services (NEPTS) and meeting the targets for kidney patients in arriving within 30 minutes of the appointment time (performance at 75% to the target of 70%). Also, an amendment had been made for the service provided to oncology patients moving from -30/+30mins to -45/+15mins to provide a better service for this group of patients
- The first meeting of the Strategic Demand and Capacity Review had taken place at WAST with the aim of making the best use of resources available and continuing the approach.

Stephen Harrhy raised the issue of red release and confirmed the ongoing work to study the impact of the immediate release on the service provided. This would include validating the data before this was shared in the public domain, although it was acknowledged that this would potentially lead to a short time lag as this was a manual process. The work to develop confidence in the information included the health board Chief Operating Officers and their teams who receive the unvalidated report and therefore can challenge the data with respect to their areas. Further updates would be provided as the work progresses.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received. In presenting the report, Stephen Harrhy highlighted key areas which included:

- Six Goals for Urgent and Emergency Care Programme (latest highlight report shared) work continuing to deliver Goal 4 and locally based work captured through the Integrated Commissioning Action Plan (ICAP) meetings.
  - A new clinical lead, Dr Tim Rogerson, had been appointed by the Six Goals for Urgent and Emergency Care Programme. Collaborative work had started on what a good emergency department would look like and a clinical event had been planned.
  - Specific work was planned in Swansea Bay and Betsi Cadwaladr UHBs to pilot an approach undertaken in Bristol 'the continuous flow work' as well as learning the system lessons from the experience in Cardiff & Vale and more recently Cwm Taf Morgannwg UHBs.
- Connected Support Cymru (previously known as Night Sitting Service) An update report would be provided on progress at the next meeting
- Data linking – the plan to hold a workshop was still in place although it was not yet scheduled as further steps were required to ensure all information sources would be available and reliable. At that stage, a workshop would be held with all relevant health boards, WAST and Digital Health and Care Wales (DHCW) staff. Members noted that DHCW had also been commissioned by Welsh Government to develop an urgent and emergency care dashboard
- Health Education and Improvement Wales (HEIW) – Education commissioning of Paramedics and Advanced Paramedic Practitioners (APPs). Positive conversations had taken place with the EASC Team and it was suggested and agreed that Alex Howells, CEO of HEIW would be invited to periodically attend the Committee

meeting. Members suggested the importance of the timescales for this work to meet academic timetables.

EASC FINANCIAL PERFORMANCE REPORT MONTH 12 2022/23

The EASC Financial Performance Report at month 3 in 2023/24 was received. There were no variances to report on the financial position given the very early point in the financial year.

SUMMARY OF THE EASC MANAGEMENT GROUP MEETING HELD ON 22 JUNE 2023

The first summary from a meeting of the EASC Management Group was received. The aim of the report was to ensure consistency of issues identified at the ongoing meetings.

Members noted:

- Ongoing discussions on a health board by health board basis re operational matters of WAST staff undertaking supporting duties within EDs to help flow and get the balance right
- Work to ensure the consistency of data, especially in relation to immediate release.

EASC SUB-GROUPS CONFIRMED MINUTES

Approved:

- EASC Management Group 20 April 2023
- Non-Emergency Patient Transport Services Delivery Assurance Group notes 13 April 2023
- Emergency Medical Retrieval and Transfer Service Delivery Assurance Group 6 March 2023

EASC GOVERNANCE

The report on EASC Governance was received which included the:

- EASC Risk Register and suggested approach to risk appetite
- EASC Assurance Framework
- EASC Key Organisational Contacts
- Welsh Language Commissioner – Final Report and Decision Notice
- Letter to host in relation to the statutory Duty of Quality and Candour.

Noted that:

- The Risk Register had five red risks in total, three scoring the highest level at 25.
- The EASC Assurance Framework had been updated in line with the changes above to the risk register
- 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 and ongoing work
- Letter to host in relation to the statutory Duty of Quality and Candour - Stephen Harrhy had signed on behalf of the Committee to confirm that EASC would use reasonable endeavours to comply with the legislation and activities where appropriate and cooperate and provide any necessary data and/or information it requires, as Host Health Board to discharge its duties under the Health and Social Care (Quality and Engagement) (Wales) Act.
  A formal report on the EASC compliance would be included in next year's Annual Governance Statement (Added to Action Log).

Members agreed to the use of CTMUHBs Risk Appetite Statement for commissioning risks until arrangements could be developed for the new Joint Committee.
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 services provided to HB local communities and to WAST • The ongoing formal engagement process for the EMRTS Service Review, further meetings planned for later in the year
Matters requiring Board level consideration
• 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. • 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 – especially in relation to the quality of services patients receive
Forward Work Programme and Annual Business Plan
Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	19 September 2023			

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	20 July 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Chair's Report

The Chair updated the Committee on her attendance at recent meetings, both within NWSSP and externally. A development day was held with the NWSSP Senior Leadership Team and Heads of Service in June which will help to inform the similar event planned for Shared Services Committee members in November.

The Committee NOTED the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- A very positive Joint Executive Team meeting had been held recently with Welsh Government;
- The Service Improvement Team are undertaking a number of areas of work including Payroll, Accounts Payable and the Customer Service Excellence programme;
- The NWSSP Procurement - Supply Chain recently hosted a visit from an Icelandic Health Care delegation to review warehouse management systems; and
- The planned move from Companies House to the Welsh Government offices in Cathays Park is progressing and is scheduled for January 2024.

The Committee NOTED the update.

Items Requiring SSPC Approval/Endorsement

Annual Review 2022/23

The Committee reviewed the Annual Review and noted the wide ranging and

significant achievements of NWSSP during the 2022/23 financial year.

The Committee APPROVED the Annual Review.

Revisions to Standing Orders

The Committee received the Standing Orders which have been updated for a number of external (e.g. Duties of Quality and Candour; establishment of Llais) and internal (e.g. changes to the Scheme of Delegation) factors. The Standing orders will need to also be formally approved by the Velindre University NHS Trust Board.

The Committee ENDORSED and APPROVED the suggested revisions to the Standing Orders prior to formal approval by the Velindre University NHS Trust Board.

All-Wales Establishment Control Programme

Establishment Control is a functionality within ESR that enables organisations to accurately report on both funded establishments and vacancy data. It is the formal process for matching data on funded posts in an organisation to the details of the staff employed in those posts. Establishment Control ensures activity connected to recruitment, workforce and budgetary changes can be actioned in a controlled way and supports the accurate reporting of vacancy data.

The Committee APPROVED the paper which recommends the initiation of a programme of work to scope, assess and recommend options for the implementation and roll out of Establishment Control across NHS Wales organisations.

Items for Noting

PPE Update

Audit Wales undertook a review of PPE procurement and supply during the pandemic and produced a report in April 2021 that was positive in the roles that NWSSP had taken in this regard. There were however a number of recommendations made, which were split between NWSSP and Welsh Government. While the agreed actions for NWSSP were largely implemented at the time, it was considered useful to update the Committee on the current position, particularly given the recent focus on this issue at the UK Public Inquiry. The Committee were assured that the agreed actions within the gift of NWSSP to implement, had been completed.

Annual Governance Statement

The final version of the Annual Governance Statement was provided to the Committee for noting, having earlier been approved by the Audit Committee. The Partnership Committee had reviewed the draft Statement at its meeting in May and the only significant changes since that version were the inclusion of the Head

of Internal Audit reasonable assurance opinion and the full year sustainability figures.

Audit Committee Annual Report

The report detailed the work of the Audit Committee during the 2022/23 financial year, and also included the results of the annual survey into the effectiveness of the Committee. There were no items of concern to report.

Finance, Performance, People, Programme and Governance Updates

Finance –A break-even financial position is forecast for 2023/24 however this is dependent upon a number of income assumptions and generating sufficient savings to support the transitional and removal costs relating to the transfer of significant volumes of medical records from Brecon House. Welsh Risk Pool spend to Month 3 is £6.456m compared to £10.277m at Month 3 last year. The high-level forecast for 2023/24 is £135.727m which is in line with the IMTP forecast. This requires £26.494m to be funded under the Risk Share Agreement.

People & OD Update – Both in-month and 12-month sickness absence rates are improving and remain very low. Statutory and Mandatory training rates are good, but PADR compliance needs improvement. There has been a particular focus on retention of staff in recent weeks.

Performance – The in-month May performance was generally good with 34 KPIs achieving the target against the total of 38 KPIs. The four KPIs that are current rated as amber are for Audit and Assurance and Recruitment, with two amber KPIs in each service. Professional influence benefits amount to £34M at end of May.

IMTP Q1 Progress Report - At the end of Quarter 1 83% (129) of our objectives are on track. Reporting on objectives remains on a self-assessment basis by the divisional Heads of Service, scrutinised through the Quarterly Review process.

Project Management Office Update – Two projects are currently rated as red, these are the Brecon House relocation where issues with the current building being unsafe and the cost of relocation of records, and the TrAMS project and the affordability of the proposed solution as part of the wider capital programme.

Corporate Risk Register – There are currently six red risks on the Corporate Risk Register. These cover energy costs, staffing shortages, the Legal & Risk Case Management System, Brecon House, TrAMs, and the reputational issues for NWSSP relating to the situation at BCUHB.

The Committee NOTED the above Reports.

Papers for Information

The following items were provided for information only: • Declarations of Interest Annual Report 2022/23; • Gifts & Hospitality Annual Report 2022/23; • Counter Fraud Annual Report 2022/23; • Welsh Language Annual Report 2022/23; • Health & Safety Annual Report 2022/23; • PPE Stock Report; • Finance Monitoring Returns (Months 2 and 3); and • 2023/24 Forward Plan.
AOB
N/a
PART B
The Part B agenda included the approval of the following contract extensions: • International Recruitment; • TRAC; and • E-Expenses. Updates were also provided on: • TrAMs; • Home Electronics Scheme; and • BCUHB – procurement services and recent reports.
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	Thursday 21 September 9am – 11am

MEETING	NWSSP Senior Leadership Group
DATE	31 August 2023
PREPARED BY	Carly Wilce, Corporate Services Manager
PRESENTED BY	Peter Stephenson, Head of Finance and Business Development
RESPONSIBLE HEAD OF SERVICE	Andy Butler, Director of Finance and Corporate Services

TITLE OF REPORT
NWSSP Audit Committee Assurance Report – July 2023.

PURPOSE OF REPORT
The purpose of this paper is to provide the NWSSP SLG with assurance over the key issues considered by the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership, at its meeting on 11 July 2023.

VELINDRE UNIVERSITY NHS TRUST AUDIT COMMITTEE FOR NWSSP ASSURANCE REPORT

1. CEFNDIR/BACKGROUND

The Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership (Audit Committee) provides assurance to the SLG on the issues delegated to them through the Trust and NWSSP Standing Orders. A summary of the business matters discussed at the meeting held on 11 July 2023, is outlined below:

ALERT	No matters to alert/escalate.
ADVISE	No matters to advise.
ASSURE	**NWSSP Update**

	The Managing Director presented the committee with an extensive update as to key developments within NWSSP. Main highlights discussed are as follows- • Audit & Assurance Services underwent a second external quality assessment. No issues raised and the review was very positive; • Accounts Payable continues to experience an exceedingly large volume of invoices to process, with 135,000 invoices received in March 2023; • The year-end finances were currently subject to audit but a £12k surplus was noted and £2m was given back to Health Boards and Trusts; • Total liabilities for the Welsh Risk Pool are £1.5bn: • The lack of capital funding is a major concern impacting a number of significant projects including the Laundry Services Transformation Plan; • Securing a building for TrAMS in Southeast Wales was progressing and needs to be completed as soon as possible to protect continuity of services; • 89% of vehicles available to lease as part of the salary sacrifice scheme are either electric or hybrid, and LED lighting has been installed across the majority of sites; • Reinforced Autoclaved Aerated Concrete has been found in both Brecon House and Companies House. NWSSP are looking to permanently exit both sites, but in the meantime control measures are in place to mitigate risks to staff safety; and • The move from Companies House to the Welsh Government, Cathays Park 2 building is out for consultation and the move is anticipated to take place in January 2024.
ASSURE	**External Audit Position Statement** Audit Wales provided a detailed update as to current and planned audit work. The audit of NWSSPs finances had thus far produced no issues of significance and the audit should complete by the end of July.
ASSURE	**Internal Audit Reports** The following reports were presented to the Committee for consideration: **ICT Follow Up** The follow up review was positive and achieved reasonable assurance, with six priority recommendations for action**.** **Final Procurement – National Sourcing** The audit achieved reasonable assurance with one high, 3 medium and 2 low risks recommendations for action. **Cyber Security** The review was very positive and achieved substantial assurance, with one recommendation raised. **Head of Internal Audit Opinion & Annual Report 2022-23** The Head of Internal Audit presented the 2022-23 Head of Internal Audit Opinion and Annual Report to the Committee, which achieved an overall rating of reasonable assurance. The report was very positive and demonstrated the significant amount of work performed throughout the year. Regular audit progress reports had been submitted to each NWSSP Audit Committee throughout the 2022-23 reporting period. The report summarised key findings and outcomes of systems that NWSSP provided to NHS Wales.
ASSURE	**Internal Audit Position Statement**

	Head of Internal Audit presented the Position Statement together with an overview of other activity undertaken since the previous meeting. Key points to highlight were: • The 2022/23 internal audit workplan is complete; and • The 2023-24 work plan is in progress.
ASSURE	**Annual Counter Fraud Annual Report 2022-23** The 2022-23 Annual Counter Fraud Annual Report was presented to the Committee, which highlighted activities undertaken by NWSSP's Counter Fraud Manager and demonstrated how measures had been delivered to counter fraud, bribery, and corruption during the period. A key point to note is, the Service Level Agreement between NWSSP and Cardiff & Vale for the provision of 75 days of Local Counter Fraud Services from CAVUHB had been withdrawn due to resourcing implications and the agreement terminated on 30 June 2023.
ASSURE	**Counter Fraud Position Statement** The Counter Fraud Position Statement was presented to the Committee, with an overview of other activity. As of 30 June 2023, a total of 49.25 days of Counter Fraud work has been completed against the agreed 242 days, as detailed in the Counter Fraud Annual Work-Plan for the 2023/24 financial year. The statement summarised the following activity in the last quarter: o Eight fraud awareness sessions have been delivered to 263 NWSSP staff; o Seven new fraud referrals have been made; o The new e-learning module is now available to all staff on ESR; and o No Fraud Prevention Notices (FPN) have been issued by the NHS Counter Fraud Authority.
ASSURE	**Audit Committee Annual Report 2022-23** The 2022-23 Audit Committee Annual Report reflects the positive work undertaken throughout the period. All meetings were continued to be held virtually via Teams and no meetings were cancelled.
ASSURE	**Audit Committee Terms of Reference Review July 2023** The Audit Committee Terms of Reference paper was presented to committee members. In line with the NWSSP Standing Orders, the Terms of Reference are required to be reviewed annually and approved by the Committee. There were no significant changes to report and the document remained fit for purpose.
ASSURE	**2022-23 Annual Governance Statement (AGS)** The Annual Governance Statement was presented to the committee for final approval. The statement was a positive assessment of the governance of NWSSP during 2022/23 financial year and the statement had already been presented to the Senior Leadership Group and the Shared Services Partnership Committee for endorsement.
ASSURE	**Governance Matters** The **Governance Matters** paper detailed the contracting activity for the last quarter. **18** contracts had been let for NWSSP and **31** further contracts for NHS Wales. There have been no further declarations made as to gifts, hospitality or sponsorship since the last meeting and no internal audits reports have received limited or no assurance. Of **232 audit recommendations**, **219** have been implemented, **11** are not yet due, **1** is not in the gift of NWSSP and **1** is overdue.

	The **Corporate Risk Register** contains **5** red risks, **12** amber, **2** yellow and no green risks.
ASSURE	**Annual Report of Conflicts of Interest** The committee received the Annual Conflicts of Interest report, containing the details of compliance with the annual exercise. Overall compliance was generally good at nearly 80%, but it was noted that some areas do require some attention. These services are hard to reach areas, such as laundry Services and Health Courier operatives' which are considered a much lower risk. Compliance would continue to be managed and monitored and it was agreed that an update would be brought back to the next Audit Committee in October.
ASSURE	**Annual Report on Gifts, Hospitality & Sponsorship 2022-23** The Annual report for Gifts, Hospitality and Sponsorship for 2022-23 financial period provides a full list of all accepted and/or declined declarations offered to NWSSP staff during the financial period.
ASSURE	**Audit Committee Forward Plan for 2023-24** Members were presented with the Audit Committee forward pan of business for the 2023-24 period. The Quality Assessment of internal Audit had been deferred from the July to the October meeting.
INFORM	**Items for Information** The following items were provided for information: • **Welsh Language Annual Report 2022-23**

2. ARGYMHELLIAD/RECOMMENDATION

The SLG is asked to:

- **NOTE** the Assurance Report

TRUST BOARD

TRUST WIDE POLICIES UPDATE

DATE OF MEETING	28/09/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
ISO14001:2015 Management Group	30/06/2022	APPROVED
Executive Management Board – RUN	31/08/2023	APPROVED
Strategic Development Committee	05/09/2023	APPROVED

ACRONYMS	
EMB	Executive Management Board

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy for the Management of Policies, Procedures and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the Consent Agenda.

1.2 The purpose of this report is for the Trust Board to note the policies that have been approved during the period **June 2023 to September 2023.**

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Following approval at the relevant forum the policies below were uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

2.2 The list of Policies **APPROVED** since the last Trust Board are outlined below:

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
PP03 – Trust Environmental Policy	Executive Director of Strategic Transformation, Planning and Digital	Strategic Development Committee	June 2023	**1**
(PP08) – Waste Management Policy	Executive Director of Strategic Transformation, Planning and Digital	Strategic Development Committee	June 2023	**2**

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Trust has a defined process for the management of policies and written control documents. The purpose of which is to ensure staff are aware of their responsibilities with regards to Trust policy documents and to provide a 'model' guide and consistent approach for the development, management and dissemination of the Trust's documents
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Each policy has been individually assessed to ensure compliance with EQIAs
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the policies that have been approved during the period **June 2023 to September 2023**.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Ref: PP 03

TRUST ENVIRONMENTAL POLICY

Executive Sponsor & Function: Director of Strategic Transformation, Planning and Digital

Document Author: Trust Sustainability Manager

Approved by:

Approval Date: June 2023

Date of Equality Impact Assessment: 11.04.2022

Equality Impact Assessment Outcome: APPROVED

Review Date: 2025

Version: 1.1

CONTENTS

1. Policy Statement

1.1. Velindre University NHS Trust is an environmentally conscious organisation. As such we acknowledge the potential environmental impact that our operations may have on the environment.

1.2. The Trust is committed to demonstrating leadership in sustainability and has comprehensive plans to deliver significant improvements, with the help of its staff, key partners and other stakeholders.

1.3. The Trust has successfully maintained the BS EN ISO14001: 2015 Environmental Standard certification which demonstrates our commitment to environmental management.

2. Scope of Policy

2.1. This policy applies to all staff, activities, products, and services provided by Divisions within Velindre University NHS Trust.

3. Aims and Objectives

3.1. The Policy aims are –

- To outline the management of the Environmental Management System (EMS) within Velindre University NHS Trust and produce Environmental Statements for each division
- To minimise the Trust impact on the environment
- To recognise the requirements outlined within the BS EN ISO14001:2015 and ensure the Trust is fully compliant with all relevant legislation, including the Well-being of Future Generations (Wales) Act 2015 and Environment (Wales) Act 2016.

3.2. The Policy objectives are -

- To maintain our registration to the environment management standard to BS EN ISO 14001: 2015.
- To strive to integrate the EMS into all business processes where economically and operationally feasible.
- To protect the environment, prevents pollution and meets other specific relevant commitment(s).
- To minimise waste to landfill by reducing our waste generation and by segregating and recycling waste where economically and operationally feasible.
- To co-ordinate business transport so as to reduce consumption.
- To use energy, water, materials and other natural resources as efficiently as possible, giving particular regard to the long-term sustainability of consumable items.

- To ensure that the environment is considered in the procurement of goods and services.
- To give appropriate consideration for the environment in the goods and services we provide to staff and clients.
- To work with local businesses, neighbours, partners or suppliers to encourage commitment and improvement in our local environment.
- To support other relevant management roles to demonstrate leadership as it applies to their areas of responsibility.

3.3. This policy will be communicated to all employees and organisations working for or on our behalf. Employees and other organisations are expected to co-operate and assist in the implementation of this policy, whilst ensuring that their own work, so far as is reasonably practicable, is carried out without risk to themselves, others, or the environment.

4. Responsibilities

This policy provides a high level overview of the responsibilities. The Environmental Manual [hyperlink] provides further detail.

4.1. Chief Executive (Top Management)

The Chief Executive has overall responsibility for environmental issues across Velindre University NHS Trust and is accountable to the Trust Board and Welsh Government for environmental performance.

4.2. Director of Strategic Transformation, Planning and Digital (Top Management)

Directors have responsibility for the day to day management of environmental performance within the Divisions and s of the Trust.

4.3. Trust Environmental Development Officer

The Environmental Development Officer has responsibility for the corporate management of environmental issues and is responsible for ensuring Divisional and environmental information and best practice are shared via the Trust Sustainability Management Group. This responsibility includes ensuring that the organisation receives competent advice from appropriate sources.

4.4. Divisional & Management Lead(s) / EMS Team

The Divisional and Hosted Management Leads are responsible for the day to day management of the EMS. This includes the production of reports and reviews as required within the standard.

4.5. Internal EMS auditors

The internal EMS auditors are responsible for auditing the EMS in accordance with agreed scopes and programmes, in order to ensure that planned arrangements are being complied with and the requirements of the standard are being met.

4.6. Velindre University NHS Trust Estates Management Group and ISO14001:2015 Management Group

The Trust Estates Management Group comprises of the Estates Department. The Estates Management Group oversees the development and implementation of sustainability initiatives. The ISO14001:2015 Group consists of key divisional colleagues who input into the Trust EMS. The purpose of the group is to ensure sufficient and effective monitoring of the EMS. Members meet once a month and the agenda aligning with the Management Review timetable. All members are trained internal auditors, and undertook several internal audits over the previous year to ensure compliance and continue improvement of the standard.

5. Definitions

5.1. Environmental Management System (EMS)

"Part of the management system used to manage environment aspects, fulfil compliance obligations and address risk and opportunities" *(BSI (2015). Environmental management systems - Requirements with guidance for use (ISO 14001:2015). London: BSI. pvi).*

5.2. BS EN ISO14001: 2015

The international standard that specifies requirements for an effective environmental management system (EMS). It provides a framework that an organisation can follow, rather than establishing environmental performance requirements. Part of the ISO14000 family of standards on environmental management, ISO14001 is a voluntary standard that organisations can certify to. Integrating it with other management systems standards, most commonly ISO9001, can further assist in accomplishing organisational goals.

6. Implementation/Policy Compliance

6.1. Any advice required on implementation of this policy should be obtained via the Trust Environmental Development Officer.

6.2. Periodic sampling will be undertaken to verify compliance with the requirements of this policy.

6.3. Disciplinary action under the terms of the Trust's Disciplinary Procedure will be taken against any employee, regardless of status, who shows wilful disregard for the policy and associated working practices.

7. Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative impact has been identified.

8. References

8.1. BSI (2015). *Environmental management systems - Requirements with guidance for use (ISO 14001:2015).* London: BSI. pp35.

8.2. Velindre University NHS Trust, (2022) Trust Environmental Policy Ref: PP03

8.3. Velindre University NHS Trust, (2018) Trust Environmental Policy Ref: PP03

8.4. Velindre University NHS Trust, (2015) Trust Environmental Policy Ref: PP03

8.5. Velindre University NHS Trust, (2013) Trust Environmental Policy Ref: Black 125

9. Getting Help

For further information or help regarding this policy please contact the Assistant Director of Estates, Environment and Capital Development or the Trust Sustainability Manager.

10. Related Policies

10.1. This policy should be read in conjunction with, or reference made to, the following Trust documents:

- Business Continuity Management Policy (GC12)
- Fire Safety Policy (PP01)
- Security Policy (PP02)
- Ionising Radiation Safety Policy
- Health, Safety and Welfare Policy
- Waste Management Policy (PP08)
- Control of Substances Hazardous to Health Policy (PP33)
- Risk Management Policy (PP35)
- Asbestos Policy (PP04)
- Control of Contractors Policy (PP05)
- Infection Prevention and Control Policies (ref IPC)
- Planning, Performance and Estates policies (ref PP)
- HV Electricity Supply Systems (PP11)

- High Voltage Electrical Supply Operational Policy (PP12)
- Electrical Low Voltage Policy (PP13)
- Water Safety Policy (PP09)
- Adverse Weather Policy (WF13)
- Homeworking Policy (WF45)
- Flexible Working Policy and Procedure (WF23)
- Lease Car Policy (FP03)
- Trust Well-being Objectives

11. Information, Instruction and Training

11.1. All employees within Divisions and s of Velindre University NHS Trust will be provided with mandatory Environmental Awareness Training.

11.2. It is the manager's responsibility to ensure new members of staff complete Environmental Awareness Training as part of their departmental induction.

11.3. Training may be delivered through:

- The Statutory and Mandatory training programme
- A dedicated Environmental E-Learning Course

11.4. Specialist training for key staff (e.g. Oil Spill kit Training, Internal Auditor Training) will be provided as required by departmental managers through either internal or external trainers.

12. Main Relevant Legislation

12.1. The Trust and its staff will comply with all existing and new environmental management requirements, both legislative and provided as NHS guidance and in relation to the BS EN ISO14001:2015 environmental standard.

12.2. NHS relevant standards and Welsh Health Technical Memorandums (WHTMs) include:

- Standards for Health Services in Wales – Environment (Standard 12)
- WHTM 07-01 - Safe Management of Healthcare Waste (2013)
- HTM 07-02 - Encode - making energy work in healthcare. Environment and sustainability. Part A: Policy and management 2015 (Published in Wales 2016)
- HTM 07-02 - Encode - making energy work in healthcare. Environment and sustainability. Part B: Procurement and energy considerations for new and existing building facilities 2015 (Published in Wales 2016)
- WHTM 07-03 - NHS Wales Car Parking Management: Environment & sustainability (2015)

- HTM 07-04 - Water management and water efficiency (2012)
- HTM 07-07 - Sustainable health and social care buildings (2011)

12.3. Government Legislation / Regulations include, but are not limited to:

- Environment (Wales) Act 2016
- Planning (Wales) Act 2015
- Wellbeing of Future Generations (Wales) Act 2015
- The Environmental Protection (Single-use Plastic Products) (Wales) Bill (2022)
- Climate Change Act 2008
- Environmental Protection Act 1990
- The Waste (England and Wales) Regulations 2011
- The Waste Electrical and Electronic Equipment (Amendment) Regulations 2018
- The Environmental Permitting (England and Wales) (Amendment) Regulations 2018
- The Hazardous Waste (England and Wales) Regulations 2005
- The Controlled Waste (England and Wales) Regulations 2012
- Fluorinated Greenhouse Gases (Amendment) Regulations 2015
- The Energy Performance of Buildings (England and Wales) Regulations 2012
- Welsh Government Towards Zero Waste Strategy
- The Air Quality Standards Regulations 2010
- The End-of-Life Vehicles (Amendment) Regulations 2010
- Modern Slavery Act 2015
- Welsh Government Ethical Employment in Supply Chains Code of Practice 2016
- The Conservation of Habitats and Species Regulations 2010
- The Ionising Radiations Regulations 2017
- A Green Future: Our 25 Year Plan to Improve the Environment (HM Government) 2018

Appendix 1a – Trust Headquarters Environmental Statement

VELINDRE UNIVERSITY NHS TRUST HEADQUARTERS ENVIRONMENTAL POLICY STATEMENT

Velindre University NHS Trust Headquarters is a division within Velindre University NHS Trust. Our activities include providing strategic guidance and support for the practices by which the Trust is governed through administrative support. We acknowledge the detrimental impact that our operations and activities have on the environment and this Policy Statement underlines our commitments to reduce our environmental impact, endeavouring to work and operate more sustainably. We will work to meet the aims and objectives outlined in the U.N. Sustainable Development Goals Agenda, Well-Being of Future Generations (Wales) Act 2015, Environment (Wales) Act 2016 and all other relevant environmental and sustainability legislation passed by both the U.K and Welsh Governments.

Senior Management and Trust Executives, in co-ordination with the Trust's Sustainability Manager, are accountable for the effectiveness of the environmental management system (EMS) and are responsible for ensuring that it is communicated, understood, implemented and regularly maintained at all levels within the organisation until intended outcomes are achieved. Senior Management and Trust Executives fully endorse this policy and have provided assurances that it is entirely compatible with both the context and strategic direction of the organisation. Senior Management and Trust Executives will promote and are committed to the continual improvement of the EMS to consistently improve environmental performance. Progress will be measured against documented environmental objectives centred around our significant environmental aspects, compliance objectives (including legislative), with appropriate consideration given to risks and opportunities. Action Plans have been developed to achieve objectives and are maintained as part of the EMS internal auditing, monitoring and management review processes – available to interested parties where appropriate.

Senior Management and Trust Executives are committed to ensuring that the organisation:

- Adheres to Velindre NHS Trust's Environmental Policy
- Complies with all compliance obligations where these relate to our environmental aspects
- Provides employees and others with the resources they need for the EMS including support, direction and encouragement to fulfil the requirements
- Maintains our registration to the environmental management standard **BS EN ISO 14001:2015**
- Strives to integrate the EMS into all business processes where feasible
- Abides by the Environment (Wales) Act 2016 and ensures we achieve legislative ambitions to decarbonise and enhance the natural, local flora and fauna and endeavours to remove greenhouse gas pollution generated by our activities wherever possible
- Reduces waste to landfill, improves recycling rates (particularly for non-clinical plastic) and encourages good practice in waste segregation – adhering to the Trust's Waste Management Policy
- Minimises business transport in line with the Trust Travel Plan ambitions, encouraging and enabling active, green and carbon neutral transport and considering if travel is essential and cannot be conducted over Teams or by other virtual means
- Encourages efficient use of energy, water and materials insofar as safely and practicably possible. Promote resource efficiency with due regard given to the long-term sustainability of consumable items
- Ensures that the direct and indirect impact of decisions relating to procurement on the environment and sustainability are always considered, and supports the trialling of novel, innovative and 'green' alternatives
- Gives appropriate consideration for the environment and sustainability in the goods and services we provide to clients and staff
- Works with local businesses, neighbours, partners and suppliers to encourage improvement in our local environment – adhering to the Well-Being of Future Generations (Wales) Act 2015 (A Wales of Cohesive Communities & a Prosperous Wales) and other relevant environmental and sustainability legislation
- Supports other relevant management roles to demonstrate leadership as it applies to their areas of responsibility

This policy will be communicated to all employees and organisations working for, or on our behalf. Employees and other organisations are expected to co-operate and assist in the implementation of this policy, whilst ensuring that their own work, so far as is reasonably practicable, is carried out without risk to themselves, others or the environment. This policy will be reviewed annually or when necessary, by Senior Management and Senior Executives and will be amended and re-issued regularly. Previous versions of this policy will be archived and are available upon request. This policy statement is available to interested parties upon reasonable request.

Signed Dated

Appendix 1b – Velindre Cancer Centre Environmental Statement

VELINDRE CANCER CENTRE ENVIRONMENTAL POLICY STATEMENT

Velindre Cancer Centre is a division within Velindre University NHS Trust. We acknowledge the detrimental impact that our operations and activities have on the environment and this Policy Statement underlines our commitments to reduce our environmental impact, endeavouring to work and operate more sustainably. We will work to meet the aims and objectives outlined in the U.N Sustainable Development Goals Agenda, Well-Being of Future Generations (Wales) Act 2015, Environment (Wales) Act 2016 and all other relevant environmental and sustainability legislation passed by both the U.K and Welsh Governments.

Senior Management and Trust Executives, in co-ordination with the Trust's Sustainability Manager, are accountable for the effectiveness of the environmental management system (EMS) and are responsible for ensuring that it is communicated, understood, implemented and regularly maintained at all levels within the organisation until intended outcomes are achieved. Senior Management and Trust Executives fully endorse this policy and have provided assurances that it is entirely compatible with both the context and strategic direction of the organisation. Senior Management and Trust Executives will promote and are committed to the continual improvement of the EMS to consistently improve environmental performance. Progress will be measured against documented environmental objectives centred around our significant environmental aspects, compliance objectives (including legislative), with appropriate consideration given to risks and opportunities. Action Plans have been developed to achieve objectives and are maintained as part of the EMS internal auditing, monitoring and management review processes – available to interested parties where appropriate.

Senior Management and Trust Executives are committed to ensuring that the organisation:

- Adheres to Velindre NHS Trust's Environmental Policy
- Complies with all compliance obligations where these relate to our environmental aspects
- Provides employees and others with the resources they need for the EMS including support, direction and encouragement to fulfil the requirements
- Maintains our registration to the environmental management standard BS EN ISO 14001:2015
- Strives to integrate the EMS into all business processes where feasible
- Abides by the Environment (Wales) Act 2016 and ensures we achieve legislative ambitions to decarbonise and enhance the natural, local flora and fauna and endeavours to remove greenhouse gas pollution generated by our activities wherever possible
- Reduces waste to landfill, improves recycling rates (particularly for non-clinical plastic) and encourages good practice in waste segregation – adhering to the Trust's Waste Management Policy
- Minimises business transport in line with the Trust Travel Plan ambitions, encouraging and enabling active, green and carbon neutral transport and considering if travel is essential and cannot be conducted over Teams or by other virtual means
- Encourages efficient use of energy, water and materials insofar as safely and practicably possible. Promote resource efficiency with due regard given to the long-term sustainability of consumable items
- Ensures that the direct and indirect impact of decisions relating to procurement on the environment and sustainability are always considered, and supports the trialling of novel, innovative and 'green' alternatives
- Gives appropriate consideration for the environment and sustainability in the goods and services we provide to clients and staff
- Works with local businesses, neighbours, partners and suppliers to encourage improvement in our local environment – adhering to the Well-Being of Future Generations (Wales) Act 2015 (A Wales of Cohesive Communities & a Prosperous Wales) and other relevant environmental and sustainability legislation
- Supports other relevant management roles to demonstrate leadership as it applies to their areas of responsibility

This policy will be communicated to all employees and organisations working for, or on our behalf. Employees and other organisations are expected to co-operate and assist in the implementation of this policy, whilst ensuring that their own work, so far as is reasonably practicable, is carried out without risk to themselves, others, or the environment. This policy will be reviewed annually or when necessary, by Senior Management and Senior Executives and will be amended and re-issued regularly. Previous versions of this policy will be archived and are available upon request. This policy statement is available to interested parties upon reasonable request.

Signed Dated

Appendix 1c – Welsh Blood Service Environmental Statement

WELSH BLOOD SERVICE ENVIRONMENTAL POLICY STATEMENT

Welsh Blood Service is a division within Velindre University NHS Trust. We acknowledge the detrimental impact that our operations and activities have on the environment and this Policy Statement underlines our commitments to reduce our environmental impact, endeavouring to work and operate more sustainably. We will work to meet the aims and objectives outlined in the U.N Sustainable Development Goals Agenda, Well-Being of Future Generations (Wales) Act 2015, Environment (Wales) Act 2016 and all other relevant environmental and sustainability legislation passed by both the U.K and Welsh Governments.

Senior Management and Trust Executives, in co-ordination with the Trust's Sustainability Manager, are accountable for the effectiveness of the environmental management system (EMS) and are responsible for ensuring that it is communicated, understood, implemented and regularly maintained at all levels within the organisation until intended outcomes are achieved. Senior Management and Trust Executives fully endorse this policy and have provided assurances that it is entirely compatible with both the context and strategic direction of the organisation. Senior Management and Trust Executives will promote and are committed to the continual improvement of the EMS to consistently improve environmental performance. Progress will be measured against documented environmental objectives centred around our significant environmental aspects, compliance objectives (including legislative), with appropriate consideration given to risks and opportunities. Action Plans have been developed to achieve objectives and are maintained as part of the EMS internal auditing, monitoring and management review processes – available to interested parties where appropriate.

Senior Management and Trust Executives are committed to ensuring that the organisation:

- Adheres to Velindre NHS Trust's Environmental Policy
- Complies with all compliance obligations where these relate to our environmental aspects
- Provides employees and others with the resources they need for the EMS including support, direction and encouragement to fulfil the requirements
- Maintains our registration to the environmental management standard BS EN ISO 14001:2015
- Strives to integrate the EMS into all business processes where feasible
- Abides by the Environment (Wales) Act 2016 and ensures we achieve legislative ambitions to decarbonise and enhance the natural, local flora and fauna and endeavours to remove greenhouse gas pollution generated by our activities wherever possible
- Reduces waste to landfill, improves recycling rates (particularly for non-clinical plastic) and encourages good practice in waste segregation – adhering to the Trust's Waste Management Policy
- Minimises business transport in line with the Trust Travel Plan ambitions, encouraging and enabling active, green and carbon neutral transport and considering if travel is essential and cannot be conducted over Teams or by other virtual means
- Encourages efficient use of energy, water and materials insofar as safely and practicably possible. Promote resource efficiency with due regard given to the long-term sustainability of consumable items
- Ensures that the direct and indirect impact of decisions relating to procurement on the environment and sustainability are always considered, and supports the trialling of novel, innovative and 'green' alternatives
- Gives appropriate consideration for the environment and sustainability in the goods and services we provide to clients and staff
- Works with local businesses, neighbours, partners and suppliers to encourage improvement in our local environment – adhering to the Well-Being of Future Generations (Wales) Act 2015 (A Wales of Cohesive Communities & a Prosperous Wales) and other relevant environmental and sustainability legislation
- Supports other relevant management roles to demonstrate leadership as it applies to their areas of responsibility

This policy will be communicated to all employees and organisations working for, or on our behalf. Employees and other organisations are expected to co-operate and assist in the implementation of this policy, whilst ensuring that their own work, so far as is reasonably practicable, is carried out without risk to themselves, others, or the environment. This policy will be reviewed annually or when necessary, by Senior Management and Senior Executives and will be amended and re-issued regularly. Previous versions of this policy will be archived and are available upon request. This policy statement is available to interested parties upon reasonable request.

Signed Dated

PP08

WASTE MANAGEMENT POLICY

Executive Sponsor & Function: Director of Strategic Transformation, Planning, and Digital

Document Author: Trust Sustainability Manager

Approved by:

Approval Date: June 2023

Date of Equality Impact Assessment: 11.04.2022

Equality Impact Assessment Outcome:

Review Date: 2025

Version: 1

1. Introduction/Aim

1.1. Velindre University NHS Trust is an environmentally conscious organisation, as shown by the accreditation to BS EN ISO14001: 2015 by its Divisions and Hosted Organisations. Procedures and work instructions relating to waste disposal as well as objectives and targets for waste reduction form a key element of an ISO14001 accredited Environmental Management System (EMS).

1.2. Velindre University NHS Trust is committed to ensuring that all waste generated within the organisation is managed safely and in full compliance with all statutory requirements. Adherence to the guidance provided in the Welsh Health Technical Memorandum (WHTM) 07-01 will ensure the Trust complies with all legal requirements with respect to the management of health care waste.

1.3. The Trust supports the aims which are contained within the Welsh Government's strategy for Wales 'Towards Zero Waste' and will encourage all Divisions within the Trust to limit the amount of waste produced, insofar as is reasonably and economically practicable.

1.4. This is to be achieved by careful financial management and consideration of the waste disposal implications arising out of all activities of the Trust in the delivery of its services in reference to the Waste Hierarchy (Appendix A).

2. Objectives

2.1. The desired outcome the Trust is seeking to achieve through the policy is to ensure:

- The management of waste complies with all regulatory requirements and the Trust Division and Hosted Organisation accreditation to BS EN ISO14001: 2015. This compliance will ensure that best practice guidelines are developed, implemented and maintained as far as is reasonably practical.

- The Trust staff are trained and have the necessary equipment to manage waste safely and not endanger themselves or others whilst carrying out their duties.

- Current and future targets set by both the Welsh Government and Velindre University NHS Trust will be monitored and reported at Trust level as part of its Integrated Medium Term Plan (IMTP) and at Divisional and Hosted Organisation level through organisation specific delivery plans.

- Divisions within Velindre University NHS Trust have a nominated lead(s) with responsibility for waste in their local respective sites.

- All Divisions have procedures and records to ensure compliance with all legislation relevant to waste management. Procedures should be current and regularly reviewed.
- Duty of Care documentation is held for the time specified in the Environmental Protection [Duty of Care] Regulations.

- All relevant environmental documentation is held for the time specified in relevant legislation and regulations.

2.2. This policy will be communicated to all employees and organisations working for or on our behalf. Employees and other organisations are expected to co-operate and assist in the implementation of this policy, whilst ensuring that their own work, so far as is reasonably practicable, is carried out without risk to themselves, others, or the environment.

2.3. This policy will be reviewed at least every three years or where deemed necessary and will be amended and re-issued. Previous versions of this policy will be archived and are available upon request.

3. Scope/Area of Application

3.1. All staff, activities, products and services provided by Divisions within Velindre University NHS Trust.

4. Roles and Responsibilities

4.1. The Chief Executive

Has overall responsible and is accountable to the Trust Board for the management of waste within the organisation, this includes:

- Ensuring there are clear lines of accountability for waste management throughout the Trust.
- The provision of resources and implementation of all measures needed to comply with the relevant waste management legislation and relevant guidance.

4.2. Director of Strategic Transformation, Planning, Performance and Estates

Has been given delegated responsibilities to:

- Ensure that waste is managed appropriately throughout the organisation and advises the Trust Board accordingly.
- These responsibilities include ensuring that the organisations receives competent advice regarding waste management and that adequate training and monitoring takes place.

4.3. Directors of Divisional s

The Director is responsible for ensuring:

- The policy is implemented in their Division or Hosted Organisation.
- They have a nominated lead(s) with responsibility for waste in their local respective sites as part of their Division or Hosted Organisation.

4.4. The nominated lead(s) with responsibility for waste

Each Division will have a nominated lead(s) with responsibility for waste in their local respective sites as part of their Division or Hosted Organisation. This lead(s) will ensure:

- All waste records are maintained in accordance with the regulations at the time.
- For divisions / organisations covered by the all-Wales contract, the all-Wales clinical waste consortium Duty of Care schedule shares out monthly audits across the different disposal facilities.
- Waste strategies and targets are implemented, monitored and reported to the relevant Trust Division, or Hosted Organisation.
- Attendance at relevant waste meetings at Trust and Divisional level and if appropriate external meetings.
- Departmental / site waste audits are undertaken by the lead(s) for waste to ensure correct procedures are followed. Results of these audits are reported to the Department Manager and subsequent action plans are agreed and reviewed to assess effectiveness.
- Repeat adverse waste audit reports of a department or waste contractor are reported to the Division Director, the Division Health and Safety committee, the Trust Health and Safety Committee, the Executive Director of Nursing and Quality and/or if required the all-Wales clinical waste consortium.
- Adverse incidents related to waste management are reported in line with the Trust's Incident Reporting & Investigation Policy

4.5. Managers

All managers will ensure that:

- Staff under their control are aware of the Trust Waste Management Policy and associated Divisional waste policies and procedures and that the training requirements of staff are fulfilled.
- When required engage with external and internal waste audits and implement action plans derived from said audits.
- Staff under their control are encouraged to report all waste related incidents and near misses in line with the Trust's Incident Reporting & Investigation Policy [QS 01].

4.6. All Staff

- Are responsible for adhering to waste legislation, this policy and the operational procedures to which it refers.
- Will discuss any waste related issues with their manager.
- Will assist with any enforcing authority investigation and if required engage with waste management audits.
- Will report adverse incidents related to waste management in line with the Trust's Incident Reporting & Investigation Policy [QS 01] and Corrective and Preventative Actions.

5. Implementation and Policy Compliance

5.1. Any advice required on implementation of this policy should be obtained via the Trust Environmental Development Officer.

5.2. Periodic sampling will be undertaken to verify compliance with the requirements of this policy.

5.3. Disciplinary action under the terms of the Trust's Disciplinary Procedure will be taken against any employee, regardless of status, who shows wilful disregard for the policy and associated working practices.

5.4. The Division's 's responsible person for waste will ensure waste contractors comply by maintaining relevant documentation and carrying out Duty of Care audits on said contractors as required.

5.5. Waste Management Audits will be conducted departmentally within Divisions s as required, evaluating compliance with waste regulation, Trust Waste Management Policy and Divisional Waste Procedure. The results of these audits will be forwarded to department managers to identify good practice, non-conformances or areas requiring improvement if relevant.

5.6. The following information related to waste management should be held by the responsible person for waste within each Division for a minimum of three years:

- Trust Waste Management Policy.
- Divisional Waste Management Procedure.
- Safe System of works for staff working in the waste management chain.
- Training Records.
- Waste Contractor relevant licenses (e.g. Waste Carrier License).
- Hazardous waste producer registration [if required].
- Copies of any waste exemptions and authorisations pertaining to the Division
- Waste consignment and transfer notes.
- Copies of Duty of Care Audits.
- Copies of any paperwork relevant to waste management between the division and any Enforcing Authority.
- Emergency plans or reference to their location, emergency contact numbers.

6. References

6.1. Department of Health (2013). Welsh Health Technical Memorandum 07-01 – Safe management of healthcare waste. Crown Copyright. pp187

6.2. Welsh Government (2021) Beyond Recycling 2021: A Strategy to Make the Circular Economy In Wales a Reality

6.3. Velindre University NHS Trust , (2022) Trust Sustainability Strategy

6.4. Velindre University NHS Trust , (2018) Trust Waste Management Policy Ref

7. Related Policies

7.1. This policy should be read in conjunction with, or reference made to, the following Trust documents:

- Trust Environmental Policy

- Business Continuity Management Policy
- Incident Reporting and Investigation Policy
- Risk Assessment Policy
- Security Policy
- Ionising Radiation Safety Policy
- Health, Safety and Welfare Policy
- Trust Environmental Policy
- Fire Safety Policy
- Control of Substances Hazardous to Health Policy
- Risk Management Policy
- Asbestos Policy
- Control of Contractors Policy
- Infection Prevention and Control Policy
- Trust Well-being Objectives

8. Information, Instruction and Training

8.1. All employees within divisions of Velindre University NHS Trust will be provided with mandatory Environmental Awareness Training.

8.2. It is the manager's responsibility to ensure that new members of staff complete Environmental Awareness Training as part of their departmental induction.

8.3. Training may be delivered through:

- The Statutory and Mandatory training programme
- A dedicated Environmental E-Learning Course

8.4. Specialist training for key staff (e.g. Oil Spill kit Training, Internal Auditor Training) will be provided as required by departmental managers through either internal or external trainers.

9. Main Relevant Legislation

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- HTM 07-02 - Encode - making energy work in healthcare. Environment and sustainability. Part B: Procurement and energy considerations for new and existing building facilities 2015 (Published in Wales 2016)
- WHTM 07-03 - NHS Wales Car Parking Management: Environment & sustainability (2015)
- HTM 07-04 - Water management and water efficiency (2012)
- HTM 07-07 - Sustainable health and social care buildings (2011)

9.3. Government Legislation / Regulations include, but are not limited to:

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- Climate Change Act 2008
- Environmental Protection Act 1990
- The Waste (England and Wales) Regulations 2011
- The Waste Electrical and Electronic Equipment (Amendment) Regulations 2018
- The Hazardous Waste (England and Wales) Regulations 2005
- The Controlled Waste (England and Wales) Regulations 2012
- Welsh Government Towards Zero Waste Strategy
- The End-of-Life Vehicles (Amendment) Regulations 2010
- Modern Slavery Act 2015
- Welsh Government Ethical Employment in Supply Chains Code of Practice 2016
- A Green Future: Our 25 Year Plan to Improve the Environment (HM Government) 2018
- Code of Practice for Wales - Separate collection of waste materials for recycling
- Waste Separation Requirements (Wales) Regulations 2023

TRUST BOARD

TRUST SEAL REPORT: JUNE 2023 – SEPTEMBER 2023

DATE OF MEETING	28/09/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal request (**period June to September 2023**).

1.2 Board members are asked to view the contents of the report. Further information or queries should be directed to the Director of Corporate Governance and Chief of Staff.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis: Please refer to the Seal Register at **Appendix 1**.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the contents of the Trust Board Seal Register included in Appendix 1.

Appendix 1 – Seal Register

Date	Document Details	Signed
27th July 2023	Agreement for the execution of Highway improvement works at Lady Cory Field and Park Road in the City of Cardiff, pursuant to Section 278 and Section 38 of the Highway Act 1980.	Mr Stephen Harries, Vice Chair Mr Steve Ham, CEO
14th August 2023	Advanced Design Development Agreement between Velindre University NHS Trust and SACYR UK Ltd, relating to the design of a new Cancer Centre at Whitchurch, Cardiff, in addition to the associated deed of Grant.	Prof. Donna Mead OBE, Chair Mr Steve Ham, CEO
23rd August 2023	Section 104 Agreement between Velindre University NHS Trust and Dwr Cymru Welsh Water (DCWW) regarding lateral drains / sewers at land lying to the North-West of Whitchurch Hospital.	Mr Stephen Harries, Vice Chair Mr Steve Ham, CEO
19th September 2023	Habitat Licence (Land at Whitchurch Hospital), between Cardiff and Vale University Health Board and Velindre University NHS Trust.	Mr Stephen Harries, Vice Chair Mr Steve Ham, CEO
19th September 2023	Habitat Licence (Land at Longwood Drive, Cardiff and Hollybush Estate), between The County Council of the City and County of Cardiff and Velindre University NHS Trust (inc. Supplemental Agreement).	Mr Stephen Harries, Vice Chair Mr Steve Ham, CEO

TRUST BOARD

Wales Infected Blood Support Scheme Annual Report

DATE OF MEETING	28/09/23
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	MARY SWIFFEN-WALKER, Service Manager, Wales Infected Blood Support Service
PRESENTED BY	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE & CHIEF OF STAFF
APPROVED BY	Steve Ham, Chief Executive
EXECUTIVE SUMMARY	Attached is the Wales Infected Blood Support Scheme Annual Report. This was approved at Shared Services Committee. It is shared with the Trust Board for noting on an annual basis given the governance arrangements of the work include the governance group being chaired by the Trust Director Corporate Governance & Chief of Staff.
RECOMMENDATION / ACTIONS	The annual report is for NOTING.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Shared Service Partnership Committee	Sept 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS *Approved by SSPC*	

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

Cynllun Cymorth Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Wales Infected Blood Support Scheme

Annual Report 2022-23

Wales Infected Blood Support Scheme (WIBSS)

VELINDRE UNIVERSITY NHS TRUST

THROUGH

NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

AND

VELINDRE CANCER CENTRE (VCC)

ANNUAL REPORT 2022/2023

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Canolfan Ganser Felindre
Velindre Cancer Centre

Cynllun Cymorth Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

Contents

Introduction

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

Taking over from the existing UK schemes (Eileen Trust, Macfarlane Trust, MFET Ltd, Skipton Fund and Caxton Foundation), now referred to as the Alliance House Organisations (AHOs), WIBSS aims to provide both a streamlined financial payment service and personalised support for Welsh beneficiaries. WIBSS also offers a dedicated Welfare Rights Service and a Psychology and Well-being Service.

As at 31 March 2023, WIBSS supports 223 beneficiaries, including bereaved spouses and partners. However, the welfare and psychological support is also provided to wider family members of our beneficiaries.

The Purpose of the Report

To provide an update on the finance and support services during 2022-23 as part of the Wales Infected Blood Support Scheme.

To detail the proactive work carried out by WIBSS during 2022-23.

To look ahead to WIBSS priorities relating to 2023-24.

Key matters arising during 2022-23

Service delivery post COVID-19:

The way in which WIBSS services are provided returned to normal during 2022-23 following some required adjustments, resulting from the COVID-19 pandemic. Home visits and face-to-face appointments were reinstated.

Public Inquiry - The Infected Blood Inquiry

This is an independent public statutory inquiry established to examine the circumstances in which men, women and children treated by the National Health Service in the United Kingdom were given infected blood and infected blood products, since 1970. The Inquiry is Chaired by Sir Brian Langstaff.

In 2022-2023 we responded to four Rule 9 requests from the Infected Blood Inquiry.

- The first request sought information regarding number of beneficiaries registered with the scheme, how they had acquired their infection, the nature of their infection, and how many had been registered with a legacy scheme.
- The second request concentrated on what services are offered by WIBSS, what help the service provides to support people applying to join the scheme and whether WIBSS had undertaken a customer satisfaction survey.
- The third request sought information regarding the eligibility criteria for bereaved spouses and partners to join the scheme.
- The fourth request sought some additional clarification regarding the information supplied in the first request.

WIBSS co-operated fully with the inquiry and responded to all Rule 9 requests within the required timeframe.

On 11 November 2022, Dr Caroline Coffey, WIBSS Consultant Clinical Psychologist appeared before the Inquiry. A copy of the evidence session can be accessed from the Inquiry website.

Transcript – London – Friday 11 November 2022 (Keith Carter and Specialist Psychological Support) | Infected Blood Inquiry.

The Inquiry is now in its last phase, after four and a half years of hearings and evidence gathering. On 3 February the Inquiry Chair closed the Inquiry's public hearings, explaining that he would now be focused on writing his reports, the first being an interim report on compensation which was subsequently published on 5 April 2023. The Inquiry's final report will be published in the autumn of 2023.

Interim Compensation Payments

In May 2021, it was announced by UK Government that Sir Robert Francis QC would carry out a study to look at the options for a framework for compensation, and to report back to the Paymaster General with recommendations, before the independent Infected Blood Inquiry reports.

In June 2022, the UK Government published the study by Sir Robert Francis QC:

> "It makes recommendations for a framework for compensation and redress for the victims of infected blood, which can be ready to be implemented upon the conclusion of the Infected Blood Inquiry, should the Inquiry's findings and recommendations require it."

On 29 July 2022, the Inquiry published its first Interim Report concerning the single issue of interim compensation payments. The Chair welcomed Sir Robert's report and recommended that the UK Government should pay an interim payment of "no less than £100,000" to current beneficiaries and bereaved partners who were in receipt of regular support payments from the 4 UK Infected Blood Support Schemes. A copy of the report can be accessed from the Inquiry Website.

First Interim Report | Infected Blood Inquiry

On 17th August, the UK Government announced that these interim payments would be made to those who had been infected and to bereaved partners by end of October 2022.

Infected Blood victims to receive £100,000 interim compensation payment - GOV.UK (www.gov.uk)

The commitment to pay interim compensation met, in full, the recommendations set out by inquiry chairman Sir Brian Langstaff in his interim report. That report built on the Compensation Framework Study undertaken by Sir Robert Francis QC in his detailed consideration of the issues.

Following the announcement, WIBSS wrote to all our beneficiaries and bereaved partners notifying them of the decision. Welsh Government instructed WIBSS to make the payments to all beneficiaries of the scheme, in receipt of regular payments in October 2022. This was actioned on 27th October 2022. Any beneficiaries joining the scheme, after October 2022, who receive on-going payments, have also subsequently received the payments, in line with government policy.

As a result of the announcement, WIBSS received an increased number of enquiries about registering with the scheme.

There remains one outstanding issue relating to the payment of the interim compensation amount to the estates of beneficiaries who sadly died between the date of the announcement by the Inquiry and the agreement by Governments to make the payment. It continues to be raised, and WIBSS awaits instruction on this matter from the Welsh Government.

On 5 April 2023, the Inquiry published its second Interim Report concerning the framework for compensation. A copy of the report is available from the Inquiry website:

Second Interim Report | Infected Blood Inquiry

The UK and devolved Governments have acknowledged the report but have yet to decide upon its recommendations at the time of writing.

Governance Group

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government (WG), through Velindre University NHS Trust.

The WIBSS Governance Group (VCC and NWSSP) is authorised to:

Investigate or have investigated any activity within its Terms of Reference, and in performing these duties, shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust, relevant to the Governance teams' remit, subject to any restrictions imposed by General Data Protection Regulations (GDPR).

It can seek any relevant information it requires from any employee, and all employees are directed to co-operate with any reasonable request made by the Board.

It is empowered with the responsibility for:

Reviewing and advising on the management of the WIBSS budgets, including running costs, the annual beneficiaries' budgets and provisions.

Advising Welsh Government on rate changes and the potential financial and service implications of policy changes, both within Wales and other areas within the UK.

Implementation of Welsh Government policy.

Ongoing negotiation and partnership with Welsh Government to ensure the smooth running of the service.

The membership of the WIBSS Governance Group is as follows:

- Director of Corporate Governance
  Velindre University NHS Trust (Chair)
- Welsh Government Finance Representative
- Director of Operations
  Velindre Cancer Centre
- Welsh Government Policy Representative
- Director of Planning, Performance and Informatics
  NWSSP
- Senior Welfare Rights Manager and Deputy WIBSS Manager
- WIBSS Service Manager
- Consultant Psychologist

During 2022-23, the Governance Group met four times on 5th April 2022, 11th July 2022, 10th October 2022 and 8th March 2023.

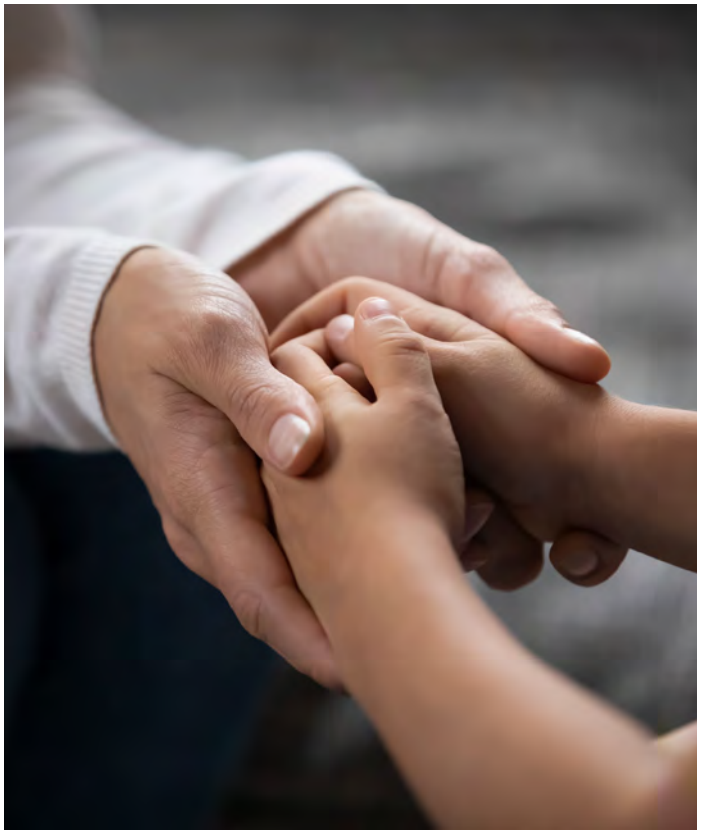
Financial Support

The scheme recognises that individuals living with hepatitis C and/or HIV face extra costs for things like insurance, travel insurance, care costs and travel costs to attend hospital appointments etc. Financial support is available for:

- New Applicants to the scheme
- Members of previous legacy schemes

There are varying levels of financial support available to beneficiaries of the scheme. These are set out in the Finance Section of this report and are also published on our website.

Home - WIBSS (wales.nhs.uk).



Child Payments

Following receipt of Directions from Welsh Government, at the end of December 2022, child payments were introduced to WIBSS with effect from 1st January 2023.

The payment is intended for the care and support of a child/children, up to the age of 18 or 21, if in full-time education, who are either the biological child or form part of the household of an infected beneficiary.

To date, 18 successful applications have been received for Child payments for a total of 31 children. This equates to a total of £69,600 pa. Payments are being paid monthly /quarterly.

Appeals Process

If an application to join the scheme is unsuccessful, an applicant can appeal if they disagree with the outcome of their application. Appeals are heard by a panel of independent medical experts with relevant clinical or similar experience in the field.

An appeal will not be considered in cases where it is acknowledged that the applicant is not eligible under the current eligibility criteria, but the applicant disagrees with those criteria (in such cases, the application could only be reconsidered if the Welsh Government agreed to amend the eligibility criteria).

During 2022-23, one appeal was submitted, and an appeals panel was convened in September 2022. The panel considered all the documentation received by WIBSS from the applicant and scrutinised the decision-making process of WIBSS. The panel then considered all the evidence, and upheld the original decision made by WIBSS to reject the application and the appellant was notified of the panel's decision.

The appeals panel process does not cover appeals regarding the Discretionary Small Grants process.

Beneficiaries' activity 2022-23

There are 223 beneficiaries & bereaved partners registered for support through the scheme. This is broken down into the following groups. (Valid as at 31st March 2023).

Beneficiary Group	Number of registered Beneficiaries
Hepatitis C Stage 1	**43**
Hepatitis C Enhanced Stage 1+	**77**
Hepatitis C Stage 2	**41***
HIV	**2**
HIV & Hep C Stage 1 (Co-infected)	**3**
HIV & Enhanced Stage 1+ (Co-infected)	**11**
HIV & Hep C Stage 2	**2**
Bereaved Spouse/Partner	**44***
Child Payments	**18**

**2 beneficiaries are classified as both existing beneficiaries and as bereaved spouse/ partners.*

2 beneficiaries passed away during Q4 2022/23. However, they are still included in the above numbers as they continued to receive payments until the end of the quarter in which they died i.e., the 31 March 2023.

Payment Rates

The levels of payments available to beneficiaries in 2022/23 are set out in the table below.

Beneficiary Group	Annual Payments
Hepatitis C Stage 1	**£19,498**
Hepatitis C Enhanced Stage 1+	**£29,569**
Hepatitis C Stage 2	**£29,569**
HIV	**£29,569**
HIV & Hep C Stage 1 (Co-infected)	**£40,135**
HIV & Enhanced Stage 1+ (Co-infected)	**£46,469**
HIV & Hep C Stage 2 (Co-infected)	**£46,469**
Child Payment; 1st Child	**£3,000**
Child Payment; 2nd & Subsequent Children	**£1,200**

WIBSS pay annual payments monthly or quarterly, depending on beneficiary preference. Payments are made on the 20th of the month. Where the 20th falls on a bank holiday or weekend, payment will be the nearest working day prior to the 20th.

One-off non-discretionary lump sum payments are also paid to successful new applicants to the scheme. Under Parity, a new applicant who is Hep C Stage 1 would be entitled to a £50,000 lump sum payment.

A beneficiary who moves from Hep C Stage1 to Hep C Stage 2 would receive an additional £20,000 lump sum payment. A new applicant who has already progressed to Hepatitis C Stage 2 would receive a £70,000 lump sum payment.

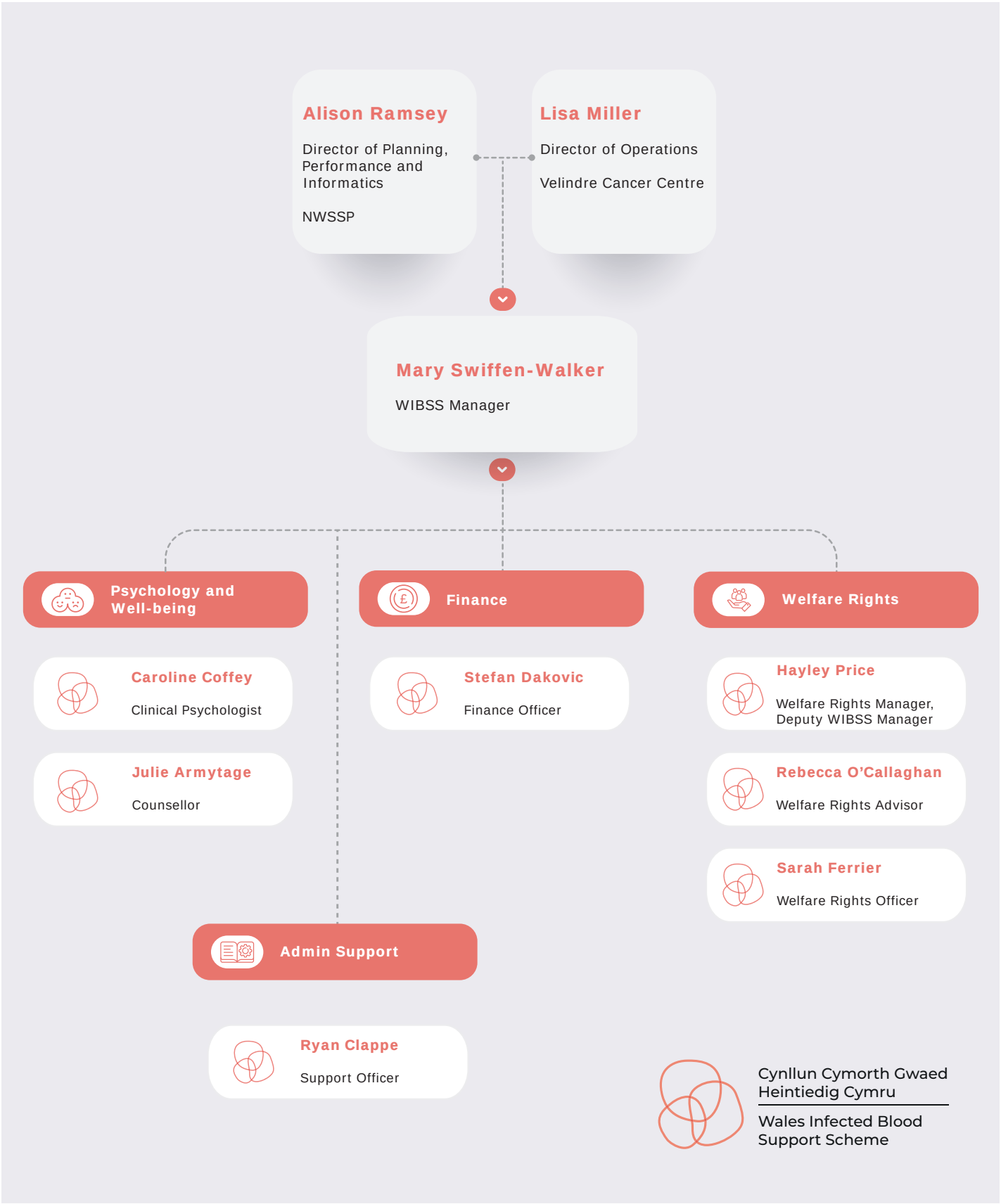
A new applicant who has HIV would be entitled to a lump sum payment of £80,500. If they were co-infected HIV and Hep C Stage 1, the lump sum would be £80,500 + £50,000 = £130,500 and Stage 2 would be £80,500 + £70,000 = £150,500.

A one-off non-discretionary lump sum payment of £10,000 is also paid to the bereaved spouse/partner/dependant relative or estate of a deceased infected beneficiary to assist with funeral costs.

WIBSS also make regular payments to bereaved spouses/partners/dependant relatives, of an infected beneficiary who has passed away. These payments are equal to 100% of the rate the deceased beneficiary was on at time of death for one year and 75% of the rate thereafter.

WIBSS Structure

The day-to-day WIBSS team consists of eight members of staff, led by the WIBSS Manager.



Financial Report

The table below summarises the claims expenditure for 2022-23, which includes the Interim Compensation payments processed in October 2022 referred to earlier in this report.

The announcement confirmed that an interim compensation payment of £100,000 would be paid to registered infected and bereaved partner beneficiaries of the UK Infected Blood Support Schemes.

These costs include widows and small grants payments.

WIBSS Claims Expenditure	2022 -23	2021-22 Comparative
No. of Beneficiaries	223	217
Regular Payments	£7,484,327	£7,294,727
Interim Compensation Payments	£22,200,000*	£0
Total Payments to Beneficiaries	**£29,684,327**	**£7,294,727**

Please note the figures above have been subject to in year movements i.e., new applications, deaths in year, moves from one stage to another, ad hoc requests etc.

NWSSP provide the Health and Social Services Finance Team within Welsh Government with regular updates on forecasts throughout the year. The administration of the scheme i.e., claims expenditure, is cost neutral to both NWSSP and Velindre Cancer Centre, with Welsh Government funding the scheme in full.

Running Costs for 2022-23

A summary of the running costs for 2022-23 is set out below with a 2021-22 comparative:

WIBSS Running Costs	2022 -23	2021-22 Comparative
Pay	£244,417*	£215,298*
Expenditure	£11,160	£11,328
Total	**£255,577**	**£226,626**

**Note the 2022-23 running cost spend is not a full comparative to 2021-22, the increase in pay is due to the impact of return from maternity leave within the team during the year.*

Performance Report

WIBSS performance against Key Performance Indicators is set out below.

Descriptor of Key Performance Indicator	2022-23 Target	Status
Responding to Correspondence within set time limits	Within 4 working days	100%
Responding to Freedom of Information Requests within required deadlines	In-line with Trust Policy	100%
Dealing with applications within required timescales	Within 28 days from receipt of complete information	100%
Dealing with appeals within set time limits	1 appeal was lodged. The appeal was heard within the required timescale.	100%
Payments made on a timely basis	100% of payments to be made 0-2 days before the due date.	100%

Description of Key Welfare Rights Incidents	Status
Total Welfare Rights Cases opened in previous 12 monts	» 65
Income generated for beneficiaries (1st april 2022 - 31st March 2023)	» £65,948.82
Outstanding outcomes March 2023	» 2 Personal Independence Payment Claims (PIP) » 1 Housing Benefit » 1 Pension Credit » 1 Child Benefit » 1 Child Tax Credit Review
Onward Referrals	» 1 Occupational Therapy » 3 External Grants » 7 Internal Grants
Appeals and Reconsiderations	» 1 HM Tribunal PIP Appeal ***1 Successful*** » 2 Mandatory reconsiderations for PIP ***2 Successful*** » 1 Housing benefit backdates ***1 Successful*** » 1 Council Tax backdates ***1 Successful***

New Applications for Financial Support

WIBSS received 20 applications in 2022-23.

Application Type	Applications Received	Outcome
Hepatitis C Stage 1	13	9 Accepted, 4 Declined
Hepatitis C Stage 1 (Deceased)	1	Accepted
Hepatitis C Stage 2	3	Accepted
Windows' application	3	2 Accepted, 1 Declined
Total	**20**	**15 Accepted, 5 Declined**

Where an application is declined, it will be because it does not meet the criteria set in Wales Infected Blood Support Scheme Directions, or insufficient evidence has been provided to support the application.

To access the Directions, please visit the WIBSS Website:

Home - WIBSS (wales.nhs.uk).

The announcement regarding the interim compensation payments and the media coverage surrounding it, led to an increase in the number of queries about the service and new beneficiaries, who had been registered with one of the legacy schemes, but had not transferred to WIBSS in 2017 when the scheme was established.

Support and Assistance Grants Scheme

In 2022-23 we received 5 applications for support. This is a decrease of 58% compared with 12 applications from 2021-22.

We believe this decrease may be partly due to the Interim Compensation payments that were paid in October 2022.

Welfare Rights Service

Our WIBSS welfare rights service is Advice Quality Standard (AQS) accredited and bespoke to the needs of the individual and their family.

Although not exhaustive, below is a list of services we may be able to assist with:

- Liaising with social services to ensure complex beneficiary needs are met, such as support from a social worker/ occupational therapist/ Community Psychiatric Nurse (CPN). This may include help with adaptions to home to ensure our beneficiaries safety or mental health support.
- Signposting free NHS dental care and prescription services for those eligible due to the new benefit entitlement.
- Assisting with applying to join WIBSS including completing paperwork, requesting or chasing medical professionals seeking evidence to support applications to join WIBSS.
- Complete benefit and welfare checks, applying for benefits, debt signposting, budgeting advice, navigating financial products etc.
- Applying for a parking badge (Blue Badge), free bus travel and concessions.
- Accessing health services, such as additional care requirements and health care transportation.
- Advice around external schemes- such as NEST part of Welsh Government's Warm Home Scheme. NEST offers financial support for insulating homes or new boilers to reduce bills and increase energy efficiency.
- SureWater schemes to reduce water bills for those using higher amount of water for medical reasons.

Our welfare rights advisors can also consider the circumstances of family and carers to check their entitlement to benefits. Caring for someone can impact emotionally and financially. We can apply for benefits to support cares if eligible.

There are also other services that family and carers may wish to access, such as psychological support.

A second distinct service which was mentioned in the previous report is key worker support, which we continue to provide. We can provide a higher level of support than most welfare services due to being in-house. This may include things such as:

- Liaising with beneficiaries and wider family members to establish a trusting relationship and provide emotional support, outside of formal psychology and well-being referrals.
- Regular outbound check-ins with beneficiaries considered as vulnerable.
- Completion of paperwork and help to sort affairs for those unable to do so themselves.

Infected Blood Inquiry Calls

WIBSS experienced an increase in the number of calls from beneficiaries and family members not registered with a UK scheme yet during 2022-23. This followed the publishing of the 2nd Interim Report of the Infected Blood Inquiry (IBI). WIBSS dealt with an additional 45 calls in a 6-week period. Many of these calls were distressing to deal with, due to the highly emotive nature of the subject.

Newsletters

Newsletters are sent out quarterly to all beneficiaries unless they have opted not to receive them. These are sent out electronically or by post, depending on preference.

They are also available on the WIBSS website.

Home - WIBSS (wales.nhs.uk).

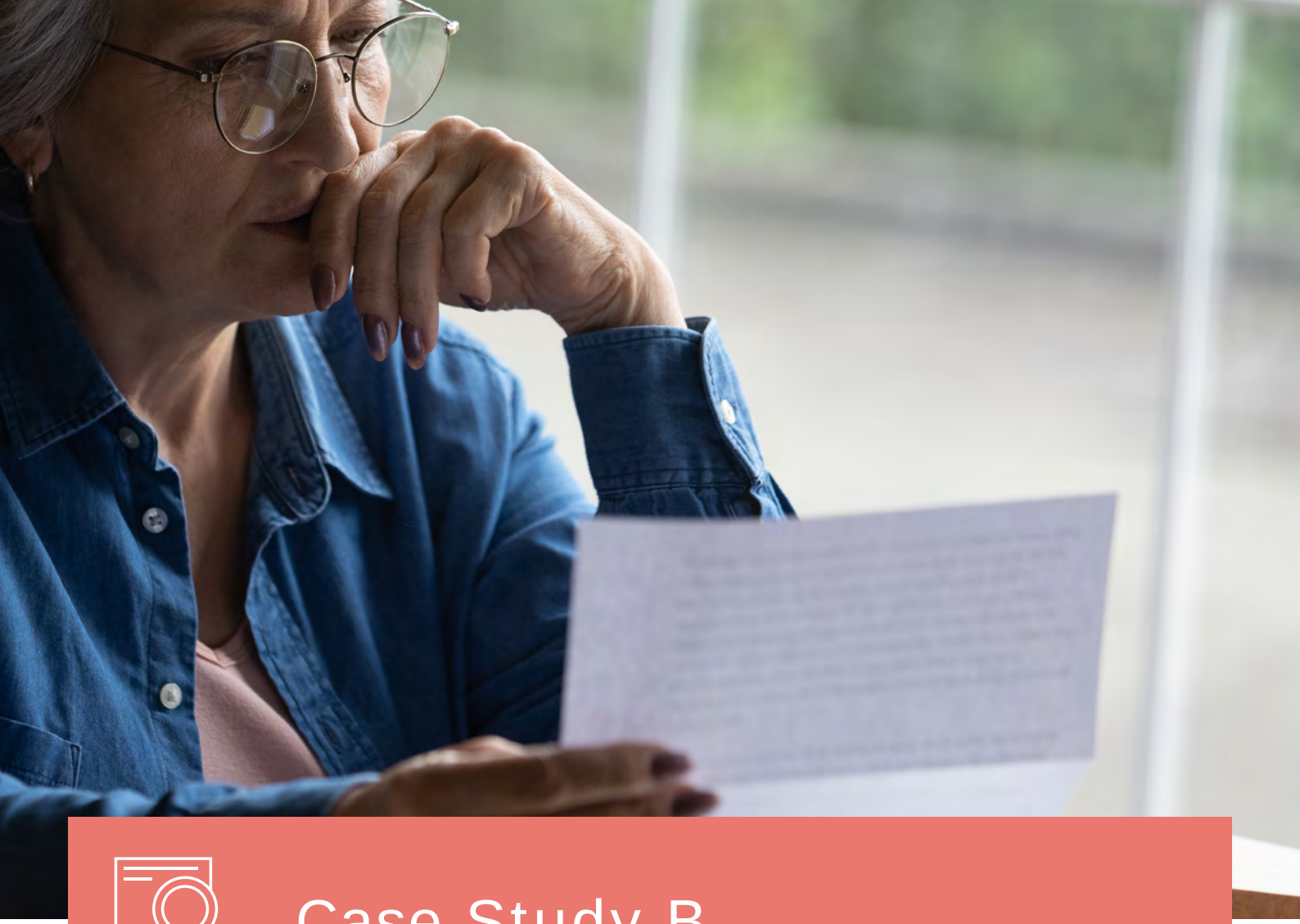
Newsletters this year covered:

- Parity update
- Interim report updates
- Reminder of the psychology and well-being service
- Uplift information
- Satisfaction survey feedback
- Benefit updates and reminders
- COVID-Newsletter referring to the financial support available.

Case Study A

Beneficiary A contacted WIBSS about a Personal Independence Payment (PIP) renewal.

We supported the client to complete the PIP renewal form. Beneficiary A was awarded higher rate mobility and lower rate care but only for two years. We submitted a mandatory reconsideration for them to consider a longer award period. As a result, the award was altered to five years. WIBSS also supported the client with a housing benefit and council tax reduction renewal form, which we completed on behalf of the beneficiary. The reduction was awarded. This beneficiary also suffered with anxiety, so a referral was made for the WIBSS Well-being and Psychology Team.



Case Study B

Beneficiary B contacted WIBSS as they were very concerned that they had not notified the Department of Works and Pension (DWP) of their WIBSS payments.

WIBSS sent letters to the DWP and council to notify them of the WIBSS payments and reminding both organisations that the payments should be disregarded when calculating mean tested benefits. We also completed the form for the beneficiary to receive the child payments recently introduced by WIBSS as they were struggling to complete the form. The beneficiary and his wife also wanted to chat about how they were struggling with everything that they had been through. The welfare team provided emotional support and suggested that they should contact the well-being and psychology team.

Psychology and Emotional Well-being Service

The emotional well-being service has been fully operational since January 2020 and has received a steady level of appropriate referrals for specialist psychological support. Individuals registered with WIBSS, their family members and bereaved family members have been able to access specialist psychological assessment and treatment concerning the emotional difficulties of being given contaminated blood products and living with a diagnosis of Hepatitis C and/or HIV. There have been approximately 80 referrals to the service, and in 2022-23 there was around 40 active cases.

The clinical work is complex, mainly relational and interpersonal in its approach. It can provide short term or longer-term therapeutic intervention, with an initial focus on building rapport and trust.

The service offers individuals, couples and family interventions, based on clinical need. These interventions can be in person appointments, telephone or by video.

There is no cap on the number of appointments available and intervention can be offered as episodes of care. Self-re-referral to the service is encouraged if needed, due to the complexity of the psychological difficulties and the likelihood of such thoughts and feelings being triggered at various life transition points and as a result of media reporting regarding the Infected Blood Inquiry.

The feedback the service has received has been overwhelmingly positive. People have been impressed with the flexibility of the service and have found talking to a therapist who is aware of the specialist context of this work and the specific issues they might face helpful and containing.

In November 2022, Consultant Clinical Psychologist, Dr Caroline Coffey gave evidence at the Infected Blood Inquiry, as part of a panel to discuss the ongoing psychological impact for beneficiaries and the need for specialist services. She has also been regularly meeting with representatives from NHS England and other partnership agencies to help plan and shape the future of the psychology service for EIBSS, as the WIBSS is considered to have many aspects of a Gold Standard service.

Transcript – London – Friday 11 November 2022 (Keith Carter and Specialist Psychological Support) | Infected Blood Inquiry.

Future plans for the service include how to further involve service users, particularly in the ongoing consideration of how to meet the 'community needs' of this population. Themes of loneliness, isolation and entrenched feelings of shame are widely documented and discussed clinically, but how to try and address these on a community or group level are ongoing challenges which WIBSS want to target.

Things we will do in 2023-24

The workplan for 2023-2024 will include the following:

- Continue to deliver a responsive WIBSS service to existing beneficiaries and those seeking to apply.
- Keep beneficiaries informed of any decisions arising from the Inquiry recommendations that may impact on them.
- Progress the work started by the Psychology and well-being team around focus groups etc.
- Work with the Welsh Government to respond promptly to any future decisions arising from the Inquiry second interim report and anticipated final report.
- To increase the profile of the Welfare Rights Service to all scheme members. Ensuring everyone is aware how they can access the service.
- We will work on improving the reporting capability of our in-house case management system. This will allow us to transform data into intelligence which we can utilise to ensure our performance meets and exceeds the needs of our beneficiaries.
- To build relationships with key professionals in health settings who support people in the community that could be eligible for the WIBSS Scheme. New applicants have joined the scheme in the current year, indicating the potential that there could still be other people who are yet to apply. We wish to be transparent and ensure that anyone would meets the criteria is aware of the existence of the WIBSS Service. By building relationships with key health professionals should raise the profile and awareness of WIBSS Service.
- Develop the WIBSS Website to continue to ensure the most up to date information is available.

Cynllun Cymorth Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Thank you for reading our Annual Report. If you would like to find out more, please visit our website, our social media channels, or use the contact details provide below:

Email

wibss@wales.nhs.uk

Phone

02920 902280

Mary Swiffen-Walker

07970 601561

Address

Wales Infected Blood Support Scheme,

4th Floor,
Companies House,
Crown Way,
Cardiff
CF14 3UB

This document was designed by the NWSSP Communications Team.
nwssp.communications@wales.nhs.uk

Cynllun Cymorth Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Cynllun Cynorthwyo Gwaed Heintiedig Cymru

Adroddiad Blynyddol 2022-23

Cynllun Cynorthwyo Gwaed Heintiedig Cymru (WIBSS)

YMDDIRIEDOLAETH GIG PRIFYSGOL FELINDRE

TRWY

BARTNERIAETH CYDWASANAETHAU
GIG CYMRU

A

CHANOLFAN GANSER FELINDRE

ADRODDIAD BLYNYDDOL 2022/2023

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Canolfan Ganser Felindre
Velindre Cancer Centre

Cynllun Cymorth Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

Cynnwys

Cyflwyniad

Wedi'i sefydlu ym mis Hydref 2017, bwriad Cynllun Cynorthwyo Gwaed Heintiedig Cymru (WIBSS) yw darparu cymorth i bobl sydd wedi'u heintio â Hepatitis C a/neu HIV yn dilyn triniaeth gyda gwaed, cynhyrchion gwaed neu feinwe'r GIG.

Ar ôl cymryd yr awenau gan gynlluniau presennol y DU (Ymddiriedolaeth Eileen, Ymddiriedolaeth Macfarlane, MFET Ltd, Cronfa Skipton a Sefydliad Caxton), sydd bellach yn cael eu hadnabod fel sefydliadau Alliance House (AHOs), nod WIBSS yw cynnig gwasanaeth taliadau ariannol symlach a chymorth wedi'i deilwra i fuddiolwyr Cymru. Mae WIBSS hefyd yn cynnig Gwasanaeth Hawliau Lles a Gwasanaeth Seicoleg a Llesiant pwrpasol.

Ar 31 Mawrth 2023, mae WIBSS yn cefnogi 223 o fuddiolwyr, sy'n cynnwys gwŷr, gwragedd a phartneriaid mewn profedigaeth. Serch hynny, darperir y cymorth llesiant a seicolegol hefyd i aelodau eraill o deuluoedd ein buddiolwyr.

Pwrpas yr Adroddiad

Rhoi'r wybodaeth ddiweddaraf am y gwasanaethau cyllid a chymorth yn ystod 2022–23 yn rhan o Gynllun Cynorthwyo Gwaed Heintiedig Cymru.

Manylu ar y gwaith rhagweithiol a wnaed gan WIBSS yn ystod 2022–23.

Edrych ymlaen at flaenoriaethau WIBSS sy'n berthnasol i 2023–24.

Materion allweddol yn codi yn ystod 2022–23

Cyflenwi Gwasanaethau Ar ôl COVID-19:

Dychwelodd y ffordd y darperir gwasanaethau WIBSS i'r arfer yn ystod 2022-23 yn dilyn rhai addasiadau gofynnol, o ganlyniad i'r pandemig COVID-19. Ailsefydlwyd ymweliadau cartref ac apwyntiadau wyneb yn wyneb.

Ymchwiliad Cyhoeddus – Yr Ymchwiliad i Waed Heintiedig

Ymchwiliad statudol cyhoeddus annibynnol yw hwn a sefydlwyd i archwilio'r amgylchiadau pan roddwyd gwaed heintiedig a chynhyrchion gwaed heintiedig i ddynion, menywod a phlant a gafodd driniaeth gan y Gwasanaeth Iechyd Gwladol yn y Deyrnas Unedig o 1970 ymlaen. Syr Brian Langstaff sy'n Cadeirio'r Ymchwiliad.

Yn 2022–2023 ymatebon ni i bedwar cais Rheol 9 gan yr Ymchwiliad i Waed Heintiedig.

- Roedd y cais cyntaf yn gofyn am wybodaeth ynghylch nifer y buddiolwyr a gofrestrwyd gyda'r cynllun, sut yr oeddent wedi cael eu heintiau, natur eu heintiau, a faint oedd wedi'u cofrestru â chynllun etifeddiaeth.

- Roedd yr ail gais yn canolbwyntio ar ba wasanaethau a gynigir gan WIBSS, pa gymorth y mae'r gwasanaeth yn ei ddarparu i gefnogi pobl sy'n gwneud cais i ymuno â'r cynllun ac a oedd WIBSS wedi cynnal arolwg boddhad cwsmeriaid ai peidio.

- Roedd y trydydd cais yn gofyn am wybodaeth ynghylch y meini prawf cymhwysedd ar gyfer gwŷr a gwragedd a phartneriaid mewn profedigaeth i ymuno â'r cynllun.

- Roedd y pedwerydd cais yn gofyn am rywfaint o eglurhad ychwanegol ynghylch yr wybodaeth a ddarparwyd yn y cais cyntaf.

Cydweithiodd WIBSS yn llawn â'r ymchwiliad ac ymatebodd i bob cais Rheol 9 o fewn yr amserlen ofynnol.

Ar 11 Tachwedd 2022, ymddangosodd Dr Caroline Coffey, Seicolegydd Clinigol Ymgynghorol WIBSS, gerbron yr Ymchwiliad. Gellir gweld copi o'r sesiwn dystiolaeth ar wefan yr Ymchwiliad.

Trawsgrifiad – Llundain – dydd Gwener 11 Tachwedd 2022 (Keith Carter a Chymorth Seicolegol Arbenigol) | Yr Ymchwiliad i Waed Heintiedig.

Mae'r Ymchwiliad bellach yn ei gyfnod olaf, ar ôl pedair blynedd a hanner o wrandawiadau a chasglu tystiolaeth. Ar 3 Chwefror, daeth Cadeirydd yr Ymchwiliad â gwrandawiadau cyhoeddus yr Ymchwiliad i ben, gan egluro y byddai bellach yn canolbwyntio ar ysgrifennu ei adroddiadau. Roedd yr adroddiad cyntaf yn adroddiad interim ar iawndal a gyhoeddwyd wedi hynny ar 5 Ebrill 2023. Bydd adroddiad terfynol yr Ymchwiliad yn cael ei gyhoeddi yn hydref 2023.

Taliadau Iawndal Interim

Ym mis Mai 2021, cyhoeddodd Llywodraeth y DU y byddai Syr Robert Francis CF yn cynnal astudiaeth i edrych ar yr opsiynau ar gyfer fframwaith ar gyfer iawndal, ac i adrodd yn ôl i'r Tâl-feistr Cyffredinol gydag argymhellion, cyn i'r Ymchwiliad annibynnol i Waed Heintiedig gyflwyno ei adroddiad.

Ym mis Mehefin 2022, cyhoeddodd Llywodraeth y DU yr astudiaeth gan Syr Robert Francis CF.

> "Mae'n argymell fframwaith ar gyfer iawndal a gwneud iawn i ddioddefwyr gwaed heintiedig, a all fod yn barod i'w roi ar waith ar ddiwedd yr Ymchwiliad i Waed Heintiedig, pe bai canfyddiadau ac argymhellion yr Ymchwiliad yn gofyn am hynny."

Ar 29 Gorffennaf 2022, cyhoeddodd yr Ymchwiliad ei Adroddiad Interim cyntaf ar y mater unigol o daliadau iawndal interim. Croesawodd y Cadeirydd adroddiad Syr Robert ac argymhellodd y dylai Llywodraeth y DU dalu taliad interim o "o leiaf £100,000" i fuddiolwyr presennol a phartneriaid mewn profedigaeth a oedd yn cael taliadau cymorth rheolaidd gan y 4 Cynllun Cymorth Gwaed Heintiedig yn y DU. Gellir cyrchu copi o'r adroddiad ar Wefan yr Ymchwiliad

Yr Adroddiad Interim Cyntaf | Yr Ymchwiliad i Waed Heintiedig

Ar 17 Awst, cyhoeddodd Llywodraeth y DU y byddai'r taliadau interim hyn yn cael eu gwneud i'r rhai a oedd wedi'u heintio ac i bartneriaid mewn profedigaeth erbyn diwedd mis Hydref 2022.

Infected Blood victims to receive £100,000 interim compensation payment - GOV.UK (www.gov.uk)

Roedd yr ymrwymiad i dalu iawndal interim yn bodloni yr argymhellion a nodwyd gan gadeirydd yr ymchwiliad, Syr Brian Langstaff yn ei adroddiad interim yn llawn. Roedd yr adroddiad hwnnw'n adeiladu ar yr Astudiaeth Fframwaith Iawndal a gynhaliwyd gan Syr Robert Francis CF pan ystyriodd y materion yn fanwl.

Yn dilyn y cyhoeddiad, ysgrifennodd WIBSS at ein holl fuddiolwyr a phartneriaid mewn profedigaeth yn eu hysbysu o'r penderfyniad. Rhoddodd Llywodraeth Cymru gyfarwyddyd i WIBSS wneud y taliadau i holl fuddiolwyr y cynllun a oedd yn derbyn taliadau rheolaidd ym mis Hydref 2022. Gweithredwyd hyn ar 27 Hydref 2022. Mae unrhyw fuddiolwyr sy'n ymuno â'r cynllun, ar ôl mis Hydref 2022, sy'n derbyn taliadau parhaus, hefyd wedi derbyn y taliadau yn dilyn hynny, yn unol â pholisi'r llywodraeth.

O ganlyniad i'r cyhoeddiad, derbyniodd WIBSS nifer cynyddol o ymholiadau ynghylch cofrestru gyda'r cynllun.

Erys un mater sy'n weddill yn ymwneud â thalu swm yr iawndal interim i ystadau buddiolwyr a fu farw yn anffodus rhwng dyddiad cyhoeddi'r Ymchwiliad a chytundeb y Llywodraethau i wneud y taliad. Mae'n parhau i gael ei godi, ac mae WIBSS yn aros am gyfarwyddyd ar y mater hwn gan Lywodraeth Cymru.

Ar 5 Ebrill 2023, cyhoeddodd yr Ymchwiliad ei ail Adroddiad Interim ynghylch y fframwaith ar gyfer iawndal. Mae copi o'r adroddiad ar gael ar wefan yr Ymchwiliad:

Yr Ail Adroddiad Interim | Yr Ymchwiliad i Waed Heintiedig

Mae Llywodraeth y DU a'r Llywodraethau datganoledig wedi cydnabod yr adroddiad ond nid ydynt eto wedi penderfynu ar ei argymhellion ar adeg ysgrifennu hwn.

Grŵp Llywodraethu

Mae'r Grŵp Llywodraethu yn monitro rheolaeth weithredol WIBSS ac yn darparu trefn lywodraethu, arweinyddiaeth ac atebolrwydd ar gyfer y cynllun, ar ran Llywodraeth Cymru (LIC) drwy Ymddiriedolaeth GIG Prifysgol Felindre.

Mae Grŵp Llywodraethu WIBSS [Canolfan Ganser Felindre (VCC) a Phartneriaeth Cydwasanaethau GIG Cymru (PCGC)] wedi'i awdurdodi i wneud y canlynol:

Ymchwilio i unrhyw waith o fewn ei Gylch Gorchwyl, ac wrth gyflawni'r dyletswyddau hyn, bydd ganddo'r hawl, ar bob adeg resymol, i archwilio unrhyw lyfrau, cofnodion neu ddogfennau sy'n perthyn i'r Ymddiriedolaeth, sy'n berthnasol i gylch gwaith y timau Llywodraethu, yn amodol ar unrhyw gyfyngiadau a osodir gan y Rheoliad Cyffredinol ar Ddiogelu Data (GDPR).

Gall geisio unrhyw wybodaeth berthnasol sydd ei hangen arno gan unrhyw weithiwr, a chyfarwyddir pob gweithiwr i gydweithredu ag unrhyw gais rhesymol a wneir gan y Bwrdd.

Mae wedi'i rymuso â chyfrifoldeb am y canlynol:

Adolygu a chynghori ar reolaeth cyllidebau WIBSS, gan gynnwys costau rhedeg, cyllidebau blynyddol y buddiolwyr a darpariaethau.

Cynghori Llywodraeth Cymru ar newidiadau mewn cyfraddau a goblygiadau posibl newidiadau polisi o ran cyllid a gwasanaethau, yng Nghymru ac mewn ardaloedd eraill yn y DU.

Gweithredu polisi Llywodraeth Cymru.

Cyd-drafod a phartneriaeth barhaus gyda Llywodraeth Cymru i sicrhau bod y gwasanaeth yn rhedeg yn esmwyth.

Mae aelodaeth Grŵp Llywodraethu WIBSS fel a ganlyn:

- Cyfarwyddwr Llywodraethu Corfforaethol
- Ymddiriedolaeth GIG Felindre (Cadeirydd)
- Cynrychiolydd Cyllid Llywodraeth Cymru
- Cyfarwyddwr Gweithrediadau
- Canolfan Ganser Felindre
- Cynrychiolydd Polisi Llywodraeth Cymru
- Cyfarwyddwr Cynllunio, Perfformiad a Gwybodeg
- Partneriaeth Cydwasanaethau GIG Cymru
- Uwch Reolwr Hawliau Lles a Dirprwy Reolwr WIBSS
- Rheolwr Gwasanaethau WIBSS
- Seicolegydd Ymgynghorol

Yn ystod 2022-23 cyfarfu'r Grŵp Llywodraethu bedair gwaith, ar 5 Ebrill, 11 Gorffennaf, 10 Hydref ac 8 Mawrth 2023.

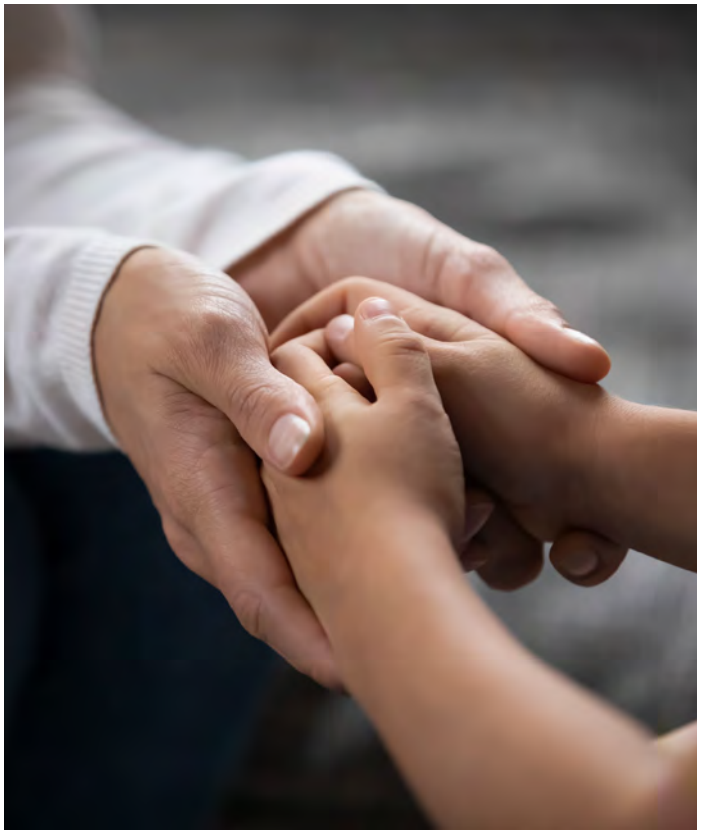
Cymorth Ariannol

Mae'r cynllun yn cydnabod bod unigolion sy'n byw gyda hepatitis C a/neu HIV yn wynebu costau ychwanegol am bethau fel yswiriant, yswiriant teithio, costau gofal a chostau teithio i fynychu apwyntiadau ysbyty ac ati. Mae cymorth ariannol ar gael ar gyfer:

- Ymgeiswyr Newydd i'r cynllun
- Aelodau o gynlluniau etifeddiaeth blaenorol

Mae lefelau amrywiol o gymorth ariannol ar gael i fuddiolwyr y cynllun. Mae'r rhain wedi'u nodi yn Adran Gyllid yr adroddiad hwn ac maent hefyd wedi'u cyhoeddi ar ein gwefan.

Hafan - WIBSS (www.gig.cymru)



Taliadau Plant

Ar ôl derbyn Cyfarwyddiadau gan Lywodraeth Cymru ar ddiwedd Rhagfyr 2022, cyflwynwyd taliadau plant i WIBSS o 1 Ionawr 2023.

Bwriedir y taliad ar gyfer gofal a chymorth i blentyn/plant, hyd at 18 neu 21 oed, os ydynt mewn addysg amser llawn, sydd naill ai'n blentyn biolegol neu'n rhan o aelwyd buddiolwr heintiedig.

Hyd yma, derbyniwyd 18 cais llwyddiannus am Daliadau Plant ar gyfer cyfanswm o 31 o blant. Mae hyn yn cyfateb i gyfanswm o £69,600 y flwyddyn. Mae taliadau yn cael eu talu yn fisol / chwarterol.

Y Broses Apelio

Os bydd cais i ymuno â'r cynllun yn aflwyddiannus, gall ymgeisydd apelio os yw'n anghytuno â chanlyniad ei gais. Gwrandewir ar apeliadau gan banel o arbenigwyr meddygol annibynnol sydd â phrofiad clinigol perthnasol neu brofiad tebyg yn y maes.

Ni fydd apêl yn cael ei hystyried mewn achosion lle cydnabyddir nad yw'r ymgeisydd yn gymwys o dan y meini prawf cymhwysedd presennol, ond bod yr ymgeisydd yn anghytuno â'r meini prawf hynny (mewn achosion o'r fath, dim ond os bydd Llywodraeth Cymru yn cytuno i ddiwygio'r meini prawf cymhwysed y gellir ailystyried y cais).

Yn ystod 2022-23, cyflwynwyd un apêl, a chynullwyd panel apeliadau ym mis Medi 2022. Ystyriodd y panel yr holl ddogfennaeth a dderbyniwyd gan WIBSS gan yr ymgeisydd a chraffodd ar broses benderfynu WIBSS. Yna ystyriodd y panel yr holl dystiolaeth, a chadarnhaodd y penderfyniad gwreiddiol a wnaed gan WIBSS i wrthod y cais a hysbyswyd yr apelydd o benderfyniad y panel.

Nid yw proses y panel apeliadau yn cwmpasu apeliadau sy'n ymwneud â'r broses Grantiau Bach Dewisol.

Gweithgarwch buddiolwyr 2022–23

Mae 223 o fuddiolwyr a phartneriaid mewn profedigaeth wedi'u cofrestru ar gyfer cymorth trwy'r cynllun. Rhennir hyn i'r grwpiau canlynol. (Yn ddilys ar 31 Mawrth 2023).

Grŵp Buddiolwyr	Nifer y Buddiolwyr cofrestredig
Hepatitis C Cam 1	**43**
Hepatitis C Cam 1+ Uwch	**77**
Hepatitis C Cam 2	**41***
HIV	**2**
HIV a Hep C Cam 1 (Cyd-heintiedig)	**3**
HIV a Cham 1+ Uwch (Cyd-heintiedig)	**11**
HIV a Hep C Cam 2	**2**
Priod/partner mewn profedigaeth	**44***
Taliadau Plant	**18**

**Caiff 2 fuddiolwr eu dosbarthu fel buddiolwyr presennol ac fel priod/partner mewn profedigaeth.*

Bu farw 2 fuddiolwr yn ystod Ch4 2022/23. Fodd bynnag, maent yn dal i gael eu cynnwys yn y niferoedd uchod gan eu bod wedi parhau i dderbyn taliadau tan ddiwedd y chwarter y bu iddynt farw, h.y. 31 Mawrth 2023.

Cyfraddau Talu 2022–23

Mae lefelau'r taliadau sydd ar gael i fuddiolwyr yn 2022/23 wedi'u nodi yn y tabl isod.

Grŵp Buddiolwyr	Taliadau Blynyddol
Hepatitis C Cam 1	**£19,498**
Hepatitis C Cam 1+ Uwch	**£29,569**
Hepatitis C Cam 2	**£29,569**
HIV	**£29,569**
HIV a Hep C Cam 1 (Cyd-heintiedig)	**£40,135**
HIV a Cham 1+ Uwch (Cyd-heintiedig)	**£46,469**
HIV a Hep C Cam 2 (Cyd-heintiedig)	**£46,469**
Taliad Plant; Plentyn 1af	**£3,000**
Taliad Plant; 2il Blentyn a Phlant Dilynol	**£1,200**

Mae WIBSS yn talu taliadau blynyddol bob mis neu bob chwarter, yn dibynnu ar ddewis y buddiolwr. Gwneir taliadau ar yr 20fed o'r mis. Pan fydd yr 20fed yn disgyn ar ŵyl banc neu benwythnos, y diwrnod gwaith agosaf cyn yr 20fed fydd y taliad.

Telir cyfandaliadau untro annewisol hefyd i ymgeiswyr newydd llwyddiannus i'r cynllun. Er cydraddoldeb, byddai gan ymgeisydd newydd sy'n Hep C Cam 1 hawl i gyfandaliad o £50,000.

Byddai buddiolwr sy'n symud o Gam 1 Hep C i Gam 2 Hep C yn cael cyfandaliad ychwanegol o £20,000. Byddai ymgeisydd newydd sydd eisoes wedi symud ymlaen i Gam 2 Hepatitis C yn cael cyfandaliad o £70,000.

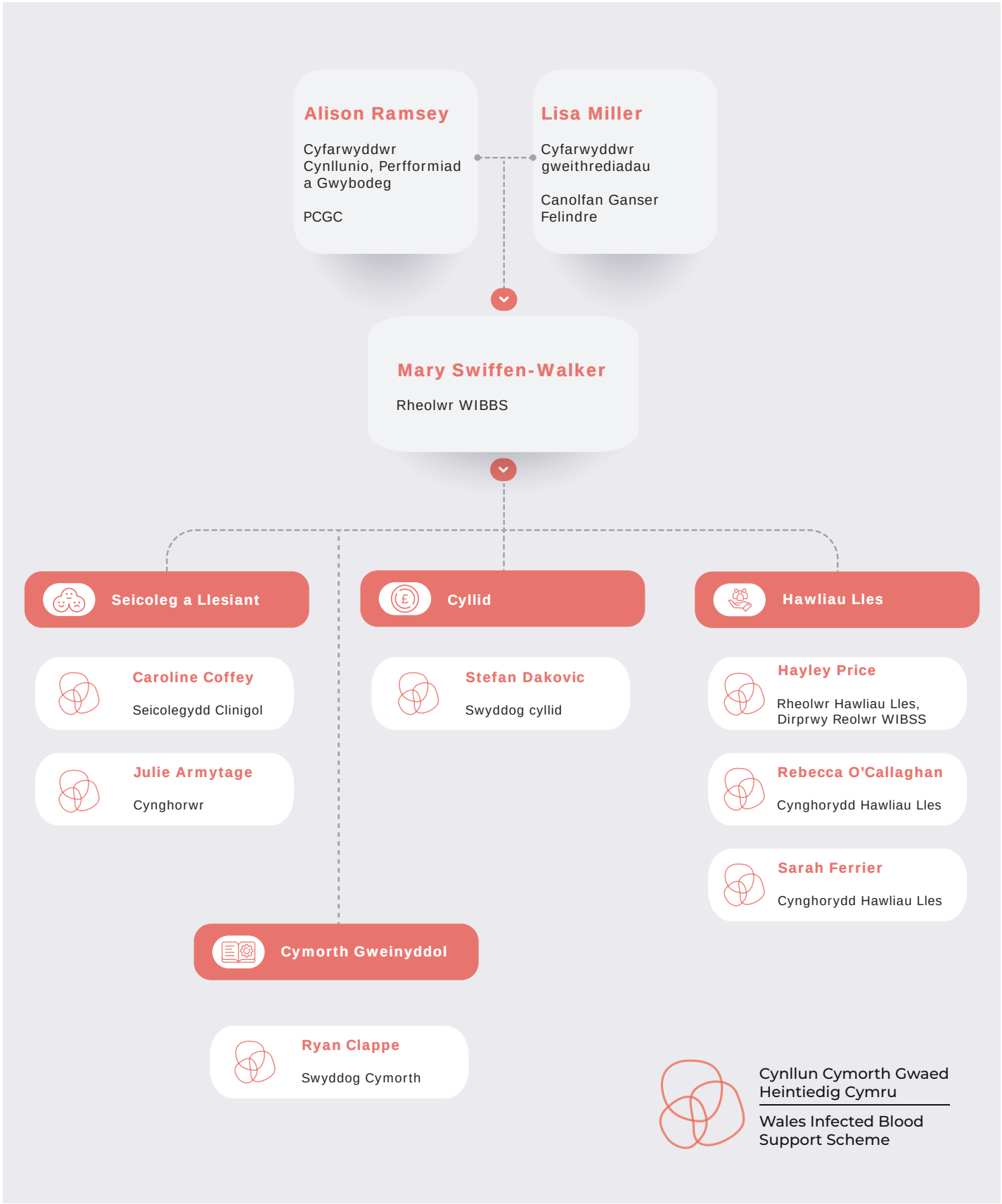
Byddai gan ymgeisydd newydd sydd â HIV hawl i gyfandaliad o £80,500. Pe bai ganddynt HIV a Hep C Cam 1 cyd-heintiedig, y cyfandaliad fyddai £80,500 + £50,000 = £130,500 a byddai Cam 2 yn £80,500 + £70,000 = £150,500.

Telir cyfandaliad untro annewisol o £10,000 hefyd i briod/partner/perthynas dibynnol mewn profedigaeth neu ystâd buddiolwr heintiedig a fu farw i gynorthwyo gyda chostau angladd.

Mae WIBSS hefyd yn gwneud taliadau rheolaidd i gwŷr a gwragedd/partneriaid/perthnasau dibynnol profedigaethus buddiolwr heintiedig sydd wedi marw. Mae'r taliadau hyn yn gyfartal i 100% o'r gyfradd yr oedd y buddiolwr ymadawedig arni adeg y farwolaeth am flwyddyn a 75% o'r gyfradd wedi hynny.

Strwythur WIBSS

Mae tîm WIBSS o ddydd i ddydd yn cynnwys wyth aelod o staff, dan arweiniad Rheolwr WIBSS.



Adroddiad Cyllid

Mae'r tabl isod yn crynhoi'r gwariant ar hawliadau yn ystod 2022-23, sy'n cynnwys y taliadau Iawndal Interim a broseswyd ym mis Hydref 2022 y cyfeiriwyd atynt yn gynharach yn yr adroddiad hwn.

Cadarnhaodd y cyhoeddiad y byddai taliad iawndal interim o £100,000 yn cael ei dalu i fuddiolwyr cofrestredig Cynlluniau Cymorth Gwaed Heintiedig y DU, sef y rhai hynny a heintiwyd a'r rhai sy'n bartneriaid profedigaethus.

Mae'r costau hyn yn cynnwys taliadau i weddwon a thaliadau grantiau bach.

Gwariant ar Hawliadau WIBSS	2022 -23	Cymharol 2021-22
Nifer y Buddiolwyr	223	217
Taliadau Rheolaidd	£7,484,327	£7,294,727
Taliadau Iawndal Interim	£22,200,000*	£0
Cyfanswm Taliadau i Fuddiolwyr	**£29,684,327**	**£7,294,727**

Sylwch fod y ffigurau uchod wedi bod yn destun newidiadau yn ystod y flwyddyn, h.y. ceisiadau newydd, marwolaethau yn ystod y flwyddyn, symud o un cam i'r llall, ceisiadau ad hoc ac ati.

Mae PCGC yn rhoi diweddariadau rheolaidd ar ragolygon i Dîm Cyllid Iechyd a Gwasanaethau Cymdeithasol Llywodraeth Cymru drwy gydol y flwyddyn. Mae'r gwaith o weinyddu'r cynllun h.y. gwariant ar hawliadau, yn niwtral o ran cost i PCGC a Chanolfan Ganser Felindre, oherwydd bod Llywodraeth Cymru yn ariannu'r cynllun yn llawn.

Costau rhedeg yn ystod 2022/23

Mae crynodeb o'r costau rhedeg yn ystod 2022–23 wedi'i nodi isod gyda chymhariaeth ar gyfer 2021–22:

Costau Rhedeg WIBSS	2022 -23	Cymharol 2021-22
Cyflogau	£244,417*	£215,298*
Gwariant	£11,160	£11,328
Cyfanswm	**£255,577**	**£226,626**

**Noder nad yw gwariant costau rhedeg 2022-23 yn gymhariaeth lawn â 2021–22. Mae'r cynnydd mewn tâl oherwydd effaith dychwelyd ar ôl absenoldeb mamolaeth o fewn y tîm yn ystod y flwyddyn.*

Adroddiad Perfformiad

Mae perfformiad WIBSS yn erbyn Dangosyddion Perfformiad Allweddol wedi'i nodi isod.

Disgrifiad o'r dangosydd perfformiad allweddol	Targed 20/21	Statws
Ymateb i ohebiaeth o fewn terfynau amser penodol	O fewn 4 diwrnod gwaith	100%
Ymateb i geisiadau Rhyddid Gwybodaeth o fewn y terfynau amser gofynnol	Yn unol â pholisi'r Ymddiriedolaeth	100%
Delio â cheisiadau o fewn yr amserlenni gofynnol	O fewn 28 diwrnod o dderbyn gwybodaeth gyflawn	100%
Delio ag apeliadau o fewn terfynau amser penodol	Cyflwynwyd 1 apêl. Gwrandawyd ar yr apêl o fewn yr amserlen ofynnol.	100%
Taliadau a wneir yn amserol	100% o daliadau i'w gwneud 0–2 ddiwrnod cyn y dyddiad dyledus	100%

Disgrifiad o ddangosyddion hawliau lles allweddol	Statws
Cyfanswm yr achosion Hawliau Lles a agorwyd yn y 12 mis blaenorol	» 65
Incwm a Gynhyrchir ar gyfer buddiolwyr (1 Ebrill 2022-31 Mawrth 2023)	» £65,948.82
Canlyniadau sy'n weddill Mawrth 2023	» 2 hawliad PIP » 1 Budd-dal Tai » 1 Credyd Pensiwn » 1 Budd-dal Plant » 1 adolygiad o Gredyd Treth Plant
Atgyfeiriadau Ymlaen	» 1 Therapi Galwedigaethol » 3 grant allanol » 7 grant mewnol
Apeliadau ac Ailystyriaethau	» 1 Apêl PIP Tribiwnlys EF ***1 yn llwyddiannus*** » 2 ailystyriaeth orfodol ar gyfer PIP ***2 yn llwyddiannus*** » 1 ôl-daliad budd-dal tai ***1 yn llwyddiannus*** » 1 ôl-daliad treth gyngor ***1 yn llwyddiannus***

Ceisiadau Newydd am Gymorth Ariannol

Derbyniodd WIBSS 20 cais yn 2022-23.

Math o Gais	Ceisiadau a dderbyniwyd	Canlyniad
Hepatitis C Cam 1	13	Derbyniwyd 9, Gwrthodwyd 4
Hepatitis C Cam 1 (Ymadawedig)	1	Derbyniwyd
Hepatitis C Cam 2	3	Derbyniwyd
Cais gweddwon	3	Derbyniwyd 2, Gwrthodwyd 1
Cyfanswm	**20**	**Derbyniwyd 15, Gwrthodwyd 5**

Pan fydd cais yn cael ei wrthod, bydd hynny oherwydd nad yw'n bodloni'r meini prawf a osodwyd yng Nghyfarwyddiadau Cynllun Cynorthwyo Gwaed Heintiedig Cymru, neu nad oes digon o dystiolaeth wedi'i darparu i gefnogi'r cais.

I weld y Cyfarwyddiadau, ewch i Wefan WIBSS

Hafan - WIBSS (www.gig.cymru)

Arweiniodd y cyhoeddiad ynghylch y taliadau iawndal interim a'r sylw cysylltiedig yn y cyfryngau, at gynnydd yn nifer yr ymholiadau am y gwasanaeth a buddiolwyr newydd, a oedd wedi'u cofrestru ag un o'r cynlluniau etifeddol, ond nad oeddent wedi trosglwyddo i WIBSS yn 2017 pan sefydlwyd y cynllun.

Cynllun Grantiau Cymorth a Chefnogaeth

Yn 2022-23 cawsom 5 cais am gymorth. Mae hyn yn ostyngiad o 58% mewn cymhariaeth â 12 cais yn ystod 2021-22.

Credwn y gallai'r gostyngiad hwn fod yn deillio'n rhannol o'r taliadau Iawndal Interim a dalwyd ym mis Hydref 2022.

Gwasanaeth Hawliau Lles

Mae ein Gwasanaeth Hawliau Lles WIBSS wedi'i achredu gan Safon Ansawdd Cyngor (AQS) ac mae wedi'i deilwra i anghenion yr unigolyn a'i deulu.

Er nad yw'r rhestr isod yn gynhwysfawr, dyma restr o'r gwasanaethau y gallwn gynorthwyo gyda hwy, o bosib:

- Cysylltu â gwasanaethau cymdeithasol i sicrhau bod anghenion cymhleth buddiolwyr yn cael eu diwallu, megis cymorth gan weithiwr cymdeithasol/ therapydd galwedigaethol/Nyrs Seiciatrig Gymunedol (CPN). Gall hyn gynnwys helpu gydag addasiadau i'r cartref i sicrhau diogelwch ein buddiolwyr neu gymorth iechyd meddwl.
- Cyfeirio at ofal deintyddol y GIG a gwasanaethau presgripsiwn am ddim i'r rhai sy'n gymwys oherwydd yr hawl i fudd-daliadau newydd.
- Cynorthwyo gyda gwneud cais i ymuno â WIBSS gan gynnwys cwblhau gwaith papur, gofyn am weithwyr meddygol proffesiynol i geisio tystiolaeth i gefnogi ceisiadau i ymuno â WIBSS neu fynd ar eu trywydd.
- Cwblhau gwiriadau budd-daliadau a lles, gwneud cais am fudd-daliadau, cyfeirio at wasanaethau dyled, cyngor cyllidebu, llywio cynhyrchion ariannol ac ati.
- Gwneud cais am fathodyn parcio (Bathodyn Glas), teithio am ddim ar fysiau a chonsesiynau.
- Cyrchu gwasanaethau iechyd, megis cymorth gydag anghenion gofal ychwanegol a chludiant gofal iechyd.
- Cyngor ynghylch cynlluniau allanol - megis NYTH, sy'n rhan o Gynllun Cartref Cynnes Llywodraeth Cymru. Mae NYTH yn cynnig cymorth ariannol ar gyfer insiwleiddio cartrefi neu foeleri newydd i leihau biliau a chynyddu effeithlonrwydd ynni.
- Cynlluniau SureWater i leihau biliau dŵr ar gyfer y rhai sy'n defnyddio mwy o ddŵr am resymau meddygol.

Gall ein cynghorwyr hawliau lles hefyd ystyried amgylchiadau aelodau teulu a gofalwyr i wirio eu hawl i fudd-daliadau. Gall gofalu am rywun effeithio arnoch yn emosiynol ac yn ariannol. Gallwn wneud cais am fudd-daliadau i gefnogi gofalwyr os ydynt yn gymwys.

Mae gwasanaethau eraill hefyd y gallai teuluoedd a gofalwyr ddymuno cael mynediad atynt, megis cymorth seicolegol.

Ail wasanaeth penodol a grybwyllwyd yn yr adroddiad blaenorol yw cymorth i weithwyr allweddol, yr ydym yn parhau i'w ddarparu. Gallwn ddarparu lefel uwch o gymorth na'r rhan fwyaf o wasanaethau lles oherwydd bod popeth yn fewnol. Gall hyn gynnwys pethau megis:

- Cysylltu â buddiolwyr ac aelodau'r teulu ehangach i sefydlu perthynas o ymddiriedaeth a darparu cymorth emosiynol, y tu allan i atgyfeiriadau seicoleg a llesiant ffurfiol.
- Gwiriadau allanol rheolaidd gyda buddiolwyr yr ystyrir eu bod yn agored i niwed.
- Cwblhau gwaith papur a helpu i roi trefn ar faterion y sawl nad ydynt yn gallu gwneud hynny eu hunain.

Galwadau i'r Ymchwiliad i Waed Heintiedig

Yn ystod 2022-23, gwelodd WIBSS gynnydd yn nifer y galwadau gan fuddiolwyr ac aelodau o deuluoedd nad ydynt wedi cofrestru gyda chynllun y DU eto. Roedd hyn yn dilyn cyhoeddi 2il Adroddiad Interim yr Ymchwiliad i Waed Heintiedig (IBI). Deliodd WIBSS â 45 o alwadau ychwanegol mewn cyfnod o 6 wythnos. Roedd yn ofidus delio â llawer o'r galwadau hyn, oherwydd natur hynod emosiynol y pwnc.

Cylchlythyr

Anfonir cylchlythyrau bob chwarter i'r holl fuddiolwyr oni bai eu bod wedi dewis peidio â'u derbyn. Anfonir y rhain yn electronig neu drwy'r post, gan ddibynnu ar ddewis y derbynnydd.

Maent hefyd ar gael ar wefan WIBSS.

Hafan - WIBSS (www.gig.cymru).

Roedd cylchlythyrau eleni yn ymdrin â'r canlynol:

- Diweddariad ar gydraddoldeb
- Diweddariadau ar adroddiadau interim
- Nodyn atgoffa am y gwasanaeth seicoleg a lles
- Gwybodaeth ar yr ymgodiad
- Adborth o'r arolwg boddhad
- Diweddariadau a nodiadau atgoffa am fudd-daliadau
- Cylchlythyr COVID yn cyfeirio at y cymorth ariannol sydd ar gael

Astudiaeth Achos A

Cysylltodd Buddiolwr A â WIBSS ynghylch adnewyddduTaliad Annibyniaeth Bersonol (PIP).

Gwnaethom gefnogi'r cleient i lenwi'r ffurflen adnewyddu PIP. Dyfarnwyd cyfradd uwch ar gyfer symudedd a chyfradd is ar gyfer gofal i Fuddiolwr, A ond dim ond am ddwy flynedd. Cyflwynwyd ailystyriaeth orfodol er mwyn iddynt ystyried cyfnod dyfarnu hwy. O ganlyniad, newidiwyd y wobr i bum mlynedd. Bu WIBSS hefyd yn cefnogi'r cleient gyda ffurflen adnewyddu budd-dal tai a gostyngiad yn y dreth gyngor, a lenwyd gennym ar ran y buddiolwr. Dyfarnwyd y gostyngiad. Roedd y buddiolwr hwn hefyd yn dioddef o orbryder, felly gwnaed atgyfeiriad at Dîm Lles a Seicoleg WIBSS.

Astudiaeth Achos B

Cysylltodd Buddiolwr B â WIBSS gan ei fod yn bryderus iawn nad oedd wedi hysbysu'r Adran Gwaith a Phensiynau (DWP) o'u taliadau WIBSS.

Anfonodd WIBSS lythyrau at yr Adran Gwaith a Phensiynau a'r cyngor i'w hysbysu o daliadau WIBSS ac i atgoffa'r ddau sefydliad y dylid diystyru'r taliadau wrth gyfrifo budd-daliadau sy'n dibynnu ar brawf modd. Gwnaethom hefyd lenwi'r ffurflen er mwyn i'r buddiolwr dderbyn y taliadau plant a gyflwynwyd yn ddiweddar gan WIBSS gan eu bod yn cael trafferth i lenwi'r ffurflen. Roedd y buddiolwr a'i wraig hefyd eisiau trafod pam oeddent yn ei chael hi'n anodd delio â phopeth yr oeddent wedi bod drwyddo. Darparodd y tîm lles gefnogaeth emosiynol ac awgrymodd y dylent gysylltu â'r tîm lles a seicoleg.

Gwasanaeth Seicoleg a Lles Emosiynol

Mae'r gwasanaeth lles emosiynol wedi bod yn gwbl weithredol ers mis Ionawr 2020 ac mae wedi derbyn lefel gyson o atgyfeiriadau priodol ar gyfer cymorth seicolegol arbenigol. Mae unigolion sydd wedi'u cofrestru gyda WIBSS, aelodau o'u teuluoedd ac aelodau o'u teuluoedd sydd mewn profedigaeth wedi gallu cael asesiad a thriniaeth seicolegol arbenigol yn ymwneud â'r anawsterau emosiynol o gael eu heintio â chynhyrchion gwaed heintiedig a byw gyda diagnosis o hepatitis C a/neu HIV. Mae tua 80 o atgyfeiriadau wedi'u gwneud at y gwasanaeth, ac yn 2022-23 roedd tua 40 o achosion gweithredol.

Mae'r gwaith clinigol yn gymhleth, yn berthynol ac yn rhyngbersonol yn bennaf ei ymagwedd. Gall ddarparu ymyriad therapiwtig tymor byr neu dymor hwy, gyda ffocws cychwynnol ar feithrin cydberthynas ac ymddiriedaeth.

Mae'r gwasanaeth yn cynnig ymyriadau i unigolion, cyplau a theuluoedd, yn seiliedig ar angen clinigol. Gellir darparu'r ymyriadau hyn mewn apwyntiadau wyneb yn wyneb, dros y ffôn neu drwy fideo.

Nid oes uchafswm ar nifer yr apwyntiadau sydd ar gael, a gellir cynnig ymyrraeth fel cyfnodau o ofal. Anogir hunan-atgyfeiriad at y gwasanaeth os oes angen, oherwydd cymhlethdod yr anawsterau seicolegol a'r tebygrwydd y bydd meddyliau a theimladau o'r fath yn cael eu sbarduno ar wahanol adegau pontio bywyd ac o ganlyniad i adroddiadau yn y cyfryngau am yr Ymchwiliad i Waed Heintiedig.

Mae'r adborth y mae'r gwasanaeth wedi'i dderbyn wedi bod yn hynod gadarnhaol. Mae hyblygrwydd y gwasanaeth wedi creu argraff ar bobl ac maent o'r farn bod siarad â therapydd sy'n ymwybodol o gyd-destun arbenigol y gwaith hwn a'r materion penodol y gallent eu hwynebu yn ddefnyddiol ac yn ymataliol.

Ym mis Tachwedd 2022, rhoddodd y Seicolegydd Clinigol Ymgynghorol, Dr Caroline Coffey, dystiolaeth yn yr Ymchwiliad i Waed Heintiedig, fel rhan o banel i drafod yr effaith seicolegol barhaus ar fuddiolwyr a'r angen am wasanaethau arbenigol. Mae hi hefyd wedi bod yn cyfarfod yn rheolaidd â chynrychiolwyr o GIG Lloegr ac asiantaethau partneriaeth eraill i helpu i gynllunio a llywio dyfodol y gwasanaeth seicoleg ar gyfer EIBSS, gan yr ystyrir bod gan WIBSS sawl agwedd ar wasanaeth Safon Aur.

Trawsgrifiad – Llundain – dydd Gwener 11 Tachwedd 2022 (Keith Carter a Chymorth Seicolegol Arbenigol) | Yr Ymchwiliad i Waed Heintiedig.

Mae cynlluniau ar gyfer y gwasanaeth yn y dyfodol yn cynnwys sut i gynnwys defnyddwyr gwasanaethau ymhellach, yn enwedig wrth ystyried yn barhaus sut i ddiwallu 'anghenion cymunedol' y boblogaeth hon. Mae themâu unigrwydd, arwahanrwydd a theimladau o gywilydd wedi ymwreiddio yn cael eu dogfennu'n eang a'u trafod yn glinigol, ond mae sut i geisio mynd i'r afael â'r rhain ar lefel gymunedol neu grŵp yn heriau parhaus y mae WIBSS am eu targedu.

Y pethau y byddwn yn eu gwneud yn 2023-2024

Bydd y cynllun gwaith yn ystod 2023–2024 yn cynnwys y canlynol

- Parhau i ddarparu gwasanaeth WIBSS ymatebol i fuddiolwyr presennol a'r rhai sy'n ceisio gwneud cais.
- Rhoi gwybod i fuddiolwyr am unrhyw benderfyniadau sy'n codi o argymhellion yr Ymchwiliad a allai effeithio arnynt.
- Gwneud cynnydd ar y gwaith a ddechreuwyd gan y tîm Seicoleg a Llesiant ynghylch grwpiau ffocws ac ati.
- Gweithio gyda Llywodraeth Cymru i ymateb yn brydlon i unrhyw benderfyniadau yn y dyfodol sy'n deillio o ail adroddiad interim yr Ymchwiliad a'r adroddiad terfynol disgwyliedig.
- Cynyddu proffil y Gwasanaeth Hawliau Lles i holl aelodau'r cynllun. Sicrhau bod pawb yn gwybod sut y gallant gael mynediad at y gwasanaeth.
- Byddwn yn gweithio ar wella gallu adrodd ein system rheoli achosion fewnol. Bydd hyn yn ein galluogi i drawsnewid data yn wybodaeth y gallwn ei defnyddio i sicrhau bod ein perfformiad yn bodloni anghenion ein buddiolwyr ac yn rhagori arnynt.
- Meithrin perthnasoedd gyda gweithwyr proffesiynol allweddol mewn lleoliadau iechyd sy'n cefnogi pobl yn y gymuned a allai fod yn gymwys ar gyfer Cynllun WIBSS. Mae ymgeiswyr newydd wedi ymuno â'r cynllun yn y flwyddyn gyfredol, gan ddangos y potensial y gallai fod pobl eraill nad ydynt wedi gwneud cais eto. Rydym yn dymuno bod yn dryloyw a sicrhau bod unrhyw un sy'n bodloni'r meini prawf yn ymwybodol o fodolaeth Gwasanaeth WIBSS. Dylai meithrin perthynas â gweithwyr iechyd proffesiynol allweddol, godi proffil ac ymwybyddiaeth o Wasanaeth WIBSS.
- Datblygu Gwefan WIBSS i barhau i sicrhau bod yr wybodaeth ddiweddaraf ar gael.

Cynllun Cymorth Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Diolch am ddarllen ein Hadolygiad Blynyddol. Os hoffech chi wybod mwy, ewch i'n gwefan, ein sianeli cyfryngau cymdeithasol, neu defnyddiwch y manylion cyswllt a nodir isod:

E-bost

wibss@wales.nhs.uk

Ffôn

02920 902280

Mary Swiffen-Walker

07970 601561

Cyfeiriad

Wales Infected Blood Support Scheme,

4th Floor,
Companies House,
Crown Way,
Cardiff
CF14 3UB

Dyluniwyd y ddogfen hon gan Dîm Cyfathrebu PCGC.
nwssp.communications@wales.nhs.uk