Public Trust Board

Thu 30 March 2023, 10:00 - 14:00

Velindre University NHS Trust Headquarters, Nantgarw, Cardiff, CF15 7QZ

Agenda

10:00 - 10:10
10 min

1. STANDARD BUSINESS

1.1. Apologies

Led by Prof Donna Mead OBE, Chair

1.2. In Attendance

Led by Prof Donna Mead OBE, Chair

1.3. Declarations of Interest

Led by Prof Donna Mead OBE, Chair

1.4. Minutes from the Public Trust Board meeting held on 31.01.2023

Led by Prof Donna Mead OBE, Chair

1.4.0 Draft Public Trust Board Minutes 31.01.23 FINAL.pdf (10 pages)

1.5. Action Log

Led by Prof Donna Mead OBE, Chair

1.5.0 ACTION LOG_Final.pdf (2 pages)

1.6. Matters Arising

Led by Prof Donna Mead OBE, Chair

10:10 - 10:20
10 min

2. KEY REPORTS

Led by Prof Donna Mead OBE, Chair

2.1. Chair's Report

Led by Prof Donna Mead OBE, Chair

2.1.0 Chair Update Mar 2023 -Final.pdf (5 pages)

2.2. Chief Executive's Report

Led by Carl James, Deputy Chief Executive

2.2.0 Chief Exec Mar 2023 -Final.pdf (3 pages)

10:20 - 11:25
65 min

3. QUALITY, SAFETY AND PERFORMANCE

3.1. VUNHST Risk Register

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

- 3.1.0a RISK REGISTER - TRUST BOARD - 30.03.2023 - Vfinal.pdf (7 pages)
- 3.1.0b Appendix 1 -RISK REGISTER - TB- ALL RISK DATA -Vfinal.pdf (5 pages)

3.2. Trust Assurance Framework

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

- 3.2.0a TAF Review Paper - MAR 23 - vfinal2.pdf (6 pages)
- 3.2.0b Appendix 1 - V30 - TAF DASHBOARD - 23.03.2023.pdf (39 pages)
- 3.2.0c Appendix 2 -NEW TAF DASHBOARD TEMPLATE - V08 - 09.03.2023.pdf (12 pages)

3.3. Performance Management Framework (January 2023)

Led by Cath O'Brien MBE, Chief Operating Officer

- 3.3.0 TRUST BOARD 30.03.23 JANUARY PMF Performance Report version 005.pdf (59 pages)

3.4. Financial Report (January 2023)

Led by Matthew Bunce, Executive Director of Finance

- 3.4.0a Month 10 Finance Report Cover Paper - Trust Board 30.03.2023.pdf (6 pages)
- 3.4.0b M10 VELINDRE NHS TRUST FINANCIAL POSITION TO JANUARY 2023 - Trust Board 30.03.2023.pdf (21 pages)
- 3.4.0c Appendix 1 - TCS Programme Board Finance Report (January 2023) - Main Report.pdf (18 pages)

3.5. Quality, Safety & Performance Committee Highlight Report 16.03.2023

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

- 3.5.0 Public Quality Safety Performance Committee Highlight Report 16.03.23 (v3approved).pdf (10 pages)

11:25 - 11:45
20 min

4. INTEGRATED GOVERNANCE

4.1. Audit Wales 2022 Structured Assessment and 2022 Audit Annual Report

Led by:

- Katrina Febry, Audit Lead (Performance) Audit Wales
- Steve Wyndham, Audit Lead (Financial) Audit Wales

- 4.1.0a 3296A2022_VUNHST_2022_Structured_Assessment_Report_final.pdf (32 pages)
- 4.1.0b 3369A2023_VUNHST_2022_Annual_Audit_Report_final.pdf (24 pages)

4.2. Audit Wales 2022 Structured Assessment Management Response

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

- 4.2.0a Structured Assessment 2022 - Management Response.pdf (2 pages)
- 4.2.0b 3296A2022 VUNHST 2022 Structured Assessment Organisational Response_Final.pdf (4 pages)

11:45 - 12:00
15 min

BREAK

12:00 - 13:05
65 min

5. PLANNING AND STRATEGIC DEVELOPMENT

5.1. Welsh Blood Service Five Year Strategy 2023/24-2027/28

Led by:

- Cath O'Brien MBE, Chief Operating Officer
- Alan Prosser, Director of Welsh Blood Service

5.1.0a WBS 5 Year Strategy Trust Board Approval Cover Paper Mar23.pdf (5 pages)
5.1.0b Appendix 1 - WBS 5 Year Strategy DRAFT.pdf (18 pages)

5.2. Integrated Medium Term Plan (IMTP) 2023-2026

Led by:

- Carl James, Executive Director of Strategic Transformation, Planning and Digital
- Matthew Bunce, Executive Director of Finance
- Cath O'Brien MBE, Chief Operating Officer
- Phil Hodson, Deputy Director of Planning and Performance

5.2.0a IMTP Cover Paper - 30th March 2023 final.pdf (5 pages)
5.2.0b VUNHST Master IMTP 2023-2026 Final Draft version 024.pdf (122 pages)
5.2.0c IMTP Summary - Trust Board 30th March 2023.pdf (26 pages)

5.3. Integrated Medium Term Plan 2022-2023 Quarter 3 Update

Led by:

- Carl James, Executive Director of Strategic Transformation, Planning and Digital
- Matthew Bunce, Executive Director of Finance
- Cath O'Brien MBE, Chief Operating Officer
- Phil Hodson, Deputy Director of Planning and Performance

5.3.0a Trust Board Cover Paper - Quarter 3 Update against IMTP Actions - Final.pdf (3 pages)
5.3.0b Appendix A - WBS IMTP Quarter 3 Progress 2022_23 - Trust Board 30th March 2023.pdf (6 pages)
5.3.0c Appendix B - VCS IMTP Quarter 3 Progress 2022_23 - Trust Board 30th March 2023.pdf (68 pages)

5.4. Building our Future Together Portfolio Initiation Document

Led by:

- Sarah Morley, Executive Director Workforce and Organisational Development
- Lauren Fear, Director of Corporate Governance and Chief of Staff

5.4.0a PID Cover Paper Board 30-03-23.pdf (4 pages)
5.4.0b PID - Building our Future Together 2023 - 008.pdf (15 pages)

13:05 - 13:15
10 min

6. CONSENT AGENDA

6.1. CONSENT FOR APPROVAL

Led by Prof Donna Mead OBE, Chair

6.1.1. Chair's Urgent Actions Report

Led by Prof Donna Mead OBE, Chair

6.1.1 Chairs Urgent Action Report_March 2023.pdf (6 pages)

6.1.2. National Imaging Academy Wales – Hosting Agreement Extension

Led by:

- Jacinta Abraham, Executive Medical Director
- Cath O'Brien, Chief Operating Officer

6.1.2a NIAW Hosting Agreement Extension Cover Paper_Mar 23.pdf (3 pages)
6.1.2b NIAW hosting agreement March 2023 - Final Draft.pdf (14 pages)

6.2. CONSENT FOR NOTING

Led by Prof Donna Mead OBE, Chair

6.2.1. Trust Wide Policies

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

- 6.2.1a TRUST WIDE POLICIES UPDATE_ Mar 23.pdf (4 pages)
- 6.2.1b Appendix 1 - CFC04 Charitable Funds Investment Policy_v5_Dec 22.pdf (11 pages)
- 6.2.1c Appendix 2 - FP02 Velindre Counter Fraud Policy_v2_Jan 2023.pdf (23 pages)
- 6.2.1d Appendix 3 - RD01 Intellectual Property (IP) Policy_v6_Feb 23.pdf (20 pages)
- 6.2.1e Appendix 4 - IPC13 CJD Policy_v7_Mar 23.pdf (26 pages)
- 6.2.1f Appendix 5 - QS19 - Ionising Radiation Safety Policy-v4.8_Mar 23.pdf (29 pages)

6.2.2. Trust Seal Report

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

- 6.2.2 Trust Seal Report Sept 2022-March 2023 v1.pdf (3 pages)

6.2.3. Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report 26.01.2023

Led by Hilary Jones, Independent Member and Acting Chair of TCS Programme Scrutiny Sub Committee

- 6.2.3 Highlight Report - PUBLIC TCS 26.01.2023 - LF.pdf (2 pages)

6.2.4. Strategic Development Committee Highlight Report 07.02.2023

Led by Hilary Jones, Independent Member and Acting Chair of TCS Programme Scrutiny Sub Committee

- 6.2.4 Highlight Report - PUBLIC SDC 07.02.23.pdf (2 pages)

6.2.5. Audit Committee Highlight Report 12.01.2023

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

- 6.2.5 Audit Committee Part A Public Highlight Report 12 January 2023 - LF Amended v2.pdf (4 pages)

6.2.6. Remuneration Committee Highlight Report 09.02.2023

Led by Donna Mead OBE, Chair and Chair of the Remuneration Committee

- 6.2.6 Remuneration Com Highlight Report_09-02-2023.pdf (2 pages)

6.2.7. Local Partnership Forum Highlight Report 07.03.2023

Led by Sarah Morley, Executive Director Organisational Development and Workforce

- 6.2.7 LPF highlight report - 07-03-2023.pdf (3 pages)

6.2.8. Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing 14.03.2023

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

- 6.2.8 WHSCC Joint Committee Briefing (Public) 14 March 2023.pdf (6 pages)

6.2.9. NHS Wales Shared Services Partnership (NWSSP) Committee Assurance Report 19.01.2023

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

- 6.2.9 SSPC Assurance Report 19 January 2023.pdf (4 pages)

13:15 - 13:15
0 min

7. ANY OTHER BUSINESS

Led by Prof Donna Mead OBE, Chair

(Prior approval required by Chair)

13:15 - 13:15
0 min

8. DATE OF NEXT MEETING

Thursday, 25th May 2023

13:15 - 13:15
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 from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

13:15 - 14:00
45 min

LUNCH: 13:15-14:00

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

PRESENT	
Professor Donna Mead OBE	Chair
Steve Ham	Chief Executive
Stephen Harries	Vice Chair
Vicky Morris	Independent Member
Professor Andrew Westwell	Independent Member
Gareth Jones	Independent Member
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director
Sarah Morley	Executive Director of Organisational Development and Workforce
ATTENDEES	
Lauren Fear	Director of Corporate Governance and Chief of Staff
Carl James	Director of Strategic Transformation, Planning and Digital
Cath O'Brien MBE	Chief Operating Officer
Emma Stephens	Head of Corporate Governance
Kay Barrow	Corporate Governance Manager
Lenisha Wright	Business Support Officer, Secretariat

1.0.0	STANDARD BUSINESS	ACTION LEAD
	The Chair opened the meeting and welcomed everyone in attendance.	
1.1.0	**Apologies noted:** • Hilary Jones, Independent Member • Martin Veale, Independent Member • Nicola Williams, Executive Director of Nursing, AHPs and Health Science	
1.2.0	**In Attendance** Regular Attendees: • Katrina Febry, Audit Wales Lead • Stephen Allen, Chief Officer, Community Health Council (CHC) • Emma Rees, Deputy Head of Internal Audit Additional attendee: • Nigel Downes, Interim Deputy Director of Nursing, Quality and Patient Experience (deputising for Nicola Williams)	
1.3.0	**Declarations of Interest** There were no declarations of interest to **NOTE**.	

1.4.0	**Action Log** Action 7.2.0 from meeting held 27/01/2022 was discussed **(Cardiff Cancer Research Hub, Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust)** Following discussion of the above action it was agreed that steps to establish legally binding Heads of Terms with a timeline will be shared at Trust Board March 2023. Board members confirmed there was sufficient information contained in the log to provide assurance that the actions identified as complete could be **CLOSED** and **NOTED** the updates provided. The Action Log was **APPROVED**.	
1.4.1	**Matters Arising** There were no matters arising which were not included on the action log.	
2.0.0	**CONSENT ITEMS**	
2.1.0	**For Approval**	
2.1.1	**Minutes from the Public Trust Board meeting held on 24.11.2022** The Trust Board **APPROVED** the Minutes of the meeting held on **24.11.2022** as an accurate and true record.	
2.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chairs urgent action taken between the 16/11/2022 – 23/01/2023 as outlined in **Appendix 1** of the report.	
2.1.3	**Commitment of Expenditure Exceeding Chief Executive's Limit** Clarity was given on the following: The Trust submitted bids to Welsh Government for funding from **Value Based Health Care**. The Trust was successful in three of the bids submitted, the scope of one of which was building the infrastructure of the Trust which includes business intelligence, digital staff, project management and back filling staff positions. This was done to ensure resources are in place to ensure the best delivery to patients and donors. In order to progress efficiently with some of this work, bringing in external support into the Trust is the intention. To do so, some of the funding obtained from the bid would need to be utilised and possibly existing Trust budget. It was clarified that there is adequate funding from Welsh Government, to establish initial contracts however if there were extensions to these contracts, discussions and decisions will be undertaken through Executive Management Board. Correction: • It was noted that Paper 2.1.3d Appendix 4 page 8 is to be reviewed to clarify the boxes that need to be selected.	

	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.	
2.1.4	**Amendment to Standing Orders – Schedule 3** The Trust Board **APPROVED** the amendments to the Trust Board Standing Orders – **Schedule 3** as outlined in section **3** of this report and included in ***Appendix 1 & 2.***	
2.1.5	**Trust Wide Policies** The Trust Board **APPROVED** the following Quality and Safety Policy endorsed for approval by the Executive Management Board and Quality, Safety and Performance Committee: • Management of Safety Alerts and Important Notification Policy (Reference QS02).	
2.2.0	**For Noting**	
2.2.1	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report dated 17.11.2022** The Trust Board **NOTED** the contents of the report dated 17.11.2022 and actions being taken.	
2.2.2	**Strategic Development Committee Highlight Report dated 08.12.2022** The Trust Board **NOTED** the contents of the report dated 08.12.2022 and the actions being taken.	
2.2.3	**Quality, Safety & Performance Committee Highlight Report dated 17.01.2023** The Trust Board **NOTED** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 17th January 2023.	
2.2.4	**Audit Committee Highlight Report dated 12.01.2023** It was noted the Audit Committee Highlight Report dated 12.01.2023 will be circulated to the Trust Board outside the meeting.	
2.2.5	**Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing (10.01.2023 and 17.01.2023)** The Trust Board **NOTED** the contents of the WHSSC Joint Committee Public Briefings.	
2.2.6	**Emergency Ambulance Services Joint Committee (EASC) Briefing (08.11.2022 and 05.12.2022)** The Trust Board **NOTED** the contents of the EASC Briefings.	
3.0.0	**KEY REPORT**	
3.1.0	**Chair's Update** The Trust Board **NOTED** the contents of the update report.	
3.2.0	**Chief Executive's Update**	

	It was noted that in regard to Industrial Actions, a good relationship exists between the Trust and Royal College of Nursing (RCN) members, supporting discussion around derogations. The Trust Board **NOTED** the content of the update Report. **ACTION**: A short briefing (2-3 paragraphs) on the Industrial Action will be prepared and shared with the Board on planning pre-strike days and outcomes following strike action.	**SM**
4.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
4.1.0	**Delivering Excellence Performance Report** Cath O'Brien MBE highlighted the following key points for the Velindre Cancer Service (VCS) and the Welsh Blood Service (WBS) November 2022 Performance Report: **Velindre Cancer Services** • There is a changeover from CANISC with the implementation of the new digital health care record system (DHCR). Data sets will undergo a validation process in the coming weeks as part of the implementation. • It was noted that the new linear accelerator (LINAC) is key to improving Radiotherapy waiting times. • Work is currently underway to improve patient pathways. • Work is being undertaken with the Welsh Ambulance Services NHS Trust (WAST) to extend capacity to include arrangements to transport patients back on the same day or in a shorter space of time. It was confirmed that this excludes emergency cases. • Systemic anti-cancer therapy (SACT) performance has been maintained in the midst of increasing workload. • Continuous work is being undertaken with Health Boards to accommodate increase in demand and to better manage planning. • There were four patient falls at first floor ward during November 2022. Assurance was given to the Board that no harm had come to patients and that two of the four falls were deemed avoidable. Relevant processes and actions have been carried out and learnings extracted. The following was noted: • The sepsis 100% compliance is reassuring to the Board. • The tables provide targets but actual performance against targets is not included. It was confirmed that both will be reported together in the new performance management framework format from the next reporting cycle. • The two new LINAC machines in respect of the Medium-Term Plan will be included in the March 2023 Trust Board report. Discussion: • Data that is not available for November, December and January will be circulated via email as a report by exception to the Board. An email will be sent out in the coming week to advise the Board about how information will be circulated prior to the March 2023 Board meeting.	

	• Pathways are currently under review to improve performance for palliative radiotherapy. There are a very small number of patients for palliative radiotherapy, therefore if one patient did not attend treatment, it results in a large difference on a graph or in the percentage difference. • Assurance was given that patient flows are monitored through a range of workarounds. Any breach identified is reported via the Senior Leadership Team (SLT) to respective staff to ensure efficient response to addressing issues such as waiting times. Any breach in waiting times is also reported to the consultant with immediate activity undertaken. ****ACTION**: An email to be circulated to Board Members in the coming week to advise on the timescales in terms of how performance data for November 2022, December 2022 and January 2023, will be circulated to the Board prior to the March 2023 Board meeting. **Welsh Blood Service** • The Welsh Blood Services (WBS) maintained performance targets in November 2022, in the midst of challenges experienced in the Blood Services not just in Wales but throughout the United Kingdom. • There has been improvement in the recruitment of bone marrow volunteers and stem cell collections. A wider campaign is underway to ensure continuous improvements in recruiting bone marrow volunteers. • A new forecasting method is in the process of being implemented to improve wastage rates. To note: The Board applauded the excellent performance of the Welsh Blood Service in terms of rigour and overall performance during challenging circumstances, which has been noted across the United Kingdom. **Workforce and Organisational Development (WOD)** Sarah Morley highlighted the following key points: • Sickness absence is 6.1% based on the latest figures. Matters are being managed on a case by case basis. • There has been significant improvement at all levels for statutory and mandatory training. • The recent assessment on Wellbeing assigned a Gold Standard rating to the Trust. The assessor recognised that wellbeing is embedded throughout the Trust. • The following was included in the Corporate Health Assessment Report: *What was very clear from this assessment was that the ethos and culture of staff health and wellbeing is embedded in everything they do throughout the Trust. They are an exemplar employer and a sense of pride and passion shone through during the assessment.* Discussion: • A discussion has been held with Welsh Government on the review of targets for WOD. Welsh Government have recognised the	**COB**

	challenge in this regard. The Board will be notified of any further updates. The Trust Board **NOTED** the contents of the Performance Reports.	
4.2.0	**Financial Report (November 2022)** In presenting the report, Matthew Bunce highlighted the following: • The November 2022 report reflects the Trust is still forecasting to remain within revenue targets. • In terms of Capital, both discretionary and the All Wales Welsh Government funded schemes are on target. • Processes are changing for example COVID funding and the involvement of Commissioners. There is in place a Nationally agreed funding mechanism with agreed protection for the year for COVID. • There are discussions taking place around how some of the data pertaining to the TCS financial position can be better presented going forward. Discussions and clarifications: • With energy prices fluctuating, it is expected that Welsh Government will encounter a challenging year. • There is a range of other pricing instabilities in the market in addition to energy. • Uncertainties and unpredictability in the market are affecting all NHS Wales organisations. • It is hoped that the Trust will achieve the level of activity forecasted for the year, however there is still some level of risk in this regard. • A challenging year is expected with cost and service pressures. As an organisation, management of risk is crucial. • It is important to understand our data. Operational groups looking at predicting future clinical demand however, this is internal intelligence only. • The financial plan forms part of the Integrated Medium-Term Plan (IMTP) expected to be submitted end March 2023, however the governance processes need to be carried out prior to submission. A draft financial plan has been received at Executive Management Board. The Trust Board **NOTED**: • the contents of the November 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs. • the TCS Programme financial report for November 2022 attached as Appendix 1.	
4.3.0	**VUNHST Risk Register and Risk Appetite for Approval** In presenting the risk register, Lauren Fear highlighted the following: • Risk appetite was discussed and endorsed at Audit Committee. There was good discussion around the change to the Risk Appetite level defined as cautious. Risks defined as cautious will be reported	

	to Committee and Board at **level 15** rather than **level 12** going forward. This supports proactive reporting and provides assurance that these risks are appropriately managed. • There was some discussion at Audit Committee and Quality, Safety & Performance Committee around one of the risks about email use for clinical matters. The review of this risk is currently underway. • There was good discussion at both Audit Committee and Quality, Safety & Performance Committee on the template and the way in which information is presented. In particular, a key element to be made clearer is in terms of actions and impact of those actions on the risk score. With the support of Audit Committee members, the template will be reviewed and amended. Discussions and comments regarding risk appetite: • The Trust has been reporting level 12 risks which other Health Boards do not include in their risk reporting. The proposal to report levels 15 and 16 brings the Trust in line with other Health Boards. • It was clarified that risk appetite is reviewed every two years for the Trust. • Information shared with the Board reflects the current status risks. Going forward, input on how risks have been actively managed to achieve the current status will be provided, giving further assurance. Discussions and comments regarding the risk register. • Risk ID 2187: Radiotherapy Physics Staffing - There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing (page 11). This risk has been open for 844 days. It was noted that extensive work has been done to address matters and support recruitment to positions for example, rotation work. Assurance was given that the risk has been actively managed throughout this time, with short and long-term plans in place. The risk relates to challenges encountered Nationally to recruit staff into key positions. • The risk involving email volume was discussed at Quality, Safety & Performance Committee. The information presented was not clearly articulated to give assurance. This will be amended to reflect the controls in place in managing the risk. The Trust Board: • **APPROVED** the revised Risk Appetite level, following initial discussions at the Board Development session on 8th November 2022 and endorsement at Audit Committee, in January. • **NOTED** the risks level 16 and 15 reported in the Trust Risk Register and highlighted in this paper. • **NOTED** the on-going developments of the Trust's risk framework.	
4.4.0	**Trust Assurance Framework** Discussions have been held at Quality, Safety & Performance Committee and Audit Committee on process, framework and further improvements to the Trust Assurance Framework. Lauren Fear highlighted some of the key points following these discussions, summarised on page 2 of the report:	

	• The importance of ensuring 2nd and 3rd lines of defence are correctly captured. Where gaps exist, these must be explicitly referenced in the actions going forward. • Where gaps exist in assurance ratings or controls, a corresponding action must be included. • It must be ensured that where actions have been undertaken, this must be reflected in the assurance mechanisms. • The Trust Assurance Framework template is currently under review. Once the review is finalised, a draft template will be circulated to Audit Committee members following submission to Executive Management Board. • A number of risk scores have remained static. Risk owners are challenged to review risk scores and ensure these are appropriately assessed in light of the changes to the Trust Assurance Framework. • There will be a number of changes reflected in the next cycle of reporting. Discussions and contributions: • The resilience of the Governance team in terms of developing the Trust Assurance Framework was applauded. • The importance of Executive ownership was emphasised. • Consistency will be applied in ensuring the use of job titles rather than the names. The Trust Board: • **DISCUSSED AND REVIEWED** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 2. • **DISCUSSED AND REVIEWED** the update to the Trust Assurance Framework Dashboard, included at **Appendix 1.**	
5.0.0	**LEGAL MATTERS**	
5.1.0	**Infected Blood Inquiry** Cath O'Brien MBE highlighted the following: • Final oral submissions were received by the inquiry. The Trust submitted a written response following advice from Trust legal representatives. • The written statement prepared by Legal Counsel was submitted to the inquiry. The statement submitted, confirmed that the Welsh Blood Service would consider whatever recommendations the inquiry makes, with a view to building on improvements going forward. Discussion and contributions: • Feedback is awaited from the inquiry as to whether the written response submitted has been accepted. The Trust Board members **NOTED** the update.	
7.0.0	**ANNUAL REPORTS**	
7.1.0	**Annual Equality, Diversity & Inclusion Report 2021-22**	

	Sarah Morley highlighted the following: • The report is for the year ending 31st March 2022 which needs to be published by 31st March 2023. Following publication, the report for the year ending 31st March 2023, will be produced and taken through the reporting cycle in July 2023. • This report has been endorsed by the Quality, Safety & Performance Committee. • The data contained in the report is required under statute. Clarification: • Appendix 1 includes Shared Services and is based on statutory requirements. Appendix 2 excludes Shared Services. This will be made clearer with future reporting. The Trust Board **APPROVED** the report.	
7.2.0	**Gender Pay Gap Report 2022** Sarah Morley highlighted the following: • This report has been endorsed by the Quality, Safety & Performance Committee. • The gender pay gap for the year ending March 2022 is 4% which includes Shared Services. Further analysis reflects a 14% mean gender pay gap. • Actions have been identified to address the gender pay gap and is recorded on page 5 of the report. • It was found that there are less women than men in senior roles which magnifies the gap in pay. Included in the actions is an assessment of process such as recruitment to identify any potential blockages. Comments, questions and queries: • The bonus payment scheme has been revised as the new clinical excellence awards scheme and has been revised to remove any discrimination. • The number of staff included in the clinical excellence awards scheme is small which could skew the numbers. It was noted that there may be factors such as this that could skew the distribution of data for other aspects which will be looked into. • It was noted that the data incorporated for Shared Services includes approximately 1400 medical trainee staff. • Detailed data within each of the staffing groups is important to understand the overall picture and also for identifying any potential issues. The Trust Board **APPROVED** the report.	
7.3.0	**Gender Equality Executive Champion Presentation** Cath O'Brien MBE highlighted the following: • Cath O'Brien MBE is appointed the Executive Ambassador for Sex (Gender). As part of the presentation, Cath shared her personal experience with regard to prejudice.	

	• The importance of the Board's responsibilities with regard to equality pertaining to sex was noted. • The definition of Gender as defined by the World Health Organisation, refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy. • In ensuring equality, it is important to look at the cultural and biological construct. • The Equality Act 2010 legally protects people from discrimination in the workplace. • It is the responsibility of the Trust to consider all individuals in carrying out day to day services. • The elements of social and biological constructs for patients and donors needs further introspection to ensure provision of the best service pathways, planning and models. Way forward: • It was noted that the finalised Gay, Lesbian, Bisexual, Transgender, plus (LGBT+) action plan from Welsh Government is awaited. Following receipt of the final plan from Government, training will be rolled out in the organisation starting with the Board at Board Development. The Trust Board **NOTED** the presentation.	
7.4.0	**Annual Sustainability Report 2021-22 (including Decarbonisation)** Carl James highlighted the following: • The report provides a summary of the Sustainability works from April 2021 – March 2022 within the Sustainability Team. • The report has been presented to Quality, Safety & Performance Committee. There were questions around the figures for electric and gas. It was confirmed to the Board that the figures are accurate. **Note**: It was noted that this is a well-presented report in terms of visuals utilising pictures and infographics. This could be shared with other departments will soon be submitting annual reports, to follow the same layout and presentation of information. The Trust Board **APPROVED** the Internal Annual Sustainability Report 2021-2022.	
8.0.0	**ANY OTHER BUSINESS** There were no other items.	
9.0.0	**DATE and TIME OF THE NEXT MEETING** Thursday, 30th March 2023.	
10.0.0	**CLOSE**	

VELINDRE UNIVERSITY NHS TRUST

PUBLIC TRUST BOARD MEETING 31 JANUARY 2023
ACTION LOG

ACTIONS ARISING FROM 27/01/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
7.2.0	**Cardiff Cancer Research Hub, Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust** The next phase of development to include agreement to key principles that will go on to establish a formal Heads of Terms for the model going forwards.	Executive Medical Director	**January 2023**	The Heads of Terms (HoT) document has been completed and presented to Executive Management Board on 6th February 2023 and the RD&I sub committee on 28th February 2023. Legal review of the HoT is planned. HoT are not legally binding but are a precursor to an appropriate future legally binding agreement.	**CLOSED**
ACTIONS ARISING FROM 24/11/2022					
7.1.0	The risk in relation to Brachytherapy is currently green however, due to new issues a review and update of the risk is to be done.	Chief Operating Officer	**31/01/2023**	A review of this risk has been completed and is incorporated in the updated risk register as part of the March governance cycle.	**CLOSED**

ACTIONS ARISING FROM 31/01/ 2023					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
3.2.0	A short briefing (2-3 paragraphs) on the Industrial Action will be prepared and shared with the Board on planning pre-strike days and outcomes following strike action.	Executive Director of OD and Workforce	**March 2023**	No briefing has been received since the January 2023 Board meeting. A briefing will be presented to the Board for any future Industrial Actions.	**CLOSED**
4.1.0	An email to be circulated to Board Members in the coming week to advise on the timescales in terms of how performance data for November 2022, December 2022 and January 2023, will be circulated to the Board prior to the March 2023 Board meeting.	Chief Operating Officer	**March 2023**	Email issued to Board Members 24/03/2023	**CLOSED**

TRUST BOARD

CHAIR REPORT

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

- Board Development Sessions
- Board Champion for Research
- Chairs Away Day with the Minister
- Engagement with Health Technology Wales Chair
- International Women's Day
- Fundraiser recognised with a High Sheriff Award
- Wear Red for Velindre Fundraising Event

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1. Board Development Sessions

16th February 2023

An excellent Board Development Session was held on 16th February 2022. The topics discussed were:

- Compassionate and collective leadership in health and social care, led by Michael West CBE
- Introduction to Intellectual Property, led by Nia Roberts, an intellectual property and innovation expert
- Realising the value of FAKTION Intellectual Property, led by Professor Robert Jones, Associate Medical Director for Research, Development and Innovation and Sarah Townsend Head of Research and Development
- Progress on the development of the 2023-2026 Integrated Medium Term Plan

8th March 2023

The Trust Board met to discuss reflections on the Audit Wales Report of Betsi Cadwaladr University Health Board. The Chairs of NHS Wales had agreed that all NHS Wales organisations would contribute their views on a series of themes which has been highlighted in Audit Wales' review.

The Trust Board discussed these themes and the summary was submitted to the Chair of the all Wales Chair peer group. Along with the other submissions, these were collated into a summary to inform the away day discussion with the Minister for Health and Social Care on 16th March.

It was a valuable discussion and will support informing the upcoming Board Development schedule.

2.2 Board Champion for Research

On 20th March Health and Care Research Wales announecd that all NHS Organisations in Wales have appointed one of their non-executive directors to be the voice of research and development on thier Boards. I am delighted to confirm that Professor Andrew Westwall has agreed to take on this role and he is profiled on the Health and Care Reaserch Wales launch material as the Velindre University NHS Trust Board Champion.

As further context, in March 2021, all four nations of the UK signed up to a new 10 year vision for research - Saving and Improving Lives: The Future of UK Clinical Research Delivery - which lays out the ambition to create a world-leading UK clinical research environment.

As part of Wales's commitment to embed research across the NHS, Chief Medical Officer Dr Frank Atherton asked all NHS organisations to nominate an Independent member on the Board to champion research as part of their wider portfolio of responsibilities. Wales is the first UK nation to introduce such as initiative.

The Independent members will work closely with the Executive Director responsible for research, as well as the directors of Research and Development in each organisation, to ensure that research is on the radar at Board level and that the profile of research is increased amongst staff and patients across all health boards and NHS organisations.

2.3 Chairs Away Day with the Minister

The Chairs of NHS Wales organisations attended an away day with the Minister for Health and Social Care on 16th March. It was a full agenda and valuable time spent with colleagues across the system.

Part of the discussions included reflections on the Audit Wales Report on Betsi Cadwaladr University Health Board.

2.4 Engagement with Health Technology Wales Chair

The Chair would like to update the Board on a recent meeting with Peter Groves, Chair of Health Technology Wales. In addition, the Chair invited Peter to attend the all Wales Chairs meeting to introduce some changes to Health Technology Wales working. The Trust Board will be receiving a regular update from Health Technology Wales in the July meeting, which will include the latest Annual report.

2.5 International Women's Day

The Chair is pleased to share the activities which the Trust led on International Women's Day on 8th March. It is a global day celebrating the social, economic,

cultural and political achievements of women. It also aims to highlight that everyone should challenge gender stereotypes, call out discrimination, draw attention to bias, and seek out inclusion. This year's theme was #EmbraceEquity. Staff from across the Trust recorded a video to share what International Women's Day 2023 means to the organisation https://www.youtube.com/watch?v=3LT0xqcRalc&embeds_euri=https%3A%2F%2Fnhswales365.sharepoint.com%2F&feature=emb_imp_woyt.

Later that week, the Chair attended an International Women's Day event at the Angel Hotel to speak about inspirational women in Velindre. It was also a fundraising event for the Charity.

2.6 Fundraiser recognised with a High Sheriff Award

The Chair is delighted to report that our long-standing Ambassador, supporter and fundraiser Tracey Davies was awarded a High Sheriff Award on 27th March for services to the community and services to Velindre. Maria Thomas, High Sheriff of Old Mid Glamorgan presented the award to Tracey for her contribution to charitable causes, and over £300,000 raised for Velindre over the last 8 years.

2.7 Wear Red for Velindre Fundraising Event

One of the Charity's annual flagship campaigns "Wear Red for Velindre" took place on 8th February. On behalf of the Board, the Chair would like to again thank the

many supporters, including hundreds of schools, clubs and businesses, who wore red and hosted red-themed fundraising events.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Carl James, Acting Chief Executive Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Acting 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:

- Destination 2033
- UK Covid-19 Public Inquiry
- Welsh Blood Service Medical Director

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Destination 2033

As discussed in March's Strategic Development Committee, the Chief Executive would like to note the upcoming launch of the Trust's 10 year Strategy and supporting Enabling Strategies. Given the launch was postponed from end of 2022 due to industrial action, the title will be amended to Destination 2033. The launch will be aligned to the Integrated Medium Term Plan outlining how the coming three years will build towards our collective long term vision and importantly set in the context of the reality of the here and now. The Building our Future Together approach, covered later in this agenda, explains how this will all be underpinned by a "Working Together to Build our Future" culture and staff engagement approach.

2.2 UK Covid-19 Public Inquiry

As the Board is aware, the Inquiry was established in the summer of 2022 to examine the UK's response to, and the impact of, the Covid-19 pandemic, and to learn lessons for the future. Module 3 of the Inquiry will examine the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland. The Trust Board agreed in it's November meeting to apply for Core Participant status of Module 3, as part of a group of NHS Wales organisations.

The Trust received a letter from the Chair of the Inquiry to say that the Inquiry has confirmed the Trust is a Core Participant as part of the group of NHS Wales organisations.

The preliminary hearing for Module 3 was held on 28th February and the high level timetable was announced, with Rule 9 information requests expected over summer 2023, with public hearings from spring 2024.

2.3 Welsh Blood Service Medical Director

The Chief Executive would like to again thank Dr Janet Birchall who retired in March after five years as Medical Director in the Welsh Blood Service. Since joining the Welsh Blood Service, Janet has been a key member of the Senior Management

Team and has played an integral role supporting the Service through its most difficult period following the Covid-19 outbreak.

A leader in her field, Janet has over 30 years of experience, including a position as Chair at the British Society for Haematology Guideline Writing Groups, helping to define best practice across the UK. Her expertise was recognised further when she received the Mollison Award at the British Blood Transfusion Society Annual Conference in September 2019 for making "a significant contribution to the practice of clinical transfusion medicine."
The Chief Executive would like to welcome Dr Edwin Massey to his new role as the Medical Director. Edwin has over 20 years of experience in blood transfusion, including previous roles working for NHS Blood and Transplant and the University Hospitals Bristol and Weston.

Before joining the Welsh Blood Service in 2021 as a Consultant Haematologist, Edwin was Responsible Officer and Associate Medical Director for Diagnostic and Therapeutic Services for NHSBT.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

TRUST BOARD

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NA – Public Meeting

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Circulated out of Committee to EMB Members	07.03.2023	**Noted**
Quality, Safety and Performance Committee	16.03.2023	**Discussed & Noted**

ACRONYMS			
VCC	Velindre Cancer Centre	SMT	Senior Management Team
WBS	Welsh Blood Service	ELT	Extended Leadership Team
SLT	Senior Leadership Team		

1. SITUATION / BACKGROUND

The purpose of this paper is to provide the Trust Board with an update on:

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF) included at ***Appendix 1,*** which may affect the achievement of the Trust's Strategic Objectives, and the level of assurances in place to evidence the effectiveness of the management of those risks.

- The ongoing work to support the continued development, articulation and embedding of the Trust Assurance Framework across the organisation. As outlined in 2.1.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Development work during Jan-March reporting period:

- During sessions with both WBS SMT and VCC SLT the Strategic risk are being reviewed and refreshed; the outcome of which will be shared through the May 2023 governance cycle.

- The Trust Assurance Framework template has been reviewed, updated and discussed with Independent Members who sit on the Audit Committee who reviewed the template, which will roll out in April 2023. Please refer to ***Appendix 2***

- Sitting alongside the refreshed Trust Assurance Framework and Dashboard a 'How to guide' will be developed to assist in the completion and update of the Trust Assurance review cycle and Dashboard.

- The Performance Framework and Quality Framework are considered in the new TAF Dashboard template for further review.

- Revised reporting mechanism is being worked on to enable the integration of Trust Assurance Framework into Datix.

- It was agreed through the Quality, Safety and Performance Committee that there would be a deep dive on a rolling basis of the strategic Trust Assurance Risks.

2.2 Trust Assurance Framework Dashboard

- Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since January 2023.

	NO REVIEW TAKEN PLACE
	REVIEWED – NO CHANGES
	REVIEWED AND UPDATED

		MAY 22	JUN 22	JUL 22	SEPT 22	NOV 22	JAN 23	MAR 23
01	COB							
02	CJ							
03	SFM							
04	SFM							
05	CJ							
06	NW							
07	CJ							
08	MB							
09	CJ							
10	LF							

Actions on specific strategic risks

TAF 01: Demand and Capacity

Residual Risk Score – 12. This remains unchanged since the previous review and there is no specific evident trend emerging in the data.
Overall Level of Control Effectiveness – This remains as Partially Met (PE)
Sources of Assurance – There have been no changes to the sources of assurance.
Action Plan for Gaps Identified – The action plan has been updated is largely progressing on target.

A meeting was held between the two division to bring this risk to its target level and it was identified that there is no further action can be taken by WBS at present. In future the implementation of the LINC Programme will enable more granular information on blood utilisation and this risk will be further identified on the implementation of LINC in 2025.

Further actions are currently being identified in Velindre Cancer Service as part of the capacity and demand review process and these actions will be completed though the next business cycle,

TAF 02: Partnership Working and Stakeholder Engagement

Residual Risk Score – 8.This remains unchanged since the previous review. The residual risk has decreased from 12 to 8 since September 2022.
Overall Level of Control Effectiveness - This remains as Partially Met (PE)
Sources of Assurance – There have been additions to the sources of assurance and the assurance rating has been updated to Positive Assurance (PA) for some lines of controls
Action Plan for Gaps Identified – An additional action has been included since the last review.

TAF 03: Workforce Planning

Residual Risk Score – 12. The residual risk increased from 9 to 12 in the September 2022 governance reporting cycle and has remained at this level since that time.
Overall Level of Control Effectiveness – This remains as Partially Met (PE)
Sources of Assurance – The sources of assurance have been strengthened to include 2nd and 3rd lines of defence for all key controls.
Action Plan for Gaps Identified – The action plan has been updated to provide a further level of detail and assurance on the planned timetable for delivery of the associated programme of work to mitigate this risk.

TAF 04: Organisational Design

Residual Risk Score – 9. This remains unchanged since the previous review with no trend emerging since March 2022.
Overall Level of Control Effectiveness - This remains as Partially Met (PE)
Sources of Assurance – There have been no changes or additions to the sources of assurance since the previous review
Action Plan for Gaps Identified – The action plan has been updated with progress reports. The due dates on the action plan have been reviewed.

TAF 05: Organisational Culture

Residual Risk Score – 12. This remains unchanged since the previous review with no trend emerging since March 2022.
Overall Level of Control Effectiveness – A thorough review of the levels of control effectiveness has been carried out resulting in an overall Control Effectiveness rate of Partially Met (PE), although there has been some change to effectiveness rating for some controls.
Sources of Assurance – There have changes to some assurance ratings since the previous review
Action Plan for Gaps Identified – The action plan has been reviewed and updated.

TAF 06: Quality and Safety

Residual Risk Score – 15. This remains unchanged since the previous review with no trend emerging since March 2022.
Overall Level of Control Effectiveness – This remains as Partially Effective (PE), unchanged since the last review.
Sources of Assurance – Gaps in assurance remain unchanged since the last review.
Action Plan for Gaps Identified – The action plan remains unchanged since the last review.

TAF 07: Digital Transformation

Residual Risk Score – 12. This remains unchanged since the previous review with no trend emerging since March 2022.
Overall Level of Control Effectiveness – This remains as Partially Effective (PE) despite a shift in some key control ratings individually.
Sources of Assurance – There have been additional lines of defence added and levels of assurance updated.
Action Plan for Gaps Identified – The action plan has been reviewed and progress noted.

TAF 08: Trust Financial Investment

Residual Risk Score – 12. The residual risk decreased from 16 to 12 in the July 2022 governance reporting cycle and has remained at this level since that time.
Overall Level of Control Effectiveness - This remains as Partially Met (PE)
Sources of Assurance – There have been no changes to the sources of assurance.
Action Plan for Gaps Identified – There have been no changes to the gaps in assurance.

TAF 09: Future Direction of Travel

Residual Risk Score –12. The residual risk remains unchanged since the last review.
Overall Level of Control Effectiveness - This remains as Partially Met (PE), however some individual control effectiveness levels have been updated.
Sources of Assurance – Sources of assurance levels have been updated since the previous review.
Action Plan for Gaps Identified – The action plan has been developed since the last update reported to committees.

TAF10: Governance

Residual Risk Score – 12. This remains unchanged since the previous review with no trend emerging since March 2022. However, this is anticipated to decrease in line with the development and implementation of the Governance, Assurance and Risk Programme of work across the Trust.
Overall Level of Control Effectiveness – This remains as 'Effective' (E).
Sources of Assurance – No amendments have been made nor additions since the last review.
Action Plan for Gaps Identified – A formal programme of work for Governance, Assurance and Risk continues and reports into the wider Organisational Development programme for the Trust, this encompasses 20 key projects underpinning the further development and operationalisation of the Trust Assurance Framework.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Trust Board is asked to:

4.1 **DISCUSS AND REVIEW** the progress made and next steps in supporting the continued development and embedding the Trust Assurance Framework, as outlined in section 2.1.

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

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce
05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,

08	**Trust Financial Investment Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance
09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence functions that own and manage risk	Second Line of Defence functions that oversee or specialise in risk management	Third Line of Defence functions that provide independent assurance
Self-Assurance	**Internal oversight/**specialist control teams, such as**:**	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as:
Risk and control management as part of day-to-day business management Staff training and compliance with policy guidance Teams take responsibility for their own risk identification and mitigation	Quality & Safety IT Governance (corporate/Clinical)	External Audit Regulators & Commissioners Wales Audit Office reviews Stakeholder reviews Scrutiny from public, Parliament, and the media
Examples of assurance	***Examples of assurance***	***Examples of assurance***
Management Controls / Internal Control Measures *Local management information / departmental management reporting* *Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)* *Operational planning / Business Plans - Delivery Plans and Action Plans* *Governance statements / self-certification* *Local procedures* *Exceptions reporting* *Targets, Standards and KPIs* *Incident Reporting* *Staff Training Programmes*	*Board, Committee and Management Structures which receive evidence from* *Finance reports* *KPI's and management information* *Quality, Safety and Risk reports* *Training records and statistics* *Performance reports* *BAF, VUNHS risk register* *Policies and Procedures including Risk Management Policy* *Compliance against Policies*	*Recent internal audit reviews and levels of assurance* *External Audit coverage* *Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews* *Patient Feedback / Patient experience feedback* *Staff surveys / feedback* *Comparative data, statistics, benchmarking*

KEY CONTROLS

KEY CONTROLS		
CONTROL TYPE	**DESCRIPTION**	**EXAMPLES**
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

STRATEGIC GOALS
1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
3 - A beacon for research, development and innovation in our stated areas of priority
4 - An established 'University' Trust which provides highly valued knowledge and learning for all
5 - A sustainable organisation that plays it part in creating a better future for people across the globe

RISK DESCRIPTORS	
Inherent Risk	Score the exposure before any action has been taken to manage it or if existing controls failed entirely
Residual risk	The threat that remains after all existing controls have been applied
Target risk	Where risks are outside acceptable levels, a target risk score is agreed. This is the level that future mitigation that should be achieved which will vary over time

DEFINITIONS

CONTROL EFFECTIVENESS

Effective	Control in implemented/ embedded; working as designed; with associated sources of assurance	E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

ASSURANCE RATING

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA

Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA
Not Assessed	Assessment of the assurance arrangements is pending.	Not Assessed

RISK SCORE

IMPACT MATRIX

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/enquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complain (stage 2) complaint Local resolution (with potential to go to independent Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/competence	Short term low staffing level that temporally reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage loss of contract/payment made by results claim(s) >£1million
Service/ business interruption environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

LIKELIHOOD MATRIX

LIKELIHOOD (*)					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD

RISK MATRIX	**LIKELIHOOD(*)**				
CONSEQUENCE(**)	**1- Rare**	**2- Unlikely**	**3 - Possible**	**4 - Probable**	**5 - Expected**
1 -Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

RISK ID:	TAF 01	We fail to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges
LAST REVIEW	Mar-23	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Apr-23	RISK DOMAIN Performance and Sustainability
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS

SOURCES OF ASSURANCE

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

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	Vein - 2 - Vein programme (patient pathway) submitted for funding to Welsh Government in August 2022. Programme led by C&VUHB on behalf of all Health boards in Wales and is supported in an oversight capacity by the Blood Health National Oversight Group. Intial funding bid declined with caveats. These are currently being progressed with re-submission date of February 2023.	Jul-25
Blood Health National Oversight Group project is underway identifying inappropriate use of blood.	Lee Wong	Self assessment Gap analysis for Patient Blood Management Conservation strategies completed in August 2022 and submitted to Blood Health National Oversight Group in Sept 2022. This has been further supported by key PBM audits undertaken from October - November 2022. These have been tabled for BHNOG meeting in January 2023. Ongoing funding via the Value Based Healthcare (VBHC)programme for pre-operative anaemia work is progressing and will link in with both the PBM conservation strategies and the audits.	Dec-24
Engaging with Health Boards to seek further information on recovery and wider operational plans; such as waiting time initiatives and to formalise a route for planning and managing demand variation, including clinical choices.	Lisa Miller	Contact has been made with HBs and work has been done on data sets and will continue to be reviewed in regular VCS/HB meetings	Complete
A formal demand and capcity review meeting has been established at VCC	Lisa Miller	The group has been established and is currently meeting weekly to address the impact on capacity due failure of third party provision. Currently expericencing above usual demand for SACT	Complete
There is a weekly meeting between the Executive Team and Senior Leadership Team established to provide an opportunity for collaboration and oversight for addressing the immediate challenge at VCC	Steve Ham	This meeting is a short term focused meeting pending revised capacity plans	Complete

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
LAST REVIEW	Mar-23	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Apr-23	RISK DOMAIN: Partnership
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	4	12	2	4	8	2	3	6

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

GAP IN CONTROLS							GAPS IN ASSURANCE					
ID	Key Control	Owner	Prevent	Mitigat	Detecti	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight; new performance management framework implemented March 2023	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA

2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in place with LB partners; regional/national arrangements in place for blood and cancer services; will be enhanced by creation of Executive Function in Welsh Government in April 2023	PA	Strategic Development Committee/ Quality Safety and Performance Committeee; introduction of Executive Function in WG will support effective system comnmissioning ; Executive Function in WG from Aoril 2023 will enhance arrangments	PA	Regulatory scope re MHRA tbc; clear stanadards for services understood and suppported by commissioning arrangements across NHS Wales	PA
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office	PA
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;		X			E	Agreed to model for each organisation	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
GAP IN CONTROLS									**GAPS IN ASSURANCE**			

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Linked to developments in ways of working for the Trust, the actions to enhance the effectiveness of the controls will be specifically developed and reported on.	Complete
1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James		Complete
1.3	Development of CCLG leadership and goverancne arrangements: towards Alliance System: agree next steps with CEOs	Carl James		Complete
1.4	Development of Phase 2 of PMF with additionalperfromance measures/quality metrics	Carl James	Design stage commenced	Mar-24

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Mar-23	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Apr-23	RISK DOMAIN Workforce and Organisational Development
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	4	3	12	2	3	6

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

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/ reg tracker update	PA
C3	Workforce Planning – Skills Development	Susan Thomas	X			PE	Provide operational managers with skills and capabilities to undertake effective workforce planning. Provide formal training and produce a suit of workforce planning tools.	PA	Joint Finance and Workforce Report to QSP		Wales Audit Workforce Planning National Review	

TAF DASHBOARD

WORKFORCE PLANNING

C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation Sheets	PA	Joint Finance and Workforce Report to QSP		Wales Audit Workforce Planning National Review	
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff meeting to feedback on implementation plan	PA	Joint Finance and Workforce Report to QSP		Wales Audit Workforce Planning National Review	
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	Recruitment and retention repots via Board	PA				
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Reports via Trust Committee cycle on updates	PA				
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports monthly to operational managers with improvemnt plans/actions set out.	PA	Performance reporting to Executives and Trust Board		Internal Audit Reports	
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	PE	Agile Project and Programme Board	PA	Policies and proceedures to be imbedded with Hybrid Working Principles			

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

TAF DASHBOARD

WORKFORCE PLANNING

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and a range of outputs defined to deliver between September 2022 and February 2023.	Mar-23
1.2	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	The annual workplan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff.	Mar-23
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Hybrid Working project is presenting the details of a desk top booking appraoch to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Workign Toolkit has been developed in draft and will be finalised and published in February 2023.	Mar-23

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.**
LAST REVIEW	Mar-23	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Apr-23	**RISK DOMAIN** **Performance and Service Sustainability**
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	4	**12**	3	3	**9**	2	2	**4**

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

KEY CONTROLS

SOURCES OF ASSURANCE

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

TAF DASHBOARD

ORGANISATIONAL CULTURE

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

TAF DASHBOARD

ORGANISATIONAL CULTURE

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Embedding of Organisational Design approach for the Trust to encapsulate both process and cultural elements that need to be inplace to allow the organisation to achieve its strategic goals	Sarah Morley	The Building our Future Together (BOFT) draft Portfolio Initiation Document has been presented to EMB in December 2022. Whilst the PID is a live document and therefore is continuing to evolve the inidivdual Projects within it are progressing with Highlight Reports going to EMB. The BOFT Steering Group will begin meeting in March 2023 which will provide the opportunity to engage with a wider stakeholder group on progress against these indiviual elements of work.	Mar-23
1.2	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2032 strategy. This broader work is being scoped during January 2023 with details being presented to EMB in February 2023.	Apr-23

TAF DASHBOARD ORGANISATIONAL CULTURE

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
LAST REVIEW	Mar-23	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Apr-23	**RISK DOMAIN** **Performance and Service Sustainability**
EXECUTIVE LEAD	Carl James	

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

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

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

1.3	Performance reporting in place to ensure delivery of required quality/performance in core service	Carl James	x		x	PE	Executive Management Board review/ patient and donor feedback/ new PMF launched in March 2023	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x		E	Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x			E	Executive Management Board review / staff feedback	PA	Strategy Committee/QSP/Internal Audt Review / CHC; 7 steps of assurance launched to enhance assurance arrangments	PA	Audit Wales; various external audit repots; 7 steps of assurance launched to enhance assurance arrangments	PA
1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x			PE	Executive Management Board review / staff feedback	IA	Internal Audt Review	PA	Audit Wales/HIW	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	Not possible to fully determine whether the activities the Trust is undertaking are delivering the desired strategic outcomes at a Board level i.e. many of the outcomes for cancer and blood services are population based and the Trust currently does not get this information
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented (new quality metrics not sufficiently developed and/or utilised)	Inability to fully determine whether the services are maximising performance to deliver the desired outputs/outcomes at a service/Trust level
Not all supporting strategies approved by the Board e.g. Clinical and Scientifc strategy	No agreed date - initial plans being developed to progress strategy in 2023/2024

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in May 2022 (on track for May 26th 2022). Trust strategy and enabkers developed and approved (with launch in Sept 2022)	Complete
Develop IMTP to provide priority for action and application of resource	Carl James	Final draft going to Board for approval March 2022	Complete
Information requirements being scoped	Cath O'Brien	First phase to support new performance measures (on track for September 2022)	Complete
Develop clinical and scientific strategy	Jacinta Abraham	Jaz Abrahams/Nicola Williams/Carl James will be jointly responsible. Initial scoping meetings commenced and resourcing being indentifed prior to commencing work	2023 (comple tion date to
Implement revised performance management framework	Carl James	New scorecards being finalised for implementation (on track for September 2022). Additional cycle agreed to test PMF (october board edevelopment session) - target date for live PMF Dec 22 / Jan 23 Cycle. PMF being trialed currently and will Go Live in April 2023 (using February 2022 data/cycle). Phase 1 PMF launched in March 2023	Complete
Phase 2 of PMF to develop additional measures/qualityu metrics	Carl James	Design stage	Mar-24

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Mar-23	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Apr-23	Goal 1	RISK DOMAIN	Quality and Safety/ Comliance and Regulatory

		RISK SCORE (See definitions tab)								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
EXECUTIVE LEAD	Nicola Willams	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		5	5	**25**	3	5	**15**	2	5	**10**

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

KEY CONTROLS							**SOURCES OF ASSURANCE**					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE	Staff feedback	PA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
C2	CIVICA pt/donor feedback system being implemented	Nicola Williams			X	PE	Patient/Donor Feedback	PA	Quality, Safety & Performance Committee	IA	HIW Inspect	PA
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE	15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
							EMB	IA			Professional bodies	Not Assessed
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE	Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
							PMF	IA				Not Assessed

TAF DASHBOARD

QUALITY AND SAFETY

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

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework approved in July 2022, implementation commenced. Quality & Safety Operational Group Planning meeting held, inagural meeting arranged in October 2022.	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality statutory guidance 12 week consulation due in October 2022 & Duty of Candour regulation changes 12 week consultation commenced on 20th September 2022.	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The current mapped meeting reporting structure does not cover floor to board at divisional level
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires full establishment - to operationally pull together all stands and feed into EMB & QSP

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Framework finalised and approved by Board in July 2022	COMPLETE
1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Alan Prosser Paul Wilkins	Corporate OCP completed and recruitment commenced. Update 13.01.23: Integrated Quality & Safety Group established - Corporate Hub not fullly established due to delay in populating OCP posts WBS Quality Hub requirements determined – minor changes required from existing arrangements. Update 13.01.23: WBS Hub development in final stages VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through. Update 13.01.23: VCC hub design under consideration by VCC SLT	Oct-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Implementation plan developed and approved	Mar-23
1.4	Instigate a Quality & Safety operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Planning meeting held, draft terms of reference developed and membership agreed. Inagural meeting planned for October 2022. Update 13.01.23: Meeting underway - Quality BI work underway to support the active triangualtion	Oct-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Being picked up through the Datix project Board. Update 13.01.23: Formal Audit to assess compliance has been comissioned	Dec-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley	Compassionate Leadership is woven through the Trust 'Inspire' Leadership Programme. A broader Trust wide programme is being developed for all leaders and managers which forms part of the 'Building our Future Together' Portfolio.	Apr-23
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Investigation training provided to officers within corporate quality & safety team and both divisions. Update 13.01.23: Training provided - a scope of who has undertaken it underway	Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group. Consultations planned for Autumn 2022.	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23

1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and established for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23. Update 06.10.2022 - Defined project as part of the Building Our Future Together work programme.	Mar-23
1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	COMPLETE

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
LAST REVIEW	Mar-23	5 - A sustainable organisation that plays it part in creating a better future for people across the globe
NEXT REVIEW	Apr-23	**RISK DOMAIN** Performance and Service Sustainability
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	3	3	9

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			E
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE	Staff feedback	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C4	Training & Education packages for donors, patients	Chief Digital officer	X			PE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA	Wales Audit Office	PA
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			E	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office/Centre for Digital Public Services	PA
C7	Digital inclusion – in wider community	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	Not Assessed
C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

TAF DASHBOARD

DIGITAL TRANSFORMATION

C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	PA
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital officer			X	PE	Review via Divisional SMT / SLT	PA	Review via EMB / Trust Board	PA	Wales Audit Office	PA
C13	Cyber assurance controls in place	Chief Digital officer		X		PE	Review via Divisional SMT / SLT. Cyber Security eLearning (Stat. & Mand.) Board Development Sessions.	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office. WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital officer	X	X		PE	Digital Programme established. Architectural Review Board	Not Assessed	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed	Wales Audit Office	Not Assessed

TAF DASHBOARD

DIGITAL TRANSFORMATION

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c1,c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2.
Digital architecture needs to be developed to guide digital transformation activities.	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls, as per action 1.1.
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.	
Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Chief Digital officer	CDO started on 1st July as anticipated, key controls in the TAF reviewed and can be presented at a future SDC. Paper on Digital Programme on Strategic Development Committee agenda 14th December 2022 for initial consideration. SDC session on development of TAF key controls outstanding.	Nov-22
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital officer	Creation of the Reference Architecture included as part of the scope for the Digital Programme. Assurance will be monitored through that route once the Digital Programme is established.	Feb-23
1.3	Review the scope/scale/need for a Digital Programme to provide assurance around digital activities in the Trust	Chief Digital officer	An overview of the proposed Digital Programme was presented to the Strategic Development Committee on 14th Dec. This is now being worked through to confirm governance arrangements	CLOSED
1.4	Confirmation of the SIRO/Cyber Security roles and responsibilities	Chief Digital officer	AGREED ROLES AND RESPONSIBILITIES	CLOSED

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.		
LAST REVIEW	Mar-23	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations		
NEXT REVIEW	Apr-23	**Goal 2**	**RISK DOMAIN**	**Financial Sustainability**

EXECUTIVE LEAD	Matthew Bunce	**RISK SCORE (See definitions tab)**								
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**		
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
		4	4	**16**	3	4	**12**	2	4	**8**

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

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

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Support the embedding of investment framework within Divisions	David Osborne	Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.	Mar-23
	Investment scrutiny with services against commitments made and intended.	David Osborne	Completed and subject to continuous review	Completed
	Key objectives of investment framework and relationship to contract performance and value identified	David Osborne	Completed	Completed
	Investment framework to be articulated and agreed by Divisions and Exec	David Osborne	Due through Q3	Jan-23
	Investment framework to be applied within IMTP process	David Osborne	Due through Q3	Mar-23
1.2	Review of contracting model for impact of COVID related measures	David Osborne	Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.	Mar-23

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

	Protected Enhanced rates secured for 22-23	David Osborne	Completed	Completed
	Contract currencies of concern identified and impact assessed	David Osborne	Impact of hyperfractionation reviewed	Completed
	Business Cases completed for Brachytherapy	David Osborne	Business case prepared and agreed	Completed
	Engage with National Funding Flows Group for contract agreements for future financial years	David Osborne	Ongoing. National Funding flows workstream has been delayed due to capacity constraints in the national group therefore November milestone missed. Work is ongoing with the National team and an outcome is expected by Feb-23 with regards to contract arrangements	Feb-23
	Internal Review of investment in Covid-related capacity for VCS	David Osborne	An internal review is being conducted to understand the impact of funding made available to VCS in response to Covid. A meeting is scheduled for 18th January to review the initial outcome from this work.	Feb-23
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Programme of work developed across the following workstreams: Benchmarking / good practice; Investment Categorisation; Governance process; Prioritisation Criteria; Business case templates and Decision Support Tools.	Jul-23
	Benchmarking / good practice assessment	Chris Moreton	Work has been conducted to understand where good practice exists within other LHBs / wider NHS.	Completed
	Investment Categorisation	Chris Moreton	Draft set of categories have been produced which contain the Scale of Change; Type of Change; Source of Funding and Type of Funding. Draft categories to be reviewed and finalised / agreed as part of framework.	Mar-23
	Governance and processes	Chris Moreton	Terms of Reference for Strategic Capital Board have been reviewed by Chris Moreton with suggested updates aligned to the SFIs. Once SCB ToR agreed, Capital Financial Control Procedures to be updated. High level process review for capital investment in progress. Revenue investment review process to be completed.	Apr-23
	Prioritisation criteria	Chris Moreton	Criteria need to be developed and agreed - work in progress	May-23
	Business Case Templates and Decision Support Tools	Chris Moreton	Updated draft investment categories have been incorporated within the Trust Board report template. Gap analysis of business case templates and decision support tools to be completed.	Jul-23

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.								
LAST REVIEW	Mar-23	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Apr-23	Goal 2			RISK DOMAIN			Research and Development		
EXECUTIVE LEAD	Carl James	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	2	4	8	2	3	6

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			E	Executive Management Board review	PA	Strategic Development Committee; QSP Committee monitoring; 7	PA	Audit Wales Reviews	PA
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE	Executive Management Board review; partnership boards in place with LB partners; regional/national arrangements in place for blood	IA	Strategic Development Committee; QSP Committee; 7 levels of assurance and WG IQPD review	IA	Audit Wales Reviews; WG IQPD review and JET review bi-annually	PA

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

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of clinical and scientific strategy	New PMF not yet in place with revised measures to track delivery of Trust strategy
Limited commercial expertise (capacity) within the Trust	Local commissioning/regional commissioning processes unchanged with no new ways of measuring effectiveness
Robust commissioning arrangements across Wales	

Clear understanding of strategic direction/system design with partner LHBs	
Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capability to leverage the strategic oppo	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James	On track for May 2022. The overarching Trust Strategy "Destination 2032" was approved in the January Trust Board. The Enabling Strategies were subsequently approved, as outlined below, in the May 2022 Trust Board.	COMPLETE
1.2	Board decision on strategic areas of focus/to pursue	Board	Final enabling strategies on track for may 2022 - allowing prioritisation to occur in future IMTPs. Trust Enabling Strategies were approved by the Trust Board in May 2022.	COMPLETE
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board decisions)
1.4	development of clinical and scientific strategy	Jacinta Abraham		tbc
1.5	Development of KPIs and PMF to track strategy delivery	Carl James	Draft KPIs developed and PMF being plioted	Complete
1.5	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions)
1.6	Phase 2 of PMF and wider measurement to track strategic execution of Destination 2032 and other strategies	Carl James	Design phase; requires implementation plan and BI support	Mar-24

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.									
LAST REVIEW	Mar-23	1 - Outstanding for quality, safety and experience									
NEXT REVIEW	Apr-23	**Goal 1**			**RISK DOMAIN**		**Compliance and Regulatory**				
EXECUTIVE LEAD	Lauren Fear	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	3	4	**12**	2	4	**8**	

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

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

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

TAF DASHBOARD

GOVERNANCE

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Complete
Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.	Complete
Develop and iplement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	This will be picked up in the overall Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work	Dec-23
Appropriate frameworks will be aligned with the Trust Assurance Framework	Lauren Fear	Project TAF1.0 within the Governance, Assurance and Risk (GAR) programme of work is underway to align frameworks with the Trust Assurance Framework. The Risk Framework is currently being mapped.	Mar-23
Refresh of Trust Assurance Framework risks	Lauren Fear	Project TAF 2.0 withint he GAR Programme has started, risks are reveiwed on a monthly basis and reported through governance routes accordingly	Dec-23
Revised reporting mechanism to be developed	Lauren Fear	Project TAF 3.0 withint he GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams, led by Execs	Mar-23
Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	Work is ongoing mapping the Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	Mar-23

SECTION 1

RISK ID		RISK TITLE				RISK SCORE TREND	
EXEC LEAD		STRATEGIC GOAL		RISK DOMAIN			

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	
				#NAME?										

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)	RATING		Overall Trend in Assurance	

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE		CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN							
Action Ref	**Action Plan**	**Owner**	**Due Date**	**Progress Update**	**Date of Update**	**Impact of Changes on Risk**	**When the action is complete, detail the impact on assurance level/control**

SECTION 1

RISK ID	TAF 10	**RISK TITLE**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.			**RISK SCORE TREND**	TAF 10 12 12 12 12 12 12
EXEC LEAD	LAUREN FEAR	**STRATEGIC GOAL**	1 - Outstanding for quality, safety and experience	**RISK DOMAIN**	Compliance and Regulatory		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	4		

SECTION 3

Overall Level of Effectiveness: (Refer to 7 Levels of Assurance (see definitions tab))	RATING	E	Overall Trend in Assurance (Refer to 7 Levels of Assurance (see definitions tab))	Too few data points at present

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)	Lauren Fear		X		E						
C2	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Aiudit Committee Trust Board	6	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Audit Review	4	Audit Committee Trust Board	4	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	4
C4	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	6	Divisional Management Arrangements for overseeing effective implementation and monitoring	6	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	6	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial assurance) Audit Wales review outcomes of report as part of Annual Report - Accountability Report	6
C5	Board Development Programme	Lauren Fear	X			PE	Programme established	4	Independent Member Group repurposed and second meeting now held. Further embedding through 2022/23	4		
C6	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self- assessment exercise. All actions complete /on track to complete by end of this financial year.	5			Audit Wales review of Quality Governance Arrangements	5
C7	Qulaity of assurance provided to the Board	Lauren Fear	X			E	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

None	Third line of defence in respect of C5 - Board Development Programme: No course of action is proposed.	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE	None	CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
C5	Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	6	Complete	Supported by the development priorities identified through an externally facilitated programme of Board development underway.			
	Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	6	Complete	Terms of Reference and supporting refreshed standard agenda has been agreed by Independent Members for the Independent members Group.			
	Develop and iplement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	4	Dec-23	This will be picked up in the overall Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work			
	Appropriate frameworks will be aligned with the Trust Assurance Framework	Lauren Fear	4	Mar-23	Project TAF1.0 within the Governance, Assurance and Risk (GAR) programme of work is underway to align frameworks with the Trust Assurance Framework. The Risk Framework is currently being mapped.			
	Refresh of Trust Assurance Framework risks	Lauren Fear	3	Dec-23	Project TAF 2.0 withint he GAR Programme has started, risks are reveiwed on a monthly basis and reported through governance routes accordingly			
	Revised reporting mechanism to be developed	Lauren Fear	3	Mar-23	Project TAF 3.0 withint he GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams, led by Execs			
	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Mar-23	Work is ongoing mapping the Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board			

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce

05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	**Trust Financial Investment Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance

09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

DEFINITIONS

CONTROL EFFECTIVENESS

Effective	Control in implemented/ embedded; working as designed; with associated sources of assurance	E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence functions that own and manage risk	Second Line of Defence functions that oversee or specialise in risk management	Third Line of Defence functions that provide independent assurance
Self-Assurance	**Internal oversight/**specialist control teams, such as**:**	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as:
Risk and control management as part of day-to-day business management Staff training and compliance with policy guidance Teams take responsibility for their own risk identification and mitigation	Quality & Safety IT Governance (corporate/Clinical)	External Audit Regulators & Commissioners Wales Audit Office reviews Stakeholder reviews Scrutiny from public, Parliament, and the media
Examples of assurance	***Examples of assurance***	***Examples of assurance***
Management Controls / Internal Control Measures *Local management information / departmental management reporting* *Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)* *Operational planning / Business Plans - Delivery Plans and Action Plans* *Governance statements / self-certification* *Local procedures* *Exceptions reporting* *Targets, Standards and KPIs* *Incident Reporting* *Staff Training Programmes*	*Board, Committee and Management Structures which receive evidence from* *Finance reports* *KPI's and management information* *Quality, Safety and Risk reports* *Training records and statistics* *Performance reports* *BAF, VUNHS risk register* *Policies and Procedures including Risk Management Policy* *Compliance against Policies*	*Recent internal audit reviews and levels of assurance* *External Audit coverage* *Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews* *Patient Feedback / Patient experience feedback* *Staff surveys / feedback* *Comparative data, statistics, benchmarking*

STRATEGIC GOALS

KEY CONTROLS		
CONTROL TYPE	**DESCRIPTION**	**EXAMPLES**
Preventative	These controls are	• Authorisation limits

1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
3 - A beacon for research, development and innovation in our stated areas of priority
4 - An established 'University' Trust which provides highly valued knowledge and learning for all
5 - A sustainable organisation that plays it part in creating a better future for people across the globe

RISK DESCRIPTORS	
Inherent Risk	Score the exposure before any action has been taken to manage it or if existing controls failed entirely
Residual risk	The threat that remains after all existing controls have been applied
Target risk	Where risks are outside acceptable levels, a target risk score is agreed. This is the level that future mitigation that should be achieved which will vary over time

	designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	of and separation of duties • Pre-employment screening of potential staff
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

RISK SCORE

LIKELIHOOD MATRIX					
LIKELIHOOD (*)					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

RISK RATING MATRIX - IMPACT X LIKELIHOOD					
RISK MATRIX	**LIKELIHOOD(*)**				
CONSEQUENCE(**)	**1- Rare**	**2- Unlikely**	**3 - Possible**	**4 - Probable**	**5 - Expected**

1 -Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

IMPACT MATRIX

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
01	Compliance *Statutory duty/ inspections*	No or minimal impact or breach of guidance/statutory duty	Minor breach of guidance/statutory duty Reduced performance rating if unresolved Verbal reports from Regulator	One breach guidance/statutory duty Challenging recommendations Observation reports from regulator	Multiple breaches in statutory duty Enforcement action Improvement notices	Multiple breeches in statutory duty Prosecution Severely critical report
02	Environmental *Environmental impact*	No or minimal impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
03	Financial Sustainability *Including claims*	Insignificant cost increase Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim(s) less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million	Loss of >1 per cent of budget Claim(s) >£1million
04	*Information Governance* General Data Protection *Regulation (GDPR)*	Minimal privacy impact requiring no or minimal intervention	Minor impact on an individual's privacy	Moderate privacy impact requiring professional intervention Possible ICO reportable breach Could result in an event which impacts on a moderate (less than 100) number of patients/donors	Major breach leading to possible larger scale privacy breaches Likely ICO reportable breach if IG standard not adhered to Could result in an event which impacts on a major (between 100 and 1000) number of patients/donors	Serious breaches and non-compliance Definite ICO report required if breach occurs Could result in an event which impacts on a major (more than 1000) number of patients/donors
05	Partnerships Relationships with internal and external stakeholders and in working with system partners	No or minimal issues in establishing and maintaining effective relationships with internal and external stakeholders No or minimal misalignment of operational actions or strategic approach with system partners Minimal issues with collaborative working initiatives within our cancer and blood and transplant systems	Minor issues in establishing and maintaining effective relationships with internal and external stakeholders Minor misalignment of operational actions or strategic approach with system partners Minor issues with collaborative working initiatives within our cancer and blood and transplant systems	Moderate issues in establishing and maintaining effective relationships with internal and external stakeholders Moderate misalignment of operational actions or strategic approach with system partners Moderate issues with collaborative working initiatives within our cancer and blood and transplant systems	Major issues in establishing and maintaining effective relationships with internal and external stakeholders Major misalignment of operational actions or strategic approach with system partners Major issues with collaborative working initiatives within our cancer and blood and transplant systems	Failure to establish and maintain effective relationships with internal and external stakeholders Severe misalignment of operational actions or strategic approach with system partners Severe issues with collaborative working initiatives within our cancer and blood and transplant systems

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
06	Performance and Service Sustainability *Business objectives/projects* *Service/business interruption*	Failure to achieve minor objective No or minimal service issue **Programme/ projects** Insignificant cost increase Less than 5 per cent schedule slippage against timescales	Failure to achieve significant/key objective. Minor impact on service. **Programme/ projects** 1-10 per cent over project budget. 5-10 per cent schedule slippage against timescales	Failure to achieve multiple significant/ key objectives. Moderate impact on service. **Programme/ projects** 10-25 per cent over project budget. 10-40 per cent schedule slippage against timescales	Failure to achieve crucial objectives. Major impact on service. **Programme/ projects** 25-50 per cent over project budget. 40-100 per cent schedule slippage against timescales	Gross failure to achieve multiple crucial objectives Service failure **Programme/ projects** >50 per cent over project budget More than 100 per cent schedule slippage against timescales
07	Quality *Quality/complaints/ audit / GxP*	Peripheral element of treatment or service suboptimal Informal complaint/enquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local	Treatment or service has significantly reduced effectiveness	Non-compliance with national standards with significant risk to patients or donors if unresolved	Non-compliance with national standards with severe risk to patients or donors if unresolved

			Resolution Single failure to meet internal standards	Formal complaint (stage 2) complaint Multiple failures to meet internal standards	Multiple complaints/ independent review Multiple failures to meet national standards	Inquest/ombudsman inquiry Gross failure to meet national standards
		Temporary insignificant impact upon process or performance with no impact on quality or safety of components produced. Donor/patient/staff discomfort	Temporary minor decline in existing performance or process, no impact on quality or safety of components produced. Donor/patient/staff discomfort, minor interventions required e.g., reassurance.	Temporary moderate erosion of existing performance or process, with the potential for impact on quality or safety of components produced. Short term harm, donor/patient/staff requiring treatment from medical practioner.	Sustained erosion of existing performance or process, tis has an effect on quality or safety of components produced. Donor/ /staff admission to hospital required, or increased stay in hospital >3days.	Significant uncontrolled erosion of performance or process which has a serious effect on the quality and safety of components produced. Fatal, life threatening, disabling, prolonged hospitalisation, incapacitating the donor or patient if transfused. (SABRE)
08	Reputational *Adverse publicity/ reputation*	Potential for public concern	Local media coverage Minor reduction in public confidence	Local media coverage Moderate reduction in public confidence	National media Coverage with <3 days service well below reasonable public expectation Major reduction in public confidence	National media Coverage with >3 days service well below reasonable public expectation. Gross loss of public confidence
09	Research and Development	Departure from: Established good practice guidelines, and/or Procedural requirements	Departure from: Applicable legislative requirements, and/or Established Good Clinical Practice (GCP) guidelines, and/or	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "major" and/or "other" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" and/or "major" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" that leads to recommendations of: Communication of the critical findings to external parties, for

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
		has occurred in a Research Study that is not a Clinical Trial of an Investigation Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example, other competent authorities, other government departments or UK NHS Research Ethics Committees Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions Infringement Notice Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution
10	Safety *Impact on safety of patients, staff or public (physical or psychological harm)*	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients or donors	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects RIDDOR/agency reportable incident An event which has an effect on a large number of patients or donors
11	Workforce and OD *Human resources/ organisational development/ staffing/ competence*	Short term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff. Very low staff morale Very poor staff attendance mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff Very poor staff attending mandatory training /key training on an ongoing basis

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL

RAG rating	ACTIONS	OUTCOMES
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.
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.
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.
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.
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.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full
5	Majority of actions implemented; outcomes not realised as intended
4	Increased extent of impact from actions
3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
2	Symptomatic issues being addressed
1	Actions for symptomatic issues, no defined outcomes
0	Enthusiasm, no robust plan

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

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

DATE OF MEETING	30/03/23
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance Wayne Jenkins, Assistant Director, Sarah Richards, Interim General Services Manager
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates
REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT	22nd February 2023	**NOTED**
VCC SLT	24th February 2023	**NOTED**
EMB	2nd March 2023	**APPROVED**
QSP Committee	16th March 2023	**NOTED**

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

1. VELINDRE NHST PERFORMANCE REPORT FOR THE PERIOD APRIL TO JANUARY 2023

1.1 This report provides an overview, now presented in the 'new PMF format', of the performance our Trust for the period April to January 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. The January reporting cycle will be the first time that the Quality Safety and Performance Committee and the Trust Board will receive performance reports in the new style PMF format.

1.2 The new performance report format adopts a 'balanced scorecard' or 'dashboard' approach which seeks to 'triangulate' the interplay between operational delivery, service quality and safety, our people and physical/finance resources. The Executive Summary, in Section 3, gives a high-level overview, drawing attention to key areas of performance across the organisation as a whole, showing the interconnection between many of these areas.

1.3 The Performance Management Framework (PMF) Scorecards, in Section 6, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care. The Scorecards incorporate hyperlinks to data analysis of our performance against each Key Performance Indicator (KPI) for Cancer and Blood and Transplant services. PMF scorecards have also been developed for Trust-wide Services, including Estates, Health and Safety, Digital, Workforce and Finance.

1.4 Individual 'service level' VCC and WBS PMF reports were presented initially to the VCC and WBS Senior Leadership Teams (SLT) and have been reviewed by the Chief Operating Officer at their divisional performance review meetings.

1.5 The Trust Board Scorecard KPIs

The Velindre Cancer Centre, Welsh Blood and Transplant and Support Services Scorecards in Section 6 focus on a selection of critical measures that provide an overview of performance in the areas of clinical quality and safety, operational delivery, patient and donor experience, staff wellbeing and financial balance.

2. PERFORMANCE MANAGEMENT FRAMEWORK SCORECARDS AS AT MONTH 10 JANUARY 2022/23

2.1 The New Trust Board PMF Reporting Format

The Performance Report for the period April to January 2023 is presented in the new reporting format, endorsed by both the EMB and the Strategic Development Committee (SDC). This consolidated format replaces the previous separate VCC, WBS, Workforce and Finance performance reports. However, introducing new reporting structures and presenting KPI performance in different ways, employing new statistical techniques and graphics, needs to be managed carefully, and opportunities to improve the presentation will be taken as the move towards the new financial year.

The process of developing the new PMF performance reporting style has involved extensive engagement and discussion with Independent Members, Executive Directors, Community Health Council Representatives plus detailed work with Directorate Leads and key staff responsible for gathering, collating and reporting performance. In particular, suggestions around the presentation of performance to the public, the development of new KPIs measures and the general support for the direction of travel, have been particularly helpful. A range of potential KPI measures that will further enhance our performance reporting are being considered for development.

The development of our new PMF reporting processes and enhanced KPI metrics will be an evolving process with ownership and support at all levels, including exploring more efficient and streamlined methods of performance data collection. During 2023/24, the PMF Development Project Group will look to evaluate potential Business Intelligence solutions that automate KPI collection, analysis and reporting, and approach potential benchmarking partners for both tertiary cancer and blood services.

2.2 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 against individual KPIs is no longer 'RAG rated' in the traditional way. Performance is now 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. A baseline, as at April 2022, has also been set as a default for each KPI to reflect our current average performance at the beginning of the current financial year.

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

3. VELINDRE NHST PERFORMANCE REPORT EXECUTIVE SUMMARY TO JANUARY 2023

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

3.1 Cancer Centre Service Overview

VCC continues to experience challenge in providing capacity to meet the overall demand for services within SACT and Radiotherapy, with referrals increasing as Health Boards undertake additional activity to address their longest waiting patients. There continues to be variation in demand and tumour sites. Regular operational meetings continue to take place between VCC and the local Health Boards, which help to provide a more detailed picture of the expected number of referrals to VCC from Health Boards and changes to specialist teams and practice that are likely to impact on demand for services from VCC.

Alongside better intelligence on demand to support planning, there is a comprehensive programme of work supported by activity plans to maximise efficiency and productivity to demonstrate the most effective use of resources. However, it should be noted that variation in referral patterns occurring continues to be a challenge as Health Boards undertake focused activity within specific specialist areas.

In January, this led to a specific notable raise in Breast referrals. However, despite this pressure and the operational impact of the digital system changes which are outlined further below, we continue to deliver at target with emergency SACT treatment reaching 100% and Non-emergency SACT being 1% below the 98% target.

There is currently no fully validated performance data available for radiotherapy services, due to the transition to the new data warehouse and reporting following the implementation of the new Digital Health and Care Record (DHCR) phase 1 in November 2022. This required a full rebuild of the data warehouse that enables this data to be produced. In such major projects, this is well recognised and work cannot commence until the system has gone live and initial adaptations have been completed. Due to the fact that SACT activity information is derived from the Chemocare system, the requirement to re-build the warehouse reports has not stopped SACT activity data being made available.

Originally intended to be completed in February, a small but significant number of further changes have had to be made as the system has been adapted post go live. As a result, the data is not yet fully available and will require further work. Furthermore, the opportunity has been taken to build reporting functionality for the new Radiotherapy Time to Treatment targets that have been mandated by Welsh Government; the data standards for which have been confirmed at the end of March. A substantial data validation exercise is now required to provide patient level reporting on breaches and it is anticipated that this will be completed by the end of April (requires specific staff resource). This will however give us an opportunity to report against the new metrics.

The introduction of the new Digital Health and Care Record (DHCR) system has ensured that there is now a sustainable electronic system in place that can support the Cancer Centre in the safe management of their patients into the future and brings VCC in line with the standardized approach to management of the patient administration system across the Health system in Wales. DHCR has removed the risk of the CANISC system stability and made our records more widely accessible in Health Boards, particularly with the Radiotherapy and SACT treatment summaries.

The DHCR implementation has presented a substantial change on the way in which we plan, manage and record the care of our patients. The move away from the previous CANISC system which had been in place for over 20 years, was the culmination of 2 years of planning and created multiple changes in processes and work flows. Whilst these changes were planned, it is recognised that in any major service change, there will be a period of ‘settling down’ whilst service users get used to the system, ways of working are confirmed, and technical teething problems are addressed. As we move through the post implementation phase, we have continued to make adaptation to the system and ways of working.

The system has been configured to meet our need by DHCW as well as its integration with other VCS digital systems, for example for radiotherapy. A small number of technical issues were experienced which have been addressed, together with some system configuration adaptation as we use the system in day-to-day practice. Unlike CANISC DHCR is a linear system, which means each episode of care relating to the patient needs to be ‘outcomed’ in a timely manner on the system before they can record the next stage of their treatment pathway and this is a change of the way in which we work.

Digital and operational services are continuing to work together and will be undertaking an operational impact to understand the challenges being faced by service groups. This will help to identify if there are further technical system changes which may require the support of DHCW to address, and also provide the opportunity to review current ways of working, resource changes or gaps, and additional training needs. In addition, through our networks with Health Boards we are comparing system practices and undertaking benchmarking to inform the ways in which we can benefit from using the new DHCR system with the experience of using the system that we now have.

Whilst activity data for radiotherapy from the DHCR system is being recorded, it is currently undergoing significant validation, there is also ongoing work to include radiotherapy data that is currently entered manually for costing views. In the interim, safeguards are in place to minimise any risk of missing individual patients. An activity list is produced from the system and a manual review is undertaken to cross check the activity list against the system. This is continuing to take place whilst we address the reporting issues within the system and ensures that patients are not missed. Patients are also continuing to be prioritised in line with national guidance.

Whilst bedding in and adjustments are still taking place, some early post go live issues, particularly in relation to system interfaces, resulted in an increase in patient waiting times breaches due to the appointment process and notification issues during the first weeks. A small number of patients reported not receiving appointments and therefore did not attend at the planned time. These we immediately followed up. There have also been administrative challenges in processing appointment outcomes which have been prioritised to ensure timely access to appointments for SACT and Radiotherapy but a backlog of documentation is still being worked through.

All targets have been met for Pressure Ulcer, Falls, Sepsis and Delayed Transfers of Care. In December and January we experienced an unusual increase in Healthcare Associated Infections. Each has been reviewed within the MDT and there is no evidence of infection transmission. This increase mirrors the experience nationally.

3.2 Welsh Blood Service Overview

At 98% quality incident investigations closed within 30 days continues to exceed target (90%) for January.

No adverse event reports were submitted to the Medicines and Healthcare Regulatory Agency (MHRA) or the Human Tissue Authority (HTA) and no serious hazards of Transfusion (SHOT) incidents were reported this month.

Collection performance exceeded demand for the month, resulting in stock growth, helping the service recover its stock holding post the Christmas holiday period and lifting the blue alert on O negative stocks on January 11th 2023.

Red cell expiry wastage continues to perform strongly a result of close alignment of supply and demand for red cells.

All clinical demand for platelets was met representing a strong performance against this metric. However, platelet wastage continues to be above target at 23%. The main contributory factor is high variability in demand over the month, making pre-planning more difficult. A Platelet Group will be established in March 2023 to consider the opportunities to improve supply and demand alignment into the new financial year.

The number of new donors recruited to the Welsh Bone Marrow Donor Registry (WBMDR) increased from 137 to 213 in January. A trend which is expected to continue into February as the recovery plan continues to focus on Schools/College/University engagement

programme, paid advertising, marketing campaigns aimed at existing donors and engagement with external marketing companies to explore wider recruitment opportunities.

The total stem cells collected in January was 4. The total stem cell provision for the service was 7 (4 collected and 3 imported for Welsh patients). The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment.

At 97% donor satisfaction continues to perform above target.

In January, 7,522 donors were registered at donation clinics with 6 concerns (0.08%) reported within this period. Of these 6 concerns, 2 were formal and were follow ups to concerns originally raised and responded to in December 2022, from donors who were dissatisfied with our initial responses. Both were responded to within timescale. The remaining 4 concerns were informal and new to the service.

Antenatal turnaround times provided to customer hospital within 3 working days has returned to above target for January and quarterly reporting of D and -C quantitation results provided to customer hospital within 5 working days continues to strongly perform.

3.3 Workforce and Wellbeing

The key workforce risk for the Trust is the availability of skilled people to provide services and how we support their wellbeing while in the workplace. Trust wide sickness absence data continues to remain high month on month with the current cumulative absence at 6.24% to January 2023 still above the Welsh Government Target of 3.54%. Winter cold and flu viruses have resulted in short-term sickness, throughout the Trust. A raft of wellbeing interventions and actions are taking place across the service.

Trust wide PADRs this month remains at 77% and there are ongoing interventions to support managers in completing reviews following the implementation of the All Wales Pay Progression Policy. Statutory and Mandatory training remains above target at 88% and has been consecutively on target for the whole year form Jan 22 – Jan 23.

3.4 Nursing and Quality

The Trust's Quality & Safety Framework was approved at the Trust Board in July 2022. The Integrated Quality & Safety Governance Group has been established and inaugural meeting held. The Divisions will need to develop Service level Quality and Safety metrics and these to be included within the Performance Management Framework. Corporate and Divisional Quality Hubs are in the process of being established. The Trust's Nursing Standards have been approved and launched.

3.5 Patient and Donor Experience

Velindre Cancer Centre experience uses 0-10 patient satisfaction rating against an 85% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 95% that continues to meet the target.

3.6 Finance

At this stage of the financial year the overall revenue budget (excl. Covid and the exceptional cost pressures) remains broadly 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 January 23 remains underspent by £0.002m, with an outturn forecast position of Breakeven.
The Trust has now received confirmation from WG that funding will be provided for the both the incremental increase in energy prices and Covid response.

It is expected that any potential cost pressures are managed by budget holders to ensure the delegated expenditure control limits are not exceeded in line with budgetary control procedures.
Performance against both the currently agreed All Wales Capital and Discretionary programme budget allocations are at this stage expected to deliver to within the CEL.

The Trust has now dipped under the PSPP performance target of processing 95% of Non-NHS Supplier invoices within the 30-day target which is under urgent review. The finance team is working with the NWSSP accounts payable and the service to understand reasons for recent under performance with a view to target specific failures and bottlenecks in the process.

3.7 The following section 6 contains the VCC, WBS and Trust-wide Services PMF Scorecards using the six Quality Safety Framework domains to report the Trust's overall performance against a range of National and local targets.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below) Quality and Safety considerations form an integral part of IMTP 2022/23 to 2025/26 plans and PMF to monitor and report on progress against our strategic objectives
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below) VUNHST IMTP 2022/23 to 2025/26 plans must be delivered within the Trust's financial envelope

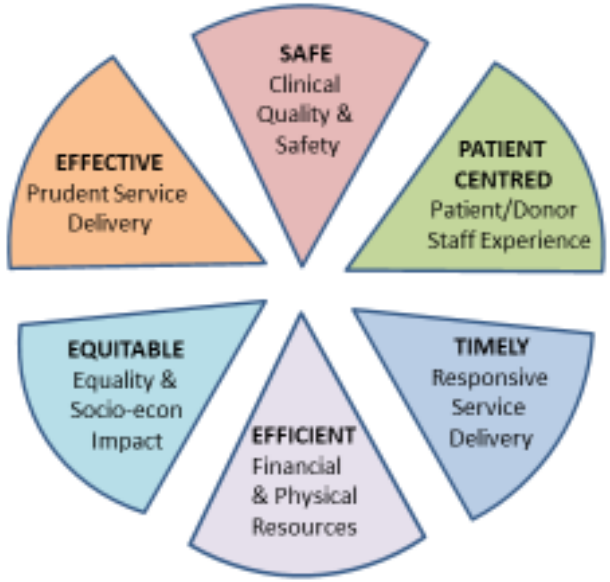
5. RECOMMENDATIONS

5.1 The Trust Board is asked to **NOTE** the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 6.

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

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework



Welsh Blood Service

Trust Board Scorecard as at January (Month 10) 2022/23

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	85%	85%	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	0	0	0	✓	→	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	3	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	4	✗	→	KPV.04
	Hand Hygiene	National	Monthly	TBA	TBA	TBA	✓	→	KPV.08
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	→	KPV.01
	Number of Incidents reported to Regulator / Licensing Authority	Local	Monthly	3	0	0	✓	↓	KPI.30
	Carbon Emissions – carbon parts per million by volume	National	Annually	TBA	TBA	TBA	✓	→	EST.06
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	0	0	0	✓	↑↓	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	102%	100%	106%	✓	↑	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.08%	Max 1%	0.21%	✓	↑	KPI.26

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
	% Time Expired Platelets (adult)	Local	Monthly	16%	Max 10%	23%	✗	↑↓	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	1	7	4	✗	→	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.31%	3.54%	6.24%	✗	↓	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	69%	85%	77%	✗	↑	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	N/A	85%	93%	✓	→	KPV.11
	% Donor Satisfaction	Local	Monthly	96%	95%	97%	✓	→	KPI.09
	% of 'formal' concerns responded to within 30 working days	Local	Monthly	100%	85%	100	✓	→	KPV.12
	% Responses to Formal Concerns within 30 Working Days	Local	Monthly	100%	90%	100%	✓	→	KPI.03
Timeliness	% Patients Beginning Radical Radiotherapy Within 28 days (JCCO)	National	Monthly	87%	98%	NDA	✗	↑↓	KPV.14
	% Patients Beginning Palliative Radiotherapy Within 14 days (JCCO)	National	Monthly	79%	98%	NDA	✗	→	KPV.15
	% Patients Beginning Emergency Radiotherapy Within 2 days (JCCO)	National	Monthly	84%	98%	NDA	✗	↑↓	KPV.16
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	69%	98%	97%	✓	↑↓	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	97%	90%	97%	✓	→	KPI.17

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 10 (January)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline April '22	Target	Actual	In Month Position	Cumulative data trend	
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.002 m	✓	➔	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£14.346M	£14.346M	✓	➔	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.128 m	£0.140 m	✗	➔	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.064 m	£1.064 m	✓	↑	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	94%	✗	➔	FIN.60
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	TBA	TBA	TBA	✓	➔	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	TBA	TBA	TBA	✓	➔	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	TBA	TBA	TBA	✓	➔	WOD.80
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	TBA	TBA	TBA	✓	➔	WOD.81

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

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

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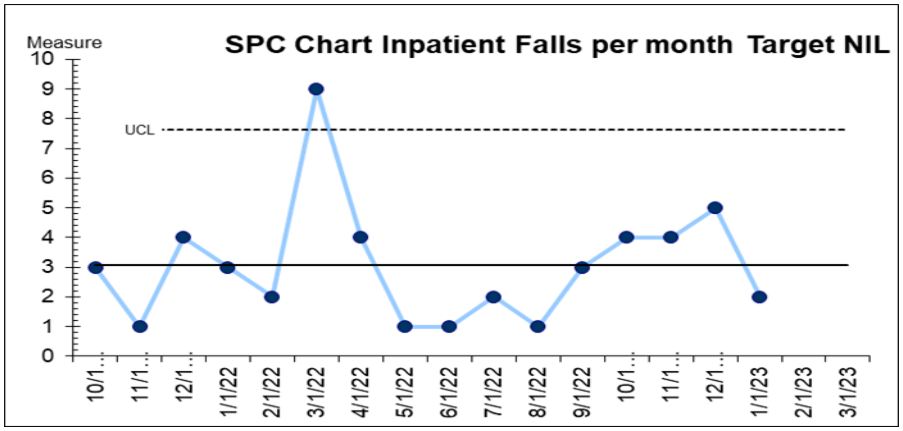
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual Number	1	4	3	2	9	4	1	1	2	1	3	4	4	5	2
Avoidable Falls	0	0	1	0	0	1	1	0	2	0	1	2	2	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

There were no avoidable inpatient falls in January 2023. Performance on Target.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.01

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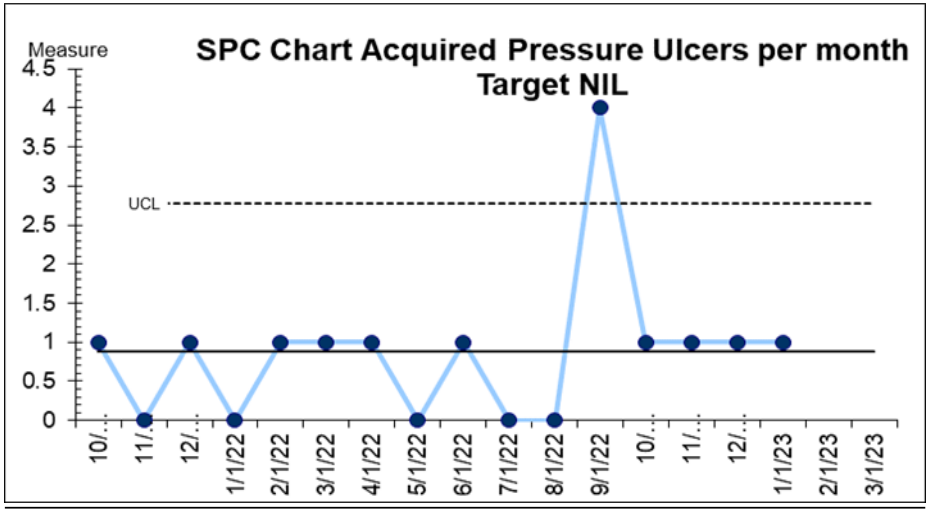
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual Number	0	1	0	0	1	1	0	1	0	0	4	1	1	1	0
Avoidable Ulcers															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, except for 4 pressure ulcers in September.

Performance

There were no VCC acquired Pressure ulcers in January 2023. Performance on target

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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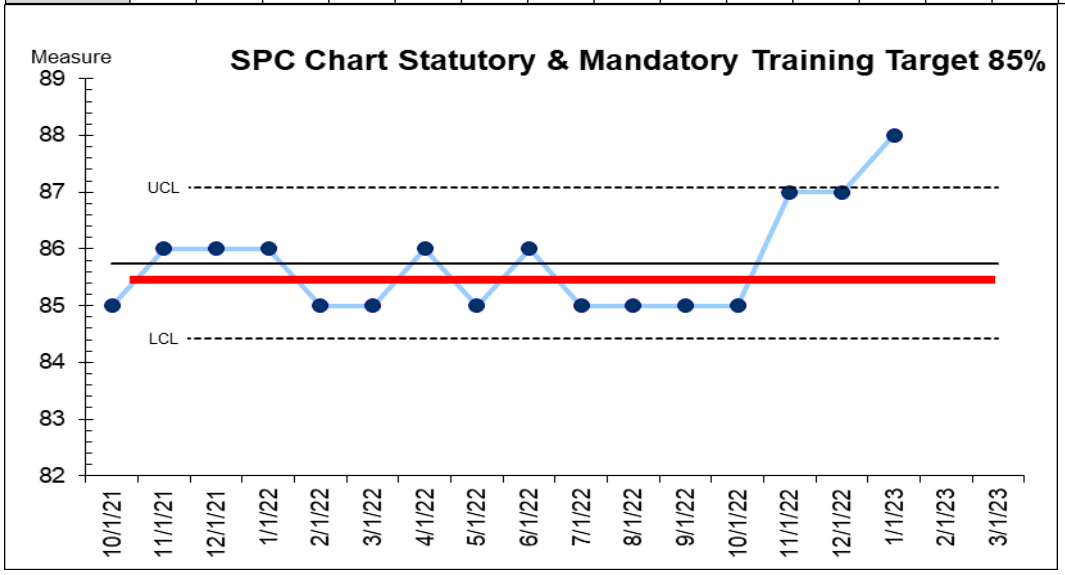
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: Carl James

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	86	86	86	85	85	86	85	86	85	85	85	85	87	87	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 86% against the 85% target, with the target being met for the last year.

Performance

Assessment of current performance, set out key points:

- Compliance target is being met
- VCC at 85%
- WBS at 94%
- Corporate Services at 88%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Improved 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 • The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Monthly	Head of OD People and OD Senior Business Partner

Expected Performance gain – longer-term

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

Risks to future performance

Set out risks which could affect future performance

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

KPI Indicator KPV.07

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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	No 21	Dec 21	Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Hospital Acquired Thromboses	0	0	1	0	1	0	0	0	1	0	0	0	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:

- Performance on target

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.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 July 2021 to September 2022

VCC	Nov 21	Dec 21	Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
C.diff	0	0	1	0	1	0	0	0	0	0	0	0	0	1	1
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
E.coli	0	0	0	0	0	0	0	0	1	0	0	0	0	1	3
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg	0	0	0	0	0	0	0	0	0	0	0	0	0	1	4

Performance

Assessment of current performance, set out key points:

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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

KPI Indicator KPV.08

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Hand Hygiene

Target: TBA

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene

VCC	Dec 21	Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Hand Hygiene															
Target Nil															

This measure is under development

Performance

Assessment of current performance, set out key points:

- Performance is on target

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPI.30

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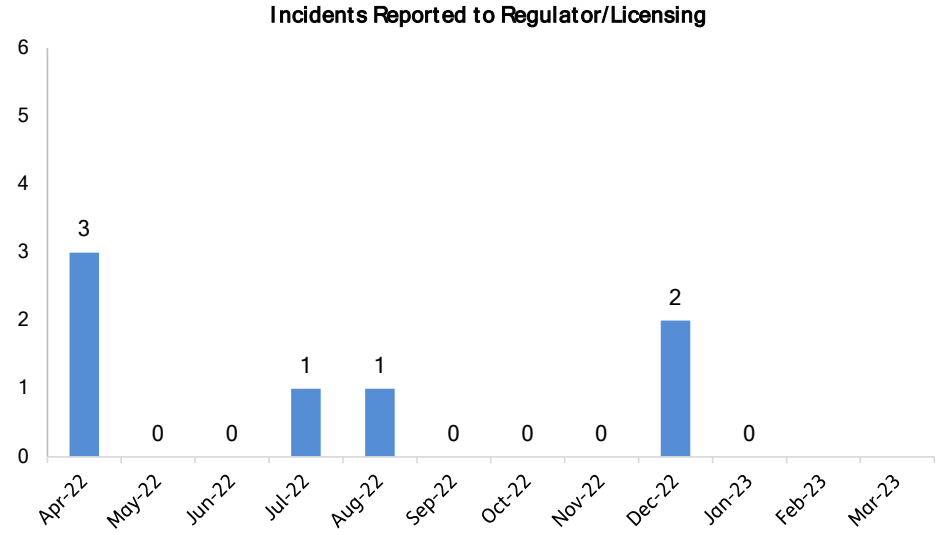
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Nov 21	Dec 21		Jan 22	Feb 22	Mr 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual	2	0		0	1	0	3	0	0	1	1	0	0	0	2	0
Target	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0



Performance

Assessment of current performance, set out key points:

No Serious Adverse Blood-Related Event (SABRE) reports were submitted to the Medicines and Healthcare Product Regulatory Agency (MHRA) in January 2023.

No adverse event reports were submitted to the Human Tissue Authority (HTA) in January.

There were no Serious Hazards of Transfusion (SHOT) incidents reported during the month.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

N/A

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

N/A

Risks to future performance

N/A

KPI Indicator EST.06

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

Target: -16%

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23
Actual Number															
Target -16%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	-3%	

[Graph and data to be inserted under development]

Performance

Assessment of current performance, set out key points:

- insert text
- insert text
- insert text

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

EFFECTIVENESS

KPI Indicator KPV.05

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Number of Delayed Transfers of Care (DToC)

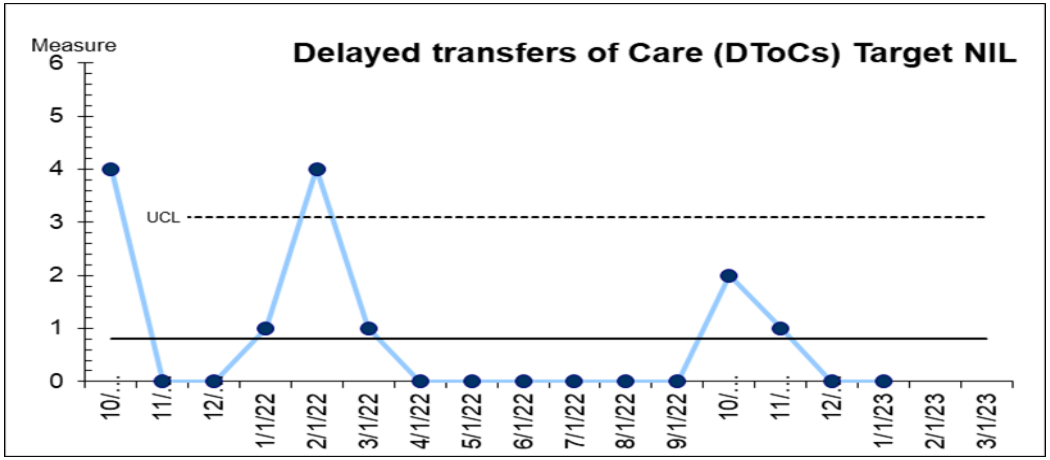
Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Performance

VCC	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	0	0	1	4	1	0	0	0	0	0	0	2	1	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 two 'special cause' or exceptional variations in October 2021 and February 2022.

Assessment of current performance, set out key points:

There were 0 DTOC in January 2023. Performance on target.

.

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 from February with reporting requirements commencing March 2023 once system access has been granted.	End of March 2023	Head of Nursing

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPI.04

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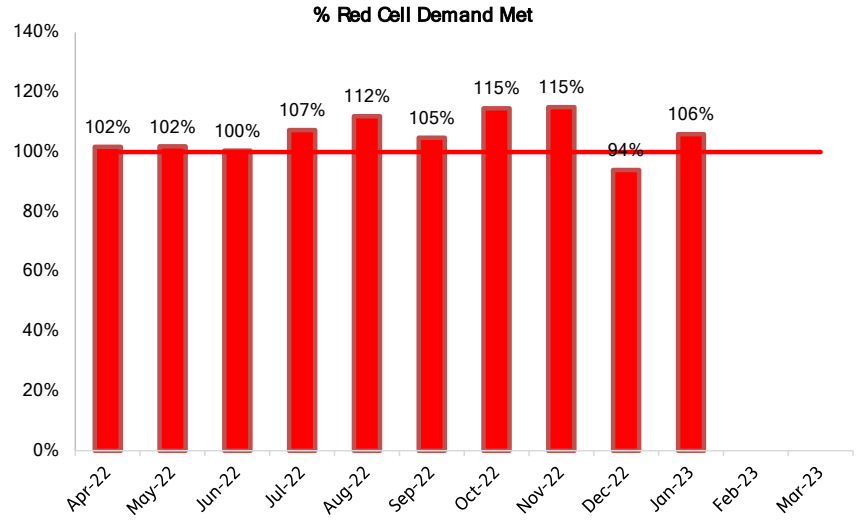
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Tracey Rees

Current Performance against Target or Standard

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	101	99	110	100	100	102	102	100	107	112	105	115	115	94	106
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

All clinical demand was met during this period, whilst collection also exceeded demand over this period indicating potential stock growth.

Demand (full weeks) averaged at 1451 units per week, and the 'Blue Alert' for O negative blood group shortage that had commenced on 30th December 2022, ended on 11th January 2023 once stocks had recovered.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
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	Jayne Davey / Tracey Rees

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

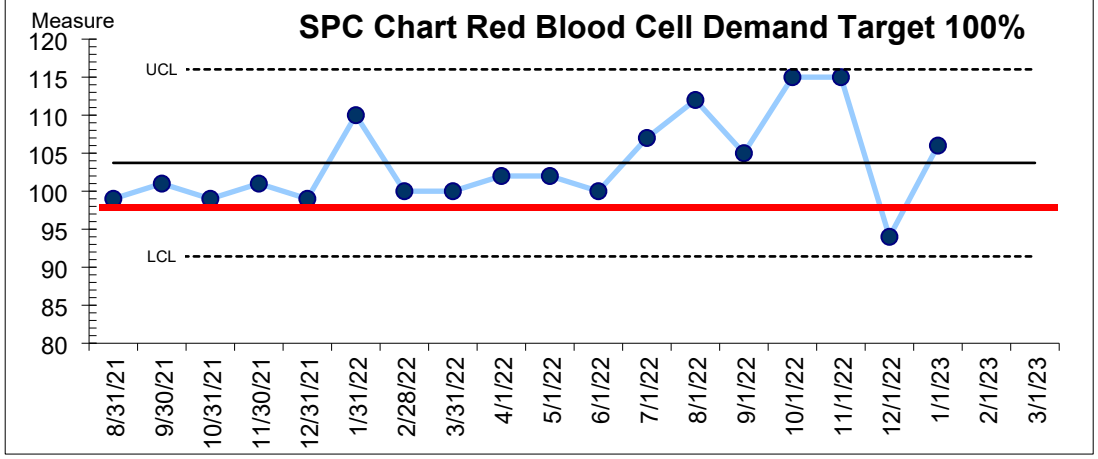
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
N/A	N/A	Jayne Davey / Tracey Rees

Expected Performance gain – longer-term N/A

Risks to future performance

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



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

KPI Indicator KPI.26

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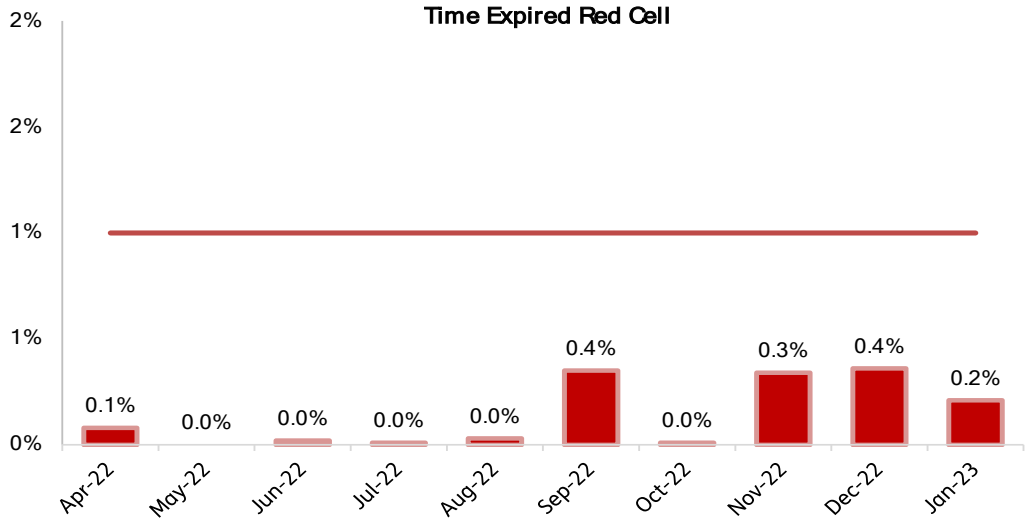
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	0.08	0.05	0.05	0.04	0.08	0.08	0.00	0.02	0.01	0.03	0.35	0.01	0.33	0.36	0.21
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:
This metric remains within the target.
Red cell shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

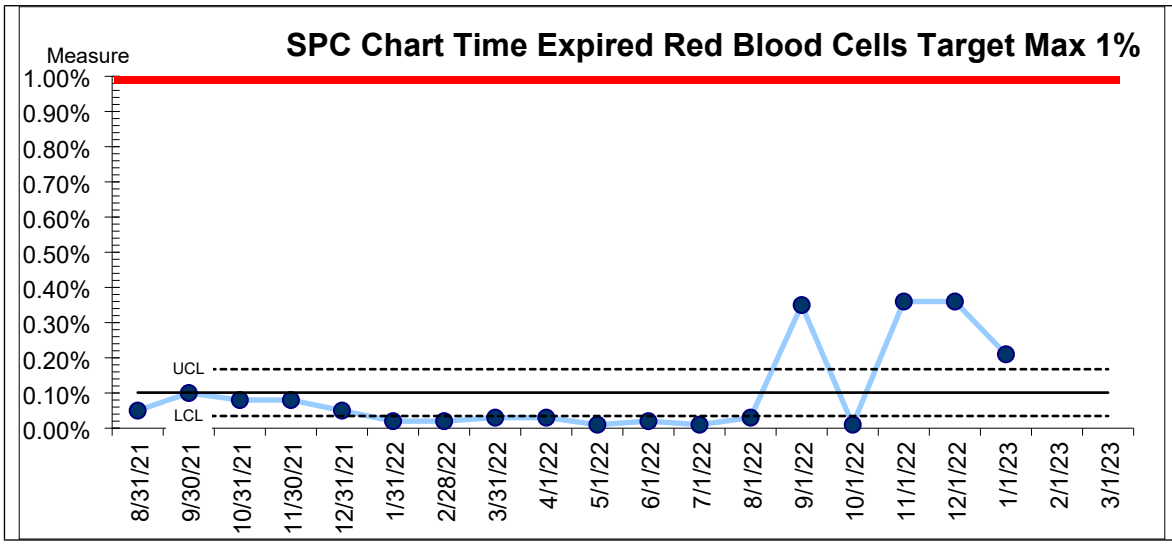
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term
N/A

Risks to future performance
High stock levels lead to a risk of increased time expiry

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



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

KPI Indicator KPI.25

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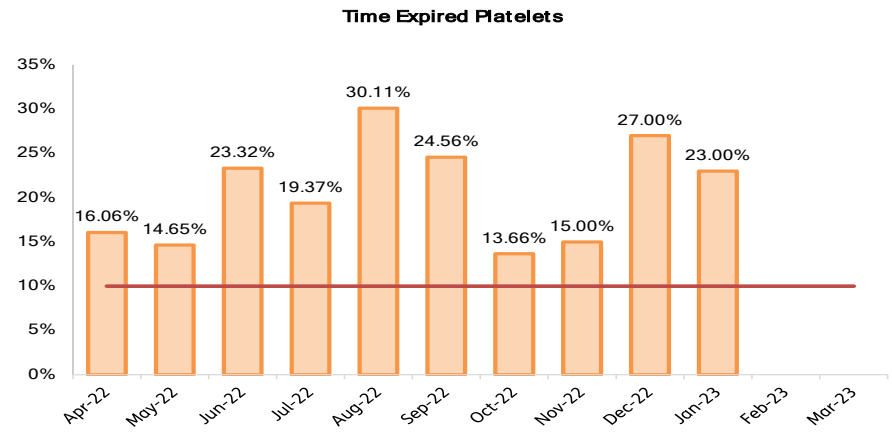
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	10	17	15	17	14	16	15	23	19	30	25	14	15	27	23
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



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

Performance

Assessment of current performance, set out key points:

Platelet wastage performance exceeded target and is due to:

- Planned increased production to counterbalance the expected deficit because of bank holidays resulting in units produced in December expiring in early January.
- Increased wastage is caused by reduced demand. Pre planning for production occurs based on previous week's issues as it takes a least 2.5 days for a platelet to be available for issue with a shelf life of 7 days.

Variability in demand during January was not consistent making pre-planning more difficult.

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
A Platelet Strategy Board will be established to co-ordinate the work of the two Task and Finish Groups that were convened following the platelet review that took place in November 2022 and other ongoing work streams in Clinical Services.	Qtr 4	Tracey Rees
Develop a forecasting tool to inform decisions around pooled platelet manufacture (Task & Finish Group 1).	Trial in March 23	Peter Richard son

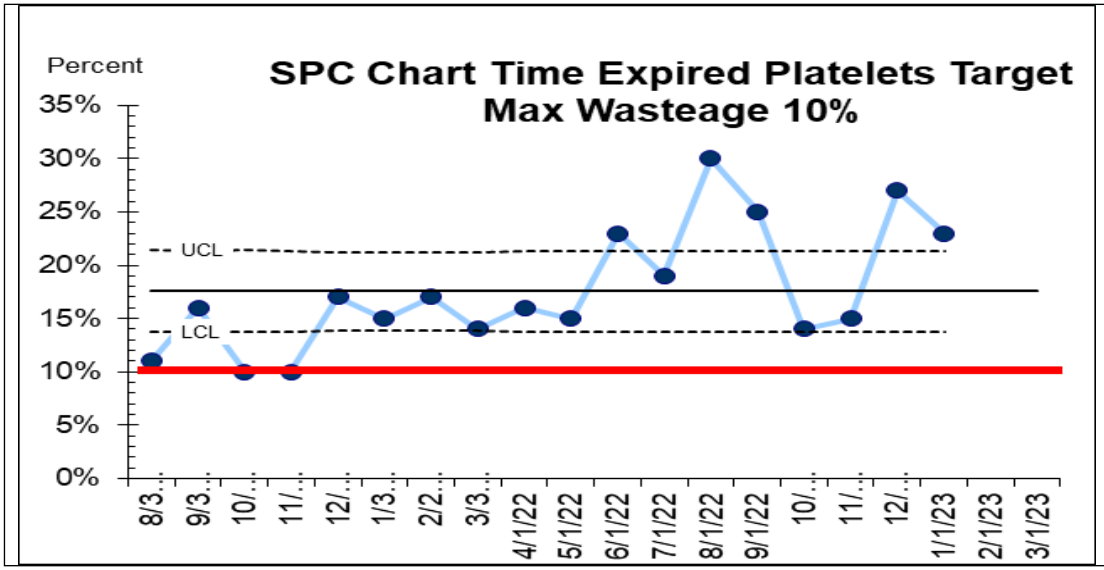
Expected Performance gain - immediate

Improved wastage rates - tool has been designed to provide more granular detail to allow subtle changes in production.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Review the clinic collection pan for Apheresis (Task & Finish Group 2) to ensure the clinic times are optimised, given to additional 2 day shelf life of platelets.	Qtr 1 23 onwards	Jayne Davey

	Expected Performance gain – longer-term A risk-based approach balancing platelet expiry against ability to supply platelets for clinical needs. Platelet expiry at WBS will reduce.
	Risks to future performance
	Set out risks which could affect future performance



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

KPI Indicator KPI.13

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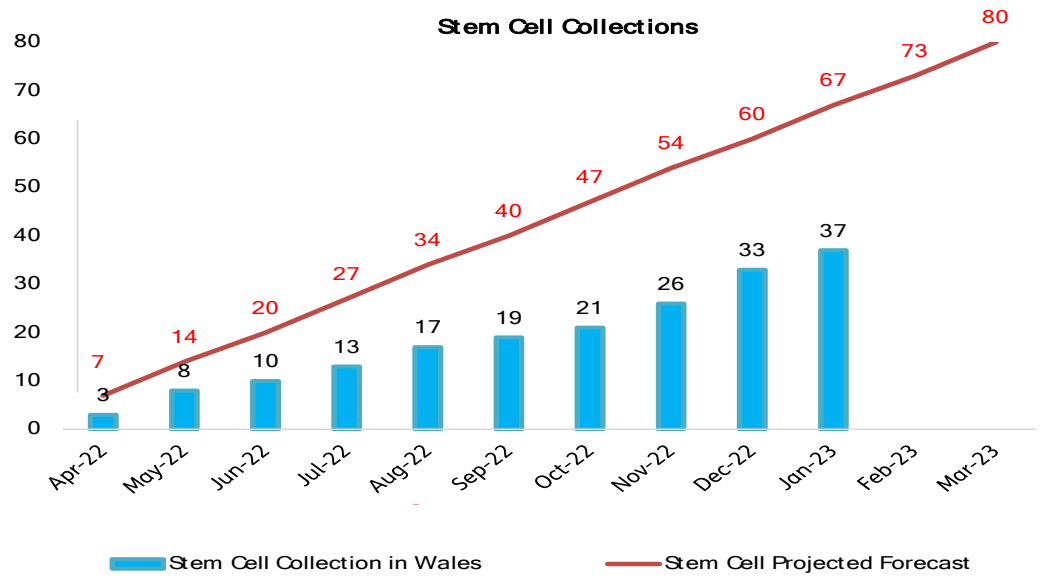
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23
Cumulative Actual	32	33	39	44	47	3	8	10	13	17	19	21	26	33	37
Cumulative Target p/a	54	60	67	73	80	7	14	20	27	34	40	47	54	60	67



Performance

Performance for January did not meet target. The total number of stem cells collections for January was 4 (4 collections were cancelled during January for patient reasons) and 1 peripheral blood lymphocyte collection.
The total stem cell provision for the service was 7 (4 collected and 3 imported for Welsh patients).
The Service continues to experience a cancellation rate of approx. 30% compared to 15% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

As above

Service Improvement Actions – tactical (12 months +)

	imescale:	**Lead:**
Implementation of the five-year strategy.	Qtr 1 2023 onwards	Tracey Rees

Expected Performance gain – longer-term

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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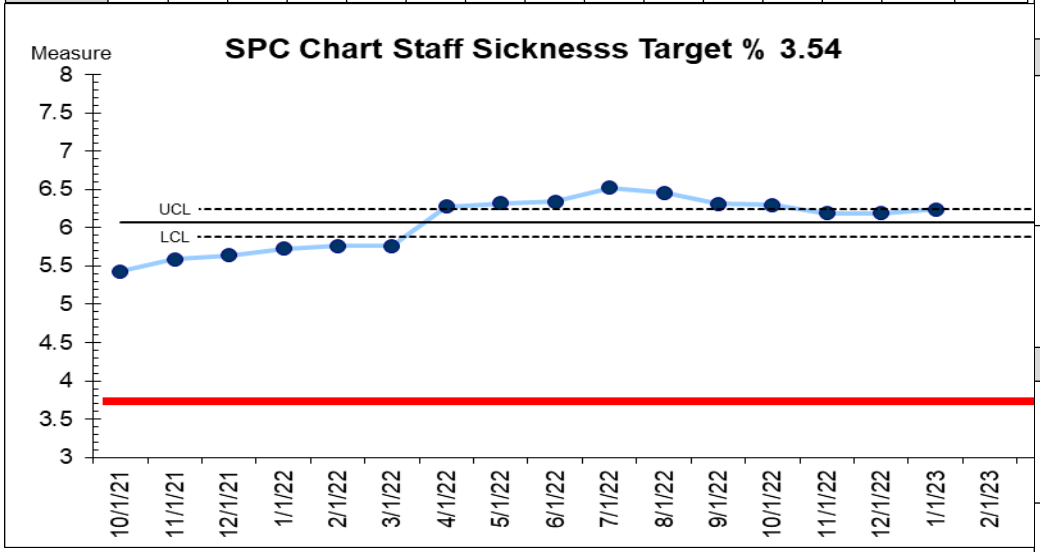
Staff Sickness levels against Target

Target: 3.54%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	5.58	5.63	5.73	5.81	6.07	6.30	6.36	6.42	6.53	6.50	6.36	6.30	6.19	6.19	6.24
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

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

Risks to future performance

Set out risks which could affect future performance

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

KPI Indicator WOD.36

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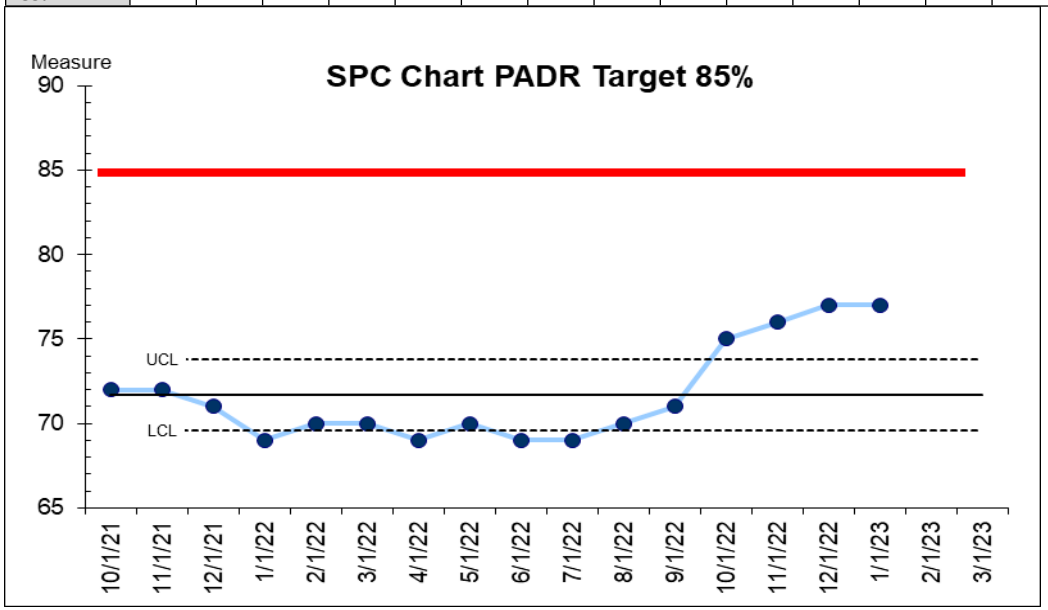
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	72	71	69	70	70	69	70	69	69	70	71	75	76	77	77
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 improving trend over the last 6 months. However, performance falls consistently short of the 85% target.

Performance

Assessment of current performance, set out key points:

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

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

Risks to future performance

Set out risks which could affect future performance

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

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

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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	Nov21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul22	Aug22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Would you recommend us? %										89	89	88	nda	nda	93
Your Velindre Experience? %													nda	nda	84
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 93% achieved in January was due to 122 survey responses to the VCC 'Would you recommend us? CIVICA survey.

51 patients responded to "Your Velindre Experience" CIVICA survey. Of these 51 responses, 43 responded 9/10 and 10/10. The remaining patients responded 7/10 and 8/10. No further narrative was provided to assess the reason for the 7 and 8/10 response.

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.	February 2023	SLT

Expected Performance gain – immediate

Patient Experience and Concerns manager in post since February 2023.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

KPI Indicator KPI.09

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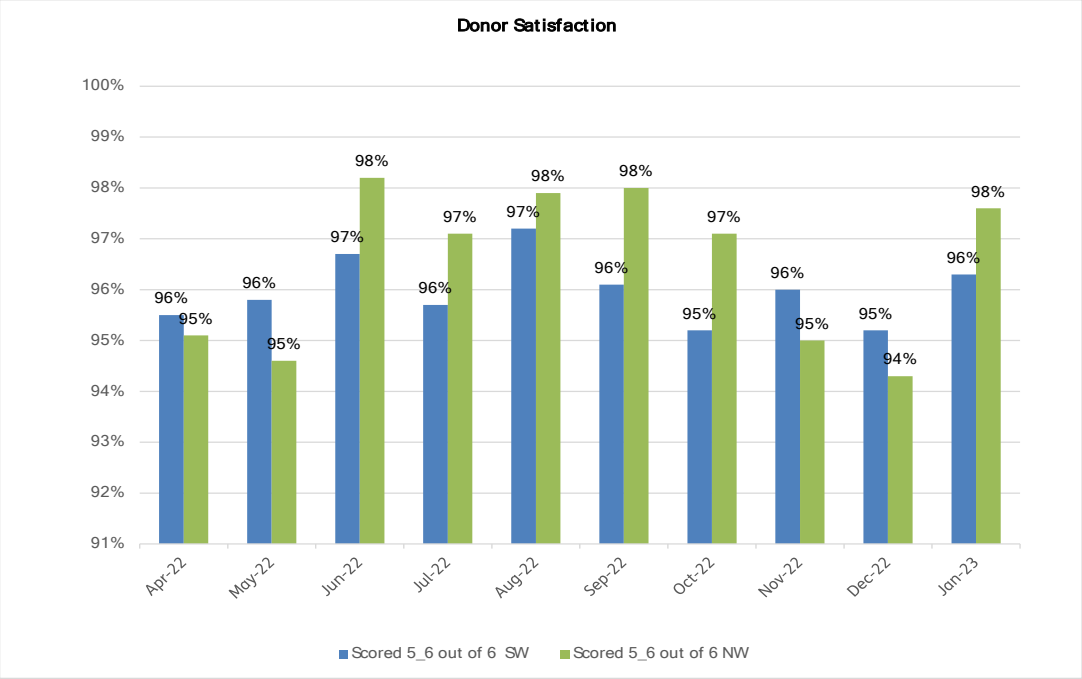
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	98	96	95	95	97	96	96	97	96	97	97	96	96	95	96.6
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 96.6% donor satisfaction exceeded target for January.

In total there were 1,079 respondents to the donor survey, 219 from North Wales, and 848 from South or West Wales.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Findings are reported on at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams. 'You Said, We Did' actions are taken from the reporting.	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:
N/A		

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	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	M 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %									100	100	100	100	100	100	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:

- Target deadline has been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Patient Experience and Concerns manager in post since February 2023

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.03

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

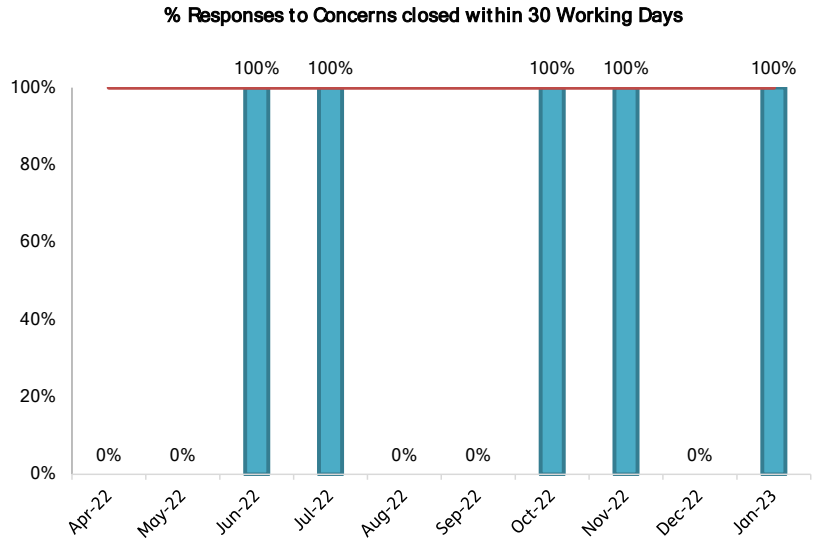
Target: 90%

SLT Lead: Alan Prosser

Current Performance against Target or Standard

WBS	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %			n/a	100	n/a	n/a	n/a	100	100	n/a	n/a	100	100	N/A	100
Target 90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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



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

Performance

Assessment of current performance, set out key points:
All concerns were managed in line with PTR regulations, all timescales achieved.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to monitor this measure against the '30 working day' target compliance. Continued reemphasis of concerns reporting timescale needs to all staff involved in concerns management reporting	Ongoing	Janet Birchall

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Ongoing monitoring and oversight of concerns management in line with PTR.	Ongoing	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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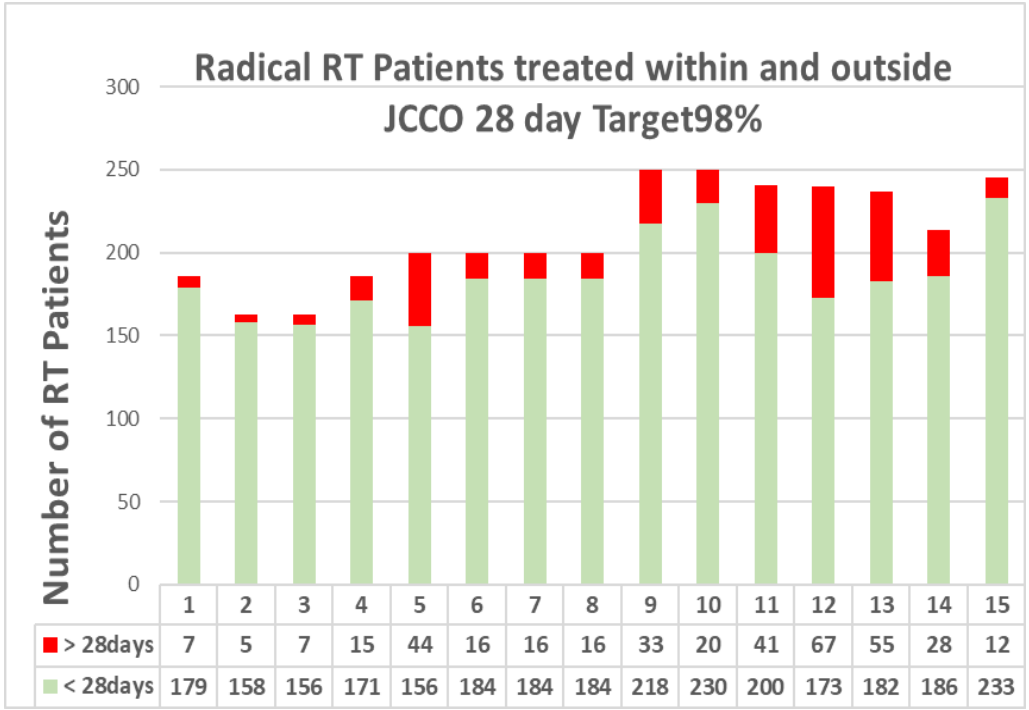
Radical Radiotherapy Patients Treated Within 28 Days (JCCO)	
Target: 98%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



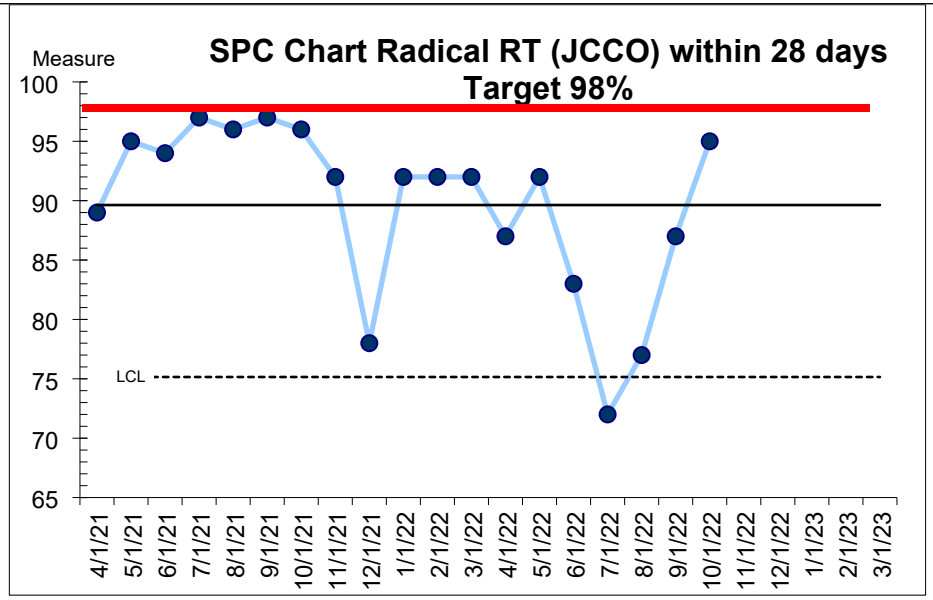
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
> 28days	7	5	7	15	44	16	16	16	33	20	41	67	55	28	12
< 28days	179	158	156	171	156	184	184	184	218	230	200	173	182	186	233

Assessment of current performance, set out key points:

Due to the implementation of DH & CR, there are no waiting list reports yet available to accurately report Radiotherapy performance. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during late February, following which a period of data validation will ensue. The targets affected by this are the 3 Radiotherapy waiting time targets.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Gradual increase in LINAC capacity by 8% has occurred from Mid-July onwards. Work being undertaken within the Directorate extended working days and increased utilisation of LINAC capacity from 73.5 planned hours in June to up to 76.5 hours delivered in December	January 2023 complete Ongoing	Radiation Services Lead
• Fleet configuration changes to support Breast patient treatment options have been implemented.		
• Escalation processes continue to monitor predicted failures to meet time to treatment metrics and prioritise patients to commence treatment and minimise delay where possible, undertaken through weekly capacity meetings.	Ongoing January 2023	
• Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group.		
• Review of patients who were not ready for treatment to assess whether treatment planned too soon. Collate lessons learnt and review pathway.		SI Manager
• The Prostate HDR business case was approved by Senior Leadership Team at the Velindre Futures Programme Board in June 2022. The preferred option		



SPC Chart Analysis

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

of extended days will be the model utilised in the expansion.		Radiation Services Manager

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Working with each SST to develop a tailored capacity delivery plan based on demand projections and treatment options e.g. Brachytherapy, molecular radiotherapy. • Recruitment and appointments in progress for additional front-line resources.	Q3/4	Heads of Service and SST's Leads

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Risks remain however to provide specific Brachytherapy capacity and Radiotherapy Physics capacity and there are significant risks associated with the age of the equipment and potential breakdown, and lack of specialist workforce.

KPI Indicator KPV.15

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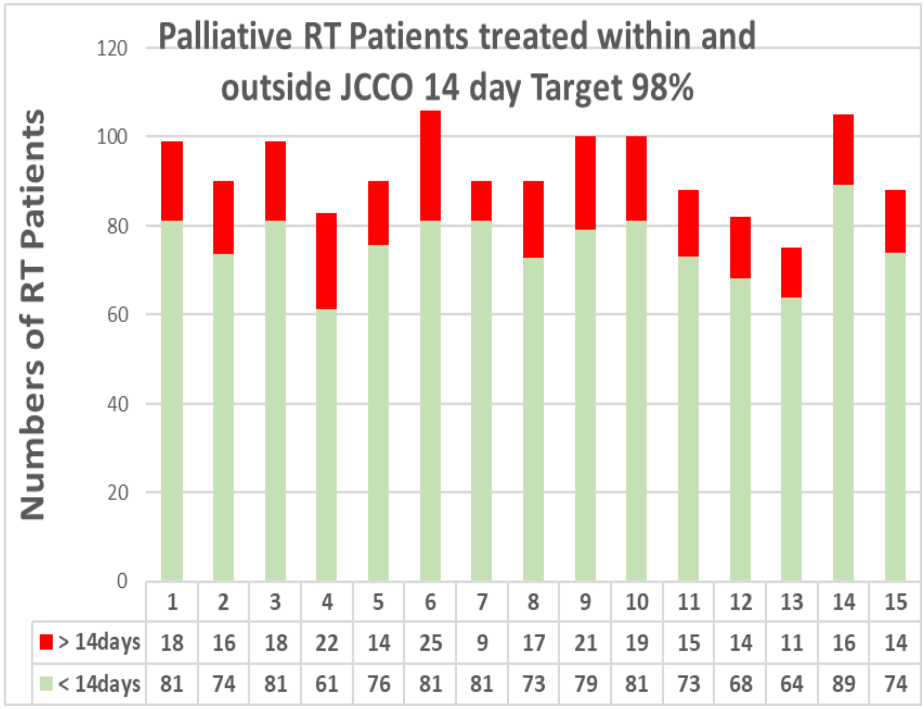
Palliative Radiotherapy Patients Treated Within 14 Days (JCCO)	
Target: 98%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
> 14days	18	16	18	22	14	25	9	17	21	19	15	14	11	16	14
< 14days	81	74	81	61	76	81	81	73	79	81	73	68	64	89	74

Due to the implementation of DH & CR, there are no waiting list reports yet available to accurately report Radiotherapy performance. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during late February, following which a period of data validation will ensue. The targets affected by this are the 3 Radiotherapy waiting time targets.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

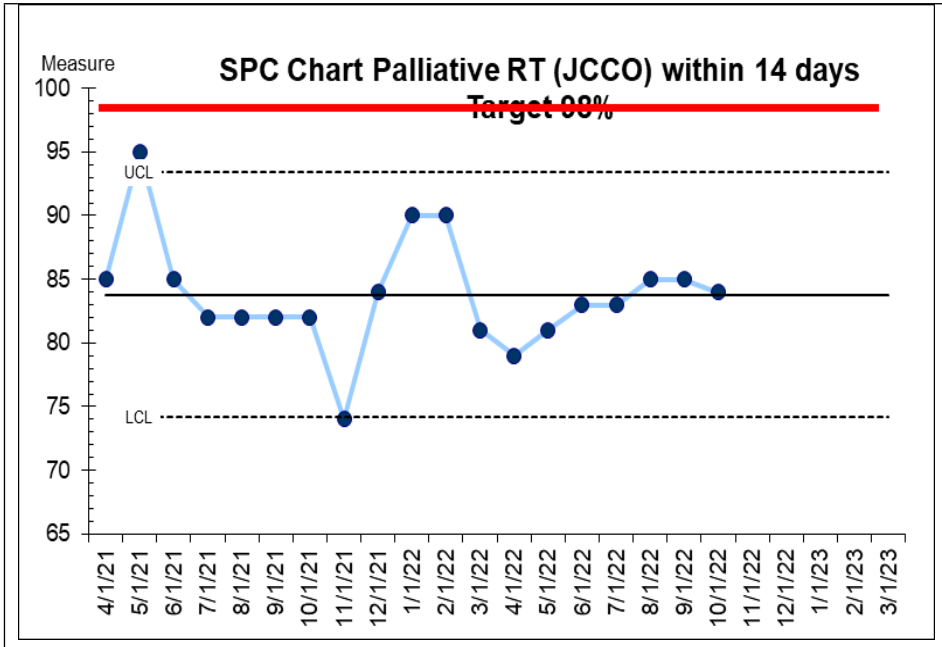
Service Improvement Actions – tactical (12 months +)

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

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 with a dip in performance June to November. However, the average performance of 84% consistently falls below the 98% target.

KPI Indicator KPV.16

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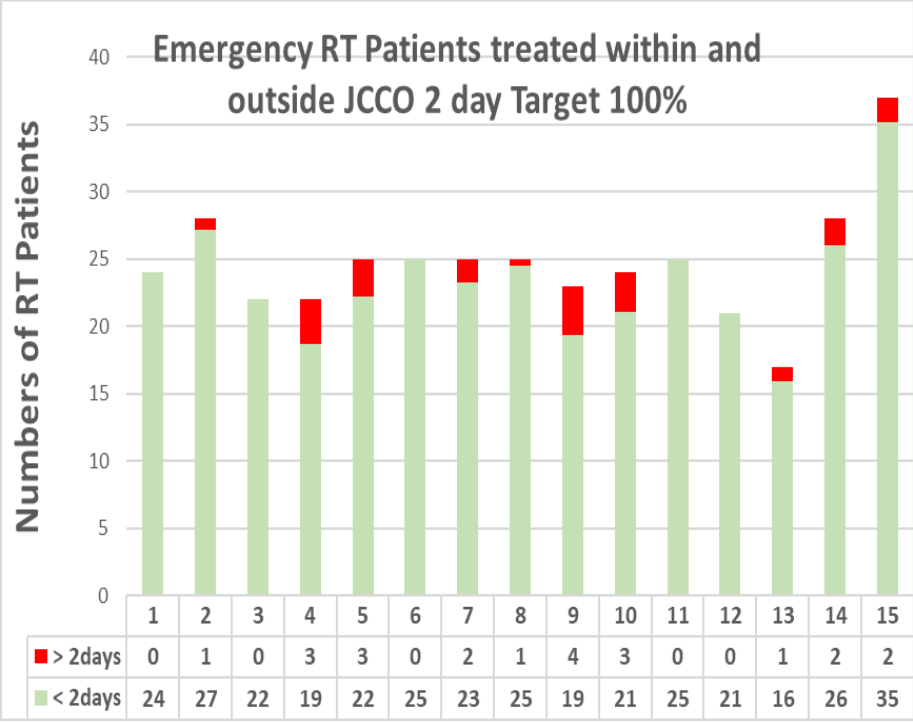
Emergency Radiotherapy Patients Treated Within 2 Days (JCCO)

Target: 98%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
> 2days	0	1	0	3	3	0	2	1	4	3	0	0	1	2	2
< 2days	24	27	22	19	22	25	23	25	19	21	25	21	16	26	35

Performance

Due to the implementation of DH & CR, there are no waiting list reports yet available to accurately report Radiotherapy performance. These are being rewritten to match the interface issues between the existing operational systems and the new DH & CR. We are expecting this to be functioning during late February, following which a period of data validation will ensue. The targets affected by this are the 3 Radiotherapy waiting time targets.

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Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

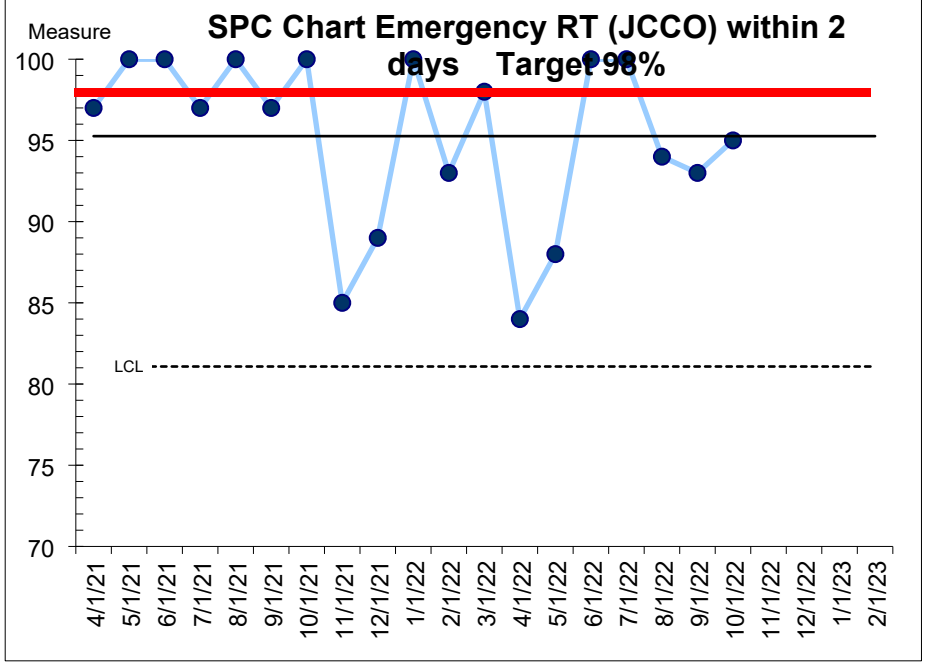
Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-



SPC Chart Analysis

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

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

	No 21	Dec 21	Jan 22	Feb 22	Mar22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	**99**	99	94	91	71	69	61	59	66	77	89	96	98	96	97
Target 98%	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**
More than 21 days	**5**	**4**	**21**	**32**	**118**	**116**	**146**	**147**				**14**	**6**	**12**	**9**
Within 21 days	**367**	**347**	**329**	**319**	**400**	**375**	**375**	**355**				**341**	**354**	**322**	**336**

The number of patients scheduled to begin non-emergency SACT treatment in August 2022 (409) was higher than the number in July (389).

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Attendances	2,189	2,344	2,015	2,315	2,357	2,214	2,316	2,180	2,047	2,276	2,017	1,832
2020/21 Attendances	1,219	1,212	1,375	1,537	1,641	1,696	1,941	1,891	1,982	1,957	1,975	2,253
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,189	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,488	2488	2464	2500				

This high level of activity was a major factor in the improvement in both the overall performance but also the reduction in breaches and the volume of patients treated nearer the target days.

Performance

Of 345 patients treated, 9 patients waited over 21 days = performance of 97%.

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	6	1	1	1

1 x patient waited 56 days. There were challenges associated with contacting the patient for outpatient & SACT appointments. Administrative processes impacted by the DHCR implementation and postal strike affected normal appointment processes. Consultant confirmed no harm occurred.
2 patients waited > 28 days. At the time of the report SACT&MM are awaiting feedback from the relevant consultant re: any clinical concern for each of these patients.

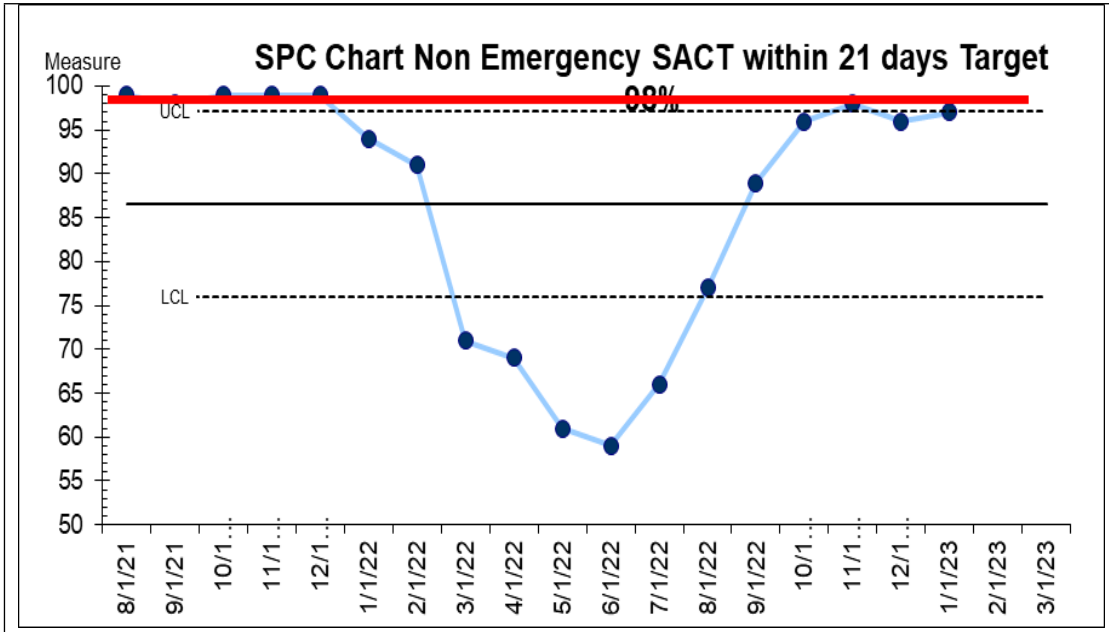
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Incremental gains in pharmacy capacity are being delivered through reviews of working practices and the focus on maximising SACT provision.		BT
• Discussions with Aneurin Bevan UHB regarding the reintroduction of services at Nevill Hall Hospital (NHH) as an interim solution taking place.		BT

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

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



SPC Chart Analysis

The period January to June 2022 saw a significant fall and 'special cause' variation. However, the position has recovered over the last six months.

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.21

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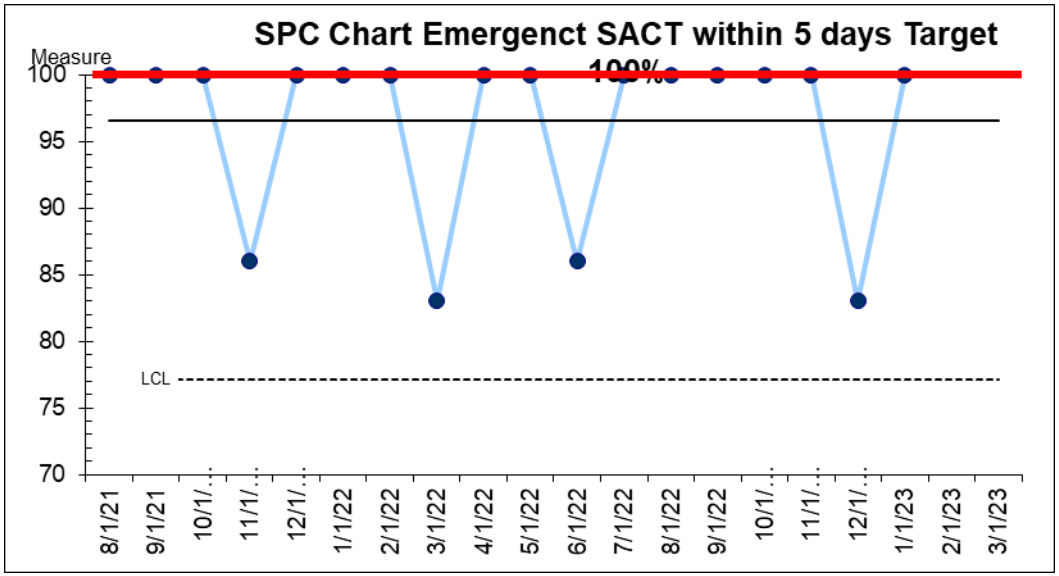
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	No 21	Dec 21	Jan 22	Feb 22	Ma 22	Apr 22	My 22	Jun 22	Jul2 2	Au2 2	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	60	100	100	100	83	100	100	86	100	100	100	100	100	83	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	2	0	0	0	1	0	0	2	0	0	0	0	0	1	0
Within 5 days	3	9	10	9	6	7	9	7			0	5	6	5	8



SPC Chart Analysis

The SPC chart shows relatively stable process that meets the 100% target, with the exception of four data points. (note small numbers)

Performance

8 patients referred for emergency SACT treatment were scheduled to begin treatment in January 2023. All were treated in target with 100% performance.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Continue to balance demand and ring fencing with capacity.	Continuous	BT

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPI.18

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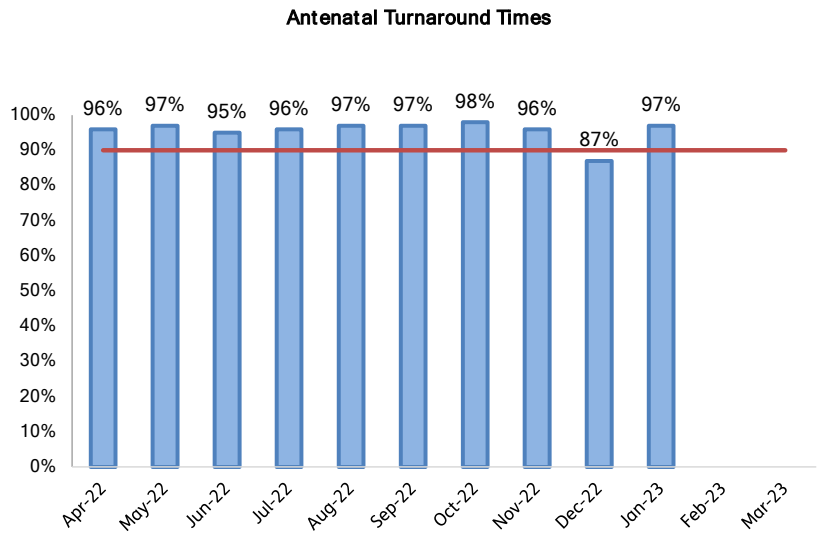
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %	97	96	96	96	96	95	96	95	96	97	97	98	96	87	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 for routine Antenatal tests has returned to above target in January 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.		Tracey Rees

Expected Performance gain - immediate
Business as usual, reviewed daily.

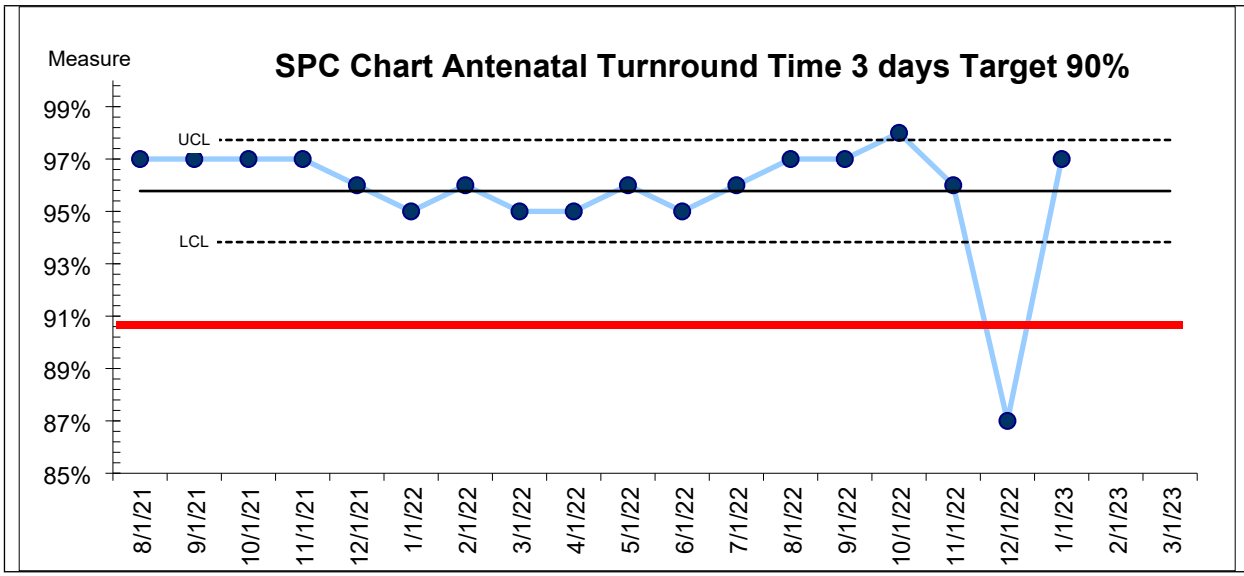
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term
N/A

Risks to future performance

Set out risks which could affect future performance



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. However, a special cause variation has occurred in December (as discussed above). The average performance of 96% exceeds the 90% target.

KPI Indicator KPI.17

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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

	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actual %	99	99	96	100	99	83	99	96	99	99	96	97			
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90			

Performance

On target this quarter.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

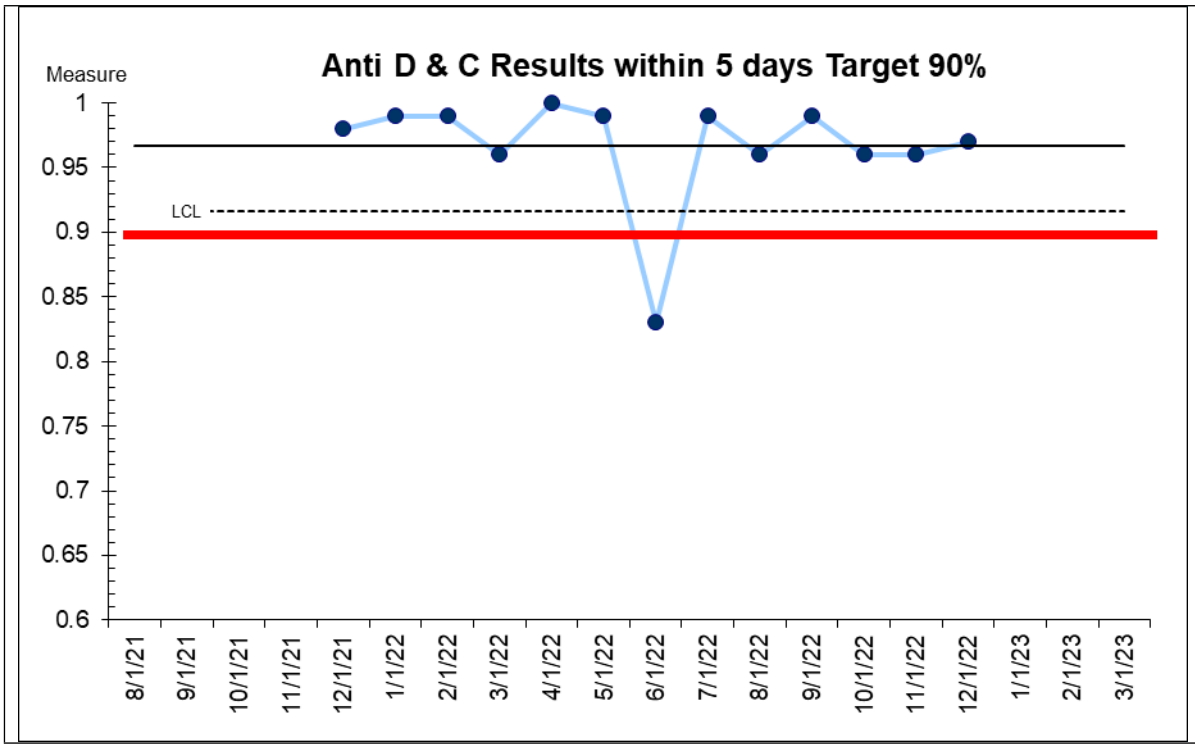
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance



SPC Chart Analysis
The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter two. However, the average performance of 96% exceeds the 90% target overall.

EFFICIENT

KPI Indicator FIN.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Finance Director

Current Performance against Target or Standard

Performance

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual £k	28	1	3	7	6	5	3	5	3	6	2		
Target Net Zero													NIL

Trust-wide Revenue Position as at January 2023

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(31,365)	(31,366)	0	(38,364)	(38,364)	0
RD&I	(617)	(617)	(0)	175	175	0
WBS	(17,207)	(17,207)	(0)	(20,856)	(20,856)	0
Sub-Total Divisions	**(49,190)**	**(49,190)**	**0**	**(59,046)**	**(59,046)**	**0**
Corporate Services Directorates	(9,216)	(9,213)	(3)	(11,515)	(11,515)	0
Delegated Budget Position	**(58,405)**	**(58,403)**	**(3)**	**(70,561)**	**(70,561)**	**0**
TCS	(551)	(551)	0	(797)	(797)	(0)
Health Technology Wales	(43)	(44)	(1)	(48)	(48)	0
Trust Income / Reserves	59,000	59,000	0	71,406	71,406	0
Trust Position	**(0)**	**2**	(2)	**0**	**0**	**(0)**

Assessment of current performance, set out key points:

The overall position against the profiled revenue budget to the end of January 2023 is an underspend of £0.002m, along with an overall outturn forecast position of Breakeven.

The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be fully funded.

Covid funding towards recovery from Commissioner's remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Actions addressed through Divisional Action Plans		M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.73

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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

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	12.4	1.0	1.411	3.134	**3.989**	4.615	5.954	7.884	9.681	11.796	14.346		
Target £27.760M CEL		1.0	1.411	3.134	3.989	4.615	5.954	7.884	9.681	11.796	14.346		20.042

Trust-wide Capital Position as at January 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M10 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - Project costs	2.394	2.496	0.000	-0.102	2.923	-0.529
nVCC - Enabling Works	14.406	8.913	0.000	5.493	13.877	0.529
Canisc Cancer Project	0.579	0.579	0.000	0.000	0.579	0.000
Fire Safety	0.500	0.294	0.000	0.206	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	1.554	0.000	6.086	7.640	0.260
WG Priority Year end Spend	0.370	0.000	0.000	0.370	0.370	0.000
WBS Infrastructure OBC Fees	0.157	0.000	0.000	0.157	0.157	0.000
Total All Wales Capital Programme	26.306	13.836	0.000	12.210	26.046	0.260
Discretionary Capital	1.454	0.510	0.191	0.753	1.714	-0.260
Total	27.760	14.346	0.191	12.963	27.760	0.000

Performance

The approved 2022/23 Capital Expenditure Limit (CEL) as at January 2023 was £27.760m. This includes All Wales Capital funding of £26.306m, and discretionary funding of £1.454m. The approved CEL has increased in year by £1.904m which reflects approval of the Canisc Cancer Project (0.579m), IRS (7.900m), Velindre's share of the WG yearend spend request (0.370m) and support fees for the WBS infrastructure OBC (£157k). This is offset by a reduction of 7.102m on the nVCC Enabling works project to reflect the latest forecast requirement for 2022/23. Following agreement with WG the £7.102m will be re-provided to the programme during 2023/24.

WG colleagues have agreed a further movement of £0.529m between the nVCC enabling and project costs which is reflected in the table above but represented as a variance rather than a CEL adjustment.

On the 22nd November the Trust received the award funding letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.900m of the total to be provided during 2022/23 with future years funding cash flow to be agreed with WG.

In January 2022 WG informed the Trust that the discretionary allocation will be significantly reduced during 2022/23 (previously £1.911m), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

Performance to date

The actual cumulative expenditure to January 2022 on the All-Wales Capital Programme schemes was £12.210m, this is broken down between spend on the nVCC enabling works £8.913m, nVCC project costs of £2.496m, Canisc Cancer Project £0.579m, fire safety £0.294m, and IRS £1.554m.

Spend and committed spend to date on Discretionary Capital is currently £0.701m leaving a remaining balance of £0.753m as at the 31st January.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position.

Service Improvement Actions – Immediate (0 to 3 months)

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

	Expected Performance gain - immediate		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
	Expected Performance gain – longer-term		
	Risks to future performance		
	Set out risks which could affect future performance •		

KPI Indicator FIN.72

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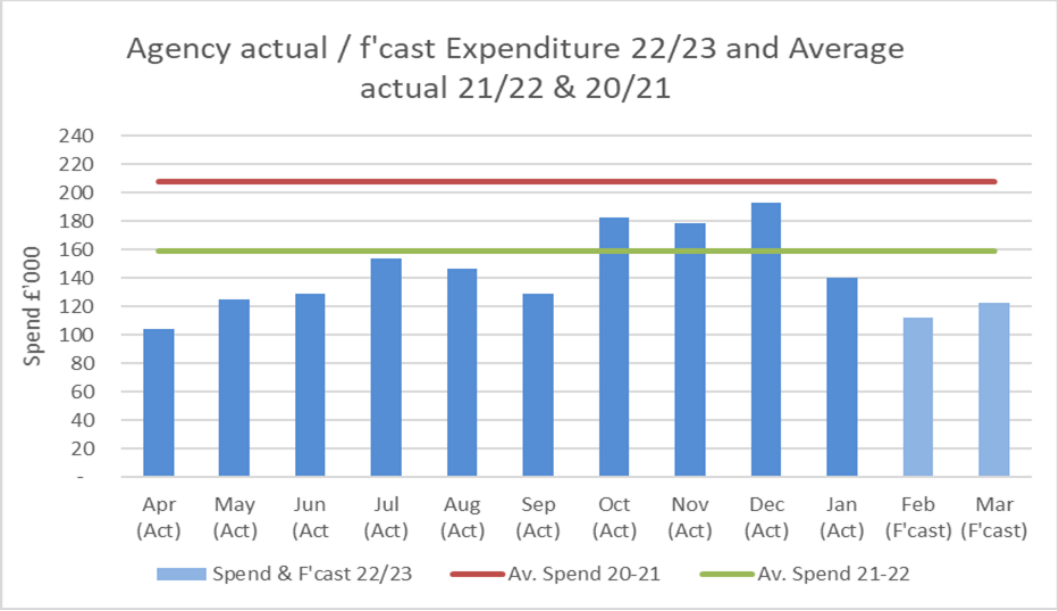
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	1.906	103	125	130	**154**	146	129	183	179	193	140		
Target £1.533M Forecast		128	128	128	128	128	128	128	128	128	128	128	128



Performance

The spend on agency for January 23 was £0.140m (December £0.193m), which gives a cumulative year to date spend of **£1.482m** and a current forecast outturn spend of circa **£1.717m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of January is £0.264m and forecast spend is circa £0.316m (£0.826m 2021/22).

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

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Cost Improvement Programme delivery against plan

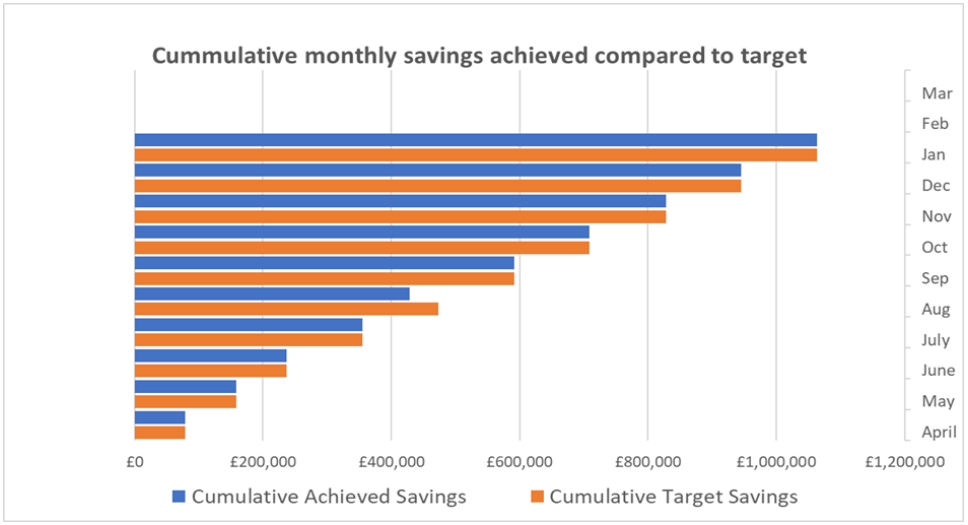
Target: Savings in line with Forecast CIP

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	21/22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 22	Mar 23
Actual	1.100	0.75	.0160	0.254	**0.355**	0.429	0.592	0.709	0.795	0.945	1.064		
Target £1.3M Forecast		0.75	0.160	0.254	0.355	0.474	0.592	0.709	0.795	0.945	1.064		1.300

Overall VUNHST Cost Improvement Programme £1.3M



Performance

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as actual saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

Two schemes continue to be impacted by Covid during 2022-23 have now turned red which relate to service redesign and supportive structures.

Service redesign and supportive structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. These plans are aligned to a number of the Trust VBHC bids that sought funding for new posts to support medical workforce redesign but were unsuccessful. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the Trust divisions however, it is recognised due to the current challenges that these saving schemes will not be achieved in the short term and therefore delivery has been removed from this financial year.

Contingency measures have been put in place on the basis that these savings schemes will not achieved this year, however these replacement schemes are both recurrent and non-recurrent in nature. **It is extremely important that divisions continue to review their current savings schemes, and where delivery is not going to be achieved this year consider the impact on next year's financial position especially where those schemes were classified as recurrent.**

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Actions delivered through Divisional Action Plans		M. Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.60

Return to Top

Public Sector Payment Performance Target Non NHS Invoices paid within 30 days

Target: 95%

SLT Lead: Finance Director

Current Performance against Target or Standard

	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23
Trust Position															
Capital & Revenue Invoices						95	95	96	96	96	96	96	96	95	94
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

Assessment of current performance, set out key points:

During January '22 the Trust (core) achieved a compliance level of **90.15%** December 22: 92.54%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.37%** as at the end of month 10, and a Trust position (including hosted) of **94.91%** compared to the target of 95%.

PSPP compliance levels have temporarily dropped in performance over the last couple of months which is bring urgently reviewed in order to understand the reason for the dip.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Working with both NWSSP and the service the finance teams are urgently reviewing the invoices that have failed in month with a view to target both bottlenecks and repeat offenders	28/02/2023	M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

EQUITABLE

KPI Indicator WOD.81

Return to Top

% Workforce declared Welsh Speakers in Trust at Level 1

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

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	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.79

Return to Top

Diversity of Workforce % Black, Asian and Minority Ethnic people applying Wales version of Workforce Race Equality Standard (WRES)

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

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	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	My 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Actual %															
Target TBA%															

[Indicator and targets are under development and ESR data validation required so figures should be treated with caution at this stage]

SPC Chart Analysis
The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST JANUARY 2022 (M10)

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB QS&P	01/03/2023 16/03/2023	Noted

ACRONYMS	
IMTP	Integrated Medium Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre
MMR	Monthly Monitoring Returns
HTW	Health Technology Wales

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of January 2023.

1.2 This financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as they are directly accountable to WG for their financial performance. Only the balance sheet (SoFP) and cash flow provides 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	(0.004)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.550	14.537	27.760
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	90.2%	94.4%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl. Covid and the exceptional cost pressures) remains broadly 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 January 23 is an underspend of **£0.002m**, with an outturn forecast position of **Breakeven**.

The Trust has now received funding towards both the pay award and the temporary increase in Employers NI.

The Trust has now received confirmation from WG that funding will be provided for the both the incremental increase in energy prices and Covid response costs.

It is expected that any potential cost pressures are managed by budget holders to ensure the delegated expenditure control limits are not exceeded in line with budgetary control procedures.
Two saving schemes relating to service redesign and supportive structures have turned red with contingency plans have been put in place to ensure that the saving target is met for this financial year.
The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be funded. Covid funding towards recovery from commissioners remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

2.3 PSPP Performance

During January '23 the Trust (core) achieved a compliance level of **90.15%** (December 22: 92.54%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.37%** as at the end of month 10.

PSPP compliance levels have temporarily dropped in performance over the last couple of months which is under urgent review. The finance team are working with NWSSP Accounts payable to understand the reasons behind the recent dip performance with a view to specifically target the invoices that are failing which should support a quick recovery in order for the 95% target to be achieved during 2022-23.

2.4 Covid Expenditure

Covid-19 Revenue Spend / Funding 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.199		0.199	0.375	0.176
PPE	0.070		0.070	0.335	0.265
Cleaning	0.289		0.289	0.427	0.138
Other Covid Response	0.286		0.286	0.967	0.681
Covid Recovery - Internal Capacity		3.167	3.167	6.056	2.889
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.845	**3.428**	**4.273**	**12.310**	**8.037**

The overall gross funding requirement related to Covid has reduced further and currently stands at £4.273m, with £0.845m being recognised for funding from WG, and the balance of £3.428m being sought from our Commissioners.

The £4.273m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, largely due to the liquidation of the Rutherford Cancer Centre (RCC).
Other funding / cost reduction reflects control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

2.5 Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

A review of the reserves position is currently underway which is following confirmation from WG that both Covid and the Exceptional National Costs will be funded, however any potential release of reserves which are recurrent in nature will need to be ringfenced to support next years expected financial pressures on both energy and Covid recovery staff capacity.

Unavoidable cost pressures and investment decisions will still be considered for reserves funding during 2022/23.

2.6 Financial Risks

Covid

The Trust continues to be in dialogue with Commissioners with regards to the costs of additional capacity required to meet the demands placed on our Planned Care services. To date, the full requirement of £3.458m, which has been invested in securing additional capacity, has not been agreed by Commissioners. The Trust is managing any shortfall this year however next year when it is anticipated income protection will cease in part or fully, the Trust is expecting to take the full financial shortfall of c£1.5m into 2023-24. The shortfall will need to be met next year through the 1.5% discretionary uplift, additional Trust savings or disinvestment from a proportion of the Covid recovery staffed capacity

2.7 Capital

a) All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget.

Slippage on the nVCC Enabling works has resulted in the Trust returning £7.102m of funding to WG during 2022/23 which will be re-provided next financial year.

The Trust (during November) received the funding award letter from WG in relation to IRS.

The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.9m of the total to be provided during 2022/23.

The Trust CEL was fixed on the 31st October. At this point WG expect any further slippage to be managed internally by the Trust.

b) Discretionary Programme

The Trust discretionary capital allocation for 2022/23 is £1.454m. This represents a 24% reduction in capital allocation compared to £1.911m in 2021/22 and is reflective of the reduced overall NHS capital budget position.

The Trust Discretionary Programme for 2022/23 was approved by EMB in August and is expected to deliver and remain within the CEL.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of January 2023 is an underspend of £0.002m with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

The Trust Board is asked to **NOTE:**

4.1 the contents of the January 2023 financial report and, in particular, the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs.

4.2 the TCS Programme financial report for January 2023 attached as **Appendix 1**.

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 JANUARY 2022/23

TRUST BOARD
30/03/2023

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2022-23.

2. Background / Context

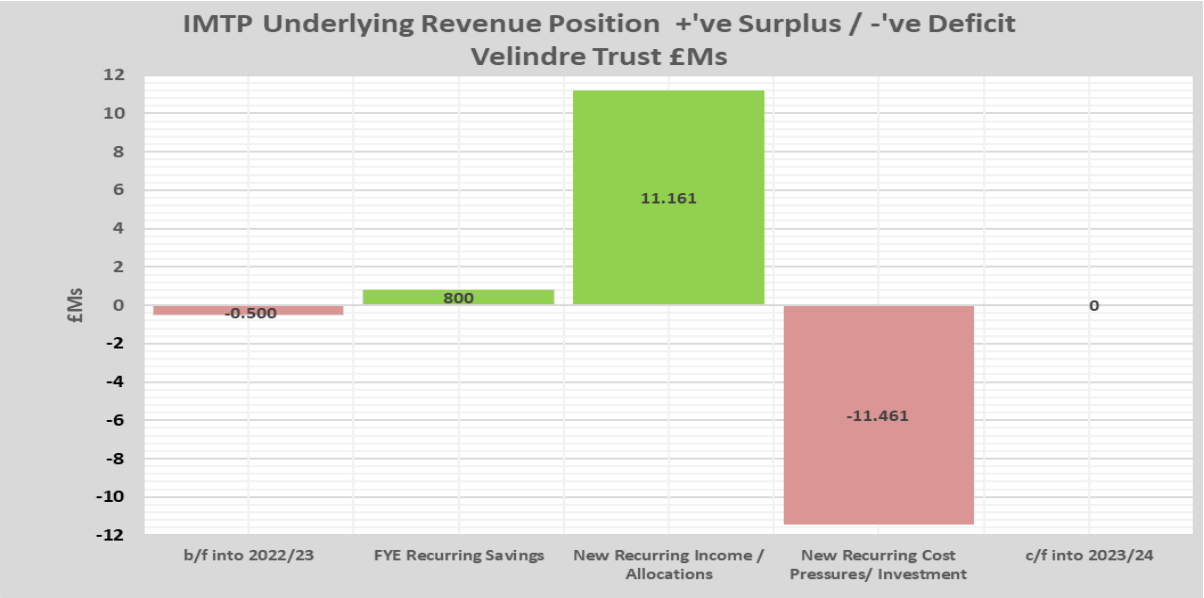
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2022-23 to 2024-25 to Welsh Government on the 31 March 2022.

- For 2022-23 the Plan (excl Covid) included;
  - an underlying **deficit of -£0.5m** brought forward from 2021-22,
  - FYE **of new cost pressures / Investment** of **-£11.461m,**
  - offset by **new recurring Income** of **£11.161m,**
  - and Recurring FYE **savings schemes** of **£0.8m,**
  - Allowing **a balanced position** to be carried into 2023-24.

- The underlying deficit is expected to be eliminated during 2022/23 through the discretionary uplift in funding, enabling a balanced position to be carried into 2023/24.

- **To eliminate the brought forward underlying deficit, the savings target set for 2022-23 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or managed through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2022/23	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2023/24
Velindre NHS Trust	-0.500	0.800	11.161	-11.461	0

3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.004)	0.002	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.550	14.537	27.760
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	90.2%	94.4%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	0	0	0

Revenue

The Trust has reported a £(0.004)m overspend for January '23, with a cumulative position of £0.002m underspent, and an outturn forecast position of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at January '22 is **£27.760m**. This represents all Wales Capital funding of **£26.306m**, and Discretionary funding of **£1.454m.** The Trust reported Capital committed spend to January'23 of £14.537m and is forecasting to remain within its CEL of £27.760m for 2022-23.

The Trust's CEL is broken down as follows:

	£m Opening	£m Movement	£m January 2023
Discretionary Capital	**1.454**	**0.000**	**1.454**
All Wales Capital:			
Fire Safety	0.500	0.000	0.500
CANISC Cancer Project	0.000	0.579	0.579
TCS Programme	23.902	-7.102	16.800
IRS		7.900	7.900
Priority Year end Spend		0.370	0.370
WBS Infrastructure Fees		0.157	0.157
Subtotal All Wales Capital	**24.402**	**1.904**	**26.306**
Total CEL	**25.856**	**1.904**	**27.760**

With WG agreement, slippage on the TCS Programme has led to a further £0.709m being handed back during January, in total of £7.102m has been provided back to WG during 2022-23. This funding will be re-provided to the programme during 2023/24. WG have now stated that they cannot accept any further slippage this financial year so the programme will need to be manged to the latest CEL.

The Trust has now received approval from WG for the Integrated Radiotherapy Solution (IRS) capital expenditure with £7.900m being provided during 2022-23 and has also been awarded £0.370m as part of the request for year-end priority schemes, along with £0.157, towards the OBC fees for the WBS infrastructure case which gives a revised Trust CEL of £27.760m for 2022-23.

PSPP

During January '22 the Trust (core) achieved a compliance level of **90.15%** December 22: 92.54%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.37%** as at the end of month 10, and a Trust position (including hosted) of **94.91%** compared to the target of 95%.

PSPP compliance levels have temporarily dropped in performance over the last couple of months which is under urgent review. The finance team are working with NWSSP Accounts payable to understand the reasons behind the recent dip performance with a view to specifically target the invoices that are failing which should support a quick recovery in order for the 95% target to be achieved during 2022-23.

Efficiency / Savings

At this stage the Trust is currently planning to fully achieve the savings target during 2022-23. Replacement schemes have been put in place to support under delivery on two schemes that have turned RAG rated red and will not be achieved during this financial year.

Revenue Position

Cumulative				Forecast		
£1,771 Underspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(146,758)	(146,800)	43	(180,772)	(180,796)	24
Pay	64,403	63,664	739	77,190	76,387	803
Non Pay	82,355	83,135	(780)	103,582	104,408	(827)
Total	0	(2)	2	(0)	(0)	(0)

The overall position against the profiled revenue budget to the end of January 2023 is an underspend of **£0.002m**, along with an overall outturn forecast position of **Breakeven**.

The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be fully funded. Covid funding towards recovery from commissioners remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

4.1 Revenue Position Key Issues

Income Key Issues

Income is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans having already been put in place to support recovery particularly around plasma sales which has seen a significant overachievement over the last few months.

VCC and Corporate over achievement to date on private patient, SACT homecare and Bank interest.

Pay Key Issues

The total Trust vacancies as at January 2023 is 124wte, VCC (65wte), WBS (33wte), Corporate (15Wte), R&D (9wte), TCS (0wte) and HTW (2wte).

The Trust has now received the pay award funding of £3.065m from WG relating to 2022/23. Following review by Divisions the funding gap remains at £450k which relates to unfunded incremental drift. The funding gap for this year will be met through the high level of vacancies that has been carried through the Trust across the period, along with the release of the additional annual leave provision carried forward from last year. The recurrent financial impact into future years will need to be considered as part of the IMTP process which is currently underway.

The Trust has now received the full funding of £0.339m from WG towards the temporary increase in Employers NI rates (1.25%).

Vacancies throughout the Trust although reducing remain high, however several posts in both VCC and WBS have been appointed at risk in response to Covid activity backlog and additional capacity required for forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. In addition, work continues to be underway in both divisions 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.

Both VCC and WBS hold a £0.450m vacancy factor target, which will need to be achieved during 2022/23 in order to balance the overall Trust financial position.

Non Pay Key Issues

The expected increase in energy prices for December currently stands to £0.671m (December £0.676m). The stepped increase of £0.671m has been recognised as an Exceptional National cost pressures by WG with confirmation now received that this will be fully funded.

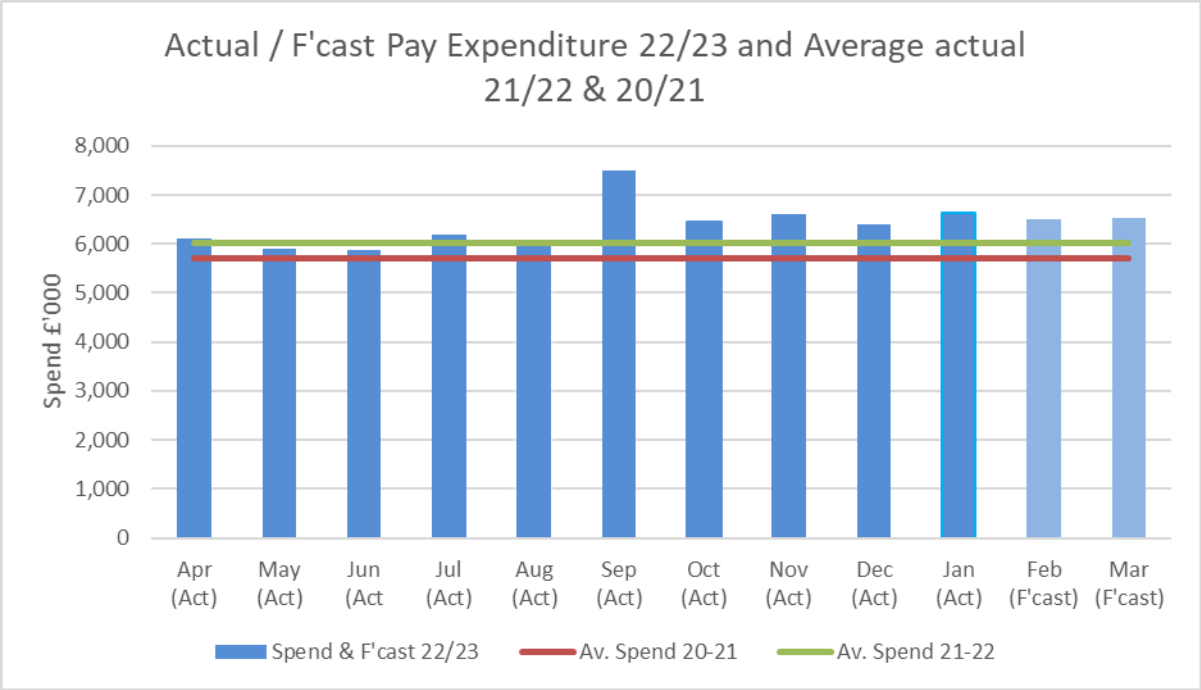
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The savings target for each division was set as VCC £0.700m, WBS £0.500m and Corporate £0.100m as part of the IMTP for 2022/23.

The Trust reserves and previously agreed unallocated investment funding is held in month 12 and is released into the position to match spend as it occurs throughout the year.

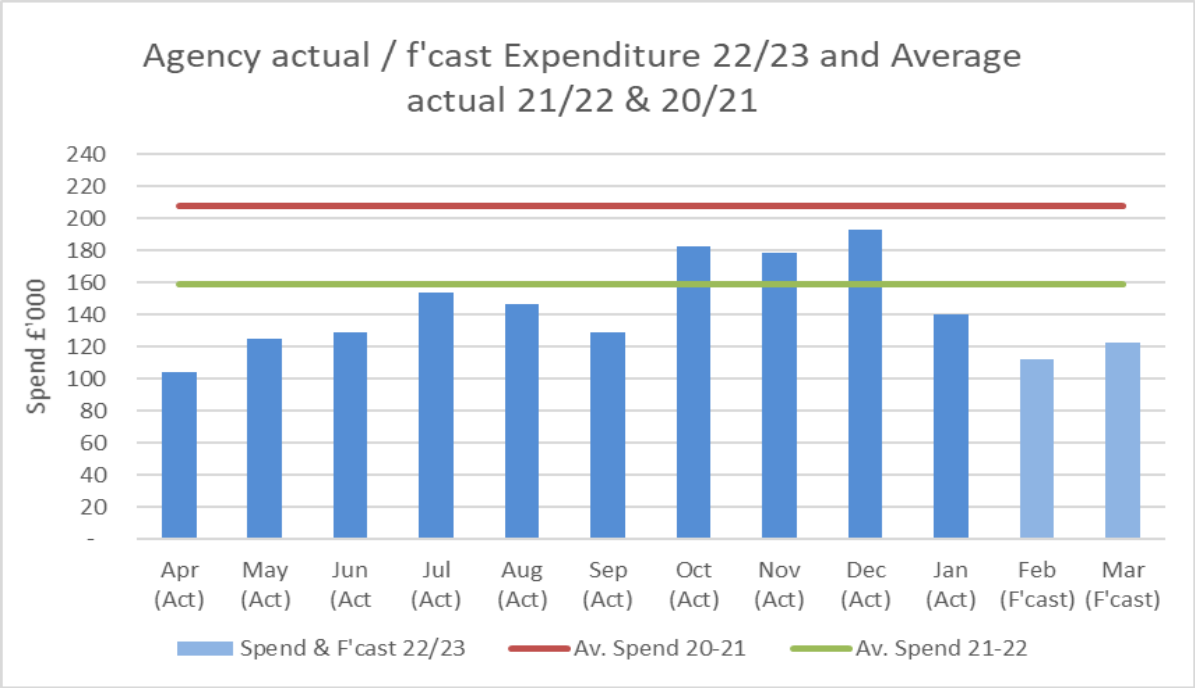
4.2 Pay Spend Trends (Run Rate)

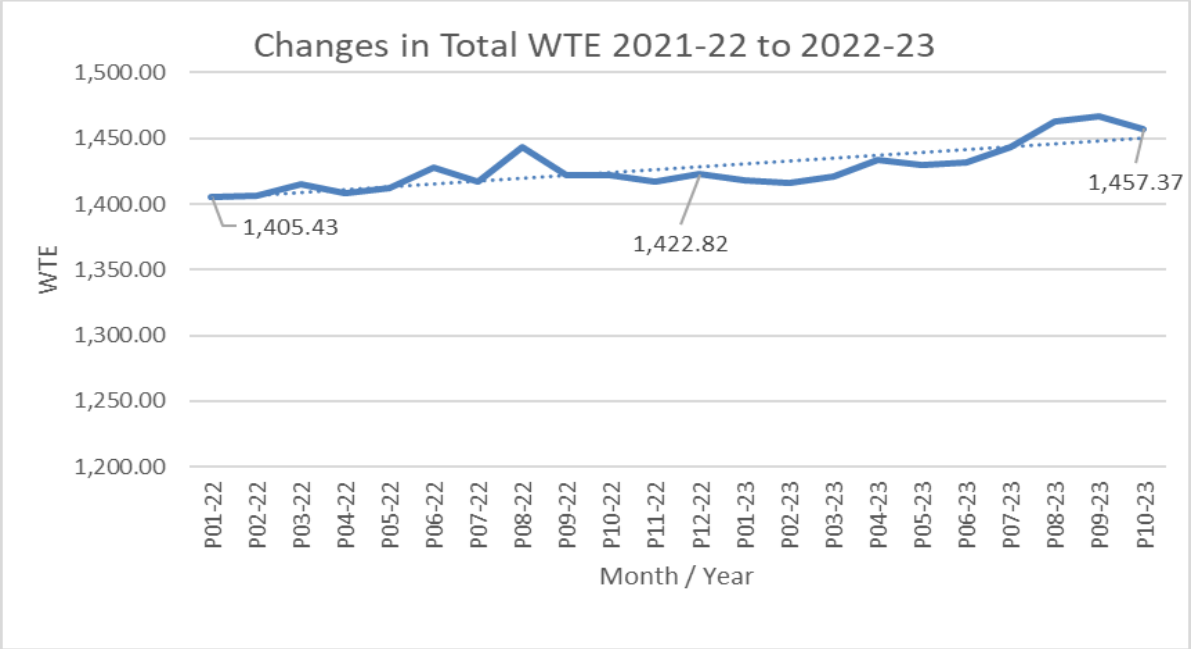
The pay award for 2022/23 was paid in September (back dated to April) as demonstrated in the spike in pay spend shown in the graph below. Agency costs have decreased this year from the 2021/22 levels which is due to the reduction of agency staff previously recruited to support Covid response. Further reductions in the use of agency were expected in 2022/23 by recruiting staff required on a permanent basis. However, more agency staff have been required recently in

particular to support the running of estates in VCC to ensure delivery of ongoing maintenance and statutory compliance duties. The service are actively trying to recruit into current vacancies in order to reduce the need of agency support however this is proving to be a challenge.

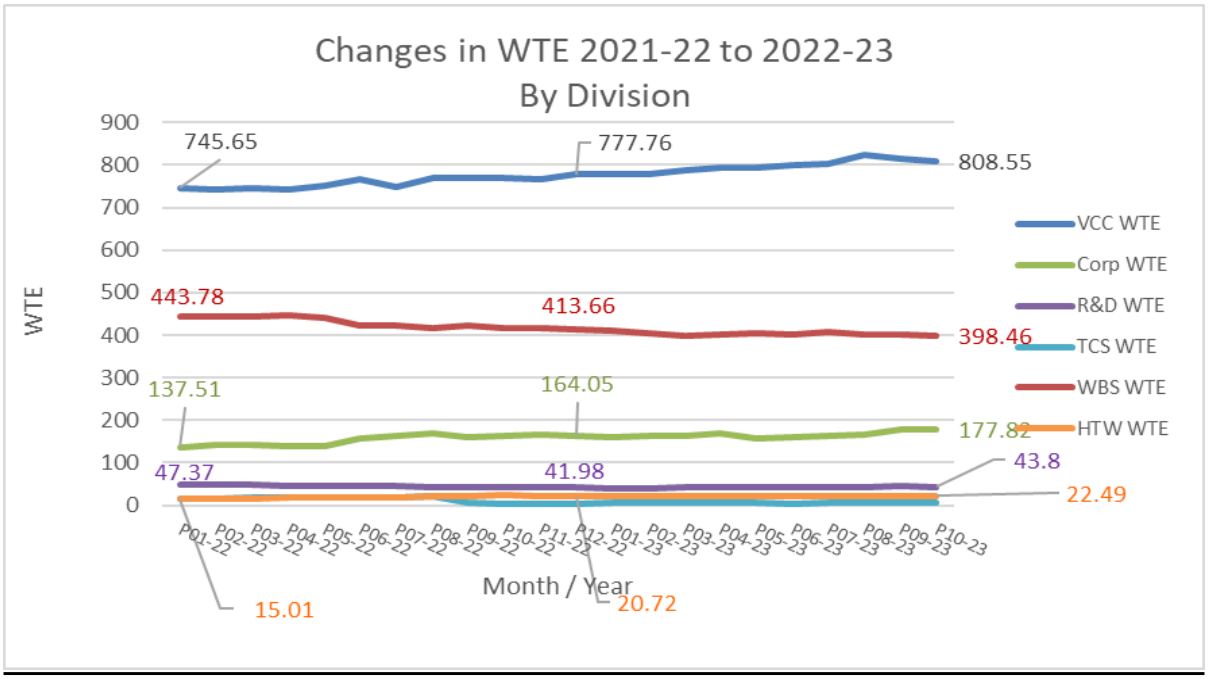


The spend on agency for January 23 was £0.140m (December £0.193m), which gives a cumulative year to date spend of **£1.482m** and a current forecast outturn spend of circa **£1.717m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of January is £0.264m and forecast spend is circa £0.316m (£0.826m 2021/22).



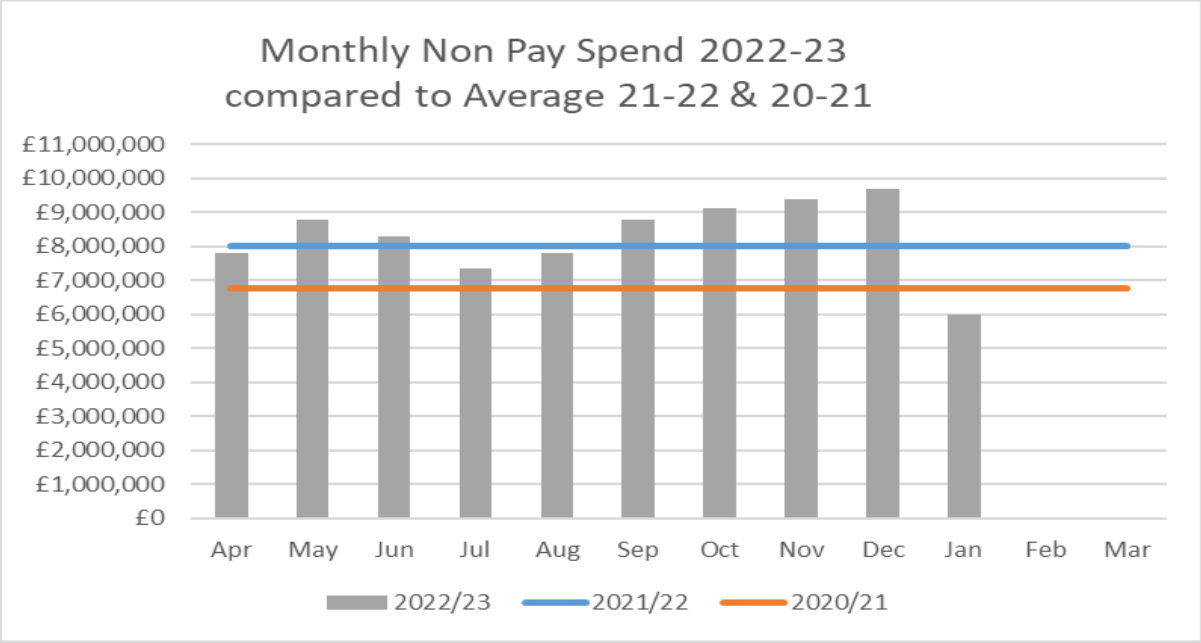


The increase in WTE (20) during November is largely within VCC and relates to the recruitment of Nurses and HCSW into service area's such as inpatients, Chemotherapy and Prince Charles.



4.3 Non Pay

Non-pay 21/22 (c£96m) average monthly spend of £8m was £1.2m higher than the reported monthly average spend for 20/21 (£6.8m). Most of the monthly average increase (circa £0.9m) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and an increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 is currently £8.3m which is an average increase of circa £0.3m against 21/22 expenditure and is mainly due to the increase in NICE / High Cost drugs.



Drugs movement during January relates to receipt of rebates on a significantly higher scale than anticipated which has been relayed to and will be passed on to the Health Boards and WHSSC. In addition, there has been delays in implementation of new NICE drug treatments for SACT compared to the horizon scanning used to forecast patient volumes and cost.

4.4 Covid-19

The latest forecast funding requirement as at 31st January in relation to Covid for 2022-23 has been further revised down to £4.273m (December £4.388m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £4.273m total Covid requirement £0.845m (IMTP plans £2.104m) is being requested directly from WG, and the balance of £3.428m (IMTP plans £10.206m) being sought from our commissioners.

Covid-19 Revenue Spend / Funding 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.199		0.199	0.375	0.176
PPE	0.070		0.070	0.335	0.265
Cleaning	0.289		0.289	0.427	0.138
Other Covid Response	0.286		0.286	0.967	0.681
Covid Recovery - Internal Capacity		3.167	3.167	6.056	2.889
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.845	**3.428**	**4.273**	**12.310**	**8.037**

The latest forecast spend and funding requirement from WG has decreased by a further £0.035m from £0.880m reported in December to £0.845m. Cost reduction on Mass Vaccination with WBS no longer providing storage and distribution support to NHS Wales.

The Trust has now received confirmation that funding will be provided from WG for all associated Covid response costs.

The Trust Covid expenditure is based on activity demand forecast modelling which commenced in 2021/22 and has been updated regularly working with Health Board operational teams. The Trust has already invested £2.943m in additional capacity. The anticipated funding requirement of £4.150m for outsourcing has been removed as the Rutherford went into liquidation earlier this year. The Trust had also been working up plans to expand internal capacity which it has now established in its outreach Centre at Prince Charles Hospital (from October) for SACT, with forecast additional cost above that already invested in Covid capacity of circa £0.261m. In addition, the Trust has developed plans for expanding Radiotherapy capacity internally through use of weekend working which will require existing staff to work additional hours as WLIs with enhanced pay rates. The full cost and operational deliverability of this additional capacity is still being worked up. These additional investments in capacity to meet the activity demand from Health Boards will not be fully covered through LTA marginal income leading to an additional financial pressure to the Trust which it is managing through use of non-recurrent measures in 2022-23. However, with the anticipated removal of the LTA income protection in 2023-24 there will be a significant financial risk of c£1.5m which the Trust may not be able to cover depending on demand and its ability to deliver activity within the current capacity.

Other cost reduction from IMTP plans reflects financial control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.300m for 2022-23, £0.800m recurrent and £0.500m non-recurrent, with £0.750m being categorised as actual saving schemes and £0.550m being income generation.

The divisional share of the overall Trust savings target has been allocated to VCC £0.700m (54%), WBS £0.500m (38%), and Corporate £0.100m (8%).

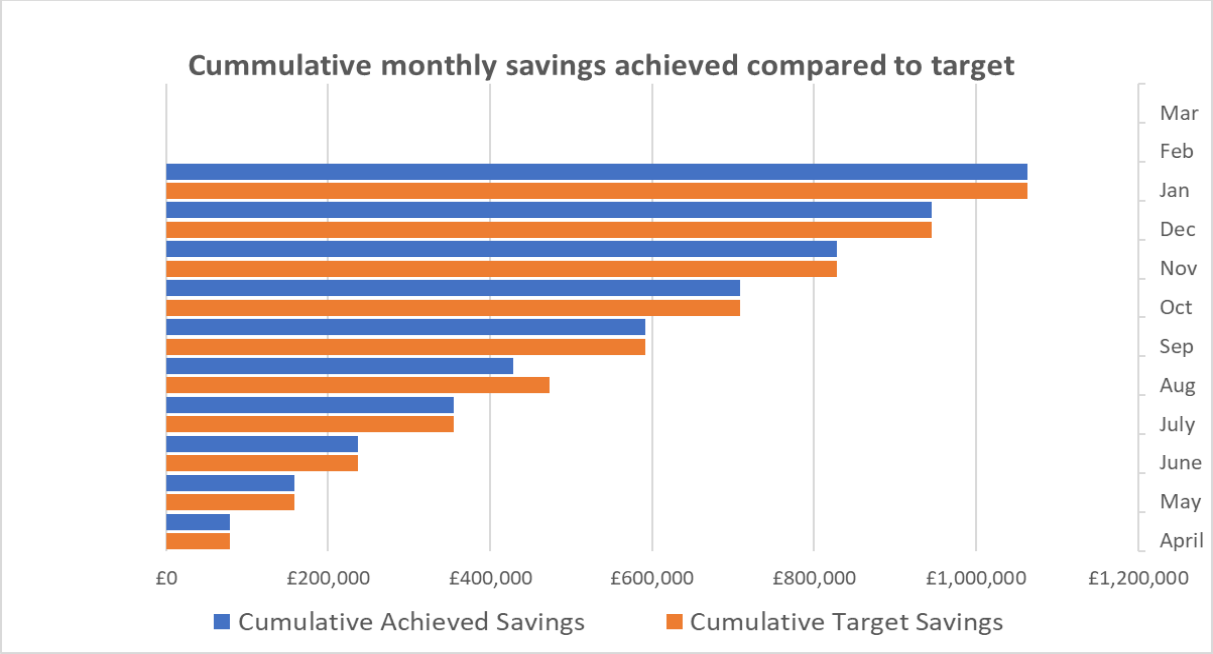
Two schemes continue to be impacted by Covid during 2022-23 have now turned red which relate to service redesign and supportive structures.

Service redesign and supportive structures is a key area of savings for the Trust which are focused on removing inefficiencies in the ways the Trust are working. These plans are aligned to a number of the Trust VBHC bids that sought funding for new posts to support medical workforce redesign but were unsuccessful. The ability to enact these saving schemes is proving to be difficult due to the legacy of the pandemic and current workforce situation, particularly the high number of vacancies along with the high level of sickness that is currently being experienced throughout the Trust. Plans are still being developed by the Trust divisions however, it is recognised due to the current challenges that these saving schemes will not be achieved in the short term and therefore delivery has been removed from this financial year.

Contingency measures have been put in place on the basis that these savings schemes will not achieved this year, however these replacement schemes are both recurrent and non-recurrent in nature. **It is extremely important that divisions continue to review their current savings schemes, and where delivery is not going to be achieved this year consider the impact on next year's financial position especially where those schemes were classified as recurrent.**

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	**700**	**564**	**408**	**(156)**	**500**	**(200)**
			72%		**71%**	
WBS TOTAL SAVINGS	**500**	**417**	**417**	**0**	**500**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**100**	**83**	**83**	**0**	**100**	**0**
			100%		**100%**	
TRUST LEVEL TOTAL SAVINGS			**155**	**155**	**200**	**200**
TRUST TOTAL SAVINGS IDENTIFIED	**1,300**	**1,063**	**1,064**	**0**	**1,300**	**0**
			100%		**100%**	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Establishment Control (Corporate)	Green	100	83	83	0	100	0
Laboratory & Collection Model (WBS)	Green	50	42	42	0	50	0
Laboratory & Collection Model (WBS)	Green	50	42	42	0	50	0
Stock Management (WBS)	Green	100	83	83	0	100	0
Stock Management (WBS)	Green	150	125	125	0	150	0
Procurement - Supply Chain (WBS)	Green	50	42	42	0	50	0
Service Redesign (VCC)	Red	100	78	0	(78)	0	(100)
Supportive Stuctures (VCC)	Red	100	78	0	(78)	0	(100)
Procurement - Supply Chain (VCC)	Green	50	42	42	0	50	0
Bank Interest (Trust - In Year)	Green		0	122	122	167	167
Vacancy Factor (Trust - In Year)	Green		0	33	33	33	33
Total Saving Schemes		**750**	614	614	(0)	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	42	42	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	42	42	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	150	117	117	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	83	83	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	167	167	0	200	0
Total Income Generation		**550**	450	450	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**1,063**	**1,064**	**(0)**	**1,300**	**0**
				100%		**100%**	



5. Reserves

The financial strategy for 2022-23 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

A review of the reserves position is currently underway which is following confirmation from WG that both Covid and the Exceptional National Costs will be funded, however any potential release of reserves which are recurrent in nature will need to be ringfenced to support next years expected financial pressures on both energy and Covid recovery staff capacity.

Unavoidable cost pressures and investment decisions will still be considered for reserves funding.

6. End of Year Forecast / Risk Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however there are a couple of risks remaining which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

Covid Funding via Commissioners – *Risk TBC, Likelihood - Low*

Commissioners have not committed to providing the full funding ask of £3.428m as a block funding arrangement but have all stated that any funding required to cover additional Covid recovery costs will flow through the LTA under the national funds flow mechanism. This mechanism, whilst providing enhanced income protection over the normal LTA arrangements, does not cover the additional costs of enhanced pay rates for WLI's or additional costs above marginal when establishing new capacity. The Trust has received signed LTA's back from our commissioners, however the funding for planned care & Covid backlog capacity remains a risk for the Trust.

Whilst this remains a risk, the Trust is managing any shortfall this year.

WG have now confirmed that the full funding will flow for both Covid response costs and the Exceptional national cost pressures, so these risks have been removed from the position from 2022/23.

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 @ M10 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - Project costs	2.394	2.496	0.000	-0.102	2.923	-0.529
nVCC - Enabling Works	14.406	8.913	0.000	5.493	13.877	0.529
Canisc Cancer Project	0.579	0.579	0.000	0.000	0.579	0.000
Fire Safety	0.500	0.294	0.000	0.206	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	1.554	0.000	6.086	7.640	0.260
WG Priority Year end Spend	0.370	0.000	0.000	0.370	0.370	0.000
WBS Infrastructure OBC Fees	0.157	0.000	0.000	0.157	0.157	0.000
Total All Wales Capital Programme	26.306	13.836	0.000	12.210	26.046	0.260
Discretionary Capital	1.454	0.510	0.191	0.753	1.714	-0.260
Total	27.760	14.346	0.191	12.963	27.760	0.000

The approved 2022/23 Capital Expenditure Limit (CEL) as at January 2023 was £27.760m. This includes All Wales Capital funding of £26.306m, and discretionary funding of £1.454m. The approved CEL has increased in year by £1.904m which reflects approval of the Canisc Cancer Project (0.579m), IRS (7.900m), Velindre's share of the WG yearend spend request (£0.370m) and support fees for the WBS infrastructure OBC (£0.157m). This is offset by a reduction of £7.102m on the nVCC Enabling works project to reflect the latest forecast requirement for 2022/23. Following agreement with WG the £7.102m will be re-provided to the programme during 2023/24.

WG colleagues have agreed a further movement of £0.529m between the nVCC enabling and project costs which is reflected in the table above but represented as a variance rather than a CEL adjustment.

In January 2022 WG informed the Trust that the discretionary allocation will be significantly reduced during 2022/23 (previously £1.911m), which is reflective of the reduced overall NHS capital budget position.

Allocation of the discretionary programme was approved by EMB Shape on the 27th August.

Following a request from WG a list of prioritised bids was approved by EMB on 26th October for submission to WG should any Capital funding become available. The Trust received confirmation

during November that £0.370m of additional funding would be provided to support delivery of the priority one schemes which includes replacement Hemoflows in WBS £0.238m, Patient Monitors in VCC £0.062m and £0.070m towards Digital priorities.

On the 22nd November the Trust received the award funding letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.900m of the total to be provided during 2022/23 with future years funding cash flow to be agreed with WG.

Within the £7.900m of IRS funding, £0.694m has been released back into the discretionary programme which was previously either spent or ringfenced to support the procurement stage of the IRS project. Of the £0.694m, £0.434m was ringfenced from discretionary in 2022/23 and £0.260m will be reimbursed from the WG funding allocation as the spend was incurred last financial year.

The £0.694m will be utilised to support the remaining priority one schemes that were submitted to EMB on the 26th October but not supported by WG.

The Trust CEL was fixed on the 31st October. At this point WG expect any further slippage to be managed internally by the Trust.

On the 16th December the Trust was awarded funding of £11.400m in respect of the Integrated Radiotherapy Solution for the Satellite Centre at Nevil Hall. The funding will be drawn down from 2023/24 and beyond to match the profiled spend.

Performance to date

The actual cumulative expenditure to January 2023 on the All-Wales Capital Programme schemes was £13.836m, this is broken down between spend on the nVCC enabling works £8.913m, nVCC project costs of £2.496m, Canisc Cancer Project £0.579m, fire safety £0.294m, and IRS £1.554m.

Spend and committed spend to date on Discretionary Capital is currently £0.701m leaving a remaining balance of £0.753m as at the 31st January.

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.

Major Schemes in development that will be considered during 2022/23 and beyond in conjunction with WG include both WBS HQ and nVCC:

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	21/22 £m	22/23 £m	23/24 £m	24/25 £m	25/26 £m	26/27 £m	27/28 £m	28/29 £M	29/30	30/31
1	WBS HQ	34.646*	FBC under development	0.221	0.180	0.120	1.016	12.808	9.996	4.434	5.215	0.608	0.048
2	NVCC	*TBC	FBC Under development										

*Scheme totals and Cash flow of these schemes is still under review alongside WG.

Other Major schemes which are under discussion internally and WG are sighted on include VCC outpatients, ventilation, and plasma fractionation.

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 22	Closing Balance End of Jan-23	Movement from 1st April Jan-23	Forecast Closing Balance End of Mar 23
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	143.136	159.486	16.350	154.486
Intangible assets	8.667	7.803	(0.864)	7.303
Trade and other receivables	1,092.008	1,293.459	201.451	1,293.459
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,243.811	1,460.748	216.937	1,455.248
Current Assets				
Inventories	65.207	50.019	(15.188)	45.000
Trade and other receivables	540.227	282.004	(258.223)	319.336
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	30.404	45.313	14.909	18.500
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	635.838	377.336	(258.502)	382.836
TOTAL ASSETS	1,879.649	1,838.084	(41.565)	1,838.084
Current Liabilities				
Trade and other payables	(277.601)	(231.562)	46.039	(231.562)
Borrowings	0.00	0.00	0.000	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(341.123)	(342.274)	(1.151)	(342.274)
Current Liabilities sub total	(618.724)	(573.836)	44.888	(573.836)
NET ASSETS LESS CURRENT LIABILITIES	1,260.925	1,264.248	3.323	1,264.248
Non-Current Liabilities				
Trade and other payables	(7.336)	(7.336)	0.000	(7.336)
Borrowings	0.00	0.00	0.000	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,094.206)	(1,091.599)	2.607	(1,091.599)
Non-Current Liabilities sub total	(1,101.542)	(1,098.935)	2.61	(1,098.935)
TOTAL ASSETS EMPLOYED	159.383	165.313	5.930	165.313
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	30.935	30.934	(0.001)	30.934
PDC	112.982	118.911	5.929	118.911
Retained earnings	15.466	15.468	0.002	15.468
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	159.383	165.313	5.930	165.313

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.

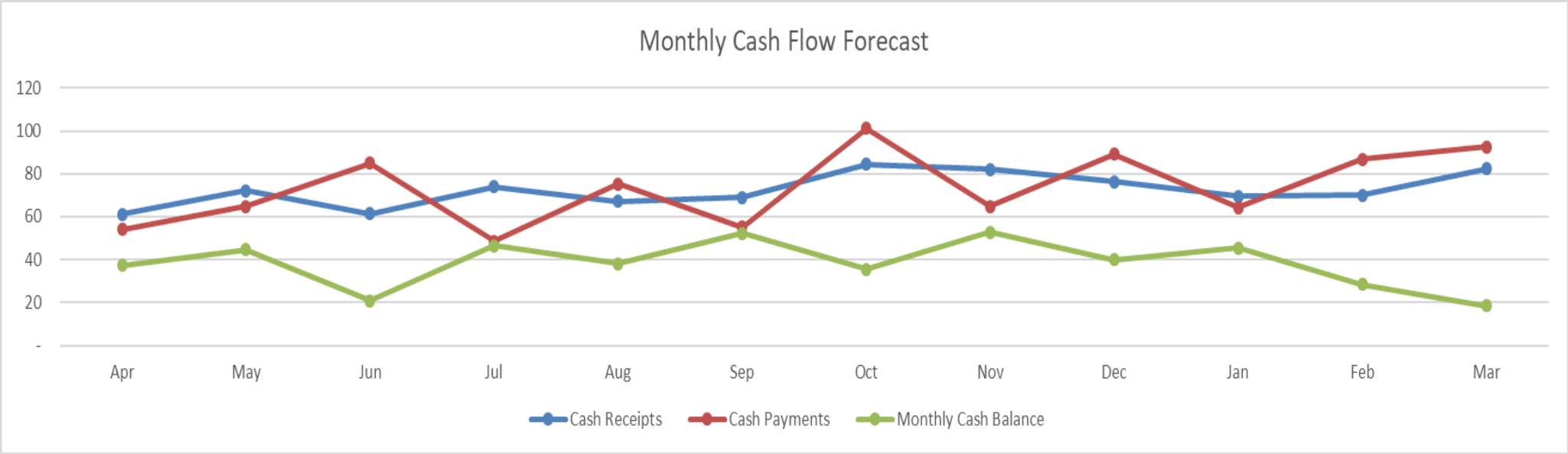
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however have now released the stock and the £4.5m will be repaid to WG during February.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual, however by the end of this financial year expectation is that cash balances should return to pre-Covid levels.

Following a request from WG the Trust transferred £5.9m of cash into the Escrow holding account during May for the nVCC programme. These funds were consequently drawn down in July from WG to reimburse the Trust ensuring that there was no cash risk to the organisation.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to 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	LHB / WHSSC income	33.135	40.208	40.042	37.491	47.836	36.522	43.649	41.695	38.513	45.628	41.970	40.018	486.707
2	WG Income	20.937	24.551	17.010	24.552	15.002	26.148	32.585	33.410	26.654	16.898	24.687	23.482	285.916
3	Short Term Loans													0.000
4	PDC				5.928								14.811	20.739
5	Interest Receivable	0.019	0.027	0.030	0.025	0.037	0.062	0.075	0.105	0.103	0.174	0.080	0.080	0.817
6	Sale of Assets													0.000
7	Other	7.106	7.289	4.321	6.094	4.246	6.395	8.220	6.982	11.052	6.891	3.283	4.047	75.927
8	TOTAL RECEIPTS	**61.197**	**72.074**	**61.403**	**74.090**	**67.121**	**69.127**	**84.529**	**82.192**	**76.323**	**69.591**	**70.020**	**82.438**	**870.105**
	PAYMENTS													
9	Salaries and Wages	21.735	29.243	29.483	29.705	29.549	34.417	36.535	33.118	32.231	32.387	32.266	32.738	373.407
10	Non pay items	30.543	33.079	54.139	17.703	44.384	20.200	63.158	29.085	55.738	30.845	44.404	47.882	471.160
11	Short Term Loan Repayment												4.500	4.500
12	PDC Repayment													0.000
14	Capital Payment	1.926	2.567	1.420	1.215	1.428	0.446	1.469	2.732	1.152	1.105	10.108	7.374	32.942
15	Other items													0.000
16	TOTAL PAYMENTS	**54.205**	**64.889**	**85.042**	**48.623**	**75.361**	**55.063**	**101.162**	**64.935**	**89.121**	**64.337**	**86.778**	**92.494**	**882.009**
		1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
17	Net cash inflow/outflow	6.993	7.185	(23.639)	25.467	(8.240)	14.064	(16.633)	17.257	(12.798)	5.254	(16.757)	(10.055)	
18	Balance b/f	30.404	37.397	44.582	20.943	46.410	38.170	52.234	35.601	52.858	40.060	45.313	28.556	
19	Balance c/f	37.397	44.582	20.943	46.410	38.170	52.234	35.601	52.858	40.060	45.313	28.556	18.500	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(31,365)	(31,366)	0	(38,364)	(38,364)	0
RD&I	(617)	(617)	(0)	175	175	0
WBS	(17,207)	(17,207)	(0)	(20,856)	(20,856)	0
Sub-Total Divisions	**(49,190)**	**(49,190)**	**0**	**(59,046)**	**(59,046)**	**0**
Corporate Services Directorates	(9,216)	(9,213)	(3)	(11,515)	(11,515)	0
Delegated Budget Position	**(58,405)**	**(58,403)**	**(3)**	**(70,561)**	**(70,561)**	**0**
TCS	(551)	(551)	0	(797)	(797)	(0)
Health Technology Wales	(43)	(44)	(1)	(48)	(48)	0
Trust Income / Reserves	59,000	59,000	0	71,406	71,406	0
Trust Position	**(0)**	**2**	(2)	**0**	**0**	**(0)**

VCC

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Full Year Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**55,278**	**55,888**	**610**	**68,303**	**68,801**	**498**
Expenditure						
Staff	37,855	37,852	3	45,476	45,362	**114**
Non Staff	48,788	49,402	(614)	61,191	61,803	**(612)**
Sub Total	**86,643**	**87,253**	**(610)**	**106,667**	**107,165**	**(498)**
Total	**(31,365)**	**(31,366)**	0	**(38,364)**	**(38,364)**	**0**

VCC Key Issues:

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

Income at Month 10 represents a surplus of **£0.610m** and a forecast outturn overachievement of **£0.498m**. This is largely from an increase in activity from the VAT savings made from providing SACT homecare, an over achievement on private patient income due to drug performance, along with a one-off drug rebate. This is offsetting the divisional income savings target of £0.691m as at the end of January.

VCC have reported a year-to-date underspend of **£0.003m** against staff, and a forecast of **£0.114m** underspent. As at month 10 the Division is still carrying a large number of vacancies with the savings generated being above the divisional vacancy factor target and offsetting the cost of agency (£1.055)m to end of January, £0.233m being directly related to Covid). In addition, the savings from vacancies are also supporting the costs of advanced recruitment into IRS.

Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. Additionally, enhanced out of hours service, for advanced life support which will be nursing led continues at this stage covered by Jnr Dr's with transition to nursing having begun but being phased.

Early recruitment into the delayed Integrated Radiotherapy Solution (IRS) has led to year to date committed cost of £0.469m.

Non-Staff Expenditure at Month 10 was **£(0.614)m** overspent, forecast **£(0.612)m** overspend. The overspend largely relates to the facilities management office pressures which were previously supported by Covid, maintenance and repair of the Linacs, transport SLA overspend, consumable spend from increased activity, and unexpected prior year invoices being received from Virgin Media, which are being partly offset by an underspend on general drugs.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**22,097**	**21,606**	**(491)**	**25,774**	**25,259**	**(515)**
Expenditure						
Staff	14,263	14,231	32	16,960	17,123	**(163)**
Non Staff	25,042	24,582	460	29,670	28,993	**677**
Sub Total	**39,304**	**38,813**	**492**	**46,630**	**46,116**	**514**
Total	**(17,207)**	**(17,207)**	**0**	**(20,856)**	**(20,857)**	**(0)**

WBS Key Issues:

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

Income underachievement to date is **£(0.491)m** forecast **£(0.515)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Targeted income generation YTD from plasma sales to research is not achieving desired levels, however contract one of two awarded for new supplier in October which includes increased selling price. Benefits of new contract reflected with significant overachievement over the past quarter, with expectation that the underachievement will recover by the year end for plasma sales with a forecast overachievement now anticipated . Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in activity being considerably lower than target. The WHSSC income for supressed income is reflected as an

underspend within the non-pay position, however WHSSC income support for the underachievement has now been fully utilised.

Staff reported a small year-to-date underspend of **£0.032m** to January, forecast **£(0.163)m**. Outturn overspend expected from posts supported without identified funding source which includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured. WG bid has been submitted to support Plasma Fractionation staffing costs.

Work is still underway to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff underspend of **£0.460m,** forecast **£0.677m** is largely due to reduced costs from suppressed activity underspends within Laboratory Services and WTAIL. WTAIL underspend is inclusive of £0.251m relating to Bone Marrow reflected to contra income underachievement as described above.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**1,488**	**1,736**	**248**	**1,583**	**1,937**	**354**
Expenditure						
Staff	8,335	7,901	434	10,104	9,616	**488**
Non Staff	2,368	3,048	(680)	2,994	3,836	**(842)**
Sub Total	**10,703**	**10,949**	**(246)**	**13,098**	**13,452**	**(354)**
Total	**(9,216)**	**(9,213)**	**3**	**(11,515)**	**(11,515)**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of January 2023 was an underspend of **£0.003m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust is currently benefiting from receiving greater returns on cash being held in the bank due to the rise in interest rates.

Significant number of vacancies being carried in Corporate (circa 8% of the total divisional workforce) which will lead to a large underspend against staff. This will offset use of agency and ensure achievement the £0.100m divisional savings target.

Non pay overspend is **£(0.680)m,** as at month 10 which largely relates to the divisional savings target FYE £(0.160)m, Microsoft agreement, Welsh Risk Pool (WRP) contribution, and the increased running costs associated with the hospital estate.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,795**	**1,649**	**(147)**	**3,233**	**2,920**	**(314)**
Expenditure						
Staff	2,235	2,084	150	2,826	2,493	**333**
Non Staff	178	182	(4)	232	252	**(19)**
Sub Total	**2,412**	**2,266**	**147**	**3,058**	**2,745**	**314**
Total	**(617)**	**(617)**	**0**	**175**	**175**	**0**

RD&I Key Issues

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

Staff vacancies remain relatively high although active recruitment slowly reducing vacancy levels, however several posted will not be filled before the year end. The underspend on staff is offsetting the innovation income target which has been challenging and not expected to be met this year.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**0**	**0**	**0**	**0**	**0**	**0**
Expenditure						
Staff	482	482	0	598	567	**31**
Non Staff	70	70	0	76	107	**(31)**
Sub Total	**551**	**551**	**0**	**674**	**674**	**(0)**
Total	**(551)**	**(551)**	**0**	**(674)**	**(674)**	**(0)**

TCS Key Issues

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

Preapproved reserves budget for strategic transformation £0.060m, non-pay costs of £0.030m, along with the total associated costs of the judicial review £0.033m has now been transferred into the TCS budget for 2022-23.

HTW (Hosted Other)

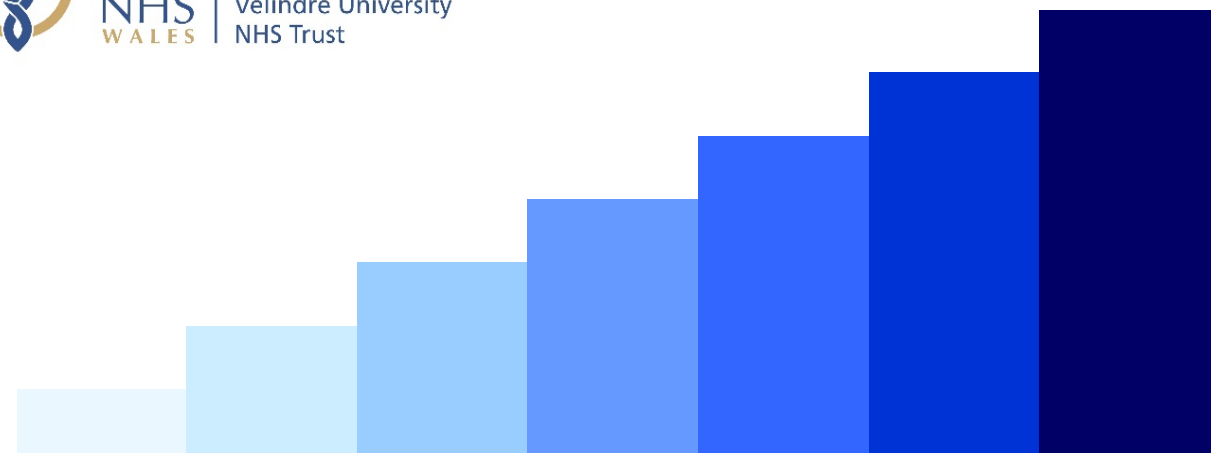
	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,386**	**1,209**	**(177)**	**1,664**	**1,664**	**0**
Expenditure						
Staff	1,234	1,114	119	1,476	1,476	**0**
Non Staff	196	139	57	235	235	**0**
Sub Total	**1,430**	**1,253**	**177**	**1,712**	**1,712**	**0**
Total	**(43)**	**(44)**	**(1)**	**(48)**	**(48)**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of January 2023 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage will be handed back to WG**.**

Appendix 1 – TCS Programme Board Finance Report

Ymddiriedolaeth GIG Prifysgol Felindre Velindre University NHS Trust



TCS PROGRAMME FINANCE REPORT 2022-23

Period Ending January 2023

Presented to Trust Board 30th March 2023

Contents Page

1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2022-23, outlining spend to date against budget as at January 2023 and the current year-end forecast.

1.2 The TCS Programme financial position is continually monitored and updated, with an update provided regularly to both the TCS Programme Delivery Board and Trust Board.

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2022-23 as at 31st January 2023 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Capital	£11.590m	£16.801m	£16.800m	£0.001m
Revenue	£0.551m	£0.674m	£0.674m	£0m
Total	**£12.141m**	**£17.475m**	**£17.474m**	**£0.001m**

2.2 The Programme is currently forecasting an overall underspend of £0.001m against a budget of £17.475m for the financial year 2022-23.

2.3 The Enabling Works forecast position reflects an under-spend of £0.530m, which will support the nVCC Project. This will be provided from the Enabling Works QRA and poses a low financial risk for the Enabling Works Project. The approach has been agreed with WG and we are awaiting formal approval.

2.4 A review of the Enabling Works Project funding requirements in January 2022 has resulted in a further virement of £0.709m from 2022-23 into 2023-24, as agreed with WG. This reduces the overall **capital** funding for 2022-23 to **£16.979m**. To date the EW Project has undertaken the following adjustments into 2023-24:

- Adjustment of £1.900m in May 2022 – delay in EW Project;
- Adjustment of £1.472m in August 2022 – delay in the Asda works;
- Adjustment of £3.021m in October 2022 – delay in the Asda works; utilities and Added Value works;
- Virement of £0.305m to the nVCC Project; and
- Adjustment of £0.709m in January 2023 – further delay in the Asda works; utilities and Added Value works.

2.5 Following the above reviews, the EW Project has confirmed its funding requirements to deliver the EW FBC in 2022-23. The project will need to manage its financial position, and any further 'slippage' will need to be managed by the Trust's Capital Programme or returned to WG without reprovision.

2.6 In December 2022, a virement of £0.305m was made from the Enabling Works Project to the nVCC Project, as agreed with WG.

2.7 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project was closed on 30th November 2022. The final costs for the Project at this time were £0.178m. Therefore, of the £0.434m funding ring fenced from the core Trust discretionary programme for the project in lieu of FBC approval, only the final requirement of £0.178m was drawn down by the Project. However, as there is provision to fund these costs in the IRS FBC, this amount was reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Moreover, the final costs for this Project will now be reported by the IRS Implementation Project, as this is where the IRS FBC funding is allocated to. The final budget and outturn for the IRS Procurement Project for 2022-23 with therefore be nil.

2.8 Provisional revenue funding of £0.020m towards pay award costs was provided to the Programme in September 2022 from the WG allocation to the Trust. However, following a review of the Programme's revenue budget and forecast expenditure for the year, there is sufficient resource from within the Programme to cover its increased pay costs. Therefore, this additional funding will not be drawn down in 2022-23. These increased costs will however be take into account when forecasting future pay costs.

2.9 The Trust has approved a budget of £0.033m for the Judicial Review matter, a decrease of £0.010m from the original budget ring fenced for this matter (further details in Section 7). The **revenue** budget has now reverted to **£0.674m** for 2022-23.

2.10 There are currently three key financial risks to the Programme:

- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage;
- Further legal fees relating to the Judicial Review matter; and
- An underspend within the PMO and SDT Projects.

2.11 These risks have mitigation plans in place or in development by the relevant Project Teams.

3. BACKGROUND

3.1 In January 2015 the Minister for Health and Social Services approved the initial version of the Strategic Outline Programme 'Transforming Cancer Services in South East Wales'. Following completion of the Key Stage Review in June/July 2015, approval was received from the Minister to proceed to the next stage of the Programme.

3.2 By 31st March 2022, the Welsh Government (WG) had provided a total of £25.904m funding (£23.283m capital, £2,261m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.111m from non-recurrent revenue funding.

3.3 NHS Commissioners agreed in December 2018 to provide annual revenue funding to the Trust to support TCS Programme, with £0.400m provided in 2018/19 and £0.420m thereafter.

3.4 The current funding provided to support the TCS Programme in 2022-23 is £17.628m capital and £0.674m revenue, as outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding

Initial Allocation (as at April 2022)

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	£21.813m	£0m	£21.813m
nVCC Project	£2.089m	£0m	£2.089m
IRS Procurement Project	£0m	£0.434m	£0.434m
Total	**£23.902m**	**£0.434m**	**£24.336m**

Overall Change to Allocation

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	-£7.406m	£0m	-£7.406m
nVCC Project	£0.305m	£0m	£0.305m
IRS Procurement Project	£0m	-£0.434m	-£0.434m
Total	**-£7.101m**	**-£0.434m**	**-£7.535m**

Current Allocation (as at November 2022)

Project	WG Capital	Trust Discretionary Programme	Total Funding
Enabling Works Project	£14.407m	£0m	£14.407m
nVCC Project	£2.394m	£0m	£2.394m
IRS Procurement Project	£0m	£0m	£0m
Total	**£16.801m**	**£0m**	**£16.801m**

Sources of Revenue Funding

Initial Allocation (as at April 2022)

Project	LHB Commissioners	Trust Reserves	Total Funding
PMO	£0.240m	£0m	£0.240m
nVCC Project	£0m	£0.073m	£0.073m
SDT Project	£0.180m	£0.131m	£0.311m
Total	**£0.420m**	**£0.204m**	**£0.624m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	Total Funding
PMO	£0m	£0.060m	£0.060m
nVCC Project	£0m	-£0.010m	-£0.010m
SDT Project	£0m	£0m	£0m
Total	**£0m**	**£0.050m**	**£0.050m**

Current Allocation (as at November 2022)

Project	LHB Commissioners	Trust Reserves	Total Funding
PMO	£0.240m	£0.060m	£0.300m
nVCC Project	£0m	£0.063m	£0.063m
SDT Project	£0.180m	£0.131m	£0.311m
Total	**£0.420m**	**£0.254m**	**£0.674m**

4. CAPITAL POSITION

4.1 The current capital funding is outlined below:

- EW Project £14.407m Capital Expenditure Limit (CEL)
- nVCC Project £2.394m Capital Expenditure Limit (CEL)
- IRS Project £0 See section 7

Total £16.801m

4.2 The capital position as at 31st January 2023 is outlined below, with a forecast underspend for 2022-23 of £0.001m.

Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£8.912m	£14.407m	£13.877m	£0.530m
nVCC Project	£2.496m	£2.394m	£2.923m	-£0.529m
IRS Procurement Project	£0.182m	£0m	£0m	£0m
Total	**£11.590m**	**£16.801m**	**£16.800m**	**£0.001m**

4.3 The forecast overspend of £0.529m for the nVCC Project will be supported by the Enabling Works Project underspend of £0.530m. This will be provided from the Enabling Works QRA and poses a low financial risk for the Enabling Works Project. The approach has been agreed with WG and we are awaiting formal approval.

4.4 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project was closed on 30th November 2022. The final costs for the Project at this time were £0.178m. Therefore, of the £0.434m funding ring fenced from the core Trust discretionary programme for the project, only the final requirement of £0.178m was drawn down by the Project. However, as there is provision to fund

these costs in the IRS FBC, this amount will reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Further details are provided in Section 7. Moreover, the final costs for this Project will now be reported by the IRS Implementation Project, as this is where the IRS FBC funding is allocated to. The final budget and outturn for the IRS Procurement Project for 2022-23 with therefore be nil.

5. REVENUE POSITION

5.1 The current revenue funding is outlined below:

• PMO	£0.300m	NHS Commissioners & Trust Reserves
• nVCC Project	£0.063m	Trust Reserves
• SDT Project	£0.311m	NHS Commissioners & Trust Reserves
Total	**£0.674m**	

5.2 Following the implementation of the annual NHS pay award in September 2022, a review of the forecast revenue pay for 2022-23 took place in November 2022. Adjustments were been made in to the relevant pay and non-pay budgets, allowing increased revenue pay costs in 2022-23 to the covered from within the Programme.

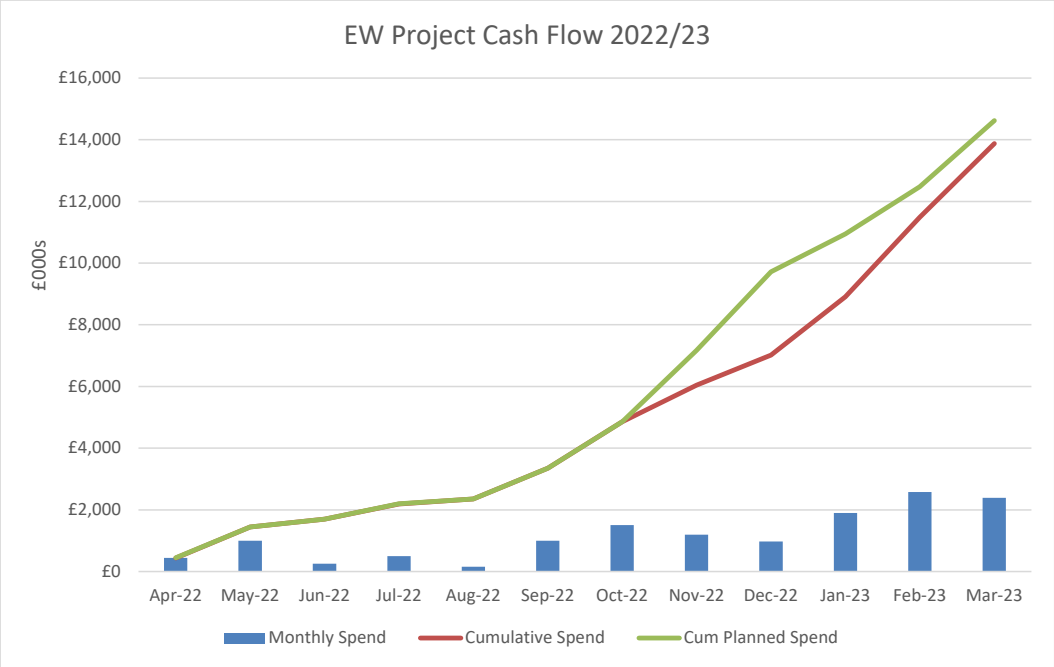
5.3 The revenue position as at 31st January 2023 is outlined below, with a forecast breakeven outturn for 2022-23 against a revised budget **of £0.674m**.

Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
PMO	£0.232m	£0.300m	£0.290m	£0.010m
nVCC Project	£0.060m	£0.063m	£0.073m	-£0.010m
SDT Project	£0.259m	£0.311m	£0.311m	£0m
Total	**£0.551m**	**£0.674m**	**£0.674m**	**£0m**

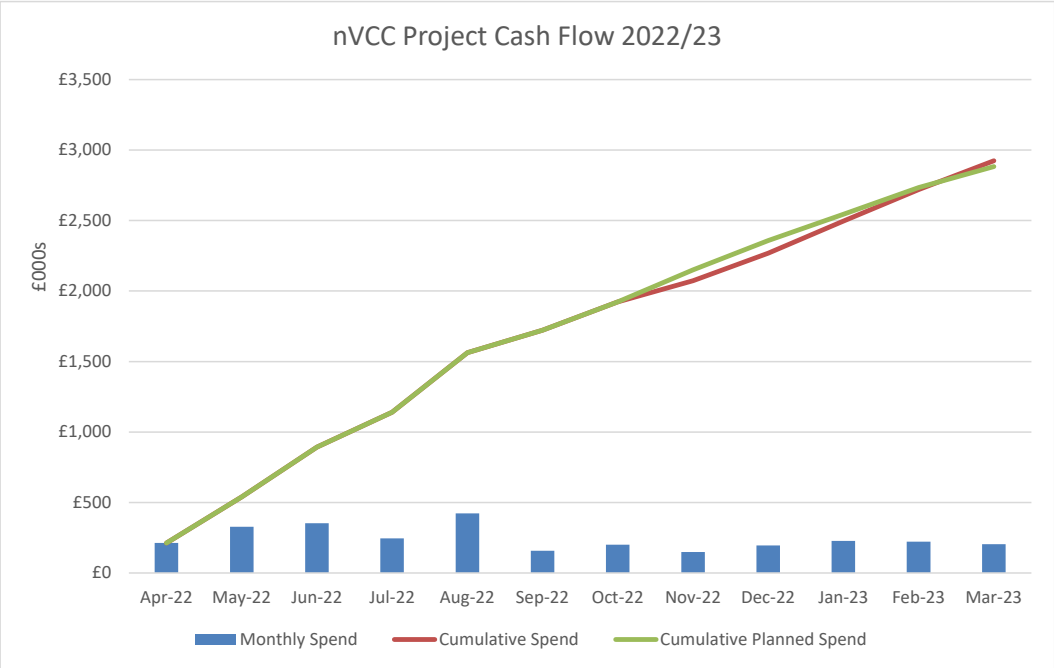
5.4 There is a risk of increased costs for the nVCC Judicial Review. However, this may be offset by a potential underspend in both the PMO and the SDT Project, therefore mitigating this risk.

6. CASH FLOW

6.1 The projected capital cash flow for the **EW Project** is outlined below. The run rate indicates that, following the capital funding adjustment in January 2023, around 75% of the costs will be incurred in the second half of the financial year. This is due to the delay in the start of the works.



6.2 The projected capital cash flow for the **nVCC Project** is outlined below. The run rate for the nVCC Project is relatively 'flat' and reflects planned activities in respect of the successful participant stage.



6.3 The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

7. PROJECT FINANCE UPDATES

7.1 A detailed table of budget, spend and variance is provided in Appendix 1.

Programme Management Office

7.2 The total revenue funding for 2022-23 is **£0.300m**. £0.0240m of this is from NHS Commissioners' funding, and the remaining £0.060m from the Trust Reserves. The provisional pay award funding of £0.010m in 2022-23 previously reported will not be drawn down as the increased costs will be covered from within the PMO financial year.

7.3 There is no capital funding requirement for the PMO in 2022-23.

7.4 The revenue position for the PMO as at 31st January 2023 is shown below.

PMO Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.223m	£0.287m	£0.276m	£0.011m
Non Pay	£0.010m	£0.013m	£0.014m	-£0.001m
Total	**£0.232m**	**£0.300m**	**£0.290m**	**£0.010m**

7.5 The forecast spend review in November 2022 has resulted in an adjustment to the pay and non-pay budgets to align them with the new forecasts.

7.6 There is a forecast underspend of £0.010m due to a delay in project and support work carried out by the PMO. However, this will be used to offset increased costs incurred by the nVCC Judicial Review, therefore mitigating this risk.

Enabling Works Project

7.7 In February 2022, the Minister for Health and Social Services approved the EW FBC. This has provided capital funding of £28.089m in total.

7.8 For 2022-23 the EW Project initially received a CEL for £21.813m but after several reviews the final CEL is **£14.407m**, with a total virement to date of £7.405m from 2022-23 to 2023-24, as agreed by Welsh Government. Following reviews, the EW Project has confirmed its funding requirements to deliver the EW FBC in 2022-23. The project will need to financially manage its position, and any further 'slippage' will need to be managed by the Trust's Capital Programme or returned to WG without reprovision.

7.9 The Project's financial position for 31st January 2023 is shown below. The forecast position reflects an underspend of £0.530m due to a delay in key activities, which will be used to support the nVCC Project as agreed by WG.

Enabling Works Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.274m	£0.220m	£0.327m	-£0.108m
Non Pay	£8.638m	£14.187m	£13.550m	£0.638m
Total	**£8.912m**	**£14.407m**	**£13.877m**	**£0.530m**

7.10 The spend relates to the following activities:

Description	Year to Date Budget Jan-23 £	Year to Date Spend Jan-23 £	Year to Date Variance Jan-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project 1b - Enabling Works FBC	183,120	273,802	-90,682	219,744	327,402	-107,658
Pay Capital Total	**183,120**	**273,802**	**-90,682**	**219,744**	**327,402**	**-107,658**
NON-PAY - PROJECTS						
EF01 Construction Costs	0	40,981	-40,981	0	40,981	-40,981
EF02 Utility Costs	62,576	62,576	0	710,613	710,613	0
EF03 Supply Chain Fees	447,678	454,251	-6,573	527,481	534,054	-6,573
EF04 Non Works Costs	204,070	306,014	-101,944	225,603	347,559	-121,956
EF05 ASDA Works	1,746,841	1,942,728	-195,887	2,584,385	2,798,271	-213,886
EF06 Walters D&B	5,627,078	5,431,191	195,887	8,735,418	8,521,532	213,886
EF07 Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	174,000	0	174,000
EFQR Quantified Risk	817,983	190,878	627,106	922,798	405,078	517,720
EFQS QRA - SCP	307,200	316,895	-9,695	307,200	316,895	-9,695
EFRS Enabling Works FBC Reserves	0	-107,428	107,428	0	-125,427	125,427
Enabling Works Project Capital Total	**9,213,426**	**8,638,085**	**575,341**	**14,187,499**	**13,549,556**	**637,942**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE	**9,396,546**	**8,911,887**	**484,659**	**14,407,243**	**13,876,959**	**530,284**

7.11 There is a risk of a further underspend within the Enabling Works Project as a result of the delay in key project activities, however at present this represents a low risk, which will be monitored by the Project.

New Velindre Cancer Centre Project

Capital

7.12 In March 2021, the Minister for Health and Social Services approved the nVCC OBC. This has provided capital funding of £5.550m in total, with a CEL for 2022-23 of £2.089m. During December 2022 a virement of £0.305m was made to the Project from the Enabling Works Project, increasing the CEL to **£2.394m**.

7.13 The capital financial position for the nVCC Project for 31st December 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an overspend of £0.775m, which will be supported from the Enabling Works Project as agreed by WG.

nVCC Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.969m	£1.274m	£1.163m	£0.110m
Non Pay	£1.527m	£1.120m	£1.760m	-£0.640m
Total	**£2.496m**	**£2.394m**	**£2.923m**	**-£0.529m**

7.14 The spend relates to the following activities:

Description	Year to Date Budget Jan-23 £	Year to Date Spend Jan-23 £	Year to Date Variance Jan-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership	173,980	173,502	478	208,776	208,085	691
Project 2a - New Velindre Cancer Centre OBC	894,060	795,016	99,044	1,065,097	955,306	109,790
Pay Capital Total	**1,068,040**	**968,518**	**99,522**	**1,273,873**	**1,163,391**	**110,481**
NON-PAY						
nVCC Project Delivery	**66,220**	**64,144**	**2,076**	**84,000**	**84,000**	**0**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	696,423	1,348,309	-651,886	731,127	1,497,909	-766,782
VC10 Legal Advice	0	14,660	-14,660	0	14,660	-14,660
VC11 S73 Planning	0	89,169	-89,169	0	89,169	-89,169
VC12 nVCC FBC	81,453	68,170	13,283	106,453	93,170	13,283
VCRS nVCC Reserves	99,274	-57,252	156,525	198,547	-18,997	217,544
nVCC Project Capital Total	**877,150**	**1,463,056**	**-585,907**	**1,036,127**	**1,675,911**	**-639,784**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**2,011,409**	**2,495,719**	**-484,309**	**2,394,000**	**2,923,303**	**-529,303**

7.15 There is a financial risk relating to advisory fees to conclude the tender evaluation stage, and Successful Participant to Financial Close stage. The additional fees could be in the range of c£0.100m. The Project's financial position will be monitored closely over the remaining months of the financial year.

Revenue

7.16 No revenue funding has been provided for the nVCC Project by WG in 2022-23. Therefore, the Trust has provided **revenue** budget of **£0.063m** from the Trust reserves. This is £0.010m less than was previously reported due to a budget of £0.033m provided for the Judicial Review matter as opposed to the original ring fenced budget of £0.043m. This revised budget was based on a revised forecast spend for the year.

7.17 The revenue financial position for the nVCC Project for 31st January 2023 is shown below, reflecting a forecast breakeven spend against a budget of **£0.063m**.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Project Delivery	£0.027m	£0.030m	£0.030m	£0m
Judicial Review	£0.033m	£0.033m	£0.043m	-£0.010m
Total	**£0.060m**	**£0.063m**	**£0.073m**	**-£0.010m**

7.18 The legal team has provided an estimated final cost for the Judicial Review matter of £0.134m. £0.084m of this was expended in 2021/2022, and the remaining £0.050m is expected during 2022-23. Therefore there is a risk of an overspend in this financial year. However, this will be offset by a potential underspend in the PMO Project, therefore mitigating this risk.

Integrated Radiotherapy Solution Procurement Project

7.19 Ministerial approval of the IRS Final Business Case during November 2022, and subsequent signing of the contract with the preferred bidder, instigated the closure of the IRS Procurement Project on 31st November 2022. Continuation of the overall project will continue with the IRS Implementation Project, managed by Velindre Cancer Centre.

7.20 The final costs for the IRS Procurement Project are £0.182m, as outlined below.

Pay	£0.083m
Legal Advisors	£0.096m
Other Costs	£0.003m
Total costs	**£0.182m**

7.21 Estimated costs of £0.127m in 2022-23 for bunker refurbishment LA5 previously reported by the Project will now be covered directly by funding provided directly from the FBC, and will be reported by the IRS Implementation Project, who will also manage this work. These costs have been removed from the final Project costs.

7.22 Of the £0.434m funding ring fenced from the core Trust discretionary programme for the project, only the final requirement of £0.178m was drawn down. However, as there is provision to fund these costs from the FBC funding letter provided by WG, this was reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Moreover, as the FBC funding was allocated to the IRS Implementation project, the costs for 2022-23 will be allocated to the Implementation project, resulting in a budget and outturn of nil for the IRS Procurement Project for the financial ear 2022-23.

7.23 There is no revenue requirement for the Project in 2022-23.

7.24 The capital position for the IRS Project for 31st January 2023 is outlined below, with an adjusted budget and outturn of nil at year end.

IRS Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.083m	£0m	£0m	£0m
Non Pay	£0.100m	£0m	£0m	£0m
Total	**£0.182m**	**£0m**	**£0m**	**£0m**

7.25 There are no financial risks associated with this Project.

Service Delivery and Transformation Project

7.26 The total revenue funding for 2022-23 is £0.180m from NHS Commissioners' funding and £0.131 from Trust reserves. The provisional pay award funding of £0.010m in 2022-23 previously reported will not be drawn down as the increased costs will be covered from within the SDT project for this financial year. The resulting budget is **£0.311m** for this financial year.

7.27 There is no capital funding requirement for the Project in 2022-23.

7.28 The SDT Project revenue position as at 31st January 2023 is shown below.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.259m	£0.291m	£0.291m	£0m
Non Pay	£0m	£0.020m	£0.020m	£0m
Total	**£0.259m**	**£0.311m**	**£0.311m**	**£0m**

7.29 The forecast spend review in November 2022 has resulted in an adjustment to the pay and non-pay budgets to align them with the new forecasts.

7.30 There is a financial risk of an underspend due to a delay in work carried out by the Project. However, this may be utilised to offset possible increased costs incurred by the nVCC Judicial Review, therefore mitigating this risk.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are currently three key financial risks to the Programme:

- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage;
- Further legal fees relating to the Judicial Review matter; and
- An underspend within the PMO and SDT Projects.

These risks have mitigation plans in place or in development by the relevant Project Teams

9. TCS SPEND REPORT SUMMARY

9.1 At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

9.2 Appendix 3 provides cumulative report to 31st March 2022. The report for the financial year 2022-23 is currently being updated

9.3 The cumulative report shows a total spend for the TCS Programme of £30.352m (£26.481m Capital, £3.871m Revenue). The total pay costs for this period were £11.303m.

9.4 The spend to 31st March 2022 for each Project within the Programme is summarised below.

Programme Management Office £1.656m
Project 1 Enabling Works £10.559m
Project 2 nVCC.....£13.234m
Project 3a Integrated Radiotherapy Solution.....£0.1.049m
Project 3b Digital Strategy.....£0.200m
Project 4 Radiotherapy Satellite £0.385m
Project 5 SACT and Outreach £0.002m
Project 6 Service Delivery and Transformation £3.266m
Project 7 Decommissioning.....£0m

9.5 The five deliverables with the highest spend during this period are:

Project Control.....£4.390m
Feasibility Studies.....£2.734m
Planning and Design £2.669m
Outline Business Case (inc revision and approval).....£2.456m
Project Agreement.....£1.838m

APPENDIX 1: TCS Programme Budget and Spend 2022-23 as at 31st January 2023

CAPITAL	Year to Date			Financial Year		
	Budget Jan-23	Spend Jan-23	Variance Jan-23	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	173,980	173,502	478	208,776	208,085	691
Project 1b - Enabling Works FBC	183,120	273,802	-90,682	219,744	327,402	-107,658
Project 2a - New Velindre Cancer Centre OBC	894,060	795,016	99,044	1,065,097	955,306	109,790
Project 3a - Radiotherapy Procurement Solution	82,882	82,882	0	0	0	0
Capital Pay Total	**1,334,041**	**1,325,201**	**8,840**	**1,493,617**	**1,490,794**	**2,823**
NON-PAY						
nVCC Project Delivery	66,220	64,144	2,076	84,000	84,000	0
Project 1b - Enabling Works FBC	9,213,426	8,638,085	575,341	14,187,499	13,549,556	637,942
Project 2a - New Velindre Cancer Centre OBC	877,150	1,463,056	-585,907	1,036,127	1,675,911	-639,784
Project 3a - Radiotherapy Procurement Solution	95,119	99,531	-4,413	0	0	0
Capital Non-Pay Total	**10,251,914**	**10,264,817**	**-12,903**	**15,307,626**	**15,309,468**	**-1,842**
CAPITAL TOTAL	**11,585,955**	**11,590,018**	**-4,063**	**16,801,243**	**16,800,261**	**981**

REVENUE	Year to Date			Financial Year		
	Budget Jan-23	Spend Jan-23	Variance Jan-23	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	222,715	222,715	0	286,809	275,551	11,258
Project 6 - Service Change Team	259,160	259,160	0	291,376	291,376	0
Revenue Pay total	**481,875**	**481,875**	**0**	**578,185**	**566,927**	**11,258**
NON-PAY						
nVCC Project Delivery	27,003	27,003	0	30,000	30,000	0
nVCC Judicial Review	33,000	33,000	0	33,000	43,215	-10,215
Programme Management Office	9,600	9,600	0	13,191	14,100	-909
Project 6 - Service Change Team	0	0	0	19,624	19,624	0
Revenue Non-Pay Total	**69,603**	**69,603**	**0**	**95,815**	**106,940**	**-11,124**
REVENUE TOTAL	**551,478**	**551,478**	**0**	**674,000**	**673,866**	**134**

APPENDIX 2: TCS Programme Funding for 2022-23

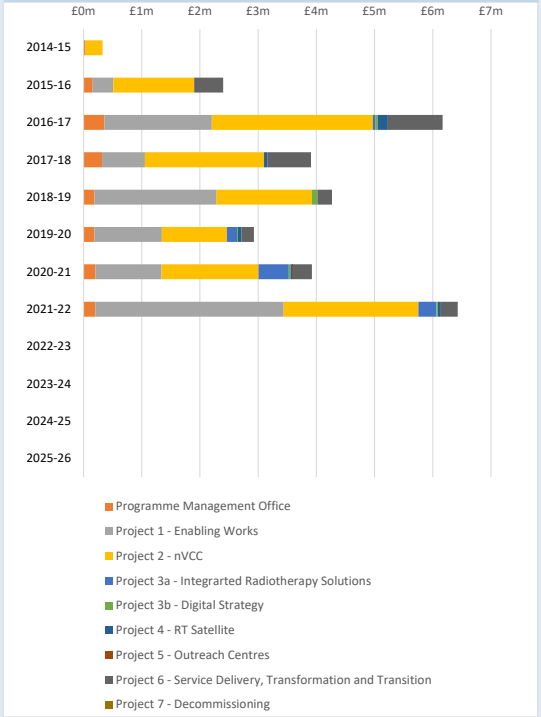
Description	Funding Type	
	Capital	Revenue
Programme Management Office Commissioner's funding Trust Revenue Funding Pay Award Funding – assumed (September 2022) Pay Award Funding – reversed (November 2022)	**£0m**	**£0.300m** £0.240m £0.060m £0.010m -£0.010m
Enabling Works OBC 2022-23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022 Virement of funds from 2022-23 to 2023-24 financial year (May 2022) Virement of funds from 2022-23 to 2023-24 financial year (August 2022) Virement of funds from 2022-23 to 2023-24 financial year (October 2022) Virement of funds to the nVCC Project (December 2022) Virement of funds from 2022-23 to 2023-24 financial year (January 2023)	**£14.406m** £21.813m -£1.900m -£1.472m -£3.021m -£0.305m -£0.709m	**£0m**
New Velindre Cancer Centre OBC 2022-23 CEL from Welsh Government funding for nVCC OBC (March 2021) Virement of funds to the nVCC Project (December 2022) Trust revenue funding from reserves	**£2.394m** £2.089m £0.305m	**£0.063m** £0.063m
Integrated Radiotherapy Procurement Solution Trust Discretionary Capital Allocation Reduction in requirement of capital funding Reimbursement of funds back to the Trust discretionary programme	**£0m** £0.434m -£0.256m -£0.178m	**£0m**
Radiotherapy Satellite Centre No funding requested or provided for this project to date	**£0m**	**£0m**
SACT and Outreach No funding requested or provided for this project to date	**£0m**	**£0m**
Service Delivery, Transformation and Transition Commissioner's funding Trust revenue funding from reserves Pay Award Funding – assumed (September 2022)	**£0m**	**£0.311m** £0.180m £0.131m £0.010m

Description	Funding Type	
	Capital	Revenue
Pay Award Funding – reversed (November 2022)		-£0.010m
VCC Decommissioning No funding requested or provided for this project to date	**£0m**	**£0m**
Total	**£16.801m**	**£0.674m**

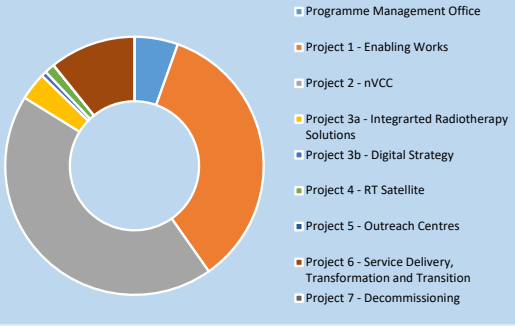
APPENDIX 3: TCS Cumulative Spend Report to 31st March 2022

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

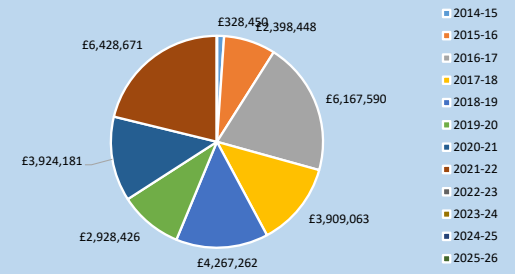
SPEND PER PROJECT PER YEAR



SPEND FOR EACH PROJECT ACROSS ALL YEARS



SPEND FOR EACH YEAR ACROSS ALL PROJECTS

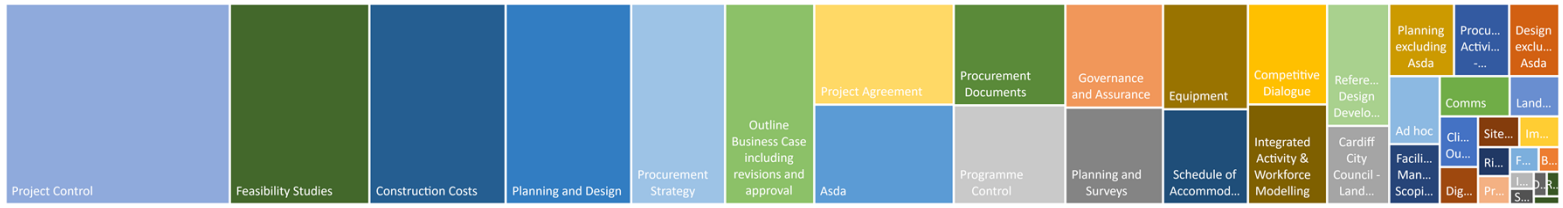


TOTAL SPEND BY PROJECT TO DATE	£30,352,092
Programme Management Office	£1,655,897
Project 1 - Enabling Works	£10,559,242
Project 2 - nVCC	£13,234,264
Project 3a - Integrarted Radiotherapy Solutions	£1,049,380
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£385,490
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,266,123
Project 7 - Decommissioning	-

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

1	Payroll	£11,048,740
2	Mott MacDonald	£5,614,021
3	DLA Piper	£3,398,669
4	Non Pay Costs	£1,043,962
5	Price Waterhouse Coopers	£848,084

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS



TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30th March 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee and Independent Member
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR DISCUSSION

ACRONYMS	
MES	Medical Examiner's Service
PMF	Performance Management Framework
SACT	Systemic Anti-Cancer Therapy
DHCR	Digital Health Care Record
PTR	Putting Things Right
WRP	Welsh Risk Pool
NWSSP	NHS Wales Shared Services Partnership
IMTP	Integrated Medium Term Plan

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 16th March 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. HIGHLIGHT REPORT: Meeting held on 16th March 2023

3.1 Triangulated themes

Enhancing Committee effectiveness and governance continued to be a core theme of the meeting to continually improve how the Committee operates and enhance its assurance mechanisms. The October 2022 effectiveness survey identified the need for more succinct and higher quality assurance / exception focussed papers, with focussed reporting and effective tracking of improvement actions. It was recognised that the newly established operational Integrated Quality & Safety Group and the work due to commence on the implementation of the 7 levels of assurance framework will play a key role in improved reporting and Committee effectiveness; however, the group will require time to mature.

A core theme from the meeting related to the current challenge in achieving the above and in meeting the Duty of Quality requirements as the main mechanism for data capture currently is manual. This makes effective capture of all required quality information difficult and requires a considerable amount of clinical validation, taking clinical time away from delivering care and treatment. The Committee agreed that an automated quality dashboard is required with a robust business intelligence infrastructure as part of the Quality Management System that is required by the Duty of Quality. This will facilitate automation of processes (releasing valuable clinical time), effective triangulation of quality data, support effective prioritisation and earlier identification of risk.

The Committee also identified the need for significant workforce transformation as a triangulated theme that emerged from across a number of papers. Very different multi-professional staffing models are required, that facilitates top of licence working delivered through new multi-professional Advanced Practice roles, so that the Trust can meet the care, treatment and service delivery challenges.

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 all Quality, Safety & Performance Committee meetings at:
https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-committee-2023/quality-safety-performance-committee-papers-17012022/

3.3 *Summary of Committee Highlights*

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

ALERT / ESCALATE	• **Duty of Quality Requirements** It was noted that meeting the Duty of Quality requirements may not be achievable by the 1st April 2023 as a result of challenges presented by the current manual mechanism for the capture of data; this is an onerous process, requiring a considerable amount of clinical validation and staff time, removing staff from their role in delivery of care and treatment. In order to achieve effective and efficient capture of all quality information across the Trust, it was agreed that a quality dashboard / robust business intelligence structure is required as a matter of urgency, to facilitate automated processing and effective triangulation of this information. Further discussion is taking place at Executive level to urgently resolve this.
ADVISE	• **Medical Examiner's Service (MES) & Mortality Framework Report**

	The Committee was advised through a comprehensive report and discussion of progress made and actions being taken to ensure the Trust is meeting its statutory responsibilities in respect of mortality reviews and the Medical Examiner Service requirements. Good progress has been made and a dedicated resource has recently been committed to support the establishment of a robust mortality framework for the Trust. The Committee was also advised that there are new data standards approved by the Welsh Government, Welsh Cancer Network and Welsh Information Standards Board, requiring comprehensive radiotherapy and Systemic Anti-Cancer Therapy datasets including 30 day mortality metrics. For these new requirements to be met, significant clinical validation automated data capture through a quality metric / business intelligence mechanism is required. The new national reporting requirements commence on 01/04/2023 and as manual data validation and collation is currently in place, relying on significant clinical validation, there is a possibility that the Trust will be unable to start providing this information from 01/04/2023. • **Trust Risk Register / Trust Assurance Framework** The (newly formatted using the 7 levels of assurance) report provided the status of the risks reportable to Trust Board, in line with the renewed risk appetite levels, in addition to actions undertaken since the last Committee meeting. The Committee was advised that all fields within the Risk Register will be completed in consistent and appropriate order prior to sighting at Committee. Staff guidance will continue to ensure consistent input of Datix information. Emerging trends and themes will also be included in the report going forward for ease. • **Triangulated Workforce & Organisational Development Performance Report / Finance Report** Considerable discussion took place in relation to the triangulated workforce and finance report including the key workforce and associated financial risks currently faced by the Trust. The ability to deliver service requirements through the current workforce model remains the main risk, with transformation of the multi-professional workforce across the Trust (and associated re-allocation of finance) required. A number of projects are currently in progress, focusing on hotspot areas in addition to addressing changes required to the workforce model as a whole.

Local development of plans will be supported by a workforce development framework, utilising 6 areas of action planning; these will focus on recruiting the appropriate skill mix and optimisation of capacity, improvements to ways of working, effective use of and retention of the current workforce and ensuring accessibility to qualified staff required to meet temporary short term needs of the organisation.

The Committee was advised that focus also remains on reducing sickness levels (as this remains higher than pre-pandemic levels) via the number of wellbeing resources already in place, in addition to further actions undertaken by the Healthy and Engaged Steering Group. Work-related stress is now also highlighted on the Trust Risk Register.

- **Performance Management Framework (PMF) Report**

The Trust Performance Report was received in the new format that seeks to provide an enhanced view of the Trust performance for the period January to April 2023, using statistical control charts. Two minor transcription errors were identified within the document provided that will be amended for February's data: the omission of Hand Hygiene and the listing of the patient experience target at 85%, to be amended to 95%.

The need to enhance the framework during the next year with additional quality outcome measures to meet the Duty of Quality requirements was also recognised.

The following performance areas were highlighted:

- ***Velindre Cancer Service*:**
  - Comprehensive programmes of work are in place to manage continued challenges in terms of providing capacity meet overall Systemic Anti-Cancer Therapy (SACT) and Radiotherapy demand. 100% compliance was achieved in relation to emergency SACT and 97% in relation to non-emergency SACT.
  - Significant manual monitoring of all waiting lists is currently in place across all areas until the availability of electronic data (following the introduction of the new Digital Health Care Record (DHCR) system). Manual validation of Radiotherapy data is also currently being undertaken for this reason. There is currently no date for when this data may be available electronically and it is anticipated that resource issues will continue over the immediate weeks / months.
  - Analysis of a slight increase in healthcare associated infections over the period - analysis has identified no trends or themes. An

increase has been seen across Wales in recent years which had not been felt to date in the Trust.

- ***Welsh Blood Service*:**
  - 98% of quality incident investigations were closed within 30 days during January and no adverse events were reported.
  - Collections exceeded demand for the month, with minimal wastage.
  - Platelet wastage remains above target, to be addressed by a platelet task and finish group.
  - An increase in bone marrow and stem cell collection activity.

- **Quality & Safety Quarter 3 Report**

The report provided an overview of Trust responsibilities in relation to key elements of Quality & Safety for the period 01/10/2022-31/12/2022.

The Committee was advised that a recent validation audit of Putting Things Right (PTR) by the Welsh Risk Pool (WRP) had identified an anomaly in the classification of the Trust's reporting of compliance with 30-working day concerns response. WRP advised that changes are taking place nationally regarding classifications but day one is currently classed as day concern received, Trust had been recording this as day 0. This had resulted in the completion of only 4 of 9 PTR concerns within 30 days during quarter – all 9 had been responded to within 31 working days. The Committee was assured that the Trust had made the necessary system changes to rectify this error moving forward.

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

The Trust Estates Group Highlight Report was moved from consent to the main agenda to allow further discussion due to a number of items for discussion:

- Health and Safety / Fire Safety Mandatory Training levels remain below the required levels; however some improvement has been evidenced and take up will be further encouraged among staff.
- Estates and Statutory Compliance – Staffing remains an issue for the department; however, recruitment is underway and a full team is anticipated by the end of May 2023 in order to more effectively support the delivery of Estates services.
- Limited assurance was received on the Low Voltage Audit as a result of recruitment issues and training of 'Competent and Authorised Persons'. Full resolution of this is expected by the end of July 2023.

ASSURE	• **Welsh Blood Service (WBS) – Donor Story** The Committee received a video donor story in relation to Genetic Haemochromatosis. A review of the frequency of donations for the population of Wales with haemochromatosis has been undertaken by the WBS, allowing people with hereditary haemochromatosis to donate blood more frequently, provided that eligibility criteria are met. This not only supports effective management of the donor's condition, but also provides additional blood / blood products for NHS Wales which prior to these changes would have been discarded. The video included a Donor with haemochromatosis describing the positive impact this change has had on him. • **Quality, Safety & Performance Committee Governance** The Committee received the following papers: ○ *Terms of Reference and Operating Arrangements* – Two key revisions to the Trust Standing Orders – Schedule 3 were received (addition of the Trust Integrated Quality & Safety Group and reflection of this in the wider governance and accountability framework). Further amendments will be made to the accountability framework are anticipated, as the Integrated Quality & Safety Group matures. ○ *Cycle of Business* – Key revisions to the Committee Cycle of Business were received following a review undertaken during February 2023 in conjunction with Executive Directors across the Trust. Minor amendments / omissions identified will be rectified accordingly. ○ *Committee Effectiveness Survey* – The Committee noted the 27% response rate to the targeted feedback questions circulated following the January 2023 Committee. The resulting proposed actions were approved by the Committee and it is anticipated that more robust feedback will be received in due course. • **NHS Wales Shared Services Partnership (NWSSP)** The Committee received the following reports from NWSSP: ○ *CIVAS@IP5 Report* **–** The Committee received assurance that the service is currently meeting all regulatory requirements and that two service complaints had been fully investigated and closed.

	○ *Implementation of Duty of Quality Update* – The Committee received the current position and an assessment of NWSSP's readiness to comply with the Duty of Quality requirements. ○ *Self-assessment of Health and Care Standards Update* **–** This provided a summary of the final iteration of Health and Care Standards action plan and acknowledgement of the new approach to reporting required from 1st April 2023 (as a result of the commencement of the Duty of Quality).
ASSURE	• **Finance Report** The Committee received the Financial Report, outlining the Trust position for the period to end of January 2023. The following was highlighted: ○ Public Sector Payment Performance had seen a reduction in compliance during January (to 90%) as a direct result of vacancies within Shared Services' payment teams. It is anticipated, however, that the compliance target will be achieved by year end. ○ Confirmation that funding will be provided by Welsh Government for the significant increase in energy prices, in addition to COVID response costs. ○ All KPIs remain on target and it is anticipated that the Trust will achieve financial break-even by 2022-23 year end. • **Value Based Healthcare** The Committee received its first Value Based Healthcare report, which outlined progress made in relation to the Value Based Healthcare programme of work and associated bid submitted to Welsh Government (in August 2022). It was advised that funding had been received for 2 of 5 projects submitted (WBS Preoperative anaemia pathway and Value Intelligence Centre) to support progress of the work programme. • **Integrated Medium Term Plan (IMTP) 2022/23 Quarterly Actions Progress Report** The Committee received the 2022/23 Quarter 3 IMTP position. Committee members advised that a more enhanced understanding of key deliverables for the Quality, Safety & Performance component of the IMTP is required, in addition to analysis of targets, accurate associated narrative and high level assurance that targets will be met. The

	Committee was assured that work is being undertaken across both divisions to achieve this. • **Assurance Report Medicines Management Group** The Medicines Management Group report was moved from consent to the main agenda to allow further discussion in the following areas: ○ Assurance that all outstanding areas of compliance with the Patient Safety Notice (PSN 055 – Safe Storage of Medicines) will be completed by the end of March 2023 and from this time the Trust will be fully compliant. ○ The management of clinical guidelines where there have been changes in practice or new treatment options identified has been prioritised following streamlining of the review process. ○ A revised policy procedure framework is in place to support medication requests for unlicensed and 'off label' medications by the Medicines Management Group. • **Nosocomial Transmission Update** The Committee received the current position in relation to patient nosocomial COVID-19 reviews and was assured that all remaining known cases will be reviewed by the 24th March 2023. • **Internal Audit Reports** Two recent Quality & Safety related Internal Audit reports (that had received reasonable assurance) and management action plans were received and noted by the Committee: Patient / Donor Experience and Clinical Audit.
INFORM	• **Policies for endorsement** The Committee APPROVED the following two policies: ○ QS19 – Ionising Radiation Safety Policy ○ IPC13 – Policy for the Prevention and Control of transmissible spongiform encephalopathies (Creutzfeldt-Jakob Disease (CJD)) minimising the risk of transmission. The agenda and papers for the Quality, Safety & Performance Committee (all meetings) can be accessed at: https://velindre.nhs.wales/about-us/quality-safety-performance/
APPENDICES	N/A

4. RECOMMENDATION

The Trust Board is asked to **DISCUSS** and **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 16th March 2023.

Archwilio Cymru
Audit Wales

Structured Assessment 2022 – Velindre University NHS Trust

Audit year: 2022

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Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.

Contents

Summary report

About this report

1 This report sets out the findings from the Auditor General's 2022 structured assessment work at Velindre University NHS Trust (the Trust). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004.

2 Our 2022 Structured Assessment work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. NHS bodies and their Boards need to have sound corporate governance arrangements that can provide assurance to the public and key stakeholders that the necessary action is being taken to deliver high quality, safe and responsive services, and that public money is being spent wisely.

3 The key focus of the work has been on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. We have not reviewed the Trust's arrangements for hosting the NHS Wales Shared Services Partnership as part of this work. The approach we adopted to deliver our work is detailed in summarised in **Appendix 1**.

4 We have also provided updates on progress against recommendations identified in previous structured assessment reports.

Key messages

5 Overall, we found **that the Trust is generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance, and effective arrangements for managing its finances and other resources.**

6 The Trust's Board and its committees continue to operate effectively and are actively using learning to drive improvement. However, opportunities remain to improve the public availability of key papers and documents on the Trust's website. The Trust continues to have a stable Executive Team and organisational structure. It has reviewed and strengthened its systems of assurance which should enable the Board and its committees to assess and improve organisational performance and effectiveness once fully operational. However, it needs to reinstate the log for

tracking recommendations relating to the quality and safety of services made by external inspection and regulatory bodies.

7 The Trust has good planning and stakeholder engagement arrangements. It has a clear strategic vision, supported by goals and objectives, which the Trust articulates in its new ten-year strategy (Destination 2032), enabling strategies, and Welsh Government approved 2022-25 Integrated Medium-Term Plan (2022-25 IMTP). However, whilst the Trust's strategic priorities as set out in the 2022-25 IMTP, are specific, measurable and timebound, they do not set out the intended outcome. Whilst reporting on delivery of the 2022-25 IMTP is good, opportunities exist to strengthen reports to provide greater detail on whether the intended outcome has been achieved.

8 The Trust has effective arrangements for managing its financial resources and continues to meet its financial duties. However, the Trust is aware that it faces risks to maintaining financial sustainability in the medium- to long-term. Financial controls are effective, and the Trust continues to produce clear and accessible financial reports to support effective monitoring and scrutiny.

9 Staff well-being continues to be a priority for the Trust. But its arrangements for measuring and reporting on the effectiveness of well-being interventions require strengthening. The Trust has ambitious plans in place to harness the potential of digital to transform service delivery, but some plans remain uncosted. Furthermore, arrangements for monitoring and reporting on the benefits of digital require strengthening. The Trust has a clear vision for its estates and environmental sustainability and has good arrangements in place for ensuring Board-level oversight and scrutiny of key estates related risks and matters.

Recommendations

10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 2**. [**Appendix 2** will be completed once the report and organisational response have been considered by the relevant committee.]

Exhibit 1: 2022 recommendations

Recommendations
Improving administrative governance arrangements
R1 We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing:

Recommendations

- missing committee meeting papers;
- the Register for Gifts, Hospitality and Sponsorship and the Declarations of Interest Register; and
- the ten-year strategy and enabling strategies.

The Trust should establish a clear and robust process to ensure it publishes key papers and documents on its website in a timely and ongoing basis.

Reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies

R2 The Quality, Safety, and Performance Committee has not received the log which tracks recommendations relating to the quality and safety of services made by external inspection and regulatory bodies since early in 2020. The Trust should immediately reinstate the tracker to enable the committee to oversee, scrutinise, and challenge the progress it is making in addressing both quality and safety recommendations and any relating to performance.

Establishing measurable outcomes for strategic priorities

R3 The Trust has translated its strategic priorities into specific objectives and actions in the 2022-25 IMTP (including timescales for delivery). The Trust should seek to articulate the intended outcomes for each strategic objective/action in future IMTPs, including what success would look like.

Enhancing reporting on 2022-25 IMTP delivery

R4 The Trust's arrangements for reporting delivery of the 2022-25 IMTP are reasonable, but it needs to better describe the impact the actions are making. The Trust should report on the impact of actions delivered to date to allow the Board to better understand the extent that delivery of the IMTP is making a difference and determine any actions that need to be rolled forward to the 2023-26 IMTP.

Improving reporting on the benefits arising from digital investments

R5 Whilst there is good reporting on progress in delivering key digital projects and programmes, the reports do not provide an assessment of what difference they are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.

Detailed report

Governance arrangements

11 In this section of the report, we provide our views on the Trust's governance arrangements, with a particular focus on:

- Board and committee effectiveness;
- the extent to which organisational design supports good governance; and
- key systems of assurance.

12 Details of progress made on previous year recommendations relating to the Trust's governance arrangements are provided in **Exhibit 2** and **Exhibit 3.**

13 We found that **the Trust has good governance and leadership arrangements, supported by improving systems of assurance.**

Board and committee effectiveness

14 We considered the extent to which the Board and its committees conduct their business effectively and support good governance. In examining this, we have looked at whether:

- the Board and its committees demonstrate appropriate levels of public transparency;
- meetings are conducted appropriately supported by clear Schemes of Delegation, Standing Orders, Standing Financial Instructions, and Registers of Interest;
- there is an appropriate and well-functioning committee structure below the Board;
- the Board and its committees receive the right information, including views from staff and service users; and
- there is evidence of sufficient self-review by the Board and its committees.

15 We found that **the Board and its committees operate effectively and are actively using learning to drive improvement. However, opportunities remain to improve the public availability of key papers and documents.**

16 The Trust continues to demonstrate appropriate levels of public transparency. All public Board meetings are live-streamed to allow the public to observe virtually, with recordings made available on the Trust's website (see **Exhibit 2, 2021 R1**). The Trust, however, does not live-stream or record its committee meetings. The Trust minimises the use of private sessions, reserving these for confidential and sensitive matters only. Where it uses private sessions, the Trust publishes the 'minutes' on its website.

17 The Trust continues to circulate Board and committee papers to attendees in advance of meetings. However, the Trust does not always publish these on its website in advance of meetings and within the required timescales set out in the Standing Orders (**Recommendation 1**). For instance, the Trust did not publish

papers for the 4 October 2022 Audit Committee and the 13 October 2022 Strategic Development Committee prior to the meetings (see **Exhibit 2**, **2021 Rec 1**). We also found that the papers for some committee meetings were still missing from the Trust's website long after they had occurred. A review of the Trust website (30 November 2022) found that the following committee papers were still not available:

- January, May, and October 2022 Audit Committee papers;
- January, February, and March 2022 Quality, Safety, and Performance Committee papers; and
- October 2022 Strategic Development Committee papers.

18 The organisation's governance arrangements support the effective conduct of Board and committee business. The Trust appropriately reviews its Standing Orders, Scheme of Reservation and Delegation, and Standing Financial Instructions on a frequent basis. It last updated the Standing Orders in January 2022, which included new terms of reference for four committees. It received Board approval in January 2022 following scrutiny by the Audit Committee. The Standing Orders and Standing Financial Instructions are available on the Trust website, and reflect the changes made in January 2022. The Audit Committee receives the Register for Gifts, Hospitality and Sponsorship and the Declarations of Interest Register on a quarterly basis, which it last reviewed in October 2022. Whilst these registers are available in Audit Committee papers, the Trust has not published them separately on its website (**Recommendation 1**). We routinely observe declarations of interest taken at the start of Board and committee meetings as a standing item on all agendas.

19 The Trust continues to have a stable Board. Two new Independent Members assumed their posts in August and November 2021. In general, Independent Members' terms are staggered, which minimises Board instability and helps reduce the risk of losing knowledge and experience when terms end. We found that Independent and Executive Board members continue to have a healthy relationship, which in turn facilitates informal and formal flows of information. We have observed Independent Members offering a good balance of challenge and support. From our observations, we note that Independent Members often scrutinise officers on the impact of decisions on patients and donors. We have observed robust scrutiny of waiting time performance for patient referrals for Systematic Anti-Cancer Treatment and Radiotherapy.

20 The Trust has a streamlined Board and committee structure, which appropriately reflects the organisation's business. The Board committee structure is well embedded and there is a commitment to review and amend, as necessary. The Trust reviewed its committee structure in March 2022, and there are plans to undertake a more detailed review of the effectiveness of committees during 2023.

21 The Trust has kept virtual Board meetings under review as COVID-19 restrictions have started to relax. In May 2022, it began a phased return to face-to-face meetings by holding a 'hybrid' Board meeting, with some members attending in-person and others attending virtually. Subsequent Board and committee meetings

have adopted this model, and these generally work well. Moving forward, the Trust envisages continuing with a hybrid model. We found that Board and committee meetings are well chaired, and members continue to observe good virtual etiquette.

22 There is good cross-referral of matters between committees and from committees to the Board. Cover reports clearly identify where papers have previously been scrutinised by a committee, and meeting chairs helpfully remind attendees of this to help avoid unnecessary repeat discussions. There is a shared intent to ensure that, in future, cover papers also include a summary of previous discussions, and that the Trust reflects the resulting agreed actions in papers. The Trust also intends to look at the scheduling of committee meetings to ensure Executive Directors have sufficient time to action any agreed changes to agenda items prior to them being considered for approval at a later meeting, where this applies.

23 In our 2021 structured assessment report, we found that the Quality, Safety, and Performance Committee agenda items often went into too much detail. The Trust fully recognises this view. Our review of the Trust's quality governance arrangements (reported in August 2022) found improvements during 2022, with committee meetings running to time, and more focused discussions on key matters. Once fully operationalised, the new Quality and Safety Governance Group should help further by triangulating and refining exception reporting to committee, and play a role in ensuring that the detail of committee papers is pitched correctly. The Trust recognises there is more work to do. It has set out further improvements in an action plan to address findings from the Quality, Safety, and Performance Committee's annual effectiveness review. There are also additional relevant actions set out in the Quality and Safety Framework Implementation Plan.

24 Our observations of the Board and committee meetings in summer and autumn 2022 have found that cover reports and verbal presentations are beginning to draw attention more concisely to key matters for escalation or assurance. The Trust fully recognises there is more work to do to ensure that discussions in all Board and committee meetings do not become impeded by too much detail in papers and cover reports. It is also encouraging to note that Trust is working to try and better triangulate workforce, performance, and finance information.

25 The Trust continues to provide good Board training and development opportunities and seeks opportunities for further improvements. The Board is required to undertake an annual self-assessment of its effectiveness. The Board concluded in its Accountability Report 2021-22 that it could define itself as "having well developed plans and processes and can demonstrate sustainable improvement throughout the organisation" and scored itself a four out of a possible five. The Trust is one of only two NHS bodies in Wales that uses this maturity assessment.

26 The Trust has continued to engage regularly with patient advocates from the Community Health Council. Representatives also regularly attend Board and committee meetings and provide views on service changes and public accessibility to Trust business. Quality, Safety, and Performance Committee meetings

commence with either a patient, a donor, or a staff story, which usefully sets the tone for the remainder of the meeting.

27 The Trust is engaging with staff across the organisation to understand how they feel and to address findings from the 2021 NHS Staff Survey. The Trust intends that the outputs of this work give a picture of the culture of the organisation and inform the next iteration of the Trust Behaviours and Values.

Exhibit 2: progress made on previous year recommendations

Recommendation	Description of progress
Transparency of Board business 2021 R1 Some committee meeting papers are missing from the website, as are links to recordings of Board meetings. The Trust should ensure that it strengthens the process for the collation, sign off and timely publication of: • Board and committee meeting papers; and • recordings of Board meetings.	**Superseded** Our review found that recordings of most Board meetings are available on the Trust website. Similarly, the Trust ensures that Board papers are available in advance of meetings. However, we found that the Trust has not published some committee papers in advance of meetings, and some remain unpublished long after the meeting date. As a result, this recommendation is superseded by a new recommendation (see **Exhibit 1 – R2 Improving administrative governance arrangements**).

Organisational design

28 We considered the extent to which the Trust's organisational structure supports effective governance. In examining this, we have looked at whether:

- the responsibilities of Executive Directors are clear, and that they have balanced and equitable portfolios of work;
- there is clarity on the role of the Board Secretary, and there are adequate resources in place to support the work of the Board and its committees; and
- the organisational structure supports effective governance and facilitates whole-system working.

29 We found that the **Trust has a stable Executive Team and organisational structure.**

30 The Trust continues to have a stable Executive Team and organisational structure. Executive portfolios are appropriate and balanced. The role of Board Secretary is undertaken by the Director of Corporate Governance and Chief of Staff. Whilst

corporate governance and risk management resources are lean, the Trust told us that current capacity is adequate.

31 Due to the small size of the organisation, the Trust recognises it has limited capacity to support service improvement and transformational work programmes. The Executive Management Team has recently contracted an external consultant to design a prioritisation framework for core service delivery improvements and transformational activity. The Trust intends to use these outputs to populate and prioritise a roadmap of work programmes to inform the development of the 2023-26 IMTP. The Trust recognises it needs to ensure that the roadmap matches available capacity and that it puts sufficient change management capability in place to support delivery.

Systems of assurance

32 We considered the extent to which the Board and its committees oversee, scrutinise, and challenge organisational risks, performance, and quality of services. In examining this, we have looked at whether:

- there is an effective Board Assurance Framework (BAF) in place, which is actively reviewed and owned by the Board;
- the BAF is underpinned by appropriate systems for managing risks and performance; overseeing the quality and safety of services; and handling information in a secure manner; and
- effective action is taken to address audit and review findings and recommendations.

33 We found that **there has been extensive activity to renew and strengthen sources of assurance. Once fully operational, these sources of assurance should provide good coverage to enable the Board and its committees to assess and improve organisational performance and effectiveness.**

34 We considered the Trust Board Assurance Framework (TAF) and risk management arrangements as part of our review of the organisation's quality governance arrangements (reported in August 2022).

35 As part of our quality governance review, we said that Board committees need to review strategic risks more methodically. Committees, as part of their cycles of business, should consider the controls and gaps in assurance outlined in the TAF and receive and monitor progress against associated action plans. To date, scrutiny of the TAF has concentrated on its development, rather than the content. However, in November 2022, the Trust assigned each strategic risk to a committee and set out that each one would consider their cycle of business to ensure appropriate consideration of the associated controls and sources of assurance. The Trust plans to enhance the TAF by incorporating links to risks within the Corporate Risk Register, key performance measures, and audit recommendations. It also plans to further develop the articulations of strategic risks to ensure they align with the priorities set out in the 2023-26 IMTP (see **Exhibit 3**, **2019 R2**).

36 In our quality governance review, we also reported that whilst the Trust had made progress to develop and improve risk management arrangements during 2020 and 2021, there were still outstanding areas of work. We found that risk registers presented to meetings do not always include enough information to allow good scrutiny and challenge. We recommended that the Trust should determine what information it needs to include in all risk registers (including the Corporate Risk Register) to enable good management and scrutiny. This should, for example include opening, current and target risk scores, and provide sufficient clarity on existing controls and effectiveness of mitigating actions.

37 The Trust has made positive progress with its operational risk management arrangements since our quality governance review. It has completed the migration of Welsh Blood Service risks to the new version of DATIX[1] and approved amendments to the Risk Management Framework (see **Exhibit 3**, **2016 R7c**). Rollout of risk management training continues. A review of the information contained in risk registers is underway. Work is in progress to address risk management recommendations set out in our quality governance review and Internal Audit's 2021 Board Assurance Framework report. However, it is too early to assess the effectiveness of these arrangements and whether they are helping to reduce risk scores (see **Exhibit 3**, **2019 R2**).

38 In our quality governance review, we found that there has been considerable progress to improve governance arrangements for quality and safety, with the approval of a new Quality and Safety Framework in July 2022. However, it was too early to assess the effectiveness of new arrangements in practice.

39 The Trust is in the process of revising and enhancing its performance management arrangements. It is developing a 'balanced scorecard' approach aligned to six domains of care – safe, effective, service user centred, timely, efficient, and equitable care. There will be specific performance scorecards for the Board; the Quality, Safety, and Performance Committee; the Executive Management Board; and the divisional senior management teams. The proposed approach is based on a hierarchy of performance measurements appropriate to the remit and scrutiny requirements at each organisational level. This will allow the Trust to develop a broader range of performance measures, such as the inclusion of more outcome measures. The Board will take assurance from the detailed review and challenge undertaken by each level below. The Trust intended that the Quality, Safety and Performance Committee and Board would receive the new and revised performance reports at the planned November 2022 meetings. However, it did not achieve this target due to operational pressures. Despite this, the Trust's performance management arrangements are helping to provide operational focus to improve performance.

[1] Datix is a web-based incident reporting and risk management system used by healthcare organisations.

40 The Trust has effective arrangements for overseeing information governance at a committee-level, but some operational arrangements require improvement. In 2020, Internal Audit completed a baseline review of the arrangements in place for the management and control of information governance and information communications technology using the COBIT 2019 Framework[2]. As part of their assessment, Internal Audit scored the Trust's arrangements under each of the headings of the framework. The Trust scored well under many of the headings but particularly well in its information governance arrangements (94%). In terms of cyber security, the Trust scored 61% and 71% for managed security and managed security services, respectively. Internal Audit highlighted several opportunities for the Trust to strengthen its cyber security arrangements and will complete a further review of these arrangements by March 2023. The Quality, Safety, and Performance Committee receives information governance assurance reports on a quarterly basis, which provide a good overview of the Trust's activities in relation to data protection, physical security, and information security. At 82.59%, the Trust's compliance against mandatory information governance training is only slightly below the NHS Wales target of 85%[3].

41 Improvements have been made to the Trust's arrangements for tracking internal and external audit recommendations. An Internal Audit review of the Trust's audit trackers in 2022 highlighted that the organisation did not have a procedure note in place to set a standard for responding to internal and external audit recommendations. The Trust subsequently developed a draft procedure which the Audit Committee endorsed in July 2022. The Audit Committee now reviews the full tracker twice a year and considers overdue and completed actions for closure at each meeting (see **Exhibit 3**, **2018 R4b**). Prior to the pandemic, the Quality, Safety, and Performance Committee received a tracker for recommendations made by other external inspection and regulatory bodies, such as Healthcare Inspectorate Wales. However, the committee has not received the tracker since early in 2020 (**Recommendation 2**).

[2] COBIT (Control Objectives for Information and Related Technologies) is an IT management framework developed by the Information Systems Audit and Control Association to help organisations develop, organise, and implement strategies around information management and governance.

[3] As reported in the July 2022 Information Governance Assurance Report to the Quality, Safety, and Performance Committee.

Exhibit 3: progress made on previous year recommendations

Recommendation	Description of progress
Risk management **2016 R7c** The Trust should standardise the format of its various risk registers, ensuring the good practice elements of each register are spread across the organisation.	**Complete** The Trust has completed the migration of all risk registers to DATIX.
Board assurance and risk management **2019 R2** The Trust should complete the development of its Board Assurance Framework with pace, ensuring that it is appropriately underpinned by up-to-date risk management arrangements. Specifically, the Trust should • review the principal risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new Board Assurance Framework; • update the Risk Management Framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; and • provide risk management training to staff and Board members on resulting changes to the risk management framework	**On-track, but not complete** The Trust has populated its Assurance Framework with strategic risks, and it intends to review these risks to ensure they align with the Integrated Medium-Term Plan. The Trust has updated its Risk Management Framework and Risk appetite, with the former articulating the escalation arrangements. The one outstanding area is the rollout of risk management training, which is not yet complete.
Tracking Internal and External audit recommendations **2018 R4b**	**Complete** There is a mechanism in place for Audit Committee to agree to the closure of recommendations.

Recommendation	Description of progress
Implement a mechanism for ensuring that when Internal Audit and External Audit actions are completed, the responsible officer provides a brief summary of the actions taken to the Audit Committee, along with a request to close the action	
Clinical audit scrutiny 2018 R5a The Quality and Safety Committee should review and approve clinical audit plans, ensuring that clinical audit plans address any risks to achieving strategic priorities and organisational risks.	We have not considered these recommendations as part of our 2022 structured assessment work as Internal Audit will be undertaking a clinical audit review. We will, therefore, consider them as part of our 2023 structured assessment work.
Clinical audit scrutiny 2018 R5b Improvements should be made to the content of clinical audit reports from both VCC and WBS to clearly identify the audit findings, any associated risks and actions for improvement and follow-up.	
Clinical audit scrutiny 2018 R5c The Quality and Safety Committee should assure itself that clinical audit findings are addressed.	
Clinical audit scrutiny 2018 R5d Clinical audit scrutiny The Audit Committee should clarify how it assures itself that the clinical audit function is effective	

Strategic planning arrangements

42 In this section of the report, we provide our views on the Trust's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium-term Plan;
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

43 Details of progress made on previous year recommendations relating to the Trust's strategic planning arrangements are provided in **Exhibit 4**.

44 We found that **the Trust has a clear strategic intent supported by good planning and stakeholder engagement arrangements. However, opportunities exist to enhance delivery reporting arrangements.**

Vision and strategic objectives

45 We considered the extent to which there is a clear vision and long-term strategy in place for the organisation. In examining this, we have looked at whether:

- the vision and strategic objectives are future-focussed, and rooted in a detailed and comprehensive analysis of needs, opportunities, challenges, and risks;
- the vision and strategic objectives have been developed and adopted by the Board; and
- the long-term strategy is underpinned by an appropriate long-term clinical strategy.

46 We found **that the Trust has a clear vision and goals in its long-term strategy, supported by a suite of enabling strategies.**

47 The Trust's vision of 'Excellent Care, Inspirational Learning, Healthier People' is clearly set out in its new ten-year strategy, 'Destination 2032'. The strategy has five clear strategic goals which seek to address post-pandemic opportunities, challenges, and risks. Destination 2032 is supported by a series of enabling strategies, one each for sustainability, people, digital, and estates. Destination 2032 was approved by the Board in July 2022, and the enabling strategies in May. Whilst these strategies are available in Board papers, they are not published separately on the Trust's website (**Recommendation 1**).

48 The pandemic caused a delay to completing Destination 2032 and the enabling strategies, but work recommenced in 2021. Board members were actively involved in developing the strategies, and the Trust engaged well with a broad range of internal and external stakeholders as part of the planning process. Destination 2032, along with the enabling strategies, set a clear direction of travel for the organisation.

49 The Trust has separate strategies for Velindre Cancer Centre and the Welsh Blood Service, which are both framed in the context of Destination 2032. The Trust has delayed the establishment of a Clinical and Scientific Strategy Board while it determines the resources required to support these arrangements. The Executive Management Board has agreed the terms of reference for the Clinical and Scientific Board. The Trust recognises that it needs to establish the Clinical and Scientific Strategy Board without further delay to provide a formal route for clinicians to inform the development of its clinical and scientific plans and work in areas such as value-based healthcare, National Clinical Framework requirements, and the Duties of Candour and Quality.

Planning arrangements and the Integrated Medium-Term Plan

50 We considered the extent to which the Trust has been able to produce an approvable Integrated Medium-Term Plan (IMTP) for 2022-2025. We also considered the extent to which the Board maintains effective oversight of the process for developing corporate strategies and plans. In examining this, we have looked at whether:

- the IMTP was submitted within the required timeframes in line with Welsh Government guidance;
- the draft and final versions of the IMTP were discussed, challenged, and agreed by the Board prior to submission;
- the IMTP received approval from the Minister for Health and Social Services;
- the extent to which the Board maintains effective oversight of the process for developing corporate strategies and plans;
- whether corporate strategies and plans have been developed in liaison with relevant internal and external stakeholders; and
- whether prudent and value-based healthcare principles are considered and reflected in corporate strategies and plans.

51 We found that **the Trust has good planning arrangements. It also has an approved IMTP, which received appropriate Board-level input and scrutiny.**

52 The Trust was able to produce a balanced and Welsh Government approved IMTP for 2022-25 (the 2022-25 IMTP). The 2022-25 IMTP, which was prepared in accordance with Welsh Government planning guidance, describes the operating context, identifies the key factors influencing the priorities within the plan, and has appropriate coverage of the Trust's operations for the three-year period. The 2022-25 IMTP is available on the Trust's website.

53 An assessment of demand for blood and cancer services by commissioning Health Boards has also helped to inform the 2022-25 IMTP. However, demand for cancer services was higher than planned during 2022 due to ongoing impacts resulting

from the pandemic[4]. In addition, capacity for radiotherapy and Systematic Anti-Cancer Treatments is reduced due to factors including workforce pressures, the need to maintain social distancing, and ageing radiotherapy equipment 'downtime'. The Trust had planned to commission external capacity, but this option became unfeasible. The Trust has demonstrated flexibility in its planning arrangements to secure additional capacity via increasing workforce, equipment, and physical spacing. The Trust's actions are having a positive impact on waiting times in the latter stages of 2022.

54 There was good Board-level engagement throughout the development of the 2022-25 IMTP. The Strategic Development Committee provided appropriate scrutiny of the planning arrangements on behalf of the Board. We found that the Board and the Strategic Development Committee effectively scrutinised and challenged the 2022-25 IMTP prior to its submission. The Board formally approved the 2022-25 IMTP in March 2022 and submitted to Welsh Government within the required timeframe. The Minister for Health and Social Services approved the 2022-25 IMTP in July 2022 and set out accountability conditions which the Trust is actively addressing.

55 The Trust has effective planning arrangements. The planning process is co-ordinated by the Trust's Strategic Planning Team. They are supported by planning managers in each division as well as the finance team, and overseen by the Executive Management Board. The Trust is also effective at involving internal and external stakeholders in developing corporate strategies and plans. There is evidence of good engagement with the Community Health Council, commissioners, patients, donors, and other stakeholders in developing Destination 2032 and the supporting enabling strategies, and the 2022-25 IMTP.

56 The 2023-26 IMTP will set the context and actions to deliver the Trust's new vision and strategic goals. In addition, the work to prioritise improvement and transformation plans will help shape the 2023-26 IMTP (see **paragraph 31**). The 2023-26 IMTP will also need to set out the challenges, risks, and opportunities relating to the set up and running of the new Velindre Cancer Centre, including cost pressures and uncertainties associated with planning assumptions.

57 The Trust recognises that it is at an early stage in its value-based healthcare journey. It has a clear set of priorities and an implementation plan to guide its approach to embedding value-based healthcare across the organisation. Recent funding from Welsh Government should enable the Trust to move at pace to deliver on its ambitions by increasing capability and expertise in this area. This should also allow the Trust to ensure that value-based healthcare principles inform the Trust's overall approach to strategic planning.

[4] During the earlier phases of the pandemic screening for cancer was lower than 'normal' levels, meaning that there was an element of catch-up occurring during 2022, in addition where patients are presenting later, cancer can be more progressed and requiring more intensive treatment.

Implementation and monitoring arrangements

58 We considered the extent to which the Board oversees, scrutinises, and challenges the implementation and delivery of corporate strategies and plans. In examining this, we have looked at whether:

- corporate strategies and plans contain clear milestones, targets, and outcomes that aid monitoring and reporting; and
- the Board receives regular reports on progress to deliver corporate strategies and plans.

59 We found that **whilst the IMTP contains clear objectives and actions, supported by timescales for delivery, it lacks supporting intended measurable outcomes. Progress reporting is reasonably effective, but reports should provide greater assurance that the Trust is taking appropriate action when delivery is off-track.**

60 In the 2022-25 IMTP, the Trust has set out its strategic priorities for the three years covered by the plan. Each strategic priority is translated into specific objectives and actions, with timescales for delivery. However, the Trust should better articulate what successful delivery of the strategic priorities set out in the 2022-25 IMTP will look like, the outcomes it wants to achieve, and how these will be measured (**Recommendation 3**). The benefit of doing so is to demonstrate that in delivering an action, the Trust has achieved the intended outcome, and if not, that further action may be necessary. We recognise it is difficult for the Trust to demonstrate the direct impact of its work on cancer service patient outcomes, especially as these are affected by factors outside its control. Nonetheless, this is an important part of demonstrating the Trust's impact of improving cancer patient outcomes.

61 The Trust has reasonably effective arrangements for reporting delivery of the 2022-25 IMTP. Officers presented the Quarter 1 and Quarter 2 2022-2023 progress report to the Board in November 2022, which used Red, Amber, Green (RAG) ratings to highlight progress. There was a good discussion in the Board meeting on additional information that would be useful to include in future reports to support scrutiny. For example, where delivery is off-track, reports should explain the reasons why and the remedial action needed and / or actions in-progress. In our view, there is also scope to provide greater detail on the impact of actions delivered to date (see **paragraph 60**), and the extent to which limited service improvement and change management capacity is inhibiting delivery (see **paragraph 31**). This would allow the Trust to understand the effectiveness of its actions and assess which actions it either needs to revise or roll forward to the 2023-26 IMTP (**Recommendation 4**). Going forward, the Quality, Safety, and Performance Committee will play a greater role in reviewing and monitoring progress in more detail.

Exhibit 4: progress made on previous year recommendations

Recommendation	Description of progress
Articulation of strategic priorities 2021 R2 Not all the Trust's strategic priorities in the Annual Plan are supported by specific, timebound actions for delivery, and the intended outcome. In future, the Trust should ensure that all strategic priorities are supported by discrete objectives, each underpinned with specific, timebound actions for delivery and the intended outcome.	**Superseded** In the 2022-25 IMTP, strategic priorities are supported by specific, measurable and timebound actions for delivery, but they lack intended outcomes. This recommendation is superseded by a new recommendation (see **Exhibit 1 - R3 Establishing measurable outcomes for strategic priorities**.)

Managing financial resources

62 In this section of the report, we provide our views on the Trust's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

63 We found that **the Trust has effective arrangements for managing its financial resources but faces several risks to maintaining financial sustainability in the medium- to long-term.**

Financial objectives

64 We considered the extent to which the Trust has effective arrangements in place to meet its key financial objectives. In examining this, we have looked at whether the Trust:

- met its financial objectives for 2021-22, and is on course to meet its financial duties in 2022-23; and
- has a clear and robust financial plan in place, which includes realistic and sustainable savings and cost improvement plans.

65 We found that **the Trust met its financial duties for 2021-22 and has a clear financial plan to deliver services in 2022-23.**

66 The Trust met its financial duties in 2021-22, reporting a small surplus of £41,000 at the end of the financial year. The Trust also achieved its statutory financial duty

to achieve break-even over a three-year rolling period (2019-20 to 2021-22), reporting an overall three-year surplus of £103,000.

67 The Trust's 2022-25 IMTP is underpinned by a comprehensive Strategic Financial Plan. The plan is based on a clear series of assumptions regarding the Trust's expected income from its commissioners and Welsh Government funding to support recovery from the COVID-19 pandemic, the cost pressures facing the Trust in terms of pay and non-pay inflation, and the cost saving potential of services. Financial risks to the successful delivery of the plan are clearly set out, as well as the actions the Trust is taking to manage and mitigate against them.

68 For 2022-23, the Trust has set a savings requirement of £1.3 million (a 2% target), of which £800,000 is recurrent and £500,000 non-recurrent. Of the £1.3 million, £750,000 are savings schemes and £550,000 are income generating schemes. As of Month 6 2022-23, the Trust reported that the ongoing implications of the pandemic and increased prices caused by current market conditions will impact on saving scheme delivery. As a result, the Trust has asked that where there is risk to delivery of savings, alternative savings and cost reductions are identified and implemented to ensure that the overall targets are met.

69 As of Month 6 2022-23, the Trust reported that it is on course to achieve financial balance by the end of the financial year. However, this assumes that:

- Welsh Government and the Trust's commissioners will fully reimburse all additional COVID-19 costs along with exceptional national cost pressures;
- that the Trust receives all other planned additional income; and
- that the Trust achieves its savings targets.

Financial controls

70 We considered the extent to which the Trust has appropriate and effective arrangements in place for allocating, authorising, recording, and managing the use of its financial resources. In examining this, we have looked at whether:

- there are effective controls in place to ensure compliance with Standing Financial Instructions and Schemes of Delegation;
- the Audit Committee maintains appropriate oversight of arrangements and performance relating to single tender actions, special payments, losses, and counter-fraud;
- there are effective financial management arrangements in place; and
- financial statements were submitted on time, contained no material misstatements, and received a clean audit opinion.

71 We found that **the Trust continues to have good controls for managing the use of its financial resources.**

72 The Trust continues to have effective controls in place to ensure compliance with its with Standing Financial Instructions and Scheme of Reservation and

Delegation. Since our last structured assessment report, Internal Audit has issued reasonable assurance ratings on the Trust's:

- financial systems relating to non-pay expenditure, fixed assets, and debt management (reported in May 2022);
- arrangements for scrutinising expenditure above the Chief Executive's limit (£100,000) (reported in May 2022); and
- processes underpinning financial and service sustainability, namely budgetary control (revenue budgets) and savings plans (reported in October 2022).

We did not identify any significant control weaknesses from our review of the Trust's 2021-22 financial statements.

73 The Trust continues to report regularly to the Audit Committee on procurement, losses, special payments, and counter-fraud matters to support effective oversight, scrutiny, and challenge. Procurement reports continue to clearly set out the number of Single Tender Actions and Single Quotation Authorisations and the reasons why officers did not follow standard procurement procedures. The value and reasons for deviation from standard procurement procedures also continue to be clearly set out in these reports. The Trust has recently enhanced these reports to provide additional context for members of the Audit Committee, and further improvements are planned by the Trust's new Head of Procurement to strengthen the assurances provided.

74 The Trust continues to log urgent decisions taken by the Chair between scheduled Board meetings. All urgent decisions are subsequently presented to the Board in writing for scrutiny and ratification.

75 The Trust has a good understanding of its cost pressures which are clearly set out in its Strategic Financial Plan. These include energy and fuel cost increases, the Employers National Insurance uplift (which was subsequently repealed by the UK Government), the living wage, and other extraordinary levels of cost inflation. However, these cost pressures alongside wider workforce costs and increased service demand may impede the Trust's ability to maintain financial sustainability in the medium- to long-term.

76 Financial management arrangements are effective. The Trust has set clear budgets and savings targets for each of the divisions and enabler functions. At Month 6 2022-23, the reported financial position of all divisions and enabler functions was breakeven (noting a small underspend in Corporate Services), and an expected outturn position of breakeven.

77 The Trust submitted good quality draft financial statements for audit by the Welsh Government imposed deadline of 29 April 2022. The Audit Committee considered these on 13 June 2022. Our audit identified no material misstatements, and we

issued an unqualified audit opinion, except for the regularity opinion, for which we issued a qualified opinion[5].

Monitoring and reporting arrangements

78 We considered the extent to which the Board oversees, scrutinises, and challenges the organisation's financial performance. In examining this, we have looked at whether:

- reports to the Board provide a clear picture of the organisation's financial position, as well as the key financial challenges, risks, and mitigating actions taken; and
- Board members sufficiently challenge ongoing assessments of the financial position.

79 We found that **the Trust continues to produce clear and accessible financial reports that support effective monitoring and scrutiny**.

80 The Trust continues to report financial performance at every public Board meeting and Quality, Safety, and Performance Committee meeting. The Trust publishes this information on its website alongside its Board and committee papers. The finance reports provide timely and high-quality information and contain a good mixture of text and exhibits to convey key messages. The reports set out the revenue, capital, and savings position of the Trust, and clearly highlights key financial risks with their associated mitigating actions and cost implications. We have observed good scrutiny and challenge around the organisation's financial position at both Board and Quality, Safety, and Performance Committee meetings.

Managing the workforce, digital resources, the estate, and other physical assets

81 In this section of the report, we provide our high-level views on the Trust's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff wellbeing (please note we will be undertaking a separate review of the organisation's workforce planning arrangements);
- arrangements for managing its digital resources; and
- arrangements for managing its estate and other physical assets.

82 We found **that the Trust has clear plans in place to support staff well-being, harness the benefits of digital, and improve its estate. However,**

[5] We issued a qualified regularity opinion to all Health Boards and the Velindre University NHS Trust due to clinicians' pension tax liabilities.

arrangements for monitoring and reporting on their outcomes require strengthening, particularly in relation to staff well-being and digital.

Supporting staff wellbeing

83 We considered the extent to which the Trust has appropriate and effective arrangements in place for supporting staff wellbeing. In examining this, we have looked at whether:

- mechanisms to seek staff views about their wellbeing needs are effective, and appropriate action is taken to respond to findings; and
- actions to support and improve staff wellbeing are actively monitored by the Board, including actions taken in response to our report on how NHS bodies supported staff wellbeing during the COVID-19 pandemic[6].

84 We found that **the Trust continues to prioritise staff well-being, but its arrangements for measuring and reporting on the effectiveness of well-being interventions require strengthening.**

85 The Trust continues to prioritise staff well-being in line with its People Strategy and 2022-25 IMTP. The Trust recognises that having healthy, valued, and engaged staff will result in improved retention, increased innovation, lower levels of sickness absence, and have a positive effect on patient and donor experience. The People Strategy outlines key deliverables to achieve this[7].

86 In September 2022, Internal Audit completed an advisory review of the effectiveness of staff well-being support and initiatives which found that:

- the Trust captures, monitors, and reports a range of staff related activity to assess well-being levels; and
- intervention effectiveness measurement is not prominent in Trust reporting and not sufficiently well-defined to effectively assess the impact on well-being.

Internal Audit recommended that the Trust should consider other interventions to further support improvements in staff well-being, and fully explore and develop the means and measures by which the success or effectiveness of its well-being initiatives will be determined. In our view, this should also include surveying staff directly to better understand how they are feeling and whether the well-being services and initiatives they access are meeting their needs.

[6] Taking care of the carers? How NHS bodies supported staff wellbeing during the COVID-19 pandemic.

[7] People Strategy key deliverables include developing a Health and Well-being Framework; appointing a Clinical Psychologist to support staff; improving staff engagement by developing an Engagement Strategy; and delivering a range of mental, physical, and financial well-being support.

87 In May 2022, the Audit Committee received the Trust's management response to our Taking Care of the Carers report. The Trust reported to the Audit Committee in July 2022 that it had fully addressed all six recommendations.

88 The Board and Quality, Safety, and Performance Committee continue to receive and consider key workforce metrics at every meeting, including staff sickness levels, Performance Appraisal and Development Review (PADR) completion rates, and statutory and mandatory training levels. Until July 2022, the report also included reasons for staff sickness. The latest report (November 2022) showed that the Trust was meeting the statutory and mandatory training target of 85%, its PADR completion rates were improving, but staff sickness, at 6.31%, remained above the organisation's target of 3.54%.

Managing digital resources

89 We considered the extent to which the Trust has appropriate and effective arrangements in place for managing its digital resources. In examining this, we have looked at whether:

- there is a Board approved digital strategy in place which seeks to harness and exploit digital technology to improve the quality, safety, and efficiency of services, as well as to support new models of care and new ways of working; and
- benefits arising from investments in digital technology are actively monitored by the Board.

90 We found that **the Trust has ambitious plans to harness the potential of digital to transform service delivery, but some of its digital plans are not costed or funded and arrangements for monitoring and reporting on the benefits of digital require strengthening**.

91 The Trust has a clear digital vision as set out in its ten-year Digital Strategy, which the Board approved in May 2022. The strategy clearly sets out how digital technology and insight can support the drive to continually improve the quality, safety, experience, and outcomes of services to meet the ambitions described in the Trust's wider ten-year Trust strategy. The Trust also recognises the opportunities that exist to better harness data sources to provide greater insights into population needs and expectations with a view to challenging professional assumptions and support wider service improvement plans.

92 The Trust has fully costed its larger digital projects as part of the 2022-25 IMTP planning process. The Corporate Risk Register presented to the Audit Committee in July 2022 reflects the risk that the digital services team are unable to support agreed divisional/Trust strategic and operational digital objectives as a result of limited capacity within the team. It details a series of mitigating actions, including developing a digital financial strategy, regularly reviewing the digital work plan to ensure the Trust aligns digital 'delivery' to its overall strategic priorities, and using agile principles to prioritise digital services resources.

93 There is good reporting from the Digital Services Operational Group report to the Quality, Safety, and Performance Committee on key digital projects and programmes and significant IT business continuity incidents. Whilst the reports provide a good overview of progress, they do not provide an assessment of what difference digital projects and programmes are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. As a result, the Quality, Safety, and Performance Committee is unable to actively monitor and scrutinise the benefits arising from the Trust's investment in digital programmes and projects and provide full assurance to the Board. The Trust, therefore, should consider how best to monitor and report the benefits of its digital investment to demonstrate to the Board the extent that it has achieved its intended impacts and outcomes (**Recommendation 5**).

Managing the estate and other physical assets

94 We considered the extent to which the Trust has appropriate and effective arrangements in place for managing its estate and other physical assets. In examining this, we have looked at whether:

- there are Board-approved strategies and plans in place for managing the organisation's estates and its wider physical assets;
- there are appropriate arrangements in place for the Board to review, scrutinise, challenge, and approve significant capital projects and programmes; and
- there are appropriate arrangements in place for the Board to maintain appropriate oversight of the condition of the estate and other physical assets.

95 We found that **the Trust has a clear vision for its estates and good arrangements for ensuring Board-level oversight and scrutiny of key estates related risks and matters.**

96 The Trust has a clear vision for estate as set out in its Estates and Sustainability Strategies, which the Board approved in May 2022. The Estates Strategy has a clear focus on having a safe and high-quality estate which provides a great experience for staff, patients, donors. The Sustainability Strategy has a clear focus on maximising the Trust's contribution to its communities and mitigating its environmental impact on the planet. The Sustainability Strategy includes a decarbonisation plan to support delivery of the Trust's ambitions to be Carbon Net Zero. The key deliverables are set out in the 2022-25 IMTP.

97 The Trust has an established process for prioritising competing capital cases, both in terms of submissions to the all-Wales Capital Fund and the Trust's Discretionary Capital Programme. The 2022-25 IMTP clearly sets out the Trust's capital schemes and sources of funding. The Trust's Board routinely receives business cases relating to significant capital projects and programmes for review, scrutiny, and approval.

98 The Trust has effective arrangements in place for the Board and its committees to maintain appropriate oversight of matters relating to the estate in terms of health and safety, fire safety, and environmental and statutory compliance. The Trust's Estates Assurance Group reports regularly to the Quality, Safety, and Performance Committee. The reports helpfully draw attention to the key matters requiring consideration by the committee. The Quality, Safety, and Performance Committee receive the Annual Estates Report and the Annual Health and Safety Report and consider overall progress. The Trust's Transforming Cancer Services[8] Scrutiny Sub-Committee maintains effective oversight of all estates and capital matters, risks, and issues associated with the Transforming Cancer Services programme, including those associated with the development of the new Velindre Cancer Centre.

99 The Trust has an aging estate to manage in terms of the current Velindre Cancer Centre and there is a programme of work to upgrade Welsh Blood Service facilities. As at 2020-21, the Trust's risk adjusted cost for addressing all backlog maintenance is £1,875,521. Corporate risks relating to capital assets are scrutinised by the Quality, Safety, and Performance Committee. The Trust's challenge in the short- and medium-term will be achieving an appropriate balance between maintaining the current estate whilst investing in the future estate. The Trust is aware of this challenge and recognises that it will involve difficult investment decisions.

[8] The Transforming Cancer Services programme aims to meet the increasing demand and complexity of cancer care and to deliver more care closer to home.

Appendix 1

Audit approach

Exhibit 5 sets out the approach we adopted for delivering our structured assessment work at the Trust.

Exhibit 5: audit approach

Element of audit approach	Description
Observations	We observed Board meetings as well as meetings of the following Committees: • Quality, Safety, and Performance Committee; • Strategic Development Committee; and • Audit Committee.

Element of audit approach	Description
Documents	We reviewed a range of documents, including: • Board and Committee Terms of Reference, work programmes, agendas, papers, and minutes; • Key governance documents, including Schemes of Delegation, Standing Orders, Standing Financial Instructions, Registers of Interests, and Registers of Gifts and Hospitality; • Key organisational strategies and plans, including the IMTP; • Key risk management documents, including the Board Assurance Framework and Corporate Risk Register; • Key reports relating to organisational performance and finances; • Annual Report, including the Annual Governance Statement; • Relevant policies and procedures; and • Reports prepared by the Internal Audit Service, Health Inspectorate Wales, Local Counter-Fraud Service, and other relevant external bodies.
Interviews	We interviewed the following Senior Officers and Independent Members: • Chair of the Board; • Director of Strategic Transformation, Planning and Digital and (at the time of the review) Interim Chief Executive; • Director of Corporate Governance and Chief of Staff; and • Executive Director of Finance.

Appendix 2

Organisational response to audit recommendations

Exhibit 6 will be completed once the report and organisational response have been considered by the relevant committee.

Exhibit 6: organisational response

Recommendation	Organisational response	Completion date	Responsible officer

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Annual Audit Report 2022 – Velindre University NHS Trust

Audit year: 2021-22

Date issued: March 2023

Document reference: 3369A2023

Purpose of this document

This document is a draft supplied in confidence solely for the purpose of verifying the accuracy and completeness of the information contained in it and to obtain views on the conclusions reached.

Handling prior to publication

This document has been prepared for the internal use of Velindre University NHS Trust as part of work performed/to be performed in accordance with statutory functions.

The Auditor General has a wide range of audit and related functions, including auditing the accounts of Welsh NHS bodies, and reporting to the Senedd on the economy, efficiency, and effectiveness with which those organisations have used their resources. The Auditor General undertakes his work using staff and other resources provided by the Wales Audit Office, which is a statutory board established for that purpose and to monitor and advise the Auditor General.

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We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

[Mae'r ddogfen hon hefyd ar gael yn Gymraeg. This document is also available in Welsh.]

Contents

Summary report

About this report

1 This report summarises the findings from my 2022 audit work at Velindre University NHS Trust (the Trust) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Trust, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- Audit of accounts
- Arrangements for securing economy, efficiency, and effectiveness in the use of resources

3 This year's audit work took place at a time when NHS bodies continued to respond to the unprecedented and ongoing challenges presented by the COVID-19 pandemic. Health bodies were not only tackling the immediate challenges presented by the public health emergency but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed. I have considered the impact of the current crisis on both resilience and the future shape of public services.

4 I aimed to ensure my work did not hamper public bodies in tackling the crisis, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 As was the case in the previous two years, the delivery of my audit of accounts work has continued mostly remotely. The success in delivering it reflects a great collective effort by both my staff and the Trust officers.

6 I have adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the crisis and to enable remote working. I have commented on how NHS Wales is tackling the backlog of patients waiting for planned care. My local audit teams have commented on how governance arrangements have adapted to respond to the pandemic, and the impact the crisis has had on service delivery.

7 This report is a summary of the issues presented in more detailed reports to the Trust this year (see **Appendix 1**). I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2022 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2022 Audit Plan and how they were addressed through the audit.

10 The Chief Executive and the Executive Director of Finance have agreed the factual accuracy of this report. The Board received the report at the 30 March 2023 Board meeting and every member received a copy. We strongly encourage the Trust to arrange its wider publication. The report will be available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Trust's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit); however, I brought some issues to the attention of officers and the Audit Committee for improvement.

13 By following a Ministerial Direction to the Permanent Secretary of the Welsh Government, the Trust incurred expenditure on NHS Clinicians' pension tax liabilities, which I deem to be outside its powers to spend, so I issued a qualified opinion on the regularity of the financial transactions within the Trust's 2021-22 accounts.

14 The Trust met its financial duties in 2021-22; however, as my opinion was qualified regarding the NHS clinicians' pension tax issue, I issued a substantive report setting out the details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of Performance Audit work has led me to draw the following conclusions:

- Significant progress has been made to improve the Trust's quality governance arrangements.

- The Trust is generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance, and effective arrangements for managing its finances and other resources.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2022 Audit Plan set out the key risks for audit of the accounts for 2021-22 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2021-22 accounts

20 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. However, in common with most other NHS bodies in Wales we did qualify our regularity opinion in respect of clinicians' pensions tax liabilities, which occurred after the Trust followed a Ministerial Direction to the Permanent Secretary of the Welsh Government. My work did not identify any material weaknesses in internal controls (as relevant to my audit). However, I brought some issues to the attention of officers and the Audit Committee for improvement.

21 The Trust submitted its draft accounts within the required deadline. The accounts, and supported working papers, were of good quality, and officers of the Trust provided us with an appropriate level of support and engagement to enable us to complete the audit on a timely basis.

22 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the accounts. My Financial Audit Engagement Lead reported these issues on 13 June 2022. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	There were two uncorrected misstatements above our trivial level but lower than our materiality level within the 2021-22 accounts: • In line with many other Welsh health bodies and in compliance with instructions from Welsh

Issue	Auditors' comments
	Government under Technical Update 7, the Trust had not applied the latest rate of indexation from the District Valuer in the calculation of land and building assets within the financial statements. This resulted in the asset carrying values (Net Book Value) being understated by £1,107,000 and the annual depreciation charged to expenditure being understated by £13,000. • Our sample testing identified a number of fully depreciated assets that had been disposed of but not removed from the Trust's Fixed Asset Register and therefore the accounts. As these assets have been fully depreciated, they had no Net Book Value and were therefore carried at nil value in the Statement of Financial Position, however the Gross Book Values and Accumulated Depreciation figures within Note 13 of the accounts were both overstated by £570,000.
Corrected misstatements	There were some misstatements in the accounts that were corrected by management. None of these were material.
Other significant issues	We reported one additional issue to the Audit Committee as a result of our audit. This related to the payment of bonus payments to several independent members contrary to a Welsh Government pay circular. The Trust has since taken action to recover these payments.

23 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position as at 31 March 2022 and the return was prepared in accordance with the Treasury's instructions.

24 My separate audit of the charitable funds financial statements is complete. The accounts were certified on 25 January 2023 prior to the Charity Commission deadline of 31 January 2023.

Regularity of financial transactions

25 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive the income and incur the expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Trust does not have the powers to receive or incur.

26 The Trust incurred expenditure on NHS clinicians' pension tax liabilities, which I deem to be outside its powers to spend, so I issued a qualified opinion on the regularity of the financial transactions within the Trust's 2021-22 accounts. The Trust's accounts included £0.337million of expenditure and funding in respect of clinicians' pension tax liabilities. The amounts were included following a Ministerial Direction issued on 18 December 2019 to the Permanent Secretary of the Welsh Government. The Ministerial Direction was required because this arrangement could be viewed by HMRC to constitute tax planning and potentially tax avoidance, hence making the expenditure irregular. Managing Welsh Public Money specifically states that "public sector organisations should not engage in…tax evasion, tax avoidance or tax planning". A Ministerial Direction does not make regular what would otherwise be irregular. Alongside my audit opinion, I placed a substantive report on the Trust's accounts to highlight the NHS clinicians' pension tax liabilities issue.

27 I have the power to place a substantive report on the Trust's accounts alongside my opinions where I want to highlight issues. Where the Trust fails one of its financial duties - to break-even over a three-year period and to have an approved three-year plan in place - or my opinion is qualified, I will issue a substantive report.

28 The Trust met its financial duties in 2021-22, reporting a small surplus of £41,000 at the end of the financial year. The Trust also achieved its statutory financial duty to achieve break-even over a three-year rolling period (2019-20 to 2021-22), reporting an overall three-year surplus of £103,000. My opinion, however, was qualified regarding the NHS clinicians' pension tax issue, so I issued a substantive report setting out the details.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

29 I have a statutory requirement to satisfy myself that the Trust has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Trust over the last 12 months to help me discharge that responsibility. This work has involved:

- reviewing the effectiveness of the Trust's quality governance arrangements; and

- undertaking a structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

30 My conclusions based on this work are set out below.

Quality governance arrangements

31 My review examined whether the organisation's governance arrangements support delivery of high quality, safe and effective services. The review focused on both the operational and corporate approach to quality governance, organisational culture and behaviours, strategy, structures and processes, information flows and reporting.

32 My work found **that that significant progress has been made to improve the Trust's quality governance arrangements**. There are opportunities for improvement as set out in the paragraphs below.

33 The Trust has approved a new Quality and Safety Framework. It sets out the arrangements through which the Trust will meet its quality and safety responsibilities from floor to Board, clarifies roles and responsibilities, and sets out the ambition to ensure learning and improvement are embedded. The Trust has set out ambitious quality priorities and has appropriate arrangements to monitor delivery. However, quality priorities are not specific or time-bound, and thus do not easily allow assessment of whether they have been achieved.

34 Good progress has been made to improve the Trust's risk management arrangements. However, the Trust should ensure that risk reports provided for monitoring and scrutiny at all levels include the necessary detail to enable good scrutiny and challenge. The Board and its committees also need to ensure they scrutinise the Trust's progress in addressing gaps in controls and assurances of strategic risks. Furthermore, opportunities exist to improve the scrutiny of risks appearing in risk registers, both operationally and by the Board's committees.

35 The Trust's reporting of clinical audit has improved, although opportunities remain to demonstrate how learning is being embedded. The Trust has also made good progress in implementing the requirements of the Medical Examiner Service.

36 The Trust has a well-established Values and Behaviour Framework which encourages an open and learning culture. The Trust's compliance with statutory and mandatory training is good but has been impacted by the pandemic. The Trust demonstrates a strong commitment to learn from service user and staff experiences. There are good arrangements to collect service user feedback, which have been enhanced by an electronic system to collect real time feedback and a new patient engagement strategy for cancer services. There is a culture of staff feeling able to raise concerns; however, some staff are concerned that the Trust will not act in response to concerns.

37 The new Quality and Safety Framework has enabled the Trust to clarify the operational quality and safety governance structures and flows of assurance

required to support quality governance. The identified resources for quality governance are appropriate, and the Trust has plans in place to address gaps in resources. The agendas of Quality, Safety, and Performance Committee meetings are becoming more manageable and focussing on key matters. However, the timeliness of some data and information does not always support effective scrutiny.

Structured assessment

38 My 2022 structured assessment work took place at a time when NHS bodies were not only continuing to tackle the challenges presented by COVID-19 but were also seeking to recover and transform services to respond to the significant numbers of people who are waiting for treatment and improve population health.

39 My team focussed on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on the organisation's governance arrangements; strategic planning arrangements; financial management arrangements; and arrangements for managing the workforce, digital assets, the estate, and other physical assets. Auditors also paid attention to progress made to address previous recommendations.

Governance arrangements

40 My work considered the Trust's governance arrangements, with a particular focus on:

- Board and committee effectiveness;
- the extent to which organisational design support supports good governance; and
- key systems of assurance.

41 My work found that **the Trust has good governance and leadership arrangements, supported by improving systems of assurance**.

42 The Trust's governance arrangements enable the Board and its committees to conduct their business effectively. Whilst the Board remains committed to openness and transparency, opportunities remain to improve the public availability of key papers and documents. There is good cross-referral of matters between committees and from committees to the Board. The quality of papers prepared for Board and committee meetings is improving, with reports beginning to draw attention more concisely to key matters for escalation or assurance.

43 The Trust has a stable Executive Team and organisational structure. Independent and Executive Board members continue to have a healthy relationship, which in turn facilitates informal and formal flows of information. Independent Members offer a good balance of challenge and support. Whilst corporate governance and risk management resources are lean, the Trust believes that current capacity, and also taking into account the plan for enhancing resourcing in 2023-4, is adequate. The

Trust continues to provide good Board training and development opportunities, and the Board actively pursues opportunities for self-reflection and improvement.

44 There has been extensive activity to renew and strengthen sources of assurance. The Trust's Assurance Framework is underpinned by appropriate risk management and performance management arrangements, which continue to develop and improve. The Trust has effective arrangements for overseeing information governance at a committee-level, but some operational arrangements require improvement. The Trust has also made a number of improvements to its arrangements for tracking internal and external audit recommendations.

Strategic planning arrangements

45 My work considered the Trust's strategic planning arrangements, with a particular focus on the organisation's:

- vision and strategic objectives;
- Integrated Medium-term Plan;
- planning arrangements; and
- arrangements for implementing and monitoring the delivery of corporate strategies and plans.

46 My work found that **the Trust has a clear strategic intent supported by good planning and stakeholder engagement arrangements. However, opportunities exist to enhance delivery reporting arrangements**.

47 The Trust's vision and strategic goals are clearly set out in its new ten-year strategy, 'Destination 2023'. The ten-year strategy is supported by a series of enabling strategies which focus on sustainability, people, digital, and estates. Collectively, they set a clear direction of travel for the organisation. The Trust produced a financially balanced Integrated Medium-Term Plan (IMTP) for 2022-25, which was approved by Welsh Government. The Board was actively involved in shaping and scrutinising the 2022-25 IMTP prior to formally approving and submitting it to Welsh Government.

48 The Trust has effective arrangements in place to oversee the development of corporate plans and strategies. The Trust is also effective at involving internal and external stakeholders in developing corporate strategies and plans. Whilst the 2022-25 IMTP sets out clear objectives and actions, the Trust needs to set out what successful delivery of the strategic priorities set out in the 2022-25 IMTP plans will look like, the outcomes it wants to achieve, and how these will be measured. The Trust has reasonably effective arrangements for reporting delivery of corporate plans and strategies. However, there is scope for reports to provide greater assurance to the Board that the Trust is taking appropriate action when delivery is off-track.

Managing financial resources

49 My work considered the Trust's arrangements for managing its financial resources, with a particular focus on the organisation's:

- arrangements for meeting key financial objectives;
- financial controls; and
- arrangements for reporting and monitoring financial performance.

50 My work found that **the Trust has effective arrangements for managing its financial resources but faces several risks to maintaining financial sustainability in the medium- to long-term**.

51 The Trust's arrangements for securing financial balance are good. The Trust met its financial objectives to breakeven in 2021-22 and over a three-year rolling period (2019-20 to 2021-22). The Trust is forecasting an overall breakeven position for 2022- 23. The Trust has a good understanding of its cost pressures which are clearly set out in its Strategic Financial Plan. However, these cost pressures alongside wider workforce costs and increased service demand may impede the Trust's ability to maintain financial sustainability in the medium- to long-term.

52 The Trust continues to have good controls for managing the use of its financial resources, with good reporting to the Audit Committee on procurement, losses, special payments, and counter-fraud matters. The Trust has good arrangements for monitoring and reporting financial performance. Finance reports provide timely and high-quality information, and support effective Board-level oversight, scrutiny, and challenge.

Managing the workforce, digital resources, the estate, and other physical assets

53 My work considered the Trust's arrangements for managing its wider resources, with a particular focus on the organisation's:

- arrangements for supporting staff wellbeing;
- arrangements for managing its digital resources; and
- arrangements for managing its estate and other physical assets.

54 My work found that **the Trust has clear plans in place to support staff well-being, harness the benefits of digital, and improve its estate. However, arrangements for monitoring and reporting on their outcomes require strengthening, particularly in relation to staff well-being and digital**.

55 Supporting staff well-being is a clear priority for the Trust. It has good arrangements in place to support the mental, physical, and financial well-being of staff. Whilst the Trust captures, monitors, and reports a range of staff related well-being activity, its arrangements for measuring and reporting the effectiveness of its well-being interventions require strengthening.

56 The Trust has a clear digital vision, which is set out in its Board-approved Digital Strategy. The strategy clearly sets out how digital technology and insight can support the drive to continually improve the quality, safety, experience, and

outcomes of services to meet the ambitions described in the Trust's wider ten-year strategy. There is good Board-level reporting on key digital projects and programmes and significant IT business continuity incidents. Whilst reports provide a good overview of progress, they do not provide an assessment of what difference digital projects and programmes are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended.

57 The Trust has a clear vision for its estates, which is set out in its Board-approved Estates and Sustainability Strategies. The Trust has an established process for prioritising competing capital cases, and the Board routinely receives business cases relating to significant capital projects and programmes for review, scrutiny, and approval. The Trust has effective arrangements in place for the Board and its committees to maintain appropriate oversight of matters relating to the estate in terms of health and safety, fire safety, and environmental and statutory compliance. However, the Trust has an aging estate to manage in terms of the current Velindre Cancer Centre and there is a programme of work to upgrade Welsh Blood Service facilities. Significant preparatory work towards building the new Velindre Cancer Centre is now being progressed. There will be a challenge, in the short- to medium-term, to achieve an appropriate balance between maintaining the existing estate whilst investing in the future estate.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Trust in 2022.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	13 June 2022
Opinion on the Financial Statements	13 June 2022
Audit of Accounts – Addendum Report	19 July 2022
Charitable Funds – Audit of Financial Statements Report	19 January 2023
Performance audit reports	
Review of Quality Governance Arrangements	August 2022
Structured Assessment 2022	January 2023
Other	
2022 Audit Plan	April 2022

My wider programme of national value for money studies in 2022 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts

Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are a number of performance audits that are still underway at the Trust. These are shown in the following table, with the estimated dates for completion of the work.

Report	Date
Review of workforce planning arrangements	March 2023
2022 Local Work	TBC

Appendix 2

Audit fee

The 2022 Audit Plan set out the proposed total audit fee of £238,783 (excluding VAT). My latest estimate of the actual fee is in keeping with the fee set out in the outline.

In addition to the fee set out above, the audit work undertaken on the shared services provided to the Trust by the NHS Wales Shared Services Partnership cost £2,154.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2022 Audit Plan set out the risks for the audit of the Trust's 2021-22 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
Management Override The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.31-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for biases; and • evaluate the rationale for any significant transactions outside the normal course of business.	Planned audit work completed and no issues arising.
Inventory balance Our 2020-21 audit opinion was qualified as we did not attend any of the Trust's stock takes. The Trust, through NWSSP, continue to have an integral role in procuring and distributing Personal Protective Equipment, particularly to NHS Wales bodies and social care providers,	We will attend a number of stock counts at a number of the stores facilities operated by the Trust and develop additional audit procedures to obtain assurance that the inventory balance within the financial statements is materially correct.	Various audit procedures where undertaken, including attending a number of stock counts, and sufficient assurance was obtained upon both the year-end inventory balance.

Audit risk	Proposed audit response	Work done and outcome
in response to the pandemic. Whilst a reduction in the year-end inventory balance is expected within the 2021-22 financial statements the value of the stock holdings will continue to be material. A number of related audit risks exist, particularly in regard to our need to obtain sufficient audit assurance upon: • the 2021-22 opening inventory balance; • the 2021-22 stock taking arrangements and final inventory balance; • stock donations to assist countries and the associated accounting treatment; and • any valuation adjustments concerning obsolete or slow-moving stock have been appropriately considered in calculating the year-end balance.		
NHS pension tax liabilities The implementation of the 'scheme pays'	We will review the evidence one year on around the take-up of the scheme and the need for	The Trust included a provision of £377,000 relating to NHS Clinicians' pension tax liabilities. This

Audit risk	Proposed audit response	Work done and outcome
initiative in respect of the NHS pension tax arrangements for clinical staff is ongoing. Last year we included an Emphasis of matter paragraph in the audit opinion drawing attention to your disclosure of the contingent liability. Applications to the scheme will close on 31 March 2022, and if any expenditure is made in-year, we would consider it to be irregular as it contravenes the requirements of Managing Welsh Public Money. This would then result in the qualification of our regularity opinion.	a provision, and the consequential impact on the regularity opinion.	was deemed to be outside the Trust's powers and so a qualified regularity opinion was issued.
Break even duty NHS Trusts have a financial duty to break even over a three-year rolling period. Although the Trust is forecasting a break-even position, this duty increases the risk that management judgements and estimates included in the financial statements could be biased in help achieve this financial duty. Where the Trust fails this financial duty, I will place a substantive	The audit team will focus its testing on areas of the financial statements which could contain reporting bias.	The Trust achieved its break-even duty – no issues arising.

Audit risk	Proposed audit response	Work done and outcome
report on the financial statements highlighting the failure.		
Capital expenditure The Trust has purchased Matrix House during 2021-22 and expenditure has continued to be incurred in relation to construction of the new Velindre Cancer Centre. There is a risk that the related capital expenditure has not been appropriately accounted for within the financial statements.	We will monitor the position as part of our ongoing audit work and review the accounting treatment within the financial statements.	No issues arising.
NHS Wales Informatics Service / Laundry There have been two significant changes in regard to the functions hosted by the Trust during 2021-22. NHS Wales Informatics Service transferred from the Trust to form Digital Health and Care Wales on 31 March 2021, and laundry functions have transferred to the Trust from a number of Health Boards.	We will review the accounting treatment and disclosures in relation to these transfers.	No issues arising.

Audit risk	Proposed audit response	Work done and outcome
IFRS16 Introduction of IFRS 16 Leases has been deferred until 1 April 2022. There may be considerable work required to identify leases and the COVID-19 national emergency may pose additional implementation risks. The 2021-22 accounts will need to disclose the potential impact of implementing the standard.	We will review the completeness and accuracy of the disclosures.	No issues arising.
Covid 19 There continues to be increased funding streams and expenditure in 2021-22 to deal with the COVID-19 pandemic. These could have an impact on the risks of misstatement and the shape and approach to our audit.	We will identify the key issues and associated risks and plan our work to obtain the assurance needed for our audit.	No issues arising.
Covid-19 – qualitative issues Although COVID-19 restrictions have now been removed, there have been ongoing pressures on staff resource and of remote working that may impact on the preparation, audit and publication of	We will discuss your closedown process and quality monitoring arrangements with the accounts preparation team and make arrangements to monitor the accounts preparation process. We will help to identify areas where there may be gaps in arrangements.	The draft accounts and supporting working papers were of good quality. Neither were any material adjustments made to the financial statements as a result of our audit.

Audit risk	Proposed audit response	Work done and outcome
accounts. There is a risk that the quality of the accounts and supporting working papers may be compromised leading to an increased incidence of errors. Quality monitoring arrangements may be compromised due to timing issues and/or resource availability.		

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Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

TRUST BOARD

STRCUTURED ASSESSMENT 2022
MANAGEMENT RESPONSE

Date of meeting	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	**DATE**	**OUTCOME**
Executive Management Board	20/03/023	APPROVED

1. SITUATION/BACKGROUND

The Executive Management Board welcomed the work of Audit Wales in compiling the Structured Assessment.

The Executive Management Board support the recommendations set out in the report and have compiled management responses, attached as Appendix 1.

This Management Response will be received by the Audit Committee in April 2023.

2. 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
	There are no specific items which require an EQIA resulting from the management response to recommendations.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the Management Response to the 2022 Structured Assessment.

Organisational response

Report title: Structured Assessment 2022 – Velindre University NHS Trust
Completion date: March 2023
Document reference: 3296A2022

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
R1	**Improving administrative governance arrangements** We found that opportunities remain for the Trust to improve the public availability of key papers and documents on its website. This includes publishing: • missing committee meeting papers. • the Register for Gifts, Hospitality and Sponsorship and the Declarations of Interest Register; and • the ten-year strategy and enabling strategies. The Trust should establish a clear and robust process to ensure it publishes key papers and documents on its website in a timely and ongoing basis.	Yes	Yes	Tracking has been implemented to ensure the completeness and timely publication of committee agenda bundles and other key governance papers as part of the weekly Corporate Governance Team meeting. 10-year strategy: An engagement and communications plan has been developed to the support the launch of the Trust 10-year strategy in May 2023. This will include publishing the strategy on the Trust website.	22nd March 2023 31st May 2023	Operational Lead: Corporate Governance Manager Executive Lead: Lauren Fear – Director of Corporate Governance and Chief of Staff Carl James, Executive Director of Strategic Transformation, Planning and Digital

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
R2	**Reinstating arrangements for tracking recommendations made by external inspection and regulatory bodies** The Quality, Safety, and Performance Committee has not received the log which tracks recommendations relating to the quality and safety of services made by external inspection and regulatory bodies since early in 2020. The Trust should immediately reinstate the tracker to enable the committee to oversee, scrutinise, and challenge the progress it is making in addressing both quality and safety recommendations and any relating to performance.	Yes	Yes	The Quality & Safety Extract of the Trust wide Legislative & Regulatory Compliance Register will be received at each meeting of the QSP Committee – together with the associated Improvement Plan using the 7 levels of assurance template. Note: the Trust wide Legislative & Regulatory Compliance Register is already established and received in full by the Trust Audit Committee.	March 2023	Operational Lead: Head of Quality & Safety & Head of Corporate Governance Executive Lead: Nicola Williams, Executive Director Nursing, AHP & Health Science
R3	**Establishing measurable outcomes for strategic priorities** The Trust has translated its strategic priorities into specific objectives and actions in the 2022-25 IMTP (including timescales for delivery). The Trust should seek to articulate the intended outcomes for each strategic objective/action in future	Yes	Yes	The Trust IMTP 2023-2026 sets out a range of priorities which have specific objectives related to their delivery which are timebound. Further work will be undertaken to: (i). improve the SMART elements of the objectives	30th March 2023	Executive Lead: Carl James, Executive Director of Strategic Transformation, Planning and Digital

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
	IMTPs, including what success would look like.			(ii). align them to measurable outcomes/output key performance indicators within the Performance Management Framework (phase 2)	December 2023	
R4	**Enhancing reporting on 2022-25 IMTP delivery** The Trust's arrangements for reporting delivery of the 2022-25 IMTP are reasonable, but it needs to better describe the impact the actions are making. The Trust should report on the impact of actions delivered to date to allow the Board to better understand the extent that delivery of the IMTP is making a difference and determine any actions that need to be rolled forward to the 2023-26 IMTP.	Yes	Yes	The Trust IMTP for 2023-2026 will outline the impact / benefits of actions we are taking as outlined in our IMTP. The process for developing the IMTP has included an assessment of actions which should be rolled forward to 2023 – 2026. In respect of reporting, we will ensure that progress updates are provided to: • Senior Leadership Team at their monthly meetings • Executive Management Board at their monthly meetings • Quality, Safety and Performance Committee at their bi-monthly meetings • Trust Board at their bi-monthly meetings	31st May 2023	Executive Lead: Carl James, Executive Director of Strategic Transformation, Planning and Digital

Ref	Recommendation	High priority yes / no	Accepted yes/no	Organisational response	Completion date	Responsible officer
R5	**Improving reporting on the benefits arising from digital investments** Whilst there is good reporting on progress in delivering key digital projects and programmes, the reports do not provide an assessment of what difference they are making, whether they are sufficiently resourced, and if digital is enabling wider service improvement as intended. The Trust should consider how best to monitor and report the benefits of its digital investment to demonstrate the extent that it is delivering the intended impacts and outcomes.	Yes	Yes	The further development of digital benefits will be undertaken in several ways: (i). a range of key performance indicators that are reported to the Executive Management Board (ii). improving the clarity of benefits in projects/business cases on a case-by-case basis (iii). implementing the measures set out within the digital strategy and key service plans (e.g., quality metrics) which will demonstrate the impact of digital services on service quality and outcomes and including an overall % spent on digital technology	31st May 2023 Not time bound – as related to each business case February 2024	Executive Lead: Carl James, Executive Director of Strategic Transformation, Planning and Digital

TRUST BOARD

WELSH BLOOD SERVICE 5 YEAR STRATEGY 2023/24 – 2027/28

DATE OF MEETING	30/03/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Sarah Richards, Interim General Services Manager
PRESENTED BY	Alan Prosser, Director of Welsh Blood Service
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, & Digital
REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT Executive Management Board (Run) Strategic Development Committee	13/01/2023 15/03/2023 24/03/2023	ENDORSED FOR APPROVAL

ACRONYMS	
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 The Welsh Blood Service (WBS) has developed its five year strategy that sets out the vision for the future of the Welsh Blood Service and how it will be achieved. It aligns with the Velindre University NHS Trust strategy 'Destination 2032' that sets out a clear direction for the organisation over the coming years.

The Trust Board are asked to **APPROVE** the Strategy (appendix 1).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Internal Engagement

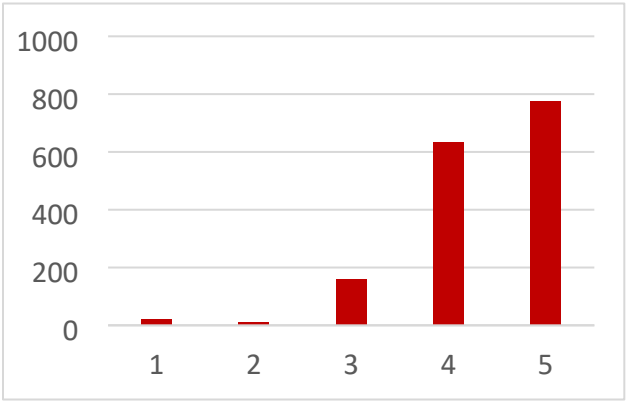
The document has been developed in collaboration with the WBS staff. Engagement exercises were then carried out with the Senior Management Team, Executive Management Team and the Strategic Development Committee.

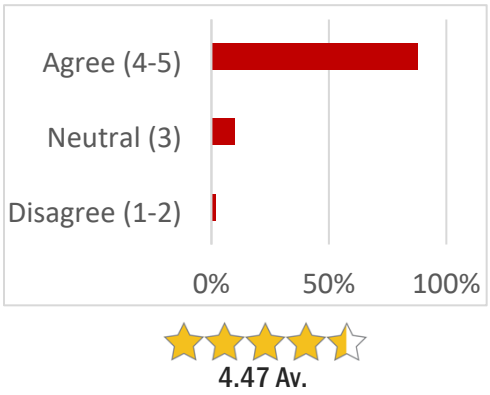
2.1..1 Donor and Wider Public Engagement

Following a meeting with the national Community Health Council on 23/11/2022, who were asked to comment on the draft strategy, we jointly developed a questionnaire to engage with both donors and the general public.

Donors and the wider public were invited to complete a short survey on WBS' strategy for the next five years. The survey was sent to everyone who donated between 01/11/2022 and 31/12/2022 and shared through social media inviting the wider public to complete. The service received 1,954 responses from the donor survey and a further 110 through social media channels.

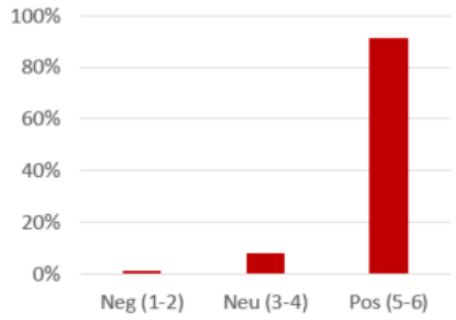
Respondents were asked how agreeable the proposed WBS vision is, where scoring 1 = completely disagree, and 5 = completely agree.





The survey asked respondents to tell us how relevant the proposed WBS strategic goals are, where scoring 1 = not relevant at all, and 6 = highly relevant.

S1



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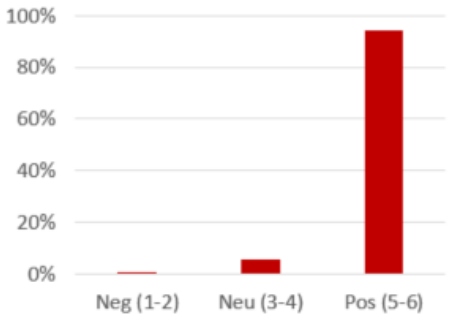

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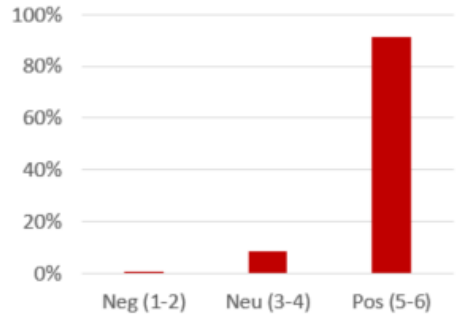
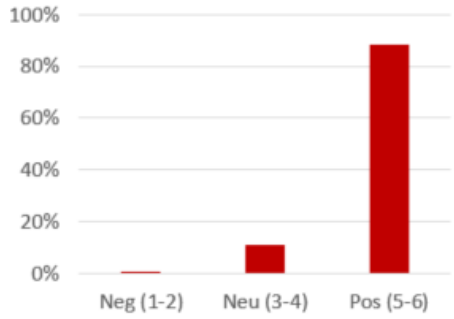


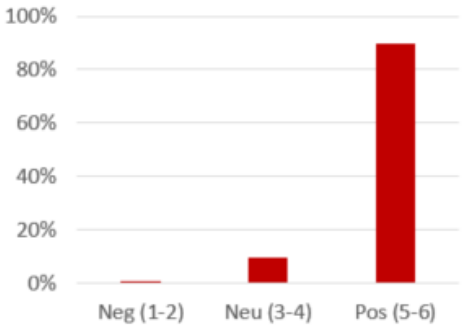
5.61 Av. score

S4



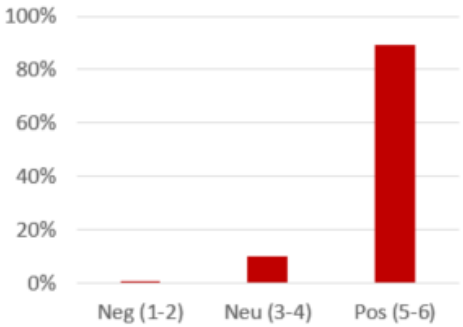
5.52 Av. score

S5



5.57 Av. score

S6



5.54 Av. score

2.2 **Duty of Quality**

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 places a duty on WBS to consider the 6 domains of quality in everything it does. As such the Welsh Blood Service has ensured each of the strategic themes aligns with and supports each of the six quality domains.

2.3 **Next Steps**

Once the strategy has been signed off, we will work with the Trust Communications Team to align the design to the Trust Strategy and the four enabling strategies (Estates, Digital, Sustainability and Workforce) to ensure a consistent look and feel.

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	Yes
	Being finalised.

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 are asked to **NOTE** engagement activities to date and **APPROVE** the WBS 5 Year Strategy 2023/24 – 2027/28.

Welsh Blood Service

Blood and Transplant Services for the Future

5 Year Strategy

2023/24 – 2027/28

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Foreword

A very warm welcome to the *Welsh Blood Service Strategy.* We are extremely proud of the excellent care and services we provide to patients, donors, a wide range of partners and our track record of success. We care deeply about the communities we serve and see clearly the difference that a safe, high quality, accessible and sustainable blood service can make in supporting us to continually improve the quality, safety, experience and outcomes of the services we provide.

The provision of a high quality blood service is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in.

The *Welsh Blood Service Strategy* sets out our vison for blood and transplant services in Wales for the next five years. It sets out where we are now, where we want to be in 2028 and the steps we will take to get there.

Importantly, it describes how we will work with work with our patients, donors, staff and communities to ensure they have a safe and enjoyable experience which helps to improve their overall health and well-being; together with our role in making a wider contribution to communities and society we serve.

Who we are and what we do

The Welsh Blood Service is a division of Velindre University NHS Trust and plays a vital role in giving thousands of people, both across Wales and internationally, a lifeline in their time of greatest need.

We strive to provide our donors with the best possible experience and provide safe, high quality, modern and efficient laboratory, diagnostic and transplant services.

We provide the following specialist services:

- Collection of voluntary, non-remunerated blood, platelet and stem cell donations from the general public.
- Processing and testing of blood donations.
- Distribution of blood and blood components to 20 hospitals across Wales.
- Provision of advice and guidance regarding appropriate blood component use to health boards across Wales.
- Provision of an antenatal screening service to hospitals.
- Specialist laboratory services, assisting the investigation of complex serological problems.

- The Welsh Transplantation & Immunogenetics Laboratory, providing testing and clinical advice on donor compatibility and selection to local providers of Renal and Stem Cell Transplant Services.
- Operates a panel of unrelated potential blood stem cell donors in Wales – the Welsh Bone Marrow Donor Registry which exports stem cells to patients across the world and imports stem cells for the patients of Wales.
- Hosts the UK National External Quality Assessment Service (NEQAS) external quality assessment scheme for histocompatibility and immunogenetics and the Welsh Assessment of Serological Proficiency Scheme (WASPS) which contribute to the maintenance of quality standards in the transfusion and transplantation community.
- Holds a wholesaling licence to supply blood-derived medicinal products (both NHS and commercial) for purchase by our customer hospitals.
- Supports NHS Wales in assuring appropriate and prudent use of blood by facilitating and advising the Blood Health National Oversight Group.
- Provides logistic support to the NHS including the storage and distribution of Coronavirus vaccine during the pandemic.

Strong clinical and scientific leadership and governance helps to ensure that the quality of our service remains at the forefront of our decision-making. This assurance is maintained through our commitment to ensuring the services we provide meet the high standards of our regulators and auditors, such as the Medicines and Healthcare Regulatory Agency (MHRA), Human Tissue Authority (HTA), UK Accreditation Services (UKAS) and the Health and Safety Executive (HSE).

Blood and transplantation is an evolving area of healthcare which encompasses a broad and transferable set of skills.

Looking to the Future

The future for blood and transplant services in Wales is an exciting one. We will seek to:

- Build upon our existing services and capabilities to improve what we do currently; and
- Develop a new range of services and expertise to support the development of health. Health care and well-being across Wales. Our areas of focus will include the collection of plasma for medicines and support national resilience in the supply of plasma-derived products.

This aligns with the Velindre University NHS Trust strategy 'Destination 2032' that sets out a clear direction for the organisation over the coming years.

Quality at our Heart

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 places a duty on WBS to consider the 6 domains of quality in everything we do. Quality means safe, timely, effective, efficient, equitable and person-centred health care which is embedded within a culture of continuous learning and improvement. We have highlighted how our strategic themes are helping us to achieve this.

Our Vision

To be recognised by the people of Wales and our peers as a leader in transplant and transfusion services

Our Strategic Themes

Strategic Theme 1	Build a sustainable donor base that meets clinical need and represents the diverse communities we serve
Strategic Theme 2	To provide a world class donor experience
Strategic Theme 3	Drive the prudent use of blood across Wales
Strategic Theme 4	Quality, safety and value: doing it right, first time
Strategic Theme 5	Achieving excellence in research, development and innovation to improve outcomes for our patients and donors
Strategic Theme 6	Sustainable services that deliver the greatest value to our communities
Strategic Theme 7	Develop great people and a great place to work

Strategic Theme 1

Build a sustainable donor base that meets clinical need and represents the diverse communities we serve

Quality Domains
Use Pie chart highlighting:
Equitable, Effective, Efficient

Our Objectives are to ..

- Make it easy for people in Wales to repeatedly donate.
- Make it easy for the people of Wales to become bone marrow volunteers.
- Improve our donor experience and increase donor retention, loyalty and advocacy.
- Have the right type and number of donors, in the right place at the right time, collecting only what hospitals need.
- Develop a donor base which represents the diverse communities we serve

We will ..

- Expand and explore partnership opportunities to sustain our donor base and improve diversity, working in collaboration with our partners.
- Introduce new technology to identify, engage and motivate our donors more effectively.

- Use behavioural insights to better understand and our donors and tailor our engagement to meet their needs.

- Continue to work with a wide range of stakeholders to develop a plan to increase the amount of donors from diverse communities.

Strategic Theme 2

To provide a world class donor experience

Quality Domains
Use Pie chart highlighting:
Person-centred

Our Objectives are to ..

- Put donors at the heart of our decision-making ensuring service development is informed by them.
- Use innovative solutions to provide the best donor experience before, during and after donating.
- Deliver a more person centred service and experience for our donors.
- Provide our donors with the information they need to make informed choices.

We will..

- Develop a Donor Strategy that will enable us to firmly embed the voice of all our donors.
- Adopt a user based design approach for service developments which uses people's experiences to increase the value we provide.
- Implement our Digital Development Plan to ensure we make best use of new technology.
- Implement a donor app to empower donors to self-serve.
- Improve our website to provide support and resources for our donors.

Strategic Theme 3

Drive the prudent use of blood across Wales

Quality Domains
Use Pie chart highlighting:
Effective, Safe

Our Objectives are to ..

- Provide system leadership in prudent use of blood.
- Support the maintenance of good blood health in donors across Wales
- Work with partners to deliver a system which utilises blood components in clinical settings in an efficient and prudent way.

We will..

- Continue to develop our system leadership role to support the health care system across Wales.
- Work collaboratively with health boards to implement the Blood Health Plan.
- Support effective planning and management of the blood supply chain, identifying best practice principles for stock management and blood usage.
- Use evidence and data to support the reduction in avoidable variation across hospitals in Wales.

- Standardise education, procedures, guidelines and policies to promote a safe, best practice, and consistent approach across Wales.

Strategic Theme 4

Quality, safety and value: doing it right, first time

Quality Domains *Use Pie chart highlighting:*
Effective, Efficient, Safe

Our Objectives are to ..

- Implement the Quality Act and Duty of Candour.
- Minimise potential harm to our donors, patients and staff.
- Implement innovative service improvement opportunities to improve the quality and safety of the services we provide.
- Maximise the use of technology to deliver efficient services and no avoidable waste.
- Nurture a culture of learning and continuous improvement.

We will..

- Implement a Quality Hub structure that oversees the experience of service users alongside regulatory and clinical governance standards in line with the Duty of Quality.
- Streamline, digitise and automate our processes to improve safety and efficiency and minimise waste.
- Optimise our operational footprint and staffing models.
- Gain efficiencies from scale and our collective expertise.

- Drive continuous improvement using service improvement methodology, benchmarking, data and analytics, as well as international best practice.

Strategic Theme 5

Achieving excellence in research, development and innovation to improve outcomes for our donors and patients

Quality Domains *Use Pie chart highlighting:*
Safe, Timely, Equitable, Effective, Efficient, person-centred

Our Objectives are to ..

- Utilise research, development and innovation to support the evolution of existing services and the development of new services and products.
- Develop our research, development and innovation capacity and capability.
- Develop our research, development & innovation infrastructure to support increased activity.

We will ..

- Develop a research, development and innovation strategy
- Align our processes and systems with major developments in science, infrastructure, technology and informatics.
- Establish systematic approaches to horizon scanning and integrate them into our research programme.
- Integrate system wide data sets to develop insights.

- Develop our research capacity by increasing the number of staff actively involved in research, development and innovation

- Increase the number of staff undertaking formal research programmes e.g. MSc; PhDs etc.

- Actively identify and partner a range of NHS, commercial and academic institutions to develop an exciting programme for Research Development and Innovation which supports transformational service change and improved outcomes.

Strategic Theme 6

Sustainable services that deliver the greatest value to our communities

Quality Domains *Use Pie chart highlighting:*
Equitable, Efficient

Our Objectives

- To reduce our impact on the environment
- To achieve carbon neutral
- To Increase the bio-diversity on our sites
- Provide a wide range of benefits and value to the communities we serve.

We will..

- Deliver our decarbonisation plan and transition to renewables.
- Work collaboratively with the local community and our partners to implement our bio-diversity plan.
- Work with local community organisations to deliver environmental sustainability initiatives.
- Utilise digital technology to improve efficiency and minimise waste.

Strategic Theme 7

Develop great people and a great place to work

Quality Domains *Use Pie chart highlighting:*
Equitable, Effective, Person-centred

Our Objectives are to ..

- Develop a culture where staff feel valued, their opinion matters and their well-being is paramount to our shared success.
- Create an environment which enables our staff to feel motivated and able to achieve their potential.
- Promote transparent and collaborative decision making.
- Create high quality places to work from and more flexible ways of working that attract and retain the best talent.

We will..

- Develop our strategic workforce planning to ensure we have the people, with the right skills, in the right place at the right time
- Provide excellent learning and development opportunities and flexible career pathways.
- Deliver more integrated and collaborative working with health, academia and industry ensuring the development of high quality, technology enabled learning environments.
- Support increased academic and vocational training and development to maximise opportunities for all entry pathways and ensure inclusivity.
- Improve our approach to succession planning through implementation of our talent management plan.
- Refurbish our buildings and facilities to provide a better working experience.
- Implement a flexible approach to working (remote & office based) which supports staff well-being and meets business need.

Measuring our Success

Build a sustainable donor base that meets clinical need and represents the diverse communities we serve
• % recruitment of new 16-30 year old stem cell donors • % recruitment of new whole blood and apheresis donors • % of occasions WBS have had to import blood • % increase in our donor pool from ethnic minorities • % of our donor pool that represents communities we serve

To provide a world class donor experience
• % of donors that rate their experience as excellent. • % of deferrals on clinic • % of successful donations • % of donors who recommend the Welsh Blood Service • Compliments • Concerns

Drive the prudent use of blood across Wales.
• % O D Negative blood against overall blood issues. • % wastage of blood components in hospitals across Wales. • % cell salvage used as alternative to transfusion. • Anaemia pathway outcomes.

Quality, safety and value: doing it right, first time
• % of time expired blood components. • % of demand for blood components met. • % of Patient Testing turnaround times. • % of serious findings by regulators and professional bodies. • % serious untoward incidents. • % never events. • % customer hospitals satisfaction. • % compliance with guidelines and standards • Productivity Levels.

Achieving excellence in research, development and innovation to improve outcomes for our donors and patients
• Impact of our research and development. • Staff who are routinely involved in research, development and innovation. • Impact of our innovation.

Sustainable services that deliver the greatest value to our communities.
• Water consumption. • Energy consumption. • Renewable sources. • Carbon footprint of the estate. • Net bio-diversity gain: value of natural capital. • Sustainable development assessment: our contribution to communities. • Social value: our contribution to society. • % of fleet which is electric/hybrid.

Develop great people and a great place to work.
• % attendance at work. • % mandatory and statutory training • % of staff who've taken up education and training opportunities • % of staff who rate us as an excellent employer. • % of staff who would recommend us as an employer to their family or friends. • % of workforce who are Welsh speakers. • Diversity of our workforce.

TRUST BOARD

Integrated Medium Term Plan (IMTP) 2023/24 – 2025/26

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	APPROVE THE IMTP 2023/2024 – 2025/2026

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	20th March 2023	ENDORSED FOR SUBMISSION TO THE STRATEGIC DEVELOPMENT COMMITEE
Strategic Devlopment Committee	24th March 2023	DECISION PENDING (AS OF BOARD PAPER PUBLICATION DATE)

ACRONYMS	
VUNHST	Velindre University NHS Trust
EMB	Executive Management Board
IMTP	Integrated Medium Term Plan

1. SITUATION/BACKGROUND

1.1 The Trust, on 22nd July 2022, received confirmation from the Welsh Government that its IMTP for 2022 – 2025 had been approved in accordance with the requirements of the NHS Wales Planning Framework and the duties set out by section 175 of the National Health Service (Wales) Act 2006. However, there is a requirement to update and refine our approved plan for the period 2023/24 – 2025/26.

1.2 The submission of a Trust Board approved IMTP for 2023/24 - 2025/26 by the 31st March 2023 is part of the Trusts' statutory duties.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The IMTP is framed within the Trusts' ambition for the future, following the Boards' approval of the Trust strategy '*Destination 2032*', and brings together the immediate, medium and long-term ambitions of the organisation.

2.2 Notwithstanding this, and in accordance with the Welsh Government guidance, the IMTP is particularly focused on 2023/2024 and in ensuring that there are robust plans in place to deliver the required levels of service which achieve the appropriate levels of quality, safety and experience.

The Requirement:

2.3 Velindre University NHS Trust is required to submit a financially balanced and Trust Board approved IMTP to the Welsh Government by 31st March 2023. Prior to approval by the Trust Board the IMTP must be approved by:

- Velindre University NHS Trust Executive Management Board (completed)
- Velindre University NHS Trust Strategic Development Committee (meeting on 24th March 2023)

2.4 The key elements of the plan are outlined below:

Planning Guidance

2.4 The IMTP has been developed in line with the NHS Wales Planning Framework and the most recent Welsh Government policy requirements.

Capacity to Deliver Safe, High Quality Services with an Excellent Experience

2.5 The IMTP sets out a range of capacity solutions to deliver the required level of activity during 2023/2024. If the forecast demand and capacity assumptions are within reasonable tolerances we are forecasting that the Cancer and Blood Service will deliver the required level of service to meet demand.

2.6 The delivery of the national targets and requirements will require increased levels of efficiency and productivity, a prudent healthcare approach to reduce unwarranted variation and the identification and implementation of medical, scientific and technological advances to achieve a sustainable position.

2.7 The IMTP also sets out a range of actions required to implement the cancer and blood transformation programmes and the associated wider strategic ambitions of the Trust (e.g. reducing inequalities, enhanced digital services and the development of sustainable services) as well as our ambitious infrastructure programmes (e.g. re-development of the Welsh Blood Service Headquarters, implementation of the Integrated Radiotherapy Solution, development of the Radiotherapy Satellite Centre and opening of the new Velindre Cancer Centre).

Commissioner Engagement

2.8 The priorities set out within the IMTP have been discussed with our commissioners and reflects their service needs.

Finance

2.9 Welsh Government requires the submission of *'balanced'* IMTP plans, where commitments to deliver services are matched by available resources, in terms of workforce, physical infrastructure and finance. The IMTP 2023/2024 – 2025/2026 sets out a balanced positon over the period. Notwithstanding this, the plan has been developed on a number of assumptions, many of which are relatively sensitive in the current operating environment e.g. activity levels for cancer services; blood requirements and energy costs. It is also based upon the

achievement of a realistic but challenging value/cost improvement Programme being delivered.

2.10 Given these uncertainties, many of which sit outside direct control of the Trust, the Acting Chief Executive submitted an Accountable Officer letter to the Chief Executive of NHS Wales on 28th February 2023 which set out the range of risks related to the submission of the IMTP 2023/2024 – 2025/2026. The Trust has arrangements in place to monitor and manage the risks. Delivery of the IMTP will be reported to the Board using existing arrangements.

Risks to delivery

2.11 There are numerous risks associated with the delivery of the IMTP plan. They are not considered to be new risks associated with 2023/2024 but risks which are have been apparent for some time and are well understood by the Trust e.g. balancing demand and capacity; workforce challenges (attracting/recruitment) and staff well-being; increasing capacity and capability to deliver complex transformation programmes; and funding and affordability. These risks are set out in the IMTP, the Trust risk register and Trust Assurance Framework and will be actively managed during the year.

Summary

2.12 We are currently in line with our Programme to submit a Trust Board approved IMTP to the Welsh Government by 31st March 2023. Key milestones are summarised below:

Milestone	Date
IMTP endorsed by the Executive Management Board	20th March (completed)
IMTP endorsed by the Strategic Development Committee	25th March 2023 (verbal update to be provided as paper issue to Trust Board prior to this meeting)
IMTP approved by the Trust Board	30th March 2023
IMTP submitted to the Welsh Government	31st March 2023

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Delivery of the actions included within the IMTP 2023/24/2025/26 will help to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	Each service change / development included within the IMTP will be subject to an individual Equality Impact Requirement as required.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes. The IMTP Plan contains a range of financial risks. Further work will be undertaken to reduce this risk in a number of specific areas and as outlined in the financial plan.

4. RECOMMENDATION

4.1 The Trust Board is asked to:

(i) **APPROVE** the IMTP for submission to the Welsh Government on 31st March 2023 together with the risks to delivery.

(ii) **NOTE** that there will be a final QA of the document prior to submission to the Welsh Government;

(iii) **APPROVE** the IMTP for submission to the Welsh Government on 31st March 2023 following final quality assurance.

Draft Submission to Welsh Government

Velindre University NHS Trust	Integrated Medium Term Plan 2023/24 - 2025/26 (1st April 2023 to 31st March 2026)

CONTENTS

Introduction

We are delighted to present the Velindre University NHS Trust Integrated Medium Term Plan (IMTP) for 2023 - 2026. Our plan builds upon our approved plan for 2022 – 2025 and is and output of the excellent work undertaken by teams from across the Trust and strong engagement with our many stakeholders. We have set ourselves a set of ambitious priorities, which build upon our strengths, and which will result in the people who use our services receiving excellent and person-centred care. Our IMTP sets out our plans across four distinct areas.

Firstly, the plan sets out our commitment to ensuring that we have firm foundations to support the delivery of high quality, safe and effective services which provide an excellent experience to all of our service users. This will include the establishment of our Quality Management System, supported by enhanced Business Intelligence capacity and expertise.

The second area signals the continued strategic development of the Trust. This will see us explore opportunities across the health and social care system to identify areas where we can further support our partners in achieving outcomes and benefits for the populations we serve. It outlines our key strategic priorities and objectives and describes the programmes of work we have established to ensure that these will be delivered.

Thirdly, the plan identifies our priorities related to the implementation of enhanced models and integrated pathways of care and services for blood and cancer services. This will see donors and patients being able to access services as close to home as possible, being able to receive a wider range of information services digitally, and having access to a trials and other services provided by our partners which may add value for them.

Finally, our plan describes our ambition to significantly develop our buildings and upgrade our equipment by 2026. These infrastructure improvements, together with our clinical and sustainability plans, will provide us with the opportunity to deliver a carbon ne-zero organisation and a range of wider benefits to support the development of thriving and resilient communities across Wales.

The plan we have set out demonstrates the challenging, but exciting times, ahead the Trust. We look forward to working with our commissioners, staff, patients, donors and partners to deliver the changes set out within the plan and continue our transformation into the future.

Part 1

Organisation Overview

An overview of Velindre University NHS Trust and the services we provide

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

Overview of Our Services

The Trust was established in 1994 and is one of eleven statutory NHS organisations in Wales. We provide a range of specialist services at the national and regional level.

Non-surgical tertiary oncology services

We provide non-surgical tertiary oncology services to patients from across South East Wales. We work closely with local partners in ensuring that our services are offered at appropriate locations, in line with best practice standards. An increasing number of services are also delivered on an outreach basis. Our specialist treatment, teaching and research work serves a population of approximately 1.7million.

Blood and Transplant Services

We deliver a range of essential and highly specialised services including the collection and production of blood and blood components to treat patients; and supporting the transplant programmes through our Welsh transplantation and immunogenetics laboratory services. This is a national service supporting the 3.3million population of Wales

Hosted Services

Our Trust is responsible for hosting the following organisations on behalf of the Welsh Government and NHS Wales:

- **NHS Wales Shared Services Partnership (NWSSP):** who provide a wide range of support services to NHS Wales including procurement, recruitment and wider back office services

- **Health Technology Wales (HTW):** a national body working to improve the quality of care in Wales. It collaborates with partners across health, social care and the technology sectors to identify, appraise and advise on the adoption of technology or models of care to ensure an all-Wales approach.

Part 2

The Operating Environment

Making sense of our environment, our commitment to quality and the challenges we face

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

Our Commitment to Quality and Safety: Our Golden Thread

Our Trust strategy sets out our commitment to quality and safety:

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: A leading provider of clinical services that always meet, and routinely exceed, expectations

Quality and safety is at the heart of everything we do. We will ensure we will continue to put our patients and donors at the centre of everything we do, working towards optimum quality, safety and experience and continual learning and improving. Our strategic goals will be achieved by ensuring that we meet in full the requirements of the Duty of Quality (Health and Social Care Quality and Engagement (Wales) Act 2020)) and by ensuring that quality improvement is driving all strategic decision making. We will also ensure that our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to continually learn and improve.

We are currently in the process of delivering a range of transformational changes across our cancer, blood and transplant services which will provide better care, enhanced clinical experiences and improved outcomes. We are committed to ensuring that quality, safety and experience is at the centre of all changes. This includes developing a Quality Management System (QMS) with robust business intelligence mechanisms, knowing '*what good looks like*' across all services, always striving to achieve this and continually monitoring and reviewing. We will develop robust quality and experience (patient, donor and staff) metrics (real time where possible) and integrated quality dashboards as part of the QMS that informs all of our strategic decision making. We will further develop our culture with a focus on creating an environment of psychological safety, openness, transparency, kindness and compassion and by ensuring we learn and put sustained improvements in place when things don't go as planned.

Our Trust has a strong track record of patient safety and quality improvement in all services we deliver. We will further build on this and embrace all opportunities for improvement across the organisation, which are strengthened by the clear requirements set out within the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the Welsh Governments Quality Framework (2021), the new Health and Care Quality Standards (2023), the National Clinical Plan (2021), the Wales Cancer Plan (2021), the NHS Wales Safe Care Collaborative (2023) and the Blood Health Plan (2017). We aspire to be leading the way in respect of Quality, Safety and

experience and have a clear plan over the next three years which will help us to make continued progress.

The scale and pace of change required will not be possible without the development of our multi-professional clinical, scientific, medical, AHP, and nursing professional leaders. We are developing a strong cadre of clinical leaders at all levels (service delivery level to Board level) who will help to drive the required patient/donor centred clinical transformation and quality improvements required.

This will need to be supported by the development of a QMS that includes high quality integrated digital, business intelligence and informatics systems to provide us with clinically driven, outcome and patient / donor focussed triangulated data and information to provide meaningful insight into our clinical decision-making, service delivery and how we are learning and improving. Further work will be undertaken to further enhance the Trusts Performance Management Framework ensuring it is focussed on quality, safety, harm, outcomes and that it evidences continual improvement. Our Chief Clinical Information Officer and Chief Nursing Information Officer will work with technical specialists to guide us.

We will continue to actively engage and participate with Improvement Cymru, the Safe Care Collaborative and national improvement work Programmes. Our five Quality Improvement Goals are being progressed through the collaborative. We have also agreed to take targeted action following the review of our baseline safety culture survey; this will further enhance our improvement capability.

The Trusts Quality Hubs will be further developed creating an integrated approach to quality, safety, experience and improvement from departmental level to Board.

Whilst we are proud of what we have achieved to date, we recognise that considerable more work is required to have robust quality and safety foundations in place. This IMTP has been developed with quality, safety and experience at its centre and will work with all partners to secure the best possible outcomes over the coming three years.

Our Plan for 2023 – 2026 and Beyond

Our Quality and Safety Framework (2023 – 2024) provides the framework and mechanism through which the Trust will meet its Quality and Safety responsibilities as outlined in the Health and Social Care (Quality and Engagement) Wales Act 2020 and the NHS Wales Quality and Safety Framework – Learning and Improving (2021). The framework has been developed in line with Quality standards (Duty of Quality): safe, effective, person-centred, timely, efficient and equitable and sets the structure for embedding quality, safety, outcomes, experiences and learning from service level

to Board across all areas of the Trust. This framework will be further refined during 2023, to reflect the requirements of the Duty of Quality statutory guidance when it is published.

Our Quality and Safety Vision:
All Velindre University NHS Trust staff put quality, patient / donor safety and experience firmly at the heart of everything they do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement.

Our Quality and Safety Framework – Key Aims:

Our framework is developed to support us in delivering our vision for quality and our strategic objectives. This will include meeting our responsibilities in relation to the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the NHS Wales Quality and Safety Framework: Learning and Improving (Welsh Government 2021). In order to achieve this, the framework will:

- Articulate the expectations of the Board in relation to quality and patient / donor safety
- Improve the provision of safe care through clear lines of communication and reporting from service level to Board and Board to service level
- Provide clarity of roles, responsibilities and lines of reporting in respect of Quality, Safety and Experience
- Develop a Quality Management System and a robust automated business intelligence infrastructure
- Provide a structure within which Corporate Services, Divisions, Departments and teams can:
    - Engage and actively listen to donors, patients, their families, staff and other key stakeholders to improve experience, outcomes and therefore efficiency
    - Empower everyone to put quality and patient safety at the heart of everything they do, ensuring quality drives delivery of care to improve experience and outcomes
    - Promote a quality and patient / donor safety focused culture in all aspects of care delivery they are responsible for and beyond
    - Clearly articulate a common understanding and ownership in relation to their individual and collective role, responsibility and accountability related to quality and patient / donor safety
    - Be sufficiently aware of potential risks to quality in delivery of safe and effective care
    - Demonstrate effective processes for escalating, investigating, managing and reporting on concerns about quality and patient / donor safety

- Use triangulated data to drive quality improvement, ensuring issues of equity are also identified and where appropriate addressed

The Establishment of Quality Hubs

Three Quality hubs are under development to support the delivery of this framework and the Duty of Quality legislative requirements:

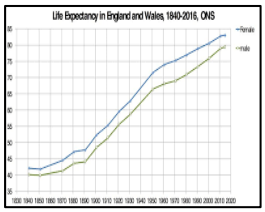
- **The Corporate Quality Hub** will have a central co-ordinating role pulling together all elements of Quality and Safety, will interface significantly with national work and bodies, as well as professionally supporting the Divisional Quality Hubs. The Corporate Quality Hub and Divisional Quality Hub Leads will formally meet at least monthly in the Quality and Safety Governance Group, that will provide analysis of all outputs / outcomes and ensure effective assurance reporting through the provision of triangulated assurance or exceptions reporting through to the Executive Management Board, Quality, Safety and Performance Committee and the Trust Board.

- **Welsh Blood Service (WBS) Quality Hub and Velindre Cancer Centre (VCC) Quality Hub**: These will be led by a nominated divisional senior leader and will support the Divisional Senior Management Teams in executing their Quality, Safety, regulatory and assurance responsibilities by ensuring effective oversight, co-ordination, learning, assurance and triangulation of 'the whole' and effective functioning of Divisional Quality and Safety Group.

The main drivers facing the NHS its partners

Our Trust serves a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities, requiring us to better coordinate and join up care.

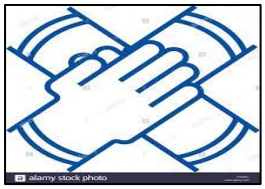
People's expectations are changing with the reasonable expectation that our services will be personalised to their needs. This is challenging us to think differently about how we can modernise and improve the way people access care and the quality and experience of it.



There are significant differences in healthy life expectancy and quality of life across different areas within Wales, with recent data suggesting that this gap is widening.

Attracting, training, supporting and retaining the right workforce is one of our biggest challenges and a key challenge across the NHS.

Digital technology, innovation and artificial intelligence are creating opportunities to transform the delivery of our services as well as opportunities to personalise our services so that we can make them more effective, efficient and valuable to people.



The Trust has been growing opportunities to collaborate across our regional health system and wider networks to join up care, share learning and improve outcomes.

The climate emergency and need to develop a sustainable approach to living on the planet; a global challenge we need to respond to.

What do our Local Health Board partners require from us?

The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector. Our primary health partners are set out below:

Organisation	Relationship
Aneurin Bevan University Health Board	Commissioner
Betsi Cadwaladr University Health Board	Commissioner
Cardiff and Vale University Health Board	Commissioner
Cwm Taf Morgannwg University Health Board	Commissioner
Hywel Dda University Health Board	Commissioner
Powys University Health Board	Commissioner
Swansea Bay University Health Board	Commissioner
Welsh Ambulance Service NHS Trust	Provider
Public Health Wales NHS Trust	Provider
Health Education and Improvement Wales	Provider
NHS Wales Shared Services Partnership	Provider of services
Digital Healthcare Wales (DHCW)	Provider of services
Welsh Health Specialist Services Committee	Specialist Commissioner

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our Local Health Board partners to ensure that our key strategies are aligned, that there are a clear set of shared priorities and to ensure that we can provide sufficient capacity and capability to deliver commissioned services of the highest quality.

Engagement with people who use our services to design them in partnership

Effective and ongoing engagement is vital in the development of our services and we strive to make it as easy as possible for patients and donors to share feedback following their care.

There are a number of ways used to listen, discuss and learn about our services.

Velindre Cancer Services

Our service plans respond to feedback from patients and donors, their families and carers, Velindre staff, Health Boards, third sector and other partners. A range of engagement events and workshops have been undertaken with key stakeholders over the last three years.

Social Media continues to offer a productive two-way conversation tool with our online cancer community. This helps us to listen and respond to compliments, queries and concerns. Our Patient Advice and Liaison Service is able to respond in a timely and efficient manner, capturing mini-stories and signposting to wider online surveys.

Blood and Transplant Services

The Blood Service also has daily interactions with members of its community of donors. We are committed to listening to our donors and we do this by circulating a comprehensive survey to every donor that enters a donation session each month.

The service operates a dedicated donor contact centre which exists to inform, educate and assist donors in contributing to the health of the nation by donating their blood, platelets or bone marrow. The service also engages existing and prospective donors through its donor engagement team. This team uses social media, the press, the website and face-to-face interactions to promote blood, platelet and bone marrow donations in Wales.

The engagement department is present in the communities of Wales, building close links and partnerships with community groups, sports teams, businesses, education providers and other socially engaged groups that have an influence in their localities. The engagement team is also committed to having a presence at the high profile national events that occur each year across Wales, such as the National Eisteddfod.

What are the challenges we face?

At an organisational level ……..

Service Delivery is Complex: Our frontline services face a number of challenges with the blood and transplant service working to maintain a healthy donor base, meet the national demand for blood and maintaining regulatory compliance. The non-surgical tertiary oncology service faces increasing demand, accentuated by COVID-19; the challenge of providing capacity to see patients quickly; and the need to keep pace with new treatments and continuously improved levels of quality, safety and experience.

Maintaining a Healthy Workforce: The commitment, resilience and professionalism of our staff has been remarkable over the last three years given the impact of COVID-19. However, there have been consequences with staff sickness increasing over this time period as well as the ongoing impact to the mental well-being of our workforce.

Developing a Sustainable Workforce: The NHS workforce across the UK is fragile with shortages in a number of areas/specialisms. These are particularly acute in a number of services provided by the Trust e.g. a shortage of oncologists.

Delivering Key Transformation Programmes: The Trust is currently delivering a number of highly complex transformation programmes including the Transforming Cancer Services Programme and the Welsh Blood Service Lab Modernisation and Infrastructure Programmes. The level of change required is significant and the risk to delivery has increased as a result of the direct and indirect impact of COVID-19.

Working Effectively as a Partner across the System: The Trust is a provider of specialist services at a regional and national level which enables strategic step change in the quality and experience of services to be achieved by the healthcare system at scale. It also brings challenges, including the need to manage numerous relationships with commissioner organisations.

Decarbonisation and Net Zero: The NHS is one of the largest carbon emitters in the UK, the delivery of carbon net zero is essential. It will require careful planning, huge cultural and behavioural change and capital investment; at a significant scale.

Sustainability and Wider Social Value:
We are fully committed to making a wider contribution to the communities it serves to deliver a thriving and prosperous Wales. The Welsh Governments policy requires us to think innovatively about how it can maximise the social value it can generate as an Anchor Institution in accordance with key policies such as the Foundational Economy.

Funding: The medium-term funding position for the NHS is a challenging one, both in revenue and capital terms.

So what does all this mean for the Trust, the services we provide?

The next three years will undoubtedly provide both challenge and opportunity in equal measure. Our intention is to see the challenges as opportunities to support us in taking the learning from the pandemic to place quality, safety and experience at the heart of everything we do. We are committed to working with patients, donors and our health and public service partners to understand, design and deliver services which are truly person focused and deliver the experience and outcomes that people value most.

Our focus during this period will be on:

Delivering the Fundamental Cornerstones of Healthcare Provision
These include:

- Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework and the National Clinical Framework to provide services of the highest possible quality
- Delivering services that meet the national clinical quality and safety standards and provide an excellent experience
- Treating patients as quickly as possible
- Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales
- Developing agile and flexible capacity plans which allow us to respond quickly to changes in demand for our services
- Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past three years
- Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working

Improving Population Outcomes and Reducing Inequalities
The Trust will work with our Local Health Board and wider partners to identify opportunities where we can support the improvement of public health and population outcomes through primary and primary and secondary prevention. This will focus on a number of areas:

- Improving access to our services to increase uptake and reduce inequalities and ill-health
- Strengthening our decision-making (systems/processes/culture to consciously address poor outcomes and inequalities in the communities we serve

- Working with our health partners where it is clear and compelling that we can add value and make a difference
- Developing a range of strategies and plans that enable us to help our staff to improve their health and well-being
- Secondary prevention: making the most of the opportunities of '*every contact counts'* with patients, donors, partners to support them in improving their health and well-being.

Regional Working, Partnerships and Collaboration to Improve Outcomes

The Trust will:

- Work with Local Health Board partners to strengthen the Cancer Collaborative Leadership Group and to lead on the delivery of improving cancer outcomes for patients in South East Wales
- Develop the Velindre@ research hub philosophy across all LHB partners in South East Wales
- Further develop the Blood Health Oversight Group work programme to improve the prudent use of blood and blood products across Wales

System Leadership

The Trust will continue to develop our system leadership role in Wales in areas where we can add value. Our initial focus will be on developing the contribution we can make in:

- Working with Health Boards, the Cancer Collaborative Leadership Group and wider partners to improve cancer services
- Working with Health Boards to deliver the National Blood Health Plan
- Working with Health Boards, universities and commercial partners to deliver cutting edge research, development and innovation across South-east Wales

Delivery of Transformation Programme

Non-surgical Tertiary Oncology Services:

The Trust will progress a number of key areas of work within the Transforming Cancer Services Programme and Velindre Futures programmes:

- Implementation of the Nuffield Trust recommendations including:
  - Delivery of the Acute Oncology Service regional model
  - Implementation of revised pathways for unscheduled care
  - Delivery of the Cardiff Research Hub ad University Hospital Wales, Cardiff.

Development of the infrastructure to support regional cancer services including:

- Implementation of the Integrated Radiotherapy Solution. This includes the replacement of 2 LINACS at the Velindre Cancer Centre.
- Completion of the enabling works for the new Velindre Cancer Centre
- Construction and delivery of the new Velindre Cancer Centre in Whitchurch, Cardiff

- Construction and delivery of the radiotherapy satellite centre at Nevill Hall, Abergavenny

Blood and Transplant Services:
The Trust will progress a number of key areas of work within blood and transplant services including:

- Laboratory Modernisation programme
  - Scoping and planning of the future laboratory services plan
  - Refurbishment of the Talbot Green facility and carbon reduction
- Plasma for Fractionation: developing the case for change and delivery of the Programme

Research, Development and Innovation
The Trust will continue to drive our research, development and innovation ambition for our patients and donors and focus on

- Joint delivery, with Cardiff and Vale UHB and Cardiff University, of the Cardiff Cancer Research Hub
- Implementing our Cancer Research and Development Strategy (2021-2031)
- Building upon and enhancing our Welsh Blood Service Research and Development Strategy
- Embedding our Innovation Plan
- Developing our national and international Research, Development and Innovation Partnerships

Mental Health and Emotional Well-Being - Supporting the Workforce

The Trust will continue our programme of work to support the physical, mental and emotional well-being of our staff across a number of areas:

- Promoting healthier lifestyle choices including healthier food options, access to physical activities, and support to reduce and stop smoking
- Providing accessible information and resources on physical health and well-being for people who experience mental health problems
- Delivering staff training on mental health issues
- Increasing access to the Employee Assistance Programme and other support and counselling services
- Establishing a part-time dementia liaison nurse position within the Trust
- Providing a programme of mental health awareness training for all staff, with a proposal for Mental Health Awareness to become a mandated module in the Trust's core management training framework

Part 3

How will The Trust respond?

In this chapter we set out the main strategic priorities for 2023 to 2026.

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

Destination 2032: Our View of the Future

Our Purpose: To Improve Lives

Our Vision: Excellent Care, Inspirational Learning, Healthier People

Our Strategic Goals

Trust Strategic Priorities for 2023 – 2026

Our Trust strategy '*Destination 2032*' identifies a number of priorities which will support us in achieving our goals. In light of the current operating environment our priorities are focused on 2023 - 2026.

Strategic Goal 1: Outstanding for quality, safety and experience

Our objectives are to:

- Provide harm free care, the best outcomes and a great patient and donor experience
- Listen to, and learn from, patients and donors experiences of our care to drive continuous improvement
- Be an organisation which consistently demonstrates Compassionate Leadership in everything we do
- Be recognised as 'outstanding' by Health Inspectorate Wales, the Medicines and Healthcare Products Regulatory Authority and by UK and international peers for the services we provide

We will achieve these by:

- Implementing the requirements within the Health and Social Care Quality and Engagement Act
- Implementing a quality and safety management framework which will drive every action we take and decision we make
- Delivering the national programme for Compassionate Leadership across the organisation.
- Continuing the development of a quality led culture which drives the highest standards of care and safety and ensures all staff live the ethos that 'the standard you walk past is the standard we set'.
- Getting the basics right by improving access and transport to our services; reducing the need for journeys for care and improving car parking and public transport if you have to visit us
- Continuing to develop an open, transparent, just and learning culture which allows excellence to flourish
- Developing a value based healthcare programme which supports us in reducing unwarranted clinical variation and inefficiencies, using best practice as our benchmark.
- Providing staff with education, training and support to develop improvement skills and knowledge which drive quality and safety standards
- Developing our performance management framework to report our performance on quality, safety and experience in an uncomplicated way to ensure everyone can easily see how we are doing
- Benchmarking the quality, safety and experience of our services nationally and internationally to identify learning and improvement

Strategic Goal 2: A leading provider of clinical services that always meet, and routinely exceed, expectations

Our objectives are to:

- Achieve national and internationally recognised standards of care which keep pace with emerging evidence
- Be a trusted and influential partner across Wales to deliver great local health services which meet need
- Become a 'centre for excellence' and leading provider across the UK for the highly specialist services we deliver
- Become a system leader in our areas of expertise nationally and internationally
- Identify a range of new services that the Trust could deliver to improve quality, experience and outcomes across Wales

We will achieve these by:

- Delivering services which comply with all statutory and professional standards
- Implementing the National Clinical Framework to continuously improve the quality, experience and outcomes of the services we provide
- Implementing our patient/donor/citizen engagement strategy to continuously hear what people need and value from our services
- Co-designing models of care in partnership with people from all parts of the communities with the aim improving access to our services and providing care at home or close to home wherever appropriate and desired
- Working with the community and our partners to reduce inequalities in healthcare
- Rapidly adopting evidence-based research outcomes which improve patient and donors quality, safety and experience of care
- Developing and implementing our clinical and scientific strategies which will set out what services we will deliver over the next ten years; focusing our offer on delivering services that we believe we can truly become leading experts in
- Agreeing with our Local Health Board partners and the Welsh Government the system leadership roles we will undertake to maximise the value we can add for our patients, donors and partners
- Working with the Welsh Government and other partners to plan, fund and deliver world class buildings, facilities and technology for patients, donors and staff
- Benchmarking our performance nationally and internationally to see how we perform against our peers and to identify learning and improvement

Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority

Our objectives are to:

- Deliver world class research, development and innovation to improve tomorrow's care
- Accelerate the implementation of research and new discoveries to improve our patient's and donors experience and outcomes
- Prioritise research, development and innovation that is clinically relevant and patient and donor centred
- Build a sustainable culture of multi-professional research, development and innovation involving the whole organisation
- Publish and promote research of the highest quality which achieves UK and international recognition

We will achieve these by:

- Implementing the our research, development and innovation strategy across which sets outs a prioritised programme of work in cancer, blood and transplant services
- Giving every donor, patient and carer access to the latest research
- Advancing new treatments, interventions and care by increasing new studies locally, widening access to early phase/solid tumour advanced therapies and integrating novel research into clinical studies
- Building a culture of curiosity where research, development and innovation is an 'Always Event' involving all 1500 employees in the Trust, staff challenge the status quo and make it better
- Increasing the number of lead investigators and clinical academics within the Trust
- Recruiting honorary entrepreneurs and academics whilst also developing entrepreneurs, with a flow of staff between our partner organisations on exchanges to attract and retain world class talent
- Creating a cadre of blended professionals, to promote knowledge exchange with impact on improvements of patient outcomes
- Establishing exciting work programmes with our local health and academic partners at Cardiff University, Cardiff Metropolitan University, Swansea University, University of South Wales and Trinity St. David's University.
- Increasing our research, development and innovation infrastructure to keeps pace with our ambition. This will include:
    - Establishing the research hub with Cardiff and Vale University Health Board and Cardiff University
    - Providing world class facilities via the Welsh Blood Service Infrastructure Programme; the new Velindre Cancer Centre; Velindre@ research hubs at University Health Board partners; and the Collaborative Centre for Learning and Innovation
    - Developing the Library Service into a sustainable Trust wide Evidence Centre
- Generating reinvestment income through partnerships with industry for commercial research, development and innovation

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all

Our objectives are to:

- To deliver inspirational teaching which is enhanced and informed by world-class research and professional practice
- Create a supportive and enriching learning environment for all of our learners
- Provide a learning experience that learners rate as excellent
- Be rated as a high quality provider of education and learning nationally and internationally in a number of priority areas
- Raise the profile of the University Trust on a UK and international stage

We will achieve these by:

- Developing a highly quality education and training programme which is aligned to the needs of our local, national and international partners
- Appointing visiting professors and Professors of Practice to the Trust and aligning their work with priority areas of industry and business partners
- Attracting academics with national/international reputations and foster partnerships with leading organisations from around the world in our stated areas of priority
- Equipping all learners to make the best use of physical and digital learning resources and utilise Cardiff as a living classroom
- Increasing our investment in a range of funded strategic initiatives to ensure staff have the time and environment to undertake learning. We will invest additional funds in:
  - Supporting our workforce to undertake MSCs and PhDs
  - Supporting our workforce to take up Fellowships
  - Supporting our workforce to obtain professional, technical and role specific qualifications and accreditations
  - Providing research and learning opportunities for students from our university partners, industry and other sectors
- Developing unique learning opportunities in specialist areas including the Velindre School of Oncology and Welsh Blood Service Modernising Scientific careers programme
- Developing a marketing and communications strategy which attracts learners to our programmes and raises the profile of the Trust
- Identifying a range of partners and collaborators to enhance our offer and brand across the globe

Strategic Goal 5: A sustainable organisation which contributes to a better world for future generations across the globe

Our objectives are to:

- Be recognised as a leading NHS Trust for sustainability nationally
- Be a carbon 'Net Zero' NHS organisation by 2030
- Become an anchor organisation in the communities we serve which enhances their economic, social, environmental and cultural well-being
- Support the transformation from ill-health to well-being across Wales

We will achieve these by:

- Developing clinical service models which support sustainability e.g. more care at home
- Implementing our sustainability strategy
- Applying the principles of the circular economy into our business processes through design, procurement, re-use and lifecycle.
- Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day')
- Implementation of our carbon reduction plan which will see us achieve Net Zero and transition to renewable energy for our services and facilities.
- Investing in a range of refurbishments and new buildings which will support our carbon reduction and healthier buildings and healthier people approach. These include:
  - Major refurbishment of the Welsh Blood Service, Llantrisant site by 2024
  - Construction of a Radiotherapy Satellite Centre at Neville Hall by 2024
  - Construction of a new Velindre Cancer Centre by 2025
- Implementing an attractive approach to agile working for our staff which reduces avoidable travel, improves well-being and offers the potential to support money going into local communities
- Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport
- Using our procurement activities and NHS Wales Shared Services capability to drive a sustainable approach and achieve wider ethical and social value in areas including local employment and prosperity; carbon reduction; anti-slavery and unethical practices.
- Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprenticeships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Governments Foundational economy

Delivering our strategy will support us in:

- Focusing on delivering excellence in our core clinical services
- Placing quality and safety at the centre of everything we do
- Developing our clinical, scientific and healthcare professional leadership
- Becoming world leaders in specific areas of research, development and innovation
- Expanding our culture of learning across staff, students and the communities we work with
- Delivering carbon net zero operations and wider benefits and social value for our communities
- Moving towards a future which will see us becoming a valued partner in the prevention, public health and wider social policy areas; helping to find solutions to deep-seated problems in Wales such as poverty and deprivation

To deliver our strategic goals by 2032 we have refreshed our Welsh Blood Service Strategy from 2023-2027 (Note – Velindre Cancer Centre has previously been approved)

These are supported by a range of refreshed enabling strategies / frameworks including:

- Digital Strategy
- People Strategy
- Sustainability Strategy
- Estates Strategy

Our strategic plans provides the Trust with a clear line of sight and the ‘golden thread’ between our Purpose, Vision, Strategic Goals and the priorities contained within our Integrated Medium Term Plan. This has enabled us to effectively prioritise our activities and resources over the coming years as summarised below.

Our service and enabling plans outlined within this IMTP outline the specific actions we will take to deliver these organisational priorities.

Organisational Priorities (Note: not listed in priority order)

Implementing and Embedding the 'Building our Future Together' Programme	Development of a Trust Private Patients Strategic Plan	Implementation of Trust Digital Health and Social Care Record	Delivery of the TCS Digital and Equipment Programme to support the delivery of the nVCC and RSC	Agreement of Trust contribution to Advanced Welsh Medical Genetics
Implementation of the Duty of Quality Act	Continued implementation of the Staff well-being Programme	Implementation of the 'Transformation Access to Medicines Programme' (Velindre component)	Delivery of a Radiotherapy Satellite Centre (RSC) at Nevill Hall Hospital	Continued development and implementation of the Collections Modernisation Programme
Implementation of the Duty of Candour	Implementation of the Patient Engagement Strategy	Delivery of the WBS Talbot Green Infrastructure Programme	Continued development and implementation of the Laboratory Services Modernisation Programme	Full implementation of the Regional Acute Oncology Service (Velindre component)
Implementation of a Trust-wide Quality Hub	Implementation of the Trust Sustainability Strategy to support the All-Wales de-carbonisation target	Delivery of the new Velindre Cancer Centre (nVCC)	Continued implementation of the Welsh Bone Marrow Donor Registry Programme	Implementation of the Velindre Outreach Programme
Delivery of University Status programmes of work	Implementation of the Trust Digital Programme	Implementation of the Integrated Radiotherapy Solution to support the delivery of the nVCC	Continued development of the Trust's '*Plasma for Medicines*' Programme	Implementation of the SACT Service Transformation Project
Delivery of the Cardiff Cancer Research Hub	Implementation of Digital National Systems and Digital Cloud Infrastructure	Delivery of the nVCC Service Transition Project to support the delivery of the nVCC	HEP B Testing - Delivery of the Retrospective Testing Programme and changes to the collection model	

Part 4

Translating our priorities into high quality services

We describe our service delivery framework for Strategic Trust Programmes

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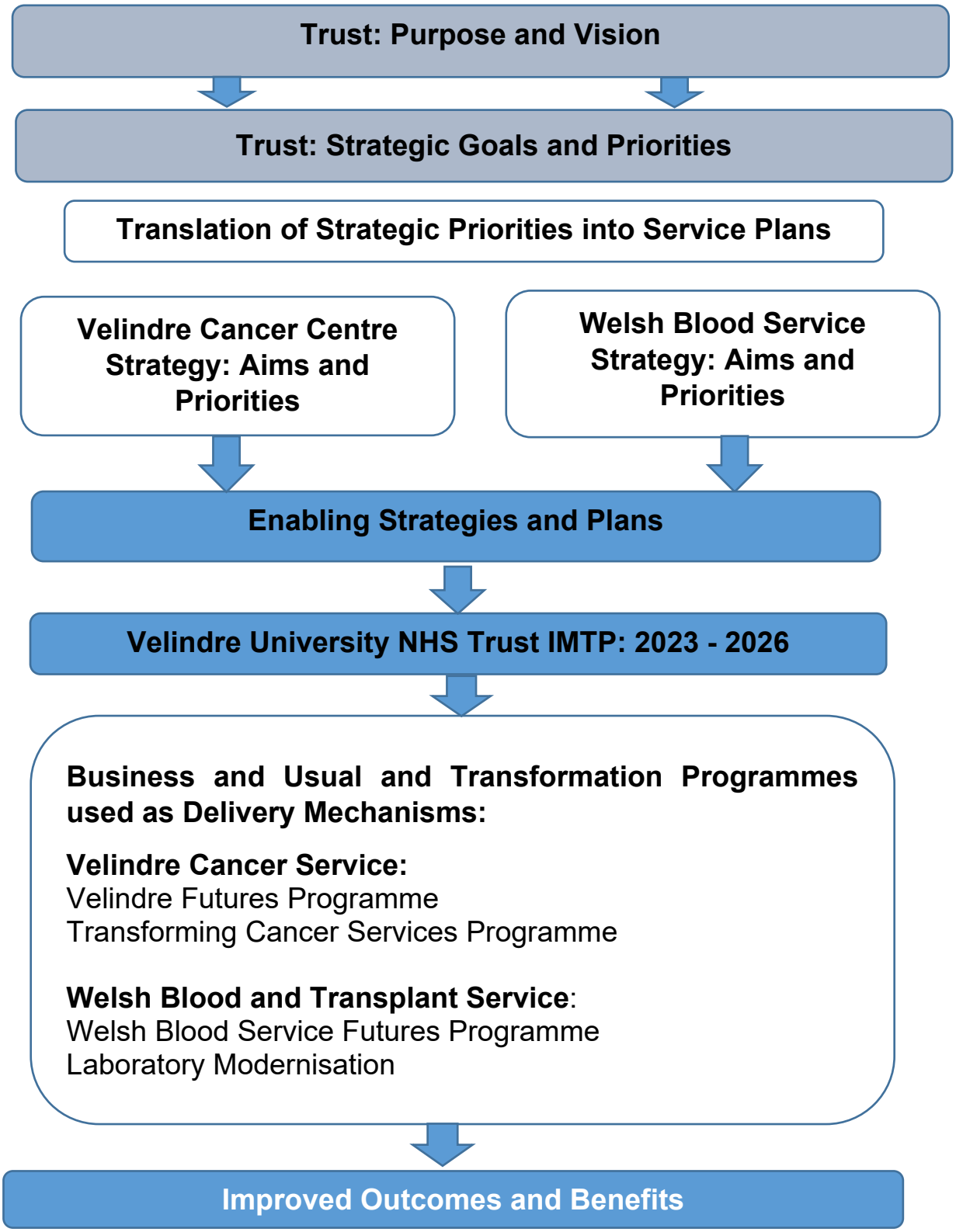
Our Strategic Delivery Framework

Our strategic delivery framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation.



Trust Programmes

There are a range of programmes that we will progress at an organisational level, embedding them into the services that we deliver. These include:

Sustainability: Delivering value and decarbonisation

Our Sustainability Strategy '*Destination 2032*' sets out a clear ambition for the organisation over the coming years with the following aims:

- Deliver sustainable services which add wider social value for the communities we serve
- To be recognised as an exemplar organisation in relation to the delivery of the Well-Being of Future Generations Act
- Deliver Biodiversity Net Gain and enjoyment of our green spaces to improve health and well-being
- To be Carbon Neutral by 2030
- Use resources efficiently: zero waste to landfill by 2025 and reduced consumption of energy and water

It provides a roadmap for us to maximize our contribution to our communities and to mitigate our impact on the planet whilst delivering high quality services for our donors, patients and carers. It is supported by a decarbonisation plan which will allow us to deliver Carbon Net Zero.

Value-Based Healthcare:

The Welsh Government and NHS Wales has set out on an ambitious and exciting journey which focuses on the delivery of high quality patient outcomes through improving patients involvement in decision-making using the best evidence available; avoiding unnecessary variation in care and by being innovative in determining who to best use resources in order to improve overall outcomes.

Our financial strategy aims to be an enabler to the clinical, service, workforce, digital and estates plans, which set out how the Trust, in conjunction with National Public Health Service for Wales (NPHSW), its commissioners and Welsh Health Specialised Services Commissioner (WHSSC), will:

- Address cancer population healthcare needs and specialist cancer service delivery requirements
- Deliver the Laboratory modernisation programme and infrastructure improvements in the Welsh Blood Service, support implementation of the Blood Health Plan for Wales and continuous improvement in technology and practice in transplant services

The financial strategy is designed to support the Trust in meeting the aims of '*A Healthier Wales*" and '*Wellbeing of Future Generations Act*'. Our approach aims to meet the '*quadruple aims*' of improved population health and wellbeing; better quality and more accessible health and social care services; higher value health and social care; and a motivated and sustainable health and social care workforce as well as sustainable development principles contained in the Act. Whilst the Trust is at an early stage in its Value-based Healthcare (VBHc) journey, as evidenced through our self-assessment, we are keen to move at pace to deliver on some of the key objectives with our 3 strategic priorities for VBHc:

- Culture, Socialisation and Education
- Measurement of Outcomes and Cost in a meaningful way
- Prudent Healthcare and Service Prioritisation

We will:

- Adopt VBHc as a way of improving the outcomes for its patients and donors
- Ensure that our approach to VBHc will not be the creation of a separate programme of work, but that we will embed value and prudent principles within the existing clinical and service delivery teams and business mechanisms
- Ensure that all of our staff consider value as part of their every-day work. To support this we have:
    - Embedded value and prudent healthcare principles at the centre of the work of the Trusts cancer SSTs, Velindre Futures, clinical audit, quality and safety and improvement / transformation teams.
    - Invested in a dedicated expert VBHc role to drive out aims and objectives.

Velindre Cancer Service Plans to Improve Value:

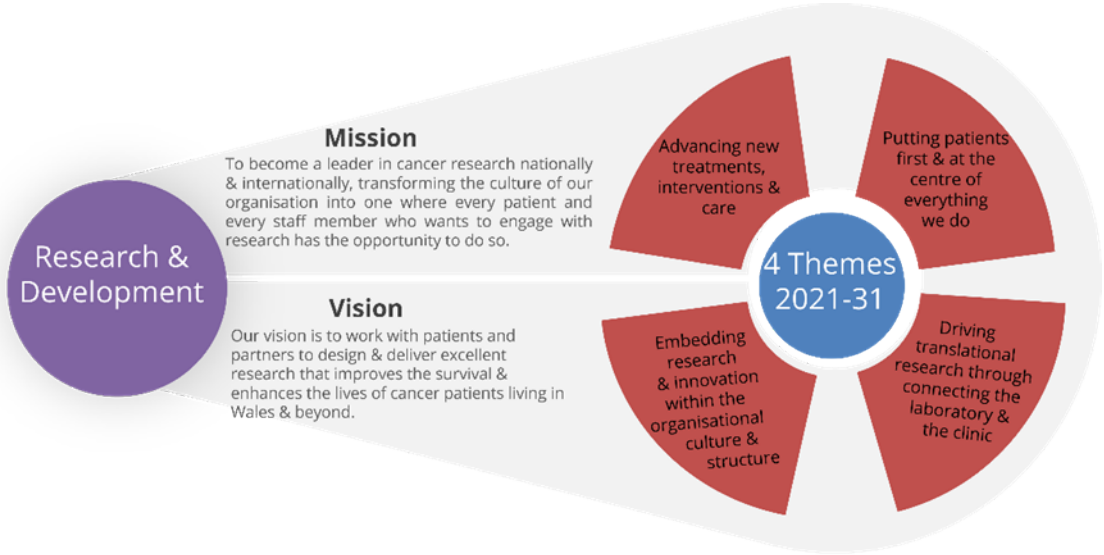
- Remove waste and variation and improving the technical efficiency of its services.
- Optimise the Clinical Delivery Model through workforce redesign that places duties with appropriate roles, for example, non-medical outlining and prescribing whilst maintaining the highest standards of clinical care and patient outcomes.
- Implementation of patient PROMs (outcome measures) and PREMs (experience measures) which will ensure the effective capture of data for the Trust tertiary services and across the wider cancer pathways.
- Use of digital services to drive value by creating and connecting a digital cancer services community in South-east Wales that will transcend organisations and form the digital environment to enable data collection for service improvement and transformation to be facilitated.
- Working with partners to improve cancer pathways and focus around linking outcomes and cost, prehabilitation (supporting patients preparing in advance of treatment), prevention and improving outcomes.

Welsh Blood Service Plans to Improve Value:

Our strategic priorities are aligned with the NHS Wales Blood Health Plan in '*supporting individuals to manage their health and wellbeing, avoiding unnecessary intervention, using evidence and transparent data to drive service planning and improvement to reduce unnecessary variation and to avoid harm, placing safety and quality at the core of patient care*'. The spirit and substance of these priorities support the delivery of value based prudent healthcare.

Specific objectives include changes in practice to meet service development needs, including the potential development of a new plasma for fractionation service, subject to Ministerial approval, establishment of an Occult Hep B testing service, a programme for Laboratory Modernisation, and a reduction of variation in the usage of intravenous immunoglobulins (IVIG), ensuring continuity of patient care in an efficient and effective way. Additionally, a key objective is in the development of an increasingly prudent and sustainable supply chain flexible to match patient demand in Wales, with the ambition to improve the efficiency of the blood supply chain whilst maintaining and improving donor experience and care, alongside positive outcomes and the avoidance of harm for patients.

Research, Development and Innovation:



Our Aims are to:

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

In line with the Trusts' Strategic goal to be ***"A beacon for research, development and innovation"***, we are committed to building on our excellent national and international reputation, based on successful delivery and management of a wide portfolio of research, development and innovation and a firm commitment to partnership working. The overarching prioritisation of research and innovation within the Trust is clear and embedded within the two divisions, both of which are focused in their approach and have developed robust research strategies and plans for innovation. Patients and donors remain at the centre of this activity and through the 4 key priorities identified below, we seek to radically improve access to research and innovation whilst building a sustainable and capable clinical and scientific workforce for the future.

The Velindre Cancer Service plays a key role to play in the cancer research network in South East Wales (SEW). It provides an important link between the 3 University Health Boards in the region for collaborative clinical cancer research, offering opportunities for patients to access clinical trials and a range of other research studies, either at Velindre Cancer Centre (VCC) itself or in outreach facilities. The Velindre Cancer Service is also in a prime position to provide the crucial connection between laboratory cancer researchers and patients, enabling research to '*bridge the translational gap*' and bring new discoveries from the laboratory to the clinic for patient benefit. The development of a new Velindre Cancer Centre in Whitchurch, Cardiff brings with it opportunities for both clinical and non-clinical research and innovation, which are being explored and will contribute to the design and facilities of the new build.

The Welsh Blood Service is a unique organisation within the Welsh healthcare system, with the capacity to perform research and to implement and disseminate evidence-based innovations and new technologies on an all Wales basis, in order to advance donor care and our reputation for transfusion and transplantation medicine.

Our Priorities:

Strategic Priority 1: We will Drive Forward the Implementation of our Cancer Research and Development Ambitions

We have set out our Cancer Research and Development Ambitions for the next ten years. These have been developed by multidisciplinary research leads from the Cancer Centre, University partners and Patient and Public representatives.

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

Our Research Themes:

- **Putting patients First and at the Centre of Everything We Do**: patients will help set the research agenda and we aim to increase opportunities for patients and their families to take part in research, so that within 10 years most of our patients are offered research and innovation opportunities at some point in their cancer journey.
- **Advancing New Treatments**, I**nterventions and Care:** We will lead and take part in well-designed Clinical Trials and other research studies, providing the evidence base required to bring new, improved treatments and interventions into the clinic to enhance patient care. Research that is led from Wales will be prioritised and new infrastructure for research delivery will be developed, including a Cardiff Cancer Research Hub for Early Phase and Translational research delivery on the University Hospital of Wales (UHW) site and a firm footprint for research at the new Velindre Cancer Centre, particularly to enable cutting-edge radiotherapy research.
- **Driving Translational Research** through connecting the laboratory and clinic: We will work closely with our academic (university) partners to enable translational ('*bench to bedside*') research, bringing new discoveries (novel drugs, imaging techniques and/or technological advances) through from the laboratory to the clinic to benefit patients. We will also enable reverse translation ('*bedside to bench*') research where patient samples/scans and/or data are taken back to the laboratory to generate new knowledge. Developing Clinical Academic posts that link across clinical-academic boundaries will be key to success in this theme.
- **Embedding Research and Innovation within the Organisational Culture:** We will establish an organisational culture that values research and build capacity and capability within the multi-disciplinary workforce, providing dedicated ring-fenced time and training opportunities for staff from all disciplines who wish to engage with research. The appointment in 2020 of a Velindre Professor of Nursing and Interdisciplinary Research is important in this endeavour.

Our research will be facilitated by a governance and enabling infrastructure, supported by a communication, engagement and funding strategy and delivered by an agile research workforce. Close collaboration with our regional NHS and Academic partners and engagement across different sectors will be key to success (see Strategic Priority 4).

Strategic Priority 2: The Trust will Maximise the Research and Development Ambitions of the Welsh Blood Service

The Welsh Blood Service has an established Research and Development strategy, developed in collaboration with our staff, scientists, clinicians, academia and other UK blood services. Our aims are to drive improvement, increase our research

activity, be open to collaboration and build our reputation for research and development, in order to improve donor and patient health.
We will continue to develop our 4 Welsh Blood Service Research and Development themes which are:

- **Transplantation**: including solid organ and stem cell transplants
- **Donor Care and Public Health**: including donor recruitment and retention strategies, aiming to enhance their experience and continued engagement.
- **Products**: including blood components, immuno-haematology, manufacturing and quality management.
- **Therapies**: including preparation of cellular and blood therapies for research.

We will also honour the expectation of our staff that Research and Development is an embedded function that is part of an evidence based, first class service, delivered with pride. We will also maximise opportunities to improve and expand the services at WBS, through feasible and evidence-based Research and Development.

The Welsh Blood Service Research and Development team will continue to grow commercial Research and Development opportunities and the significant potential of our Component Development Lab. We will continue to actively seek strong academic and professional Research and Development partners, nationally and internationally. These will include high quality networks such as the international BEST Collaborative and the European Blood Alliance. We will leverage these partnerships to further explore the potential of Advanced Therapies aligned to our unique Service. Finally, we will continue to build the capacity and capability of our workforce and to embed a positive culture around Research and Development activity.

Strategic Priority 3: The Trust will Implement the Velindre Innovation Plan
In partnership with the Welsh Government Health and Care Innovation Team and the Velindre Charity, a Velindre Innovation infrastructure has been established to deliver a step change improvement in the quality and quantity of multi-disciplinary and multi-partner innovation to achieve our Trust's purpose to improve lives.

Over the course of our plan we will have agreed innovation priorities and themes that will including emerging technology and informatics, commercialisation, workforce, engagement, arts and creativity, new hospital design, sustainability and future generations and social innovation with community benefit. At the Velindre Cancer Service, these will also include patient outcomes and patient experience, primary and community oncology care, diagnostics, advanced cancer treatments and therapies, supportive care and palliative care. At the Welsh Blood Service these will include, plasma fractionation, donor engagement, experience and care, components and products, stem cell and transplant, along with advanced blood-based therapies and innovative logistics.

We will have a clear process for triaging and accelerating innovation. We will have a strong platform for delivering innovation that will include the right people and culture, flexible and responsive innovation funding, toolkits, and a responsive IP protection procedure. To increase our capability and capacity we will have strong partnerships that with both the public and private sector. We will build an innovation premium through awards, targeted promotion, publication and delivering value through a Performance framework, aligned to the Welsh Government's Innovation Strategy and Programme.

Strategic Priority 4: The Trust will Maximise Collaborative Opportunities Locally, Nationally and Internationally

Across the Health Boards we will work with our colleagues to maximise research opportunities for our patients and donors. This will include the Velindre@ Programme which aims to evolve the research infrastructure across South-East Wales, enabling local access to clinical research. The partnership with Cardiff and Vale University Health Board and Cardiff University to develop the Cardiff Cancer Research Hub will provide a safe environment to provide cutting edge and complex advanced therapies for patients and enable translational research in collaboration with Advanced Therapies Wales and our Haematology and University partners.

We will also work with scientists within Cardiff and beyond to bring new therapies into the clinic for the very first time as well as generating reverse translation opportunities involving both systemic therapy and radiotherapy. Moreover, we will increase the number of Velindre Chief Investigators who can collaborate with the Centre for Trials Research (CTR) in Cardiff University. Through interactions with the Cardiff Experimental Cancer Research Centre (ECMC), the Wales Cancer Research Centre (WCRC), and Health and Care Research Wales (HCRW), we will maximise research opportunities across all fields of cancer research including early diagnosis, interventional therapies and palliative and supportive care.

In addition, with the All Wales Medical Genomics Service, we will become the only hub in the UK to offer a 500 gene panel to all new metastatic cancer diagnoses, providing outstanding potential for precision medicine research opportunities with all our patients.

At a national level we will continue to work with our colleagues across the UK, including the National Cancer Research Institute (NCRI). We will also develop our already healthy relationship with the third sector, industry partners and contract research organisations (CROs) to both deliver commercial research and to collaborate in the design and delivery of clinical trials with Velindre University NHS Trust acting as a sponsor.

We will strengthen our Academic Partnership Board with multiple HEI partners across Wales to help us to shape our Trust University Status whilst ensuring that multi-professional development of research and innovation remains central to this agenda. Lastly, and most importantly, we will work with patients and the public to ensure that the research we develop and offer is relevant to their needs.

System Leadership and Regional Partnership Working

The development of leadership roles, partnerships and collaboration are vital in NHS Wales achieving the best outcomes for the population we serve. The Trust is a partners in a number of exciting programmes of work which we will continue to pursue. These include:

Cancer Services

The development of the cancer system across South East Wales and the implementation of the Nuffield Trust recommendations.

Development of Acute Oncology Services Across South East Wales:
Acute oncology ensures that cancer patients who develop an acute cancer-related or cancer treatment related problem receive the care they need quickly and in the most appropriate setting.

Development of a Cardiff Cancer Research Hub:
Velindre University NHS Trust, Cardiff and Vale University Health Board and Cardiff University have a shared ambition to work in partnership together and with other partners to develop a Cardiff Cancer Research Hub.

Blood and Transplantation

Advanced Therapies Wales:
The Programme was established in 2019 on behalf of the Welsh Government following publication by the Welsh Government of the Advanced Therapies Statement of Intent. The Programme is part of the Precision Medicine initiative within the Health and Social Services Group. The Statement of Intent outlines the challenges, opportunities and actions necessary to develop a sustainable strategic approach to developing the Advanced Therapy Medicinal Products sector in Wales.

Focus will continue to be on supporting the development of clinical trials in Wales and facilitating a collaborative approach to research and development with the Cardiff Cancer Research Hub.

There will also be a focus on working with the Welsh Health Specialised Services Committee and Local Health Boards in Wales to support the implementation of NICE approved Advanced Therapies for the Welsh population.

Plasma Derived Medicinal Products:
Over the five years there have been sustained annual increases in the global demand for Plasma Derived Medicinal products, in particular Immunoglobulin. As a result, all UK blood services have devoted resource to scoping out potential plasma collection Programme to improve availability of Immunoglobulin. The Welsh Blood service will work in collaboration with other services from across the United Kingdom so what we are able to achieve sufficient volumes of plasma.

We also continue to work with the Welsh Government to develop this Programme over the next 3-5 years, including agreeing of the annual Welsh demand for plasma-derived Immunoglobulins that Wales would seek to contribute. The work will be delivered through a Wales Programme Board linking to the other UK nations as the work progresses and final agreements on a model are made.

Building our Future Together

In response to the development of our Trust Strategy ('*Destination 2032'*) we have reviewed the structure and ways of working both internally, with our Health Board Partners and the wider health system. The driver being a consideration of the type of organisation we need to be to deliver our purpose and our vision and how we listen and respond to what our own staff and leadership teams have been saying through survey and other engagement mechanisms over the last two years.

To enable us to move forward within the current context, deliver our ambitions and take account of what our people say about working in our Trust we recognise that we need to make changes across our systems in a way that takes account of how people work and interact with each other.

To achieve this we must take a considered and planned approach to effect change across a number of inter-related elements and therefore an organisational design approach will be applied.

Our response has been the development of our *'Building our Future Together'* Programme.

Aims and Objectives

- Ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as its golden thread
- Provide a way of working and shape to the organisation which enables us to maintain focus
- Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future
- Daw together our organisational developments with a common sense of purpose
- Improve our effectiveness, efficiency and value based approach
- Develop the mechanisms which enable us to prioritise where and when we focus our efforts
- Provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition
- Support realistic, authentic and compassionate leadership

These aims will be realised under the following inter-related areas of work.

- Quality as an Organisational Strategy
- Prioritisation & Co-ordination Arrangements
- Values & Culture

- Internal Staff Communication & Staff Engagement
- Governance Risk and Assurance
- Performance Management
- Leadership Development
- Value Based Healthcare
- Quality Framework
- Ways of Working
- Clinical & Scientific Arrangements

Part 5

Our Service Delivery Plans

Our Velindre Cancer Centre and Welsh Blood and Transplant Service delivery plans for 2023 to 2026

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

Our clinical services

Cancer Services Non-Surgical Tertiary Oncology

A key focus for us from 2023/24 – 2025/26 will be the implementation of our enhanced regional clinical model and the successful delivery of our new infrastructure programmes. We want to ensure that, in all areas, we are consistently working in ways which result in the best possible outcomes for our patients. We will do this by continuing to empower our teams to design the best possible processes and pathways and to lead change. The input of our patients, their families and our partners across south-east Wales will be fundamental to this process.

The ambitious programme of change we are taking forward includes major undertakings such as designing a paperless working environment and embedding and optimising the CaNISC replacement Digital Healthcare Record (DHCR) in addition to work to support the new Velindre Cancer Centre (nVCC) development. We are committed to delivering initiatives which will improve the support provided to our patients across the entirety of their care pathways. This will include significant proactive change in service provision in outpatients, SACT, and radiotherapy as well as plans to further develop our active engagement and support to primary care, palliative care and therapies. This list is not exhaustive.

All of this will happen against a background of growing demand for cancer services. In responding to this demand, we have constantly sought to innovate. Changes such as the introduction of virtual consultation methods, the extension of SACT delivery with additional service through the mobile unit with Tenovus, and the expansion of the SACT homecare service are all adaptations which will need to be sustained in the medium term. This will enable us to meet the projected increase in demand and respond to patient care requirements as we work with our health board partners to further our shared ambition for the future of cancer services in south-east Wales.

The leadership and co-ordination of this work through the Velindre Futures initiative continues. In addition, the delivery of the Velindre Cancer Service elements of regional programmes e.g. Acute Oncology Service, the continued delivery of the Nuffield Recommendations and the implementation of our outreach service improvements must align and dovetail with our Velindre Future initiatives and wider service modernisation and transformation projects.

We have also entered the implementation phase of the Integrated Radiotherapy Solution. This constitutes a further key work programme which underpins the ongoing delivery of sustainable radiotherapy services as well as enabling the new Radiotherapy Satellite Centre at Nevill Hall Hospital.

Together these changes form an agenda of unprecedented change for Velindre Cancer Services. They will be delivered alongside the repatriation of services back to Local Heath Boards following the centralised delivery at the Velindre Cancer Centre which was established during the pandemic, as well as growing service capacity to meet the patient demand that has been supressed in the past two years.

The delivery of our plan for 2023/24 – 2025/26 will be done in partnership with our Local Health Board partners. The increased delivery of outreach services for patients across South-east Wales, ahead of our transition to a new Velindre Cancer Centre in Whitchurch Cardiff, is central to our service plan.

Our Priorities for 2023 -2026

The Velindre Cancer Services Strategy '*Shaping our Future Together*' sets out our strategic priorities.

Strategic Priority 1:	**Equitable and consistent care, no matter where; meeting increasing demand.**
Strategic Priority 2:	**Access to state-of-the-art, world-class, evidence-based treatments**
Strategic Priority 3:	**Improving care and support for patients to live well through and beyond cancer**
Strategic Priority 4:	**To be an international leader in research, development, innovation and education**
Strategic Priority 5:	**To work in partnership with stakeholders to improve prevention and early detection of cancer.**

Our five strategic priorities and the key programmes of work that underpin them include a range of projects such as the delivery of the Integrated Radiotherapy Solution, the Radiotherapy Satellite Centre and delivering the nVCC including planning transition to the new site. Wider ongoing service transformation delivered through the Velindre Futures Programme will drive continuous improvement in the quality of service we deliver.

Alongside this work, the sustainable delivery of our services for patients and the provision of sufficient capacity continues to be our primary focus. Our capacity challenge will not only be in the delivery of treatment by SACT and radiotherapy, but also in the other services which support patient care including radiology, therapies, pharmacy and palliative care.

This requires the delivery of outpatient and SACT services at local hospital sites in collaboration with health boards as well as expanding capacity across our full range of services at the cancer centre. This will enable us to plan to meet expected levels of demand and ensure equity of access to our services locally across the region.

Velindre Futures is the vehicle which will deliver the changes we need to realise in order to successfully meet our ambitions including the VCC element of the regional work and the implementation phases of the TCS programme. Established in 2020, Velindre Futures is a clinically led initiative that directs the development of the clinical model and future service configuration, working in partnership and collaboration with staff, patients and carers and the public. It will ensure that the Cancer Centre systems and processes remain fit for purpose and patient centred, now and in the future. It will also enable the VCC aspects of regional collaborative working.

Through 2023 and beyond, the *Velindre Futures* work programme will ensure the delivery of the key recommendations identified alongside the existing service changes planned.

This is an ambitious programme of work that will be prioritised and delivered through 2023/24 – 2025/26 as we continue to focus on increasing capacity to manage demand increases.

Core to service change is ensuring that the voice of the patient, their carers, families and the public are involved in shaping what we do. To enable this, a new framework for engaging with patients and the public will be developed to draw on best practice and set our expectations and ideas **(*see below*).**

Our Clinical Model

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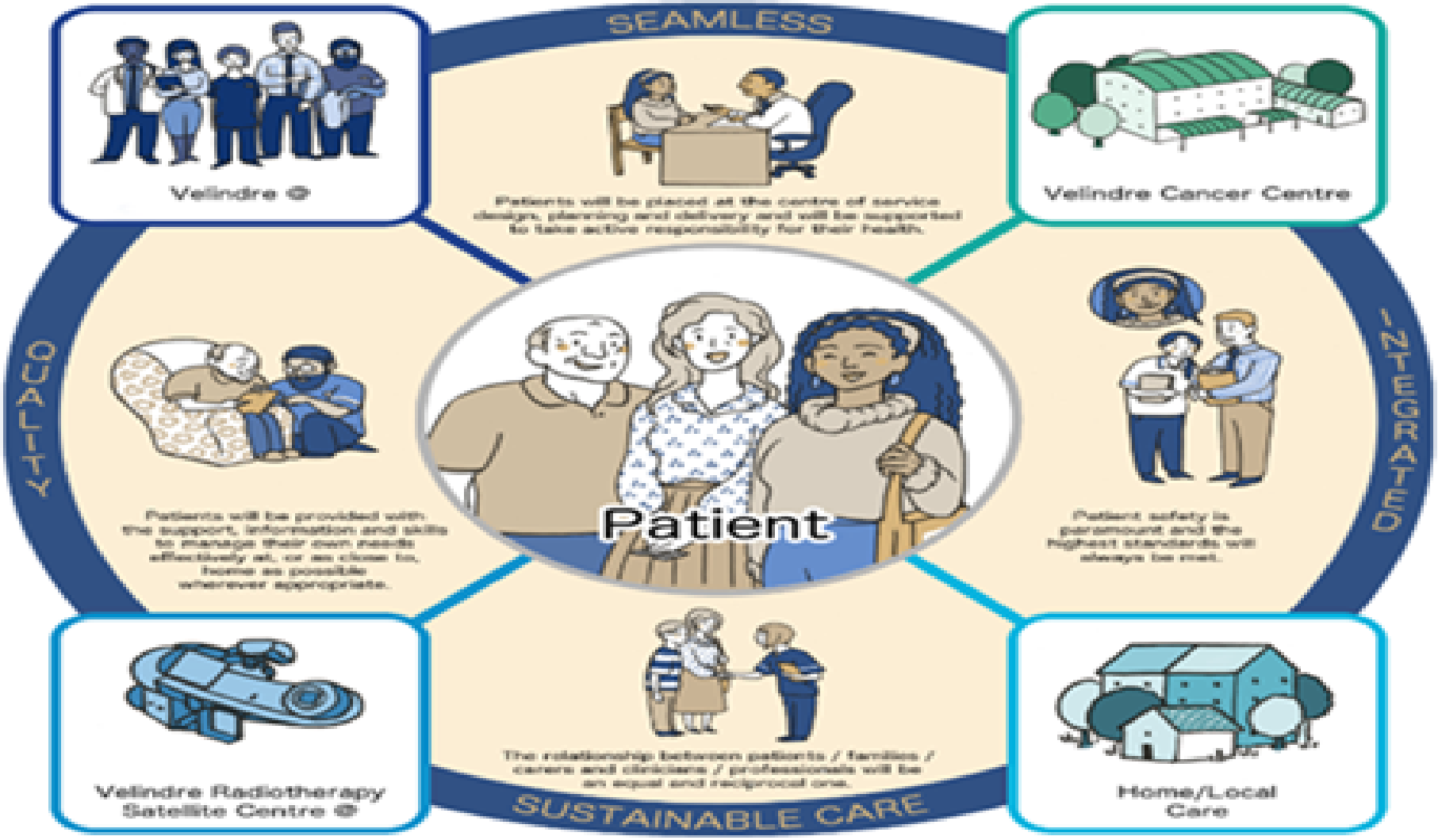

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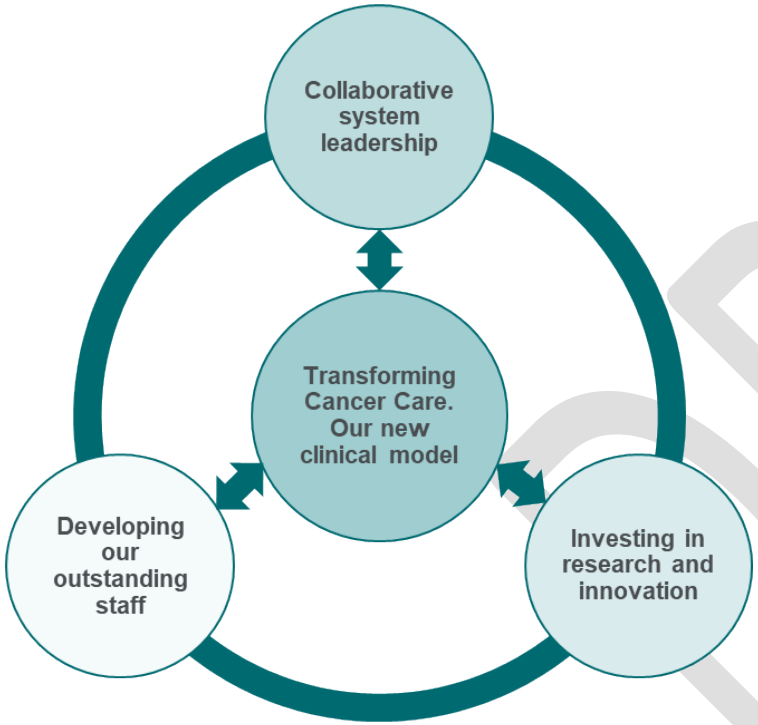
Our Approach



Collaborative System Leadership:

- Play a lead role in the development of a system wide approach to cancer services in the region through the Cancer Collaborative Leadership Group.
- Continue to lead and contribute to key areas of care and research, including through embedding our new clinical model, both nationally and internationally.
- Support the development of the diagnostic network and single cancer pathway as key enablers of service transformation.
- Support the development of integrated health and social care and research models across south Wales/Wales.

Investing in research and innovation:

- Increase participation in clinical trials, Velindre sponsored studies, and become renowned for qualitative research.
- Developing a research network across south-east Wales with our LHB and University partners.
- Lead the research and innovation agenda through taking an active leadership role in partnership with universities, commercial partners and the Research Network.
- Increase our opportunities to be at the forefront of innovation.

Developing our outstanding staff:

- Developing our clinical, scientific, nursing and allied health professional leadership capability
- A consistent approach to quality improvement through the Quality and Safety Framework.
- Developing a comprehensive approach to Education and Training.
- A focus on engaging and empowering staff.
- New workforce skills and leadership development to meet our workforce challenges.

Velindre Cancer Centre: How we will Meet Our Challenges

The Challenge…	We will meet this by…
Cancer Incidence is Increasing	✓ Expanding our role in the early diagnosis of cancer ✓ Promoting effective public health messages – making every contact count
There Continues to be Variation in Outcomes Throughout Wales	✓ Delivering more services of consistent quality in outreach settings closer to patients' homes ✓ Delivering a Radiotherapy satellite centre, in collaboration with Aneurin Bevan University Health Board ✓ Leading on the standardisation of Acute Oncology Services across and the development of a Cancer of the Unknown Primary service across SE Wales
There is a Gap Between Forecast Demand and Supply Which We Need to Close	✓ Continuing to implement techniques which are resource neutral or that deliver efficiencies elsewhere in the process ✓ Developing a robust, flexible, highly skilled and responsive workforce ✓ Rationalising treatment pathways and identifying efficiencies
Treatments are Becoming More Complex and New Advances are Continuously Emerging	✓ Ensuring, in collaboration with health board partners, that sufficient linear accelerator capacity is available to accommodate new techniques ✓ Effective horizon scanning
More People are Living With and Beyond Cancer	✓ Ensuring timely access to robust, high quality Clinical Psychology and Therapies services

Our priorities for 2023/24 – 2025/26
We have identified a range of key deliverables:

Strategic Priority 1: To meet increasing demand

- Reduce patient backlog and waiting times
- Support improved compliance with the Suspected Cancer Pathway
- Implementation of new national Quality Performance Indicators for radiotherapy treatment
- Implementation of quality and safety framework, assurance and reporting tools
- Delivery of clinical audit programme
- Deliver quality improvements in brachytherapy service
- Delivery of quality and safety requirements and Healthcare Associated Infections/Infection Prevention Control Requirements
- Delivery of next phase of Velindre Futures / TCS Programme:
    - Implementation of unscheduled care pathways
    - Implementation of regional acute oncology service model
    - Implementation of V@UHW Research hub
    - Agreement of V@ CTM and AB service model and phased implementation
- Development of sustainable workforce model and agreement for funding with LHB to support transition to improved clinical model and stepped change in capacity

Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments

- Identify and secure additional capacity to deliver radiotherapy and SACT requirements
- Deliver infrastructure phase of TCS Programme:
    - Support the opening of the radiotherapy satellite centre in Nevill Hall
    - Commission 2 new linear accelerators in Velindre Cancer Centre and begin delivering treatments to patients.
    - Identification of V@ outreach requirements in LHB models/facilities

Strategic Priority 3: Improving care and support for patients to live well through and beyond cancer

- Enhance our assessment unit to improve access and support for patients with acute needs
- Increase the range of holistic therapies available to patients during/following their treatment
- Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners
- Patient self-management programmes
- End of life/palliative care

Strategic Priority 4: To be an international leader in research, development, innovation and education

- Implementation of Research and Development strategy

• Implementation of V@UHW Research hub • Progress a range of strategic partnerships to take innovation to market
Strategic Priority 5: To work in partnership with stakeholders to improve prevention and early detection of cancer • Deliver our secondary prevention programme to support patients in improving their health and well-being • Deliver our Macmillan primary care programme to support improved detection and diagnosis of cancer

Forecasting Demand and Capacity to Deliver Services

Demand for cancer services is driven by the need to deliver care for patients newly diagnosed with cancer, but also by the requirement to make available new cycles of treatment to existing patients e.g. patients with metastatic disease who are prescribed further therapy. Demand is also influenced by the availability of new treatment regimens.

Demand for non-surgical cancer services at VCC has been increasing steadily in recent years. Prior to the COVID-19 pandemic, demand for our services was predicted to increase by between 2%-5% every year. This widely accepted forecast was based upon growth in incidence, improved access and increasing treatment complexity.

The demand forecast for 2023/24 and beyond uses this pre-pandemic baseline supplemented with additional data from a major exercise we have led in conjunction with our health board partners, the Wales Cancer Network, Improvement Cymru and the Welsh Government Delivery Unit.

The demand modelling initially focused on historic flows of patients from primary care to diagnosis and on to treatment. This approach was used to develop a predictive model which could forecast external demand driven by new patient referrals. We have used this model to quantify capacity requirements for 2023/24 and beyond. We will continue to use this model to review demand in the future.

The table below provides a summary of the planning assumptions that underpin the capacity and delivery plan for 2023/24

Forecast Growth in Demand for our Services in 2023/24

Service	2023/24
Radiotherapy	6%
Nuclear Medicine	9%
Radiology Imaging	9%
Preparation and Delivery for Systematic Anti-Cancer Therapy	12%
Ambulatory Care Services	6%
Outpatient Services	10%
Inpatient Admitted Care	2%

The forecast increases in demand for 2023/24 requires changes to clinical practice and service delivery. The increased utilisation of virtual outpatient attendances, the mix of oral and IV infusion SACT delivery, the expanded use of hypofractionation in administering radiotherapy treatments to certain patient groups and the delivery of patient care in outreach settings. This work is ongoing alongside activity to identify efficiencies and developments across all treatment pathways.

Systemic Anti-Cancer Therapy (SACT)
Demand for SACT is driven not only by new patient referrals but, by the requirement to offer on-going treatments to patients undergoing subsequent cycles of care. This is increasingly prevalent because there more treatment options, patients are living longer and receiving intermittent SACT regimens and because of the increasing use of 'maintenance' regimens.

There is a direct impact of the increasing demand on SACT which is seen in Out-patients, and on the Ambulatory Support Unit where treatment related toxicities are assessed and managed.

External Beam Radiotherapy
The development and improvement of radiotherapy treatment pathways, to meet revised treatment start targets, will continue. This activity represents a key constituent of the pathway improvement programme included in our plan for 2023/24 – 2025/26.

Outpatient Services
The forecast increase in demand for Outpatient services presents a significant challenge. We have therefore developed plans from 2023/24 – 2025/26 to transform and improve our patient pathways. This will ensure that we have sufficient capacity to meet demand.

Key Programmes of Work 2023 - 2024

The initiatives listed below include a wide range of projects to deliver our ambition, however alongside these there is also an extensive programme of ongoing "business

as usual" replacement of equipment, digital systems upgrades and projects that are ongoing.

Meeting Demand

Sustaining and building capacity in all areas of the service to meet the patient demand and the demand pattern to enable us to consult with and treat people in accordance with the appropriate professional standards for care and time to treatment.

Velindre Futures

- Continue to deliver service change each of the directorate service areas; Medical, SACT and Medicines Management, Radiation Services, Integrated Care, Operational Services including Outpatients.
- Primary Care Oncology – exploring where we can provide additional support for primary care, and working in partnership with Primary Care colleagues to strengthen patient pathways and Care Closer to Home.
- Working to meet the Suspected Cancer Pathway and improved compliance with the new time-to-treatment Quality Performance Indicators in radiotherapy.
- Palliative care – reviewing the service requirements and ongoing service developments aligned with the End of Life Care Board programme, ensuring the ability to meet the internal demand for specialist palliative care services, implementing and embedding Advance Care Planning at the Cancer Centre. For instance, embed electronic Advance and Future Care Planning patient records into healthcare records in patients with palliative care needs.
- Delivery of the pharmacy TrAMS programme.
- Patient support services development including: Strengthening the 24/7 Helpline.
- Increase the range of therapies available to patients during/following their treatment – including pre-hab.
- Outpatient transformation programme – working to modernise the outpatient model of care delivery, including implementing 'supported self-management' for cancer patients with a Values Based Health Care approach (rather than the traditional outpatient model of '*follow up*').
- Disease 'Site Specific Team' (SST) Transformation programme – working with the SSTs and regional partners to ensure that patient pathways are effective, efficient and smooth and that clinical outcomes and patient experience of care is optimised.
- Supporting specific treatment developments identified by SSTs as priorities. These will be delivered through external negotiations e.g. commissioning, and internal programmes of work to tackle gaps in service, access to trials, pathway reviews etc.

Specific Major Projects

- Preparing for a paperless environment – defining the wider project structure and embedding and optimising the Welsh Patient Administration System (WPAS) and the Welsh Clinical Portal (WCP) in all service areas.
- The joint delivery, with Aneurin Bevin University Health Board, of a Radiotherapy Satellite Centre at Nevill Hall Hospital. This includes implementation of the operating model for the Centre and the commissioning of new Radiotherapy equipment.
- The implementation of the Integrated Radiotherapy Solution (IRS). This includes the commissioning of new linear accelerators at the Velindre Cancer Centre (existing and new Centre to open in 2025) and the commissioning of linear accelerators at the Radiotherapy Satellite Centre
- The delivery and transition to a new Velindre Cancer Centre in 2025.

Supporting Projects

- Digital enablement of all Velindre Future Projects.
- Patient Engagement: Establishing the new ways of working to enable delivery of the aspirations in the new patient framework.
- Workforce for the Future: Further modernise our workforce model to ensure we have all staff operating at the top of their licence and make the most of advanced practice and consultant roles.
- Working with HEIW and the Cancer Network to ensure that Velindre has a workforce which is '*fit for the future*' with new roles, succession planning and the upskilling staff through development programmes.

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patients satisfaction dashboard	Review operational model	Review SLAs	Development of a transition and implementation plan to support the move to the Satellite Centre in 2024/25	Complete recruitment to any additional posts identified in workforce plan Develop stakeholder communication plan	Installation of 2 standard linear accelerators and a CT Sim at the existing Satellite Centre Education and training of staff prior to the opening of the Satellite Centre Opening of the Satellite Centre at Nevill Hall Hospital in December 2024	Post-Project evaluation	% Patients beginning radical Radiotherapy within 28 days (Target 98%) % Patients beginning palliative Radiotherapy within 14 days (Target 98%) Patient satisfaction (PREMS) Patient Outcomes (PROMS)
Trust Strategic	**Implementation of Integrated Radiotherapy**	• Improved patient outcomes	Clinical commissioning of first	Realise initial pathway improvements.	Decommissioning and removal of second linear	Installation and commissioning	TPS/OIS readiness for	Phase 3 at nVCC commences	

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
Goals 1, 2, 3, 4 and 5	**Solution Programme by 2026/27**	• Improved quality of care • Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	replacement linear accelerator at the existing VCC First patient treatment (June 2023)	Initiate digital implementation and develop Manage	accelerator. Bunker refurbishment commenced in advance of installation of second replacement linear accelerator.	of second replacement linear accelerator at VCC	cloud confirmed Plans firmed up for nVCC Installation	(subject to construction timelines) Installation of 8 linacs at the nVCC	
Trust Strategic Goals 1 and 2	**Implementation of findings of Clatterbridge peer review within brachytherapy services by Q1 2024/25**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Brachy therapy service improvement group. Identify actions requiring divisional/Trust support.	Optional appraisal to be completed to identify and agree service model required to address capacity gap. Continue to	Business case to be completed (if required) to address additional resource requirement. Continue to	Continue to implement local actions.			% Patients seen within 62 day waiting time as part of their first definitive treatment

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Improved productivity and efficiency levels • Improved patient satisfaction	Gather and review baseline data set for theatre utilisation and determine capacity gap Work with Cardiff and Vale University Health Board to review anaesthetic provision and associated SLA	implement local actions. In conjunction with CAV review processes and flows aligned to Brachy theatre utilisation	implement local actions				
Trust Strategic Goals 1, 2 3 and 4	**Implement Radiology Informatics System (RISP)**	• Improved diagnostics information • Better information sharing and enhanced clinical decision-making • Improved patient outcomes • Improved quality of care	Continue to engage with DHCW facilitated project board		Development of a local implementation plan to support National implementation	Development of a local implementation plan to support National implementation	Scope new equipment and software needs Finalise inputs into National Business Case Confirm Trust	Support system '*go-live*' Post-project evaluation	

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction					arrangements for '*go live*' Design new workflow and processes		
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Reduction in avoidable admissions • Improved patient satisfaction		Complete phase 2 of SDEC programme Develop business case to secure ongoing funding			Embed SDEC models of care		% Reduction in inappropriate inpatient admissions Patient satisfaction (PREMS) Patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Quality Management System (Hub) within Velindre Cancer Services by Q2 2023/24**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Task and Finish group. Agree scope of Quality Management System.	Identify resource within VCC to support delivery of functions of QMS Develop and implement revised governance structure	Fully implement QMS	Establish patient engagement hub	Refine requirements and develop stretch targets to drive improvement .		Number of concerns Number of incidents Number of avoidable falls Number of avoidable pressure ulcers Number Patient satisfaction (PREMS) Patient outcomes (PROMS) Number of clinical audits Number of deaths within 30 days Number of claims

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
Trust Strategic Goals 1 and 2	**Implementation of Cancer Nurse Specialist Review by Q3 2023/24**	• Improved patient outcomes • Improved quality of care • Improved patient safety • Improved patient • Satisfaction • Reduction in avoidable admissions	Identify possible funding requirements and develop business case to support change of service model / finance	Align work to wider scope/review of CNS as part of charity funding expectations	Engage with commissioners on matter of funding of CNS posts	Review and evaluate impact of implementation			% of Patients to have access to a key worker
Trust Strategic Goals 1, 2, 4 and 5	**Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Services**	• Increased service resilience • Increased workforce resilience • Increased levels of efficiency and productivity • Reduced costs • Improved access to medicines in a timely manner	Progress Pilot 3 - BOPA Centralised (Separated) Clinical Verification Process	Clinical and technical elements of Clinical Verification separated Undertake local compounding of materials	Define local financial impact of model. Further review / development of SACT processes to ensure service sustainability	Confirm Pay Tech Service resource that must remain @nVCC	VCC specific actions dependent on nature of agreed national service model	VCC specific actions dependent on nature of agreed national service model	Will align to National quality metrics

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
Trust Strategic Goals 1, 2 and 5	**Expansion of VAPP services by Q4 2023/24**	• Provision of care at home/close to home • Reduced patient needs to travel • Increased patient experience / satisfaction		Develop service model for expansion of service (to include opportunities for service transformation).	Develop workforce plan. Develop financial plan and supporting business case.	Realise service expansion subject to any resource requirement being secured. Evaluation of service change.			% Face-to-face outpatient appointments % Virtual appointments Patient satisfaction (PREMS)
Trust Strategic Goals 1, 2 and 5	**E-prescribing implementation of phases 1 and 2 for E-prescribing for general medicines in line with national timeframes**	• Improved quality • Improved patient safety • Improved information (access to and sharing of) • Improved levels of efficiency and productivity • Reduction in carbon emissions	Establish engagement with ePMA suppliers, arrange demonstrations and identify preferred supplier Map business processes and consider the effects ePMA will have on ways of working	Develop local procurement specification Identify resource required for implementation team Develop business case to support recruitment of implementation team Develop project plan for implementation	Recruit VCC system implementation team	Recruit to VCC System Implementation Team (if staff additional to Pre-implementation Team required)	ePMA system implementation		Will align to National quality metrics

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
Trust Strategic Goals 1, 2, 4 and 5	**Implementation of SACT improvement programme by Q1 2024/25**	• Improved quality • Improved patient safety • Reduced waiting times • Improved levels of efficiency and productivity • Reduced costs • Improved patient experience	Commence implementation of changes in response to findings of capacity reviews in nursing, treatment booking and pharmacy Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs.	Implementation of findings from capacity reviews in nursing and booking NHH interim service model in place Best practice service model in place ready to transition to nVCC	Best practice service model identified and implemented in preparation for transition to nVCC		% Patients Beginning Non-Emergency SACT within 21 days (Target 98%) % Patients Beginning Emergency SACT within 5 days (Target 100%)
Trust Strategic Goals 1 and 2	**Enhance the Velindre Cancer Services SACT telephone helpline to provide 24hr advice, triage service and achieve required standards by Q3 2023/24**	• Improved quality • Improved patient safety • Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Establish working group as part of the Safe Care Collaborative Technical capability to record all telephone calls is in place Digitalise UKONS tool and upload to clinical system	Develop guidelines for audit. Conduct audit process	SACT treatment helpline fully implemented	Respond to audit findings Ensure the SACT triage line is achieving agreed VCC standards in accordance with the VCC Generic Patient Enquiry implementation action plan	Adapt the service as required in response to the National model		Patient satisfaction (PREMS)

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
			Revise guidelines for escalation of calls.						
Trust Strategic Goals 1, 2 and 4	**Implementation of pathway programme to support optimisation of cancer pathway and transition to nVCC by Q4 2024/25 with**	• Improved quality • Improved patient safety • Reduced waiting times • Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Establish governance structure, develop work plan and define timelines (programme to encompass a number of work streams which will include a focus on supporting improved system-wide Suspected Cancer Pathway compliance, improving compliance against new radiotherapy time-to-treatment (previously known as COSC) targets and improved flow and	establish work streams to support the delivery of the pathway programme to include RRTT Develop action plan in response to support work with Improvement Cymru and Toyota to address area for improvement establish project teams to take forward Safe care Collaborative project and ensure clear scope of work Develop and Implement new	Develop supporting business case(s) where required to support new delivery models, identifying funding stream. implementation of pathway improvements where possible review ways of working and identify opportunities for workforce reconfiguration continued engagement in Safe Care Collaborative programme, including review of existing	Develop and implement revised processes / pathways. implementation of service delivery model for Attend Anywhere continued engagement in Safe Care Collaborative Programme identify new ways of working and opportunities for workforce reconfiguration	Implementation of required service changes Evaluation of new models of care		% Elective Radiotherapy Patients treated within 14 and 21 Days (COSC targets 80% and 100%) % Urgent Scheduled Radiotherapy Patients treated within 2 and 7 Days (COSC target 80% and 100%) % Emergency Radiotherapy Patients treated within 1 Day (COSC target 100%)

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
			performance in Outpatients) Identify two tumour sites to commence pathway work. Set up workshop to undertake mapping sessions and agree key processes and treatment specific pathways for focus Identify service improvements / opportunities for change aligned to best practice / national standards Gather and review baseline data sets Establish Task	service and delivery model for Attend Anywhere.	pathways for MSSC and SACT telephone helpline Implementation of services delivery model for Attend Anywhere				Patient outcomes (PROMS) % Face-to-face outpatient appointments % Virtual appointments

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
			and Finish Group to identify service improvement opportunities within outpatients department and medical records/medical secretaries Initiate service improvement projects in conjunction with the Safe Care Collaborative within MSSC pathway and SACT telephone helpline Review lessons learned/benefits from previous Attend Anywhere pilot, identify tumour site group to initiate work,						

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
			secure approval to proceed Establish project group						
Trust Strategic Goals 1, 2 and 5	**Digitisation of Medical Records programme by Q4 2024/25**	• Improved patient safety • Improved access to information (for sharing / decision-making) • Improved levels of efficiency/productivity • Reduced carbon emissions	Establish Project group	Identify service improvements / opportunities for change	Identify additional resource requirements Undertake options appraisal Explore off-site storage options as part of a phased transition	Develop supporting business case(s) Initiate phased delivery of the Project	Full implementation of the digitising Medical Records Programme	Post-project evaluation	Patient outcomes (PROMS)
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of national prehabilitation to rehabilitation deliverables by 2025/26**	• Improved quality • Improved patient safety • Reduction in cancelled treatments • Improved patient health and well-being	Continue engagement with Prehab to Rehab south-east Wales collaborative and WCN national prehabilitation group Establish local	Establish task and finish group to develop prehabilitation website for VCC patients	Introduce prehabilitation (self-management) website for VCC patients Introduce physical activity prehabilitation group sessions.	Introduce virtual physical activity programme Develop local service improvement plan	Advance implementation of plan(s) to support service improvement at VCC	Full Programme implementation Post-programme review	Patient satisfaction (PREMS) Patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Improved clinical outcomes • Improved patient experience	governance structure, develop work plan and define timelines Review funding streams and commissioning models to facilitate prehabilitation service development.						
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025)**	• Improved quality • Improved patient safety • Improved patient dignity and experience • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being	Secure FBC approval from the Welsh Government Secure full planning permission Complete clinical design Ground clearance works	Achieve financial close Ground clearance works	Commence nVCC construction	nVCC construction Revise/refine delivery plans Develop plans to support the transition of services from VCC to the nVCC	nVCC construction Commence implementation of service transition plans Develop plans to support the transition of services from VCC to the nVCC	nVCC construction Implement transition phase nVCC opens (December 2025)	Patient satisfaction (PREMS) Patient outcomes (PROMS) % Staff satisfaction % Staff sickness (Note: a comprehensive list of benefits and KPIs are included

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Reduction in carbon emissions • not more that 5% staff absent through work due to sickness							within the Full Business Case)
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Outreach Programme by 2025/26**	• Increase care close to home • Improved access • Improved equity • Improved patient experience • Reduction in carbon emissions	Project board re-established in conjunction with HBs	Service model developed and agreed in partnership with ABUHB Development of service model in partnership with CTMUHB Development of service model in partnership with CTMUHB	Identify and agree additional workforce requirements and funding streams Development of service model in partnership with CTMUHB Development of service model in partnership with CTMUHB	Service model developed and agreed with both CTMUHB and C&VUHB	Opening of the Cancer Satellite Centre at Nevill Hall Hospital	Opening of other identified Satellite Centres	% of Patients treated by Local Health Boards % of Patients treated at VCC Average patient travel time Patient satisfaction (PREMS) Patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Phase 1 of the regional Acute Oncology Service by 2023/24**	• Improved quality • Improved patient safety • Improved clinical outcomes • Reduction in avoidable admissions • Improved patient experience • Reduction in carbon footprint	Establish an acute care programme board Agree scope and develop a statement of intent	Undertake review of service model at VCC and identification of required next steps	Develop communication strategy Develop AOS framework for VCC and service model	Undertake engagement on service model for nVCC	Identify additional resource required to support delivery Develop business case, if required	Transition to nVCC	% of avoidable inpatient admissions
Trust Strategic Goals 1, 2 and 4	**Implementation of national programme for palliative care and end of life in line with national timeframes**	• Improved quality of care • Reduction in avoidable admissions • Improved patient experience	Review baseline data and outcome from pilot work to date. Identify scope of palliative radiotherapy within VCC and as part of a regional model.	Develop agreed costed model for palliative radiotherapy Identify opportunities for workforce redesign and develop associated workforce plan Identify possible funding options	Collaborate with Cardiff and Vale University Health Board to explore options for regionalised chronic pain service Review and develop agreed costed model for palliative radiotherapy Identify opportunities for workforce	Develop business case to support palliative radiotherapy model if required	Service delivery model agreed, funding identified and secured Service implementation plan developed		Patient satisfaction (PREMS) Patient outcomes (PROMS) % of inappropriate inpatient admissions

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
					redesign and develop associated workforce plan				
Trust Strategic Goals 1, 2, and 4	**Implementation of new services / delivery models by 2025/26.**	• Improved quality • Improved patient safety • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being • Enhanced organisational reputation for quality of service	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service developments Establish working group to develop service model to support delivery of internal mammary lymph node (IMN) radiotherapy for eligible patients with breast cancer	Finalise the priority of implementation of key treatments where external funding is required and agree timescales Determine requirement for additional funding and where appropriate commence business case developments for agreed treatments in phased approach according to priority and timetable agreed	Identify preferred service model and any additional resource requirement. To support delivery of partial breast and axillary radiotherapy for eligible patients with breast cancer Develop strategy and service model to support adoption of motion management	Identify additional resource required to implement partial breast and axillary radiotherapy and develop business case for consideration by commissioners Expand SRS service to support the routine treatment of patients with more than 3 metastases Identify additional resource required to	Develop service model to support implementation of Lutetium PSMA service following NICE appraisal Develop business case to support implementation of Lutetium PSMA service Train Medical Physics Expert to		Patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
			Continue to engage with WHSSC service appraisal process in relation to proposed PRRT service Develop service model to support implementation of PRRT service for eligible patients with neuroendocrine tumours Identify additional resource required to expand HDR brachytherapy boost treatments for eligible patients with prostate cancer. Develop business case	Identify additional resource required to implement IMN and develop business case if required for consideration by commissioners. Develop service models to support delivery of extreme hypofractionated radiotherapy for eligible patients with prostate cancer if required Identify additional resource required to implement extreme hypofractionated radiotherapy for eligible patients with prostate cancer and		support the expansion of the SRS service and develop business case, if required	support implementation of Lutetium PSMA service Train Medical Physics Expert to support implementation of HDR brachytherapy boost service Develop plan for implementation of expanded HDR brachytherapy boost service		

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
			for WHSSC to support expansion of HDR brachytherapy boost service Develop service model and associated pathways to support delivery of new indications for Stereotactic Ablative Radiotherapy (SABR)	develop business case for consideration by commissioners Develop business case to support implementation of PRRT service to WHSSC and funding stream for additional revenue resource if required Train Medical Physics Expert to support implementation of PRRT service					
Trust Strategic Goals 1, 2 and 5	**Implement DHCR phase 2 by 2024/25**		Review learning from phase 1 to support implementation of further phases continue implementation of training plan	Review learning from phase 1 Establish revised governance structure	Clarify scope and service delivery requirements	Develop work plan to support implementation.			

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
			Identify super users/champions for each service group to continue to support implementation Establish revised governance, reporting and delivery structure for VCC agreed scope and prioritisation of phase 1b (VCC specific) agree scope and prioritisation of phase 2						
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Centre for Collaborative Learning and Innovation by Q4 2024/25**	• Creation and sharing of knowledge across Wales/wider to improved cancer care • Development of network of partners to	Workshop to be held to scope CFCL and ways of working Review opportunities for CfCL to support the establishment and delivery of a	Workshop to be held to scope CfCL and ways of working	Review potential projects aligned to CfCL, e.g. school for oncology, ARC, etc.	Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate			Patient outcomes (PROMS) % Utilisation of Facility Number of attendees ton education

IMTP Strategic Priorities Velindre Cancer Services 2023 to 2026									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2023/26 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		tackle key issues • Creation of knowledge economy and innovation across Wales • Physical space to support innovation and development working across the region/Wales/wider	primary care education and development programme to facilitate improved engagement and pathway delivery between and with primary and community care and Velindre			improved engagement and pathway delivery between and with primary and community care and Velindre			and training Programmes

Blood and Transplant Services

The Welsh Blood Service (WBS) is an operating division of Velindre University NHS Trust collecting voluntary, non-remunerated whole blood and blood component donations from the general public and providing advice and guidance regarding appropriate blood component use in Health Boards throughout Wales. Donations are processed and tested at the laboratories based in WBS headquarters in Talbot Green, Llantrisant, before distribution to 20 customer hospitals throughout Wales. We have a Stock Holding Unit (SHU) and staff base in Wrexham, north Wales and also have staff based in Bangor, north Wales and Dafen, west Wales. The WBS laboratory services also include antenatal patient testing and a reference centre for complex immunohaematology investigations.

WBS supports the solid organ and stem cell transplant programmes that run out of Cardiff and Vale University Health Board and manages the Welsh Bone Marrow Donor Registry, which provides haematopoietic stem cell products nationally and internationally and provides the UK National External Quality Assurance Scheme for Histocompatibility and Immuno-genetics (NEQAS) an international quality assessment service.

In addition, we hold a wholesaling dealers licence to supply medicinal products to our customer hospitals. Between December 2020 and January 2023 the Welsh Blood Service distributed frozen COVID-19 vaccines to Health Boards, GPs and Pharmacies across Wales.

The service models are supported by strong Research, Development and Innovation (R, D and I) derived from within WBS and working closely with other Blood Services across the home nations and globally. Investing our time in supporting and facilitating R, D and I is fundamental in ensuring we remain a leading service within the fields of blood component, transplant and transfusion services.

We are committed to ensuring the services we provide meet the high expectations required by patients, donors, staff and partner organisations across health, academia and industry. Our services must be high quality, clinically safe, effective and underpinned by a strong evidence-base.

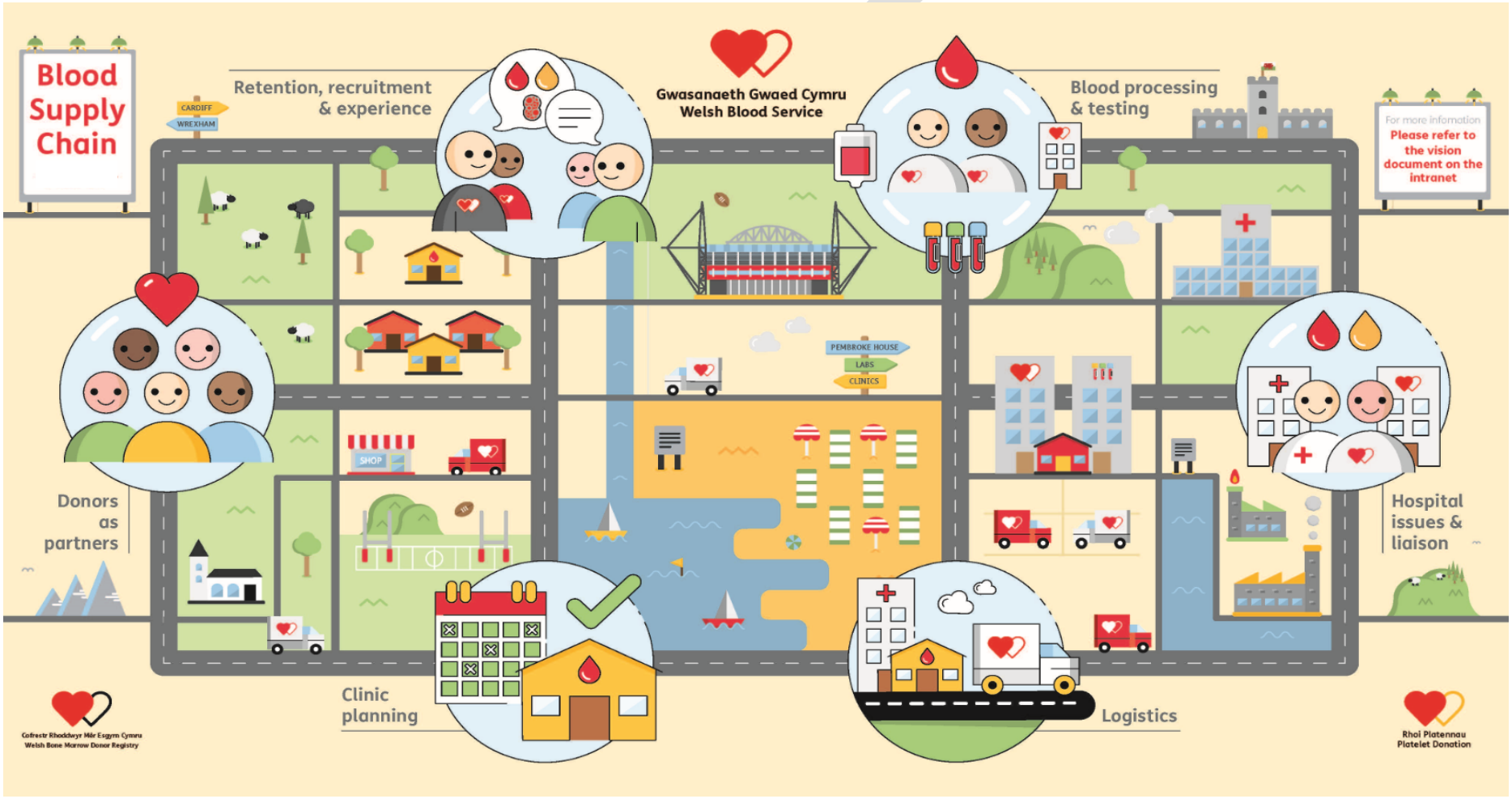
Strong clinical and scientific leadership and governance helps to ensure that the quality of our service remains at the forefront of our decision-making. This assurance is maintained through our commitment to ensuring the services we provide meet the high standards of our regulators and auditors, such as the Medicines and Healthcare Regulatory Agency (MHRA), Human Tissue Authority (HTA), UK Accreditation Services (UKAS) and the Health and Safety Executive (HSE).

The delivery of our blood, transfusion and transplantation services requires working in partnership and collaboration with colleagues within our corporate and support functions:

- Digital support is fundamental to the provision of modern services that minimise unnecessary work, maximise efficiency and support clinical safety.
- Data from our Business Intelligence Service is used to support planning of our service delivery and development and provide a means of monitoring performance and measuring our success.
- Strong corporate governance and project structures, provided by our Innovation and Improvement Hub and business support team, are important in ensuring the successful delivery and continuous improvement.
- Maintaining a safe, sustainable and efficient estates infrastructure from which to run our services and look after our staff, is an essential requirement of WBS and is managed in partnership between our corporate estates team and local facilities team.
- Working with our People and Organisational Development team helps ensure that the well-being of our staff remains an important part of service.
- Strong financial and procurement support helps to ensure services are delivered within our agreed financial envelope and we meet our Standing Financial Instructions (SFIs) obligations.

Our clinical model for the blood supply chain is illustrated below**.**

Our Clinical Model for Blood Supply Chain



Our Strategic Priorities

Strategic Priority 1:	**Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve**
Strategic Priority 2:	**To provide a world class donor experience**
Strategic Priority 3:	**Drive the prudent use of blood across Wales**
Strategic Priority 4:	**Quality, safety and value: doing it right, first time**
Strategic Priority 5:	**Achieving excellence in research, development and innovation to improve outcomes for our patients and donors**
Strategic Priority 6:	**Sustainable services that deliver the greatest value to our communities**
Strategic Priority 7:	**Develop great people and a great place to work**

Forecasting Demand for Blood Components

Meeting Demand - Planning assumptions
The following assumptions have been made when forecasting the demand for blood components:

- COVID-19 infection prevention and control (IPC) measures continue to be reviewed in accordance with Public Health Wales guidance and currently consist of face coverings when >1 metre physical distance cannot be maintained.
- We expect demand for 2023/24 to remain in line with 2022/23. However, we know from our analysis that there is natural variation in relation to demand; therefore, our collection model builds in sufficient capacity to account for this. In parallel, we will continue to review on a fortnightly basis and will adjust where required for the upcoming quarter.

Figures are subject to external changes which may have a significant impact on blood component usage by hospitals (our customers) throughout the year.

We will continue to monitor actual issuing against forecasted issuing throughout the year and will adjust the planned whole blood and apheresis platelet collection and the corresponding product manufacturing accordingly, to meet demand.

The Blood Health Team will continue to work with hospitals on appropriate and prudent blood component use and minimise hospital waste.

Meeting Demand for Red Blood Cells
The Clinic Planning department will aim to schedule donation clinics to collect enough whole blood to meet the estimated demand during the year, flexing the collection plan in accordance with changes to demand.

Based upon our planning assumptions, we have modelled how much whole blood we will need to collect from our donors compared to red blood cell issuing to Health Boards, in order to support safe and effective patient care. There is always a challenge in the interpretation of Health Board activity planning and impact on red blood cell demand due to the myriad of factors that influence usage.

Meeting demand for Platelets
Based upon our planning assumptions, we have modelled how many platelets we expect to manufacture, both from whole blood and apheresis, compared to issuing to Health Boards, in order to support safe and effective patient care.

Platelet demand will be met through a combination of apheresis derived and the pooling of whole blood platelets. The amount of whole blood required for pooled platelets is accounted for in the above assumptions and is complimented by the production of platelets from apheresis.

We will flex our production of pooled platelets appropriately to ensure supply chain integrity. However, it is important to note that platelet demand can be volatile due to the nature of the component, the short shelf life (7 days), the blood group complexities and the requirement for special bleeds, as well as the two different manufacturing methods (apheresis and pooled), which in turn can lead to higher wastage levels.

Based upon the above assumptions the plan for 2023/2024 will ensure that we meet demand for all blood components.

Key Programmes of Work during 2023 - 2024

Programme	Deliverable
Talbot Green Infrastructure	Develop and implement an energy efficient, sustainable, estate at Talbot Green site that will facilitate a future service delivery model.

Digital Transformation	Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS). Implement improved donor interaction functionality.
Laboratory Services Modernisation	Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS including: Develop and implement a platelet strategy. Implementation of Foetal DNA typing.
Plasma for Medicines	Work with Welsh Government on developing and introducing a Plasma for Medicines service model for Wales.
Occult Hepatitis B Infection in UK Blood Donors	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.
Pre-Operative Anaemia Pathway (Value-based health care model)	Implementation of the Pre-Operative Anaemia Pathway programme.
Collections Modernisation Programme	Establish a collections modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service including: Develop and implement donor strategy. • Revised blood collection clinic portfolio. • Introduce clinically led collection team model.
Service Development and Regulation	Develop and implement strategy for sustained growth and retention of stem cell donor panel. Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology.
Safe Care Collaborative	Donor Adverse Event Reporting Project Haemochromatosis Patients Project
Workforce	Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning.

Contingency Planning

Work is ongoing through the Blood Health Team and Collections Team to align the collection profile with demand for specific blood groups. We are continuing to work closely with the hospital blood banks and service leads for blood transfusion to understand and help manage appropriate demand and meet the required capacity. In further support of effective stock use, the Blood Health National Oversight Group is continuing to provide leadership across Wales.

For business continuity purposes, and if required, we can call on mutual aid support with the other UK Blood Services or in extreme circumstances would instigate the National Blood Shortage Plan which provides a structured approach to addressing the shortfall in supply.

Welsh Blood Service Plan 2023 – 2026

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2023 to 2026									
Strategic Priorities 2023/24 – 2025/26	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2023 - 2026 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2032 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2025/26.	• Personalised donor experience • Wider communication choice for donors • Increased donor retention • Improved information (for sharing/decision -making) • Increased levels of efficiency/ productivity	Prepare donor data recovery map for incorrect donor details.	Begin implementation of donor data recovery plan.	Finalise implementation of donor data recovery plan. Re-platform appointment system portal for booking blood donations.	Scope requirements of integrated communication platform.	Explore and develop bespoke donor journeys to maximise opportunities for whole blood and stem cell collection. Procure / implement integrated communicatio n platform.	Scope processes required to targeted specific donors in line with meeting service needs. Ongoing development of integrated communicati on platform, maintenance and support.	% Donor Satisfacti on (Target 95%)
	Develop and implement strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow	• Increased stem cell donor panel • Increase in stem cells supply • Improved resilience in	Develop strategy. Engagement with key stakeholders.	Formal sign off of strategy. Communication plan developed and approved.	Launch and implement strategy.	Post implementation review.	Post implementatio n review Continue to evolve operational strategy and	Continue to evolve operational strategy and monitor progress.	Number of stem cell collection s

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2023 to 2026									
Strategic Priorities 2023/24 – 2025/26	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2023 - 2026 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
	Donor Registry) by 2023/24.	stem cell supplies • Improved clinical outcomes in Wales/globally • Increased income levels		Develop implementation plan.			monitor progress.		(Annual Target 80per annum)
SP2: To provide a world class donor experience **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Implement our new donor strategy by 2025/26.	• Right size/shape donor panel • Increased resilience for supply of blood/products across Wales • Improved levels of efficiency/productivity Reduced importation and costs • Increased brand awareness and reach	Sign off strategy.	Review existing systems and processes in line with strategy.	Identify opportunities for further improvement.	Commence implementation. Review and Identify opportunities. Review current establishment.	Continue implementation.	Fully implement new strategy. Post implementation review. Refresh donor strategy if required.	% Red Blood Cell Demand Met for Hospitals (Target 100%)

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2023 to 2026									
Strategic Priorities 2023/24 – 2025/26	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2023 - 2026 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Wider population/donor education • Development of rich data to improved insights and focus efforts in right areas							
SP3: Drive the prudent use of blood across Wales **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)**	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25.	• Improved clinical outcomes for patients post operatively • Reduced length of stay post-surgery • Prudent use of (reduced demand for blood). • Increased equity of care and outcomes • Reduction in clinical complications associated with receiving	Advertise and recruit Anaemia Team Review baseline Digital Health Care Wales (DHCW) data.	Develop bespoke health board anaemia plan with key stakeholders.	Develop bespoke health board anaemia plan with key stakeholders.	Implement relevant plan as agreed. Recruit health board nurses to manage anaemia clinics.	Scope out other patient groups for anaemia management.		

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2023 to 2026									
Strategic Priorities 2023/24 – 2025/26	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2023 - 2026 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		blood products. • Compliance with the NICE guidance. • Improved efficiency • Cost efficiencies.							
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)**	Revised blood collection clinic portfolio by 2024/25.	• Increased /Sustainable collection model • Improved access for service users • Improved collection efficiency • Reduction in costs. • Improved access to donors for recruitment to the Welsh Bone Marrow Donor Registry	Continue reintroduction of Mobile Donation Collections.	Introduce 'tours' to remote areas of North West Wales.	Establish project group to progress identified fixed site options.	Continue to progress fixed site model.	Implement fixed site model.	Post implementation review.	

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2023 to 2026									
Strategic Priorities 2023/24 – 2025/26	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2023 - 2026 Timescales**						**Primary KPIs**
			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
	Introduce clinically led collection team model by 2023/24.	• Improved leadership capability. • Standardisation of terms and conditions across collection teams. • Improved quality • Improved safety • Reduction in staff turnover. • Improved collection efficiency.	Continue phased implementation of OCP (2019) outcomes. Complete new job descriptions.	Continue phased implementation of OCP (2019) outcomes. Complete review of existing service model.	Complete implementation of OCP (2019) outcomes. Develop workforce plan. Provide and promote leadership learning opportunities.	Prepare OCP 2 process in relation to clinically led service model. Complete OCP 2 consultation. Implement new clinically led collection team model.	Post implementation review.		Whole Blood Collection Efficiency per Full Time Staff (Target 1.25 units)
	Develop and implement a platelet strategy by 2024/25.	• Improved levels of efficiency • Improved alignment between capacity and demand	Establish a platelet strategy group under the Laboratory Modernisation Programme to coordinate the work.	Planning tool developed and in routine use. Review the clinic collection pan for Apheresis to ensure the clinic	Clinical and Scientific roadmap established to predict future trends e.g. cold platelets.	Continue development of the platelet strategy.	Revised strategy implemented. Component Development priorities aligned to this strategy.	Post implementation review.	% Platelet Supply meeting Demand to Hospitals (Target 100%)

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			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Reduction in avoidable waste • Reduce wastage.	Complete development of platelet planning tool.	times are optimised.	Begin development of platelet strategy.				
	Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.	• Improved availability of information • Increased efficiency /productivity through Improved patient experience • Reduced turnaround times. • Reduction in avoidable waste	Secure funding from Welsh Government.	Commence procurement process.	Complete procurement process.	Develop implementation plan.	Begin Implementation.	Continue implementation (fully implemented in 2026/27).	
	Procure new Blood Establishment Computer System (BECS) contract.	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	Commence Supplier engagement for new BECS contract.	Supplier Engagement.	Contract award.	Confirm supplier & commence implementation	Complete implementation.	BAU maintenance & support.	

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			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25.	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales • Compliance with SaBTO recommendations.	Implemented testing strategy in 2022/23. Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Implement revised strategy as required.	N/A	
	Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory	• Maintain compliance with regulatory standards • Improved quality • Improved safety • Improved donor experience.	Complete reconfiguration of the Regulatory Assurance and Governance Group to create the Divisional Quality Hub.	Validation and deployment of eQMS. Review document hierarchy structure. Adapt change management process to support	6 month review of Quality Hub delivery. Implementation of eQMS. Review amended Change Management process	Review pilot of electronic signatures and implement learnings. Review eQMS Implementation and functionality.	N/A	N/A	Numbers of critical non-conformances through external audits or inspection (Target - NIL)

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			Q1	**Q2**	**Q3**	**Q4**			
	compliance and maximises digital technology by 2023/24.		Launch the pilot of electronic signatures. Commence formal procurement of an electronic quality Management system (eQMS). Review feedback from Change Management workshops and update processes	Continuous Improvement culture.					
	Implementation of Foetal DNA typing by 2023/24.	• reduction in avoidable administration of anti-D immunoglobulin to pregnant women • Improved safety	Procure commercial kit	Undertake digital developments to support new test. Validate test.	Complete validation and implementation of new test.	Implement all-Wales service for cell free foetal DNA testing.	Embed service.	Scope expansion of foetal DNA typing service.	% Antenatal -D & -C quantitation results provided within 5 working days

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			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Improved patient experience • Reduction in avoidable waste/costs							(Target 90%)
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales.	• Secures the supply chain for Immunoglobulins in Wales • Reduces need for importation • Cost avoidance/reduction • Avoids patient rationing.	Develop project plan for supply of recovered plasma for fractionation (estimated start date April 2025). Develop high level business case for investment to support the plasma programme.	Renegotiate/renew supply contracts for diagnostic plasma to align with fractionation plan and maximise income. Develop detailed business case for plasma programme (subject to WG policy decision).	Commence validation of leucocyte filtration (NQT) blood packs. Commence validation of Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG pathway and governance arrangements are clear. Consider options for BC preparation for Welsh Government for source and recovered plasma.	Commence stock building of frozen recovered plasma from Q3. Source Plasma TBC depending on policy decision and BC support.	Commence supply of frozen recovered plasma for fractionation from Q1. Receipt of first fractionated products from Q3 Source Plasma TBC depending on policy decision and BC support.	

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			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
SP6 Sustainable services that deliver the greatest value to our communities **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2 and 5)**	Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model	• Improved donor satisfaction • Improved staff well-being • Increased service resilience • Reduction in energy consumption and utilisation • Reduction in carbon emissions • Compliance with statutory requirements • Improved efficiency, reduction in waste and carbon emissions.	Refresh of Programme Business Case (PBC). Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation.	Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation (following outcome of Feasibility Study).	Internal scrutiny of Outline Business Case (OBC).	Submission to Welsh Government.	Develop Full Business Case (FBC).	Construction commences - three year programme.	
SP7 Develop great people and a great place to work	Develop a sustainable workforce model which provides leadership, resilience and	• Enhanced workforce capacity & capability to meet need	Consult on new SMT workforce model and recruit to roles where there are	Permanently recruit to remaining SMT roles where there are currently only	Permanently recruit to remaining SMT roles where there are currently only	Review of newly implemented SLT workforce model.	Phased implementation of new Clinical Services	Continue phased implementation of new workforce models and	

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2023 to 2026									
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			2023/24				**2024/25**	**2025/26**	
			Q1	**Q2**	**Q3**	**Q4**			
(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)	succession planning by 2025/26.	• Enhanced Leadership capacity & capability • Improved staff satisfaction • Improved staff well-being • Improved service quality, safety and donor satisfaction.	substantive job holders.	seconded post holders. Scope out new WBS workforce model for Clinical Services. Laboratory Services Modernisation Programme determine requirements for future workforce in Laboratory Services.	seconded post holders. Plan and deliver training / team development sessions with new SLT. Phased implementation of new (Clinical Services workforce model. Scope out new WBS workforce model for Laboratory Services.	Phased implementation of new Clinical Services workforce model. Phased implementation of new Laboratory Services workforce model.	workforce model. Phased implementation of new Laboratory Services workforce model.	review of workforce models fully in place.	

Part 6

Our Trust-wide Support Functions

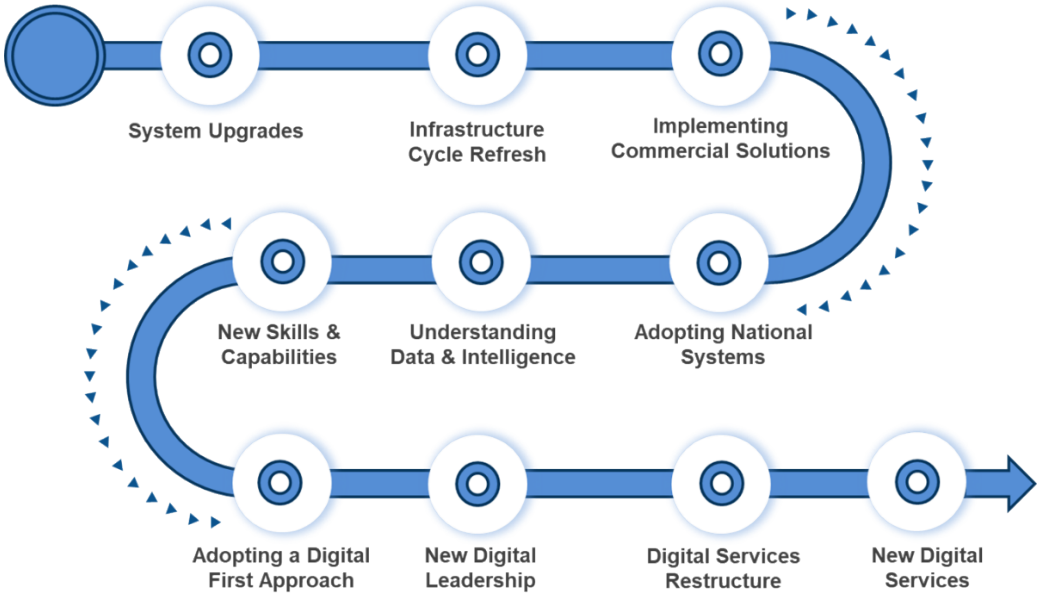
We set out how our Trust-wide enabling functions support the delivery of our Plan.

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

Digital Services

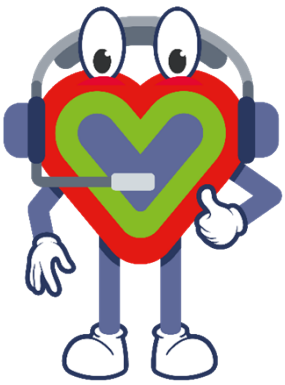
Our Journey So Far

We have a proud history of significant developments in digital services which have made a difference to the quality, safety and experience for the users of the services we provide.



These achievements over the last 5 years have put strong foundations, skills and capabilities in place to support the next stage of digital transformation across the Trust.

Our Plan for 2023 – 2026 and Beyond

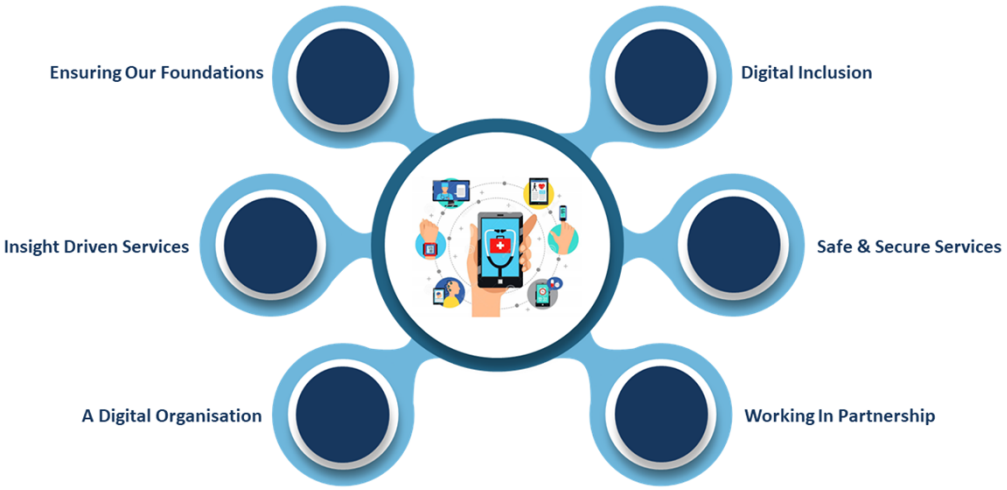


These are exciting times when you consider the opportunities ahead for Blood and Cancer Services in Wales. By taking full advantage of digital to support our transformation we have an opportunity to accelerate progress toward our ambitious long-term strategic goals.

One of the most important components of our future success will be how well we embrace the challenge of digital. Our refreshed ten year Digital Strategy describes our approach to digital in response to the Trust purpose to *'Improve Lives'"*, and its vision to deliver *'Excellent Care, Inspirational Learning, Healthier People'*.

Our Digital Vision: To Ensure Patient, Donor and Staff Experience of Digital Services is the same as our Care…… Outstanding

To deliver our vision, we have set out a number of themes which will support us in delivering a connected, people focused, personalised and sustainable future.



Theme 1: Ensuring our Foundations
We will empower our staff to have access to the high quality information, equipment and technology they require 24 hours a day, 7 days a week to deliver high quality and safe services.

Theme 2: Digital Inclusion
We will support people to become more digitally confident, included and connected.

Theme 3: Insight Driven
We will optimise the use of data and knowledge to help us make informed and insight driven decisions within the organisation and in collaboration with partners across organisational boundaries.

Theme 4: Safe and Secure Systems
We will secure our data and information through an effective approach to cyber security, working in collaboration with the Cyber Resilience Unit and the National Cyber Security Centre.

Theme 5: A Digital Organisation
We will work with patients, donors, staff and partners to create a service culture that embraces the use of digital technology to get the best quality services from it.

Theme 6: Working in Partnership
We will work to build a network of partners and capabilities which enable us to maximise the benefits from research, development and innovation and become an exemplar within NHS Wales for digital innovation and services.

Our Digital Objectives

Our objectives are to:

- Provide resilient digital services which support excellent care
- Seamlessly digitally connect patients, donors, staff and partners with our services and equally value non-digital channels
- Become a data driven, insight led organisation where staff take care of and have the right information, at the right time, all of the time
- Secure our data, information and services through an effective approach to Cyber Security
- Create a digital culture across the Trust of innovation and knowledge sharing that supports the delivery of world class services

We will achieve these by:

- Implementing our digital strategy
- Constantly evolving our IT infrastructure and Cyber Security arrangements to meet good practice with a hybrid of cloud and on premise deployment
- Implementing a digital transformation programme to drive benefits and create digital services that our patients, donors and staff value and can be accessed close to home
- Increasing the speed of development, deployment and functioning of new technologies to increase our productivity
- Working in partnership to implement a range of national systems, to support a once for Wales approach
- Working with the public and Centre for Digital Public Services and Digital Communities Wales to champion and accelerate digital inclusion
- Developing our partnership role with the Digital Intensive Learning Academy and Health Education and Improvement Wales to increase the digital literacy, skills and knowledge of our staff
- Identifying opportunities to join digital accelerator programmes and initiatives
    - Improve the quality of our data by driving data standards; identifying data champions; and improving data sharing protocols
- Transforming our information capability to provide data, information and knowledge to the right person at the right time and introduce new analytical capabilities
- Building digital partnerships with partner organisations, academia and digital providers to create value in health, wealth and well-being

The Difference this will make to our Donors, Patients, Staff and our Partners

Digital technology and services provide the opportunity to make a real shift in the relationship between health and care professionals, the people they serve, and the healthcare services we provide. Designing services in partnership with patients and donors will allow us to re-imagine services and provide a more personal experience; enabled by digital technology.

Our Welsh Blood Service Donors will be able to:

- Manage their donation appointments on the move
- View their donation history and track how it has been used
- Update their personal details when circumstances change
- Identify donation sessions close to their current location
- Identify other public services which they may find useful
- View the difference that their donation is making

Our Velindre Cancer Patients will be able to:

- Access information about their health
- Make more informed decisions over what they need from the services we provide
- Have more choice about where and how they access services
- Identify other public services which they may find useful

Our Staff and other Healthcare Partners will be able to:

- Work in more efficient ways so that they can focus on their most important tasks
- Connect digitally with their team, organisation and other health partners
- Work flexibility in terms of how and where they work
- Access the right information at the right time
- Share information across our regional partners to improve care

Workforce and Organisational Development

Velindre is committed to being an employer of choice, offering an excellent working and development environment, with staff dedicated to providing outstanding care every time for our patient and donors and recognising that the key quality and strategic objectives can only be achieved through a combination of a well led, engaged and efficient people. We strive to behave in line with our values which we are always continuing to review.

The Trust is dedicated to providing opportunities for staff to engage and develop. It strives to provide opportunities for staff to learn and has strong relationships with academia through the Trust Academic Board. There is a range of health and wellbeing

initiatives that are being made available to staff across our sites and on-line health and wellbeing resources that can be accessed at any time.

Models of care and service delivery need however to be constantly replaced and updated to support a changing NHS landscape and to meet the requirements of NHS Wales's service delivery strategy. Velindre University NHS Trust is modernising in response to new healthcare options, the national Workforce Strategy, changing social expectation and expectations of patients and donors, rapid advances in technology and economic pressures. Additionally, the expectation that people have of their working lives and career pathways are evolving. The development of our people is key to transformation.

Our Plan for 2023 – 2026 and Beyond

Our people and the needs of our patients and donors are changing and so is the way in which we deliver care. Shortages of clinical staff nationally, an ageing workforce and changes to education pathways means that are workforce profile is evolving.

As a Trust we value our staff and recognise that they are a key priority to the successful delivery of high quality services. Or aims, therefore, are to continue to develop our workforce by:

- Supporting career pathways
- Developing the leadership skills of our staff
- Providing our staff with the knowledge and skills that they need now and in the future
- Supporting the well-being of our staff
- Recognising and valuing the diversity of our staff as part of a bi-lingual culture

Our strategic ambitions build upon our strong foundation as a good employer and is essential to the delivery of our service plans for VCC and WBS.

Our Workforce Vision: To Become an Employer of Choice

Skilled and Developed People: an employer of choice for staff already employed by us, starting their career in the NHS or looking for a role that will fulfil their professional ambitions and meet their personal aspirations.

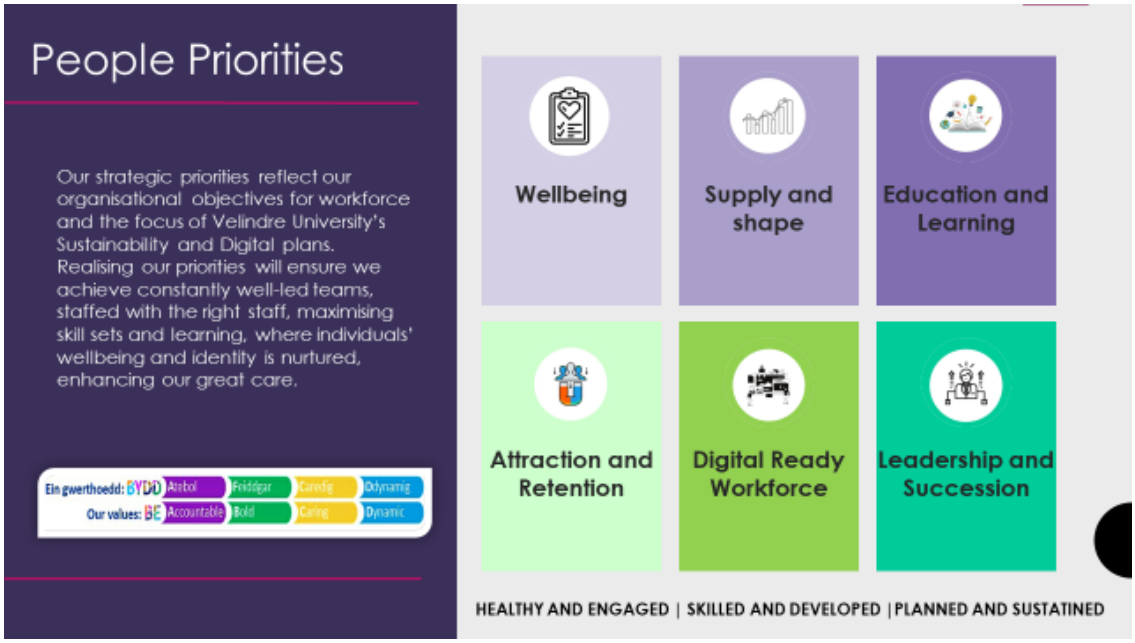
Planned and Sustained People: having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing.

Healthy and Engaged People: within a culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and cultural identity.

Our workforce plan will help ensure that we can continue to deliver world class services for our donors, patients and carers. This will only be possible if we have the right workforce in the right place with the right sills at the right time.

Our Workforce Response

To deliver our vision we have set out a number of themes which will support us in attracting, developing and retaining a workforce fit-for-now and fit-for-the future.



Theme 1: Wellbeing and Engagement
We will ensure our staff feel valued and supported

Theme 2: Supply and Shape
We will have the right people with the right skills in the right place at the right time

Theme 3: Skilled and Developed People
We will continually develop our staff to support them to achieve excellence in everything they do

Theme 4: Leadership and Succession Planning
We will develop compassionate leaders and managers which sustain our future requirements

Theme 5: Digital Ready People
We will create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology

Theme 6: Attracting and Retaining the Best Talent
We will seek to identify the best talent locally and across the globe to work in our organisation.

Delivering our Workforce Objectives – We will achieve these by:

- Implementing a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement.
- Implementing our education strategy to support staff to grow professionally and offer internal and external pathways to gain experience and knowledge
- Developing our talent management process that supports career pathways so staff have
- Developing our data, information and insight to support the embedding our workforce planning process to support new ways of working for our staff
- Implementing an agile approach to working
- Targeting an increase in bi-lingual recruitment to grow our Welsh speaking workforce
- Improve the way we celebrate success ensuring our staff feel highly valued for the amazing work they do
- Grow the Trust Inspire Leadership and Management Programme
- Working with partnerships both in academia and nationally to ensure the best leadership and management offers are provided for staff including coaching, mentoring and provision of masterclasses

With the successful implementation of the core themes we will be able to facilitate the transition of its people across all of our key deliverable areas. This will help us create and sustain a Health and Engaged, Skilled and Developed and a Planned and Sustained Workforce.

Our Key Workforce Changes

- Clinical agreed short and long-term MDT workforce plans
- Improved alignment of our education and training functions to the needs of our services
- Services delivered at a location and time which best suits our patients and donors
- All staff to be proud to, and able to, promote our core values and principles
- Improved health and well-being of our workforce.

Our Estates Plan

Our Estate

Headquarters:

The headquarters building, located in Nantgarw, Cardiff, houses the executive and corporate function of the organisation.

Cancer Services

We deliver these services from a number of locations.

Velindre Cancer Centre:
The Velindre Cancer Centre is based in Cardiff. The Centre was constructed in 1966 and has been subject to various extensions through each decade since opening. The hospital occupies a footprint of approximately 16,000m2.

Velindre@ facilities:
We provide services across South East Wales from buildings and facilities across our partner Health Board sites.

Blood and Transplantation Services

We have access to a number of locations.

Talbot Green, Llantrisant:
Constructed in 2003/4 and was extended in 2017-2019 to provide a Clinical Services and Hospital Lab Area. The building occupies a footprint of approximately 7,000m2.

Dafen:
Situated in Llanelli and is the primary base for our collection teams in West Wales. The building occupies a footprint of approximately 400m2, and houses all consumables required to support collections.

Bangor:
This is the primary base for our collection teams in North Wales. The building occupies a footprint of approximately 500m2, and houses all consumables required to support collections.

Wrexham (Pembroke House):
Pembroke House occupies a floor area of approximately 500m2. The main purpose of this building is to act as a stock holding unit providing north wales hospitals with blood products together with the main base of operations for the collections team in the North-east region of Wales.

Our Plan for 2023 – 2026 and Beyond

The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in. The estate is an important component of our future success and it is vital that we embrace the opportunities that the estate, sustainability and wider opportunities offer to create social value in the communities we serve.

'*Estates Excellence*' sets out our strategy for the next ten years and will help us maximise the opportunities which exist. It sets out what estate we require now, and in the future, and how we will work with our patients, donors, staff and communities to ensure they have a safe and enjoyable experience which helps to improve their overall health and well-being. It also sets out how we can use our estate and facilities to make a wider contribution to communities and society.

Our Estates Vision: A sustainable estate which provides a great experience for all

We have developed four themes to support the development of our estate.

Theme 1: A safe and high quality estate which provides a great experience

Theme 2: Healthy buildings and healthier people

Theme 3: Minimising our impact to the environment

Theme 4: Using our estate to deliver the maximum benefit and social value to the community we serve

Our Estate Objectives

Our objectives are to:

- Provide an estate which enables the delivery of high quality clinical services
- Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience

- Provide healthy buildings which support and enhance individual well-being
- Minimise the impact of our estate on the environment
- Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve

We will achieve these by:

- Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs
- Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces
- Investing additional resources in the maintenance of the existing estate to maintain a Category B
- Implementing our estates, digital, workforce and sustainability strategies
- Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles
- Identifying innovative ways to adopt renewable energy sources to service our requirements
- Identifying facilities we can share the use of with other public bodies and wider partners
- Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets
- Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services
- Delivering a number of transformative capital programmes which have sustainability at their centre of design:
  - Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025
  - Refurbishment / development of new outreach facilities by 2024/2025
  - Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024
  - Opening of the new Velindre Cancer Centre by 2025

Our plan is supported by an ambitious infrastructure programme which includes:

- **Development of a New Velindre Cancer Centre in Whitchurch, Cardiff:** the replacement of the existing VCC has been identified as a key commitment within the Welsh Government's '*Programme for Government*'. The new Velindre Cancer Centre will provide improved services for our patients, families and staff; will contribute to our sustainability strategic ambition of becoming a carbon net zero organisation and will deliver numerous community benefits for the population we serve.

- **Development of a Velindre Radiotherapy Satellite Centre at Nevill Hall Hospital:** the provision of a Radiotherapy Satellite Centre (RSC) has been identified as a key regional development to facilitate the delivery of timely and effective Radiotherapy services to the South-east Wales population. The ambition

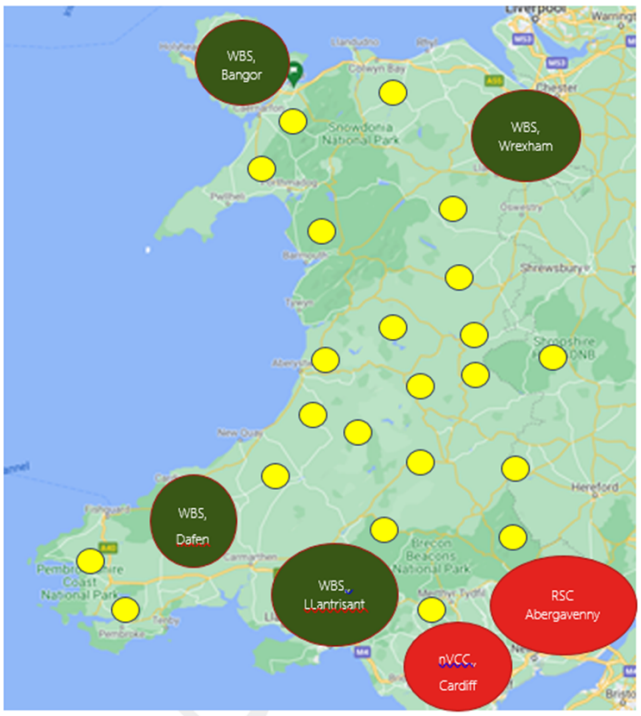
is to deliver a world-class facility that will provide specialist care for cancer patients from that locality.

- **Programme to re-develop the Welsh Blood and Transplantation Services Facility: t**his Programme sets out a number of strategic developments which will support the provision of high quality, safe, sustainable, efficient services and support the decarbonisation of our estate. It will also provide the foundation for the Laboratory Modernisation programme which will look at a range of new services to support NHS Wales.

- **Maintenance and Upkeep of the Estates:** the Trust recognises the importance of maintaining suitable environments in lieu of delivering major capital programmes so are committed to ensure there is sufficient investment in key areas to ensure environments continue to be suitable for patients and staff.

Our Transformed Estate in 2026

Our services are based on a hub and spoke model and we will continue to provide services from various buildings across Wales, some which we own / lease and some which are provided by our partners.



Key:

●	Illustration of the multiple venues across Wales we will collect blood and blood products from

Sustainable Services

We recognise the responsibility vested in us by the people we serve to make the country a better place to live, work and enjoy. We fully recognise the impact we have on the environment, the communities we operate in, the people we provide services for, and the staff who work for us.

We have a clear ambition over the next three years to deliver high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. The delivery of our plan provides us with an exciting challenge which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity across Wales.

As an anchor organisation, we are committed to embedding sustainability within our own organisation and becoming an exemplar in Wales. Our plan provides a roadmap to achieving a sustainable future which will enable us delivering high-quality clinical services whilst reducing our impact on the planet and providing a wider range of benefits for the communities we work and live in.

Our Plan for 2023 – 2026 and Beyond

The pioneering 2015 Well-being of Future Generations Act (the "Act") and the 2016 Environment (Wales) Act 2016 provides Wales with an exciting opportunity to lead the way internationally and this strategy outlines our sustainability aims and enables real action to create positive and significant change.

We are passionate about sustainability and we know the communities we serve and our workforce are too. We have an uncomplicated goal; to become a sustainable organisation that plays a part in creating a better future for people across the globe. Over the past year we have delivered a wide range of initiatives, from installing beehives and training volunteer beekeepers to holding our first ever 'Sustainable Summer Jamboree' for staff, patients and the local community to reducing the single use plastic used in the Velindre Café. Our plan is to continue to build on our achievements to realise our full ambition through close engagement and collaborative working with others to share our resources and to work together do more with what we collectively have.

Our Vision for Sustainable Services: A sustainable organisation which contributes to a better world for future generations locally and across the globe

Our vision will be supported by the following aims:

- To deliver sustainable services which add wider social value for our community
- To be recognised as an exemplar organisation of delivering the Well-Being of Future Generations Act
- To deliver a biodiversity net gain and enjoyment of our green spaces to improve health and well-being
- To become a carbon '*Net Zero*' organisation
- To use our resources effectively and efficiently: zero waste to landfill by 2025 and reduced consumption of energy and water

Theme 1: Creating Wider Value
To embed sustainability within our organisation and create more value for the people we work for and the communities we work within

Theme 2: Sustainable Care Models
To deliver the highest quality of care which minimises our impact and supports our journey to a sustainable planet

Theme 3: Carbon Net Zero
To become a carbon Net Zero organisation by 2025

Theme 4: Sustainable Infrastructure
To provide buildings which improve the well-being of our patients, donors and staff to reduce our environmental impact

Theme 5: Transiton to a Renewable Future
To reduce our overall energy requirements and transition to renewable sources

Theme 6: Sustainable Use of Resources
To reduce, re-use and recycle resources annually and adopt a circular economy approach as the '*way we do things around here*'

Theme 7: Connecting with Nature
To maximise the quality and benefits of our green space, buildings, facilities and resources to enhance nature, biodiversity and well-being

Theme 8: Greening our Travel and Transport
To reduce the health impacts associated with our business and support a transformation in the way we travel

Theme 9: Adapting to Climate Change
To ensure our organisation is well prepared to manage the impacts of climate change

Theme 10: Our people as Agents for Change
To develop a workforce which places sustainability at the heart of everything we do

Our Sustainability Objectives

Our objectives are to:

- Be recognised as a leading NHS Trust for sustainability nationally
- Be a carbon 'Net Zero' NHS organisation by 2030.
- Become an anchor organisation in the communities we serve which enhances their economic, social, environmental and cultural well-being
- Support the transformation from ill-health to well-being across Wales

We will achieve these by:

- Developing clinical service models which support sustainability
- Implementing our sustainability strategy
- Applying the principles of the circular economy into our business processes through design, procurement, re-use and lifecycle.
- Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day')
- Implementation of our carbon reduction plan which will see us achieve Net Zero and transition to renewable energy for our services and facilities.
- Investing in a range of refurbishments and new buildings which will support our carbon reduction and healthier buildings and healthier people approach. These include:
  - Major refurbishment of the Welsh Blood Service, Llantrisant site, by 2025
  - Construction of a Radiotherapy Satellite Centre at Neville Hall by 2024
  - Construction of a new Velindre Cancer Centre by 2025
- Implementing an attractive approach to agile working for our staff which reduces avoidable travel, improves well-being and offers the potential to support money going into local communities
- Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport
- Using our procurement activities and NHS Wales Shared Services capability to drive a sustainable approach and achieve wider ethical and social value in areas including local employment and prosperity; carbon reduction; anti-slavery and unethical practices.
- Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprenticeships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Governments Foundational economy

Part 7

Our Financial Plan

We set out our 3 Year Financial Plan for 2023 to 2026

Overview of our Financial Plan – 2023 – 2026

The Trust has had an approved Integrated Medium Term Plan (IMTP) since their introduction by Welsh Government (WG) in 2014-15. Central to IMTP approval has been the Trust's ability to consistently achieve a balanced year-end out-turn position annually, whilst maintaining or improving the quality of our services and delivering agreed performance measures.

Our Integrated Medium Term Plan (IMTP) for 2023-2026 sets out our Financial Strategy from 1st April 2023 to 31st March 2026. During this period, the Financial Strategy aims to enable the Trust to meet the anticipated demand for services whilst still in recovery, ensuring that we return to pre-pandemic activity levels and address the backlog. Recovery from the pandemic continues to be further compounded by significant financial challenges due to the system wide exceptional cost pressures, which include energy & fuel cost increases and extraordinary levels of cost inflation, each of which will need to be met by the Trust in 2023-24.

The financial plan for 2023-24 consists of three distinct parts:

Core Plan: Balanced

Brought Forward Underlying Surplus:

- Despite the constraints, the Trust was able to eliminate the underlying deficit of £0.500m during 2022-23 which was brought forward from the previous year through the application of discretionary uplift funding restoring the Trust to a core financially recurrent balanced position.
- The Trust is planning to bring forward an underlying surplus of £0.684m which relates to the 2022/23 discretionary uplift funding that was held due to uncertainty of WG funding support for the increase in energy prices and cover the possible LTA income shortfall risk against the Covid capacity cost investment.
- The non-recurrent component of the energy cost in 2022-23 will result in an underlying surplus being carried forward into 2023-24 which will act as contingency for further anticipated volatility in energy prices.
- The balance of the underlying surplus is forecast to reduce year-on-year as cost pressures increase over the 3-year planning period.

Growth Pressures:

- The 1.5% core discretionary uplift (sustainability) funding will currently be required to fund the continuing forecast exceptional energy cost pressure as a result of high energy prices.
- The Trust expects to secure Covid recovery and planned care backlog funding from Commissioners through LTA activity performance related marginal income - the level of this funding remains a risk with a forecast net deficit of c£1.500m compared

to the cost of additional capacity investment, on the assumption there will be no Nationally agreed LTA income protection in 2023-24.

- Local growth and cost pressures at this stage will either need to be mitigated, funded from existing budgets in service divisions or require additional savings above the £1.8m target already identified.

Savings Plans:

- The following table summarises the level of savings the Trust is planning to deliver during 2023-24 which will be required to support the increase in Energy Prices and the cost of Covid Recovery and Planned Care Backlog Capacity not covered by LTA income.

Savings Plan	2023-24 £000
CIP Planned Savings	1,275
Income Generation	525
Total Savings / Income Generation	**1,800**
CIP % (of Core LTA)	**2.3%**

Exceptional National Cost Pressures:

- WG have confirmed that there will be no funding available to support the increase in Energy costs, and whilst it is extremely challenging to predict the future trajectory of Energy prices the plan currently assumes a cost pressure above the historical baseline of £1.191m which will need to be met by the discretionary uplift funding (£1.104m) and part of the increased savings target (£0.536m).

COVID-19

Covid Programme Costs:

Per the allocation letter funding for ongoing national Covid responses, including mass vaccination, and the provision of PPE will be held centrally and allocated on actual costs incurred during 2023-24. It is recognised that any other Covid related programme costs will need to be funded by the Trust.

Covid Funding Requirement 2023-24	IMTP Total 2023/24 £k	IMTP Total 2024/25 £k	IMTP Total 2025/26 £k
Covid Mass Vaccination	x	x	x
Covid PPE	240	x	x
Total Covid Funding Requirement 2023-24	**240**	**0**	**0**

Covid Recovery and Planned Care Capacity:

- It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners from 2023-24. However, the contract performance income is not expected to match the internal level of investment which has been made to support the planned care backlog capacity leaving a potential funding deficit of c£1.500m.
- The LTA activity-based Income and associated costs are modelled on the following growth in demand assumptions:

Financial Performance Per Contract Currency Category	% Factor - Cancer Demand Modelling Advisory Group			
	2023/24	2024/25	2025/26	2026/27
Radiotherapy	6%	2%	2%	2%
Nuclear Medicine	9%	9%	9%	9%
Radiology Imaging	9%	9%	9%	9%
SACT	12%	8%	8%	8%
Ambulatory Care Services	6%	2%	2%	2%
Outpatient Services	10%	4%	4%	4%
Inpatient Admitted Care	2%	2%	2%	2%

- Committed investment in Velindre Cancer Services capacity totalled a recurrent requirement of £3.5m for 2022-23. The recurrent income funding for this additional capacity flows via performance related LTA contracting income from Commissioners.
- Work has been undertaken to review all Covid recovery investment within Velindre Cancer Services, with a view to understanding the direct capacity related benefits and mitigations such reducing, removing or repurposing these costs.

Financial Plan

The plan aims to provide services with sufficient capacity to meet demand in support of recovery from the Covid pandemic, whilst targeting improved levels of efficiency and productivity alongside sustained delivery against national targets and / or professional performance standards. In terms of efficiency the Trust has set a 2.3% savings target of £1.8m in 2023-24.

Whilst the Trust is submitting a balanced financial plan there is significant financial risk and challenges to deliver this plan due to the uncertainties around the income it will receive to cover the committed investment in Velindre Cancer Services and additional cost pressures related to delivering the planned care backlog during 2023-24.

The proposed financial plan has been developed using the latest assumptions regarding the Trust's expected income from Commissioners and Welsh Government, the likely cost pressures facing the Trust, both pay and non-pay inflation, and realistic, but challenging view of the cost saving potential of services.

These assumptions have been discussed and agreed with Commissioners and Trust Board through the IMTP engagement process.

The formal agreement of the Trust income planning assumptions will be summarised within respective Commissioner Long Term Agreements for 2023-24 which are to be signed by the 30th June. A summary financial plan for period 2023-24 to 2025-26 is presented in the following table:

Summary of Financial Plan 2023-26	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000
Underlying Core Position b/f	0	0	391	391	290	290
Unallocated reserves b/f	684	684	0	0	0	0
b/fwd. underlying deficit	**684**	**684**	**391**	**391**	**290**	**290**
Revenue						
WG Covid Programme Funding (PPE)	240	0	0	0	0	0
WG Vel Pay Commissioner Pay Award	71	71	71	71	71	71
1.5% Recurrent LTA Core Uplift (1.5% 23/24 0.75% 24/25 & *assumed 1% 25/26)*	1,104	1,104	585	585	786	786
Assumed LTA Income Growth	11,300	11,300	10,171	10,171	10,401	10,401
LTA Service Growth Investment	1,772	1,772	1,007	1,007	7,969	5,557
Covid Recovery and Planned Care Backlog	1,974	1,974	0		0	
Total Revenue	**16,461**	**16,221**	**11,834**	**11,834**	**19,227**	**16,815**
In year Changes to Operation Cost Base						
WG Covid Programme Funding (PPE)	(240)	0	0	0	0	0
LTA Service Growth Investment	(1,772)	(1,772)	(1,007)	(1,007)	(7,969)	(5,557)
VV NICE Drug Growth	(7,864)	(7,864)	(7,864)	(7,864)	(7,864)	(7,864)
WBS Contract Price/ Inflation	(3,436)	(3,436)	(2,307)	(2,307)	(2,537)	(2,537)
Exceptional National Cost Pressures	(1,191)	0	(1,090)	0	(779)	0
National / General Cost Pressures	(757)	(757)	(422)	(422)	(396)	(396)
Local Cost Pressures	(257)	(257)	(836)	(836)	(1,272)	(1,251)
Covid Recovery and Planned Care Backlog	(3,428)	(3,428)	0	0	0	0
Total In Year Changes to Cost Base	**(18,945)**	**(17,514)**	**(13,525)**	**(12,436)**	**(20,817)**	**(17,605)**
Net Opening Balance before Savings	**(1,800)**	**(609)**	**(1,300)**	**(211)**	**(1,300)**	**(500)**
Savings Plan (2.3%)	1,800	1,000	1,300	500	1,300	500
Net Income Generation	0	0	0	0	0	0
Net Opening Balance	**(0)**	**391**	**0**	**290**	**0**	**0**

Income Assumptions

Income Assumptions and Extent of Alignment with Commissioner and WG Plans:

The following are the income growth assumptions the Trust has made to meet the Covid programme and recovery & backlog costs, new inflationary and cost growth pressures during 2023-24:

- Commissioners will uplift LTA values by 1.5% which amounts to £1.104m core uplift in 2023-24, 0.75% (£0.585m) in 2024-25 in line with the HB Allocation Letter. For planning purposes, the Trust is assuming a 1% uplift for 2025-26.
- Commissioners will pass through as additional income to the LTA the 2022-23 Agenda for Change (AfC) and Doctor & Dentist Review Body (DDRB) costs as per the WG Pay award matrix.
- The 2023-24 Pay Inflation not currently agreed but is expected to be funded directly by WG over the 3 years of the IMTP (any shortfall will need be met by discretionary uplift, additional savings or absorbed by Divisions).
- **In line with WG guidance any planning assumption for the 2023-24 pay award is excluded from the IMTP financial plan.**
- The cost increase in employer's pension contributions from 14.3% to 20.6% will continue to be paid by WG. (**Per WG guidance excluded from the plan**)
- Per the allocation letter the Trust is assuming WG will provide financial cover for the Covid mass vaccination and PPE costs that is incurred during 2023-24. Covid Cleaning and supplementary staffing is no longer supported by WG.
- The Trust will receive pass through income from commissioners to cover the cost of NICE / High-Cost drugs VCC uses in delivering cancer care. The forecast annual cost growth has been estimated using historic trends and the latest horizon scanning, this amounts to a £7.864m increase in 2023-24.
- The Trust will receive pass through income from LHBs to cover the cost of wholesale blood derived products WBS supplies to them. The forecast annual cost growth for 2023-24 has been calculated based an estimated 17.5% volume growth and general price inflation totalling £3.436m.
- In 2022-23 the Trust secured funding from WG from the Value Based Healthcare (VBHC) fund. Funding will be held centrally by WG and invoices based on actual costs.
- WG has confirmed funding of the WBS business case costs for Occult Hep B Core Testing.
- WG will fund the WBS Plasma for Medicines (Fractionation) business case costs should WG decide to progress with this service development.
- The Trust is assuming as confirmed by WG when the bid was submitted that the SDEC service development funding of £0.935m available in 2023-24 is recurrent.
- It is assumed that the Trust will receive additional income from commissioners to cover any new service developments they agree to invest in. Should funding not

be agreed, developments and infrastructure will not be implemented, and costs will need to be mitigated or removed. These key service infrastructure, quality improvement, activity growth and cost pressures have been shared with Commissioners including:

	2023/24			Incremental Income				
LTA Service Infrastructure, Quality Improvement, Activity Growth and Cost Pressures (Excluding COVID-19)	LHB £k	WHSSC £k	In Year Effect £k	IMTP Total 2023/24 £k	IMTP Total 2024/25 £k	IMTP Total 2025/26 £k	IMTP Total 2026/27 £k	IMTP Total 2027/28 £k
TCS Service Development Acute Oncology Services	570		570	570	333	0	0	0
TCS Service Development Integrated Radiotherapy Solution	589		589	589	55	762	-101	-125
SACT Medicine Infrastructure Financial impacts (MIFs) 2021-22	100		100	100	100	100	100	100
TCS Radiotherapy Satellite Centre	0		0	0	519	828	11	11
TCS Radiotherapy Satellite Centre - Predicted Marginal Activity Growth	0		0	0	Marginal Income for activity growth via LTA			
TCS nVCC FBC Planned Recurrent Funding Requirement			0			3,867	1,289	
TCS nVCC FBC Planned Transition Funding Requirement (N/R)			0			2,412		
Radiotherapy Service Implementation	361		361	361				
TCS Outreach Programme			0	Planning work ongoing with LHBs to identify requirements				
Red Cell Immunohaematology (RCI) Commissioned Service Stepped Change Case		140	140	140				
Renal Contribution to On Call Rota		140	140	13				
Total Service Improvement & Growth	**1,619**	**280**	**1,899**	**1,772**	**1,007**	**7,969**	**1,299**	**-14**

- The current financial plan assumes no additional internal investments in major programmes and projects beyond resources agreed within approved business cases. Any additional funding requirements will either need to be met through a reallocation of existing resources or additional savings above the £1.8m target.

Pay Related Cost Assumptions:

- Expectation that Pay Inflation funding received will cover the cost growth. (Any shortfall will need be met by discretionary uplift, additional savings or absorbed by service Divisions.
- In line with the guidance the 2023-24 pay inflation and employer's pension contributions from 14.3% to 20.6% has been excluded from the financial plan.

Non-Pay Related Cost Assumptions:

- Latest forecast modelling of forecast energy prices suggests that the incremental cost above baseline to the Trust could be c£1.191m, however due to price volatility this could range significantly which could realise either a risk or opportunity of c£0.500m.
- The normal national cost pressures have currently been estimated at £0.709m for 2023-24. General Non-Pay inflation (£0.323m), NEPTS contract inflation (£0.050m), Enhanced Cleaning costs (£0.150m), LINC All Wales Business case (£0.075m) and an increase in digital costs through the DHCW SLA (£0.119m) such as Microsoft 365 and national IT system projects costs.
- Non-pay Inflationary uplifts on Welsh NHS SLAs of 1.5% (£0.048m) have been assumed for 2023-24 on the basis of a 1.5% core funding uplift to LTA values is passed through to the Trust.

Local Core Service Growth and Cost Pressures:

- The Trust has undertaken a robust review of its local core service growth and cost pressures, which has resulted in a number being removed or costs reduced.
- The cost pressures in the table below are included in the financial plan as needed to meet quality & safety statutory requirements and essential Trust wide digital infrastructure so unavoidable for 2023-24.

Local Cost Pressures	Recurrent/ Non-Recurrent	2023/24 £K	2024/25 £K	2025/26 £K
Mortality Reviews – Band 5 Post (VCC)	Rec	35	x	x
SQL Licenses	Rec	222	x	x
Total Local Cost Pressures		**257**	**0**	**0**

- The remaining cost pressures of circa c£0.900m are key to delivering against several key service improvement objectives or are unavoidable.
- The current financial plan assumes that these cost & growth pressures that have been identified as unavoidable for 2023-24 will at this stage need be funded either through additional marginal LTA income from activity growth or further savings within service Divisions.

Normal National / General Cost Pressures:

These normal national cost pressures are funded in part by the 1.5% discretionary core uplift (sustainability) funding and in part from savings delivery:

National / General Cost Pressures	Recurrent/ Non-Recurrent	2023/24 £K	2024/25 £K	2025/26 £K
NHS SLA Increase	Rec	48	24	30
Non-Pay Inflation	Rec	315	315	315
Enhanced Cleaning	Rec	150	x	x
Digital (DHCW SLA)	Rec	119	83	51
LINC - All Wales Business Case	Rec	75	x	x
EASC - NEPTS Contract Inflation	Rec	50	x	x
Total National Cost Pressures		**757**	**422**	**396**

Exceptional National Cost Pressures:
The Trust will be required to fund the incremental increase in forecast energy costs above baseline costs as shown in the following table.

Exceptional National Cost Pressures	Recurrent/ Non-Recurrent	2023/24 £K	2024/25 £K	2025/26 £K
Energy / Fuel Increases	Rec / Non Rec	1,191	1,090	779
Total Exceptional Cost Pressures		**1,191**	**1,090**	**779**

Other Assumptions:

- Prioritised service developments will be submitted to commissioners as business cases for funding consideration.
- Expectation is other cost pressures are avoided/mitigated as far as possible. Where costs are unavoidable additional savings will be required to fund them.
- Investment in organisational staff capacity and capability to deliver major change Programmes is required to, progress regional work to deliver improved cancer services, establish clinical leadership and to meet statutory duties around quality & safety and duty of candor. The Trust Chief Executive has discussed with Judith Paget (DGHSS) the need for additional WG funding to support these key issues
- Without WG funding support the Trust is considering what resourcing decisions are required with regards to reallocation of existing resources or delivery of additional savings and efficiencies, but this is proving difficult given competing priorities and will only enable a small element of the staff capacity and capability to be implemented with consequential impact on the Trust ambitions.

Planned Savings

The following table summarises the level of savings the Trust is planning to deliver in 2023-24.

Savings Plan	2023-24 £000
CIP Planned Savings	1,275
Income Generation	525
Total Savings / Income Generation	**1,800**
CIP % (of Core LTA)	**2.3%**

The Trust has currently identified the full savings target of £1.800m, (£1.003m RAG rated Green), (£0.797m RAG rated Amber).

Savings Plan by Division	Target £k	Identified £k	Savings Target Gap £k
Welsh Blood Service	700	700	0
Velindre Cancer Centre	950	950	0
Corporate Services	150	150	0
Total	**1,800**	**1,800**	**0**

Saving Theme	Saving Description/ Status	Division	Recurrent	Non Recurrent	Total	Scheme Type
			£'000s	£'000s	£'000s	
Sales of Plasma	based on an average 900 litres per month (existing volumes pro rata) – total income per annum of £790k, less committed income target £425k per annum.	WBS	150	0	150	Income
Collections Teams	Travel & Subsistence. Translation costs, general equipment budget reduction & printing	WBS	10	8	18	Non Pay
Establishment Control	Removal of long standing Vacancy	WBS	60	0	60	Pay
WTAIL & LABS	Reduced use of Liquid Nitrogen	WBS	55	0	55	Non Pay
Research Investment	Reduced allocation into Research	WBS	25	0	25	Non Pay
Stock Control	Non recurrent management of stock	WBS	0	125	125	Non Pay
Procurement Supply Chain	Contracting cost reductions	WBS	100	0	100	Non Pay
Transport	Permanent reduction of maintenance programmes	WBS	0	30	30	Non Pay
WBS Demand Planning	Non Pay Related Volume Driven Benefits (Blood Bags, Managed Service Contracts)	WBS	0	137	137	Non Pay
Expanded Utilisation of 3rd Party SACT Provision	Gain share with Commissioners via delivery model	VCS	200	0	200	Income
Service Workforce re-design	Recurrent removal of posts and non-recurrent vacancy freeze	VCS	50	175	225	Pay
VCS Non Pay Controls	Rationalisation of service offering both permanent and non-recurrent	VCS	0	150	150	Non Pay
Radiation Services	Agency Premium reduction	VCS	125	50	175	Pay
Private Patients	Increased recovery from existing service offer	VCS	50	50	100	Income
Procurement - Supply Chain	Contracting cost reductions	VCC	100	0	100	Non Pay
Bank interest	Utilisation of surplus bank interest above Corporate cost pressures	Corp	75	0	75	Income
Establishment Control	Vacancy Control;	Corp	0	75	75	Pay
Total			**1000**	**800**	**1800**	
Green RAG Rated Schemes			695	308	1003	
Amber RAG Rated Schemes			305	492	797	
Red RAG Rated Schemes				0	0	
Total			**1000**	**800**	**1800**	

Contracting Model & National Funds Flow Framework:

It has been assumed in the financial plan that protection measures in contracting arrangements previously agreed through the National Funding Flows group will cease in 2023-24 and will return to the pre-Covid 2019-20 normal activity level baseline and marginal rates.

However, at the DoF meeting on 17th March at which the paper was presented from the National Funds Flow group seeking DoFs agreement to one of the two proposed options:

A) Continue with the current 2022-23 framework mitigation principles in 2023-24, with the 10% underperformance tolerance reduced to 5%.

B) Remove the 2022-23 framework principles and return to extant contracting principles in 2023-24.

To facilitate a recommendation the group members were asked to submit their organisations preference for one of the options. All 8 organisations affected by the framework mitigation provided a response, resulting in a 5-3 split in favour of option A:

The recommendation from the Funds Flow group was to support the majority preference for option A.

All organisations agreed the recommendation to implement option A with the exception of ABUHB. Therefore, this means that unless ABUHB changes its position there will potentially be a formal arbitration case submitted to WG by a number of organisations in relation to this matter.

The Trust has not yet included as an opportunity in its financial plan this decision to continue with an income protection framework underperformance tolerance of 5%.

Financial Risks and Opportunities:
There are several financial risks that could impact on the successful delivery of the plan. The Trust recognises these and is taking appropriate actions as set out below, to ensure risks are appropriately managed and mitigated against. All areas of delivery are risk assessed and any identified risks are included within the Trust Assurance Framework and Trust wide Risk Register.

Key Financial Risks	Worst Case £'000	Best Case £'000	Risk Mitigation
Non-delivery of amber / red saving schemes	(797)	0	Service to urgently review savings schemes that are classified as amber with a view to turn green or find replacement schemes
Further rise in energy prices	(500)	0	Will form part of all Wales approach, reviewed and mitigated by the new Wales Energy Group (WEG) & Wales Energy Operational Group (WEOG) as a subgroup to the WEG, which will report to the NWSSP Partnership Board
Management of operational Pressures	(900)	0	Operational cost pressures to be mitigated at divisional level
SDEC Funding	(935)	0	WG assurance given when bid submitted that funding was recurrent, but require written confirmation from

			WG that the SDEC funding allocation is recurrent.
Total Risks	**(3,132)**	**0**	
Key Financial Opportunities	**Worst Case £'000**	**Best Case £'000**	**Opportunity application and action**
Covid Capacity and Backlog Activity Performance	0	700	Income generation through activity performance supports Covid Capacity and backlog infrastructure
Covid Capacity and Backlog Cost Reduction	TBC	TBC	Review service model that has been implemented to support backlog and where possible reduce or mitigate costs.
Further vacancy turnover savings above the vacancy factor held in divisions	200	400	Used to provide non-rec savings against savings schemes that are amber.
Emergency Reserve	0	500	Reserve held for emergency expenditure but could be released to support financial position non recurrently if no unforeseen costs materialise.
Reduction in Energy prices	0	500	Will form part of all Wales approach, reviewed by WEG and WEOG groups.
Contract Currency review in recognition of underlying cost base.	0	500	Review of Time Driven Activity Based Costing Model for contract currencies where Service Developments or changes have impacted the underlying cost base.
Total Opportunities	**200**	**2,200**	
Net Financial Risk	**(2,932)**	**2,200**	

Capital Plans for the Trust

The focus of the capital investment Programme is to maintain a high-quality environment in which to collect, transport, process and supply blood, treat cancer patients and provide modern treatment equipment.

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund. These include:

All Wales Approved and Unapproved Capital Schemes	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works	7.979	0.000	1.547			9.526
Integrated Radiotherapy Solution (IRS)	12.670	14.497	5.134			32.301
IRS Satellite Centre	1.347	10.065				11.412
Total Approved Capital Schemes	**21.996**	**24.562**	**6.681**	**0.000**	**0.000**	**53.239**
All Wales Unapproved Schemes						
TCS nVCC	5.768	34.132	7.147			47.047
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
Total Unapproved Capital Schemes	**8.364**	**37.794**	**21.055**	**10.896**	**10.961**	**89.070**
Total All Wales Capital Plans	**30.360**	**62.356**	**27.736**	**10.896**	**10.961**	**142.309**

Trust Discretionary:
The Trust discretionary allocation of £1.683m for 2023-24 is an increase of £0.229m from the £1.454 allocated during 2022-23.

Depreciation & Impairment Funding:

The Trust will require additional WG funding estimated at £31.4m over the three years of the IMTP 2023-24 to 2025-26 for accelerated depreciation in relation to the existing cancer centre building and equipment. These costs are set out in the table below and included in the n VCC FBC:

Cost category	2023-24	2024-25	2025-26	Total
	£000	£000	£000	£000
VCC Buildings	9,541	9,541	9,541	**28,622**
VCC Equipment	938	938	938	**2,815**
Total Costs	**10,479**	**10,479**	**10,479**	**31,437**

The Trust will require WG impairment funding in 2023-24 of £5.9m in relation to the capital costs incurred on the ASDA Enabling Works access road for the nVCC. This is currently an asset under construction and will be reflected as such in the Trust Balance Sheet in 2022-23. However, once construction is completed in 2023-24 the asset value will need to be fully impaired as the Trust does not have legal ownership of the asset, but a right to use the asset by way of a license.

Part 8

Our Performance Management Framework

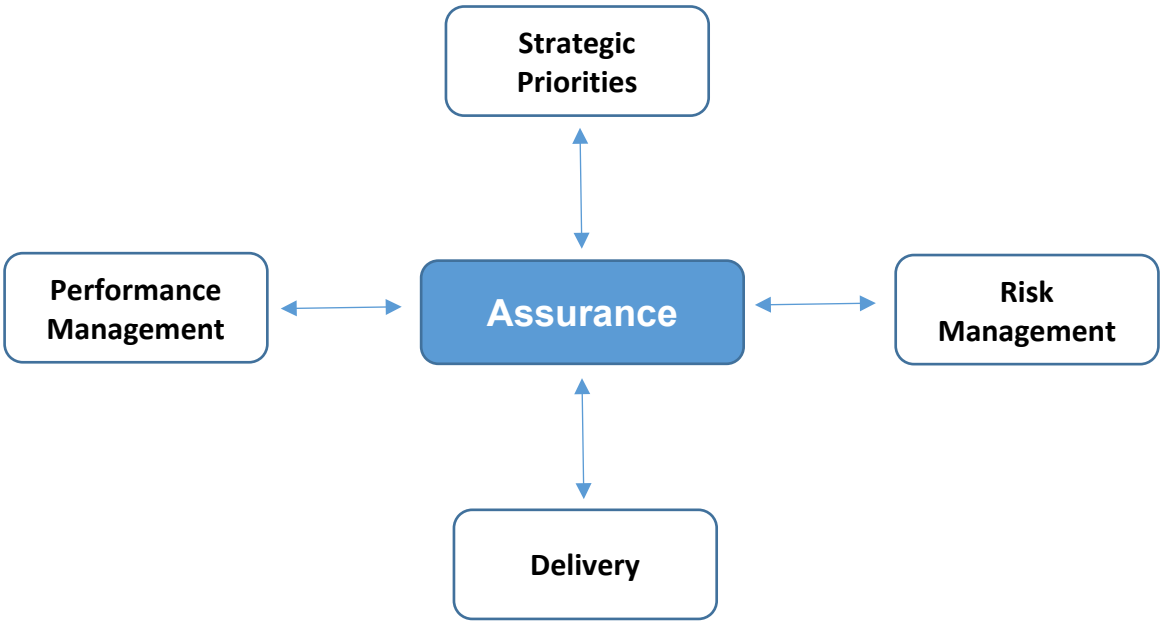
We set out how we will manage the delivery of our plan and monitor progress in delivering the changes we wish to see.

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

Managing the Delivery of our Plan

We utilise an Integrated Framework to manage the delivery of service and strategic plans. This ensures that there is a '*golden thread*' that links all organisational plans and priorities, risk, delivery and measurement into an overall system of assurance.

Integrated Performance, Risk and Assurance Framework



Plans and priorities - Our strategic aims and priorities are set out within our strategies and translated into specific objectives and actions within this plan.

Delivery - The focus of delivery are the divisional service plans which set out the actions we will take to deliver the identified priorities and objectives.

Performance Measures - We use a range of quantitative and qualitative information to allow us to monitor our progress. These are a combination of Welsh Government statutory targets and self-imposed stretch targets.

Risk Management - We assess the risk of achievement against each of our strategic aims, priorities and objectives as part of the planning process. We keep these under regular review throughout the year.

Performance Management Framework

We use a robust framework to support our staff in achieving the improvements required and in delivering our plan. The system is based upon four main elements:

- A clear set of aims, objectives, plans and supporting actions to improve quality
- A range of performance measures
- A regular process of monitoring and review

- A process of escalation/action if we are not on track to achieve our aims.

However, and despite the robust existing arrangements, a key priority for us during 2022 – 2023 will be further enhance our Performance Management Framework (PMF). This is in line with the Welsh Governments introduction of quality statements in '*A Healthier Future for Wales' (2018 to 2030)'*, and has been described in the National Clinical Framework, as the next level of national planning for specific clinical services. It forms part of the enhanced focus on quality in healthcare delivery that was put forward in A Healthier Wales and the Quality and Safety Framework (QSF).

Governance Arrangements
The Board is accountable for governance and internal control of those services directly managed and for services delivered via hosting arrangements. The Board discharges its responsibilities through its Committees and scheme of delegation.

Delivering our Plan
Our plan sets out a clear set of milestones and trajectories that are owned by the Board who will receive a regular assessment of progress against the plan. Responsibility for delivering the plan is discharged to the divisional Senior Management teams who manage the detailed progress of service objectives and their associated performance and risks. Regular meetings between the divisions and the Executive Directors will take a more strategic overview of progress.

Whilst the plan objectives and related performance will be scrutinised by the most appropriate committee, the Quality Safety and Performance Committee will assume overall responsibility for challenging plan progress and providing assurance to the Board.

Commissioning Arrangements
Health Boards are responsible for commissioning cancer and blood services from the Trust. However, there is a common view that the current arrangements are not sufficient to meet the future needs of the Trust in delivering services on behalf of our commissioners and the patients and donors who use them. We are therefore committed to working with our Health Board partners and the Welsh Government to develop a planning, commissioning and funding framework that provides us with the greatest opportunity to achieve our ambitions and achieve the levels of excellence that people can be proud of.

Implementation: How will we measure success?
We will track implementation of our plan through a small number of key metrics and strategic markers, which will be underpinned by more detailed reporting. The following metrics will be used to monitor and track implementation as they:

- **Provide a headline picture against our strategies and plans as a whole.** Identifying a small number of headline metrics allows for a simple mechanism to track progress and report to our patients, donors, staff and partners.

- **Includes a mixture of process, output and outcome measures.** This allows us to track specific actions in the short-term (process and output measures) and ensure they are translating into real change in the longer-term (outcomes and benefits).

Velindre University NHS Trust

IMTP 2023/24 – 2025/26

Velindre University NHS Trust Board

30th March 2023

Presentation Summary

1. Updates to the IMTP following feedback from the Strategic Development Committee on 24th March 2023 (Note: no material changes)
2. Strategic Context
3. Velindre Cancer Service Plan
4. Welsh Blood Service Plan
5. Workforce Plan
6. Finance Plan
7. Summary of Key Risks to the Delivery of our Plan

Updates to the IMTP following Feedback from the Strategic Development Committee on 24th March 2023

- Full QA of the document to identify and correct any formatting, spelling or grammatical errors
- Inclusion of an additional section within our introduction to emphasise our commitment to equality and diversity. This has also been supplemented with additional actions within our plan.
- Review and inclusion of additional quality and safety actions within our plan
- A review of our objectives / actions for both services to ensure that they are 'SMART'

Strategic Context - Our Approach

Strategic Goals: Destination 2032

Organisational priorities
- IMTP
- Progress against
- Organisational priorities
- Strategic choices on priorities

Service plans
- Vision for 2026
- Service plans to deliver it

Financial positon

Next Steps

Velindre Cancer Service Plan (summary)

Planning Assumptions

- 3 year delivery plan
- The Operational Plan to deliver VCC 5-year Cancer Strategy
- Informed by:
  - Wales Cancer Strategy
  - Quality statement for Cancer
  - VCC deep dives
- Aligned to ministerial priorities:
  - Planned care, recovery, diagnostics and pathways of care
  - Urgent care
  - Cancer recovery
- Supports transition to New Velindre Cancer Centre and associated regional service delivery model

Key Strategic Programmes Wwithin IMTP

Ministerial Priority	deliverable
Planned care, recovery, diagnostics and pathways of care	nVCC transition Outreach Project Radiotherapy satellite Unit Brachytherapy Improvement project National extreme hypo-fractionation programme Regionalisation nuclear medicine VAPP expansion project SACT improvement programme Outpatient Improvement programme National pre-habilitation to rehabilitation project National Palliative and end of life care programme Implementation of Quality Management System (Ihub) Centre for Collaborative Learning

Key Strategic Programmes Within IMTP

Ministerial Priority	deliverable
Urgent Care	SDEC programme (including IO) VCC/Regional telephone helpline Regional acute oncology service (Unwell patient)
Cancer recovery	Implementation of radiotherapy referral to treatment times (RRTT) (COSC)

Other priority	deliverable
digital	Implementation of IRS National Radiology Informatics system Procurement National TRAMS programme E-Prescribing Digitising medical records DHCR phase 2

Quality Statements for VCS

Objective	Quality Statement
IMTP 0.12 VCC SACT telephone helpline is in place to provide 24hr advice and triage service by Q3 2023/24 and standards being met'	No further national reported incidents in response to the SACT telephone helpline by February 2024
IMTP 0.13 Implementation of pathway programme to support optimisation of cancer pathway and transition to nVCC by Q4 2024/25	All MSSC pathway patients identified within the agreed pathway timescales will be treated within the same service day at VCC, where appropriate by February 2024

Quality Measures aligned to the Trust wide Safe Care Collaborative programme of work.

Challenges	Opportunities
Increase in demand New referrals Internal e.g. new regimes	• Pathway review and reconfiguration • Prioritisation and horizon scanning • Co-production: service delivery models • partners
Workforce • Increased specialism • Inability to recruit • Training timeline • Ways of working	• Development of advanced practitioner roles • Working with HEIW • Workforce reviews: SACT nursing, pharmacy, medical, CNS • Regional planning and delivery models
Finance £1.5m savings target	• Cost savings plans • Data quality/entry and commissioning • Engagement in Value based healthcare

Welsh Blood Service Plan (summary)

Planning Assumptions for Red Cells and Platelets

- Demand for 2023/24 to remain in line with 2022/23
- Capacity built into collection model to account for natural variation
- Minimising wastage
- Regularly monitoring actual against forecasted issuing – flexing collection and manufacturing plans accordingly

Key Priorities for 2023/2024

- Talbot Green Infrastructure – develop energy efficient, sustainable, future proofed estate
- Laboratory Services Modernisation – review & develop processes, practices and workforce requirements to support quality, safety and value
- Collection Services Modernisation – review & develop processes, practices and workforce requirements to support quality, safety and value
- Quality Assurance Modernisation – efficient and effective management of regulatory compliance maximising digital technology
- Plasma for Medicines – work with Welsh Government to develop and deliver a service model for Wales

Key Priorities for 2023/2024

- Safe Care Collaborative:
  - Donor Adverse Event Reporting Project
  - Haemochromatosis Patients Project
- Digital Transformation – implement new digital platforms to support blood supply chain and transplantation in Wales
- Workforce Model – develop a sustainable model which provides leadership, resilience and succession planning
- Service Development & Regulation, including:
  - Implementation of Pre-Operative Anaemia Pathway (value based healthcare model)
  - Implementing recommendations on blood donor testing to reduce risk of Hepatitis B transmission
  - Develop and implement strategy for growth and retention of stem cell donor panel, including increasing recruitment from ethnic minorities

Workforce Plan (summary)

Workforce Priorities

People Priorities

Our strategic priorities reflect our organisational objectives for workforce and the focus of Velindre University's Sustainability and Digital plans. Realising our priorities will ensure we achieve constantly well-led teams, staffed with the right staff, maximising skill sets and learning, where individuals' wellbeing and identity is nurtured, enhancing our great care.

Ein gwerthoedd: BYDD	Atebol	Feiddgar	Caredig	Ddynamig
Our values: BE	Accountable	Bold	Caring	Dynamic

Delivering the Priorities

- Wellbeing - Implementing a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement. Celebrating success, ensuring our staff feel valued

- Education and Learning - Implementing our education strategy to support staff to grow professionally and offer internal and external pathways to gain experience and knowledge

- Supply and Shape - Developing our data, information and insight to support the embedding our workforce planning process to support new ways of working for our staff; Developing our talent management process that support career pathways

- Attraction and Retention – Targeting an increase in bi-lingual recruitment to grow our Welsh speaking workforce; Implement an agile approach to working

- Leadership and succession – Grow the Trust Inspire Leadership and Management Programme

- Digital Workforce – Working with partnerships both in academia and nationally to ensure the staff have the skills to maximise opportunities provided by digital technology

Challenges

Workforce: Supply and Shape:

- Clinical agreed short and long-term MDT workforce plans
- Attract and retain the right people in the right place at the right time with the right skills
- Services delivered at a location and time which best suits our patients and donors

Healthy and Engaged Workforce;

- All staff to be proud to, and able to, promote our core values and principles
- Improved health and well-being of our workforce

Finance Plan (summary)

IMTP Financial Planning Assumptions

Financial Plan 2023-24

- ***Planning to deliver a balanced financial plan in 2023-24:***
  - ***based on a range of assumptions***
  - ***significant level of risk at c£3.1m which will be managed through the identified opportunities of c£2.6m***

Brought Forward Underlying Surplus:

- Eliminated the underlying deficit of £0.500m during 2022-23 and establish a core recurrent financially balanced position.
- C/fwd into 23-24 surplus of £0.684m – Rec Funding reserved in 22-23 to contribute to cost of energy price infl.& Covid response - WG didn't confirm they would fund until Nov '22
- The balance of the underlying surplus is forecast to reduce year-on-year as cost pressures increase over the 3-year planning period.

Funding Growth & Savings:

- 1.5% core discretionary uplift funding £1.104m will be utilised to mitigate exceptional energy cost pressure and other National cost pressures.
- Covid recovery & planned care backlog funding will be recovered from Commissioners through LTA activity performance related marginal income.
  - There is a £1.500m risk of shortfall in income compared to cost of additional capacity investment.
  - The plan assumes no Nationally agreed LTA income protection in 2023-24.
- £1.77m of service growth income to fund acute oncology, IRS, RT service developments, Red Cell Immuno-haematology. SACT infrastructure
- Savings of £1.8m through cost reduction and income growth to mitigate cost pressures

Cost pressures:

- Energy price Infl. and National / General Pressures of Digital – software & systems, non-pay & NHS SLA Infl., enhanced cleaning
- Local growth and cost pressures need to be mitigated, funded from existing budgets in service divisions or require additional savings above the £1.8m target already identified.

Medium Term Financial Plan – Marginal Impact

Key Planning Assumptions 23/24

Overall Position

- 1.5% LTA uplift & unallocated reserves required for unavoidable cost pressures e,g, energy
- Pay Infl. for 23-24 expected to fully funded by WG (not yet finalised - excluded from plan).

Savings Requirement

- Identified schemes against full savings target of £1.8m, (£1m RAG Green & £0.8m RAG Amber).
- Work to finalise plans or mitigate risks of Amber schemes to meet savings requirement
- Additional pressures / new investments in Divisions will require additional savings to fund
- Plan assumes Divisions will maintain a vacancy factor of at least £1m

Commissioner Funding

- £1.5m risk income not covering covid capacity cost based on 22-23 year-end outturn f'cast (no LTA protection) - may in part be mitigated if partial LTA income protection agreed for 23-24
- Activity demand modelling forecasts £0.700m additional income above the £3.5m capacity cost investment without LTA protection, assuming activity can be delivered within existing capacity
- Trust will require investment from Commissioners for new / changes to existing services.

Cost pressures / Investments

- Energy price Infl. and National / General Pressures of Digital – software & systems, non-pay & NHS SLA Infl., enhanced cleaning
- Plan assumes no additional investment in major programme / project resources beyond those agreed in capital business cases – CEO has flagged to DGH&SC need for n VCC transition
- The plan assumes Divisions will mitigate or manage 22-23 pay inflation funding shortfall of £0.5m and other local cost pressures (VCC) of c£0.800m not recognised in the financial plan

	2023-24		2024-25		2025-26	
Summary of Financial Plan 2023-26	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000
Underlying Core Position b/f	0	0	391	391	290	290
Unallocated reserves b/f	684	684	0	0	0	0
b/fwd. underlying deficit	**684**	**684**	**391**	**391**	**290**	**290**
Revenue						
WG Covid Programme Funding (PPE)	240	0	0	0	0	0
WG Velindre Pay Commissioner Pay Award	71	71	71	71	71	71
AME & Non Cash Depreciation Funding Uplift Assumption	17,502	0	11,432	0	11,432	0
1.5% Recurrent LTA Core Uplift (1.5% 23/24 0.75% 24/25 & *assumed 1% 25/26)*	1,104	1,104	585	585	786	786
Agreed LTA Income Growth - NICE / HCDs & Blood derived medicines	11,300	11,300	10,171	10,171	10,401	10,401
LTA Service Growth Investment	1,772	1,772	1,007	1,007	7,969	5,557
LTA marginal income activity - Covid Recovery and Planned Care Backlog	1,974	1,974	0	0	0	0
Total Revenue	**33,963**	**16,221**	**23,266**	**11,834**	**30,659**	**16,815**
In year Changes to Operation Cost Base						
WG Covid Programme Funding (PPE)	(240)	0	0	0	0	0
AME & Non Cash Depreciation Uplift Assumption	(17,502)		(11,432)		(11,432)	
LTA Service Growth Investment	(1,772)	(1,772)	(1,007)	(1,007)	(7,969)	(5,557)
VCC NICE / HCD Drug volume & price growth	(7,864)	(7,864)	(7,864)	(7,864)	(7,864)	(7,864)
WBS Blood derived medicines volume & price infl.	(3,436)	(3,436)	(2,307)	(2,307)	(2,537)	(2,537)
Exceptional National Cost Pressure - Energy price infl.	(1,191)	0	(1,090)	0	(779)	0
National / General Cost Pressures	(757)	(757)	(422)	(422)	(396)	(396)
Local Cost Pressures	(257)	(257)	(836)	(836)	(1,272)	(1,251)
Covid Recovery and Planned Care Backlog	(3,428)	(3,428)	0	0	0	0
Total In Year Changes to Cost Base	**(36,447)**	**(17,514)**	**(24,957)**	**(12,436)**	**(32,249)**	**(17,605)**
Net Opening Balance before Savings	**(1,800)**	**(609)**	**(1,300)**	**(211)**	**(1,300)**	**(500)**
Savings Plan (2.3%)	1,800	1,000	1,300	500	1,300	500
Net Income Generation	0	0	0	0	0	0
Net Opening Balance	**(0)**	**391**	**0**	**290**	**0**	**0**

Savings / Income Generation

Savings Plans:

- Tables below summarise level of savings Trust is planning to deliver during 2023-24 which will be required to support increase in Energy Prices and cost of Covid Recovery and Planned Care Backlog Capacity not covered by LTA income.
- Currently identified the full savings target of £1.800m (£1.000m Recurrent and £0.800m Non-recurrent):
  - £1.003m RAG rated Green: £0.695m Rec & £0.308m Non-Rec – plans in place to deliver
  - £0.797m RAG rated Amber: £0.305m Rec & £0.492m Non-Rec – plans still in development
- As well as the cash releasing £1.8m savings the Divisions will be implementing value improvement, efficiency and productivity opportunities

Trust Savings 2023/24 by Cost Improvement Plan and Income Generation

Savings Plan	2023-24 £k
CIP Planned Savings	1,275
Income Generation	525
Total Savings / Income Generation	**1,800**
CIP % (of Core LTA)	**2.3%**

Trust Savings 2023/24 by Division

Savings Plan by Division	Target £k	Identified £k	Savings Target Gap £k
Welsh Blood Service	700	700	0
Velindre Cancer Centre	950	950	0
Corporate Services	150	150	0
Total	**1,800**	**1,800**	**0**

Financial Risks and Opportunities

Key financial risks and opportunities are highlighted in the tables.

The net financial risk to the Trust has been assessed through these scenarios as follows:

- Worst Case (£2.932m) deficit
- Best Case £2.600m surplus

Key Financial Risks	Worst Case £'000	Best Case £'000	Risk Mitigation
Non-delivery of amber / red saving schemes	(797)	0	Service to urgently review savings schemes that are classified as amber with a view to turn green or find replacement schemes
Further rise in energy prices	(500)	0	Will form part of all Wales approach, reviewed by WEG and WEOG groups.
Management of operational Pressures	(900)	0	Operational cost pressures to be mitigated at divisional level
SDEC Funding	(935)	0	Seeking written confirmation from WG that the SDEC funding allocation is recurrent.
Total Risks	**(3,132)**	**0**	

Key Financial Opportunities	Worst Case £'000	Best Case £'000	Opportunity application and action
Covid Capacity and Backlog Activity Performance	0	700	Income generation through activity performance supports Covid Capacity and backlog infrastructure
Covid Capacity and Backlog Cost Reduction	TBC	TBC	Review service model that has been implemented to support backlog and where possible reduce or mitigate costs.
Further vacancy turnover savings above the vacancy factor held in divisions	200	400	Used to provide non-rec savings against savings schemes that are amber.
Emergency Reserve	0	500	Reserve held for emergency expenditure, which could be released if risks do not materialise.
Reduction in Energy prices	0	500	Will form part of all Wales approach, reviewed by WEG and WEOG groups.
Contract Currency review in recognition of underlying cost base.	0	500	Review and update contract currencies where Service Developments or changes have impacted the underlying cost base.
Total Opportunities	**200**	**2,600**	

Capital Financial Plan

All Wales Schemes

- Approved CEL
  - TCS nVCC enabling works £9.526m (April 23 – March 2024)
  - IRS - £31.773m (latest forecast position) (April 23 to March 2026)
  - IRS Satellite Centre - £11.412m (April 23 to March 2026)

- Unapproved Major Capital Programmes (In Discussion with WG)
  - TCS nVCC FBC - £48.447m
  - WBS HQ – Total £34.901m
  - Plasma Fractionation - £TBC

Discretionary

- Trust Discretionary allocation of £1.683m (2023/24) which is an increase from £1.454m (2022/23)

Accelerated Depreciation & Impairment Charge

- Accelerated depreciation funding: £31.4m over 3 years of the IMTP 2023-24 to 2025-26 in relation to the existing cancer centre building and equipment

- Anticipated impairment charge funding: requirement in 2023-24 of £5.9m in relation to capital costs incurred on the ASDA Enabling Works access road for nVCC

All Wales Approved and Unapproved Capital Schemes	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works	7.979	0.000	1.547			9.526
Integrated Radiotherapy Solution (IRS)	10.326	15.813	5.634			31.773
IRS Satellite Centre	1.347	10.065				11.412
Total Approved Capital Schemes	**19.652**	**25.878**	**7.181**	**0.000**	**0.000**	**52.711**
All Wales Unapproved Schemes						
TCS nVCC	7.168	34.132	7.147			48.447
TCS nVCC Enabling works	1.000					1.000
WBS HQ	0.120	1.016	12.808	9.996	10.961	34.901
Plasma Fractionation (under development)						0.000
WBS Fleet Replacement		1.400				1.400
WTAIL Lims Case	0.826	0.066				0.892
WBS Blood Establishment Computer System (BECS) (under development)						0.000
WBS Blood Group Analyser Replacement		0.480				0.480
WBS Asset Replacement		0.300	0.400	0.500		1.200
VCC Replacement Brachytherapy Applicators			0.300			0.300
Digital Services	0.650	0.400	0.400	0.400		1.850
Digital 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	**31.952**	**64.208**	**28.236**	**10.896**	**10.961**	**146.253**

IMTP Key Risks (summary)

Key Risks to the Delivery of our IMTP for 2023/24 – 2025/26

- Balancing demand and capacity as our plan is based upon a number of planning / demand assumptions which we will need to continually review with our Health Board partners
- Workforce:
  - Recruitment and retention of our workforce
  - Staff sickness / well-being
- Delivering a number of complex transformation programmes of work
- Financial risks (income etc.)

TRUST BOARD

TRUST INTEGRATED MEDIUM TERM PLAN FOR 2022/2023

PROGRESS UPDATE FOR QUARTER 3 (OCTOBER–DECEMBER 2022)

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

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

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	February 2023	Noted
Quality, Safety and Performance Committee	16th March 2023	Noted

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 The Integrated Medium Term Plan (2022/2025) was approved by the Minister for Health and Social Service in July 2022. Included within the approved IMTP were action plans for both cancer and blood and transplant services. Delivery of these action plans are integral in supporting the delivery of the Trust's strategic aims and objectives.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached papers (Appendices A and B) provide quarter 3 (2022/2023) progress updates in the form of IMTP Quarterly Actions Progress Monitoring templates for WBS and VCC.

2.2 Please note that the update provided reflects our position as of the end of December 2022/2023. An end of year IMTP progress report for 2022/2023 (quarter 4 (January 2023 – March 2023)) will be presented at the next Board meeting.

Feedback from the Quality, Safety and Performance Committee (16th March 2023):

2.3 The IMTP progress update reports (attached) for WBS and VCC were presented to the Quality, Safety and Performance Committee on 16th March 2023. The updates were noted and discussed in detail. Following the discussion, it was agreed that the following actions would be taken to further strengthen the monitoring arrangements:

- Cover papers / and or IMTP progress reports will need to better summarise performance by service area, and will need to:
    - Better explain the 'ca*use and effect*' of not delivering actions which are identified within the IMTP (where there is a direct correlation).

- Better articulate the impact upon Trust service quality / performance if the actions, as identified within the IMTP, were / are not delivered.

- Better triangulate delivery of IMTP actions against the Trust Assurance Framework, Performance Management Framework and the Trust Quality Framework.

2.4 A plan will be developed to achieve this, and the strengthening will support the continued improvement of services provided by the Trust.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the progress made, as of Quarter 3 (2022/2023), in delivering the key Trust actions included within the approved IMTP for 2022/2023.

Welsh Blood Service IMTP Quarterly Progress Report 2022/23 for Quarter 3

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q3**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
SP1: Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality and modern	**1.** Develop and introduce Plasma For Fractionation - Medicine Service Model for Wales.	Scope service need. Project group established.	Business case to Welsh Government.	Develop draft service model.	Service model approved.	UK wide MOU in place and induction activities are underway. Governance of the UK and Welsh Programme being considered. Timetable for UK programme has shifted and is being re-assessed	
	2. Develop and implement Donor Strategy.	Scope service need. Project structure established. Draft strategy produced.	Consultation on strategy.	Implementation plan developed.	Implementation of eDRM phase 1 to support delivery of implementation plan.	Strategy under development – consultation underway.	
	3. Develop and implement WBMDR strategy.	Scope service need project structure established draft strategy produced.	Consultation on strategy.	Implementation plan developed.	Implementation commence.	The WBMDR five-year strategy is in development and will reappraise the existing collection model and its ambition. The Recovery Plan is being implemented to increase recruitment of bone marrow volunteers.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q3**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	4. Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose.	Establish project structure review service models to meet need & undertake service/data review in light of COVID and proposed contract variation.	Undertake service/data review in light of COVID and proposed contract variation.	Complete OCP process in relation to service model.	Complete OCP process in relation to service model.	OCP concluded and the plan for implementation has been developed.	
SP2: Meet the patient demand for blood and blood products through faciltiating the most appropriate use across Health organisations	**5.** Introduction of 'live connectivity' to allow 'real-time' information to be shared WBS, laboratories and health board transfusion/clinical teams.	Scope opportunities for digital technology to support sharing real time data and transfer of goods between WBS and customers.	Establish technology solutions.	Identify resources to support implementation.	Implementation commence.	Collaboration with Cardiff & Vale UHB to secure Welsh Government funding to support electronic blood management system continues. Resubmission of the business case is scheduled for February 2023.	
SP3: Provide safe, high quality and the most advanced	**6.** Assess and implement SaBTO (guidelines 2021 release date) recommendations	Confirm role of WBS with Welsh Government establish project structure.	Complete OCP process in relation to service mode.	Establish workforce model.	Implementation.	The referral pathway is in operation with no new OBI confirmed cases identified to date. Communication documents agreed for	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q3**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
manufacturing, distrbution and testing laboratory services	on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.					implementation and Wales will be the first to initiate the recipient lookback pathway. Wales went live with lookback pathway on 16th January 2023. Working closely with Health Boards closely on identifying patient cases.	
SP4: Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services	**7.** Deliver WLIMS modules for Blood Transfusion (BT)	Scope service specification.	Undertake procurement.	Undertake procurement.	Complete USR procurement.	This project being transferred to DHCW for future management and implementation.	
	8. Implementation of Foetal DNA typing.	Engage with Antenatal Screening services to develop implementation plan.	Agree implementation plan.	Take forward implementation.	Take forward implementation.	Project groups progressing, and procurement process for the kits has started with samples for validation identified by WBS and supplied by NHSBT.	
SP5: Provide, services that are environmentally sustainable and benefit our local	**9.** Establish a quality assurance modernisation programme to develop and implement strategy which support more efficient and effective	Project to be scoped. Project structure established. Phased work plan.	Develop implementation plan.	Take forward implementation.		Tender for eQMS complete: extension to QPulse licenses for a further 12 months to December 2023. eQMS user specification considerations being addressed to support re-procurement exercise (ongoing).	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q3**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
communities and Wales	management of regulatory compliance and maximising digital technology.					Electronic signature system (Docusign) contracts signed and system activated (rollout in Q4 following initial use in Labs). Presentation to WBS SMT regarding 7 levels of Assurance Framework, Duty of Candour and Duty of Quality.	
	10. Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions.	Submit OBC for Talbot Green infrastructure Project	Procure support to develop FBC.	Appoint Healthcare planner to develop FBC.	FBC submitted to Welsh Government.	Feasibility study to commence in January 2023 to fully understand phasing in light of Laboratory Modernisation Programme and Plasma for Medicines and the impacts on this programme.	
SP6: Be a great organisation with great people dedicated to improving outcomes for	**11.** Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning.	Engagement with teams in relation to review of Clinical Services. Review of Facilities model. Review of BI.	Development of service model paper to be developed for approval.	Development of service model paper to be developed for approval.	Implementation plan developed.	Structure drafted and consultation document being prepared for consultation in Q4.	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q3**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
patients and donors.							
	12. Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS.	Scope programme of work. Establish project structure.	Develop implementation plan.	Business case submitted to WHSSC to support implementation of new standards and guidance in component development lab.	Funding secured.	Programme governance structure in place. Feasibility study underway to understand how this programme integrates with Talbot Green Infrastructure Programme.	
	13. Lead the All Wales approach to implementation of Welsh Government Statement of Intent for Advanced Therapies.	Secure funding review structure and develop work plan 2022/23.	Clinical lead appointed. Implementation of work plan.	Implementation of work plan.	Implementation of work plan.	New working group meetings started in September 2022, and the new Delivery Plan is in development. The Apheresis Status Review project start is imminent, and a new Clinical Lead position being considered. The re-engagement with Health Boards is to start in Dec/Jan	
	14. Support UK Infected Blood	IBI continues	IBI continues	IBI continues	IBI continues	Oral submissions have now concluded, with final written	

IMTP Strategic Priorities WBS Service Delivery Framework 2022/23							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**					
		2022/23				**Quarterly Progress Update for Q3**	**Progress Rating**
		Q1	**Q2**	**Q3**	**Q4**		
	Inquiry and delivery of its Terms of Reference.					submission prepared by Trust Counsel in consultation with the other UK Blood Services. The deadline for submission was 16th December 2022. Final Inquiry oral statement will be delivered on behalf of WBS by the KC representing the Trust on January 26th 2023. Initial report expected in the Summer/Autumn of 2023.	

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
Strategic Priority 1: Access to equitable and consistent care, no matter where; To meet increasing demand	**1.** SACT Capacity Plan	Maintain high level of chair utilisation at VCC to support capacity growth. (see 2023/24)	Implement programme to attract and retain SACT trained staff, and increase nurse led 'protocol' clinics to shift to a greater nurse led are model for SACT	New nursing staff in post and trained	Commence booking service review.	Task and finish group established with work plan for short term options. Impact assessments undertaken and weekly tracking of data undertaken. Capacity review of bookings team complete, nursing team underway and review of pharmacy services to commence in September. Discussions ongoing with regard to where injectable treatments are best placed to	Additional clinics commenced on 6th August and planned to mid October 2022. Plan under development to increase capacity within Macmillan Unit at PCH. Recruitment campaign has been successful. Discussions ongoing with Executive Director of Nursing and Chief Operating Officer regarding workforce plan.	Additional chair capacity supported at the Macmillan Unit at Prince Charles Hospital by the deployment of new nursing resource. Chair capacity at VCC maintained.	

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						be undertaken with a view to releasing SACT capacity.			
		Finalise interim facility plan at Neville Hall Hospital.	Work with ABUHB to identify appropriate accommodation	Review workforce requirements to support interim service model across PCH and NHH	implement plan to support interim NHH model	Initial accommodation challenges at NHH resulted in a re-focus to expand capacity at PCH. NHH are continuing to explore options which VCC will need to consider as fit for purpose. Expansion to either/both is subject to staffing capacity modelling and resourcing.	Data modelling of geographical flows underway to determine level of demand.	Cooperative work with ABUHB to prepare site/unit. Date for re-opening agreed (end of March 2023).	

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
		Commence contract with third party provider to deliver SACT chair capacity while Neville Hall is progressing	Implement staffing review agreed actions.	Develop business case for SACT Consultant Nurse/ Pharmacist.		Substantial readiness work undertaken throughout Q1. However, RCC went into liquidation June and therefore objective has to be withdrawn.			
		Commence the SACT Improvement / Transformation programme to develop a robust service which is 'fit for the future' to include review staffing model and assess workforce options.	Review of booking clerk capacity to be undertaken	Review of nursing capacity to be undertaken review of pharmacy capacity to be undertaken	Review pharmacy capacity to be completed	Task and finish group established with workplan for short term options. Impact assessments undertaken and weekly tracking of data undertaken. Capacity review of bookings team complete, nursing team underway and	Performance relative to key performance indicators improving during quarter 2. SACT task and finish group continue to meet, nurse modelling completed, pharmacy review commenced.	Compliance against time to treatment Key Performance Indicators returned to within tolerance in November. SACT Task and Finish Group recommendations issued and action plan for improvement in development.	

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						review of pharmacy services to commence in September. Discussions ongoing with regard to where injectable treatments are best placed to be undertaken with a view to releasing SACT capacity.	Additional clinics commenced on 6th August and planned to mid October 2022. Plan under development to increase capacity within Macmillan Unit at PCH.		
	2. Radiation Services Capacity Plan	Maximise Rutherford contract – revised service	MRI refurbishment in radiology	Streamline plan complexity for certain palliative scenarios.		RCC has gone into liquidation therefore this option is withdrawn Discussions are currently underway with the new private provider around contracting options for RCC.			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
		Begin project to increase Linac capacity to 80 hours (73 currently)	Implement 80 hours Linac capacity	Finalise proposals for capacity increase to 80 hours	Implement 80 hours Linac capacity	Capacity Planning meeting in place with RT treatment team – dependencies linked to recruitment start dates quarter 4	Linac capacity increased to 75 hours from July. Further expansion to 76 hours planned to take place at beginning of October. Capacity Planning meeting in place with RT treatment team – dependencies linked to recruitment start dates quarter 4.	Linac capacity periodically reduced as various upgrades carried out on TrueBeam machines as part of IRS implementation. Anticipated that expansion to 78 hours will be effected from March 2023.	

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
		Complete Brachytherapy Peer Review and submit Business Case for additional planned capacity to meet demand.	Brachytherapy action plan delivery business case potentially here as will need to follow the action plan from the peer review and workforce review			Peer Review complete and action plan in development.	Engagement with WHSSC undertaken. Commitment secured to fund expansion of prostate service to a maximum of 78 patients per year. Following benchmarking exercise undertaken with the Clatterbridge Cancer Centre a capacity and workforce review and gap analysis of gynae service ahead of the development of a service development	Workforce recruitment to support prostate service expansion underway. Implementation and staff training ongoing alongside review to inform future service model.	

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
							business case for submission to WHSSC in late 2022/23.		
		Review demand and capacity for clinical trials	Explore dose and fractionation schedules and alternative treatment approaches			Medical decision required on alternative treatment options trial capacity specifically detailed in service capacity plan			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
		Review the Linac transition capacity for IRS implementation.	Agree the position on temporary/ mobile/ fully commissioned leased bunkers while IRS process takes down fleet.				IRS updated paper approved by to Executive Management Board September with plan for first linac replacement. Radiotherapy recruitment complete, medical physics underway	Recruitment to identified medical physics roles complete.	
	3. Radiotherapy Pathway/COSC target achievement and radiotherapy clinical treatment developments	Programme to review efficiency of existing pathways continues including reduction in variation in ways of working /action plan developed.	Develop standard operating procedures for pathway management, building on those developed in Lung Pathways and emerging themes/challen	Evaluate roles for advanced practice particularly Non-Medical Outliners in optimal pathways with SST leads.	Implement agreed pathway and workforce models developed to meet COSC target requirements.	Requires VCC wide response linked to demand profile and pathway development. Requires medical leadership and decision making to implement improved ways of working	Pathway and practice review on a site by site basis progressed (led by Dr Tom Rackley). Process intended to identify and scale good practice/learning, to identify and address	Site-by-site pathway review continued to progress. Radiotherapy pathway improvement project identified for inclusion in proposed pathway	

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
			ges with SST leads.			identified from initial pathway work.	systemic issues via the Radiotherapy Management Group and other groups. Data analysis undertaken to identify trends in breaches, missed appointments and cancellations to determine areas for improvement. Further support commissioned through Improvement Cymru for pathway development/review.	improvement programme. Scope of project to be defined and Terms of Reference to be developed.	

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
							VCC actively involved in the Wales Cancer Network Lung cancer pathway review. All Site Specialist Teams (SST's) have now undertaken one deep dive session.		
						This manual data capture to deliver gap analysis.			
						Support commissioned through Improvement Cymru for pathway development/review.			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						VCC actively involved in the Wales Cancer Network Lung cancer pathway review.			
						All Site Specialist Teams (SST's) have now undertaken one deep dive session.			
		Engage with WHSSC on PRRT service to deliver patient benefit (awaiting WHSSC decision)	Engage with WHSSC on PRRT service to deliver patient benefit	PRRT business case if able to progress	Finalise business case and Delivery of PRRT plan	Service specification required from WHSSC. Initial WHSSC response to open service Q1 2023.	WHSSC have established a national MRT programme board with Velindre input. Programme board will lead on the development of a service specification, in conjunction with clinical stakeholders.	Service developing business case and preparing to engage in WHSSC facilitated appraisal process in anticipation of possible commissioning of new service in 2023-24 (formal appraisal	

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
							Work scheduled to begin in autumn 2022.	scheduled to begin in March/April 2023).	
		Review proposed RT treatment developments including IMRT to establish capacity and commissioning approach	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners with priority treatment development plan and delivery	Active engagement with commissioners remains in place. Specific business cases to be provided to Commissioners, with a focus on the highest priority developments, inclusive of clinical benefits to patients and service benefits in terms of productivity. Radiotherapy	New quarterly meeting instituted between VCC and WHSSC to review specialist services and inform planning and development work. ToRs of VCC Collective Commissioning Group reviewed and governance and reporting links strengthened.	Prostate treatment planning group established to support transfer of activity to newly commissioned linac and to consider adoption of new radiotherapy techniques. Prioritisation of new techniques identified within IMTP 2023/24	

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						developments prioritisation completed a number of years ago so needs to be reviewed radiotherapy	Specific business cases to be provided to Commissioners, with a focus on the highest priority developments, inclusive of clinical benefits to patients and service benefits in terms of productivity. Radiotherapy developments prioritisation completed a number of years ago so needs to be reviewed.		
	4. Outpatient Services/Medical Directorate	SST and Outpatient Transformation programmes to commence	The transformation objectives for the SSTs and Outpatient	Deliver transformation programmes-estate,	Deliver transformation programmes-estate,	Transformation programme structure in place with reporting into	SST reviews commenced July and continuing into August 2022.	Work initiated in Outpatients to describe patient flow, to support development of	

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
		building on pre-pandemic work. (interdependent with radiotherapy projects)	workforce will continue as previously described in quarter 1.	pathways and workforce	pathways and workforce	Velindre Futures. A draft high level outpatient work programme has been developed has been discussed with further work progressing on providing more details plans. The transformation programme is built upon the National aims and objectives. The programme is interdependent upon all other services.	Draft Outpatient Work Programme developed in collaboration with the Medical Directorate. This has been reviewed, feedback provided, plan to be adjusted and submitted for final approval. Performance Management Framework will include National targets regarding outpatient services.	activity baselines and to determine capacity and capacity constraints. Outpatient work identified as a project/workstream under within new pathway improvement programme. Scope of project and Terms of Reference to be developed.	

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
		Rolling programme of SST 'supportive reviews' to commence to work to ensure that pathways are effective, efficient and smooth, and to inform modernisation of the multidisciplinary workforce model.							
		Commence workforce modelling and planning within the SSTs and Outpatient teams (and link to radiotherapy); maximising opportunities				**OPD** capacity and demand plan under development. Nursing establishment review completed leading to a review of skill mix leading to		Workforce capacity modelling in Outpatients commenced for CNSs	

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
		for enhancing skill mix and embracing more efficient ways of working				advertisement of band 4 apprenticeship nursing roles which is the first of its type at VCC.			
						Upskilling of HCSW's			
						All trained nurses to complete SACT passport to support the demand for injectables			
		Maximise use of virtual consultations and embed into 'business as usual'. (50% at present).				Utilisation of virtual consultations has continued and is firmly embedded in to service, via	Utilisation of virtual consultations has continued and is firmly embedded in to service. Welsh	Virtual consultations continue to be utilised as standard. Rates of utilisation continue to be	

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						telephone and video conferencing technology. Virtual group sessions have also been introduced and further extended within the Therapies service. Positive feedback received from Welsh Government on use of virtual technology. Usage data is monitored by the Outpatient Management Group.	Government refers to Velindre Cancer Centre as an 'exemplar' due the rapid transformation and modernisation of outpatient appointments and group sessions.	actively monitored.	

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
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						Phlebotomy services continues function at an activity rate of an average of 100 patients per day with activity aligned to an increase in SACT. Electronic test requests are completed and issued to patients (excluding patients under Cardiff and Vale University Health Board as Velindre Cancer Centre is contracted to undertake this service) to attend their local primary or	The ratio of face to face/virtual consultations is continually monitored by the Outpatient Management Group.	Active monitoring of activity continues as standard.	

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						secondary care service for pre clinic bloods, however, it is noted that a number of GP practices have refused to complete 'hospital bloods'. The scale of this is under review.			

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		Establish optimum levels of Phlebotomy provision and notify HBs of changes in access.				Outpatient Nursing Team and Reception Staff have implemented extended working hours from 08:00 to 18:00 hours to provide support to meet increased demand. Feedback from the SST deep dives and discussions with the Medical Directorate Manager are underway in respect of demand/request for evening/weekend working without the	Opportunities to increase activity have been explored with further SACT injectable treatment delivered within the Department (within the Outpatient Treatment Room). Discussions remain on-going in relation to further opportunities.		
		Provide increased capacity incl. at evenings/week ends to meet demand initially while the more fundamental pathway changes and							

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		ways of working are introduced pending service improvement efficiency delivery.				outpatient department. Weekend working is in place and fully established for phlebotomy during bank holidays. Opportunities to increase activity within the Outpatient Treatment Room are under discussion.			
		Work to reduce demand within the Outpatient setting, including: review and streamlining of patient pathways and the implementatio				Patient pathways under review by each SST and explored during deep dive sessions. The Cancer Centre has commenced a PSA self-management		Review of workforce and physical capacity utilisation and patient pathways commenced in Outpatients.	

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		n of the 'supported self-management' model				project with the view to extending self-management models across other sites.			
		Re-commence the pre Covid Outreach Clinics	outreach project group to be re-established outreach project manager to be appointed	review of data assumptions and workforce requirements to support outreach clinics identification of gaps to support service delivery		Most outreach clinics have been repatriated. The remaining clinics are mainly within Aneurin Bevan University Health Board and have been escalated for resolution.	Engagement with Aneurin Bevan UHB undertaken to address key challenges currently being worked through to progress the return the remaining oncology clinics to Neville Hall and Royal Gwent Hospitals.	The majority of outpatient activity previously undertaken at the Royal Gwent Hospital now reinstated at that location. Ongoing discussions with ABUHB on return of outpatient activity to the Nevill Hall site.	

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Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments	5. Digital Health Care Record (CANISC Replacement)	Finalise development	Testing and training	Commence Go Live Phases– dry run	Review impact of implementation on operational delivery	DHCW have delivered much of the software as outlined in the re-profiled plan. There are elements of the individual developments that require further work. VCC along with colleagues from across the wider NHS Wales Oncology service are continuing to work closely with DHCW to resolve these issues and find a solution that aligned with both national and local requirements.		DHCW 'go live' in November. Record adopted for use by all services at VCC. Ongoing support for implementation provided by DHCR project and applications teams and DHCW.	

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		Functional testing	Operational Go Live planning	Dry run weekend planned Complete Go Live review impact on service delivery and lessons learned	Plan phase 2	All required functional testing has been completed and the data migration plan is on schedule to compete the final sign off in Q3. The training plan was completed in readiness for the operational review. Implementation and operational readiness planning commenced as planned, these will be refined as the organisation moves toward the go-live			
		User Acceptance Testing	Go Live readiness assessment						
			Go Live run through						
		Data Migration	SOP development						
		Operational service change planning							
		Training sign off							

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						scheduled for November 2022.			
	6. Integrated Radiotherapy Solution	Complete Tender Evaluation and Identify Winning Bidder, issue standstill letter.	Complete hybrid OBC/FBC and submit to WG and await approval.	LA6 Bunker Decommissioning commences	LA6 Bunker Refurb complete.	Project team evaluations concluded in April 2022. Minimum Threshold Scored Questions (MTSQ) and Pricing clarifications developed by the team, were issued and responses received from bidders were subsequently reviews for final evaluation	Engagement with Varian continued. Negotiation with Elekta to ensure ongoing maintenance of machines undertaken and commitment of expenditure papers developed for consideration by the Trust Board.	Delivery of first replacement linac (LA5) agreed for January 2023. Preparatory work in anticipation of delivery and equipment commissioning undertaken.	

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			Award IRS contract once approval of capital and revenue funding.		Service plans for second machine replacement confirmed.	Draft Procurement outcome report was developed for mid-April with a Legal review scheduled.			
			Receive vendors detailed implementation plans			Work was ongoing with the team for drafting approvals and to finalise OBC/FBC including agreement of resource for implementation, risk and benefit owners to ensure alignment and a smooth transition from			

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						procurement to implementation transition			
					Initial scoping works on TPS/OIS replacement and Phase 1 additional functionality.	Multiple legal reviews for finalisation of the IRS Procurement Outcome Evaluation Report were scheduled and attended by the team. Development of Alcatel report with the legal team for issue to bidders on procurement award outcome was developed			

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						for Board approval			
						Issued to bidders following SRO approval in early June			
					Plans for Satellite and nVCC confirmed				
						June			
						IRS Contract development was ongoing with the support of Legal for finalisation of the contract. Meetings were scheduled throughout July & August to			

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						finalise the IRS contract with Varian			
		Appoint Radiation Services Programme Manager to lead implementation and commence design of 1st bunker.	Prepare recruitment of IRS implementation posts.	Recruit to IRS implementation posts		Actions on track managed through IRS Implementation programme Board	Actions on track managed through IRS implementation programme board.	Actions on track managed through IRS implementation programme board.	
		Establish Shadow Implementation Board		Commence formal IRS implementation – shadow implementatio			The shadow IRS implementation board continues to meet with good	The shadow IRS implementation board continues to meet with good	

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				n board stands up as a formal board.			engagement between the procurement team and the implementation team.	engagement between the procurement team and the implementation team.	
	7. Acute Oncology Service- local delivery	Recruit ANPs and other staff	Pathway design with region	Pathway implementation	Pathway implementation	ANP Lead Nurse has recently completed an Establishment Review of the ANP workforce to ensure appropriate staffing levels and skill mix for the AOS service going forward.	Ongoing recruitment within the ANP team to ensure appropriate staffing levels and skill mix. Dedicated ANP to provide outreach clinical support for teams.	2 new trainee ANPs recruited. Undergoing active and ongoing training/development.	

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	8. Integrated care	Scope bed plans/model for assessment unit aligned to the VCC element of AOS.	Continue to review the unscheduled care patient pathway aligned to the VCC element of AOS.			Work continues with regional AOS teams to develop robust AOS model. Ongoing work to improve lunchtime AOS meetings with Health Boards. Work also ongoing with service leads to discuss the model for Unscheduled care and a VCC Clinical Model Review Group established and action plan developed.	Work being progressed via the Clinical Model Review Group led by Annie Evans. Presentation to the Integrated Care Operational Group by Annie Evans to define next steps.	Work undertaken to develop suite of measures / indicators to support monitoring of activity locally. MSCC pathway identified as eligible for service improvement input as part of the national Safe Care Collaborative initiative. Working group to be identified and scope of	

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								work to be defined.	
		Develop plans for delivering national projects e.g. Immuno Oncology (SDEC) Immunohematology Service – Recruit staff	Immunohematology Service Increase capacity	Immunohematology Service- further pathway work with HBs	Immunohematology Service- grow service delivery	Nursing team and administrator is in post (in line with funding), the 0.2 BI post remains outstanding and has been escalated to Cath O'Brien/Rachel Hennessy for decision.	Immunotherapy Toxicity Service launched early September. Draft SLA has been formulated for specialist endocrine sessions - awaiting instruction on signoff steps from VCC governance;	Further draft SLAs developed in order to secure further specialist support for MDT. These include gastro- and respiratory services.	

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						Modelling of the new service, Standard Operating Procedures, clinical guidelines and the patient IO pathway is under review;	An IO data application (with associated DPIA) has been developed by BI, this has been tested throughout September before handed to Digital.		
						Draft SLA has been formulated for specialist endocrine sessions - awaiting instruction on signoff steps from VCC governance;	IO Intranet and Internet page have been set up and are in process of being populated in line with service developments/guidance document sign off;		

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						An IO data application (with associated DPIA) has been developed by the Business Intelligence Team. This will be user acceptance tested via the pilot stage – awaiting confirmation that digital will support this App;	A suite of clinical guidelines/path ways has been issued to interested parties for feedback.		
						Scrutiny agreed in July to advertise 3 of the 7 funded Consultants sessions externally:			

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						A pilot of the IO service will commence 16th August 2022 to test virtual scenarios in readiness for proposed launch of service early September 2022.			
		(SDEC) Ambulatory Care – finalise staff recruitment	Ambulatory Care- increase weekday opening	Ambulatory Care- weekend opening		Recruitment of nursing and therapies staff (bid funded) is complete. The Ambulatory Care Operational Policy and the Weekend Working Standard Operating	Excellent progress made as defined in quarter 1. All staff now in place and extended days implemented. Sunday opening commenced in July and is working well.	Extended hours of operation sustained. Work commenced to develop appropriate suite of performance indicators to support ongoing	

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						Procedure have been finalised and proceeding through approval process. Patient Experiences (PREMS) and Patient Outcomes (PROMS) continue to be captured via the CIVICA Patient Experience system, following rollout of handheld devices and the App.		monitoring of activity and to allow reporting to national structures.	

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						An end-to-end process review of data capture within Integrated care is ongoing with service leads and service improvement to allow for more accurate, consistent and sustainable data capture. RD&I preparing to expedite a Head and Neck Patient Support Unit peer review; Sunday extended hours have commenced.			

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						Lessons learnt are being captured as a 'plan, do, study, act cycle in readiness for extension of Saturday hours from August 2022.			
			Deliver requirements of national projects e.g. Immuno Oncology			As above			
	9. Palliative Care	Review Cancer Associated Thrombosis clinic service: establish working SLA with Oncology	Undertake Peer Review as planned	Review of Chronic pain service.	Preparing the move from CANISC (No solution yet identified)	Review of Chronic pain service. Preparing the move from CANISC (no	Initial meeting to re-establish Cancer and Hospital Acquired Thrombosis Group held. Draft terms of		

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						solution yet identified).	reference developed to progress the finding of the April 2022 All Wales HAT audit. This will include review of the CAT clinic.		
	10. Key Treatment Development– IMN SABR Lutetium PSMA HDR Brachytherapy	Finalise the priority of implementation of key treatments where external funding is required and agree timescales.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Take forward agreed business cases in a phased approach as agreed.	Capacity paper to Executive Management Board in December 2021 confirmed no additional capacity available, and loss of capacity will occur during essential major change programme delivery - DHCR	WHSSC have established a national MRT programme board with Velindre input. Programme board will lead on the development of a service specification, in conjunction with clinical stakeholders.	Recruitment and service planning in support of HDR Brachytherapy expansion undertaken. Preparation for engagement with formal WHSSC appraisal	

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						/ IRS implementation / RSC / nVCC. Risk and Harm impact assessments will be required when extra capacity above core commissioned activity is required to implement to change / amend pathways for new service provision.	Work scheduled to begin in autumn 2022. Engagement with WHSSC undertaken. Commitment secured to fund expansion of prostate service to a putative maximum of 78 patients per year.	process related to possible commissioning of PRRT service undertaken (process scheduled to begin in March/April 2023).	
	Clinical team priorities – gaps in service therapies access to trials research MDT attendance/cover arrangements									

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		Commence business case developments for agreed treatments in phased approach according to priority and timetable agreed.	Apply 'Just do it' criteria where appropriate for clinical team	Apply 'Just do it' criteria where appropriate		Not applicable no extension / service changes yet agreed through triumvirate risk assessment			
		Finalise the priority of clinical team priorities.	Begin development of implementation plans for clinical team priorities requiring	Continue the development of implementation plans for clinical team priorities requiring				Planning group established to consider feasibility of introduction of new prostate treatment techniques	

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			support/wider discussions.	support/wider discussions.				when activity transferred to newly commissioned linac (LA5). A similar group to consider the feasibility of new breast treatments likely to be established in late quarter 4 in anticipation of delivery and commissioning of second new linac.	

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	11. Radiotherapy Satellite Centre	Support Strategic case development and review of FBC. Workforce Plan. Finance case. IRS alignment and FBC. FBC scrutiny and approval by service lead and through Boards	FBC approval-WG implement Arts strategy for RSC operational model development aligned to IRS	Ongoing liaison with ABUHB regarding build, IRS alignment project board, project team meetings	operational model delivery plan preparation	Managed through IRS Implementation Board	Managed through IRS Implementation Board.	Managed through IRS Implementation Board.	

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	12. Radiology	Commission reconditioned MRI scanner. Phase 1 capacity delivery	Review Radiology demand and align to capacity plan		Full additional capacity plan is delivered	Not started – interdependency required for radiology demand for pathway changes Treatment pathways requires completion and sign off to assess demand requirement	Commissioning of refurbished MR scanner completed. Fully operational.	Introduction of DHCW and associated disruption to routine activity reporting restricted ability to undertake demand and capacity planning.	

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	13. Patient treatment helpline	Implement new handover arrangement into SACT service.	Develop action plan to address issues identified and changes required.	Implement actions identified.	Implement associated workforce or training plans	No response provided	SACT Treatment Helpline handed over to SACT and MM Directorate. Review of why the helpline is currently being accessed towards near end of completion with view of Options appraisal being presented Autumn 2022. Initial work to stabilise the platform for recording calls completed. Further work to be considered in	Review of reasons for Helpline calls from patients completed October. Options appraisal on future operating model undertaken for review by VCC SLT. Treatment helpline identified as subject of service improvement support as part of the national	

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							conjunction with digital teams, including functionality of the telephony system	Safe Care Initiative. Working group to be identified and scope of work defined.	

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		Commence review of service functionality and fitness for purpose. Engage with digital team to explore system capability and options for future.	Engage with stakeholders at VCC and externally in developing plans to ensure all calls are appropriately directed from 1st contact.,	Implement any identified telephony systems to allow signposting to all areas.	Roll out new system and ways of working				
	14. Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners	Commence Patient panel	Commence establishment of Patient Engagement Hub and Patient Leadership Group	Patient Leadership Group recruitment and training	Continue to develop Group, staff team and patient engagement delivery. Includes underpinning nVCC.	New strategy approved Trust Board in May 2022. Final documentation and infographic have been finalised. Funding has been agreed for	Pilot of new CIVICA engage platform to enable establishment of patient panel to commence autumn 2022.	Individual appointed to work within Comms team and focus on developing patient engagement hub pilot, supported by Charities	

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						Patient Engagement Manager which is due to be advertised in late July 2022.	Launch and recruitment plan also for early autumn 2022.		
		Implement patient panel management software programme	Establish initial Patient Engagement activity for Velindre Futures projects						

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	15. Establish Primary Care project under Velindre Futures					Task and finish group to be established to scope of project and associated actions. The original IMTP did not include any objectives so will be added retrospectively.			
Strategic Priority 4: To be an international leader in research, development, innovation	16. R & D Hub (Development at UHW)	Progress the clinical scientist and clinical academic business cases.	Progress the clinical scientist and clinical academic business cases.	Business case and costs	Establish Governance Arrangements for the Hub.	**Progress the clinical scientist and clinical academic business cases.**	New south-east Wales Prehab2Rehab collaborative group formed. Inaugural meeting of group, chaired by Suzanne Rankin (CEO	Engagement with Prehab2Rehab collaborative and with the Wales Cancer Network National PREHABILITATIO N Group	

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/ Objectives**	**Key Quarterly Actions 2022/23 Timescales and Progress**							
		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
and education						· Funding for 0.5FTE Clinical Academic post (an Early Phase Realist) was recently approved at the Velindre Charitable Funds committee and the plan will be to secure match funding by Cardiff University. The business case is currently going through Cardiff University processes. · A number of posts are going through recruitment and	C&VUHB) on behalf of the Cancer Collaborative Leadership Group (CCLG), held.	continued. Active contribution to work to define the remit and scope of both groups.	

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						selection; these include a Band 8a Senior Nurse (12 months secondment), a Band 6 nurse and a Clinical Research Fellow.			
						<u>Business case costing and funding agreements in place.</u>			
						· ECMC, Cardiff's 5year renewal bid to CRUK (2023-2028) was submitted on the 30th June. If successful, the ECMC bid includes some research nurse			

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						capacity that will support the research delivery within the Hub. · WCRC's bid was submitted to HCRW for the next 2 years (2023-2025). Included in the bid were Clinical Research Fellows that would support the Hub as well as undertake postgraduate training. Also included were other opportunities to build further collaboration			

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						with Cardiff University and VUNHST. WCRC is awaiting initial feedback from HCRW.			
						· An approach has been made to HCRW regarding the additional 3.6 WTE posts. Both VUNHST and CVUHB are supplying further information with regard to this request.			
						Establish Governance Arrangements for the Hub.			

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						The Head of R&D and her team continue to work closely with the Joint Research Office (JRO) to ensure process is in place to efficiently and effectively deliver collaborative research studies that will be delivered through the Cardiff Cancer Research Hub. Areas of focus will be managing activity coming into the JRO that will be			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						delivered through the hub. The Early project review process, which has been established to manage projects from CU and CV UHB, to undertake an early assessment of their projects by the JRO team to iron out any potential issues in setting up projects continues with VUNHST now contributing to the process development to ensure			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						alignment. The intention is to ensure synergy in a streamlined process to speed up the setup process and expand capacity to deliver contracts more quickly. The Research Governance Groups will move to a joint Research Governance Group within the JRO with Velindre included as required, bringing organisational			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						governance together. This work also includes the development and execution of a Heads of Terms agreement which will be at a high level as well as the inclusion of Velindre in a Memorandum of Understanding (MOU) between the three organisations. The JRO memorandum of understanding is currently still in			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
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						draft and between C&VUHB and CU only. Work on this agreement has been on hold pending the appointment of the JRO's new Partnership and Business Development Manager who is expected to join the JRO soon. The Head of R&D and the Senior Research Contracts manager will work with the JRO to ensure that the further development of			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
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						the Moue will include the Trust's requirements. Work on the Heads of Terms agreement has commenced and it was requested by the Cardiff Cancer Research Hub Project Board at their meeting of 6 July 2022 that this document should be finalised for their next meeting in October 2022.			

Velindre Cancer Service IMTP Quarterly Progress Report 2022/23 for Quarter 3									
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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
						Project Board established to take place in September 2022. Awaiting further detail via the National Trams model to better inform potential impact on VCC.	-		
						VCC Therapies Team are working collaboratively with Health Board partners to progress prehabilitation programme. Participating in newly established South-East			

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						Wales Prehab 2 Rehab Collaborative which aims to support a system wide transformation, initiated and delivered closer to the patient's home. Participation within the collaborative will help define the service delivery need for VCC in conjunction with the work happening in our partner organisations.			

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		Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Q1**	**Quarterly Progress Q2**	**Quarterly Progress Q3**	**Progress Rating Q3**
	17. TrAMS	Establish VCC programme board and supporting sub groups: - clinical serices model - clinical trials via Trams - workforce and staff impact - finance incl private pt impact	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	A strategic workforce programme group has been established, and this group will work to provide strategic direction to the VCC Senior Leadership Team regarding the workforce modernisation. Much of the initial phase of this work will involve benchmarking with other UK and International Cancer Centres to identify best practice models	Project Board established September 2022. National TRAMS Service Model awaited.	National TrAMS service model not now anticipated until quarter 1 2023-24 at earliest due to recruitment timescales of national TRAMS posts. Internal VCC Pharmacy/SACT service change continues in anticipation of most likely service model.	

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						and ways of working			
	18. Therapies incl. collaborative work across region	Participate in regional Prehabilitation programme and scope development plan.	Review funding streams and commissioning models to facilitate prehabilitation service development.	Continue participation in regional service	Bring forward proposals for therapies development	Workforce planning owned by service leads review with Health Education Improvement Wales on 'route 2' role extension training planned for September 2022.	New south-east Wales Prehab2Rehab collaborative group formed. Inaugural meeting of group, chaired by Suzanne Rankin (CEO C&VUHB) on behalf of the Cancer Collaborative Leadership	Engagement with Prehab2Rehab collaborative and with the Wales Cancer Network National Prehabilitation Group continued. Active contribution to work to define the remit and	

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							Group (CCLG), held.	scope of both groups.	
	19. Workforce Modernisation:	Establish a workforce modernisation programme – with a 2 phased approach - 'Stabilise and Modernise' Finalise proposals for revised clinical leadership arrangements.	Align workforce plans for regional developments e.g. AOS, RSC. Advanced practice plan the potential for 'pump priming' advanced practice roles to 'kick start' the workforce	Implement Physicians Associate posts. Prepare plan for advanced practice and non-medical Consultant level roles.	Workforce modernisation programme continues	Network SCP Project Manager leading review of referral pathways with lung cancer National project used as a pilot site.	Value business case to support development of new non-medical outliner roles developed.	Two new physician's associates recruited. Value Based Healthcare business case unsuccessful in bid to secure funding for new non-medical outlining posts. Further work to be undertaken	

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			Advanced Practice Radiographers and Therapeutic Radiographers					to demonstrate benefits and to alternative means of supporting the innovation being actively explored.	
	20. Single Cancer Pathway	Focus on front end of the pathway for all tumour sites:	Develop dashboards and pathway data to make all patients' pathway points visible.	Focus on whole Breast Pathway:	Commence Action plan implementation.	SCP Project Manager requested to review data and current process with regard to referral management. Work programme and project plan awaited.	Work initiated to focus on earlier part of VCC pathways (MDT management, referrals, initial outpatient appointments, etc.) Work designed to identify and address issues and to inform future work to standardise	Work on early part of VCC pathways and on administrative interface between referring health boards and VCC identified as a project/workstream for inclusion in new pathway improvement programme.	

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							working practices.	Scope of work and ToRs to be developed. Engagement with Wales Cancer Network continued. Discussions on recruitment of project resource by the WCN to support activity at VCC ongoing. Job description to be developed by WCN.	
		Aims to Standardise patient referrals to VCC.		Mapping of Breast Pathway from patient referral to service to treatment commenced.		Joint improvement project agreed with CTUHB regarding referral management.			
		Timely receipt of all diagnostic test results and treatment pre-		Identify touch points along pathway and		Pathway development required to manage implementation			

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		requisites prior to MDT.		potential bottlenecks		of COSC measures.			
		Improve patient outcomes by early genomic testing where indicated. Develop training plans		Measure how currently delivering against the National Optimal Pathways (NOP)		No response received with regard to genomic project.			
Strategic Priority 5: To work in partnership with stakeholders	21. Engagement with HB's	Agree terms of reference and priorities for joint working with each HB.	Share patient pathway challenges in developing improvement plans.				Monthly meetings established with Cwm Taf Morgannwg, Aneurin Bevan	Meetings continued with a more developed focus on key operational issues (this	

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to improve prevention and early detection of cancer		Commence meetings to deliver on these priorities.	Agree outreach plans for outpatients and SACT with all HBs.				and Cardiff UHBs. Standardised agendas and datasets agreed. Regular discussions around outreach facilities	includes the review and development of SLAs supporting key services).	

KEY:

BLUE	Action successfully completed with benefits being realised
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

TRUST BOARD

BUILDING OUR FUTURE TOGETHER PORTFOLIO INITIATION DOCUMENT

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Sarah Morley, Executive Director of OD & Workforce and Lauren Fear, Director of Corporate Governance and Chief of Staff
PRESENTED BY	Sarah Morley, Executive Director of OD & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD & Workforce

REPORT PURPOSE	FOR APPROVAL

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

ACRONYMS	
VCS	Velindre Cancer Service
WBS	Welsh Blood Service

1. SITUATION / BACKGROUND

During Spring and Summer 2022 the Chief Executive along with the Director of Corporate Governance and Executive Director of OD & Workforce instigated the development of an Organisational Design Programme.

The detailed design of the work took place through the latter part of 2022 and early part of 2023 with the Portfolio Initiation Document being discussed at Board Development days and the Executive Management Board in December.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Following feedback from these discussions and further development of this work, the following aims of 'Building Our Future Together' have been distilled:

- ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as it's golden thread
- support the development of a positive culture within the organisation within which staff feel empowered and engaged
- provide a way of working and shape to the organisation which enables us to maintain focus
- ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future
- draw together our organisational developments with a common sense of purpose
- improve our effectiveness, efficiency and value based approach
- develop the mechanisms which enable us to prioritise where and when we focus our efforts
- provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition
- support realistic, authentic and compassionate leadership

These aims will be realised under the following inter-related areas of work which have been currently identified, with the anticipation that this may increase in order to achieve the aims above:

Senior Ownership

Ref	Programme of Work	Senior Owner
P1	Quality as an Organisational Strategy	Executive Director of OD & Workforce
P2	Prioritisation & Co-ordination Arrangements (Q5 Work)	Chief Executive Officer
P3	Values & Culture	Executive Director of OD & Workforce
P4	Internal Staff Communication & Staff Engagement	Director of Corporate Governance & Chief of Staff
P5	Governance, Risk & Assurance	Director of Corporate Governance & Chief of Staff
P6	Performance Management	Director of Transformation, Planning & Digital
P7	Leadership Development	Executive Director of OD & Workforce
P8	Value Based Healthcare	Executive Director of Finance
P9	Quality Framework	Executive Director of Nursing, AHP's and Healthcare Science
P10	Ways of Working	Chief Executive Officer
P11	Clinical & Scientific Arrangements	Executive Medical Director

A Portfolio Initiation Document (PID) has been developed to describe the Programmes of work and their objectives.

A quarterly Steering Group will be developed to help shape the Portfolio of Programmes and will have the lead Independent Board Member for the Portfolio and a representative from Health Education and Improvement Wales amongst its membership. This Steering Group will meet from May 2023.

Oversight of the Portfolio will take place at EMB (Shape) where formative discussions can take place to help develop the programmes of work and define others as necessary to achieve the objectives of the entire Portfolio. This oversight will take the form of highlight reports from each of the 11 Programmes.

Core to the success of the work that sits under the portfolio is communication and engagement with staff and wider stakeholders.

In addition there is a specific element of the work which sits under P4 (above) which is work needed to mature the Trust's staff communication and engagement approach on an on-going basis. One element of this In April, will be the launch of a number of aspects of work, including Destination 2033, aligned Integrated Medium Term Plan and associated priorities.

Other elements of this communications approach will be contained within a new rhythm of engagement between senior managers and staff via conversations across the organisation. These conversations will have inbuilt references and links to the work detailed in this PID and will be held under the banner of 'Working Together to Build our Future'. This will be fundamental to the Trust approach going forward and will form the foundation of how we want to work together as organisation. More information on this approach will be provided to the Board in May 2023.

3. IMPACT ASSESSMENT

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Equality Impact work will take place under the individual programmes of work as required.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be implications on resources as the details of the Programmes of Work are developed.

4. RECOMMENDATION

The Trust Board is requested to **APPROVE** the Portfolio Initiation Document for Building Our Future Together.

Building our Future Together

Portfolio Initiation Document (PID)

Document Control

The source of the document will be found MS Teams.

Document Version History:

Version Number	Date	Author	Summary of changes
0.1	06.07.22	Sarah Morley	Initial draft
0.2	13.07.22	Sarah Morley	Following Discussion with WBS
0.3	02/08/22	Sarah Morley	Following EMB Shape 27/07/22
0.4	31/08/22	Sarah Morley	Following discussion with CEO and
0.5	06/09/22	Sarah Morley	Following Exec Team Discussion & Feedback 5/9/22
0.6	10/10/22	Sarah Morley	Following discussions at ELT & comments on Teams Channel
0.7	24/10/22	Sarah Morley / Nicola Williams / Matt Bunce	Update on Programmes following EMB
0.8	28/02/23	Sarah Morley	Update following discussions on Culture and Compassionate Leadership

Table of Contents:

1. Context

1.1 Purpose

The purpose of this project initiation document is to outline the scope, objectives, deliverables and governance structure necessary to meet the portfolio aims, in line with the key deliverables of the Trust Strategy 'Destination 2033' and our vision of

'Excellent care. Inspirational Learning. Healthier People.'

1.2 Background

In 2019, Velindre University NHS Trust commenced work to refresh its strategic plans with the aim of setting up a clear strategic direction of travel for the next ten years. This included developing a Trust purpose and vision; goals; and a coherent and aligned set of strategies and plans to deliver them.

The process began with a number of Board sessions to start framing the Trust purpose and vision and to develop a set of strategic goals for 2032. This was followed by a series of engagement conversations with staff and teams across the Trust to further refine this work; and identify supporting plans that will be required to deliver them.

Purpose: To Improve Lives

Vision: Excellent Care, Inspirational Learning, Healthier People

Strategic Goals:

1. Outstanding for quality, safety and experience
2. A leading provider of clinical services that always meet, and routinely exceed, expectations
3. A beacon for research, development and innovation in our stated priority areas
4. An established 'University' Trust which provides highly valued knowledge and learning for all
5. A sustainable organisation which contributes to a better world for future generations across the globe

The delivery of the ambition contained within the Trust Strategy must be considered against the context within the organisation. This context has the following contributory factors:

- Many major change programmes in the Welsh Blood Service, Velindre Cancer Service and Trust-wide functions
- Continuing impacts of the pandemic on the workforce and ways of working
- Demand for cancer services outstripping capacity

- Legacy of the Trust having been reacting to constant fast changing circumstances for previous 2½ years
- Multiple and complex picture of priorities for the system and the organisation

It is in this context that the executive and wider leadership teams have been considering the structure and ways of working both internally, with our Health Board Partners and the wider health system. The driver being a consideration of the type of organisation we need to be to deliver our purpose and our vision and how we listen and respond to what our own staff and leadership teams have been saying through survey and other engagement mechanisms over the last two years.

There have been many positive messages through this feedback, but the challenges raised require us to ensure that we embed positive and supportive systems and processes that are visible and accessible to all staff and managers.

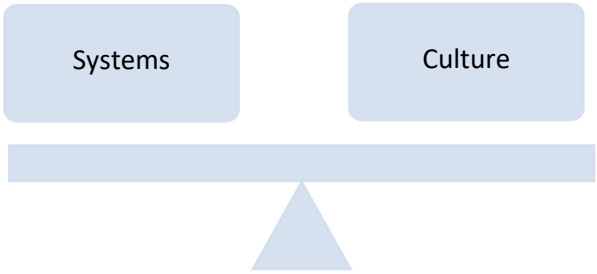
To enable us to move forward within the current context, deliver our ambitions and take account of what our people say about working in our Trust we recognise that we need to make changes across our systems in a way that takes account of how people work and interact with each other.

To achieve this we must take a considered and planned approach to effect change across a number of inter-related elements and therefore an organisational design approach will be applied.

The Chartered Institute of Personnel and Development (CIPD) defines Organisational Design as:

'the review of what an organisation wants and needs, an analysis of the gap between its current state and where it wants to be in future, and the design of organisational practices that will bridge that gap. It's a fundamental, wide reaching, future-focused activity that often requires a review of the entire organisation and its context to decide what does and doesn't work. It will therefore usually involve a holistic review of everything from systems, structures, people practices, rewards, performance measures, policies, processes, culture and the wider environment.'

In taking account of our context, ambition and internal feedback it is clear that 'Building our Future Together' must achieve a balance in its focus, objectives and actions that address the systems that hold the organisation together and the culture - values and behaviours, that determine how we will work within those systems to achieve a positive climate for staff, patients and donors.



2. Portfolio Definition

2.1 Aims and Objectives

2.1.1 The Portfolio aims to:

A) ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as its golden thread
B) Support the development of a positive culture within the organisation within which staff feel empowered and engaged
C) provide a way of working and shape to the organisation which enables us to maintain focus
D) ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future
E) draw together our organisational developments with a common sense of purpose
F) improve our effectiveness, efficiency and value based approach
G) develop the mechanisms which enable us to prioritise where and when we focus our efforts
H) provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition
I) support realistic, authentic and compassionate leadership

These aims will be realised under the following inter-related areas of work which have been currently identified, with the anticipation that this will further develop in order to achieve the aims above:

Ref	Programme of Work	Senior Owner	Link to Aims
P1	Quality as an Organisational Strategy	Executive Director of OD & Workforce	A, C, F
P2	Prioritisation & Co-ordination Arrangements (Q5 Work)	Chief Executive Officer	A, F, G
P3	Values & Culture	Executive Director of OD & Workforce	B, I
P4	Internal Staff Communication & Staff Engagement	Director of Corporate Governance & Chief of Staff	B, H

Ref	Programme of Work	Senior Owner	Link to Aims
P5	Governance, Risk & Assurance	Director of Corporate Governance & Chief of Staff	D
P6	Performance Management	Director of Transformation, Planning & Digital	F
P7	Leadership Development	Executive Director of OD & Workforce	B, I
P8	Value Based Healthcare	Executive Director of Finance	F
P9	Quality Framework	Executive Director of Nursing, AHP's and Healthcare Science	F, H
P10	Ways of Working	Chief Executive Officer	
P11	Clinical & Scientific Arrangements	Executive Medical Director	H

2.1.2 The 'Building our Future Together' outline for each of these areas of work is as follows:

- **P1 – Quality as an Organisational Strategy**
    a) Ensure that our operating arrangements are designed in a way that best supports the delivery of quality within our services
    b) Develop a clear purpose and strategic direction that reflects the needs of the post-Covid population, and offers all staff a clear sense of purpose and sense of belonging
    c) Alignment of multiple organisation-wide strategies and their associated resources
    d) Create a systems view of the organisation – building matrix working and overcoming divisional boundaries, streamlining efforts and resources to meet the need
    e) Identify a pipeline of strategic priorities for improvement or innovation and dedicate the resource and capability to operationalise and implement
    f) Develop a dashboard of meaningful measures for the Board and executive team that filter to frontline staff.
    g) Avoid duplication, mis-directed work efforts and ultimately reduce costs.

- **P2 – Prioritisation & Co-ordination Arrangements (Q5 Work)**
    a) A framework against which we can prioritise in the future.
    b) A transformation roadmap, including a set of structured priority programmes.
    c) An agreed 'operating rhythm' around the programmes, defining how these will be delivered, what the cadence and format for reporting is.

d) Structural and ways of working options and recommendations for the emerging transformation and change capability.

- **P3 – Values and Culture**
  a) Review and refine the values of the organisation
  b) Have a picture of how people feel about the organisation which will be utilised by other elements of Building our Future Together work programme
  c) Develop a Behaviours Framework
  d) Embed Values and Behaviours Framework within Trust process such as recruitment, appraisal and team working.

- **P4 – Internal Communications and Staff Engagement**
  a) Co-create an organisational narrative
  b) Communications and engagement approach to reflect whole Building our Future Together

- **P5 – Governance, Risk and Assurance**
    a) Build effective governance, risk and assurance mechanisms to support the achievement of the organisations ambitions under the following projects:
        a. (GOV 1.0) Structure
        b. (GOV 2.0) Process and Templates
        c. (GOV 3.0) Compliance and Core Process
        d. (GOV 4.0) Governance Training and Development
        e. (GOV 5.0) Board Decision Making
        f. (GOV 6.0) Delegation Framework
        g. (GOV 7.0) Assurance Through Governance Development
        h. (GOV 8.0) Hosted Organisations Effective Governance Arrangements
        i. (GOV 9.0) Innovation
        j. (GOV 10.0) Board and Committee Effectiveness
        k. (RISK 1.0) Risk Policy and Corporate Procedure
        l. (RISK 2.0) Refresh Risk Appetite
        m. (RISK 3.0) Risk Reporting Through Governance
        n. (RISK 4.0) Establishment of Risk Management Assurance Governance
        o. (RISK 5.0) Quality Information on Datix
        p. (RISK 6.0) Risk Training
        q. (TAF 1.0) Alignment of Frameworks
        r. (TAF 2.0) Refresh of Trust Assurance Framework Risks
        s. (TAF 3.0) Revised Reporting Mechanism
        t. (TAF 4.0) Mapping the Trust Assurance Framework Through Governance Cycle

- **P6 – Performance Management**
    a) Implementation of new Performance Management Framework
    b) Development of new KPI's and measures with SPC charts
    c) Refresh local stretch KPI targets
    d) Develop expertise across the organisation in populating new KPI's and narrative
    e) Develop a Performance Accountability Framework (PAF) to dovetail with new Welsh Government Accountability Conditions
    f) Continue to develop and evolve PMF reporting processes and KPI measures to better reflect patient and donor outcomes
    g) Operationalize BI to automate KPI collection, analysis and reporting
    h) Establish benchmarking with other suitable/comparable organisations

- **P7 – Leadership Development**
    a) Build a high performing leadership culture built on compassionate leadership principles across the Trust at all levels of leadership
    b) Build organisational capacity and capability including developing a cadre of highly effective patient and donor focussed senior leaders

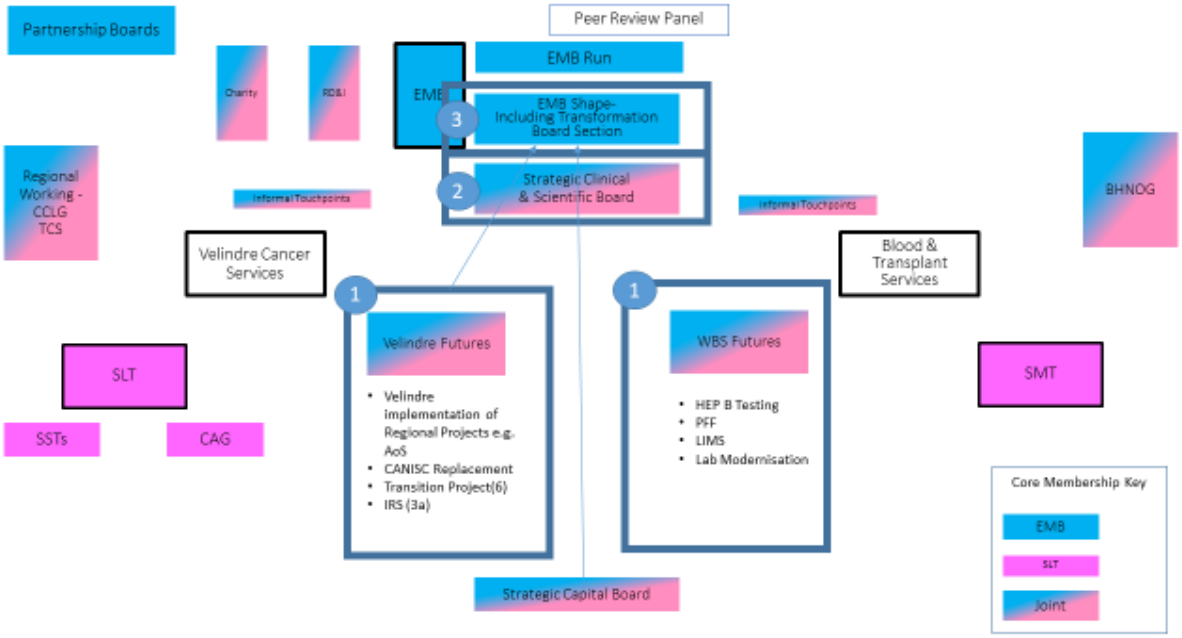
c) Build and maintain effective relationships and working arrangements between Board members and between Executive Teams and Divisional Senior Leadership Teams. This will include addressing areas of conflicting styles and behaviours in senior leadership teams
d) Develop matrix working and embed change management capability across a diverse and dispersed organisation

- **P8 – Value Based Healthcare**
  a) Accelerate our development to deliver our 3 strategic priorities for VBHC:
     - Embed culture, socialisation and education of Value
     - Measurement of Outcomes & Cost in a meaningful way
     - Prudent Healthcare & Service Prioritisation
  b) In support of these strategic priority areas, the financial strategy for Velindre will be an enabler to the clinical, service, workforce, digital and estates plans, which set out how the Trust, in collaboration with the Division operational teams, commissioners and Public Health Wales will:
     - Address cancer population healthcare needs and maximise value in specialist cancer service delivery requirements
     - Deliver and maximise values in the Welsh Blood Service improvement and modernisation programme

- **P9 – Quality & Safety Framework**
  a) The Quality & Safety Framework will support the Trust in delivering its Quality and Safety vision. In order to achieve this, the framework will:
     - Articulate the expectations of the Board in relation to quality and patient / donor safety
     - Improve the provision of safe care through clear lines of communication and reporting from service level to Board and Board to service level
     - Provide clarity of roles, responsibilities and lines of reporting in respect of Quality, Safety and Experience
     - Provide a structure within which Corporate Services, Divisions, Departments and teams can:
     - Engage and actively listen to donors, patients, their families, staff and other key stakeholders to improve experience, outcomes and therefore efficiency

- Empower everyone to put quality and patient safety at the heart of everything they do, ensuring quality drives delivery of care to improve experience and outcomes
- Promote a quality and patient / donor safety focused culture in all aspects of care delivery they are responsible for and beyond
- Clearly articulate a common understanding and ownership in relation to their individual and collective role, responsibility and accountability related to quality and patient / donor safety
- Be sufficiently aware of potential risks to quality in delivery of safe and effective care
- Demonstrate effective processes for escalating, investigating, managing and reporting on concerns about quality and patient / donor safety
- Use triangulated data to drive quality improvement, ensuring issues of equity are also identified and where appropriate addressed.

- **P10 – Ways of Working**
  a) Implementation of agreed new working structures and reporting arrangements as per the chart below:



- **P11 – Clinical & Scientific Arrangements**
  b) Establish Clinical & Scientific Board to strategically ensure Trust prioritisation & IMTP is grounded in Clinical & Scientific strategic priorities
  c) Develop Trust Clinical & Scientific Strategy

2.2 Scope

The scope of the Portfolio will be limited to developing effective systems, process and ways of working for Velindre University NHS Trust underpinned by agreed values and behaviours.

2.3 Trust Assurance Framework

The Programmes contained within the BOFT are mapped to the Trust Assurance Framework as follows:

Ref	Programme of Work	TAF	
P1	Quality as an Organisational Strategy	04	ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.
P2	Prioritisation & Co-ordination Arrangements	10	GOVERNANCE: There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
P3	Values & Culture	04	ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.
P4	Internal Staff Communication & Staff Engagement	04	ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.
P5	Governance, Risk & Assurance	10	GOVERNANCE: There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
P6	Performance Management	10	GOVERNANCE: There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
P7	Leadership Development	04	ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.
P8	Value Based Healthcare	08	TRUST FINANCIAL INVESTMENT RISK: There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.
P9	Quality & Safety Framework	06	Quality & Safety Risk: Trust has approved its integrated Quality & Safety Framework and is in

			the process of setting up the required mechanisms, systems, processes and datasets. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.
P10	Ways of Working	10	GOVERNANCE: There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
P11	Clinical & Scientific Arrangements	04	ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.

Reports against progress of the objectives, deliverables and benefits realisation plan will be undertaken on a monthly basis and reported to EMB (Shape) Transformation Board.

2.4 Constraints and Dependencies

2.4.1 Portfolio Constraints

The following constraints have been identified:

- Commitment of senior leaders to fully implement the change inherent in the delivery of the portfolio and areas of work
- Availability of individuals from the Divisional and Trust wide Teams and their ability to commit time to the work groups and task and finish groups.
- Available and adequate resource to adequately deliver the portfolio and its benefits

2.4.2 Programme Dependencies

The following dependencies have been identified:

- Velindre and WBS Futures Programmes
- Engagement with the programme by the Divisional Senior Leadership Teams and Extended Leadership Team
- Identification of a partner organisation who can share their experience of successfully implementing these changes

3. Portfolio Approach

3.1 Roles and Responsibilities

The key Programme roles are as follows:

The Senior Responsible Officer (SRO) is accountable for ensuring that the portfolio meets its objectives and delivers the outcomes and benefits of the work.

The Senior Owners of each of the work areas will be responsible for developing project arrangements that will allow the delivery of the project objectives.

3.2 **Partner Organisation**

During the lifetime of the Building our Future Together Programmes the Trust will identify and work with partner organisations that have previously implemented and worked with the methods and strategies to their benefit.

3.3 **Governance and Engagement**

The portfolio will utilise the following governance and engagement mechanisms:

Executive Management Board (Shape) – Transformation Board

Will provide oversight and guidance to the Portfolio and light touch governance of the Programmes and Projects that sit within it. A highlight report will be received from each Programme of work with detailed updates by exception.

Strategic Development Committee

Will receive updates on progress from the Programmes and achievement against the objectives and deliverables.

Building our Future Together Steering Group

Chaired by Chief Executive, quarterly meetings

Will take a high level overview of the Portfolio and Programmes within it. The Steering Group will act in the capacity of a critical friend to the work and encompass membership from both inside and outside the organisation to bring additional view points to bear. This will form part of the Executive Management Board on a quarterly basis beginning in April 2023.

Initial Membership:

Building our Future Together Lead Independent Member
HEIW Representative
Director Improvement Cymru

Leadership Summits

There will be quarterly Building our Future Together Leadership Summits to bring together the members of VCS Senior Leadership Team, WBS Senior Management Team and the Trust Extended Leadership Team to discuss, develop and enhance the work under the associated programmes of work.

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	**CONSIDER** and **ENDORSE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board Members – Via Email	07/02/2023	Approved
Trust Board Members – Via Email	09/03/2023	Approved
Trust Board Members – Via Email	17/03/2023	Approved
Trust Board Members – Via Email	20/03/2023	Approved

ACRONYMS	
CCS	Crown Commercial Services
DCWW	Dwr Cymru Welsh Water
EW	Enabling Works
nVCC	New Velindre Cancer Centre
NWSSP	NHS Wales Shared Services Partnership

SO	Standing Orders
SFI	Standing Financial Instructions

1. SITUATION/BACKGROUND

1.1 In accordance with Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Director of Corporate Governance & Chief of Staff, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Director of Corporate Governance & Chief of Staff must ensure that any such action is formally recorded, and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.

1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

1.3 This report details Chair's Urgent Action taken between the **31/01/2023** – **20/03/2023**.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

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

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Legal impact was captured within the documentation considered by the Board.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

4.1 The Board is asked to **CONSIDER** and **ENDORSE** the Chairs urgent action taken between the **31/01/2023** – **20/03/2023** as outlined in ***Appendix 1, page 4 of this report***.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. Variation and amendment of Standing Orders

The Trust Board were sent an email on the **07/02/2023** to **APPROVE:**

- The amendment to the Trust Standing Orders which includes the revised membership of the Trust Board in line with The Health and Social Care (Quality and Engagement) (Wales) Act, to comprise of the Vice Chair and one additional Executive Director.

*The Vice Chair absteined from this request in regards to the reference to the role of Vice Chair, however approval was provided for the additional Executive Director role.

No objections to approval were received.

Recommendation Approved by:

- Donna Mead, Chair
- Stephen Harries, Vice Chair (*_in part_*)
- Steve Ham, Chief Executive Officer
- Hilary Jones, Independent Member
- Gareth Jones, Independent Member
- Professor Andrew Westwell, Independent Member
- Sarah Morley, Executive Director of Orgaisational Development & Workforce

2. NWSSP Teams Voice Telephony Contact Centre Solution

The Trust Board were sent an email on the **09/03/2023** regarding the upgrade of the **telephony and contact centre solution for NWSSP:**

- To **AUTHORISE** the Chief Executive to **APPROVE** the financial commitment to be awarded as summarised within the attached and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements where appropriate.

A number of queries were raised and subsequently addressed. No objections to approval were received.

Recommendation Approved by:

- Donna Mead, Chair
- Stephen Harries, Vice Chair
- Carl James, Acting Chief Executive Officer
- Hilary Jones, Independent Member
- Gareth Jones, Independent Member
- Vicky Morris, Independent Member
- Martin Veale, Independent Member

3. nVCC – Dwr Cymru Welsh Water (DCWW) Main Issues ASDA Contract

The Trust Board were sent an email on the **19/03/2023** regarding the **DCWW Water Main Issues – ASDA Contract for the nVCC.**

The Trust Board were requested to:

- To **AUTHORISE** the Chief Executive to **APPROVE** the financial commitment to be awarded as summarised within the attached and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements where appropriate.

A number of supplementary queries were raised following Board approval for completenes. These were subsequently addressed and did not impact the prior approval secured.

No objections to approval were received.

Recommendation Approved by:

- Donna Mead, Chair
- Stephen Harries, Vice Chair
- Carl James, Acting Chief Executive Officer
- Hilary Jones, Independent Member
- Gareth Jones, Independent Member
- Vicky Morris, Independent Member
- Martin Veale, Independent Member
- Matthew Bunce, Executive Director of Finance

4. Transfer of All Wales Energy Contract to Crown Commercial Services (CCS) framework

The Trust Board were sent an email on the **20/03/2023** regarding the requirement to seek Board approval for the transfer of the Energy contract from the All Wales agreement to the CCS framework.

The Trust Board were requested:

1. To **APPROVE** the proposed approach to Energy procurement governance arrangements, including:
    - The revised governance group arrangements, and
    - The proposed new Energy procurement contractual arrangements with Crown Commercial Services
    - The commitment to CCS energy baskets:
        - Locked (L6): 1st Oct ’23 – 31st Mar ‘24
        - Locked (L12): 1st Apr ’24 – 31st Mar ‘25

2. To **AUTHORISE** the Chief Executive to **APPROVE** the financial commitment to be awarded as summarised within the attached and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements where appropriate.

No objections to approval were received.

Recommendation Approved by:

- Donna Mead, Chair
- Stephen Harries, Vice Chair
- Carl James, Acting Chief Executive Officer
- Professor Andrew Westwell, Independent Member
- Martin Veale, Independent Member
- Vicky Morris, Independent Member
- Matthew Bunce, Executive Director of Finance

TRUST BOARD

NATIONAL IMAGING ACADEMY WALES HOSTING AGREEMENT EXTENSION

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Director Corporate Governance & Chief of Staff
PRESENTED BY	Dr Jacinta Abraham, Executive Medical Director Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Dr Jacinta Abraham, Executive Medical Director Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	**FOR APPROVAL**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
NIAW	28/02/2023	IN SUPPORT
CTM Executive Leadership Group	06/03/2023	IN SUPPORT

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
NIAW	National Imaging Academy Wales

1. SITUATION/BACKGROUND

1.1 CTMUHB currently hosts the National Imaging Academy Wales (NIAW) on behalf of Health Bodies in Wales. The current hosting agreement expires on 31 March 2023 and therefore the CTM Board, and other Health Bodies Boards in NHS Wales, are being asked to extend the hosting agreement for a further 3 years to 31 March 2026.

As such, the purpose of this report is to seek Trust Board **APPROVAL** to extend the hosting agreement until 31 March 2026.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Phillip Wardle, Director of the Imaging Academy is seeking support from all Health Bodies in Wales to agree a three year extension for CTMUHB to continue to host the NIAW. Phillip Wardle has confirmed the support of Steve Moore, lead Chief Executive Officer (CEO) in Wales for Imaging for this agreement.

2.2 The hosting agreement, attached, has been updated to accurately reflect references, but the detail of the main document remains unchanged from the original hosting agreement signed by all CEOs.

2.3 The updated hosting agreement has been shared with all Directors of Governance in partner Health Boards and Trusts, seeking their CEOs signatures and securing Board approvals where necessary to allow the continuation of hosting from 1 April 2023.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 At Trust Board in July 2022, approval was given to participate in a Hosting Assurance Framework. The Framework was developed in collaboration with the organisations hosted by CTMUHB, to summarise and deliberately distinguish between the accountabilities for operational delivery and governance. The Framework details the arrangements and requirements for organisations hosted by CTMUHB to support effective governance and provide clarity of roles of individuals and in particular, of the CTMUHB Audit and Risk Committee.

3.2 The extension of the hosting agreement does not pose any new risks to the Trust.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The framework is designed to support strong governance and assurance.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Not applicable for this document.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Meets governance principles of the Trust
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	See detail in hosting agreement.

5. RECOMMENDATION

5.1 The Trust Board is asked to **APPROVE** the extension to the hosting agreement for the National Imaging Academy for Wales until 31 March 2026.

Cwm Taf Morgannwg University Health Board
&
NHS Wales Health Boards & Trusts

Hosting Agreement
1st April 2023 – 31st March 2026

Date: March 2023	**Version:** Final Draft

Purpose and Summary of Document:

This agreement is to enable and facilitate the hosting of the NHS Wales National Imaging Academy Wales by Cwm Taf Morgannwg University Health Board (CTMUHB) on behalf of NHS Wales Chief Executives.

The agreement is intended to ensure that hosting arrangements are clear and transparent and that the rights and obligations of all parties are documented and agreed. The agreement sets out appropriate financial arrangements and the obligations of all parties to the agreement.

1. Parties to this agreement

The parties to this agreement are:

1. Cwm Taf Morgannwg University Health Board (CTMUHB), which is the host body.
2. The NHS Wales National Imaging Academy Wales (the NIAW), which is the hosted unit and, for the purposes of this agreement, includes all subsidiary functions, teams and services forming part of the NIAW.
3. All NHS Wales Health Boards and Trusts, on whose behalf the National Imaging Academy Wales will work.

The signatories to this agreement are:

Name	Designation	Signing on behalf of:	Signature	Date
Paul Mears	Chief Executive	Cwm Taf Morgannwg University Health Board (Host)		1.4.2023
Phillip Wardle	Director	National Imaging Academy Wales		
Nicola Prygodzicz	Chief Executive	Aneurin Bevan University Health Board		
Gill Harris	Interim Chief Executive	Betsi Cadwaladr University Health Board		
Suzanne Rankin	Chief Executive	Cardiff & Vale University Health Board		
Steve Moore	Chief Executive	Hywel Dda University Health Board		

Name	Designation	Signing on behalf of:	Signature	Date
Carol Shillabeer	Chief Executive	Powys Teaching Health Board		
Mark Hackett	Chief Executive	Swansea Bay University Health Board		
Jason Killens	Chief Executive	Welsh Ambulance Service NHS Trust		
Steve Ham	Chief Executive	Velindre University NHS Trust		
Tracey Cooper	Chief Executive	Public Health Wales Trust		

1 Named points of contact

The following individuals will act as the primary points of contact in relation to any issues that may arise under this agreement:

- For CTMUHB:
  - Executive Director of Therapies and Health Sciences
  - Executive Director of Strategy & Transformation
- For the NIAW:
  - Director

2 Purpose and scope of this agreement

This agreement is to enable and facilitate the hosting of the National Imaging Academy Wales by CTMUHB on behalf of NHS Wales Chief Executives.

The agreement is intended to ensure that hosting arrangements are clear and transparent and that the rights and obligations of all parties are documented and agreed.

The National Imaging Academy Wales' annual work plan and performance management arrangements are agreed between the Director of the National Imaging Academy Wales and the Collaborative Executive Group, prior to final sign off by the Collaborative Leadership Forum.

3 Status of this agreement

This agreement is not legally binding and no legal obligations or legal rights arise between the parties from it. The parties enter into this agreement intending to honour its content and spirit.

This agreement is one which is subject to S.7 of the NHS (Wales) Act 2006.

The parties agree that they shall act:

- in the spirit of good faith
- in the interests of minimising costs to themselves
- in the interests of maintaining quality at all times
- in accordance with any applicable statute, directions, orders, guidance or policy.

4 Duration of this agreement

This agreement commences on 1 April 2023 and will run for a period of three years until 31 March 2026.

5 Monitoring and review of this agreement

The Director of the National Imaging Academy Wales will liaise regularly with either CTMUHB's Executive Director of Therapies and Health Sciences or Executive Director of Strategy & Transformation, to monitor the operation of this agreement and to address and resolve any practical issues that may emerge.

5.1 Six monthly formal review meetings

The Chief Executive, CTMUHB and the Director of the NIAW (or nominated deputies) will meet six monthly to discuss current/live issues, the NIAW's progress on establishing governance arrangements with the NHS, and any particular issues relating to hosting arrangements. They will also include early discussions on possible changes or additions to the NIAW's role and remit.

5.2 Review meetings

The named points of contact (section 1) will meet at least six monthly to discuss hosting arrangements and any particular areas of concern. These meetings will include discussion of:

- matters relating to workforce, finance, procurement, facilities and any other corporate support services (note IT requirements will be met via a separate agreement with Digital Healthcare Wales (DHCW)

- possible changes to the NIAW's remit and any other matter which is likely to impact on the corporate support provided by CTMUHB.
- financial performance and any variance against budget, in particular potential over or underspends.

The NIAW will provide a short written report before each quarterly meeting confirming compliance with policies and procedures (e.g. statutory and mandatory training compliance), highlighting any areas of non-compliance.

5.3 Audit & Risk Committee

The Director of the NIAW will attend the CTMUHB Hosted Bodies Audit & Risk Committee at least annually, or as requested by the Audit & Risk Committee, to provide assurance to the Committee that the NIAW is complying with the Hosting Agreement and to highlight and discuss any areas of risk or non-compliance.

5.4 Annual Assurance Statement

The National Imaging Academy Wales will provide an annual Governance Compliance/Assurance Statement to CTMUHB, to confirm that they have complied with the hosting arrangements, highlighting any areas of concern, risk or non-compliance. This statement will inform CTMUHB's Governance Statement which forms part of the Annual Accountability Report.

5.5 Review

The agreement will be reviewed in the fourth quarter of each year by all parties to ensure that it is operating effectively and amendments will be agreed as required.

6 Termination and notice period

The parties acknowledge that if one of the signatories to this document withdraws or otherwise terminates its responsibilities this agreement will terminate twelve months after that event and a new agreement will be drafted and agreed by all the parties that wish to continue to engage with each other in respect of NIAW.

7 Background

In 2016, NHS Wales Chief Executives confirmed their intention to establish an NHS Wales National Imaging Academy Wales to primarily increase the number of Radiology trainees in NHS Wales (with increased classroom training within a dedicated and appropriately equipped facility, significantly enhancing the training capacity, with an economy of scale for required trainer time).

In April 2017 Cwm Taf University Health Board was formally requested to host the National Imaging Academy Wales and its Director and staff. This request was formally accepted on 7 July 2017, subject to confirming hosting arrangements via the hosting agreement. This agreement has been continued by Cwm Taf Morgannwg University Health Board since its formation in April 2020.

The current Director was appointed as Director of the National Imaging Academy Wales on 1st November 2018.

An extension to this agreement was approved by Health Boards and Trusts in March 2021 to be effective for the period 1st April 2021 to the 31st March 2023.

A review of this agreement was initiated in February 2023 to support an extension to the agreement for a further three year period.

8 Nature of the hosting arrangement

CTMUHB will provide services and facilities as agreed with Health Boards and NHS Trusts under this hosting agreement to enable the smooth running of the NIAW. However, CTMUHB will not be responsible or accountable for setting the direction of the NIAW or for the quality of the work undertaken by the NIAW. This rests with the Director of the NIAW reporting directly through the NHS Wales Chief Executive Officer Lead for Imaging to the Collaborative Executive Group and Collaborative Leadership Forum.

9 Appointment of the Director of the National Imaging Academy Wales

The Director of the NIAW and the Academy staff are employed by CTMUHB, but the Director will be appointed by the Chief Executive of the Host Body (on behalf of NHS Boards and Trusts) on recommendation and appropriate scrutiny through interview led by the Chief Executive Lead for NHS Wales, NHS Wales Chief Executive Officer Lead for Imaging, who are also responsible for ensuring continuity of leadership for NIAW.

10 Financial arrangements

10.1 Setting of and responsibility for the National Imaging Academy Wales budget

Whilst complying with CTMUHB's Standing Orders and Standing Financial Instructions (see below), the Director of the NIAW will be accountable through the Host Body Chief Executive to the Collaborative Executive Group.

The Director of the NIAW will have an authorisation limit of £100,000 (equivalent to a Care Group Director at CTMUHB) and will specify an appropriate scheme of delegation for the management of the NIAW's budget. Expenditure over £100,000 will need authorisation from the Chief Executive, CTMUHB (following discussion with the Director of the NIAW and the Lead Chief Executive for Imaging).

CTMUHB will provide the NIAW with monthly financial budget/expenditure reports. The NIAW will be responsible for checking the accuracy of these reports and for reporting and explaining any variance of expenditure against budget profile.

Recurring and non-recurring changes to the NIAW's core budget will be agreed between the Director of the NIAW and the Collaborative Leadership Forum. Such

changes may include in-year recurring or non-recurring uplifts contributed by health boards and trusts to cover agreed additional activities.

10.2 Additional funding

In addition to its core budget, the NIAW may receive additional recurring or non-recurring income from individual NHS Wales bodies or from other sources, for specific work undertaken.

The NIAW will inform CTMUHB of all arrangements for additional funding, and the terms under which the funding is being provided. Any external funding from industry partners must be compliant with any related host body Policies.

Any additional capital funding required for the initial project, on-going maintenance and developments, will need to be provided from within the partner organisations' discretionary capital allocations or if significant, be presented via a joint capital bid to the Welsh Government.

10.3 Financial variances

The Director of the NIAW must achieve a break-even position each financial year.

The Director of the NIAW is responsible for informing the Lead Chief Executive for imaging and the CTMUHB Chief Executive, at the earliest practicable stage, of any significant forecast variances and, in particular, of risks that may result in the underwriting provisions described in section 11 below being required.

In the event that there is a predicted under or overspend against the budget for the NIAW in any year, the parties to this agreement shall consider:

- in the case of an under-spend, whether there are any alternative uses to which the funds can be put consistent with the role of the NIAW, or whether funds should be returned to contributing bodies
- in the case of an over-spend, what steps can be taken to prevent the overspend arising
- any liability that exists as a result of any overspend will be shared on a joint and several basis between the parties signed to this agreement on an agreed risk sharing basis.

10.4 Financial liabilities

CTMUHB shall be the responsible legal entity in relation to liabilities to third parties, save where excepted in this agreement.

The activities of the NIAW will be covered by the Welsh Risk Pool, via CTMUHB; however, will be subject to the normal excess arrangements.

The NHS Wales Chief Executives will collectively underwrite the financial liabilities of the NIAW (on agreed risk sharing basis), where such liabilities cannot be met from within the NIAW's budget or are not covered by the Welsh Risk Pool. This includes any costs associated with redundancy, termination or breaches of employment contract, disputes and health and safety matters.

10.5 Levy to cover the costs of hosting the National Imaging Academy Wales

An agreed annual recurring revenue requirement will be provided to CTMUHB, to cover its 'core' hosting costs.

These costs will need to be reviewed and adjusted upwards on confirmation of any additional support required by the NIAW from the host body and in recognition of any inflationary pressures.

The 'core' hosting costs will be reviewed each year, as part of the overall review of this agreement (see section 5.5) and any additional 'core' hosting costs would need to be managed within the overall agreed NIAW revenue allocation.

With the exception of the agreed hosting costs and any agreed costs arising from issues detailed in section 11, no deductions will be made from the NIAW's budget by CTMUHB and CTMUHB's Cost Reduction Programme / savings targets will not be applied.

CTMUHB will not fund or be liable for any NIAW cost pressures, which must be funded within the agreed NIAW budget.

11 Obligations of CTMUHB under this agreement

11.1 General obligations of CTMUHB

CTMUHB shall be responsible for providing services and facilities to enable the smooth running of the NIAW.

In general, unless otherwise specified, these services and facilities will be equivalent to those provided to teams and services directly managed by CTMUHB. NIAW staff are expected to comply with CTMUHB's policies and procedures.

The services and facilities covered by this agreement may be provided directly by CTMUHB or may be procured from third party providers, including, but not limited to the NHS Wales Shared Services Partnership and Digital Health Care Wales (DHCW)

In hosting the NIAW, CTMUHB shall not be required to in any way act outside its statutory powers, duties, Standing Orders, Standing Financial Instructions or governance and legal obligations.

The NIAW undertakes to indemnify CTMUHB for any liability, losses, costs, expenses and claims that might arise in relation to the management of financial resources and the risk when discharging its duties and it will hold CTMUHB harmless in respect of any claims made by any third party arising out of the operations of the NIAW. The management of any such claim will be undertaken by CTMUHB, in liaison with the NIAW. However, any such claims that arise as a result of CTMUHB not meeting its hosting duties (as detailed in this agreement), then CTMUHB would be held accountable and manage the claim.

CTMUHB will not be responsible for the validity, efficacy or approval of the NIAW's budget or other plans and the NIAW will in fulfilling its obligations not place CTMUHB in a position whereby it breaches any Statute, Regulation, Standing Order, Direction, Measure or any other corporate governance requirement.

Specific services and facilities to be provided are set out below:

- Access to some Committees of the CTMUHB Board as appropriate, in order to discharge elements of the Academy's governance arrangements. These include:
- Quality, Safety & Risk Management – Reporting via the CTMUHB Quality & Safety Committee.
- Audit & Assurance – Reporting periodically to the CTMUHB Audit & Risk Committee
- Remuneration & Terms of Services Committee (RATS)
- IR(Me)R and other Imaging Governance – Reporting via Radiation Safety Committee including Ultrasound Governance.
- Clinical/Corporate Business Meeting(s) – six monthly reviews, including oversight of delivery of hosting agreement

As well as the following:-

- Governance advice and support
- Information Governance, managing overseeing any related Data Subject Access; Freedom of Information requests and related training
- Workplace health & Safety advice & support, including incident reporting and access to Datix
- Limited ad-hoc occasional communications/media support/advice.

11.2 Workforce

CTMUHB will act as the appointing and employing body for all directly employed and existing seconded staff of the NIAW, including the Director. The following services will be provided to the NIAW:

- Payroll services (for employed staff), including processing of expenses claims etc.
- Recruitment and selection support (including provision of selection/assessment tools)
- General people resources advice, with first line advice being provided by a named People Services point of contact
- Access to occupational health services
- Access to and support of the Electronic Staff Record system
- Access to statutory and mandatory training

Any financial liabilities resulting from the direct employment of staff of the NIAW (e.g. costs associated with advertising, redundancy, termination or breaches of employment, disputes and health and safety matters) will be met from the core budget agreed for the NIAW.

In the event that the core budget has insufficient funds to meet or cover the liability, NHS Wales Chief Executives (and not CTMUHB) will collectively underwrite the financial liabilities of the NIAW (on an agreed fair shares basis).

11.3 Finance and procurement

The NIAW's budget will be included within the CTMUHB ledger and the Director and any other NIAW budget holders will be provided with an income and expenditure account and the following on the same basis as provided to CTMUHB budget holders:

- Specified budget codes for the sole use of the NIAW
- Budget holder reports and information
- Management accountancy support and advice, with first line advice being provided by a named member of the finance team
- Payment of invoices
- Internal and external audit
- Access to procurement advice and support
- Appropriate access to the Oracle finance/procurement system

CTMUHB will act as the legal entity which enters into contracts and related agreements for goods and services procured on behalf of the NIAW.

11.4 Accommodation

The NIAW's core recurring budget includes provision for accommodation. The NIAW will occupy premises procured as part of the business case, agreed with NHS Wales Chief Executives and Welsh Government. The maintenance and running costs of premises will be funded from within the NIAW's core budget.

CTMUHB as host will own and maintain the NIAW Building on behalf of NHS Wales. A separate recharge over and above the hosting fee will be charged for buildings maintenance and facilities management, as per the agreed business case.

11.5 Digital Technology

The NIAW will develop a Service Level Agreement (SLA) direct with Digital Health Care Wales to provide the following:

- network infrastructure
- file servers for document storage
- the NHS Wales network and internet
- desktop IT support
- access to mobile services (which may be charged for separately on an 'at cost' basis)
- procurement of new and replacement IT equipment
- hosting of the NIAW's internet and/or intranet sites and technical support in relation to their ongoing maintenance and development

11.6 Other corporate support services

CTMUHB will provide the NIAW with access to various services / support when required. At times there may be a requirement to charge additional costs over and above the core hosting fee for items or levels of support that are not covered within the above arrangements.

This will either be based on the time spent on the activity, or if external advice is required then that will be recharged to NIAW.

This may include, but is not limited to the following:-

a. Strategic and planning support, including help with development of business plans, etc.
b. Finance support for Business case development (both revenue and capital)
c. Additional workforce support/advice above the basic core level outlined above, including any costs associated with redundancy, termination or breaches of employment contract;
d. Welsh language / translation services
e. Legal Assistance (this will be provided by NWSSP Legal & Risk Services and recharged)
f. Internal and external audit fees, for audit & assurance purposes
g. A lease car scheme for staff meeting eligibility criteria
h. All aspects of any additional Health Board based IT support, as this is all being provided directly by DHCW to the NIAW, through a separate Service Level Agreement.

12 Reporting

Hosting reporting shall be undertaken as follows:

12.1 Responsible Officer

The Responsible Officer will be the Director of the NIAW and this person will report to the Chief Executive at CTMUHB.

12.2 Accountable Officer

The Accountable Officer will be the Chief Executive of CTMUHB, who will liaise closely with the lead NHS Wales Chief Executive for Imaging.

12.3 Variation

No variation to the Agreement will be valid unless made in accordance with the Change Control Procedure found at Annex A.

13 Obligations of the National Imaging Academy Wales under this agreement

The NIAW will comply with CTMUHB's:

- Standing Orders
- Standing Financial Instructions
- All policies and procedures where they are applicable to the activities of the NIAW as a hosted body (e.g. Health and Safety, workforce etc.)

The Director of the NIAW will have overall responsibility for the appointment of NIAW staff, whilst acting within CTMUHB's recruitment policies. Other than the provision of People Services advice and selection tools, or as specifically requested by the NIAW, CTMUHB will have no role in the appointment of staff.

The Director of the NIAW will be responsible for ensuring that all NIAW staff undertake applicable statutory and mandatory training, which will be made available by Cwm Taf Morgannwg University Health Board. With the exception of statutory and mandatory training, the responsibility for the organisation and funding of the training and development of NIAW staff will rest with the NIAW.

The Director of the NIAW is responsible for the management of risk within the National Imaging Academy Wales and its activities. The NIAW will follow CTMUHB's Risk Management Strategy and Risk Management Policy and will monitor and maintain a risk register for the NIAW on the CTMUHB Datix system. Any potential risks which could impact on the business and safety of CTMUHB will be escalated to the Chief Executive and the Executive Lead with responsibility for risk in CTMUHB. The Director of the NIAW will also ensure that the Chief Executives are apprised of any high risks and the arrangements for providing assurance regarding their management.

CTMUHB can request access to the NIAW's risk register as required, to inform and provide assurance that the overall governance arrangements of CTMUHB are being maintained.

The Director of the NIAW will be responsible for ensuring any additional pieces of work taken on by the NIAW, including expansion in workforce and budget are to be discussed and agreed with CTMUHB.

14 Intellectual property

Unless otherwise agreed (see below) all intellectual property developed or legitimately acquired by the NIAW, shall be owned collectively by the NHS Wales Health Boards and Trusts.

If the intellectual property is to be exploited in any way then terms will be agreed between all the parties in this respect.

In some circumstances, the NIAW may (through CTMUHB) enter into agreements (such as joint working agreements with industry partners) where specific conditions relating to the ownership and exploitation of intellectual property may apply.

15 Data Protection and Freedom of Information

For the purposes of information governance, data protection and freedom of information activity, all data and information held by the NIAW will be deemed to be held by CTMUHB. As a result, any requests for information under relevant legislation will be processed according to CTMUHB's Policies and Procedures. However, the Director of the NIAW will be informed as soon as possible of any relevant requests received and discussion will take place with the Director before any of the NIAW's information is released to a third party. The Director of the NIAW will be responsible for sharing relevant requests, and responses provided, with Health Boards and Trusts as appropriate.

The NIAW may enter into data sharing agreements with Health Boards and Trusts to facilitate the carrying out of its functions. As the host body, CTMUHB will need to be a signatory to such agreements and must be satisfied with their content.

16 Disputes and matters not covered by this agreement

It is inevitable that issues will arise that are not explicitly covered by this agreement. In such cases, and in the event of any disputes, all parties will seek to address these issues and identify appropriate solutions in the common interest of NHS Wales and the public served.

If any party has any issues, concerns or complaints about Hosting, or any matter in this Hosting Agreement, that party shall notify the other parties and the parties shall then seek to resolve the issue by a process of consultation. If the issue cannot be resolved within a reasonable period of time, the matter shall be escalated to the Accountable Officer and the Responsible Officer, who shall decide on the appropriate course of action to take. If the matter cannot be resolved by the Accountable Officer and the Responsible Officer within 21 days, the matter may be escalated to the Welsh Government in accordance with the NHS (Wales) Act 2006.

If any party receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to Hosting, the matter shall be promptly referred to the Accountable Officer and Responsible Officer (or their nominated representatives). No action shall be taken in response to any such inquiry, complaint, claim or action, to the extent that such response would adversely affect Hosting, without the prior approval of them (or their nominated representatives).

17 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with the laws of England and Wales and, without affecting the escalation procedure set out in section 17, each party agrees to submit to the exclusive jurisdiction of the courts of England and Wales.

Annex A

Annex A – Change Control Procedure

1. Changes may be proposed by any party to the Responsible Officer who will then discuss them with the Accountable Officer.
2. The Changes may be agreed or rejected by both of those individuals.
3. All parties will be notified of the decision and any resulting change will be recorded in writing and annexed to this agreement.
4. Any dispute regarding the proposed changes will be dealt with by the escalation procedure except in that different officers of each body will deal with the dispute.

Date of change	**Section No.**

TRUST BOARD

TRUST WIDE POLICIES UPDATE

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board		ENDORSED FOR APPROVAL
Charitable Funds Committee	December 2022	APPROVED
Audit Committee	January 2023	APPROVED
Research Development & Innovation Sub-Committee	February 2023	APPROVED
Quality, Safety & Performance Committee	March 2023	APPROVED

ACRONYMS	
AC	Audit Committee
CFC	Charitable Funds Committee
EMB	Executive Management Board
QSPC	Quality, Safety & Performance Committee
RD&I	Research Development & Innovation

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 **December 2022 to March 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 December 2022 are outlined below:

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
CFC04: Charitable Funds Investment Policy	Executive Director of Finance	Charitable Funds Committee	01/12/2022	**1**
FP02: Counter Fraud, Bribery and Corruption Policy and Response Plan	Executive Director of Finance	Audit Committee	12/01/2023	**2**
RD01: Intellectual Property (IP) Policy	Executive Medical Director	Research Development & Innovation Sub-Committee	28/02/2023	**3**

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
IPC13: Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeld-Jakob Disease) Minimising the Risk of Transmission	Executive Director of Nursing, Allied Health Professionals & Health Science	Quality, Safety and Performance Committee	16/03/2023	**4**
QS19: Ionising Radiation Safety Policy	Executive Medical Director	Quality, Safety and Performance Committee	16/03/2023	**5**

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Trust has a defined process for the management of policies and written control documents. The purpose of which is to ensure staff are aware of their responsibilities with regards to Trust policy documents and to provide a 'model' guide and consistent approach for the development, management and dissemination of the Trusts documents
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Each policy has been individually assessed to ensure compliance with EQIA's
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 **December 2022 to March 2023**.

Ref: CFC 004

Charitable Funds Investment Policy

Date to be reviewed:	December 2025	**No of pages:**	11
Author job title(s):	Deputy Director of Finance		
Responsible dept /director:	Executive Director of Finance		
Approved by:	Charitable Funds Committee		
Date approved:	1 December 2022		
Effective Date (live):	1 December 2022		
Version:	5		

Date EQIA completed	7 August 2021
Documents to be read alongside this policy:	This policy should be read in conjunction with the following information: • Terms of Reference of the Investment Performance Review Sub-Committee • The Trustees Act 2000 • CC14 Charities and Investment Matters: A Guide for Trustees

Current review changes
Reviewed in accordance with the agreed policy review period. Item 4.1 – Wording updated
Item 6.1 – Recommended cash balances have been removed Items 8.2 and 8.3 – Wording amended/updates
Items 8.7 – Access to funds updated to reflect agreement with new investment.

Version 4 changes:
General review and update to reflect change in Trust status to 'University NHS Trust' Item 10 Restraints on Types of Investments:
10.1 c) Companies that derive a significant proportion of their income from Fossil Fuels added to the exclusion criteria
10.1 d) investment in companies that are deemed to have an approach to risk mitigation around the issues of ethical employment considered 'Weak' by VE and paragraph to describe the organisation VE and their assessment approach

Executive Summary:
The purpose of this policy is to formalise the responsibilities of Velindre University NHS (UNHS) Trust Charitable Funds Trustees in respect of the management of charitable fund assets held by the Trust.

First operational:	Date: July 2012			
Previously reviewed	June 2018			
Changes made: Yes	November	June 2021	November 2022	

Charitable Funds Investment Policy

Contents

Charitable Funds Investment Policy

1. Policy Statement

This policy has been prepared following the request by Velindre UNHS Trust Charitable Funds Committee to ensure that our organisation is managing appropriately and transparently the charitable funds assets and complying with all the legal regulations, guidance and best practices established by governmental and regulatory bodies.

- This policy takes into consideration
  - Maintenance of liquidity levels.
  - Investments of charitable assets.
  - Minimum level of return required.
  - Surplus funds.
  - Restraints on types of investments.
  - Pooling of investments.
  - Fund management by Investment advisors and Investment subcommittee.

2. Purpose

The purpose of this Policy is to formalise the responsibilities of the Trustees in respect of the management of the Charitable Fund's assets held by the Trust and to translate these responsibilities into an investment strategy which complies with the Trustees Act 2000 and incorporates best established practice by:

- Ensuring that when investing Charitable Funds, Trustees achieve an appropriate balance for the charity between the two objectives of:
  - Providing an income to help the charity carry out its purposes effectively in the short term; and
  - Maintaining and, if possible, enhancing the value of the invested funds, so as to enable the charity effectively to carry out its purposes in the longer term.

- Ensuring that the following standards as defined in **the Trustee Act are followed**, whether they are using the investment powers in that Act or not:

  - That the Charity is discharging its general duty of care (as described in section 1 of the Trustee Act), which is the duty to exercise such care and skill as is reasonable in the circumstances. This applies both to the use of any power of investment and

to the discharge of the specific duties which the Act attaches to the use of investment powers. A higher level of care and skill is expected of a Trustee who is or claims to be knowledgeable about or experienced in investments, or who is paid.

- Secondly, that the Charity is complying with the following **specific duties**:

  - Trustees must consider the **suitability** for their charity of any investment. This duty exists at two levels. The Trustees must be satisfied that the type of any proposed investment (e.g. a common investment fund or a deposit account) is right for their charity (including whether it is consistent with an ethical investment policy if the charity has one). They also have a duty to consider whether a particular investment of that type is a suitable one for the charity to make. Trustees should, at both levels, try to consider the whole range of investment options which are open to them; how far they should go here will, of course, depend on the amount of funds available for investment.

  - Trustees must consider the need for diversification, i.e. having different types of investment, and different investments within each type. This will reduce the risk of losses resulting from concentrating on a particular investment or type of investment. Again, how far the Trustees can go here will depend on the amount of funds available for investment.

  - Trustees must periodically review the investments of the charity. The nature and frequency of these reviews is up to the Trustees to decide, but the reviews should be proportionate to the nature and size of the charity's investment portfolio. To review too infrequently may result in losses or missed opportunities; chopping and changing investments too frequently may incur unnecessarily high levels of transaction charges. It is recommended that a review of the investments should be carried out at least once a year.

  - Before exercising any power of investment, and when reviewing the charity's investments, Trustees must obtain and consider proper advice from a suitably qualified adviser (who may be one of the Trustees), unless the size of the funds available for investment is so small that seeking investment advice would not be cost effective.

- Ensuring that the Investments Clauses defined in the Governing Document from January 1995 (Section D Trustees Powers) are followed.

3. Scope

3.1 This policy applies to all Velindre UNHS Trust Employees and Independent Members, particularly to Charitable Funds Committee Members, Investment Subcommittee Members and Investment advisors.

3.2 The term “Employees” includes all those who have a contract of employment or

honorary contract with the Velindre UNHS Trust.

4. Aims and Objectives

4.1 Trustee's objective(s) in investing its funds:
The Trustees have agreed that the Charity Committee Funds' investment objective is to as a minimum **MAINTAIN CAPITAL** over the medium term, and to **PRESERVE CAPITAL** where an income from the Trust Investment is required; however, the priority is to maintain the value of the Trust Capital after the effect of inflation.

5. Roles and Responsibilities

5.1 The Trust Board as the Corporate Trustee Recognises its overall responsibilities for investment decisions and the need to demonstrate that they have retained overall control of decision making and have complied with their duties regarding investing Velindre UNHS Trust Charitable Funds, therefore the Trustees have agreed:

- That the Trustees and the Investment Manager are the only authorised parties able to take any decisions regarding Velindre UNHS Trust Charitable Funds Investments. These decisions have to be agreed between both parties before any action is taken.

- The Charitable Fund Committee and the Investment Performance Review Sub Committee advise the Board on the more detailed aspects of its investment policy and performance. The Terms of Reference of the Investment Performance Review Sub Committee are attached to this policy.

- The Trustees have agreed that details of their investment approach and key decision are recorded in writing in order to demonstrate that they have considered the relevant issues, taken advice appropriately and reached a reasonable decision.

- The Trustees have a formal written contract with the Investment Manager. In this agreement the Investment manager is required to follow Velindre UNHS Trust Charitable Funds Investment Policy. In this agreement the Trustees have specifically requested that The Investment Manager must not:

    - Appoint a substitute or select their own successor.
    - Reduce the normal duty of care, or places a cap on his liability for breach of contract.
    - Act in situations that might give rise to a conflict of interest unless it is reasonably necessary for them to do so.

5.2 This policy also precludes Trustees from profiting from their office.

6. Maintenance of Liquidity Levels

6.1 The Trustees shall require that a proportion of Trust Fund assets be held in immediate and short term liquid forms. These shall be:

a) Current Bank Account

The level of funds held in this account shall be as minimal as possible which is consistent with the requirement to fund all normal transactions.

b) Locally Controlled Deposit Account

The level of funds held in this account should be sufficient to provide an adequate buffer between the daily needs of the funds as financed by the current account, and the main portfolio consisting of medium and long term investments. This should obviate the necessity to prematurely liquidate assets to the potential detriment of the portfolio. The actual level will be monitored and delegated to the discretion of the Charitable Funds Investment Performance sub Committee.

c) Deposit Account Held by Investment Managers

The level of funds held in this account should be sufficient to provide a buffer between the locally held cash resources and the main portfolio. The establishment of a balance level will be delegated to the discretion of the Charitable Funds Investment Subcommittee and the Investment advisor / fund manager in managing the portfolio in total.

6.2 The Trust's officers shall be required to monitor locally held balances and commitments and inform the Investment subcommittee members and the investment manager at the earliest opportunity should it appear likely that a cash call may be required.

6.3 Investment Sub-Committee Members and Trust Officers shall be required to monitor a least every six months that the returns on Cash and cash-like investments are in line with or exceed benchmarks.

7. Investment of Charitable Assets

7.1 The Trustees must attempt to maximise the investment return on the charitable funds whilst minimising the risk to the funds themselves. Furthermore, the Trustees have a legal duty to avoid speculative forms of investment.

7.2 The Trustees Act 2000 gives to the Trustees "The General Power of Investment" where a Trustee may make any kind of investment that they could make if they were absolutely entitled to the assets of the trust. Under this Act the Trustees have to observe the following Clauses:

7.3 The general power of investment does not permit a Trustee to make investments in land other than in loans secured on land.

7.4 A person invests in a loan secured on land if he has rights under any contract under which —

(a) One person provides another with credit, and
(b) The obligation of the borrower to repay is secured on land.

7.5 In exercising any power of investment, whether arising under this Part or otherwise a Trustee must have regard to the standard investment criteria set out below:-

7.6 The Trustees must from time to time review the investments of the trust and consider

whether, having regard to the standard investment criteria, they should be varied.

7.7 Before exercising any power of investment, whether arising under this Part or otherwise, a Trustee must (unless the exception below applies) obtain and consider proper advice about the way in which, having regard to the standard investment criteria, the power should be exercised.

7.8 When reviewing the investments of the trust, a Trustee must (unless the exception applies) obtain and consider proper advice about whether, having regard to the standard investment criteria, the investments should be varied.

7.9 The exception is that a Trustee need not obtain such advice if he reasonably concludes that in all the circumstances it is unnecessary or inappropriate to do so.

7.10 Proper advice is the advice of a person who is reasonably believed by the Trustee to be qualified to give it by his ability in and practical experience of financial and other matters relating to the proposed investment.

8. Investment Risks and Profile

8.1 The Trustees recognise that all investments involve an element of risk. The level of risk that is appropriate for the Trust will be influenced by various factors, including the Trustees' attitude to risk, the Trust's capacity to afford potential investment losses and its investment objectives.

8.2 The Trustees in Order to mitigate the Capital Risk have agreed to request the investment advisor / manager to maintain a diversified portfolio of assets in order to protect the charity's investments from sudden variations in the market.

8.3 The Trustees in order to attempt minimising the risk to Velindre UNHS Trust Charitable Funds, have agreed to operate within a lower risk investment strategy, which means that investments will be skewed significantly to less volatile asset classes such as high quality investment grade corporate and sovereign bonds. Riskier assets such as equities, alternative investments and commodities may be selected but they are likely to play a less significant role.

8.4 The Trustees have determined that the purpose of the Velindre UNHS Trust Charitable Funds investment has been categorised as **GENERAL** with no specific investment purpose. The time horizon for the Trust general investment account is between 5 to 7 years.

8.5 The Trustees have requested that the Assets allocation should be distributed following the best advice from the Investment Manager and its direct effect in having a lower risk Investment strategy.

8.6 The Asset Classes allocation considered by the Trustees should include the following:

- Cash
- Sovereign Fixed Income
- Corporate Fixed Income
- Developed Market Equity
- Emerging Market Equity
- Private Equity
- Commodities
- Absolute Return

8.7 In agreement with the investment managers funds are realisable within 2 weeks.

9. Surplus Funds

9.1 Where the level of capital and income growth achieved is greater than the annual rise in the cost of living the Trustees may, at their discretion, determine to expend surpluses arising in subsequent periods or to re-invest for further income growth.

10. Restraints on Types of Investments

10.1 This policy sets out four investment constraints namely:

a) Capital held in perpetuity shall be separately identified. This capital may not be expended until notified by the Trustees. Furthermore, the Trustees shall be bound by any constraints established in the trust document or bequest.

b) Investments shall comply with the rules and regulations of the Trustees Act 2000.

c) At the discretion of the Trustees investment in companies whose trade is inconsistent with the aims of the Velindre UNHS Trust may be expressly precluded. The Trustees may not, however, preclude investments in companies for any other reason e.g. political. **HOWEVER, SUCH EXCLUSIONS AS EXPRESSLY IDENTIFIED BY THE TRUSTEES ARE COMPANIES WHO DERIVE A SIGNIFICANT PROPORTION OF THEIR INCOME FROM FOSIL FUELS, GAMBLING, TOBACCO, ALCOHOL AND ARMOURMENT ACTIVITIES.**

d) At the discretion of the Trustees investment in companies that are deemed to have an approach to risk mitigation around the issues of ethical employment considered 'Weak' by VE. VE are an organisation that provides a risk rating in relation to the Environmental, Social & Governance (ESG) factors of a company that can be brought into the financial decision making of investors.

VE assess four areas of ethical employment (fundamental labour rights; non-discrimination; child and forced labour; social standards in the supply chain), three criteria are examined (frequency of allegation; severity of allegation; responsiveness to the issue raised). The ratings for each of the three criteria

are then aggregated to give an overall rating for the company's perceived risk mitigation (advanced, robust, limited, weak).

e) There are further restrictions on investment in Russian/Belarussian companies.

11. Selection of Investment Managers

11.1 The Charitable Funds Committee's recommendations to the board of Trustees regarding the selection of investment manager(s) must be based on prudent due diligence procedures. A qualifying investment manager must be a registered investment advisor under the Investment Advisor Act of 1961, or a bank or insurance company which is authorised and regulated by the Financial Services Authority.

11.2 Investment Managers are to be reviewed at a minimum of five years.

11.3 A Trustee of the Velindre UNHS Trust Funds is specifically excluded from providing investment advice, even though they may be so authorised.

12. Fund Management – Delegation of Investment Advisors

12.1 This Investment Policy has been established to act as a basis for financial advice received from the appointed financial advisor / investment manager.

12.2 The Financial advice received from Financial Advisors / Investment Manager must take into consideration the management of the main risks associated with investments such as Capital Risks, Liquidity Risks, Market Risks, Valuation Risks, Tax Risks, and Environmental, Social and Governance Risks.

12.3 The delegation of advice is subject to the conditions below:

a) Advice is compliant with the investment policy adopted by the Trustees.

b) The delegated powers may be withdrawn at any time.

c) The delegation will be reviewed at least every three years.

d) The Trustees are liable for acts or defaults of the investment advisors, since responsibility may not be delegated under the Trustees Investment Act 1961.

e) Investment managers shall be reviewed regularly regarding performance, personnel, strategy, research capabilities, organization and business matters, and other qualitative factors that may impact their ability to achieve the desired investment results.

13. Fund Management – Delegation Review

13.1 A report will be expected from the Investment Advisors demonstrating how the Trust's portfolio performance compares with movements in various published indices and other appropriate investment performance "benchmarks" on a six months basis. These investment performance indicators will be agreed between the Trustees and the Investment Advisors and should provide an assessment of both capital growth as well as income performance.

13.2 The Investment Fund Manager is also required to:

a) Provide subsidiary tax certificates for all interest and dividend payments and contract notes in respect of investment sales and purchases as soon as possible.

b) Provide a monthly statement of dividends received.

c) Provide a monthly statement of investment purchases and sales.

d) Provide a fund portfolio on a quarterly basis.

e) Hold the charity's share certificates in a wholly owned nominee company.

f) Attend the Charitable Funds Committee as and when required.

13.3 These investment reports shall be reported to the Charitable Funds Committee every six months.

14. Review

The Deputy Director of Finance will review the operation of the policy as necessary and at least every 3 years.

15. Legislation

- The Trustees Act 2000
- CC14 Charities and Investment Matters: A Guide for Trustees.
- Velindre UNHS Trust Charitable Funds Governing Document from January 1995.

16. Further Information

Further information and support is available from the Deputy Director of Finance on Tel: 02920 316240
Mobile: 07971284383
Matthew.bunce2@wales.nhs.uk

REF: FP 02

Counter Fraud, Bribery and Corruption Policy and Response Plan

Executive Sponsor & Function:	**Executive Director of Finance**
Document Author:	**Executive Director of Finance & Local Counter Fraud Specialist**
Approved by:	**Audit Committee**
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Table of Contents

1. Introduction

1.1. One of the basic principles of public sector organisations is the proper use of public funds. It is therefore important that all those who work in the public sector are aware of the risk of and means of enforcing the rules against fraud and other illegal acts involving dishonesty or damage to property. For simplicity all such offences are hereafter referred to as “fraud”, except where the context indicates otherwise. This document sets out Velindre NHS Trust’s policy and response plan for detected or suspected fraud.

1.2. It is essential that all staff are aware of, and are able to access up-to-date, accurate Velindre University NHS Trust (VUNHST) policies to ensure they are aware of current approved practices to help reduce risk.

1.3. VUNHST already has procedures in place that reduces the likelihood of fraud occurring. These include Standing Orders, Standing Financial Instructions, documented procedures and a system of internal control and a system of risk assessment. In addition, VUNHST tries to ensure that a risk (and fraud) awareness culture exists throughout the organisation.

1.4. This document is intended to provide direction and help to those officers and directors who find they have to deal with suspected cases of theft, fraud or corruption. It gives a framework for response, advice, and information on various aspects and implications of an investigation.

1.5. The three crucial public service values which must underpin the work of the health service: accountability, probity, and openness. VUNHST is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. It is therefore committed to the reduction of any fraud occurring within VUNHST, and to the rigorous investigation of any such cases that do occur.

1.6. VUNHST wishes to encourage anyone having reasonable concern that a fraud has or may be occurring to contact the Counter Fraud service. It is VUNHST policy that no employee will suffer in any way as a result of reporting reasonably their concerns.

1.7. The flowcharts in section 6.2 describe VUNHST response when a referral is made to the Counter Fraud service. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions.

1.8. VUNHST has a Service Level Agreement with Cardiff & Vale University Health Board for the provision of the Local Counter Fraud service. The Counter Fraud Manager will report directly to the Director of Finance and will produce an agreed work plan to follow, to fulfil the requirements of the role.

2. What is Fraud?

2.1. Fraud:

The Fraud Act 2006 was introduced on the 15th of January 2007 and is focused upon the dishonest behaviour of an individual and the intent to make a gain or cause a loss. It includes the following offences that could be committed against the NHS:

- Fraud by false representation (s.2) – dishonestly misrepresenting something using any means, e.g. by words or actions.
- Fraud by failing to disclose information (s.3) – not saying something where there is a legal duty to do so.
- Fraud by abuse of a position of trust (s.4) – abusing a position where there is an expectation to safeguard the financial interests of another person or organisation.

Areas where fraud may occur include but are not limited to:

- *Travel and expense claims*
- *Petty cash vouchers*
- *Items of Service claims from independent contractors*
- *Time sheets*
- *Fraudulent use of authorised leave*
- *Overpayment of salary/wages*
- *Fraudulent use of VUNHST resources*
- *Working whilst on the sick*
- *Handling of cash*
- *Misappropriation of equipment*

This is covered in more detail at section 7.

2.2. Bribery and Corruption:

"The offering, giving, soliciting of an inducement or reward that may influence the actions taken by a body, its members or officers."

Source: The Code of Audit Practice – Audit Commission

Corruption does not always result in a loss. The corrupt person does not have to benefit directly from their deeds, they may unreasonably use their position to give some advantage to another.

It is a common law offence of corruption to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

Corruption prosecutions tend to be most commonly brought using specific pieces of legislation dealing with corruption, i.e. under the The Bribery Act 2010.

2.3. Bribery Act 2010

The Bribery Act 2010 received Royal Assent on 8th April 2010 and came into force on 1st July 2011. The Bribery Act 2010 will abolish all existing UK Anti-Bribery Laws and replace them with a suite of new offences markedly different to what has gone before. The Bribery Act 2010 makes it a criminal offence to "give, promise or offer a bribe and to request, agree to receive or accept a bribe either at home or abroad". It will increase the maximum penalty for bribery to 10 years imprisonment, with an unlimited fine. In addition, the Act introduces a 'corporate offence' of failing to prevent bribery by the organisation not having adequate preventative procedures in place. An organisation may avoid conviction if it can show that it had such procedures and protocols in place to prevent bribery. The 'corporate offence' is not a standalone offence, but always follows from a bribery and/or corruption offence committed by an individual associated with the company or organisation in question.

3. Public Service Values

Source: WHC (2006) 090 'The Codes of Conduct and Accountability for NHS Boards and the Code of Conduct for NHS Managers Directions 2006'.

3.1. The codes reinforce the seven principles of public life (The Nolan Principles) and focuses on the three crucial public service values which must underpin the work of the health service: accountability, probity, and openness.

- Accountability: Everything done by those who work in the NHS in Wales must be able to stand the test of scrutiny by the Welsh Government, public judgments on propriety and professional codes of conduct.
- Probity: There should be an absolute standard of honesty in dealing with the assets of the NHS in Wales: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and

suppliers, and in the use of information acquired in the course of the NHS in Wales's duties.

- Openness: There should be sufficient transparency about the NHS in Wales's activities to promote confidence between the NHS body and its staff patients and the public.

4. VUNHST Policy Statement

4.1. VUNHST is absolutely committed to maintaining an honest, open, and well-intentioned atmosphere within the organisation. It is also committed to the elimination of any fraud within VUNHST, and to the rigorous investigation of any such cases.

4.2. VUNHST wishes to encourage anyone having reasonable suspicions of fraud to report them. Therefore, it is also VUNHST policy, which will be rigorously enforced, that no employee will suffer in any way as a result of reporting reasonably held suspicions.

4.3. All members of staff can therefore be confident that they will not suffer in any way as a result of reporting reasonably held suspicions of fraud. For these purposes "reasonably held suspicions" shall mean any suspicions other than those which are raised maliciously and found to be groundless.

5. Roles and Responsibilities

5.1. Executive Director of Finance

The Director of Finance, in conjunction with the Chief Executive, monitors and ensures compliance with the Counter Fraud Directions for the organisation.

The Director of Finance will, depending on the outcome of investigations and/or the potential significance of suspicions that have been raised, inform appropriate senior management accordingly.

The Director of Finance and Local Counter Fraud Specialist (LCFS) will be responsible for informing third parties such as external audit or the police at the earliest opportunity, as circumstances dictate.

The Director of Finance will inform and consult the Chief Executive in cases where the loss may be above the agreed limit or where the incident may lead to adverse publicity.

If an investigation is deemed to be appropriate, the Director of Finance will delegate to the LCFS, who has responsibility for leading the investigation, whilst retaining overall responsibility himself/herself.

The Director of Finance or the LCFS will consult and take advice from the Director of Workforce and OD, if a member of staff is to be interviewed or disciplined.

The Director of Finance or LCFS will not conduct a disciplinary investigation, but the employee may be the subject of a separate investigation as part of a disciplinary process.

5.2. Local Counter Fraud Specialist

Local Counter Fraud Specialists (LCFS) are located in each NHS organisation. The Lead LCFS is appointed by the Executive Director of Finance and will be responsible for investigating cases of fraud up to a value of £15,000. All investigations involving more than £15,000 and/or Corruption must be referred to the NHS Counter Fraud Service (Wales) Regional Team. Only individuals who are accredited as Counter Fraud Specialists will be responsible for investigating cases of fraud. The LCFS will be responsible for notifying all cases of fraud to NHS CFS (Wales) in the appropriate manner and via the CLUE Case Management System. The LCFS shall:

- Report to Executive Director of Finance.
- Provide a written report at least annually to VUNHST on counter fraud work within the organisation.
- Be entitled to attend Audit Committee meetings and have a right of access to all Audit Committee members and the Chairman and Chief Officer of VUNHST.
- Undertake, as agreed with VUNHST Executive Director of Finance, proactive work to detect cases of fraud and corruption, particularly where systems weaknesses have been identified. This work shall be carried out so as to complement the detection of potential fraud and/or corruption by auditors in the course of routine audits.
- Proactively seek and report to CFS (Wales) opportunities where details of counter fraud work (involving action on prevention, detection, investigation, sanctions or redress) can be used within presentation or publicity in order to deter fraud and corruption.
- Investigate cases of suspected fraud in accordance with the division of work specified in the Directions as amended and replaced from time to time. Refer to CFS (Wales) all cases appropriate to them.
- Inform CFS (Wales) of all cases of suspected fraud investigated by VUNHST.

- Investigate, report and effect remedy in relation to identified system weaknesses within the organisation that can allow the opportunity for fraud to occur.

5.3. NHS Counter Fraud Service (Wales)

The NHS Counter Fraud Service (CFS) (Wales) will investigate all cases that do not fall within the responsibility of the Local Counter Fraud Specialist.

NHS CFS (Wales) will be responsible for the investigation of cases above £15,000, all corruption cases, and any case at the request of the LCFS, where the CFS (Wales) specialist knowledge and resources could assist with the investigation.

Counter Fraud Service Wales will act as the point of contact for the LCFS in relation to liaison with the Crown Prosecution Service.

5.4. NHS Counter Fraud Authority

On the 1st November 2017, an independent special health authority was implemented in England entitled the NHS Counter Fraud Authority (NHSCFA). This was achieved under amendment from the UK Government Secretary of State for Health.

As a result of this, the previous arrangements which Welsh Ministers entered into with the predecessor organisation of the NHSCFA i.e. NHSBSA/NHS Protect, which was pursuant to section 83 of the Government of Wales Act 2006, which deals with the discharge of certain counter fraud functions in relation to the health service in Wales were reviewed and remained effective with the NHSCFA.

NHSCFA has responsibility for all policy, operational and training matters relating to the prevention, detection and investigation of fraud, bribery and corruption in the NHS.

NHSCFA also provides advice, guidance and risk measurement to NHS Bodies in Wales on all aspects of fraud, bribery and corruption. All instance where fraud is suspected are properly investigated, until their conclusion, by staff who are fully trained and accredited and who are duly nominated by NHSCFA.

5.5. VUNHST Management

Managers must be vigilant and ensure that procedures to guard against fraud, bribery and corruption are followed.

They should be alert to the possibility that unusual events or transactions could be symptoms of fraud, bribery and corruption. If they have any doubts, they must seek advice from the nominated LCFS.

Managers must instil and encourage an anti-fraud, and anti-bribery and corruption culture within their team and ensure that information on procedures is made available to all employees. The LCFS will proactively assist the encouragement of an anti-fraud culture by undertaking work that will raise fraud awareness.

All instances of actual or suspected fraud, bribery or corruption which come to the attention of a manager must be reported immediately to the lead LCFS. If formal investigation is undertaken by the LCFS/CFS managers have a duty to produce any documents or evidence that is required by the investigation team in a timely manner.

Line managers at all levels have a responsibility to ensure that an adequate system of internal control exists within their areas of responsibility and that controls operate effectively.

The responsibility for the prevention and detection of fraud and corruption therefore primarily rests with managers but requires the co-operation of all employees.

6. The Response Plan

6.1. Introduction

The flowcharts in section 6.2 describe VUNHST intended response to reported suspicion of fraud. The flowcharts are intended to provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any future criminal or civil actions. Each situation is different; therefore, the guidance in the flowcharts will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

Further details on the processes in the flowchart are provided in section 6.3 (Commentary on Flowchart Items).

6.2. Flowcharts

Chart 1 – Suspicion of Fraud

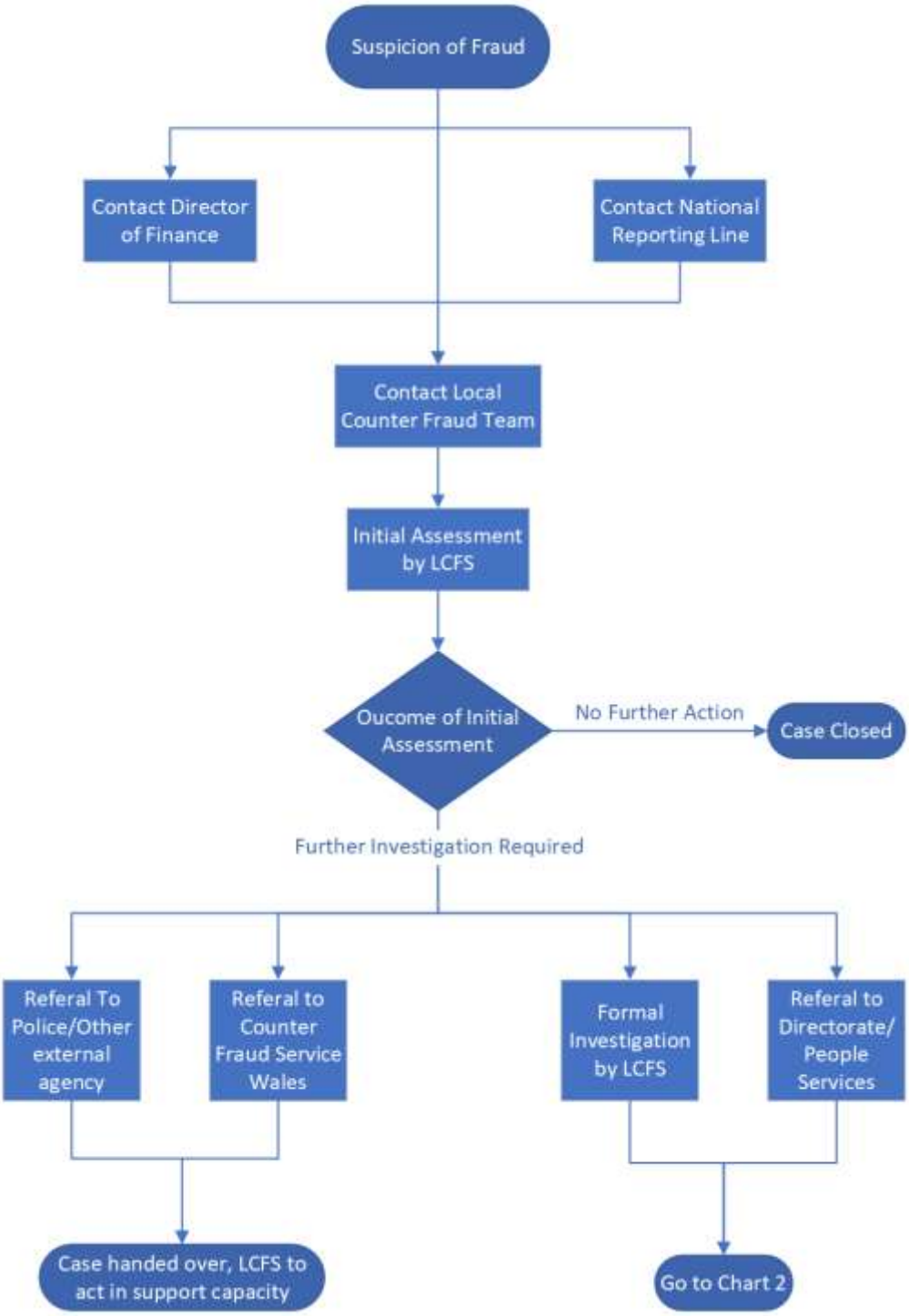


Chart 2 – Local Counter Fraud Investigation

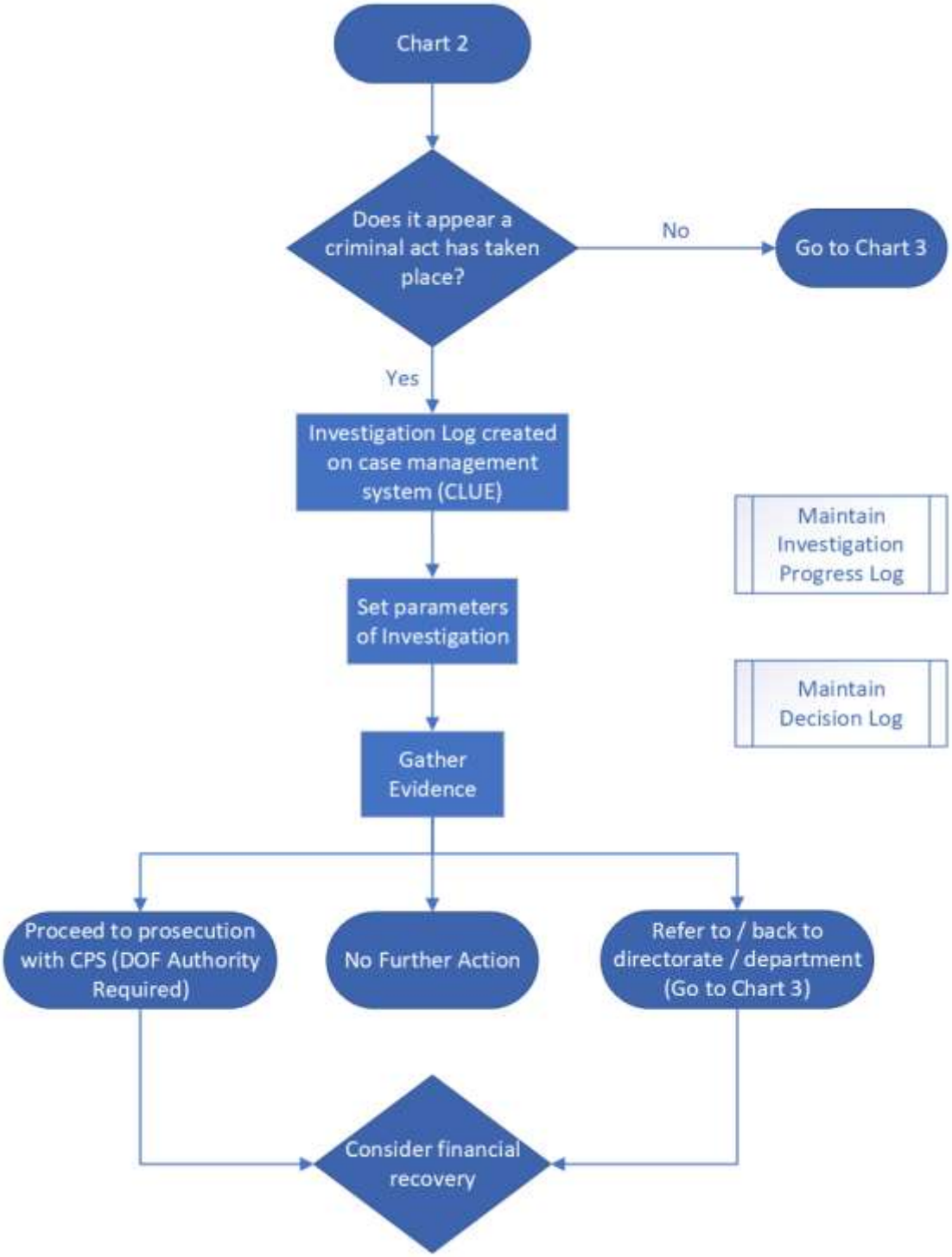
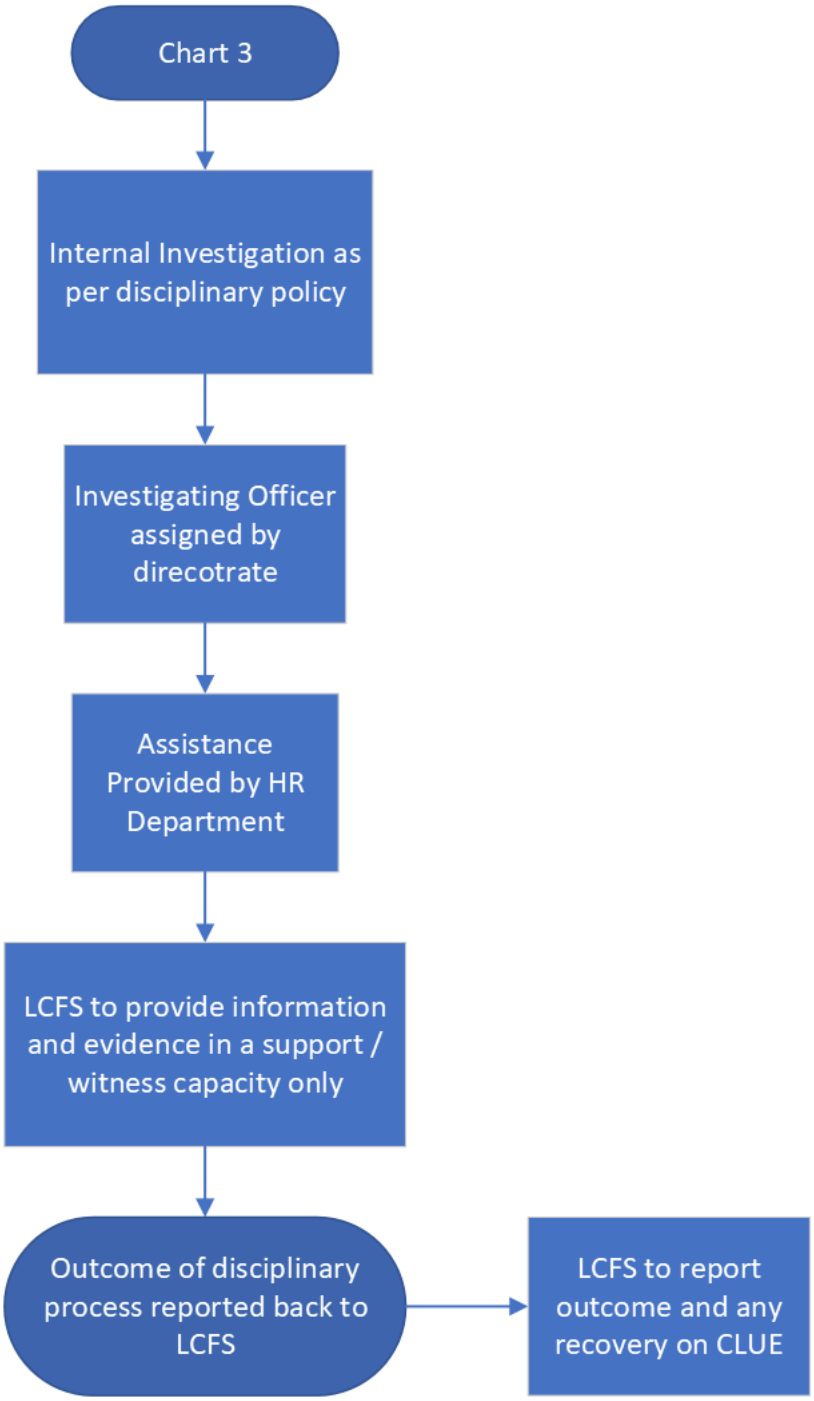


Chart 3 – Disciplinary Process



6.3. Commentary on Flowchart Items

Further explanation of many items is also given elsewhere in this document.

CHART 1 – SUSPICION OF FRAUD

6.3.1. The Local Counter Fraud Specialist (LCFS)

The Lead LCFS will be authorised to treat inquiries confidentially and anonymously if so requested by the individual making the referral.

The LCFS will receive appropriate skill-based training leading to professional accreditation and will be able to respond tactfully and appropriately to concerns raised by staff.

LCFS services are currently provided as part of a Service Level Agreement with Cardiff & Vale University Health Board.

6.3.2. Suspicion of Fraud or Any Irregularities/Anomalies

If any VUNHST employee has any concerns that a fraud has or is taking place, then he/she should discuss any suspicions in the first instance with the Nominated Lead LCFS on 02921 836265.

However, an employee may choose instead to contact the “NHS Fraud & Corruption Reporting Line” on 0800 028 4060.

This contact can be made anonymously.

Time may be of the utmost importance to prevent further loss to VUNHST.

6.3.3. Upon receipt of a referral LCFS will carry out an initial assessment to understand and identify whether there are reasonable grounds to suspect whether criminal offences have been committed. If not, the case will be concluded with no further action taken. Should there be issues of managerial concern evident then LCFS will liaise with appropriate departmental management and Human Resources department.

LCFS will consider and decide whether the case needs to be referred on to other agencies e.g. Police and Counter Fraud Service Wales. If this is appropriate then LCFS will make the appropriate arrangements. In some instances, a joint investigation may take place.

CHART 2 – LOCAL COUNTER FRAUD INVESTIGATION

6.3.4. Progress of investigation

All investigations carried out by the Counter Fraud Department, will be led by an accredited LCFS and will be overseen by the Head of Counter Fraud. All investigations into fraud will be compliant with the Criminal Procedures and Investigations Act 1990 and the Police and Criminal Evidence Act 1984.

The Local Counter Fraud Specialist in charge of the investigation (OIC) will keep a log of events to record the progress of the investigation. This will commence immediately following referral. If a criminal offence is suspected then the referral will be promoted to formal investigation and recorded upon the NHS CFA case management system (CLUE).

6.3.5. Does it appear a Criminal Act Has Taken Place?

In some cases, this question may be asked more than once during an investigation. The answer to the question obviously determines if there is to be a criminal investigation. In practice it may not be obvious if a criminal act has taken place. If a criminal act is believed to have occurred, the matter will be dealt with by the LCFS/CFS (Wales) as appropriate. If other criminal offences are involved e.g. theft, criminal damage, consideration should be given to reporting the matter, after consultation with the LCFS, to the police

6.3.6. Evidence

For the purposes of criminal proceedings, the admissibility of evidence is governed by the Police and Criminal Evidence Act (PACE). For non-criminal (i.e. civil or disciplinary) proceedings, PACE does not apply, but should nevertheless be regarded as best practice.

It is imperative that the collection of evidence must be coordinated if several parties are involved in an investigation, e.g. LCFS and internal audit, police and solicitors. The LCFS will take the lead on this. Evidence gathering requires skill and experience and professional guidance should be sought where necessary. There is a considerable amount of case law concerning the admissibility of evidence and incorrect procedure can lead to a prosecution collapsing.

6.3.7. Witnesses

If a witness to the event is identified, then they will need to give a written statement. The LCFS will take a chronological record using the witness's own

words. (The witness should be prepared to sign the document as a true record) and advised that the statement may be used as evidence should the matter proceed to court. All witness statements will be completed in accordance with Section 9 Criminal Justice Act 1967 and on the witness statement document provided for this purpose. All witnesses will be provided with ongoing guidance and support throughout the process.

6.3.8. Physical Evidence

Upon taking control of any physical evidence, it is very important that a record is made of the time, date, and place it is taken from and by whom, continuity is essential. If evidence consists of several items, for example many documents, each one should be tagged with a reference number corresponding to the written record. It is the responsibility of the LCFS to manage the retrieval, documentation and storage of physical evidence collected during the course of an investigation.

Documentary evidence should be properly recorded, it will need to be numbered and include accurate descriptions of when and where it was obtained and who it was obtained by and from. In criminal actions evidence on or obtained from electronic media needs a document confirming its accuracy.

6.3.9. Interviews

Any interviews carried out with a suspect during the course of a fraud investigation will be carried out only by an accredited LCFS, and will be compliant with the relevant codes and sections of the Police and Criminal Evidence Act 1984.

The subject of the investigation will be written to and advised of the reason for the interview and that he/she is entitled to have a person present at the interview who can act in a legal capacity (i.e. solicitor), but they are not entitled to have a friend, work colleague and/or union representative present at the interview.

The person being interviewed is also to be informed that whilst their attendance at the interview is voluntary, should they not attend, then the matter may be referred to the police which could then result in their subsequent arrest.

Prior to the start of an interview, the interviewee will be assessed with regard to their wellbeing and a decision will be made whether or not it is appropriate

to continue with it. If it is not appropriate, then an alternative date in the future will be sought.

The interview under caution will be tape recorded and once the interview has concluded the interviewee and their legal representative will be provided with a notice informing them of their entitlement to a copy of the recording made. All recordings must be made on a recording device authorised for the purpose.

6.3.10. Investigate Internally

If, after discussion with the LCFS, it appears a criminal act has not taken place, or that the act/s are of a minor nature and it would not be proportionate nor in the public interest to proceed criminally, the next step should be an internal review to determine the facts. The review may recommend various courses of action; instigate an investigation under VUNHST Disciplinary Policy and Procedure; establish what can be done to recover a loss and what may need to be done to improve internal control to prevent the event happening again. Internal disciplinary investigations are the responsibility of the Directorate/Departmental management in conjunction with the workforce and OD department.

6.3.11. Recovering a Loss

The seeking of financial redress or recovery of losses should always be considered in cases of fraud, bribery or corruption that are investigated by either the LCFS or NHS Counter Fraud Service (Wales) where a loss is identified. As a general rule, recovery of the loss caused by the perpetrator should always be sought. The decisions must be taken in the light of the particular circumstances of each case. Redress allows resources that are lost to fraud, bribery and corruption to be returned to the NHS for use as intended, for provision of high-quality patient care and services.

Where recovering a loss is likely to require a civil action, in the absence of established procedures for this recovery, e.g overpayments policy and debt collection agencies, it will be necessary to seek legal advice. Where external legal advisors are required, due to the possible high cost implications, the investigation manager must ensure that the Director of Finance is consulted. The decision of whether to proceed with any civil action will rest with the Director of Finance.

6.3.12. Court Action, Adverse Publicity and/or Police Involvement

Where the investigation reaches a stage where the case is likely to end up in a criminal prosecution via the criminal justice system, then the LCFS must

liaise with the Finance Director. Should the investigation or prosecution be likely to lead to adverse publicity then LCFS should also liaise with VUNHST Communications/Press relations Department. Where a fraud is suspected and the need to use the police to carry out an arrest and/or search, then lead LCFS will make the appropriate arrangements and liaise with the relevant organisation directly. The Director of Finance will be appraised accordingly.

No member of staff should contact members of the press without the authority of the Director of Finance and or the Communications/Press Relations team.

6.3.13. Risk Management

At the conclusion/during the course of an investigation it may become clear that system or process weaknesses or failings have provided the opportunity for fraud or loss to occur. In these circumstances LCFS will conduct a risk assessment into the target area and report accordingly upon any weaknesses identified. The CLUE case management system will be used for this purpose. Any weaknesses and recommendation for remedial action will be reported to the relevant directorate or department. Any risks identified during the course of an investigation will be recorded on the local risk register by departmental management in conjunction with the LCFS. This may give rise to future proactive work such as Local Proactive Exercises that will be conducted by the LCFS to test that remedial actions have been undertaken. Where fraud risk assessment/fraud proofing work is required, departmental management must assist in providing all necessary information requested by the LCFS or Internal Audit in relation to the processes or systems under review.

CHART 3 – DISCIPLINARY PROCESS

6.3.14. Disciplinary Procedure

VUNHST Disciplinary Policy and Procedure has to be followed in any disciplinary action taken by VUNHST towards an employee (including dismissal). This may involve the investigation manager recommending a disciplinary hearing to consider the facts, the results of the investigation (a formal report) and take appropriate action against the employee.

In the event of a disciplinary investigation taking place where a suspicion of fraud exists, then the appointed investigating officer must liaise with the LCFS to agree a way forward. A decision will be made whether the investigations can run concurrently or whether the internal investigation will need to be put on hold until the completion of the criminal investigation or part of it.

In some cases where a fraud is suspected it may be deemed by the Lead LCFS that the matter is of a minor nature, or that it would not pass the relevant evidential or public interest threshold tests, and therefore a formal criminal investigation will not progress. In these instances' the LCFS will keep departmental management and HR department appraised that no further action will be taken. A disciplinary investigation can still take place in these circumstances. If a disciplinary investigation only ensues following the report of a fraud or fraud related offence, the internal investigating officer and HR representative will ensure that the LCFS is kept appraised of the process and any resulting action that takes place. The LCFS will act in support of any disciplinary only investigation in the position of a witness only. Any evidence gathered by the LCFS will be shared with management if it assists with the case.

As per national requirements LCFS will report any outcome on the CLUE case management system.

7. The Law and its Remedies

7.1. Introduction

Section 6 of the NHS Counter Fraud Manual provides in-depth details of how sanctions can be applied where fraud and corruption is proven and how redress can be sought.

To summarise, local action can be taken to recover money by using the administrative procedures of the organisation or civil law. In cases of serious fraud, bribery and corruption, it is recommended that parallel sanctions are applied. For example: disciplinary action relating to the status of the employee in the NHS; use of civil law to recover lost funds; and use of criminal law to apply an appropriate criminal penalty upon the individual(s) and/or a possible referral of information and evidence to external bodies – for example, professional bodies – if appropriate. This is known as the triple track approach.

Actions which may be taken when considering seeking redress include:

- no further action
- criminal investigation
- civil recovery
- disciplinary action
- confiscation order under the Proceeds of Crime Act 2002 (POCA)
- recovery sought from ongoing salary payments

In some cases (taking into consideration all the facts of a case), it may be that VUNHST under guidance from the LCFS and with the approval of the Director of Finance, decides that no further recovery action is taken.

Criminal investigations are primarily used for dealing with any criminal activity. The main purpose is to determine if activity was undertaken with criminal intent. Following such an investigation, it may be necessary to bring this activity to the attention of the criminal courts (Magistrates' Court and Crown Court). Depending on the extent of the loss and the proceedings in the case, it may be suitable for the recovery of losses to be considered under POCA.

7.2. Proceeds of Crime Act

The NHS Counter Fraud Service (Wales) can also apply to the courts to make a restraining order or confiscation order under the Proceeds of Crime Act 2002 (POCA). This means that a person's money is taken away from them if it is believed that the person benefited from the crime. It could also include restraining assets during the course of the investigation.

7.3. Fraud Act 2006

The Fraud Act came into force on 15th January 2007.
The following offences have been repealed:

- **Theft Act 1968**
  - Obtain property by deception (section 15)
  - Obtain money transfer by deception (section 15A)
  - Obtain pecuniary advantage (section 16)
  - Procure execution of valuable security (section 20)

- **Theft Act 1978**
  - Obtain service by deception (section1)
  - Evade liability (section 2)

The new Act simplifies the original deception offences. There is no need to prove that any person was deceived. The Act now outlines three ways to commit fraud:

- Fraud by False Representation (section 2)
- Fraud by Failing to Disclose Information (section 3)
- Fraud by Abuse of a Position (section 4)

Many original ‘deception’ offences will now be covered by section 2 of the Fraud Act 2006 (false representation) which has three main ingredients:

- Dishonesty
- A false representation (no limitations on how this takes place)
- Intention to commit gain or cause loss

Section 3 covers the offence of fraud by failing to disclose information where there is a legal duty to do so.

Section 4 covers the offence of fraud by abuse of position where the defendant is in a privileged position expected to safeguard (not act against) the financial interests of another person.

Section 6 covers the offence of possession of articles for use in fraud. This extends to possession or control of any article, anywhere and includes electronic data.

Section 7 covers the offence of making or supplying articles for use in fraud. It is designed to capture those who supply personal financial details for use in frauds to be carried out by others; or those who manufacture software programmes for generating credit card numbers.

Section 11 of the Fraud Act – Obtain Services Dishonestly replaces ‘obtain services by deception.’ This offence requires the actual obtaining of a service and must include a dishonest act or false representation.

The test for dishonesty that is currently relied upon rests in case law and the cases of Ivy v Genting Casino 2017 and *Barton and Booth v R 2020.*

7.4. Corruption

The definition (in the context of the Prevention of Corruption Acts) is the offering, giving, soliciting, or acceptance of an inducement or reward, which may influence the action of any person.

8. References

This policy should be read in conjunction with:

- Standing Orders
- Standing Financial Instructions
- Disciplinary Procedures
- Standards of Business Conduct
- I.T Security Policy

- Public Relations and Communications Strategy
- Whistleblowing Policy
- Dignity at Work Policy
- VUNHST policies relating to:
    - Gifts
    - Hospitality
    - Conflicts of Interest
    - Procurement
    - Capital/PFI Contracts

9. Further Information

Further information and a copy of the fraud policy and response plan may be obtained from the LCFS or VUNHST intranet.

NHS Fraud and Corruption: Dos and Don'ts
A desktop guide for VUNHST

FRAUD is the deliberate or reckless intent to permanently deprive an employer of money or goods through false representation, failing to disclose information or abuse of position.

CORRUPTION is the deliberate use of bribery or payment of benefit-in-kind to influence an individual to use their position in an unreasonable way to help gain advantage for another.

DO	DO NOT
• **Note your concerns** **Record details such as your concerns, names, dates, times, details of conversations and possible witnesses. Time, date and sign your notes.**	• **Confront the suspect or convey concerns to anyone other than those authorised, as listed below** **Never attempt to question a suspect yourself; this could alert a fraudster or accuse an innocent person.**
• **Retain evidence** **Retain any evidence that may be destroyed, or make a note and advise your LCFS.**	• **Try to investigate, or contact the police directly** **Never attempt to gather evidence yourself unless it is about to be destroyed; gathering evidence must take into account legal procedures in order for it to be useful. Your LCFS can conduct an investigation in accordance with legislation.**
• **Report your suspicion** **Confidentiality and anonymity will be respected – delays may lead to further financial loss.**	• **Be afraid of raising your concerns** **The Public Interest Disclosure Act 1998 protects employees who have reasonable concerns. You will not suffer discrimination or victimisation by following the correct procedures.**

If you suspect that fraud against the NHS has taken place, you must report it immediately, by:

- directly contacting the Local Counter Fraud Specialist, or
- telephoning the free phone NHS Fraud and Corruption Reporting Line, or
- contacting the Director of Finance.

Do you have concerns about a fraud taking place in the NHS?

If so, any information can be passed to the NHS Fraud and Corruption Reporting Line: **0800 028 40 60**

All calls will be treated in confidence and investigated by professionally trained staff

Your nominated Local Counter Fraud Specialist are:

Gareth Lavington - Head of Counter Fraud – Gareth.Lavington2@wales.nhs.uk– 02921836265

Nigel Price - Local Counter Fraud Specialist – Nigel.Price@wales.nhs.uk – 02921836481

Henry Bales – Local Counter Fraud Specialist – Henry.Bales@nhs.wales.uk – 02921836264

If you would like further information about the NHS Counter Fraud Service, please visit **www.nhscfa.co.uk or Counter Fraud - Home (sharepoint.com)**

Ref: RD01

INTELLECTUAL PROPERTY (IP) POLICY

Executive Sponsor & Function:	Executive Medical Director and RD&I Board Lead
Document Author:	Head of Research & Development
Approved by:	Research, Development & Innovation Sub Committee
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Equality Impact Assessment Outcome:	Approved
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Version:	06

Contents

1. INTRODUCTION

Intellectual Property (IP) is the term used to describe new ideas that result in the generation of some output such as a new device, diagnostic or therapeutic product document, design, or an improved way of working.

The core principles of the Policy relating to Intellectual Property is under pinned by the following three fundamental principles:

1. The management and exploitation of intellectual property must deliver benefits to patients and service users.
2. That industry has an important role to play in developing innovations.
3. That individuals who contribute intellectually to new ideas that generate an income to the Trust should be rewarded for their contributions.

2. POLICY STATEMENT

Velindre University NHS Trust recognises the importance of innovation and creativity as essential elements in the process of continual improvement. The UK Policy Framework for Health and Social Care Research (https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/) places a duty on the Trust to have in place a mechanism for the exploitation of IP arising from its employees. Innovation in the NHS also occurs in the delivery of patient care and in the education and training of employees. The purpose of this document is to detail a policy for the effective management of IP within the Trust taking into account the principles referred to above and also arrangements with the Trust's academic and commercial partners.

3. SCOPE OF POLICY

This Policy applies to IP opportunities arising from activity involving:

- All staff that are full or part-time employees of the Trust where employment activity results in the generation of any form of IP either within the course of a working day or outside normal working hours and/or away from the place of work, where IP relates to their area of employment by the Trust. This includes IP generated in the course of education or training which is funded by the Trust, especially if the Trust also contributes towards creation of IP by, for example, acting as sponsor of the research in accordance with the UK Policy Framework for Health and Social care research.
- Staff with Trust contracts of employment whose payroll costs are partially or fully funded by another party (e.g. Academic Institution, Medical Charity and Government Department) unless the contract between the Trust and that party assigns ownership of the IP to that party.
- Academic staff of associated universities with honorary clinical contracts.
- Trainee professionals and students hosted by the Trust who are not also employees of the Trust who generate IP during the course of their training (IP

generated by students engaging in research for the Trust may be owned by the student, the institution with whom they are enrolled or the Trust, depending on the agreements between the student, the institution and the Trust.

- Independent Providers of Services who generate IP from research funded by the NHS are required to inform the appropriate party and share the benefits of its commercialisation. Where IP is assigned to the Trust, the Independent Provider of Services will benefit under the revenue sharing scheme of the Trust.
- For individuals who hold an Honorary Contract with the Trust, the IP Policy of their substantive employer will take precedence over the Trust's policy unless circumstances (such as the Trust's contribution to the creation of the IP for example where the honorary employee has utilised Trust equipment, consumables or the time of Trust-funded staff to create the IP) require negotiation to the contrary to ensure the Trust's contribution is fairly rewarded.
- Trust staff seconded to another organisation or employees of another organisation hosted by the Trust under contract are subject to the terms defined in the contract between the Trust and that organisation.

Please note that the applicability of this IP Policy may be subject to a person's employment contract or any other terms upon which a person is engaged by the Trust.

4. AIMS & OBJECTIVES

In order to achieve its core objectives this Policy aims to ensure that:

- There is a good awareness and understanding of IP issues throughout the Trust.
- There is a process in place for disclosure, evaluation, management and exploitation of any IP uncovered by Trust employees which is timely, transparent and supportive.
- The responsibilities of staff and management are clear.
- The support role of the R&D Departments is clear.
- The ownership of IP related to the disclosure of an idea is established clearly at the outset by the R&D Department.
- The ownership and management of IP arising from collaborative projects with other organisations, e.g. universities, is clear and supports innovation.
- There is a clear framework governing the ownership and management of the results and associated IP arising from collaborative research projects.
- The apportioning of revenue from any profits of commercialisation is clear and there is a process to implement revenue sharing.
- Potentially exploitable IP is protected appropriately.
- There is a transparent process to resolve any disputes.
- Income from IP owned by the Trust is used to improve patient care and service delivery.

5. ROLES AND RESPONSIBILITIES

5.1 **Staff Responsibilities** It is the responsibility of all Trust employees involved in the creation of IP to report any IP developments to the Trust's R&D Department in line with divisional policy and procedure and prior to any public disclosure outside the Trust (whether verbal or written)

Should employees fail to report any IP development to the Trust's R&D Department the key principles of this policy will apply retrospectively, unless public disclosure has invalidated the opportunity to protect IP. Discussion of potentially protectable IP should only be discussed outside the Trust within the strict confines of a reciprocal non-disclosure agreement.

5.2 **The Executive Medical Director** has the responsibility for IP Management and will keep the Trust's Board informed of all significant issues via the Research, Development & Innovation (RD&I) Sub Committee**.**

5.3 **The Trust RD&I Sub Committee** undertakes the role of exploitation panel and is responsible for assessing newly identified IP and determining which exploitation route, if any, should be pursued. Recommendations from the Exploitation Panel will be passed to the Trust Board for approval.

5.4 **The Trust Board** has the final decision on which IP should be exploited based on the recommendations of the Trust RD&I Committee.

5.5 **The Head of Research & Development** is the nominated Trust IP manager. The post holder will be responsible for overseeing all IP projects and will act as the point of liaison between the Trust and any All-Wales Intellectual Property Advisory Service and other stakeholders.

- Ensure that new IP is recognised and treated appropriately with regard to confidentiality
- Identify the most appropriate means of protecting the IP determine the appropriate path to take advantage of the IP & raise awareness.

5.6 **The Trust R&D Department** will provide advice and where appropriate signpost staff to other sources of information and support.

The role of the R&D Department will be to:

- Maintain the Trust's IP policy.
- Provide a contact point for Trust personnel seeking advice on IP.
- Increase the profile of IP and educate staff appropriately in the Trust, for example by facilitating awareness raising and training sessions for staff.
- Coordination with partners and national bodies in relation to IP management.
- Market and manage funding calls relating to innovation and IP.

- Where the RD&I Committee has identified an exploitation route the R&D Department will endeavour to secure the relevant resources to enable staff to develop their ideas and associated IP.
- Negotiate agreements where appropriate with third parties.

6. DEFINITION OF INTELLECTUAL PROPERTY (IP) AND INTELLECTUAL PROPERTY RIGHTS (IPR)

IP is intangible. It can be defined as the products of intellectual or creative activity in the form of novel ideas, innovation or research and development that can be given legal recognition of ownership. This ownership is a tradable commodity known as the intellectual property right (IPR). This can be a patent, copyright, design rights, trademarks, know-how, as well as medical marketing authorisations and regulatory certifications (see Appendix 1). IPR can be assigned or licensed exclusively or non-exclusively. IP can be generated where R&D, delivery or management of care or other creative work is being undertaken.

During the application process for a patent, it is imperative that the invention documentation remains confidential. Prior disclosure of this information will render the invention non-patentable in almost all regions of the world.

While IP can and often does arise from formal research projects, it is not limited to the outputs of research studies and can be generated in many other ways. For example, IP may arise as a result of staff trying to find a solution to a problem or designing a new device based on their experience while working with other staff and patients.

It should be noted that IP legislation is complicated and the scope of IP rights (what can be protected and what cannot be protected) is often a grey area. Members of staff are advised to contact the Trust R&D Department at the earliest opportunity to discuss in more detail the relevance of IP protection to their ideas and any expression of those ideas. In order to ensure protection of the IP in your idea the idea must be recorded in permanent form.

More information about IP is available on the Intellectual Property Office website (www.ipo.gov.uk).

7. IMPLEMENTATION

This policy will be maintained by the R&D Office.

Please refer to section 5 further information in relation to the responsibilities in connection with this policy.

The policy will be available via the Trust Intranet Site and from the R&D Office. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

The RD&I Committee will review the operation of this policy as required. At least every two years.

8. POLICY COMPLIANCE

8.1 Identifying and Protecting IP

Staff at all levels need to be aware of the possibility that they may generate new IP during the course of their employment. The following are examples of activities where IP needs to be considered:

- A novel treatment
- A new diagnostic technique
- A new device
- A new drug or the new use of a drug
- Use of data, software, training material
- A treatment protocol
- New management system

8.2 Ideas Disclosure

Velindre University NHS Trust R&D Department has developed an “Ideas Disclosure Form” to be used by Velindre Employees if they have an innovation that, as far as is known, is not in place elsewhere. A completed form should be submitted to the R&D Department for consideration by the RD&I Committee. The RD&I Committee will evaluate the potential of the IP and if appropriate create a plan for its management and exploitation.

The ideas disclosure form is attached in appendix 3 and the general process for the disclosure of ideas in appendix 4.

The Ideas Disclosure Form asks Velindre employees to provide information on their idea, explaining its originality/inventiveness, and how it can benefit the NHS and patients, either directly or indirectly.

In seeking to establish the originality/inventiveness of an idea, employees should investigate current patents online before completing the Idea Disclosure Form. The following link will allow Velindre employees to do a preliminary patent search (https://worldwide.espacenet.com/)

Please note the R&D Department is an official function of Velindre University NHS Trust. Therefore, any disclosure made to the R&D Department including to its staff, e.g. through the Ideas Disclosure Form, is deemed as a confidential disclosure and will be kept confidential by the R&D Department.

The Trust emphasises that staff should not disclose their idea to anyone apart from research collaborators with whom they are bound by a viable contract which includes

provisions for confidentiality, as this might jeopardise subsequent IP protection. Employees are urged to consult the Trust's R&D Department at the earliest possible stage if they have any questions about this and especially if they are uncertain about the implications of disclosing an idea to others.

8.3 Due diligence

When an idea or potential invention is notified to the R&D Department, a process of due diligence will be carried out to identify all of the contributors, their employment status and their contribution to the idea/invention. Staff are asked to provide all records as necessary to facilitate this process. Incorrect identification of inventors may in some cases invalidate a patent, so it is important that all inventors are correctly identified.

8.4 Partnering with Universities or other organisations to develop IP

The Trust may partner with its neighbouring university's IP/commercialisation facility to utilise their infrastructure and expertise. In this event both the inventor and the Trust will agree in clear terms the nature of the relationship with the partner university or other organisation. This agreement should be underpinned by three clear criteria:

- Where possible, Trust costs incurred in the development of the IP should be recovered before the benefits of commercialisation are shared with the inventor or other parties;
- That the development and commercialisation of the IP delivers benefits to patients and the Trust;
- That the inventor(s) retain the rights to receive an appropriate level of income in the event that commercialisation of the IP generates downstream revenue.

8.5 Partnering with IP specialists

The Trust may also make use of external IP specialist's for advice on matters such as licensing, funding, legal, technical, spin-out to maximise new knowledge creation.

In the above circumstances, benefits to the licencing partner organisation will need to be agreed, for example a percentage of revenue in the event that the IP generates future revenues and/or profits. To achieve this a formal licensee partnership agreement will be put in place with the external specialist organisation if the Trust intends to use or commercialise the IP in partnership.

This can be useful in helping to build long-term, productive strategic relationships between the organisations concerned.

8.6 Ownership of IP

The Trust has right of ownership to all IP produced by Trust employees in the course of their normal duties. Employees have an obligation to inform the Trust about IP generated as a result of their activities and must not sell, assign or otherwise trade IP

without Trust agreement (see appendix 2 for an extract from the Trust Contract of Employment.)

Where the potential for new IP can be identified in advance, steps will be taken by the Trust to ensure that contracts/agreements contain appropriate terms and conditions to clearly indicate the assignment of intellectual property rights (IPR) and the distribution of benefits arising from the IP.

Where such agreements are not in place, or where organisations have differing agreements, the Trust will negotiate an appropriate share of benefit in accordance with the Trust procedure.

Where Velindre University NHS Trust chooses not to exploit IP arising from the work of its employees, it will, in most cases (subject to no outstanding claims such as from a funding body), assign the IP back to the inventor(s) who may wish to pursue its further development. In return for the assignment, the inventor(s) may be asked to share a small percentage of any income generated with the Trust. Additionally, the Trust will retain the right to use the work at no cost for its own non-commercial purposes.

Where IP is generated by students of higher education institutions the IP will be owned by the student or, if the student and the institution have agreed to this, by the institution. This agreement may occur, for example, by provision in the university regulations accepted by the student, or the terms of a particular funding scheme. Where Velindre University NHS Trust provides support for such research, and there is an opportunity to seek cost recovery or an appropriate share of benefit the Trust will do so. Where appropriate, any such agreement should be negotiated by the relevant parties at the outset.

8.7 Staff Rewards Policy

Velindre University NHS Trust wish to encourage full participation by our employees in the creation and commercial exploitation of IP when it has not been generated as part of their normal duties. This policy therefore lays out a set of conditions under which staff can receive tangible rewards as a result of the intellectual contributions to the generation of IP which is commercialised. This can be done in two ways:

1. To share revenue where the Trust receives any profits from IP exploitation.
2. To allow staff to participate in and hold equity in spin-out companies.

8.7.1 Revenue Sharing from IP Exploitation

In all cases the shared revenue will be the net income attributed [by the Trust] to an IP right minus any costs incurred by the Trust in bringing the product to market. The Trust, exercising probity, will put robust systems in place to administer and calculate income arising from IP commercialisation. Revenue will be shared between the Trust and the inventor(s) according to the revenue sharing formula. In cases where several staff have been involved in generating the IP, the proportion of revenue allocated to

inventors will be divided between them evenly unless it can be demonstrated and agreed that the contribution of individuals varies significantly.

The Trust will ensure that any profits arising from the exploitation of IP, which have been disclosed by and generated by a member of staff identified to the R&D Department, are shared on the following terms:

- In all cases the shared revenue will be the net of any remaining monies after reasonable protection and exploitation costs have been deducted e.g. the costs incurred by the researcher, the clinical directorate within which the research work took place, patenting fees or other legal costs, or marketing costs.
- Where the employee produces more than one item of IP, the income from subsequent IP - unless the subsequent IP is unrelated - will be aggregated with that from the first IP for the purpose of determining the employee's share according to the sliding scale of net revenue.
- Where there is a contracted agreement with a funding sponsor to share revenue from successful exploitation of IP arising from research funded by that sponsor, the cumulative net revenue to the Trust is the income from exploitation remaining after deduction of the sponsor's share and other costs as above.

8.7.2 Velindre University NHS Trust Revenue Sharing

Consideration has been given to the revenue sharing policies of University Health Boards/Trusts and Universities in Wales and is reflected in the following revenue sharing schedule:

Cumulative net income	Inventor	Department	R&D	Trust
First £10K	100%	0%	0%	0%
£10K-£20K	60%	20%	10%	10%
£20K-£100K	50%	20%	15%	15%
£100K-£250K	40%	20%	20%	20%
Over £250K	35%	20%	15%	30%

9 COLLABORATIVE RESEARCH PROJECTS

The Trust actively encourages its staff to work collaboratively with other organisations to promote research and innovation. It is widely recognised that the issue of IP in collaborative research/innovation can be complex. The Trust aims to provide a framework whereby those that generate ideas are able to use them and are rewarded for their efforts whilst ensuring that the appropriate level of control is in place to ensure that any IP arising from collaborative research always benefits patients and donors

and facilitates the collaborative process.

It is therefore important before embarking on a collaborative venture that all parties, the researchers, contract managers and funders, agree the principles of the collaboration. These can be set out in a Heads of Terms (HoT) which allows research decision makers to identify in plain language what they regard as the key issues before instructing their lawyers to draw up a formal agreement (see Template Heads of Terms at Annex 5).

10 SHARED MATERIALS

Materials are defined as equipment, reagents and biological materials, including cell lines, tissues, bacterial strains, plasmids and viruses. When such materials are distributed to other researchers or used in a project, they should be subject to a Material Transfer Agreement (MTA) which will be managed via the Trust's R&D Department.
This agreement should define the limitations of use of the material and recognises the interest in the IP that may arise from its use. This agreement must be in place prior to distribution and use of the material. The use of trademarks and design rights associated with the aforementioned materials should also be the subject of this agreement.

11 RESOLUTION OF DISPUTES

Where there is dispute about the inventor(s) of IP, dated written records associated with the generation of the IP will be used to establish the inventor(s) of the IP and to determine their level of contribution/remuneration. In the absence of documentary evidence, the Chief Executive of the Trust shall decide, taking such professional advice as appropriate and this decision will be final.

12 NON-COMPLIANCE

If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate workforce and organisational development policies.

13 TRAINING

Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Divisional Nurse, Departmental Manager, Head of Nursing and Head of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

14 EQUALITY

The Trust is committed to ensuring that, as far as is reasonably practicable, the way it

provides services to the public and the way it treats its Employees reflects their individual needs and does not discriminate against individuals or groups.

The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation

15 GETTING HELP

For further information on this Policy all Velindre University NHS Trust staff should contact the Velindre University NHS Trust R&D Department using the email address Velindre.R&DOffice@wales.nhs.uk.

AgorIP a company supported by Welsh Government, EU & Swansea University works with businesses, academics and NHS Wales providing IP advice and to bridge the gap between products and the market place (www.agorip.com).

16 REFERENCES

- Welsh Assembly Government, 'Intellectual Property and Innovation in Health care in Wales' – A Framework and Guidance on the Management of Intellectual Property in the NHS in Wales, February 2005
- The UK Policy Framework for Health and Social Care Research (https://www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/)

17 ACKNOWLEDGMENTS

- Abertawe Bro Morgannwg University Health Board R&D Department

APPENDIX 1 - INTELLECTUAL PROPERTY (IP) PROTECTION

This appendix includes a very brief overview on some aspects of IP protection. For more detail please consult the Intellectual Property Office website "types of IP" section (www.ipo.gov.uk/types.htm).

This information is provided for guidance purposes only and is not intended to constitute a definitive or complete statement of the law on IP, nor is any part of it intended to constitute legal advice for any specific situation.

Know-how

“Know how” rights arise automatically and do not require registration. Know-how (also known as a "trade secret") is any information that is not in the public domain which has an assumed value. Know-how is often the most valuable of all IP assets and rights arise automatically with no need for registration. For example, it can be the knowledge about how to perform a procedure or to create a product or process. Know-how can be identified and protected by a Non-Disclosure Agreement (NDA) agreement (also known as Confidential Disclosure Agreements, CDA). When working with other parties, NDAs can be reciprocal agreements whereby the boundaries of confidential information that is disclosed and received is identified and obligations on both receiving and disclosing parties are detailed. A template NDA may be obtained from the Trust R&D Department. Know-how and confidential information are not capable of assignment as property rights, but a formal information transfer coupled with a non-use and secrecy agreement can have the same effect. They persist indefinitely, as long as they remain covered by the terms of an NDA.

Copyright

Copyright rights arise automatically and do not require registration. Copyright covers a wide range of works including written and graphical information such as leaflets, articles, assessment tools, training packs, databases, computer software, “Apps” and films/videos, drawings and the 2-D representation of 3-D structures. Copyright is an automatic unregistered right that subsists if the work is "original". The requirements for originality are low. Therefore, it is best to assume that copyright will subsist in all written, graphic or photographic works generated by staff.

It is advisable to attach a statement to any works such as: Copyright Velindre University NHS Trust Date XX. All rights reserved. Not to be reproduced in whole or in part without the permission of the copyright owner. However, you may decide to designate certain areas of activity for which permission does not have to be obtained. For example, "non-for-profit organisations such as NHS Health Boards and Trusts, may reproduce this work solely for the purposes of teaching or further non-commercial research. In all other circumstances the permission of the UHB must be obtained".

Patents

Patents need to be registered to attract protection. Patents can be used to protect "technical" inventions that are new and have a utility. The vast majority of ideas will have potential utility. In Europe and the majority of countries in the world "new" means that all of the features of the invention must not have been made available to the public in a single disclosure anywhere in the world prior to the patent filing date. A public disclosure can be written, verbal or by any other means (e.g. journals, internet, meetings, posters, etc) and could merely be the result of a conversation between friends. To qualify as a patentable invention the idea must also not be obvious. The assessment of what is obvious is a complex area of patent law and in the first instance staff are advised against concerning themselves with this criterion. In the UK, some inventions are specifically excluded from patenting where those inventions consist entirely of methods of treatment by surgery or therapy or diagnostic methods. However, these inventions are patentable in other countries, notably the USA.
Excluded inventions are also a complex area of patent law and staff are advised that if they think they have an invention which lies in an excluded category to please consult the Trust R&D Department in the first instance. However, it is best not to assume an invention is excluded in the first instance.

Design Rights

Design rights arise automatically and do not require registration. Design Rights protect against the copying of the shape or configuration of an article. Design Rights may exist in addition to other forms of protection offered by patents or copyright.

The "Design Right"

The "unregistered" Design Right as it is known, similar to copyright, is an automatic right and can last up to fifteen years. It can protect the 3D features of an article, internal and external features, but there are a number of exclusions for example where the article is dependent on another article the so-called “must-fit, must match" exclusion. A surgical instrument could be protected by this right. However, unregistered design rights are generally considered to be weak IP rights and often stronger rights such as patents are sought, at least to improve levels of protection. Given the particular requirement of this “niche” aspect of IP law it is best in the first instance not to assume that the design right will protect a given article.

Registered Design Rights

Both UK and European law provide for registered design rights which last up to 25 years. Registration is required to attract protection. Registered design rights protect the appearance of a product, for example its shape, colour or texture of materials. For example, a new design of surgical gown or a patient's pillow could be the subject of a registered design right.

Trademarks

A trademark is a sign or symbol that is used to distinguish a product or service of one undertaking (e.g. a company or organisation, such as an NHS organisation) from another undertaking. Trademarks need to be registered to attract protection. Trademarks can protect words, logos, shapes, colours and even smells (e.g. the name “Coca Cola” and also the shape of the Coca Cola bottle are registered trademarks). Trademarks are the IP right that protect brands. They can last forever, providing renewal fees are paid.

Appendix 2 - Extract from Velindre University NHS Trust Contract of Employment

26. Discoveries and Inventions

26.1 If at any time during your employment you alone or with others make or discover any invention, discovery, improvement or modification which relates to or which may relate to any products, site process, equipment, system or activity of the Trust or which are actually or partially useful to the activities of the Trust ("Invention") you shall forthwith disclose full particulars of the same including drawings and models to the Trust.

26.2 You hereby agree and acknowledge that all Inventions made in connection with the business of the Trust and all rights therein made in the course of your duties shall accordingly belong to the Trust.

26.3 You shall at the request and expense of the Trust execute on demand all such documents as the Trust may require and do all such other things as the Trust may consider to be necessary to enable the Trust to obtain the full benefit in such manner as the Trust may require of any Invention and the rights therein to which the Trust is entitled, to vest the rights arising there from fully in the name of the Trust or as it may direct and to secure such patent, utility, model, copyright or design registration or other similar protections for such Inventions in any part of the world as the Trust may consider appropriate.

26.4 You hereby irrevocably appoint the Trust to be your attorney in your name and on your behalf to execute all such documents and to do all such acts as may be necessary or desirable to give *effect* to the provisions of this Clause.

Appendix 3 – Innovative Ideas Disclosure Form

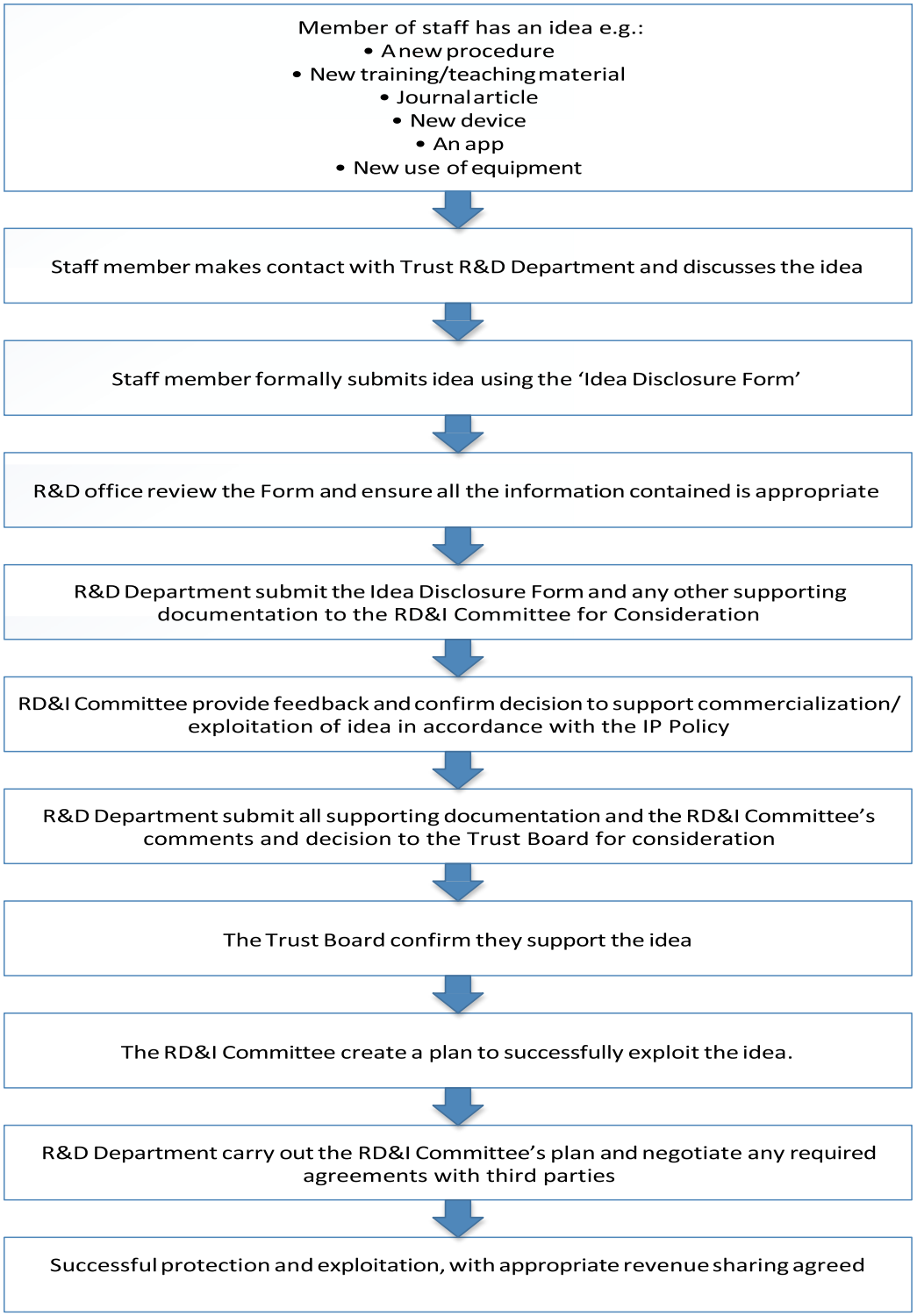
INNOVATIVE IDEAS DISCLOSURE FORM

Full Name	
Role	
Department	
Status of Employment	
The name of any collaborating individuals or parties	
Title of the project (max 60 characters)	
Idea Summary (Maximum 200 words)	
Summary of potential benefits to patients/health service (Maximum 200 words)	
What were the results of your preliminary patent	

search? A free patent search can be undertaken using the following link: (https://worldwide.espacenet.com/)	
Any other relevant information (max 200 words)	

If applicable, please include separately any supporting drawings or schematics to this application.

Appendix 4 - General Process for the Disclosure of Ideas



Appendix 5 - TEMPLATE HEADS OF TERMS (HoT)

It is important for Velindre staff engaged in research/ innovation and their managers to create the optimum conditions for a collaboration and to understand what it aims to achieve and the process for achieving it. The HoT should clearly set out the parties' intentions expressly, such as "These HoT are not intended to be legally binding except as specifically set out in this letter".

HoT enable decision makers to identify the key issues surrounding a collaborative project in plain language. The very process of creating a HoT can be a very constructive and useful way for all parties to understand the needs and expectations of the other parties at the outset and may minimise disagreements and disputes later. In this way a project is more likely to be productive. It is important to consult lawyers after you have created your draft HoT but the process itself of creating the HoT should not be confined to lawyers. A template HoT is provided below.

- The Parties
- Purpose of project
- Scope of project
- Start date and main time points
- Resources provided by each party (e.g. financial, personnel, data, existing IP etc)
- Role of each of the Parties
- Ownership of IP in results
- Access rights to IP arising in the project
- Access rights to other parties' existing IP necessary for performing the project
- Confidentiality
- IP exploitation plan
    - Management of project IP
    - Decision making relating to IP exploitation
    - Revenue/equity

- Dispute resolution
- Termination conditions

Ref: IPC 13

POLICY FOR THE PREVENTION AND CONTROL OF TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES (CREUTZFELDT-JAKOB DISEASE) MINIMISING THE RISK OF TRANSMISSION

Executive Sponsor & Function	Executive Director of Nursing, AHPs & Medical Science
Document Author:	Julianne Golding-Sherman Infection Prevention & Control Nurse
Approved by:	Quality, Safety & Performance Committee
Approval Date:	16th March 2023
Date of Equality Impact Assessment:	29/01/2019
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	March 2026
Version:	7.0

CONTENTS

ABBREVIATIONS

ACDP	Advisory Committee on Dangerous Pathogens
BSE	Bovine Spongiform Encephalopathy
CFS	Cerebral spinal fluid
CNS	Central nervous system
CJD	Creutzfeldt-Jacob Disease
COSHH	Control of substance hazardous to health
CSSU	Central Sterile Services Unit
DOH	Department of health
FRSM	Fluid Resistant Surgical Mask
HCW	Health Care Worker
JPAC	Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee
IPCT	Infection Prevention & Control Team
LP	Lumbar Puncture
NPC	National Prion Clinic
OCCH	Occupational Health
PPE	Personal Protection Equipment
SICPS	Standard Infection Control Precautions
TSE	Transmissible Spongiform Encephalopathies
vCJD	Variant CJD

1. POLICY STATEMENT

The purpose of this policy is to:

1.1 Prevent transmission of transmissible spongiform encephalopathies (TSE) including
Creutzfeldt-Jakob disease (CJD) in the healthcare setting.

1.2 To provide all staff with clear instructions for the efficient management of CJD and variant Creutzfeldt-Jakob disease (vCJD) to reduce potential risk.

At the present time Velindre University NHS Trust does not carry out surgical procedures involving medium or high risk tissues or endoscopic procedures but should the need arise proper decontamination procedures, documentation of decontamination procedures and mechanisms by which surgical instruments can be traced, must be put in place.

2. SCOPE OF POLICY

2.1 This policy outlines the approach to the management of patients with Transmissible Spongiform Encephalopathies such as CJD and similar diseases.

2.2 This policy applies to all healthcare workers (HCWs) employed within the Trust that undertake patient care, or who may come into contact with affected patients and others working within the Trust in a contracted capacity. Welsh Blood Service should also refer to the document library of the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) Position Statement November 2022 for guidance, https://www.transfusionguidelines.org/document-library/documents/jpac-position-statement-covid-19-vaccines-and-blood-transfusion-nov-2022 and Department of Health and Social Care (DOH) Minimise transmission risk of CJD and vCJD in healthcare settings Laboratory containment and control measures, last updated Nov 2021.

3. AIMS AND OBJECTIVES

3.1 The aim of this policy is to ensure that all staff within the Trust understand the risks associated with TSE's. It will provide HCWs with the information necessary to provide appropriate care for patients with TSE including CJD and to prevent transmission to other patients and HCWs. This will enable staff to ensure appropriate procedures are in place to minimise the risk of transmission within the Trust as a consequence of healthcare delivered to the patient via invasive clinical activities (Iatrogenic transmission) and surgical instruments.

4. RESPONSIBILITIES

4.1 The Chief Executive

The Chief Executive has overall responsibility and accountability to the Trust Executive Management Board for the management, prevention and control of infection across the organisation. This includes the responsibility for the provision of resources and implementation of all measures needed to comply with infection control policies and procedures, associated legislation and relevant guidance.

4.2 Executive Director of Nursing, Allied Health Professionals & Health Science

The Director of Nursing, AHP's & Medical Scientists has delegated Executive responsibility for Prevention and Control of Infection and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate staff Infection Prevention and control training, and monitoring is in place.

4.3 Departmental Managers/ Clinical Directors

- Ensure staff have access to this policy and associated guidance and legislation, ensuring staff adhere to the procedures set out in this policy.
- Ensure there are effective and adequately resourced arrangements for the management of CJD and vCJD within the trust;
- Ensure that the Infection Prevention and Control Team (IPCT) is informed of any patient who is known, suspected of, or at risk for CJD.
- Ensure appropriate departments are informed before any invasive procedures are carried out.
- Have a key role in the co-ordination of actions required.
- Ensure records of meetings are maintained.
- Staff within their area of responsibility adhere to the procedures outlined in this policy.
- Adverse incidents are reported and managed as per Trust policy.
- Staff are provided with suitable information, instruction and training as required.
- Should maintain an accurate record of patient placement within the ward at all times to facilitate accurate retrospective information gathering if required.
- Staff have access to appropriate personal protective equipment (PPE).
- Ensure necessary documentation has been completed as per policy.
- Support staff to correct any action or intervention that may have resulted in transmission of infection.

4.4 Clinical staff

- Familiarise themselves with the policy.
- Should be aware of CJD/vCJD risk existence and be responsible for ensuring their own practice complies with this policy and encouraging others to do so.
- Ensure the infection prevention and control precautions detailed in this policy are followed for any patient with suspected or confirmed CJD or vCJD.
- Inform the IPCT if a patient is confirmed or suspected as having CJD or vCJD.
- When appropriate risk assess patients for their risk of CJD.
- Understand and apply the infection prevention and control principles in this policy.
- Maintain competence, skills and knowledge in infection prevention and control by attending education events and/ or completing training.
- Communicate the infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality.
- Do not provide care while at risk of transmitting infectious agents to others; if in doubt, they must consult their line manager, IPCT or occupational health (OCCH) department.

- Report to their manager inadequate facilities, equipment or products and deficits in their own knowledge or training.
- Inform Manager, IPCT, health and safety Manger and OCCH provider if they receive a needle stick/ inoculation or other contamination injury from a patient with confirmed or suspected CJD or vCJD.
- Ensure that whole blood and platelet collection processes adhere to UK legislation to maintain optimal safety of the supply chain.

4.5 Theatre Staff

- All patients should be checked for infection control alerts, including CJD status.
- Consent forms should be complete including the CJD question where present, and the answer appropriately acted upon.
- Ensure that all surgical instruments, medical devices are tracked according to Trust policies, and that instruments do not migrate between sets.
- Ensure that single use instruments are disposed of appropriately.
- Ensure that Tracking and Traceability systems are in place and effective for instruments and devices processed in the department.
- Managers have responsibility to support the IPCT by ensuring that staff are able to attend training sessions in response to identified needs.

4.6 Infection Prevention and Control (IPCT)

Will:
Advise and support clinical teams in taking appropriate infection control measures.
Monitor, evaluate and review the policy in the light of new evidence.

4.7 Distribution

The policy will be available via the Trust intranet site. Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5. DEFINITIONS

Creutzfeldt - Jakob disease is a progressive degenerative disease of the brain which causes dementia, decline of motor and other brain functions and death, usually within a year of diagnosis. It is one of a number of diseases collectively known as TSEs caused by unconventional transmissible agents known as prions. Prion diseases are caused by one of the body's normal proteins, called the prion protein, changing its shape and forming clumps of protein in the brain. This process damages and eventually kills brain cells. Prions can also accumulate in other specific tissues depending on the type of CJD.

The worldwide incidence is about 1 per million people each year. In humans, there are three different ways these diseases can start. The commonest form, occurring in 85-94% is called sporadic CJD and this is seen all over the world. It appears to occur at random as an unlucky event when the production of prions in the brain is triggered spontaneously. Secondly, in about 15% of cases the disease can be passed down from generation to generation as a genetic condition in some families with a faulty prion protein gene. Thirdly, someone can "catch" a prion infection by being exposed to infectious prions either through accidental exposure associated with healthcare intervention (iatrogenic CJD) or consumption of products contaminated with prions (vCJD).

The incubation period of sporadic cases of CJD is unknown, but iatrogenic cases appear to have an incubation period of 2 to 15 years or more, depending on the route of inoculation.

Transmissible Spongiform Encephalopathies - A group of neurological diseases affecting both humans and animals thought to be caused by a build-up of prions in the brain, which do not share the normal properties of viruses and bacteria.

Creutzfeldt-Jakob disease - A human form of transmissible spongiform encephalopathy, which causes a variety of neurological symptoms including dementia and personality changes. The outcome is invariably fatal.

Iatrogenic CJD - A form of CJD which occurs when CJD is accidentally transmitted during medical or surgical procedures.

Prions - Infectious proteins which do not share the normal properties of viruses and bacteria and are resistant to conventional chemical and physical decontamination methods.

Variant Creutzfeldt Jakob Disease - A form of CJD first identified in 1996, thought to be linked to ingesting meat from cattle infected with Bovine Spongiform Encephalopathy (BSE).

High Risk Procedure – Procedures that involve handling of tissue with high risk of CJD transmission. High risk tissues include brain, spinal cord, cranial nerves, specifically the entire optic nerve and the intracranial components of the other cranial nerves, cranial ganglia, posterior eye, specifically the posterior hyaloid face, retina, retinal pigment epithelium, choroid, subretinal fluid and pituitary gland.

Medium Risk Procedure – Procedures that involve handling of tissue with medium risk of CJD transmission. Medium risk tissues are spinal ganglia and olfactory epithelium. In patients with suspected or confirmed vCJD the following tissues are also medium risk; tonsil, appendix, spleen, thymus, adrenal gland, lymph nodes and gut-associated lymphoid tissues.

Lymphoid Tissue – Lymph nodes, appendix, spleen, thymus, tonsil, adenoids and gastro intestinal tract sub- mucosa.

Low Risk Procedure - All procedures other than the high and medium risk procedures. Operations on the anterior eye have recently been downgraded to low risk procedures.

Human forms of TSE fall into 3 groups as shown in Table 1. These cause a variety of neurological symptoms including dementia and personality changes as well as neuromuscular symptoms such as unsteadiness and involuntary muscular jerking. All human TSEs are extremely rare. There is currently no effective treatment available and the outcome is invariably fatal.

Table 1: Classification of TSEs

Idiopathic diseases	Sporadic CJD Sporadic fatal insomnia Variably Protease-Sensitive Prionopathy (VPSPr)
Familial diseases	Familial CJD Gerstmann-Straussler-Scheinker disease (GSS) Fatal familial insomnia (FFI)
Acquired diseases	Iatrogenic CJD Kuru Variant CJD

5.1 Transmission

There is no evidence that TSEs can be spread from person to person by close or normal social contact, but can be transmitted via exposure to infected tissues by direct inoculation from contaminated surgical instruments. Other possible routes of infection are blood transfusion or, in the past eating contaminated meat. There have been documented cases of spread via the administration of hormones prepared from human pituitary glands, dura mater grafts and following neurosurgical procedures with inadequately decontaminated instruments.

In routine clinical contact, no additional precautions are needed for the care of patients with or at risk of developing TSE. However, when certain invasive interventions involving high or medium infectivity risk tissues are performed there is the potential for exposure to the agents of TSEs. In these situations it is essential that appropriate standard infection control measures are in place to prevent the iatrogenic transmission of TSEs.

Unlike microorganisms, prions are resistant to conventional decontamination processes including normal moist heat sterilisation (autoclaving) or chemical disinfection measures normally appropriate for endoscopes, surgical instruments and other reusable medical devices. Therefore a risk assessment must be undertaken before any clinical procedure where there is considered to be a risk of potential transmission.

- Brain, cerebral spinal fluid (CSF), eye and nerve tissues are infectious and there have been rare cases of transmission due to inadequate decontamination of surgical instruments. Cross infection has occurred in neurosurgery and via certain tissue grafts, e.g. corneas.
- There is no evidence of occupational transmission of the disease to medical, nursing or laboratory staff in contact with affected patients or material from them.
- The Department of Health and Social Care has reported a few cases of vCJD where prior blood transfusion has been implicated. To minimise the risk of TSE/CJD transmission from blood, exclusion criteria are in place for blood donation. The JPAC ensures blood provided for patients is as safe as possible and have taken a number of measures to try to reduce the risk of transmission of vCJD by blood, plasma and tissue products.
- Transmission due to needle stick injury has not been documented, but a very small (as yet unquantified) risk may exist.
- To prevent transmission of TSEs in medical practice it is necessary to take a two stage risk based approach. First patients affected with or at risk of

developing a TSE must be reliably identified, and second measures must be taken to ensure that any invasive device used on such patients are not used on other patients.

- Occupational transmission of CJD, vCJD or any other TSE has never been confirmed in either healthcare or any other occupational setting. If TSEs could be transmitted, this would most likely be due to exposure to high risk tissues by direct inoculation from a sharp injury or puncture wound.

5.2 Infectivity

TSE agents are not uniformly distributed through the tissues of affected individuals and certain tissues pose a higher risk. In all TSEs central nervous tissues (including the retina) have the highest infectious risk, with cornea and dura mater having a lower infectious risk.

In vCJD tissues outside the central nervous system have also been shown to be potentially infectious, especially lymphoid organs and tissues containing lymphoid structures. Most body fluids and other tissues are of negligible risk, however blood donations from people with or incubating vCJD have been linked to transmission of vCJD.

5.3 Definition of Patient Groups

In order to ensure that appropriate infection prevention and control measures are put in place, symptomatic patients (i.e. those who fulfil the diagnostic criteria for definite, probable or possible CJD or vCJD) and asymptomatic patients considered at risk of developing CJD (i.e. those with no clinical symptoms but who are potentially at risk of developing the familial disease or at risk due to iatrogenic exposures) must be appropriately identified. This is especially important if they are to undertake any surgical or endoscopic procedure.

5.3.1 Diagnosis of Definite, Probable and Possible CJD

For symptomatic cases there are internationally accepted diagnostic criteria for definite, probable and possible CJD or vCJD. These can be found via Advisory Committee on Dangerous Pathogens (ACDP) guidance at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209761/Annex_B_-_Diagnostic_criteria.pdf.

Patients suspected of having CJD or vCJD must be referred to a neurologist or consultant with appropriate expertise for investigation.

5.3.2 Asymptomatic Patients at risk from familial forms of CJD linked to genetic mutations:

- Individuals who have or have had two or more blood relatives affected by CJD or other prion disease, or a relative known to have a genetic mutation indicative of familial CJD.
- Individuals who have been shown by specific genetic testing to be a significant risk of developing CJD or other prion disease.

5.3.3 Asymptomatic Patients potentially at risk from iatrogenic exposure:

- Recipients of hormone derived from human pituitary glands, e.g. growth hormone, gonadotrophin.
- Individuals who have received a graft of dura mater. (People who underwent neurosurgical procedures or operations for a tumour or cyst of the spine

before August 1992 may have received a graft of dura mater, and should be treated as at risk, unless evidence can be provided that dura mater was not used).

- Individuals who have been contacted as potentially at risk because of exposure to instruments used on, or receipt of blood, plasma derivatives, organs or tissues donated by, a patient who went on to develop CJD or vCJD.

- Variant CJD has been reported in recipients of blood transfusion from donations taken from individuals who later developed vCJD. There is no evidence of transmission of sporadic CJD from blood or its products.

- Patients who have been specifically contacted as potentially at risk for public health purposes, including individuals considered to be at risk of: CJD/vCJD due to exposure to certain instruments used on a patient who went on to develop CJD/vCJD, or was at risk of vCJD; CJD/vCJD due to receipt of tissues/ organs; vCJD due to receipt of blood components or plasma derivatives*; vCJD due to the probability they could have been the source of infection for a patient transfused with their blood who was later found to have vCJD.

*Some recipients of UK sourced blood products from 1980 to 2001 will fall into the 'at risk' (for vCJD) group.

6. IMPLEMENTATION/POLICY COMPLIANCE

6.1 General Hospital Care

General Ward Procedures
Isolation of patients with CJD is not necessary, and they can be nursed in an open ward using standard infection control precautions (SICPs) in line with those used for all other patients. There is no evidence that normal social or routine clinical contact of a CJD patient presents a risk to HCWs, relatives and others. However, when procedures are undertaken that carry a risk of contamination with CSF, biopsy or blood samples, the precautions outlined below should be observed. Disposable gloves, apron, fluid resistant surgical mask (FRSM) and eye protection should be worn where splashing may occur.

Although cases of CJD/vCJD have been reported in HCWs, there have been no confirmed cases linked to occupational exposure. The highest potential risk in the context of occupational exposure is from exposure to high infectivity tissues through direct inoculation, for example as a result of sharps injuries, puncture wounds or contamination of broken skin, and exposure of the mucous membranes.

All HCWs who care for patients with patients with definite, probable or possible CJD/vCJD, or with potentially infected tissues, should be appropriately informed and knowledgeable in the nature of the risk to themselves or others, including which body tissues pose greatest risk of contamination, which procedures would lead to possible exposure to high risk body tissues and the relevant safety procedures if there is potential exposure to these body tissues.

Body secretions, body fluids (including saliva, blood and cerebrospinal fluid (CSF) and excreta) are all low risk for CJD. See above for information on tissue infectivity's for CJD. It is therefore likely that the majority of samples taken or procedures performed will be low risk. Contact with small volumes of blood (including inoculation injury) is considered low risk, (though it is known that transfusion of large volumes of blood and blood components may lead to CJD transmission).

6.1.1 Used or Foul Linen (contaminated with body fluids or excreta)

- Place in a red water-soluble alginate bag and white linen bag. The linen can be washed in accordance with the IPC 05 National Infection Prevention and Control Manual no further processing requirements are necessary.

6.1.2 Precautions during Ward Based Invasive Procedures

- Ward based invasive procedures must only be taken by trained and competent personnel.
- Single use/ disposable items must be used and disposed of as clinical waste for incineration.

6.1.3 Laboratory Specimens

- Blood and other specimens can be collected and processed in the same way for other patients.
- The laboratory must be informed in advance that a sample is being sent. High risk material including any specimen from, the brain, spinal cord, eye, or likely to include olfactory epithelium or lymphoid tissue must only be submitted for examination after prior consultation with the appropriate laboratory.
- Samples from known or suspected patients should be clearly marked with a Biohazard label. CJD is classified as Hazard Group 3 by the ACDP. The Approved List of biological agents provides the approved classification of biological agents into hazard groups (as referred to in control of substances hazardous to health (COSHH). The hazard groups are defined in the Table 2; when classifying a biological agent it should be assigned to one of these four groups according to its level of risk of infection to humans.

Table 2: Hazard Groups

Group	Definition
Group 1	Unlikely to cause human disease
Group 2	Can cause human disease and may be a hazard to employees; it is unlikely to spread to the community and effective prophylaxis or treatment is usually available
Group 3	Can cause severe human disease and may be a serious hazard to employees; it may spread to the community, but effective prophylaxis or treatment is usually available
Group 4	Causes severe human disease and is a serious hazard to employees; it is likely to spread to the community and usually no effective prophylaxis or treatment is available

6.1.4 Drug Administration

Only personnel aware of the hazard involved should carry out injections.

Drug administration by injection and collection of blood, CSF and body fluid samples from patients with, or "at increased risk" of, CJD, should be performed as for any other patient in-line with SIPCs, i.e. as potentially infectious:

- use of disposable gloves and eye protection where splashing may occur;
- avoidance of sharps injuries and other forms of parenteral exposure;
- safe disposal of sharps and contaminated waste; and
- single-use disposable equipment should be used wherever possible.

6.2 CARE OF PATIENTS KNOWN, SUSPECTED OR 'AT RISK' FOR TSE/CJD

6.2.1 Patient Groups Requiring Specific Precautions

(See section 5.3 for definitions of these groups)

- Symptomatic Patients
- Asymptomatic, but 'at-risk' Patients
- Familial 'at-risk' Patients
- Iatrogenic 'at-risk' Patients

- The IPCT should be notified of patients in the above categories.
- Used and fouled bed linen – no additional precautions.
- Waste material should be handled as clinical waste and disposed of by incineration.

6.2.2 Invasive Medical Procedures (peripheral central catheters, venepuncture, biopsy, lumbar puncture)

For invasive procedures e.g. lumbar puncture (LP), carried out on the ward for definitive, probable, possible or at risk CJD or vCJD patients follow the guidelines in this document.

As mentioned prions are particularly resistant to standard physical and chemical methods of inactivation and decontamination.

6.2.3 Precautions to be taken

- Special care must be taken by staff performing invasive procedures particularly LP and/or tissue biopsy to avoid inoculation injury. Particular care should also be taken with lymphoid tissue specimens from patients. Any inoculation injury to staff must be managed as per Health and Safety policy for the management of occupation exposure to blood and high risk body fluids, including first aid and reporting. It must be emphasised that no case of infection transmitted in this way has ever been reported. Staff should wear personal protective equipment (PPE) which includes; disposable gloves, apron, gown, eye protection and FRSM
- Bedding should be protected with an impervious towel/ drape whilst performing a LP.
- Single-use disposable instruments/ equipment must be used wherever practicable, these include surgical trays, LP sets. All small items

contaminated by cerebral spinal fluid (CSF) or neural tissue must be destroyed by incineration.

- The collection of blood specimens should involve the same precautions used for all work of this type with any patient, *i.e.* avoidance of sharps injuries and other forms of parenteral exposure.

6.3 PROCEDURES FOR DISINFECTION OF SURFACES, SPILLAGES, SKIN

6.3.1 Procedure for Disinfection of Surfaces and Spillages (Not Skin)

When a spillage of any fluid (including blood and CSF) from a patient with, or "at increased risk" of, CJD/vCJD occurs in a healthcare setting, the main defence is efficient removal of the contaminating material and thorough cleaning of the surface.

Protect surfaces from contamination wherever possible.

Standard infection control precautions should be followed for any spillages, which should be cleared up as quickly as possible, keeping contamination to a minimum. PPE should be worn – gloves, aprons, eye protection. Any other waste (including cleaning tools such as mop heads etc.) should be also be disposed of as clinical waste (see Table 3).

For spillages of large volumes of liquid, absorbent material should be used to absorb the spillage, for which a number of proprietary absorbent granules are available.

Standard disinfection for spillages (e.g. 10,000ppm chlorine-releasing agent) should be used to decontaminate the surface after the spillage has been removed. A full risk assessment may be required.

Ensure adequate ventilation where possible.

6.3.2 Procedure for the decontamination of skin / mucous membranes

If skin becomes visibly contaminated with blood or body fluids, wash thoroughly with soap and water.

Exposed mucous membranes or conjunctivae should be bathed with copious clean tap water where available/or bottled water from eye wash stations.

Always report exposure incidents immediately to line manager and inform occupational health and recorded as an adverse incident.

Refer to Health and Safety Policy (TBC) for the management of occupational exposure to blood and high risk body fluids.

6.3.3 CSF and Biopsy Tissue Other Than Neural Tissue

Only staff aware of the hazard should collect CSF and tissue biopsy specimens from known, suspected or at risk TSE/CJD patients. They should wear gloves and eye protection if splashing could occur.

The samples from these patients and any equipment used including that which is not disposable should be destroyed by incineration.

6.4 CLINICAL WASTE

Clinical waste generated from patients with definite, or probable, or at increased risk of CJD should be disposed of differently according to whether it has been exposed to high, medium or low-risk tissues or body fluids.

General guidance on the safe management of clinical waste is given in the guidance document Welsh Health Technical Memorandum 07-01: Safe Management of Healthcare Waste', available at http://www.wales.nhs.uk/sites3/Documents/254/WHTM%2007-01.pdf

According to this guidance, "Waste known or suspected to be contaminated with transmissible spongiform encephalopathy (TSE) agents, including CJD, must be disposed of by high temperature incineration in suitable authorised facilities."

The ACDP TSE Risk Management Sub Group have considered the disposal of clinical waste, and have agreed that tissues, and contaminated materials such as dressings and sharps, from patients with, or "at increased risk" of, CJD/vCJD, should be disposed of as described in Table 3.

Table 3 Disposal of clinical waste from patients with, or "at increased risk" of, CJD or vCJD

Diagnosis of CJD	High or medium risk tissue*	Low risk tissue and body fluids**
Definite	Incinerate	Normal clinical waste disposal
Probable	Incinerate	Normal clinical waste disposal
"At increased risk"	Incinerate	Normal clinical waste disposal

***** See Annex A1 Distribution of TSE infectivity in human tissues and body fluids. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/444243/Annex_A1_update.pdf.

** Tissues and materials deemed to be low risk include body fluids such as urine, saliva,sputum, blood, and faeces. Blood from vCJD patients is considered to be low risk except when transfused in large volumes.

6.5 INNOCULATION INJURIES

- For any incident involving 'sharps', or contamination of abrasions with blood or body fluid(s), wounds should be gently encouraged to bleed, gently washed (avoid scrubbing) with warm soapy water, rinsed, dried and covered with a waterproof dressing, or further treatment given appropriate to the type of injury.
- Splashes in the eyes or mouth should be dealt with by thorough irrigation.
- The incident should be reported to the Ward Manager/ Ward Sister/ Health and Safety Manager and an adverse event report submitted. The ward manager/ sister should report as per RIDDOR guidelines as applicable.
- Staff **must** telephone OCCH department and report injury. (Refer to Health and Safety sharps safety policy TBC). OCCH will keep a record of all accidents and

occurrences with an infectious or potentially infectious material involving the exposure of staff.
- There is no evidence to date that transmission through occupational exposure has occurred.

6.6 ACTIONS TO BE TAKEN UPON NOTIFICATION OF SUSPECTED CJD OR vCJD IN A PATIENT WHO HAS PREVIOUSLY UNDERGONE SURGERY OR ENDOSCOPY

The IPCT ***must*** be informed of any suspected case of CJD or vCJD regardless if they are currently an in-patient of the Trust or not, to allow for appropriate actions to be taken.

An incident review committee will be convened by the Head of Infection Prevention & Control to manage the incident and decide the actions that are required:

- The Executive Director of Nursing, Allied Health Professionals and Health Sciences;
- The Head of Infection Prevention & Control or deputy;
- The Trust Infection Prevention and Control Doctor/Microbiologist;
- The Health and Safety Manager or deputy;
- Head of Nursing VCC or deputy;
- Decontamination Lead;
- The Medical Director or deputy.

In the event of an incident the Public Health Wales (Health Protection Team) will be informed and theNational CJD Research and Surveillance Unit (NCJDRSU).

6.7 CARE OF THE DECEASED

On the death of a CJD patient (or patient at risk of developing CJD) the removal of the body from the ward to the cold room/ mortuary, should be carried out using normal infection control measures. No additional precautions are necessary when laying out the body.The deceased patient is placed in a body bag prior to transportation to the cold room/mortuary, in line with normal procedures for bodies where there is a known infection risk. Full details of the proposed/ confirmed diagnosis using an infection hazard notification sheet, must be given to the undertakers concerned with the deceased prior to their handling of the body (**Appendix 1**).

The infection hazard notification sheet is one way of providing those who will handle the deceased with the necessary information to do so safely. It is intended to highlight hazards associated with the deceased, which can include infection risk, implantable devices and radioactive sources. As the information is of a personal nature, it should be handled sensitively and shared only with those who need it to carry out an appropriate risk assessment and to enable appropriate precautions to be taken.

Following the death of a patient, their cultural/ religious needs and wishes, which were expressed prior to death, will be carried out as far as possible. The dignity of the deceased person will be respected throughout the whole process. Staff should

endeavor to meet the needs of both the relatives/ carers and the deceased, and if necessary ask the patient's faith representative to attend the ward if required.

6.7.1 Post-Mortem

If a post-mortem examination is required please contact a Consultant Histopathologist to discuss further.

Post-mortem examinations are required in order to confirm a clinical diagnosis and the cause of death in patients with suspected CJD or vCJD. Post-mortem examinations on CJD cases can be undertaken in any mortuary, provided that appropriate care is taken to minimise contamination of the working environment.

6.7.2 Undertakers

The undertakers should be informed of the known or potential CJD/vCJD diagnosis, prior to handling the body of the deceased. Concern about possible unknown CJD cases does not warrant a level of precaution for undertakers handling intact bodies other than those used generally for all work of this nature.

6.7.3 Viewing the Deceased

Relatives of the deceased may wish to view or have some final contact with the body. Such viewing and possible superficial contact, such as touching or kissing need not be discouraged.

6.7.4 Environmental Concerns

There is no need to discourage burial of a patient with known or suspected CJD of vCJD, and no special arrangements for burial are required. Similarly, there is no need for any extra precautions to be taken for cremation.

6.7.5 Transporting the deceased

No additional precautions are needed for transporting the body within the UK.

7. RELEVANT NATIONAL REQUIREMENTS

Department of Health (2008) The Health and Social Care Act 2008, Code of Practice for health and social care on the prevention and control of infections and related guidance (updated 2015).

The Department of Health and Social Care website below carries all the guidance on Prevention of CJD and vCJD produced by the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathy (ACDP TSE) Subgroup

https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

List of guidance documents available on the website (as at 24th November 2022)

- Health and Safety Management of Transmissible Spongiform Encephalopathy (TSE).
- Laboratory containment and control measures (updated November 2021)
- Infection Control of CJD, vCJD and other human prion diseases in healthcare and community settings

- Annex A1: Distribution of TSE infectivity in human tissues and body fluids
- Annex A2: Distribution of infectivity in animal tissue and body fluids
- Annex B: Diagnostic criteria
- Annex C: General principles of decontamination and waste disposal
- Annex D: Transport of TSE infected material
- Annex E: Quarantining of surgical instruments
- Annex F: Endoscopy
- Annex H: After death
- Annex I: Outline protocol for management of instruments and tissues from brain biopsy procedures on patients with progressive neurological disorders.
- Annex J: Assessment to be carried out before surgery and / or endoscopy to identify patients with, or at risk of CJD / vCJD
- Annex K: Guidelines for pathologists and pathology laboratories for the handling or tissues from patients with, or at risk of CJD / vCJD
- Annex L: Managing CJD / vCJD risk in ophthalmology
- Annex M: Managing vCJD risk in general surgery and liver transplantation
- CJD guidance for ophthalmologists
- Information sheet for funeral directors, relatives and others following a CJD death.

Alert to urological surgeons regarding the equipment used for patients at risk of vCJD requiring trans-rectal prostatic biopsy

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee. Donor Selection Guidelines. https://www.transfusionguidelines.org/dsg

Welsh Health Technical Memorandum 01-01: Decontamination of surgical instruments (medical devices) used in acute care. Part A: Management and Provision.
http://www.nwssp.wales.nhs.uk/sitesplus/documents/1178/WHTM%2001-01%20Decontamination%20Part%20a%20protected0119.pdf

8. REFERENCES, BIBLIOGRAPHY, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

Advisory Committee on Dangerous Pathogens (ACDP)
https://www.gov.uk/government/groups/advisory-committee-on-dangerous-pathogens

Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO)
https://www.gov.uk/government/groups/advisory-committee-on-the-safety-of-blood-tissues-and organs

Association of British Neurologists
http://www.theabn.org/

CJD International Surveillance Network
http://www.eurocjd.ed.ac.uk/

CJD Support Network
http://www.cjdsupport.net/

Creutzfeldt-Jakob disease guidance for health workers. Department of Health 2000
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082370.pdf

Department of Health and Social Care (2021). Minimise transmission risk of CJD and vCJD in healthcare settings. Prevention of CJD and vCJD by the Advisory Committee on Dangerous Pathogens' Transmissible Spongiform Encephalopathy (ACDP TSE) subgroup.
https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

DA (81)22 Report of the Advisory Group on the Management of Patients with Spongiform Encephalopathy (Creutzfeldt-Jakob Disease) (CJD).

DA (84)16 Management of Patients with Spongiform Encephalopathy (Creutzfeldt-Jakob disease) (CJD).

Health and Care Standards Standard 2.4 (2015) Welsh Government.

HSE (2013). The Approved List of biological agents. Advisory Committee on Dangerous Pathogens. Health and Safety Executive.
http://www.hse.gov.uk/pubns/misc208.pdf

HSE (2019). Managing infection risks when handling the deceased. Guidance for the mortuary, post-mortem room and funeral premises, and during exhumation.HSG283.
http://www.hse.gov.uk/pUbns/priced/hsg283.pdf

Infection prevention and control of CJD and variant CJD in healthcare and community settings Department of health (2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/427854/Infection_controlv3.0.pdf

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (2022). Position Statement. Variant Creutzfeldt-Jakob disease. https://www.transfusionguidelines.org/document-library/documents/jpac-position-statement-covid-19-vaccines-and-blood-transfusion-nov-2022

Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee. Guidelines for the Blood Transfusion Services in the UK 8TH Edition. https://www.transfusionguidelines.org/red-book

National CJD Research Surveillance Unit (NCJDRSU)
http://www.cjd.ed.ac.uk/

National Prion Clinic (London)
http://www.prion.ucl.ac.uk/clinic-services/

NEUROPRION Network of Excellence
https://www.neuroprion.org/

NHS Blood and Transplant
http://www.nhsbt.nhs.uk/

NICE interventional procedures guidance
https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-interventional-procedures-guidance

NICE (2020): Reducing the risk of transmission of Creutzfeldt-Jakob disease from surgical instruments used for interventional procedures on high-risk tissues
https://www.nice.org.uk/guidance/ipg666/resources/reducing-the-risk-of-transmission-of-creutzfeldtjakob-disease-cjd-from-surgical-instruments-usedfor-interventional-procedures-on-highrisk-tissues-pdf-1899874227866821

Public Health England
https://www.gov.uk/government/collections/creutzfeldt-jakob-disease-cjd-guidance-data-and-analysis

Public Health Wales
http://www.wales.nhs.uk/sitesplus/888/page/43948

University of Edinburgh's Centre for Clinical Brain Sciences
http://www.ed.ac.uk/clinical-brain-sciences
Welsh Blood Service
https://www.welsh-blood.org.uk/

Welsh Health Technical Memorandum 07-01: Safe Management of Healthcare Waste'. https://nwssp.nhs.wales/ourservices/specialist-estates-services/specialist-estates-services-documents/whtms-library/whtm-07-01-safe-management-of-healthcare-waste-pdf/

9. GETTING HELP

9.1 Further information and support:

Velindre IPCT: 02920 196129

9.2 National Organisations able to give advice

The following resources are available to health professionals dealing with cases of CJD:

- The National CJD Surveillance Unit in Edinburgh can provide advice on all clinical and neuropathological aspects of CJD. It can be contacted at:

The National CJD Research & Surveillance Unit
Bryan Matthews Building
Western General Hospital
Crewe Road
Edinburgh
EH4 2XUT

Telephone:
Main Office: 0131 537 1980/2128/3103
Neuropathology Laboratory: 0131 537 3084
CSF Referrals: 0131 242 6253

http://www.cjd.ed.ac.uk/

Email: loth.securecjd@nhslothian.scot.nhs.uk **(**please use this email address for sending emails containing patient identifiable information):

Email: contact.cjd@ed.ac.uk (for general enquiries)

- The National Prion Clinic (NPC) is the national referral centre for prion disease and is part of the University College London Hospitals NHS Foundation Trust (UCLH). It is funded by the NHS to provide diagnosis and care for patients with, or suspected to have, any form of human prion disease (Creutzfeldt-Jakob disease, CJD). The clinic is integrally linked with the MRC Prion Unit at the Institute of Prion Diseases, a Postgraduate Research Institute of University College London. The NPC provides diagnosis and care for all forms of prion disease (inherited, iatrogenic, sporadic and variant CJD). We aim to review new patients within a week of referral. The NPC also plays a key role in facilitating research to promote early diagnosis and the development of potential therapies.

It can be contacted at:

National Prion Clinic
Institute of Prion Diseases, Courtauld Building, 33 Cleveland Street, London, W1W

Tel: 020 7679 5142 / 020 7679 5036

uclh.prion.help@nhs.net

http://www.nationalprionclinic.org/

- The CJD Support Network is a voluntary organisation set up to provide help and support for patients of all types of CJD and their families. The Network has undertaken a case coordination initiative aimed at facilitating the co-ordination of care for patients affected by all types of CJD, and gives advice on all case co-ordination enabling cost effective care and ensuring appropriate responses to carers' needs. It can be contacted at:

CJD Support Network,
PO BOX 3936
Chester
CH1 9NG

Tel:
For admin - +44 (0)7494 211 476
For support, contact our helpline - 0800 774 7317

http://www.cjdsupport.net/

Email:
For admin - admin@cjdsupport.net
For support - support@cjdsupport.net

10. RELATED POLICIES

10.1 This policy should be read in conjunction with:

IPC 04 Decontamination of Equipment Policy
IPC 05 National Infection Prevention and Control Manual (NIPCM) (covers care of the deceased patient)
H&S TBC Management of Occupational Exposure to Blood and High Risk Body Fluids
H&S TBC Sharps safety
IPC 11 Transport of Pathological specimens
Verification of Expected/ Anticipated Death by a Registered Nurse Policy (Nursing Policy)
QS 24 Medical Devices and Equipment Management Policy
PP 08 Trust Waste Management Policy
Green 25 Waste Management Procedure
TRUSTENV06 – Waste Management
TRUSTENV07 – Spillages

11. INFORMATION, INSTRUCTION AND TRAINING

11.1 Training

Mandatory Infection Prevention and Control annual training
Further development based training as identified by training needs analysis

12. MAIN RELEVANT LEGISLATION

Compliance with the following legal documents will ensure the safety of devices and substances to prevent cross contamination to patients or HCW's:

Health and Safety at Work etc. Act 1974 The Stationery Office
www.legislation.gov.uk/ukpga/1974/37

Management of Health and Safety at Work Regulations 1999
The Stationery Office www.legislation.gov.uk/uksi/1999/3242/contents/made

Control of Substances Hazardous to Health Regulations 2002 (revised 2020) The Stationery Office www.legislation.gov.uk/uksi/2002/2677/contents/made

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 www.legislation.gov.uk/uksi/2013/645/pdfs/uksi_20130645_en.pdf

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees www.hse.gov.uk/pubns/hsis7.pdf

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 The Stationery Office www.legislation.gov.uk/uksi/2013/1471/made

Appendix1: Infection Hazard notification sheet (HSE Document)

1	Name of deceased			
2	Date and time of death			
3	Source (hospital, ward or other)			
4	Infection risk from the deceased [1]			
4a	Does the deceased present an infection risk? (ring as appropriate)			
	Yes	Suspected	None suspected	
4b	If yes, what are the likely routes of transmission? (ring all that apply) [2]			
	Airborne	Droplet	Contact	
4c	Infection (if permitted to disclose) [3]			
4d	Provide any relevant information to enable the deceased to be handled safely [4]			
5	Condition of the deceased [5]			
5a	Is the deceased leaking body fluids? Please provide details			
5b	Have accessories that present a risk of sharps injury been removed?			
5c	If yes, have the puncture points been covered or sealed?			
5d	If no, please provide details and location			
5e	Does the deceased have an implantable device? (ring as appropriate)			
	No	Yes and switched off	Yes but not switched off	

5f	If yes please provide details and location	
5g	Was the deceased receiving radiotherapy? (If yes, please provide details)	
6	Signed [6]	
	Print name	
	Hospital	

Infection Hazard Notification Sheet v1 June 2019

This information needs to be handled sensitively and securely to ensure confidentiality of the deceased's personal information. It should be shared only with those who need it to handle the deceased safely (as required by the Health and Safety at Work etc. Act 1974). This form provides one means of sharing the pertinent information.

Notes

1. Providing sufficient information on infection risks from handling the deceased will enable the appropriate precautions to be taken. Where infection is the primary cause of death, please ring 'Yes' for Q4a. Infection may not be the primary cause of death but if the deceased was suffering from an infection, please ring 'Yes' or 'Suspected' for Q4a. Where there are no indications that the deceased was suffering from an infection, or where the deceased was on a course of antimicrobial medication that would minimise the infection risk, please ring 'None suspected' for Q4a and proceed to section 5, 'Condition of the deceased'.

2. When handling the deceased, standard infection control precautions (SICPs) are considered the minimum protective measures to be used. In Q4b provide information on how exposure to infection may occur. This will help those handling the deceased to consider adopting additional control measures (transmission-based precautions or TBPs) appropriate to the route by which they can be exposed and transmission can occur.

3. If the infection is known it is helpful, though not essential, to provide specific details in Q4c of the infectious agent, to inform the risk assessment and assist with possible treatment should exposure occur. This information may only be disclosed with prior permission of the deceased or their family.

4. In Q4d provide any information relevant to infection risk that may assist in deciding whether and how the deceased should be handled during viewing, preparing (hygienic preparation), embalming, post-mortem examination or exhumation. For example, indicate why a body bag has been used, whether a body bag is necessary, and details of any counter-indications that may prevent specific activities (e.g. embalming) being performed. It may be appropriate to consult Appendix 1 of this publication (*Managing infection risks when handling the deceased*) for further information.

5. In section 5 provide information on the condition of the deceased that would be helpful in deciding whether and how they should be handled. It highlights important issues, e.g. sharp medical devices or implantable devices (e.g. pacemakers), their location and whether they need to be removed.

6. In hospital cases, the doctor and/or nursing staff with knowledge of the deceased's condition is asked to sign section 6 of this form. Where a post-mortem examination has been undertaken, the pathologist (or qualified anatomical pathology technologist) is asked to sign. In non-hospital situations (e.g. community setting), the doctor with knowledge of the deceased's condition is asked to sign.

Ref: QS 19

IONISING RADIATION SAFETY POLICY

Executive Sponsor & Function:	Executive Medical Director
Document Author:	Head of Radiation Protection Service
Approved by:	Quality, Safety & Performance Committee
Approval Date:	16th March 2023
Review Date:	15th March 2026
Version:	4.8

EXECUTIVE SUMMARY

Overview:	This Policy establishes a framework for controlling the use of ionising radiation and restricting exposure to persons within all Services provided by the Trust. The Trust will only adopt those practices that are consistent with the ALARP Principle. ALARP stands for As Low As Reasonably Practicable and the ALARP Principle is that the residual risk shall be as low as reasonably practicable.
Who is the policy intended for:	All Trust Staff working with ionising radiation
Key Messages included within the policy:	Identification of the legislation governing the use of Ionising Radiation Roles and responsibilities of key personnel in the management of radiation protection issues in terms of safety of staff, public and patients. Introduction and implementation of control measures to restrict exposure to ionising radiation. Roles and responsibilities of personnel holding entitlements to take responsibility for aspects of the medical exposure of individuals. Responsibility of all staff to work in accordance with the control measures and to report any non-compliances

PLEASE NOTE THIS IS ONLY A SUMMARY OF THE POLICY AND SHOULD BE READ IN CONJUNCTION WITH THE FULL POLICY DOCUMENT.

1. INTRODUCTION

1.1 This document establishes a framework for controlling the use of ionising radiation and restricting exposure to persons within all Services provided by the Velindre University NHS Trust.

1.2 The Trust will only adopt those practices that are consistent with the ALARP Principle. ALARP stands for As Low As Reasonably Practicable and the ALARP Principle is that the residual risk shall be as low as reasonably practicable.

1.3 Within the Trust ionising radiation is primarily employed in medical diagnosis and therapy, medical research, quality assurance, the irradiation of blood components and other related applications. These applications are confined to the Velindre Cancer Centre site and the Welsh Blood Service site at Llantrisant.

1.4 The use of ionising radiation within the UK is governed by the following statutory instruments and the Trust is committed to ensuring that the provisions of these regulations, together with the highest standards of best practice in ionising radiation safety, are fully implemented at all times:

- The Ionising Radiations Regulations 2017 (IRR 17)
- The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R17)
- Environmental Permitting Regulations 2016,(as amended 2018 and 2020)
- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 (as amended 2011 and 2019) (CDG2009)

1.5 These regulations are supported by various approved codes of practices (ACoP) and guidance notes published by the enforcing agencies and other organisations (Health and Safety Executive, Department of Health and Social Care, Welsh Government, Natural Resources Wales, Public Health England (formerly Health Protection Agency or NRPB)) and professional bodies (Royal College of Radiologists, Institute of Physics and Engineering in Medicine, College of Radiographers, Society for Radiation Protection etc.).

1.6 The Trust has followed the general guidance on good practice with respect to the radiation protection issues and legislation as detailed in the document “Medical and Dental Guidance Notes” 2002 (MDGN) and subsequent versions published by the Institute of Physics and Engineering in Medicine (IPEM).

1.7 The specific details regarding the implementation of all radiation protection requirements and associated issues are contained within the individual departments’ Local Rules, Employers Procedures (IR(ME)R 17 documents) and other associated documents.

1.8 This Policy must be read in conjunction with other relevant Trust and Division

Policies, including those on Waste Management, Clinical Evaluation, Pregnancy Tests, etc.

2. RESPONSIBILITIES

2.1 The Trust's Chief Executive carries the overall responsibility for implementing the requirements of the regulations governing work involving ionising radiation throughout all Services managed by the Trust.

2.2 To assist in discharging this responsibility the Chief Executive requires all Service Directors and Service Managers, whose services are involved in working with ionising radiation, to assume the general responsibility for ensuring that radiation safety arrangements throughout their Services are representative of best practice and satisfy the requirements of the regulations.

2.3 The Medical Director carries specific responsibilities relating to compliance with ionising radiations legislation as detailed within this Policy.

2.4 To assist the Service Directors and Service Managers in discharging these responsibilities the Chief Executive requires managers, whose departments are associated with work involving ionising radiation, to implement all necessary radiation protection arrangements outlined in this policy and as advised by the Radiation Protection Adviser (RPA), Radioactive Waste Adviser (RWA) and Medical Physics Expert (MPE).

2.5 It is the responsibility of Service Directors, Service Managers and Department Managers to keep themselves aware of radiation protection issues within their Service and consult with the Radiation Protection Supervisors (RPS), the RPA, RWA and the MPE over any issues that have radiation protection implications.

2.6 It is the responsibility of Service Directors, Service Managers and Department Managers where appropriate to ensure that radiation risk assessments are prepared in respect of all work undertaken with ionising radiation. Radiation risk assessments must be updated no less frequently than two-yearly to ensure that they remain relevant to the work undertaken. A radiation risk assessment must be undertaken;

a) in advance of a new practice being introduced,

b) whenever a significant change in the work activity takes place

2.7 It is the responsibility of Service Directors, Service Managers and Department Managers where appropriate to ensure that local rules for radiation protection are drawn up to govern all work with ionising radiation undertaken within the department or area within the department. Local rules for radiation protection must be periodically updated to ensure that they remain relevant to the work undertaken and take into account the findings of relevant radiation risk assessments.

2.8 It is the responsibility of Service Directors and Service Managers to ensure that all managers responsible for operational and estates facilities maintain

an awareness of potential problem areas associated with all work with ionising radiation. This may include drainage systems for departments using unsealed radioactive sources, roof spaces with restricted access above areas where work with ionising radiation is conducted, any known weaknesses in radiation shielding, prevailing security measures, etc.

2.9 All managers responsible for operational and estates facilities must, in consultation with the RPAs, RPSs and Department Managers, formulate systems to facilitate access by contractors, service engineers and other persons, into these problem areas. Such arrangements will involve facilities managers in the production and issuing of “Permits to Work” that detail the conditions under which work may be carried out as specified by the RPAs, the RPSs supervising the work with ionising radiation in the affected area and the department manager.

2.10 It is the responsibility of all Service Directors and Service Managers and managers responsible for departments where the medical exposure of individuals takes place to establish procedures in accordance with the IR(ME)R 17 regulations. These are listed in schedule 2 of the regulations.

2.11 Service Directors and Service Managers are required to ensure that sufficient funds are made available to department managers to implement all relevant radiation protection requirements and risk reduction measures associated with this policy or as advised by the RPA, RWA, RPS and the MPE.

2.12 Service Directors and Service Managers, Department Managers and managers responsible for operational and estates facilities are required to involve the RPA, RWA, RPS and MPE at the earliest opportunity in the planning for refurbishment or site development work, changes to existing services or the development of new services. They are further required, based on risk assessments, to make arrangements for the funding and implementation of all necessary radiation protection requirements as advised by the RPA, RWA and the MPE.

2.13 It is a requirement that all staff, working with ionising radiation, to;

a. exercise reasonable care and follow the provisions of the Local Rules, IR(ME)R 17 Policies and Procedures, Natural Resources Wales Permits and other related working instructions

b. use, as instructed, any protective equipment and personal radiation dose meters provided, to report to the Trust’s Chief Executive via the line manager, and to inform the Radiation Protection Supervisor, of any defects in such equipment and dose meters

c. undertake any training specified by the Service Director, Service Manager or Department Manager.

d. report immediately to the Service Director, Service Manager or Department Manager if an incident occurs in which a member of staff or public is unintentionally exposed to radiation

e. report immediately to the Service Director, Service Manager or Departmental Manager if they suspect that a radioactive source has been damaged, lost or stolen. Further advice on managing the incident should be sought from the Radiation Protection Adviser and Radioactive Waste Adviser.

f. not recklessly endanger the safety of others

g. report to the departmental manager when it is suspected that an "accidental or unintended exposure due either to equipment malfunction or failure of IR(ME)R 17procedures has taken place.

2.14 All medical, radiotherapy, radiology, nuclear medicine, medical physics, clinical trials and nursing staff must pay particular attention to their roles and responsibilities as detailed in the IR(ME)R 17 Policies and Procedure.

2.15 It is a requirement that Velindre University NHS Trust holds the appropriate authorisations to work with ionising radiations. This includes the provisions for prior notification, registration and consent under IRR 17, the issue of permits for the use and disposal of radioactive materials under EPR16 and having an Employer licence to authorise the administration of radioactive medicinal products to patients under IR(ME)R17.

2.16 All medical practitioners who intend to administer radioactive medicinal products for diagnostic investigations or therapy applications must also have an appropriate licence granted under the IR(ME)R 17 by the Administration of Radioactive Substances Advisory Committee (ARSAC) on behalf of the Secretary of State. It is the responsibility of the Medical Director to ensure that all such medical practitioners are appropriately licensed in advance of commencement of a new procedure for the first time and continue to remain licensed.

2.17 It is the responsibility of departmental managers to ensure that periodic reviews are undertaken of individual's compliance with the provisions of local rules for radiation protection made under the IRR 17. Reviews of procedures should also be undertaken no less frequently than annually to identify any necessary amendments. A record should be kept of these reviews.

2.18 Based on risk assessment the departmental managers will make arrangements to prioritise funding, to cover the cost of implementing unforeseen expenditure with respect to radiation safety, patient dosimetry and security issues from changes in the regulations, technological advances in radiation protection, as advised by the RPA, RPS and MPE.

2.19 Failure to follow the provisions of this policy and the local arrangements in place for radiation safety within a department or service may result in disciplinary action.

3. ORGANISATION

3.1 The Chief Executive has established a Radiation Protection and Medical Exposures Strategic Group (RPMESG) and a Radiation Protection and Medical Exposures Operational Group (RPMOSG) to formulate appropriate policies, monitor the level of compliance in the various components of the Trust, identify areas of non-compliance and initiate remedial action, and to keep him/her informed of specific issues that require his attention. The terms of reference and membership of the RPMEOG and RPMESG are linked in Appendix 1.

3.2 The Chairperson of the RPMESG reports directly to the Chief Executive.

4. ADVICE and ASSISTANCE

4.1. Radiation Protection Adviser

4.1.1 In accordance with the requirements of the Ionising Radiation Regulations 17 the Chief Executive will appoint in writing one or more individuals as the Trust's Radiation Protection Adviser (RPA). The appointment requirements and the scope of advice required under IRR 17 are given in Appendix 2.

4.1.2 Suitably experienced individuals who hold certificates issued by a body recognised by the Health and Safety Executive that enable them to act as radiation protection advisers are appointed as the Trust's RPAs.

4.1.3 Apart from fulfilling the function of an RPA as detailed in IRR 17 and the accompanying approved code of practice (ACoP), these individuals are required to be proactive in advising the Chief Executive, and those persons assigned specific tasks, on the general requirements for ionising radiation safety and the specific means of achieving compliance with the requirements of all regulations governing the use of ionising radiation in the UK.

4.1.4 The RPA is required to be proactive in keeping the Chief Executive, Chairperson of the RPMESG, Service Directors and Service Managers, Department Managers, RPSs and MPEs up to date with advances in radiation protection practice, pertinent guidance from professional bodies, Government Organisations and Enforcement Agencies, etc., and proposals to amend existing legislation or introduce new legislation associated with work involving ionising radiation as applicable to the health care environment.

4.1.5 In instances where such changes only affect the working practices within specific departments or across a Service the RPA will advise the Service Directors and Service Managers, department managers, RPSs and MPEs as to the appropriate means of implementing such changes.

4.1.6 In instances where such changes must be implemented on a Trust wide basis the Chairperson of the RPMESG with the RPA will convene a sub group (to include representatives from the services) to scrutinise the changes, formulate an action plan for the production of any new policy or the amendment of existing policies as required, the implementation of the changes into working practices and the production of all necessary documentation associated with the changes. The Chairperson of the RPMESG will be responsible for ensuring that changes in Trust-wide Policy documents (new, replacement or amended) will be developed and approved in accordance with the Trust's Policy for Policies.

4.1.7 The RPAs are ex officio members of the RPMESG and RPMEOG, and normally report to the Chief Executive through the committee structure. In instances where the RPAs believe that immediate action is required to remedy instances of non-compliance or potential noncompliance the RPAs are required to report directly to the Service Directors and Service Manager and if necessary to the Chief Executive.

4.1.8 The RPAs are required to;

a. Respond to requests to advise and assist the Chief Executive and all Service Directors and Service Managers, department managers and staff in performing all duties and tasks associated with radiation protection issues

b. Maintain and make available to all Trust employees a comprehensive library of all relevant radiation protection documents. These will include Statutory Instruments, ACoP, Guidance Notes, advice and guidance provided by the government, its agencies and professional bodies, text books, advice and guidance provided by the European Community, advice and guidance provided by international organisations (International Commission of Radiological Protection), etc.

c. Advise and assist Service Directors and Service Managers, Department Managers and Radiation Protection Supervisors in all safety, security and transport issues (in consultation with a Dangerous Goods Safety Adviser, (DGSA), and a Radioactive Waste Adviser (RWA) where necessary) associated with the delivery, keeping, use and disposal of radioactive materials.

d. Advise and assist Divisional Directors, Department Managers, Clinical Staff and Radiation Protection Supervisors in all relevant patient safety issues.

e. Be involved in the tendering for an approved dosimetry service to provide radiation monitoring facilities in accordance with the requirements of IRR 17.

f. In conjunction with department managers, formulate an effective personal radiation dose monitoring programme for staff working with ionising radiation reflecting the outcome of relevant radiation risk assessments.

g. To assist Departmental Managers in assessing the results of the personal radiation dose monitoring programme and initiating all appropriate action. To interface, on behalf of the Chief Executive, with the approved dosimetry service, on matters relating to dose results and record keeping issues, as required by IRR 17.

h. Ensure that, in instances where individuals may be required to be designated as "Classified Persons" under the requirements of IRR 17, the matter is referred to the head of the department concerned and that the Chairman of the RPMESG is notified.

When designating classified workers the Chief Executive will assign the task of ensuring compliance for the medical surveillance of such employees as required under IRR 17, for classified persons, cases of overexposure, etc., to the Trust Medical Director.

i. Interface on behalf of the Chief Executive with individuals responsible for enforcing or monitoring compliance with legislation governing work with ionising radiation

4.2. Radioactive Waste Adviser

In accordance with the requirements of the Environmental Permitting Regulations 2016 (EPR16) the Chief Executive will appoint in writing one or more individuals as the Trust's Radioactive Waste Adviser (RWA). The appointment requirements and the scope of advice required under IRR 17 are given in Appendix 3.

Suitably experienced individuals who hold certificates issued by a body recognised by the Environmental Agencies that enable them to act as RWAs are appointed as the Trust's RWAs.

The RWAs are required to;

a. Make all necessary arrangements for the permitting of radioactive substances and of radioactive waste for each of the Trusts sites under the requirements of the EPR.

b. Set individual department limits for the holding of radioactive substances on each of the Trusts sites and monitor compliance with each of the sites' EPR permits.

c. Set individual department limits for the accumulation and disposal of radioactive waste from Trust sites, co-ordinate the disposal records from all departments on each of the Trust's sites and monitor overall compliance with each of the sites' EPR permits.

d. Provide advice on and undertake compliance audits with respect to the requirements of the EPR regulations including the management of sealed sources (including High-activity Sealed Radioactive Sources)

e. Liaise with Natural Resources Wales regarding regulatory matters including (but not limited to) pollution inventory and other submissions.

f. Undertake environmental impact assessments regarding the discharges of radioactive wastes within the Trust.

g. Produce a Trust statement of the application of Best Available Techniques (BAT) within the Trust to minimise the radiological impact of radioactive discharges on the environment.

4.3. Radiation Protection Supervisor

4.3.1 The Radiation Protection Service will arrange for departmental managers' nominated Radiation Protection Supervisors to be appointed in writing by the Chief Executive in accordance with the requirements of IRR 17. The suitability of the individual for this role will be assessed by the departmental manager with input from the RPA who will advise on suitable training schemes for the RPS. Managers must draw up a role specification for the RPS that details all of the tasks delegated to him or her by the manager and this can either be issued to the individual or incorporated into the individual's Job Description.

4.3.2 Under IRR 17, the only duty assigned to the RPS is to supervise the work undertaken with ionising radiation to ensure that this is carried out in accordance with the Local Rules. Other tasks, associated with the day to day practical aspects and or management of radiation protection issues, may be assigned to the RPS by the department managers. A template role description for the Radiation Protection Supervisor is included in Appendix 5, including both the supervision duty and other duties which department managers may wish to delegate to them in the context of a broader supervisory role.

4.3.3 Department managers will consult with the RPA over documents (copies of legislation, ACoP, Guidance Notes, etc) to be provided to the RPS to assist in discharging the duties, and as reference documents for all staff working within the department. The manager will ensure that all such documents are purchased and available to the RPS.

4.3.4 All RPSs are automatically members of the RPMEOG.

4.4. Medical Physics Expert

4.4.1 It is a requirement of IR(ME)R 17 that a Medical Physics Expert (MPE) is involved as appropriate in providing expert advice for every medical exposure.

a. There shall be at least one MPE available to be involved in standardised therapeutic nuclear medicine practices and in diagnostic nuclear medicine practices. In non-standard radionuclide therapy the MPE will be closely involved in each procedure.

b. There shall be at least one MPE closely involved in every radiotherapy exposure.

c. In diagnostic radiology, MPEs shall be available to be involved as appropriate for consultation and optimisation and to be involved with high dose interventional radiology and high dose computed tomography.

4.4.2 The MPE must contribute to the matters detailed in appendix 4.

4.4.3 The Head of Radiation Services, with advice from the heads of nuclear medicine, radiation protection and radiotherapy physics, is responsible for advising the Chief Executive on making appropriate and sufficient MPE appointments.

4.4.4 All MPEs appointed on behalf of the Employer must hold certification as MPEs in their specialty by a body recognised by the Department of Health and Social Care that enables them to act in that capacity.

4.5. Qualified Person

4.5.1 The Head of the Radiation Protection Service is responsible for appointing suitably qualified individual(s) to act as the Qualified Person for the purposes of testing radiation protection instruments in accordance with IRR 17.

5. DUTY HOLDERS under IR(ME)R 17

The mechanism for entitlement of operators and practitioners is considered in section 6.2.

5.1 Employer:

In the context of IR(ME)R 17, the employer is considered to be Velindre University NHS Trust. If the Trust contracts a third party to provide services then the Trust will be the employer as regards the operators for the purpose of the Regulations, but the third party is the employer of the operators for employment law purposes.

Equipment ownership has no impact on the employer responsibilities under IR(ME)R 17.

5.2 Operator:

The operator is any person who is entitled, in accordance with departmental

written procedures, to undertake the practical aspects of a medical exposure and is adequately trained. Operators may include radiographers, medical practitioners, clinical scientists/medical physicists, clinical technologist/medical physics technicians and nurses.

5.3 Practitioner:

The practitioner is a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with the Trust's written procedures to take responsibility for an individual medical exposure. The primary responsibility of the practitioner is to justify medical exposures.

In some cases the practitioner may also undertake practical aspects of an exposure and so become an operator with regard to these specific functions.

The practitioner in Nuclear Medicine must hold an ARSAC licence specifying the range of radionuclides and pharmaceuticals that they may prescribe.

Arrangements may be put in place for an individual to authorise justification of the medical exposure on behalf of the practitioner under a Delegated Authorisation Guideline (DAG) drawn up by the practitioner. Under such an arrangement, the individual acts as IR(ME)R 17 operator for this function. This arrangement may also apply to justification of exposures involving radionuclides and pharmaceuticals.

Arrangements must also be put in place for the justification of exposures to carers and comforters.

5.4 Referrer:

The referrer is a registered medical practitioner, dental practitioner or other health professional who is entitled in accordance with departmental written procedures to refer individuals to a practitioner for medical exposure.

6. ARRANGEMENTS FOR COMPLIANCE WITH IR(ME)R 17

6.1 Written Procedures

a. Employer's standard operating procedures, covering the areas specified in schedule 2 of IR(ME)R 17 and specific to individual departments where medical exposures are undertaken, must be formulated and maintained within the work instructions and local policies and procedures of those departments. A listing is maintained by each department summarising, as a minimum, the local versions of the fourteen standard operating procedures specified. Further standard operating procedures may be added as required, but it should be borne in mind that such procedures will then be legally binding upon the organisation and its employees. The MPE must be involved in the formulation and maintenance of these procedures.

b. Clinical protocols for all standard procedures involving medical exposures are maintained within the work instructions of each department and are made available for use by all staff.

c. Where patient referrals under IR(ME)R 17 are made, referral procedures are part of each department's IR(ME)R 17 standard operating procedures and permit the referral of patients for diagnostic radiological/nuclear medicine investigations and therapy applications. Appropriate instruction regarding the referral process must be given to all relevant staff.

d. All new IR(ME)R 17 policies and standard operating procedures must be submitted to the RPMOSG for ratification and formal adoption on behalf of the Trust. Only those documents that have been confirmed as "suitable for purpose" will be ratified.

e. Quality Assurance programmes must be introduced, in consultation with the MPEs, to assess the effectiveness of policies and procedures.

f. All IR(ME)R 17 Policies, Procedures, Inventory, Protocols (Standard Operating Procedures), Diagnostic Reference Levels and all written arrangements concerning IR(ME)R 17 must be reviewed no less frequently than once every two years or whenever there are changes of equipment or working practices.

g. Whenever departments' activities overlap the managers must liaise to ensure compatibility between both departments IR(ME)R 17 Policies and Procedures. Formal written procedures must be established between these departments to detail all agreed arrangements.

6.2 Entitlement of Practitioners and Operators

a. The Medical Director has delegated authority from the Chief Executive to entitle duty holders including Referrers, Operators and Practitioners. The Medical Director further delegates authority to the departmental managers or service leads to entitle duty holders for specific IR(ME)R 17 functions in accordance with the flow chart in appendix 6. Entitlement of RPAs, RWAs, MPEs and Medical Director is by letter from the Chief Executive. Further cascaded entitlement is undertaken according to local procedure.

b. It is the responsibility of departmental managers or service leads to ensure that only individuals formally identified and entitled by the Employer can undertake Practitioner and/or Operator roles.

c. Before any individual is formally entitled to act as Practitioner or Operator, arrangements must be made to assess their experience and to determine what training must be undertaken before entitlement can take place. If an individual is entitled to undertake an IR(ME)R role by another organisation, this does not lead to automatic entitlement by Velindre University NHS Trust to undertake a similar role. Any relevant certification held by an individual (e.g. the holding of a licence issued by ARSAC) may

be taken into consideration in establishing their competence to be entitled to undertake an IR(ME)R role. Systems must be in place to provide new staff with the necessary training and expertise to permit them to act as practitioners or operators.

d. Entitlement should only be undertaken by authorised individuals as per delegation pathways from the Chief Executive and reflect prevailing professional guidance. The entitlement must follow an auditable pathway and documentation kept to show

   i) the date on which entitlement took place

   ii) the task and scope of practice for which entitlement has taken place

   iii) the identity of the person undertaking the entitlement and their delegated authority

   Details of this process are recorded in the procedures of each department. The individual being entitled shall receive formal notification and details of the scope of the entitlement

e. A list will be held by each department of its practitioners and operators, detailing the specific functions for which they are entitled to act. This list forms part of the IR(ME)R documentation and it must be made readily available to all departmental staff. This list must be updated whenever there are changes in personnel.

f. Individual procedures are in place in each department detailing how entitlement of Practitioners and Operators takes place within the framework in Appendix 6.

6.3 Referrers

a. Entitlement of Referrers is via the process described in 6.2.a.

b. It is the responsibility of departmental managers or service leads to ensure that only individuals formally identified and entitled by the Employer can undertake Referrer roles.

c. Individuals entitled to refer patients must be identified and their names recorded on the divisional list. This list forms part of the IR(ME)R 17 documentation and it must be made available to all departments. The list must be updated whenever there are changes in personnel. It is the responsibility of the Director of Cancer Services to ensure that administrative arrangements are in place to enable all those justifying a medical exposure or authorising a medical exposure on behalf of a practitioner to have at their disposal a current list of entitled IR(ME)R 17 referrers.

d. The Employer must establish referral criteria for medical exposures, reflecting prevailing national professional guidance and these are referenced in departmental documentation.

e. Systems must be in place to provide new staff with the necessary training and expertise to permit them to act as referrers. Department managers must ensure that appropriate instruction regarding the referral process must be given to all relevant staff.

f. Medical staff wishing to refer patients for radiological/nuclear medicine investigations must be given instruction on completing request forms and information on referral criteria during their induction. Referrals from General Practitioners for radiological imaging procedures are accepted according to radiology department policies.

g. Policies/procedures are required to enable referrals for diagnostic radiological/nuclear medicine investigations from non-medically qualified registered health care professionals where this is to be undertaken. In all such instances referral guidelines and the scope of referral must be agreed in consultation with the senior radiologist and department manager.

6.4 Practitioners and Operators

a. The IR(ME)R 17 Practitioner and Operator have a legal duty to comply with the procedures established by the Employer.

b. All staff acting as practitioners and operators must be aware of and conversant with the IR(ME)R 17 policies, procedures, protocols and the relevant Standard Operating Procedures. This may also include delegated authorisation guidelines issued by the practitioner.

c. Systems must be introduced to monitor and audit compliance with the IR(ME)R 17 Policies and Procedures and Standard Operating Procedures and the Results of the Audits will be submitted to the RPMEOG for comment and where necessary advice on remedial action.

6.5 Optimisation of Exposure

a. Arrangements must be made, in consultation with the MPE, to implement a dose optimisation strategy for all radiological practices and introduce and monitor Diagnostic Reference Levels (DRL), as required by IR(ME)R 17, for all standard radiological investigations and standard nuclear medicine procedures.

b. Quality Assurance programmes must be introduced, in consultation with the MPEs, to assess the effectiveness of equipment.

c. All IR(ME)R Policies, Procedures, Inventory, Protocols (Standard Operating Procedures), Diagnostic Reference Levels and all written arrangements concerning IR(ME)R 17 must be reviewed annually or whenever there are changes of equipment or working practices.

6.6 Administration of Radioactive Substances to Patients

a. In departments employing sealed and unsealed radioactive sources for diagnostic or therapeutic purposes, cross reference with the Employer licence and practitioner ARSAC licence must be undertaken before new radioactive medical products are introduced into clinical practice. Where the licence(s) does not cover such products the medical practitioner and/or Employer must obtain an endorsement to their licence to cover this new work in accordance with the requirements of IR(ME)R 17.

b. Research ARSAC licence applications are required for clinical trial procedures if they are not covered by existing licences.

c. Arrangements must be in place that medical practitioners are reminded, well in advance of the date of expiry of their licence, of the need to renew their licence issued under the IR(ME)R 17 or certificates under previous legislation. At present, an automatic reminder is generated by the ARSAC secretariat in advance of expiry of current certificates or licences.

7. ARRANGEMENTS FOR COMPLIANCE WITH IRR 17

7.1 Radiation risk assessments must include all reasonably foreseeable fault or accident situations and a consideration of the radiation dose received by relevant individuals under such circumstances. This should include the patient under examination, other patients, staff and public. They will consider the need for and type of personal radiation dosimetry to be undertaken and whether classified radiation worker status is required. An RPA must be consulted in the preparation of any radiation risk assessment.

7.2 The Local Rules are intended to protect staff, the general public and the environment and they will specify general radiation protection requirements and specific requirements identified in IRR 17. The RPMEOG must be kept aware via RPS reports of when local rules are reviewed and the broad extent of any revisions made.

7.3 Systems must be in place to ensure that all new or modified installations that are used in connection with ionising radiation(s) are subject to a critical examination under IRR 17 prior to first use.

7.4 The Local Rules identify potential hazards and provide measures that enable staff to work safely and arrangements must be in place to ensure that all staff working within the department are made aware of all issues detailed in the Local Rules and given training in their implementation and observance.

7.5 The service manager is responsible for ensuring that all staff are adequately supervised. The RPS is responsible for ensuring that the provisions of the local rules for radiation protection are followed. The RPS must report any noncompliance with the Local Rules to the department manager who, in consultation with the RPA, will investigate the reasons for the noncompliance and put in place measures to ensure that such breaches are not repeated. In instances where breaches are identified by the RPA as

serious or in instances where breaches cannot be resolved within the department the department manager will seek a solution by referring the issue to the Service Directors and Service Manager and the chairman of the Radiation Protection and Medical Exposures Operational Group.

7.6 Arrangements must be in place to ensure that Local Rules are reviewed at a frequency advised by the RPA and that radiation risk assessments are reviewed no less frequently than every two years or whenever there are changes to equipment or working practices.

7.7 A handover document must be used when transferring managerial control of a radiation controlled area between parties from within VUNHST and between VUNHST employees and those employed by other parties.

7.8 Systems must be in place to communicate with the employer of any Outside Worker who needs to enter a designated area. Outside Workers are defined as any party not employed by VUNHST who need to enter a radiation controlled or supervised area which has been designated as such by VUNHST in order to provide a service. This communication must include sufficient information to enable the employer to comply with their obligations under IRR 17 and must, in all but exceptional cases, happen before the outside worker is required to enter the designated area.

7.9 Systems must be implemented to ensure that any radiation protection instruments used to demonstrate compliance with IRR 17 are fit for use and are sent for testing before first use, for annual testing, or for testing after repair, to the Qualified Person. Before purchasing any new or replacement instruments the department manager will seek the advice of the RPA and Qualified Person with respect to the selection of the most appropriate instrument.

8. ARRANGEMENTS for RADIOACTIVE SUBSTANCES

8.1 In departments where unsealed radioactive materials are employed (Nuclear Medicine and radioisotope cubicles) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, and disposal of the radioactive materials. Additional instructions will be required with respect to hygiene, the care of patients, monitoring for the presence of radioactive materials and the selection and testing of radiation protection instruments.

8.2 In departments where sealed radioactive sources are employed (Nuclear Medicine, Research, Radiotherapy, Brachytherapy, Welsh Blood Service and RPS Cardiff) detailed instructions must be included in or referenced by the Local Rules regarding the transportation, delivery, storage, security, use, leak testing and ultimate disposal or transfer of the radioactive materials.

8.3 For security reasons suitable procedures must be in place to ensure that all necessary signage and notices do not advertise the details of radioactive materials to the general public.

8.4 The department manager will ensure that detailed records are kept of the purchase, storage, use and disposal of all radioactive materials together with

quantitative records of the disposal of sealed and unsealed radioactive materials. They will make arrangements to return copies of the disposal records to the RWA on a regular basis as determined by the RWA.

8.5 Control measures must be introduced to check at appropriate intervals the presence of all sources on a regular basis or whenever used and to monitor that activities detailed in the EPR 2016 permits and associated department limits are not breached. An annual audit should be undertaken to ensure that this process is taking place. With respect to the disposal of sealed or unsealed radioactive materials, monitoring to prevent breaches will be based on the department limits assigned by the RWA.

9. GENERAL ARRANGEMENTS for RADIATION PROTECTION

9.1 Before any individual is permitted to work with ionising radiation, arrangements must be made to assess the individual's training requirements and implement means of delivering any required training (as identified by the department manager with support from the MPE and RPA if required), monitoring the training programme and assessing the individual's performance.

9.2 Department managers must discuss any new proposed or planned uses of ionising radiation with the RPA and MPE at the planning stage.

9.3 Department Managers must ensure that any member of the department staff who has been allocated duties associated with ionising radiation is given written instructions regarding the role involvement: e.g. formulating and documenting Local Rules, quality assurance activities, IR(ME)R 17 policies and procedures; performing specific duties under the provisions of these documents; or performing other tasks directly related to or loosely associated with the Trust's radiation protection policy or general radiation protection matters. The manager must ensure that all such individuals are given adequate resources and protected time in which to carry out the assigned tasks.

9.4 Systems must be in place to keep all staff aware of their general responsibilities with regard to radiation protection (2.10) and keep all staff aware of the need to report any incident or near misses involving ionising radiation that may have resulted in the uncontrolled release of radioactive materials or the unintended exposure of patients, staff or other persons.

9.5 All incidents, involving unintended exposures of patients or staff, significant spillages of unsealed radioactive materials, theft/loss/damage of radioactive materials, breaches of disposal limits etc., must be investigated by the department manager in consultation with the RPS, the RPA/RWA and relevant MPE where appropriate. The department manager must ensure that a written report is produced following the investigation to detail the circumstances, findings and remedial measures required to reduce the possibility of such incidents occurring in the future. The MPE will be involved for the purposes of estimating doses to patients and the necessity for reporting such incidents to government agencies. The RPA may also need to be involved in to assess the risks associated with the incident and to provide any further advice. The following examples are not exhaustive;

- Incidents of significant accidental or unintended exposure (SAUE) of patients, whether due to breakdown in procedures or equipment fault,,are reportable under IR(ME)R 17 to the Healthcare Inspectorate Wales (HIW). It should be noted that such incidents may also be regarded as clinically significant (CSAUE), as defined by relevant professional guidance.

- Incidents involving over-exposure of staff or public are reportable under IRR 17 to HSE.

- Incidents involving radioactive materials are reportable to Natural Resources Wales under the Environmental Permitting Regulations 2016 and the Health and Safety Executive under IRR 17.

- Loss or theft of radioactive materials must also be reported to the police.

All such incidents must be reported following the Trusts normal incident reporting procedure.

9.6 The Divisional Directors shall ensure that adequate arrangements are in place for reporting radiation incidents, obtaining advice from Radiation Protection Advisers and Medical Physics Experts, and making external reports to enforcing agencies.

9.7 Disposal of radiological equipment shall be undertaken with advice from the Specialist Estates Services branch of NHS Wales Shared Services Partnership (NWSSP).

Appendix 1 – Radiation Protection and Medical Exposures Strategic Group (RPMESG) and Radiation Protection and Medical Exposures Operational Group (RPMOSG)

The Terms of Reference are available via the following Link:

{Update links to terms of reference for RPMESG and RPMEOG here}

Appendix 2

RPA appointment requirements and Scope of Advice

RPA Appointment

Under the requirements of the Ionising Radiation Regulations 2017 (IRR 17) radiation employers are required to appoint and consult with a Radiation Protection Adviser (RPA). The Health and Safety Executive requires that the individuals wishing to act as an RPA must demonstrate that they meet the HSE's criteria of competence and that employers select from such RPAs one or more who have suitable knowledge and experience for the employers type of work [Regulation 14 and Paragraphs 257 to 270 of the Approved Code of Practice (ACOP)].

If more than one RPA is appointed, duties will be shared between them The scope of the advice that will be provided by these individuals will include the items for statutory consultation listed in IRR 17, Schedule 4 and the issues listed in the draft Approved Code of Practice, paragraph 263 as detailed below.

Scope of Advice.

In general the RPA will be required to advise on the measures to be taken to comply with IRR 17, together with other relevant legislation on use of ionising radiation. The scope of the advice required will include:

IRR 17, Schedule 4 RPA must be consulted on the following:-

1. Implementation of requirements as to controlled and supervised areas.

2. The prior examination of plans for installations and the acceptance into service of new or modified sources of ionising radiation in relation to any engineering controls, design features, safety features and warning devices provided to restrict exposure to ionising radiation.

3. The regular calibration of equipment provided for monitoring levels of ionising radiation and the regular checking that such equipment is serviceable and correctly used.

4. The periodic examination and testing of engineering controls, design features, safety features and warning devices and regular checking of systems of work provided to restrict exposure to ionising radiation.

Approved Code of Practice (ACOP), Paragraph 263

The advice of the RPA should cover, where relevant, but not limited to, the following:

(a) Optimisation and establishment of appropriate dose constraints;

(b) Plans for new installations and the acceptance into service of new or modified radiation sources in relation to any engineering controls, design features, safety features and warning devices relevant to radiation protection;

(c) Categorisation of controlled and supervised areas;

(d) Classification of workers;

(e) Outside workers;

(f) PPE;

(g) Workplace and individual; monitoring programmes for exposed workers;

(h) Investigation and analysis of accidents and incidents and appropriate remedial actions;

(i) Employment conditions for pregnant and breastfeeding workers;

(j) Preparation of appropriate documentation such as prior risk assessments and written procedures.

In addition to the specific matters set out in Schedule 4, radiation employers are required to consult a Radiation Protection Adviser where advice is necessary for the observance of the Regulations.

Additional guidance on these matters is given in ACOP paragraphs 257 to 270.

Appendix 3

Radioactive Waste Adviser

The Basic Safety Standards Directive (BSSD)[1] requires employers to appoint 'qualified experts' to advise them about work with radioactivity that may affect people and the environment. Parts of the BSSD place specific requirements on permit holders and require qualified experts to be involved in the discharge of specific duties. The BSSD also requires that arrangements are in place to recognise the capacity of such qualified experts.

The UK environment agencies have issued a joint statement on radioactive waste advisers[2] which includes requirements in terms of appointment of individuals in this capacity and arrangements for their accreditation.

Recognition of Radioactive Waste Adviser

To be recognised formally in this capacity, an individual must be able to demonstrate that they are competent in radioactive waste management and environmental radiation protection. A syllabus has been developed detailing the competences required of a radioactive waste adviser. An approvals board established by the UK environment agencies is charged with assessing the competence of radioactive waste advisers and of maintaining a register.

The environment agencies consider a suitable Radioactive Waste Adviser (or Corporate Radioactive Waste Adviser) to have "the specific knowledge, experience and competence required for giving advice on the particular radioactive waste management and environmental radiation protection issues for which the permit holder is making the appointment".

Appointment of Radioactive Waste Adviser

A permit holder (Employer) must appoint suitable Radioactive Waste Advisers if the permit is for the accumulation or disposal of radioactive waste. The permit holder is responsible for ensuring that any Radioactive Waste Adviser appointed is "suitable" to give relevant advice on the permit holder's business. This appointment must be in writing and should include the scope of advice which the Radioactive Waste Adviser is required to give.

The permit holder is required to consult a Radioactive Waste Adviser on the following matters and will have due regard to the advice provided by the Radioactive Waste Adviser:

- Achieving and maintaining an optimal level of protection of the environment and the population

- Checking the effectiveness of technical devices for protecting the environment and the population

- Acceptance into service, from the point of view of surveillance of radiation protection, or equipment and procedures for measuring and assessing, as appropriate, exposure and radioactive contamination of the environment and the population

- Regular calibration of measuring instruments and regular checking that they are serviceable and correctly used.

Staff of the Radiation Protection Service holding accreditation act as Radioactive Waste Adviser and are formally appointed by the permit holder (Employer).

1. Council Directive 96/29/EURATOM 1996 (laying down basic safety standards for the protection of the health of workers and the general public against the dangers arising from ionising radiation).

2. Environment Agencies' Statement on Radioactive Waste Advisers, RWA-S-01 v 1.0 7 May 2011

Appendix 4

Medical Physics Expert

A medical physics expert must contribute to the following matters:

(a) Optimisation of the radiation protection of patients and other individuals subject to exposures, including the application and use of diagnostic reference levels.

(b) The definition and performance of quality assurance of the equipment

(c) Acceptance testing of equipment

(d) The preparation of technical specifications for equipment and installation design

(e) The surveillance of the medical radiological installations

(f) The analysis of events involving or potentially involving accidental or unintended exposures

(g) The selection of equipment required to perform radiation protection measurements

(h) The training of practitioner and other staff in relevant aspects of radiation protection

(i) The provision of advice to an employer relating to compliance with these regulations.

Appendix 5

Radiation Protection Supervisor role specification

Base Location

Department

Accountable to

Reports to

Liaises with Radiation Protection Adviser

Job Summary: The Radiation Protection Supervisor (RPS) will play a supervisory role in assisting the Trust to comply with the requirements of the Ionising Radiation Regulations 2017 (IRR 17). The RPS will be directly involved in the work with ionising radiation and will exercise close supervision to ensure that the work is done in accordance with Local Rules.

The only responsibility of the Radiation Protection Supervisor specified under IRR 17 is to supervise the work with ionising radiations. Overall responsibility for radiation protection matters lies with the departmental manager. However, additional duties may be delegated to the RPS as detailed below.

MAIN DUTIES AND RESPONSIBILITIES

1. Restriction of Exposure

To observe, from time to time, all procedures involving ionising radiation and to and to keep a record of this process for audit purposes. To issue instructions necessary to maintain radiation doses as low as reasonably practicable.

2. Notification of work and certain occurrences

To notify, in writing, the responsible manager:

(i) of any proposed changes in, or additions to, work activity

(ii) immediately of any damage to a radioactive source, spillage, loss or suspected loss of radioactive substances.

(iii) of any change of equipment, usage or conditions, which might affect radiological safety; of any monitoring instrument used to demonstrate compliance with the Regulations which has not been calibrated to acceptable national standards.

(iv) immediately of any incident involving equipment malfunction resulting in patient exposure much greater than intended or significantly lower than

those considered proportionate (in radiotherapy).

(v) immediately of any incident or suspected incident involving staff exposure much greater than intended.

3. Local Rules and Systems of Work

(i) To assist in the writing of Local Rules and Systems of Work and to ensure that these are adhered to.

4. Information, Instruction and Training

(i) To attend courses and receive training as recommended by the RPA.

(ii) To promulgate local Rules and Systems of Work to ensure that necessary safety information and guidance is given to all staff, outside contractors and any other persons who enter controlled or supervised radiation areas.

5. Additional Duties

(i) Dependent on the work carried out in the Department the responsible manager may delegate to the RPS specific tasks to comply with IRR 17 These requirements must be listed and attached to both this Role Specification and to the Local Rules.

(ii) The RPS must provide a six-monthly report to the Radiation Protection and Medical Exposures Operational Group.

NOTE:

The duties and responsibilities outlined in this role specification should be read in conjunction with the following where relevant to the work undertaken:

(a) The Ionising Radiations Regulations 2017

(b) Working with ionising radiation-draft Approved Code of Practice and Guidance 2017

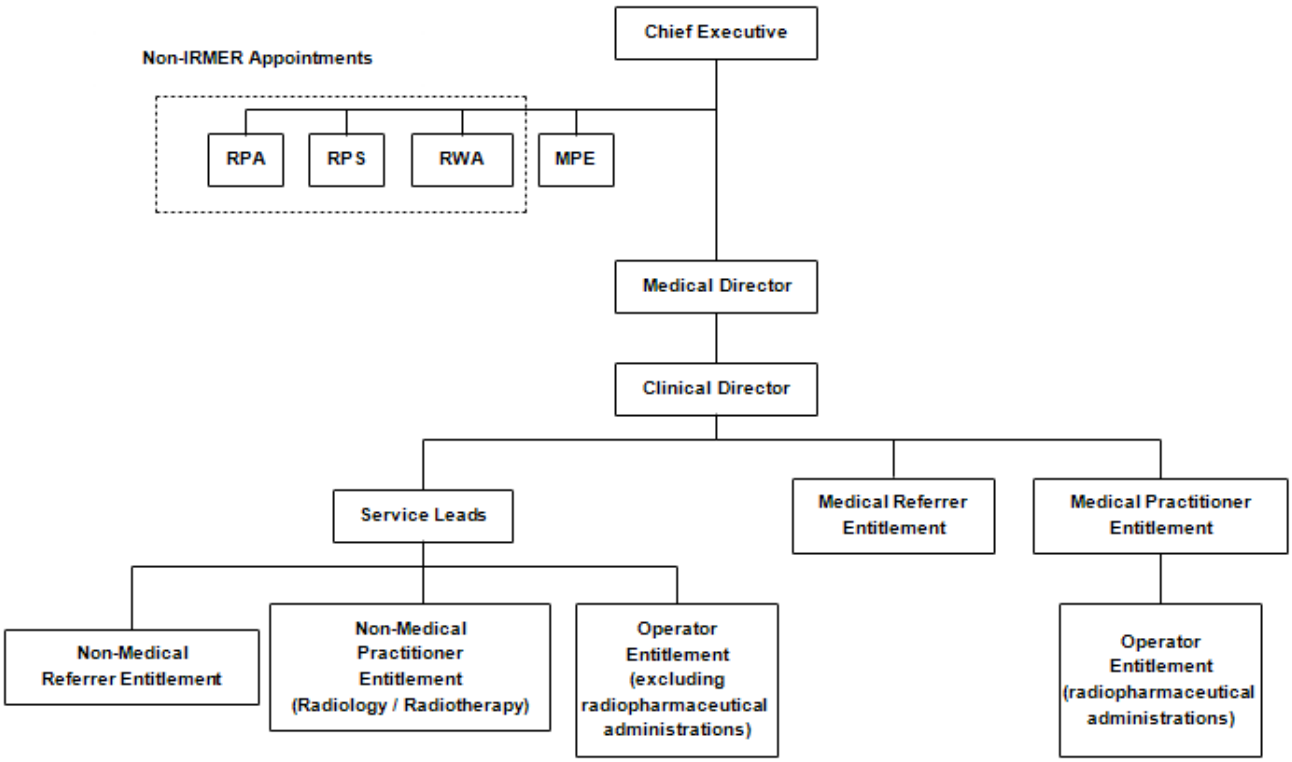
(c) The Ionising Radiation (Medical Exposure) Regulations 2017

(d) The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009 Amended 2011

(e) The Environmental Permitting Regulations 2016 and subsequent versions.

Appendix 6

IR(ME)R 17 Entitlement Responsibilities



TRUST BOARD

TRUST SEAL REPORT: SEPTEMBER 2022 – MARCH 2023

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
TCS	Transforming Cancer Services
nVCC	New Velindre Cancer Centre
NWSSP	NHS Wales Shared Services Partnership

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 **September 2022 to March 2023**).

1.2 Board members are asked to view the contents of the report and further information or queries should be directed to the Director of Corporate Governance and Chief of Staff.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal/Analysis: Please refer to the Seal Register at Appendix 1.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the contents of the Trust Board Seal Register included in Appendix 1.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 1 – Seal Register

Date	Document Details	Signed
29 September 2022	Mutual Investment Model – Design, Build, Finance and Maintenance of the New Velindre Cancer Centre, Whitchurch, Cardiff ("Project") – Successful Participant Appointment Letter ("Letter")	Prof. Donna Mead OBE, Chair Mr. Steve Ham, Chief Executive
29 September 2022	The County Council of the City and County of Cardiff and Velindre University NHS Trust and Cardiff and Vale University Local Health Board Agreement for the Execution of Highway Works at Velindre Cancer Centre, Park Road, Whitchurch in the City of Cardiff Pursuant to Section 278 and Section 38 of the Highway Act 1980	Prof. Donna Mead OBE, Chair Mr. Steve Ham, Chief Executive
14 October 2022	Land at Whitchurch Hospital, Cardiff Habitat License Cardiff and Vale Local Health Board and Velindre University NHS Trust	Prof. Donna Mead OBE, Chair Mr. Carl James, Acting Chief Executive
24 November 2022	Agreement Relating to Provision of an Integrated Radiotherapy Solution and Associated Services	Prof. Donna Mead OBE, Chair Mr. Carl James, Acting Chief Executive
19 January 2023	Supplemental Agreement relating to an Access License dated 27 April 2021 relating to use of a Haul Road on land at Whitchurch Hospital, Cardiff	Prof. Donna Mead OBE, Chair Mr. Steve Ham, Chief Executive

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	30th March 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Hilary Jones, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
WG	Welsh Government
nVCC	New Velindre Cancer Centre
FBC	Full Business Case

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 26th January 2023.

1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Trust Board.
ADVISE	**New Velindre Cancer Centre Full Business Case - Strategic Case** The nVCC FBC – Strategic Case was presented. It was noted that the Commercial Case was not currently available due to ongoing negotiations around key commercial aspects of the project. The Sub-Committee noted that Welsh Government have been informed of the four cases moving through the Trust's internal governance process and a meeting to commence scrutiny with WG colleagues is scheduled to take place next week. Noted that this process is estimated to take approximately 8-10 weeks. The all-electric design was queried and clarity on backup arrangements in the event of disruption to the electricity supply was sought. The Sub-Committee were advised that twin feeds would supply the site, with an additional backup of biofuel/oil providing sufficient cover. The Sub-Committee **endorsed** the New Velindre Cancer Centre Full Business Case – Strategic Case for Trust Board approval and agreed the recommendations.
ASSURE	There were no items identified to assure the Trust Board.
INFORM	There were no items identified to inform the Trust Board.
APPENDICES	None.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	30th March 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Gareth Jones, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
EqIA	Equality Impact Assessment
IRS	Integrated Radiotherapy Solution

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee held on 7th February 2023.

1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Trust Board.
ADVISE	There were no items identified for alert/escalation to the Trust Board.
ASSURE	There were no items identified to assure the Trust Board.
INFORM	**Integrated Medium Term Plan 2023-2026** The Committee noted the Integrated Medium Term Plan update.
APPENDICES	None.

TRUST BOARD

AUDIT COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30/03/2023
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, Audit Committee 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 12 January 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 12 January 2023:

ALERT / ESCALATE	There was nothing to be escalated.
ADVISE	**GOVERNANCE OF THE TRACKER** **Audit Action Tracker Review of Recommendations from Internal & External - Overdue and Completed Recommendations** • Discussed the seven levels of assurance, will to be applied to the Audit Action Tracker in future versions once a pathway has been agreed for moving and implementing these. • Acknowledged that two new Internal Audit reports have been added since October Committee, with 11 recommendation and 14 actions. **AUDIT POSITION UPDATE** Audit Wales highlighted to the AUDIT Committee: • It is expected that the 21/22 Charitable Funds Financial Statement will be audited by the end of January 2023. • Draft Structured Assessment Report for 2022 issued to the Trust for clearance. Audit Wales in discussions regarding timescales for finalising the report and presenting it to Board. • Commenced Workforce Planning Review at the Trust. Hoping to report on that work in April or May 2023. • Undertaking some additional planning work to identify a suitable topic for local review. The option will be explored to include this in the 2023 Audit Plan to undertake a larger piece of local work. **PRIVATE PATIENT SERVICE REVIEW** • Quality Safety and Performance is the lead in terms of oversight of the whole Action Improvement Plan. Audit Committee has been given responsibility by the Trust Board for the finance and commercial aspects. • The Committee noted the commencement of Liaison Financial Services external expert support for the areas identified in the improvement plan.
ASSURE	**TRUST RISK REGISTER** • Further work completed on Velindre Cancer Centre risks. Ongoing discussions around the use of emails by the Medical Directorate around patient information. Information Governance are aware. • Welsh Blood Service risks – Presentation at November 2022 Trust Board around some of the changes to the systems; the WHAIS (Welsh Histocompatibility & Immunogenetics Service). • The Committee endorsed the revised Risk Appetite levels, following initial discussions at the Board Development session on 8th November 2022, for Trust Board approval at today's meeting. • The Committee agreed to review the format of Trust Risk Register template offline before the next Committee reporting cycle. **TRUST ASSURANCE FRAMEWORK** • The Committee noted the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework.

	• Like with the Risk Register, it was agreed to consider the format of the template offline before the next Committee reporting cycle. **BUILDING OUR FUTURE TOGETHER - GOVERNANCE ASSURANCE & RISK PROGRAMME OF WORK** • The Committee noted the ongoing reporting of the 11 workstreams as part of the organisational development programme will take place through Strategic Development Committee into Trust Board. • The Committee discussed the programmes of work and deliverables of the Governance, Assurance and Risk Programmes of Work and agreed to include an update at each Audit Committee on progress.

INFORM	**INTERNAL AUDIT REPORTS**
	The Committee received the following internal audit reports:
	• Managing Attendance at Work
	• Patient & Donor Experience
	• Digital Health & Care Record – Implementation
	• Decarbonisation (Advisory)
	• Performance Management Framework
	• New Velindre Cancer Centre Contract Management Report – **Limited Assurance Report** . One matter arising, with three high rated recommendations.
	
	OTHER BUSINESS:
	The Committee also received written or verbal reports under the following agenda items:
	• 2022/23 Internal Audit Progress Update Report
	• Review of VUNHST Quality Governance Arrangements and Management Response
	• Equality Impact Assessments: more than a tick box exercise? and Management Response
	• The National Fraud Initiative in Wales 2020-21
	• Counter Fraud Progress Report Quarter 3
	• Procurement Compliance Report
	• Private Patient Service Debt Position
	• Receipt of Financial Technical Updates
	• Losses and Special Payments Report
	• Legislative and Regulatory Compliance Register
	• Production of Audit Committee Annual Report
	• Review of Audit Committee Terms of Reference
	• Velindre Counter Fraud Policy
	• Amendment to Standing Orders – Schedule 3
	• All Wales Audit Committee Chairs AWACC Meeting Highlight Report
	• Chairs Urgent Action Report:
	  ○ Audit Action Tracker Requested Extension Date
	  ○ Change to the 2022/23 Internal Audit Plan

APPENDICES	**NONE**

3. RECOMMENDATION

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

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE PRIVATE REMUNERATION COMMITTEE

DATE OF MEETING	30/03/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carol Meredith, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Private Remuneration Committee on 9th February 2023.

1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There are no areas to alert/escalate to the Trust Board.
ADVISE	There are no areas to advise the Trust Board
ASSURE	There are no areas to Assure the Trust Board
INFORM	**Settlement Agreement** A proposed Settlement Agreement was **APPROVED** by the Committee.
APPENDICES	N/A

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	30.03.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Carol Meredith, Business Support Officer
PRESENTED BY	Sarah Morley, Executive Director of OD and Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	
LPF	Local Partnership Forum
SLT	Senior Leadership Team
VCC	Velindre Cancer Centre
OCP	Organisational Change Policy
WBS	Welsh Blood Service
RCN	Royal Collage of Nursing

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 7th March 2023.

1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to alert/escalate.
ADVISE	Nothing to advise.
ASSURE	Nothing to assure.
INFORM	**Workforce Performance Report** The Local Partnership Forum received an update on the details highlighted by the Workforce Performance Report. **Industrial Action Update** The Local Partnership Forum received an update on the Industrial Action with no future dates planned yet for strike action due to ongoing discussions with Welsh Government. Communications to staff are on-going and there is an Industrial Action SharePoint page which is updated regularly and has received over 2500 views from staff. **Cost of Living – Partnership with Wales Union Learning Fund** The Local Partnership Forum was updated on the Wales Union Learning Fund and the events on cost of living and support for staff working from home. Workshops will be arranged for staff to take full advantage of the support available. **Healthy and Engaged Steering Group Update** The Local Partnership Forum received an update on the newly appointed Clinical Psychologist who will be supporting staff with Mental and Emotional Wellbeing. There is a Mental Health First Aider network in development, membership and training is being looked at to ensure safe and healthy operation. Menopause Buddies are working alongside Mental Health First Aiders with educational events taking place. Discussions ongoing in and outside the trust on a joint approach.

	The Anti-Racism action plan is now agreed by the Trust and will set out a programme of work for this and next year. The Trust has been accredited with Disability Confident Level 2 with focus now on gaining Level 3. In January the Trust was re-accredited with the Gold Standard of Corporate Health Standards. **Diversity Forums** A request was made for interested parties that wanted to be involved in the Diversity Forums . **Hybrid Working Project Update** The Local Partnership Forum were advised the Hybrid Working Principles were launched in the summer of 2022. Many engagement sessions had taken place across all areas of the Trust. The principles apply to all staff. A Toolkit is live on SharePoint to support staff and managers understand Hybrid Working. Policies on Flexible Working and Home Working are being updated to support Hybrid Working. **Anti-Racist Action Plan** The Local Partnership Forum were advised one action from the Anti-Racist Action Plan was to review all of the All Wales workforce policies and that Contract was awarded to Diverse Cymru which is being led by the NHS Employers through Shared Services. **Collection Teams** The Local Partnership Forum were updated on collections teams' organisational change and the recruitment and retention premise.
APPENDICES	N/A

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 14 MARCH 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 14 March 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 at:
2022/2023 Meeting Papers - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings
The minutes of the meetings held on 10 January 2023, 17 January 2023, and 13 February 2023 were **approved** as a true and accurate record of the meeting, subject to one minor amendment.

2. Action log & matters arising
Members **noted** the progress on the actions outlined on the action log.

3. Governance System and Process – WHSSC & HB Shared Pathway Saving Target
Members received a presentation on the outline governance system and process for the Joint Committee to monitor achievement of the 1% WHSSC and HB shared pathway savings target, which had been requested following the Joint Committee approving the Integrated Commissioning Plan (ICP) 2023-2024 on 13 February 2023.

Members noted that WHSSC had applied a programme management approach to establishing a mechanism to monitor savings and efficiencies and had developed a Project Initiation Document (PID) outlining that a Programme Board be established comprising of representatives from each Health Board (HB). The PID had been shared with the Management Group in readiness for detailed discussion on the 23 March 2023.

Members noted that updates on progress would be provided as a standing item on the agenda for future Joint Committee meetings.

Members **noted** the presentation.

4. Chair's Report

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

- The Chair's Action taken on 2 February 2023 to approve urgent patient expenditure for Advanced Medicinal Therapeutic Products (AMTPs) through the Blueteq High Cost Drugs (HCD) software programme,
- The request to extend the interim Chair of the Individual Patient Funding Request (IPFR) Panel from 31 March 2023 to 30 September 2023,
- That the Minister for Health & Social Services had approved a review of the national commissioning functions, linked to the commitment within a "Healthier Wales" on a set of actions to strengthen and streamline the NHS landscape in Wales. Members noted that the joint workshop between EASC and WHSSC planned for 14 March 2023 to enable a facilitated discussion on the review had been postponed as the independent facilitator had been taken ill; and
- Key meetings attended.

Members (1) **Noted** the report, (2) **Ratified** the Chairs action taken on 2 February 2023 to approve expenditure for Advanced Medicinal Therapeutic Products (AMTPs) through the Blueteq High Cost Drugs (HCD) software programme; and (3) **Approved** the recommendation to extend the tenure of the interim Chair of the Individual Patient Funding Request Panel (IPFR) to 30 September 2023 to ensure business continuity.

5. Managing Director's Report

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

- **Plastic Surgery Outreach Clinics in BCUHB: Update on Quality Concerns** - During the plastic surgery workshop held with the Management Group on 22 September 2022 to consider the future commissioning model for plastic surgery, significant quality concerns were raised by the clinical leads from St Helen's & Knowsley NHS Trust (SHKNT). Since then further concerns were raised during an SLA meeting in February 2023, WHSSC has discussed the issues with colleagues in Welsh Government (WG), and it was agreed that, given the issues did not lie directly within the WHSSC commissioning responsibility, WG will lead on the escalation process but in liaison with WHSSC. In addition, a Harm Review has been commissioned by BCUHB and the Terms of Reference (ToR) are in the process of being signed off through internal HB processes,
- **Cochlear Implant and Bone Conduction Hearing Implant Hearing Device Service – Engagement Process Update -** the formal engagement ran between 4 January 2023 and 14 February 2023. The consultation feedback is now being analysed and will be presented to members at the Joint Committee meeting on 16 May 2023; and

- **Spinal Operational Delivery Network (ODN)** - The implementation of the Spinal Operational Delivery Network (ODN) has been delayed due to unforeseen circumstances. A more detailed update will be presented to the Joint Committee meeting on 16 May 2023.

Members **noted** the report.

6. Delivering Thrombectomy Capacity in South Wales
Members received a report outlining WHSSC's position on the commissioning of Mechanical Thrombectomy for the population of Wales.

Members (1) **Noted** the report, (2) **Noted** the WHSSC Position Statement on the Commissioning of Mechanical Thrombectomy, (3) **Noted** the associated risks with the current delivery model for Welsh stroke patients requiring access to tertiary Thrombectomy centres; and (4) **Noted** the NHS Wales Health Collaborative (NWHC) proposal to strengthen and improve regional clinical stroke pathways in Wales to support the Mechanical Thrombectomy pathway to ensure that patients receive this time-critical procedure in a timely manner.

7. Eating Disorder In-Patient Provision for Adults
Members received a report outlining the medium-term options for adult inpatient eating disorder placements following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) and the current interim arrangements.

Members (1) **Noted** the information presented within the report to progress tendering and procurement options with the independent sector in line with service need for Welsh patients requiring specialist eating disorder services, (2) **Noted** the medium-term options for adult inpatient eating disorder placements following the end of the contract for eating disorder services between WHSSC and Oxford Health NHS Trust (OHNT) and the current interim arrangements; and (3) **Received assurance** that there are robust processes in place to ensure delivery of eating disorder services for adults.

In addition, it was agreed to bring the tender specification back to a future meeting to provide assurance to the JC regarding the quality requirements of the new service.

8. Neonatal Transport ODN – Additional Funding Release
Members received a report advising that the Management Group approved the release of £125k for the establishment of the Neonatal Transport Operational Delivery Network (ODN) for Swansea Bay UHB as the host provider in December 2022, and which sought approval from the Joint Committee for an additional £54k of funding to bridge the shortfall from the original funding request from SBUHB and to allow the implementation of the ODN to proceed.

Members (1) **Noted** the report; and (2) **Approved** the release of an additional £54k funding for the Neonatal Transport ODN to allow the implementation of the Operational Delivery Network (ODN) to proceed.

9. Neonatal Cot Configuration Project

Members received a report outlining the outcomes of the Neonatal Cot Configuration project, the proposed preferred option as recommended by the Project Board and seeking approval for the required long-term next steps.

Members discussed the need for broader discussion linked to interdependencies with maternity services and other core paediatric services, in developing the next steps. The challenges associated with meeting the British Association of Perinatal Medicine (BAPM) standards and the historic work previously undertaken through the South Wales plan were also discussed.

Members (1) **Noted** the background within the report, (2) **Noted** the outcomes of the Neonatal Cot Configuration Project, (3) **Noted** the financial assessment, (4) **Noted** the preferred option of the Project Board, (5) **Approved** the recommended preferred option and the release of funding in line with the provision within the 2022/25 Integrated Commissioning Plan (ICP) as an interim measure; and (6) **Did not Approve** the recommendation of the Management Group for a phase 2 programme of works to be undertaken, but agreed that the NHS Wales Directors of Planning Group consider the approach to reviewing the neonatal service model, aligning with Health Boards' strategic plans, regional work, and key service interdependencies. The output of the discussion to be brought back to the Joint Committee in May.

10. IPFR Engagement Update – ToR and All Wales Policy

Members received a report presenting the outcomes from the WHSSC engagement process with key stakeholders to update the WHSSC Individual Patient Funding Request (IPFR) Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy.

Members (1) **Noted** the report, (2) **Noted** the feedback received from the WHSSC engagement process with key stakeholders to update the WHSSC Individual Patient Funding Request (IPFR) Panel Terms of Reference (ToR) and on the specific and limited review of the All Wales IPFR Policy, (3) **Approved** the proposed changes to the WHSSC IPFR Panel ToR, (4) **Noted** that the additional feedback on the specific and limited review of the All Wales IPFR Policy is being reviewed and an update will be presented to the Joint Committee on 16 May 2023; and
(5) Noted that when the limited review of the policy was completed and approved by the Joint Committee, the updated All Wales IPFR Policy (including the WHSSC ToR) will go to each Health Board (HB) for final approval.

11. WHSSC Governance & Accountability Framework – SOs and SFIs

Members received a report providing an update on the WHSSC Governance and Accountability Framework.

Members (1) **Noted** the report, (2) **Approved** the proposed changes to the Standing Orders (SOs), prior to being issued to the seven HBs for approval and inclusion as schedule 4.1 within their respective HB SOs, **(3) Approved** the proposed changes of the Memorandum of Agreement (MoA) and Hosting Agreement in place with CTMUHB, prior to being issued to the seven HBs for approval and inclusion as schedule 4.1 within their respective HB SOs; and (4) **Approved** the proposed changes to the financial scheme of delegation and financial authorisation matrix updating the Standing Financial Instructions (SFIs).

12. Performance & Activity Report Month 9 2022-2023

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period, and outlining signs of recovery in specialised services activity. The activity decreases were shown in the context of the potential risk regarding patient harms and of the loss of value from nationally agreed financial block contract arrangements

Members **noted** the report.

13. Financial Performance Report – Month 10 2022-2023

Members received the financial performance report setting out the financial position for WHSSC for month 10 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The financial position reported at Month 10 for WHSSC is a year-end outturn forecast under spend of (£14.353m). Members noted that the under spend predominantly relates to releasable reserves of (£18m) arising from 2021-2022 as a result of WHSSC assisting Health Boards manage resources over financial years on a planned basis, as HBs could not absorb underspends above their own forecasts and to ensure the most effective use of system resources.

Members **noted** the current financial position and forecast year-end position.

14. Neonatal Delivery Assurance Group (DAG) Update
Members received a report providing a summary of South Wales Neonatal Transport Delivery Assurance Group (DAG) Report for July-November 2022.

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

15. 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.

16. 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).

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	19 January 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 attendance at recent meetings, both within NWSSP and externally. The Chair also summarised the content, outcome and next steps for the development day held with the Committee in November. This had been very successful and further development sessions would be held during 2023/24.

The Committee **NOTED** the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- Technology has been successfully implemented to allow pre-employment checks to be undertaken virtually for all UK and Irish passport holders. A reduction in time to hire has been noted since its implementation, however the level of recruitment activity continues to be a challenge across Wales;
- Following a recent national Penicillin V shortage, CIVAS@IP5 medicines unit utilised its national portfolio and MHRA wholesale dealer licence to procure significant quantities of Penicillin direct from the manufacturer to meet Health Board demands;
- From the 1st April 2023 management of all emergency planning/medicines storage of Welsh Government owned stock will transfer to NWSSP;
- From the 1st April 2023 the Low Vision Service Wales will transfer to NWSSP;
- Work is continuing to progress on the establishment of the Citizen Voice Body. A number of back-office support services will be provided via NWSSP to the new body going forward;
- Securing capital funding for the Laundry Services Modernisation Programme

continues to be an issue, NWSSP are currently considering alternative options to progress the work needed to meet the minimum standards and laundry rationalisation; and
- Neil Davies is retiring as Director of Specialist Estates Services; his deputy Stuart Douglas has been appointed and will commence in post in February.

The Committee **NOTED** the update.

Items Requiring SSPC Approval/Endorsement

IMTP 2023-26

The NWSSP IMTP and the Divisional plans reflect priorities identified by Welsh Government, NHS Wales organisations and professional peer groups. In line with the direction from the Minister for Health and Social Care, there is a focus on a smaller number of priorities for 2023-24. The IMTP and the Divisional plans reflect priorities identified by the Welsh Government where we are playing a lead national role; our customers, to support delivery of their local plans; and professional peer groups such as Directors of Workforce and Finance, as follows:

- Decarbonisation and Climate Change;
- Digital Strategy;
- Financial sustainability and good governance; and
- Employee Wellbeing.

While it is a balanced financial plan, there are a number of income assumptions and significant financial risks that need to be managed to achieve this aim.

Committee members commented favourably on both the format and the content of the plan and time timeliness in which it had been produced.

The Committee **APPROVED** the IMTP for submission to Welsh Government.

Digital Strategy

The Chief Digital Office presented the Digital Strategy setting the direction for the future provision of digital services, the approach and methodology and the desired outcomes.

The Committee **APPROVED** the Strategy.

Building Construction Frameworks

The Head of Building for Wales in Specialist Estate Services presented a paper to obtain approval for the development of the NHS Building for Wales construction frameworks which are required to be operational by the end of April 2024 when the current arrangements cease and will support expenditure of circa £1 billion during their duration.

The Committee **APPROVED** the development of the Framework and the placing of the tender notices.

Risk Appetite Statement

The overall risk appetite statement was reviewed in detail at the SSPC Development Day in November, and prior to that by the Senior Leadership Group. The outcome of these reviews was for NWSSP to be bolder in its appetite to risk and this is reflected in the revised Statement.

The Committee **APPROVED** the Statement.

Finance, Performance, People, Programme and Governance Updates

Finance –The distribution to NHS Wales has been increased to £2m and the year-end forecast outturn remains at break-even with the assumption of full funding of exceptional energy pressures and Covid costs from Welsh Government. The forecast outturn for the Welsh Risk Pool remains on track with the budget.

Performance – The in-month (November) performance was generally good with 34 out of 38 KPIs achieving target. Action is being taken to address the four amber indicators.

Project Management Office Update – The Legal & Risk Case Management System and the Laundry Transformation Projects are both currently red-rated and are also included as red risks on the Corporate Risk Register. All other projects are on track.

People & OD Update – Sickness absence rates remain very low, and there has been an increase in Statutory and Mandatory Training compliance to 91%. PADR completion has dropped slightly to 83%

Corporate Risk Register – There are now seven red-rated risks covering areas such as energy costs and provision, industrial action, insufficient staff resource, the Legal and Risk and Laundry project risks, and an issue with the roof of Brecon House that may require the lease to be terminated.

Health and Care Standards – The response to the standards have been updated to reflect the additional services taken on recently by NWSSP but remain overall at Level 4.

The Committee **NOTED** the above Reports.

Papers for Information

The following items were provided for information only:

- TRAMs Update;
- Counter Fraud Management Arrangements;
- Audit Committee Annual Report 2021/22;
- Audit Committee Assurance Report;
- Counter Fraud Annual Report 2021/22;
- Wales Infected Blood Support Scheme Annual Report 2021/22;

• Welsh Language Annual Performance Report 2021/22; • IMTP Q2 Progress Report; and • Finance Monitoring Returns (Months 6, 7, 8 and 9).	
AOB	
N/a	
Matters requiring Board/Committee level consideration and/or approval	
• The Board is asked to **NOTE** the work of the Shared Services Partnership Committee.	
Matters referred to other Committees	
N/A	
Date of next meeting	23 March 2023