Public Trust Board

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

Velindre University Trust Headquarters, Nantgarw

Agenda

10:00 - 10:20
20 min

1.
PRESENTATIONS

1.1.
NHS Wales Shared Services Integrated Medium Term Plan (IMTP)

Neil Frow, Managing Director, NWSSP and Tracy Myhill, Chair of the Partnership Committee

1.1.0 NWSSP IMTP Velindre Board Nov 23 Final .pdf (13 pages)

10:20 - 10:30
10 min

2.
STANDARD BUSINESS

2.1.
Apologies

Prof Donna Mead OBE, Chair

2.2.
In Attendance

Prof Donna Mead OBE, Chair

2.3.
Declarations of Interest

Prof Donna Mead OBE, Chair

2.4.
Minutes from the Public Trust Board meeting held on 28.09.2023

Prof Donna Mead OBE, Chair

2.4.0 Final Public Trust Board Minutes 28.09.2023_(V3)ESLFDM.pdf (13 pages)

2.5.
Action Log

Prof Donna Mead OBE, Chair

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

2.6.
Matters Arising

Prof Donna Mead OBE, Chair

10:30 - 10:50
20 min

3. KEY REPORTS

3.1. Chair's Report

Prof Donna Mead OBE, Chair

- 3.1.0 Chair's Update November latest version 2023(v3DM)_.pdf (6 pages)

3.2. Vice Chair's Report

Stephen Harries, Vice Chair

- 3.2.0 202311_Vice Chair Report.pdf (2 pages)

3.3. Chief Executive's Report

Prof Donna Mead OBE, Chair

- 3.3.0 Chief Executive's Report November - final.pdf (5 pages)
- 3.3.0a JET Slide Deck - November 2023 - Successes Snapshot H1 2023-4.pdf (3 pages)

3.4. Board Champion Report

Vicky Morris, Independent Member and Infection Prevention, Vulnerabilities and Violence and Aggression Champion

- 3.4.0 Board Champion for Safety paper (final).pdf (6 pages)

10:50 - 13:00
130 min

4. QUALITY, SAFETY AND PERFORMANCE

4.1. VUNHST Risk Register

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 4.1.0 TRUST RISK REGISTER -TB - 30.11.2023- Final.pdf (11 pages)
- 4.1.0a TB - RISK REPORT - 10.11.2023-V04.pdf (2 pages)

4.2. Trust Assurance Framework

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 4.2.0 TAF Paper -TB - 30.11.2023 - Final.pdf (9 pages)
- 4.2.0a V13 - TAF DASHBOARD 2.0 - TB Nov final.pdf (24 pages)

4.3. Public Audit Committee Highlight Report

Gareth Jones, Independent Member and Acting Chair of Audit Committee

- 4.3.0 Audit Committee Part A Public Highlight Report 19 October 2023. (GJ)docx.pdf (3 pages)

4.4. Public Quality, Safety & Performance Committee Highlight Report

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

4.4.0 Public Quality Safety Performance Committee Highlight Report 16th November 2023 v2.pdf (11 pages)

4.5.
Performance Management Framework (September 2023)

Rachel Hennessy, Interim Director of Velindre Cancer Service and Peter Richardson, Head of Quality Assurance and Regulatory Compliance

4.5.0 Trust Board 30.11.23 SEPT PMF Performance Report version 006.pdf (69 pages)

4.6.
Financial Report (September 2023)

Matthew Bunce, Executive Director of Finance

4.6.0 Month 6 Finance Report Cover Paper - TRUST BOARD.pdf (10 pages)
4.6.0a M6 VELINDRE NHS TRUST FINANCIAL POSITION TO SEPTEMBER 2023 -TRUST BOARD.pdf (24 pages)
4.6.0b Appendix 1 - TCS Programme Board Finance Report (September 2023) - Main Report.pdf (15 pages)

13:00 - 13:30
30 min

5.
PLANNING AND STRATEGIC DEVELOPMENT

5.1.
Integrated Medium Term Plan Quarter 2 Report

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

5.1.0 Trust Board 30.11.23 IMTP 2023.24 Quarter 2 Update FINAL version 007.pdf (40 pages)

5.2.
Integrated Medium Term Plan Accountability Conditions - Process for Delivery

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

5.2.0 IMTP - Reporting Against our Accountability Conditions - TB (002).pdf (5 pages)

5.3.
Blood Establishment Computer System

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

**Supported by Alan Prosser, Director of Welsh Blood Service and Carl Taylor, Chief Digital Officer*

5.3.0 PUBLIC Trust Board Report BECS Procurement - Options Paper FINAL.pdf (10 pages)
5.3.0a Appendix 1 - AW092 BECS Final Published VEAT.pdf (4 pages)

13:30 - 14:10
40 min

6.
CONSENT ITEMS

Prof Donna Mead OBE, Chair

6.1.
CONSENT FOR APPROVAL

6.1.1.
Commitment of Expenditure exceeding Chief Executive's Limit

Matthew Bunce, Executive Director of Finance

6.1.1 Trust Board November 2023 Cover Report_Commitment of Expenditure.pdf (5 pages)
6.1.1a Appendix 1 - Commitment of Expenditure Over Chief Exec Limit - Oncotype Sept 23 MB.pdf (8 pages)

6.1.1b Appendix 2 - All Wales Human Derived Products Contract Board Paper.pdf (8 pages)
6.1.1c Appendix 3 - Commitment of Expenditure Over Chief Exec Limit PCS.pdf (8 pages)
6.1.1d Appendix 4 - Commitment of Expenditure Over Chief Exec Limit HGV Contract_.pdf (8 pages)

6.1.2.
Chair's Urgent Actions Report

Prof Donna Mead OBE, Chair

6.1.2 Chairs Urgent Action Report November 2023.pdf (6 pages)

6.1.3.
Revisions to the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts; and Model Standing Financial Instructions

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

6.1.3 Revisions to SO-SFI-Trust Board Cover Report_Nov 2023.pdf (7 pages)
6.1.3a APPENDIX 1 - GC02 v39 SOs Excluding Schedules_Nov 2023.pdf (45 pages)
6.1.3b APPENDIX 2 - GC02a v39 SOs Schedule 1_Nov 2023.pdf (24 pages)
6.1.3c APPENDIX 3 - GC02b v39 SOs Schedule 2_Nov 2023.pdf (79 pages)
6.1.3d APPENDIX 4 - GC02c v39 SOs Schedule 3_Nov 2023.pdf (65 pages)
6.1.3e APPENDIX 5 - GC02d v39 SO Schedule 4_Nov 2023.pdf (26 pages)

6.1.4.
Trust Policies for Approval

Lauren Fear, Director of Corporate Governance & Chief of Staff

- Trust Claims Policy - Led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience
- Handling Concerns Policy - Led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience
- NWSSP - Registration Authority Policy - Led by Matthew Bunce, Executive Director of Finance

6.1.4a Claims Policy Trust Board November 2023.pdf (46 pages)
6.1.4b Handling Concerns Policy Trust Board November 2023.pdf (29 pages)
6.1.4c 230710-NWSSP Policy cover paper .pdf (8 pages)
6.1.4d NWSSP Provision of Registration Authority Services Agreement.pdf (8 pages)
6.1.4e NWSSP Registration Authority Policy (3).pdf (7 pages)

6.1.5.
NHS Wales Red Cell Shortage Plan

Alan Prosser, Director of Welsh Blood Service

6.1.5 NHS Wales Red Cell Shortage Plan - TB cover paper.pdf (8 pages)
6.1.5a NHS Wales Red Cell Shortage Plan 2023.pdf (24 pages)

6.1.6.
NHS Wales Shared Services Partnership - Renewal of Lease

Matthew Bunce, Executive Director of Finance

6.1.6 NWSSP Lease Approval .pdf (6 pages)

6.2.
CONSENT FOR NOTING

6.2.1.
Trust-wide Approved Policies Update

Lauren Fear, Director of Corporate Governance & Chief of Staff

6.2.1 TRUST WIDE POLICIES UPDATE November 2023 v3.pdf (6 pages)
6.2.1a National Incident Reporting and Management Policy QSP September 2023 (002).pdf (23 pages)

6.2.2.

Public Strategic Development Committee Highlight Report (07/11/2023)

Stephen Harries, Vice Chair and Chair of Strategic Development Committee

6.2.2 PUBLIC - Highlight Report SDC 07.11.2023 LF - SH.pdf (8 pages)

6.2.3.
Public Charitable Funds Committee Highlight Report (07/09/2023)

Prof Donna Mead OBE, Chair of Charitable Funds Committee

6.2.3 Charitable Funds Committee Public Highlight Report Draft 07 September 2023_ES_MB.pdf (4 pages)

6.2.4.
Public Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report (12/10/2023 & 26/10/2023)

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

6.2.4a Highlight Report - PUBLIC TCS 12.10.2023 TRUST BOARD.pdf (3 pages)
6.2.4b TRUST BOARD Highlight Report Public 26.10.2023 LF-SH.pdf (5 pages)

6.2.5.
Remuneration Committee Highlight Report (16/11/2023)

Prof Donna Mead OBE, Chair and Chair of Remuneration Committee

6.2.5 Highlight Report REMCOM 16.11.2023_.pdf (2 pages)

6.2.6.
Local Partnership Forum Highlight Report (07/09/2023)

Sarah Morley, Executive Director of Organisational Development & Workforce

6.2.6 Public - Highlight Report LPF 07.09.2023.pdf (2 pages)

6.2.7.
Public Welsh Health Specialised Services (WHSSC) Committee Briefing (19/09/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

6.2.7 JC Briefing (Public) 19 September 2023 vFinal.pdf (6 pages)

6.2.8.
Emergency Ambulance Services Joint Committee (EASC) Briefing (19/09/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

6.2.8 Chair's EASC Summary from 19 September 2023.pdf (9 pages)

6.2.9.
NHS Wales Shared Services Partnership Committee Assurance Report (21/09/2023)

Lauren Fear, Director of Corporate Governance & Chief of Staff

6.2.9 SSPC Assurance Report 21 September 2023.pdf (4 pages)

6.2.10.
Trust Seal Approval Report - 4th October -22nd November 2023

Lauren Fear, Director of Corporate Governance & Chief of Staff

6.2.10 Trust Seal Report 041023-221123 2023 v1.pdf (3 pages)

14:10 - 14:10
0 min

7.
ANY OTHER BUSINESS

Prof Donna Mead OBE, Chair

*Prior approval required by Chair

14:10 - 14:10
0 min

8.
DATE OF NEXT MEETING

Tuesday January 30th, 2024

14:10 - 14:10
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).

NWSSP IMTP 2023-2026

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

Sicrhau Gwerth, Arloesi a Rhagoriaeth drwy Bartneriaeth

Delivering Value, Innovation and Excellence through Partnership

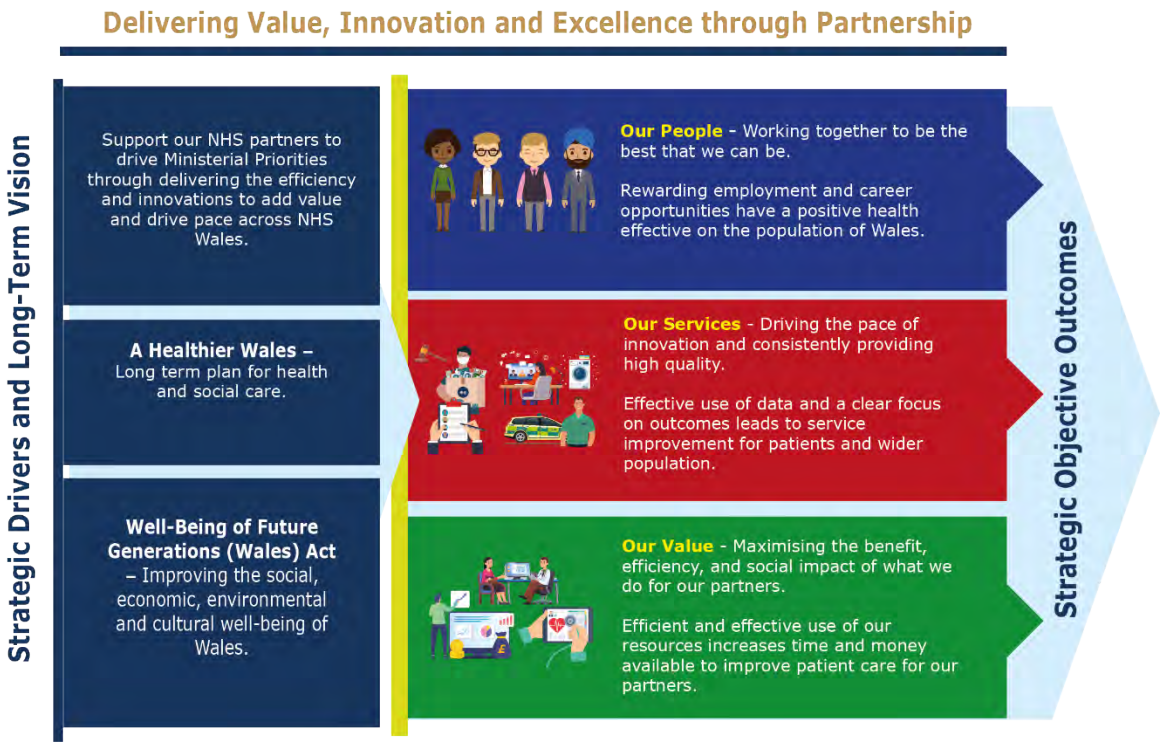
GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

IMTP 2023-26 Overview

Delivering Value, Innovation and Excellence through Partnership

Our Strategy Map

We refreshed our vision, values and Strategic Objectives giving us renewed vigour in which to move forwards at pace for 2023-26.



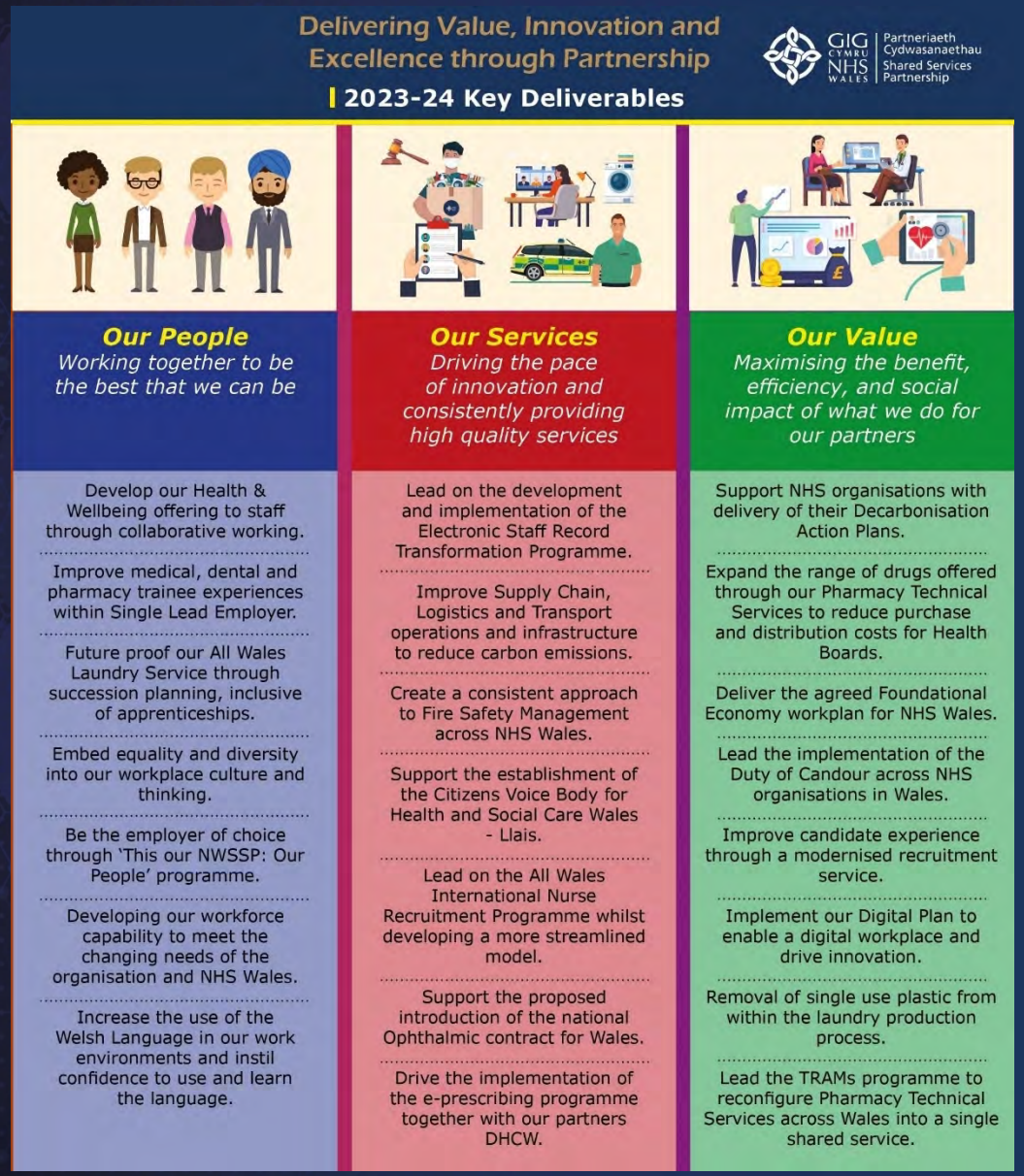
2023-24 Key Deliverables

Our key organisational priorities are focused around:

- Decarbonisation and Climate Change.
- Implementation of our new Digital Strategy as a key enabler.
- Financial sustainability and good governance.
- Employee Wellbeing.

Core functions & activity to support our plan include:

- Digital Innovation and transformation.
- Financial Sustainability.
- This is our NWSSP – Our People Plan.



Year 2 and 3 Key Deliverables

Year 2 plans provide an indicative view of further work planned and progress expected.

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2024-25 Key Deliverables

Our People
Working together to be the best that we can be

- Improve access to the legal profession with the introduction of legal apprenticeships.
- Grow our talent pipeline programmes with our Specialist Estates Engineering and Real Estate teams.
- Continue to improve our Single Lead Employer trainee experiences.
- Monitor and adapt to the impact of agile and other new ways of working.
- Train additional Counter fraud financial investigation officers.

Our Services
Driving the pace of innovation and consistently providing high quality services

- Explore digital solutions to deliver an electronic passport for NHS recruitment.
- Review and enhance our Audit Quality Assurance and Improvement Programme.
- Expand product range from the NWSSP Pharmacy Technical Unit.
- Scope provision of additional legal services including property litigation, charities law, and debt recovery.
- Further deployment of Scan for Safety Programme.

Our Value
Maximising the benefit, efficiency, and social impact of what we do for our partners

- Support the implementation of the National Medical Workforce Programme.
- Continue to drive the momentum required for NHS Wales to achieve net zero carbon by 2030.
- Increase the number of invoices processed by Accounts Payable via e-trading.
- Modernise National Distribution warehousing, hospital inventory and logistics model for NHS Wales.
- Continue the phased roll out of Datix Cymru and CIVICA Experience modules.

Year 3 plans provide an outline of opportunities to explore new innovations and develop further ongoing programmes of work.

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2025-26 Key Deliverables

Our People
Working together to be the best that we can be

- Continue to enhance and develop our Health and Wellbeing offerings to our people.
- Digitise a wider range of e-learning opportunities to support Health and Social care workforce.
- Support the Foundational Economy by creating opportunities within NWSSP for Network 75 students, apprentices, interns and others.
- Expand and improve upon the NHS Wales staff benefit offerings, e.g., home electronics, cycles and low emission cars.

Our Services
Driving the pace of innovation and consistently providing high quality services

- Influence preparations for the scheduled implementation of Electronic Staff Record replacement in 2026-27.
- Explore other opportunities to expand the Single Lead Employer model to primary care and public health roles.
- Investigate expanding our range of biological testing methods offered within our Surgical Materials Testing Laboratory.
- Development of service desk support for Scan for Safety.

Our Value
Maximising the benefit, efficiency, and social impact of what we do for our partners

- Improve Supply Chain, Logistics and Transport operations and infrastructure at all sites to reduce carbon emissions.
- Benchmark with other internal auditor providers to ensure a fit for the future Audit and Assurance service.
- Implementation of long-term case management solution within Legal and Risk.
- Continued delivery of procurement contribution to the NHS Wales Decarbonisation strategic plan.

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Partneriaeth Cydwasanaethau
Shared Services Partnership

Where are we now?

Delivering Value, Innovation and Excellence through Partnership

Where are we now?

- Year 1 2023-26, we currently have a balanced financial plan.
- There are several financial risks that need careful management, including capital pressures and an additional revenue savings target.
- At Quarter 2 majority of our planned objectives are on track to deliver in year or carry over as planned into 2024-25 and future years.
- Several additional asks from Welsh Government and other NHS organisations have already been added to our plans.

- Continued support to the vaccination campaign and Personal Protective Equipment stock holding requirements.
- Readiness for the COVID-19 Public Inquiry.
- Additional work required at pace on International Recruitment.
- Planning for further disruption through Winter because of industrial action.
- Continue to maintain accreditation standards across our services.
- We are continuing to embed the Duty of Quality into our work across NWSSP.

Customer Service Excellence (CSE)

"Customer Service Excellence aims to bring professional, high-level customer service concepts by offering a unique improvement tool to help those delivering services put their customers at the core of what they do."

The basis of this tool is the Customer Service Excellence standard which examines in depth those areas that research has indicated are a priority for customers, with particular focus on:

- Customer Insight
- Culture of the Organisation
- Information and Access
- Delivery
- Timeliness and Quality of Service

Our first Organisational Assessment took place between 16/10/23 and 20/10/23. This involved:

- 3 CSE Assessors
- 18 Individual divisional assessments
- 121 NWSSP workforce interviews
- 31 NWSSP customer interviews
- 415 pieces of evidence shared with the assessor
- Site visits – Laundry and Pharmacy Services

We can confirm that NWSSP has been awarded Customer Service Excellence Accreditation. (Final report pending).

- 12 Compliance Pluses (Exceeded CSE Requirements)
- 43 Compliances (Met CSE Requirements)
- 2 Partial Compliances (Areas of Improvement)

Digital Priorities

Initiative	Purpose / NWSSP Role	Target
TRAMS	Sourcing of digital solution to support medicines manufacturing service	TBC*
ESR	Replacement of ESR in collaboration with NHS Business Services Authority	August 2025
Oracle Cloud	Migration of Oracle Finance and Reporting from Cardiff & Vale hosting to Oracle Cloud	August 2024
Scan for Safety	Automated medicinal product / medical device tracking (cont. roll out)	By HB plan
Electronic Prescription Service	Contractor payment integration and Smart Card provision	Pilot started November 2023
Patient Registration	NHAIS primary care patient registration replacement	August 2024
Workforce Intelligence System	Replacement of (primary care) Welsh National Workforce Reporting System and Performers List solutions	August 2024

*(FBC originally targeted June 2024)

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Shared Services Partnership

Future Considerations

Delivering Value, Innovation and Excellence through Partnership

Challenging environment

Immediate focus is on the overall NHS Wales financial position with focus areas for NHS Wales being around:

1. Workforce
2. Medicines and prescribing
3. Non-pay and procurement
4. Clinical variation and service configuration
5. Continuing Healthcare and Funded Nursing Care.

Maintain momentum on Duty of Quality requirements and prioritising well-being of our staff.

NWSSP will need to have a sharp focus on:

- Financial Sustainability – grip and control.
- Our own workforce planning assumptions and overheads, including accommodation requirements.
- Outcomes – capturing the impact of our work to aid prioritisation of resources and inform decision making.
- Maximising opportunities to adopt good practice, standardise and reduce variation across NHS Wales in services we provide.

Emerging key areas of focus

Reducing the Time to Hire:

- NWSSP Recruitment Modernisation Programme linked to the Workforce Implementation Plan and the Value and Sustainability Workstream.
- Increased recruitment activity across NHS Wales continues.

Medicines and Pharmacy:

- NWSSP Pharmacy Services leading on the TRAMS Programme, Radio pharmacy solution and Medicines Value Unit Procurement initiatives.

Procurement:

- Programmes targeting for example; reduction in variation, reducing carbon footprint and increasing spend within Wales.

Payroll Modernisation:

- NWSSP Payroll Modernisation Programme linked to reducing variation and streamlining processes.

Appointment of a Deputy Medical Director:

- Additional support with Single Lead Employer, International recruitment, Speaking up Safely and Duty of Quality implementation.

Laundry Rationalisation:

- Close Glangwili laundry and consider TUPE of remaining staff from Church Village to NWSSP All Wales Laundry Service.

Accommodation Strategy

- Reducing NWSSP estate footprint to reduce costs and reflect agile working arrangements.

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Shared Services Partnership

THANK YOU
DIOLCH

Delivering Value, Innovation and Excellence through Partnership

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

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

1.0.0	STANDARD BUSINESS	ACTION LEAD
1.1.0	**Apologies noted:** • Cath O'Brien, Chief Operating Officer • David Cogan, Patient Representative	
1.2.0	**In Attendance** The Chair extended a warm welcome to the following additional attendees: • Katrina Febry, Audit Lead, Audit Wales *(observing) (attending remotely)* • Malcolm Latham, Llais Cymru Representative *(observing)* • Tony Millin, Head of Radiotherapy Physics *(for item 4.1.0)* • Helen Payne, Radiotherapy Service Manager *(for item 4.1.0)* • Dr Tom Rackley, Consultant Oncologist *(for item 4.1.0)* • Kathy Ikin, Head of Radiation Services *(for item 4.1.0)* • Rachel Hennessy, Interim Director, Velindre Cancer Service • Alan Prosser, Director, Welsh Blood Service	
1.3.0	**Declarations of Interest** There were no declarations of interest to **note** in respect of today's agenda.	
1.4.0	**Minutes from the Public Trust Board meeting held on 27th July 2023**	

	The following amendments to the minutes from the meeting held on 27th July 2023 were requested: • Hilary Jones suggested that the minutes should reflect members attending remotely. • Martin Veale indicated that Hilary Jones had been incorrectly referred to as Hilary Williams in section 8.4. • Vicky Morris noted that the title of item 8.1.0 (Annual Patient / Donor Experience Report 2022-23) should follow the introductory paragraph. • Gareth Jones noted that the first paragraph of item 8.6.0 (Welsh Language Annual Report) should read "**all** the standards". Additionally, Gareth requested the inclusion of confirmation that he had provided comments to Lauren Fear following his recent attendance at a webinar with the Welsh language Commissioner. • It was agreed that the word 'sighting' would be omitted from future minutes to avoid ambiguity. The Trust Board **approved** the minutes subject to the action of all amendments noted above by the meeting Secretariat.	**Secretariat**
1.5.0	**Action Log** Board members confirmed there was sufficient information contained in the log to provide assurance that the actions identified as complete could be **CLOSED**. There were no open items for discussion.	
1.6.0	**Matters Arising** There were no matters arising which were not included on the action log or meeting agenda.	
2.0.0	**KEY REPORTS**	
2.1.0	**Chair's Report** In presenting the update, the Chair highlighted the following: • The busy summer period had included an uplifting visit to 'Veggies for Velindre', an initiative created and developed by two siblings who had acquired an allotment near their home in Treherbert to grow and sell a range of vegetables to raise funds for the Charity. The Chair commended the collaborative nature of their work, noting that their former and current schools had now also become involved, establishing their own allotments to provide the same. • A meeting of the Chair, Executive Director of Nursing and colleagues from the University of Wales Trinity St David had taken place, to facilitate the formal signing of the Tripartite Deed of Association. This will enable the establishment of the Trust's Velindre Oncology Academy and formal accreditation of its modules, providing the required education and training for staff (and eventually nationwide) and formal recognition of this. • The Chair had taken part in the Dare Valley Country Walk and had been inspired by stories from families touched by cancer and the care they had received from Velindre. • Although not included in the report, the Chair and Executive Director of Finance had engaged in a '15 step' visit to the Welsh Bone Marrow unit	

	and were privileged to meet a donor (donating at the time) whose wish was to 'make a difference to someone's life'. It is the intention to further market the service and raise awareness of how bone marrow is collected. • The Chair noted that the Cancer Centre had engaged in British Food Fortnight and that photographs of various produce on offer at the canteen would follow. The Trust Board **NOTED** the content of the Update Report.	
2.2.0	**Vice Chair's Report** In presenting the update, the Vice Chair highlighted the following: • The successful appointment of two Consultant Medical Oncologist posts (one for Skin/Acute Oncology Service and one for Urology). • Attendance at a ceremony to celebrate the qualification of the Trust's first Assistant Practitioner, who had completed the necessary education and competencies to provide safe care. It was agreed that it would be appropriate to convey congratulations on behalf of the Board. • A visit to the new Wellbeing facility, currently under development on the Welsh Blood Service site and its importance to staff and family members. Sarah Morley commended the Welsh Blood Service's approach to wellbeing and the Trust's collaboration with union colleagues to ensure this is a priority. A number of initiatives are currently being implemented across the Trust to allow access to activities to improve wellbeing (such as a gardening club, bee hive, local choir etc.). • Carl James gave thanks to Rhiannon Freshney, Sustainability Manager, for facilitating a number of the improvements mentioned above and the Board congratulated her on the birth of her baby. The Trust Board **NOTED** the content of the update Report.	**Vice Chair**
2.3.0	**Chief Executive's Report** In presenting the update, the Chief Executive highlighted the following: • It was recognised that the summer period had been busy and challenging and the Chief Executive commended the mutual support which had been provided across the team. • Formal feedback from Welsh Government Officials following the Joint Executive Team meeting was attached; it was noted that the meeting had been both a challenging and positive experience. • The introduction of 'Working Together' staff sessions across divisions and corporate services over the coming months, forming a regular opportunity to engage with staff across the Trust to facilitate organisational change and growth. • Following the tragic incidents which occurred at the Neonatal Unit of the Countess of Chester Hospital, it had been agreed at the NHS Leadership Board that each organisation should ensure that mechanisms in place to support Quality & Safety are robust and well implemented. The NHS Wales Chief Executive is currently drafting a summary of discussions to be shared with Trust Board members in due course, to be considered collectively by the Board prior to submission of feedback.	

	• NHS financial position – The Trust's intervention status has been noted as minimal and the Trust's IMTP has been approved by Welsh Government. The Trust Board **NOTED** the content of the update Report.	
3.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
3.1.0	**VUNHST Risk Register** The Trust Risk Register informed the Board of the latest position of reportable risks in line with renewed risk appetite levels and progress against the Risk Framework. Lauren Fear highlighted the following: • A number of Transforming Cancer Services (TCS) risks are currently missing review dates due to changes to the governance programme level during August; these have been updated during September and will be reflected following the next reporting cycle. Following robust discussion, the September Quality, Safety & Performance Committee and Audit Committee had been informed of the approach to be taken, namely ensuring appropriate consideration of the root cause of risks and associated action to be taken. This will be evidenced via a profile of risk reduction towards the target score, in addition to a reduction in time of 'open' risks. • All risk owners are now requested to complete a target risk date field in Datix, which is now a permanent, mandatory element within the system. • The Executive Management Board had discussed the two longest open risks in depth; o **2465** - Use of email for clinical matters (open for 662 days) – the root cause of this risk had been confirmed as the management of communications in respect of patient information and associated mechanism in place to allow appropriate management of this. A full review of the risk has since been undertaken, identifying a risk owner and instigating an internal audit to address the underlying causes (completion anticipated 9th October 2023). o **2501** - Inflation risk for the new Cancer Centre (was open for 592 days) – This risk has decreased, following a buffer allowing for reduction in inflation rates. • Positive challenge had been received during the Quality, Safety & Performance Committee in relation to the number of digital risks and the implication of workarounds. Following review of these risks, no systemic or thematic root causes had been identified. However, the Quality, Safety & Performance Committee has requested a 'deep dive' across all digital risks; this will be presented at the November Quality, Safety & Performance Committee, prior to an update to Board. In relation to risk 2465 detailed above, Stephen Harries requested assurance that (as a new clinical system is to be implemented) there are no other forms of missed communication and emphasised the importance of regular review of communication channels. Nicola Williams assured the Board that an audit is underway to identify all areas where risk may be present; significant multifactorial work is in train to address issues / risks identified to date, namely a review of the Health Helpline, escalation processes, avoiding the use of emails for clinical communication and review of medical secretarial roles. Additionally, following the National Reportable Incident relating to a referral from a Health Board into the organisation, a rapid review had been undertaken and urgent actions instigated alongside engagement with Digital Health and Care	

	Wales (DHCW) around the electronic referral system. It was agreed to further inform the Board of the work undertaken to date. Jacinta Abraham advised that a change had been implemented to the electronic system during the lifespan of this risk, noting increasing confidence in relation to the Outpatient Oncology Note (OON), (mechanism for communication, pharmacy, tests, results, appointments and ongoing treatments); evidence that the system is accurately recording the required information has resulted in a decrease in the number of emails required. Rachel Hennessy advised that the Trust is currently working with the Cancer Network in relation to referrals, while also engaging at a national level in terms of work around wider use of email communication within the NHS. This is being led by the Head of Information Governance. The Chair thanked Colleagues for the explanation of the current position and additional assurance this provided. Gareth Jones suggested that while the oral update had provided a level of assurance, the report did not reflect this, noting that developments should be accurately captured and shared with the Board. Additionally, Gareth requested assurance that the delayed date for risk 2465 (to March 2024) had been agreed at the Quality, Safety & Performance Committee. It was confirmed that dates are determined by the risk owner/s and agreement of these does not fall under the remit of the Committee. Gareth also indicated that there had been no decrease in the rating of risk 3092 (risk of patients receiving inappropriate management/treatment as a result of inaccurate manual data entry into clinical system) since May 2023. Assurance was requested that risks are being addressed and actively managed downward. It was agreed that a method of including the detail in the document or an alternative for communicating this for assurance purposes should be implemented. Lauren Fear advised that actions taken are detailed within Datix and actions elsewhere can be referred to via the Datix action log. Additionally, a new field for the target date for risks (mentioned earlier in the meeting) had been added to Datix following discussion at Audit and Quality, Safety & Performance Committees. Gareth Jones queried what the governance is in the event that the Board do not support target scores / dates reported Lauren Fear advised that the Board or Committees do not formally approve scores and target dates and as such, these are open to challenge which will be relayed to the risk owner. Jacinta Abraham suggested better articulation of the position in relation to actions taken to manage each risk throughout its lifespan, rather than simply noting when the risk will meet the target date / be completed, therefore providing meaningful updates with the correct level of detail. Martin Veale queried whether only high level risks are included in the Risk Register and the position in relation to lower scoring risks which would have significant implications for the Trust if they were to be realised, as these may also be of interest to the Board. Lauren Fear advised that the recent risk appetite refresh had removed risks with an impact of 5 (previously reported to Board) and reporting is now by category with safety being the lowest tolerance. Assurance in relation to these risks can be provided via Senior Leadership Team meetings, which	**LF**

	explore all risks, specifically those with an impact of 5. It was agreed that a method of providing assurance to the Board that risks with an impact of 5 are being monitored and managed should be determined. Vicky Morris highlighted the requirement for risks to be assessed and understood against the Trust's Strategic Objectives, which is what would routinely be achieved via the Trust Assurance Framework (TAF). This has not been possible due to the absence of the TAF at Board meetings for 6 months and this concern was noted by the Board. Malcolm Latham noted that the Risk Register finds itself in the public domain and as such, its content should include narrative in relation to actions taken and ongoing progress for public assurance. The Chair noted that the risk title and risk in brief contain the same information for a number of risks and queried whether both columns were required. Additionally, it was noted that current controls and action plans are also the same in most cases; this requires review. The Chair requested further assurance in relation to Brachytherapy related risks. Rachel Hennessy advised the Board of the fragility of the Brachytherapy Service, primarily due to staff shortages and single points of failure. Despite the successful appointment of 2 full time staff members (resulting in 3 full time staff members), 2 of the 3 staff had moved on. Recruitment into this area remains challenging and as a result, there is ongoing work to build internal resilience where possible. Hilary Jones indicated that no risk scores had changed since the introduction of the trend line in March 2023, therefore, improvements that may have occurred since then were not reflected. Hilary also requested that sufficient time be allowed during Committee and Board meetings to discuss target dates and their acceptability. Sarah Morley noted that the risk score of risk 3001 (risk to safety as a result of work-related stress leading to harm to staff and to service delivery) had not reduced over time and that it had been challenging to justify how this could be reduced from 12 to 9. It was assessed that the risk was such that there has been some improvement in terms of interventions and sickness reduction, but not sufficient to reduce the rating from 12. Gareth Jones noted that the action plans for risk 3092 (previously mentioned highest rated risk) did not provide the required information and noted the absence of a target date for when the target figure would be reached. Gareth requested that the risk be revisited and further clarity and a target date provided. Rachel Hennessy advised that action had been taken to reduce this, however there has been a time lag due to the delay in a full rollout of systems and impact on data quality. Updates are now available. It was agreed that all points discussed above would be reflected in the next paper for the November Quality, Safety & Performance Committee. Vicky Morris suggested inviting Martin Veale and Gareth Jones to the November Quality Safety & Performance Committee to observe the deep dive discussions for assurance purposes. The Trust Board: • **NOTED** the risks level 20, 16 and 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper.	**LF** **LF**

	• **NOTED** the on-going developments of the Trust's risk framework.	
3.2.0	**Trust Assurance Framework (TAF)** Lauren Fear provided the Board with an oral update, acknowledging the absence of the Trust Assurance Framework (TAF). A comprehensive review of the TAF and Strategic Risks had been undertaken over the summer period and a reviewed articulation of these risks had been presented to the September 2023 Strategic Development Committee and Quality, Safety & Performance Committee. It was advised that the template has evolved considerably. Due to the significant amount of work now involved in articulating each individual risk, it had not been possible to complete the paper in time for September Trust Board and the complex work undertaken will require discussion in relation to how the tool is embedded. Martin Veale and Vicky Morris emphasised the importance of the availability of the TAF at the next opportune moment, noting that the 6 month absence of a paper at Trust Board had prevented a review of progress and discussion of risks against the Strategic Objectives. Hilary Jones also remarked that the Board should have received sight of updates against the previous TAF until the new TAF had been approved and was in a position to be launched. As Board members were unable to approve the revised Strategic Risks and TAF at this point, Lauren Fear suggested facilitation of this via Chair's Urgent Action as a unified Board decision would be required. The Chair agreed that this should be circulated to Board members in the first instance, with feedback / comments to be sent to Lauren Fear, before a decision regarding approval is reached (either electronically or by meeting).	**LF**
3.3.0	**Performance Management Framework (July 2023)** In presenting the Trust Performance Management Framework Report, Carl James highlighted the following: • Performance in relation to Quality, Safety & Experience remains high. • Continuing positive financial position, remaining within expected budget. • Challenges remain in relation to increasing demand, Radiotherapy and staff recruitment and retention. **Velindre Cancer Service -** Rachel Hennessy highlighted the following: • Continued improvement in Systemic Anti-Cancer Treatment (SACT) recruitment. Fragility within the service remains in relation to Pharmacy workforce, however the nursing workforce is now included in the streamlining process and the Trust has received interest from individuals selecting Velindre as their first choice of employer. • Delayed Transfers of Care (DToC) – This is a national issue and the Trust is actively engaged with the National Pathway of Care Group. Velindre generally experiences low numbers, however there is recent evidence of an increase in repatriation to patients' original Health Boards in addition to discharge into social care. Jacinta Abraham indicated that what had previously been termed Delayed Transfers of Care has been now termed Pathways of Care delays, which is not the	

	same and involves addressing any pathway where care is delayed. This will be addressed at a national level. • Evidence of benefits resulting from training around data quality within Radiotherapy, with improvements noted in performance data (based on August 2023 datasets). **Welsh Blood Service –** Alan Prosser highlighted the following: • Continued strong service performance during July, with demand for blood and platelets met (with low wastage). • A report had been submitted to the Human Tissue Authority (HTA) regarding a positive blood culture from a stem cell donation. However, no risk to the patient was identified and discussions were closed. • All quality markers and donor satisfaction remain high. • Recruitment and training of staff within Reference Serology are ongoing with anticipated improvements. • Prioritisation of Bone Marrow Donor recruitment in relation to recovery and raising awareness of the service, reaching out via education platforms, ethnic minorities and potential recruitment during blood collection sessions; an update on the position will follow in due course. **Workforce:** • Sarah Morley highlighted good performance in terms of Core Skills and Training Framework compliance (over 88%). • 74% compliance with Personal Appraisal Development Reviews (PADRs) carried out by Managers. • Continued high level of absence levels – 5.71% reported to July (5.64% year to September), which remains above the 3.54% Welsh Government target. Long term absence continues to reduce. Martin Veale queried whether the Trust Board had received sight of the Velindre patient satisfaction surveys, noted in section 2.5 of the paper. Nicola Williams confirmed that this is reported within divisional reports to the Quality, Safety & Performance Committee. The Trust Board **NOTED** the content of the report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Annexures 1 to 3. The Chair commended the cover paper and signposting to pertinent issues for the Board.	
3.4.0	**Financial Report (May 2023)** Matthew Bunce advised that the NHS Wales Chief Executive is currently chairing an All Wales group (involving key Executives) to drive a range of improvements across Wales. In presenting the report outlining the financial position for the period ended (month 4) July 2023, Matthew Bunce highlighted the following performance in relation to the standard performance indicators: • Balanced revenue position with an expected revenue outturn forecast of breakeven. • It is anticipated that the Capital target will be met, pending formal receipt of £1.8m Welsh Government funding for the nVCC project management; this figure was subsequently revised to £2.7m based on	

	further discussion with Welsh Government regarding an extension to the Works until March 2024. • The Public Sector Payment Performance Target was met, at upwards of 98% (the recent minor downturn has been resolved due to improved capacity). • The Trust has officially declared the return of capital funding in relation to the Integrated Radiotherapy Solution (IRS) project, resulting from slippage; this is to be moved to next year's plan. • A response to the submission to Welsh Government, outlining the Trust's proposed contribution to the overall financial position of Welsh NHS organisations, is expected within the next month. Agreement of this via a meeting with Welsh Government Officials will follow. • Delivery of savings target remains on track, with areas of concern being addressed via the appropriate routes. It was advised that alternative measures would be accessible to cover the shortfall (e.g. use of recurrent savings) failing delivery of all savings schemes. • Reserves remain at £500k, enabling the Trust to cover any unforeseen risks which may arise. • The main financial risk remains around ensuring the accurate and effective functioning of the new Digital Health & Care Records (DHCR) system due to challenges in operational use and accurate data capture. This risk has now reduced from £1.5m to £500k with further reduction anticipated. No questions were raised and the Chair acknowledged the significant work undertaken to achieve the current position. The Trust Board **NOTED** the content of the July 2023 financial report and in particular, the yearend financial performance which at this stage is reporting a breakeven position.	
3.5.0	**Sickness Absence Key Performance Indicator** Sarah Morley advised that performance against the Welsh Government's 3.54% sickness absence target is reported to Welsh Government by each organisation within NHS Wales on a monthly basis. Due to significant changes to the landscape since the setting of this target some 10 years ago, numerous conversations around the efficacy of the target have resulted in a review by Welsh Government. As completion of this work is not anticipated in the immediate future, the Trust has taken the decision to set a more realistic target in the interim, based on evidence that can be pursued internally. Following a benchmarking exercise, utilising annual statistics produced by the Office of National Statistics, in addition to the continued decline in sickness rates within the Trust, it was proposed that the Trust adopts an internal target of 4.7%, to be reviewed in September 2024. It was advised that this had been endorsed by both the Executive Management Board and Quality, Safety & Performance Committee. Martin Veale questioned whether the 4.7% target was achievable. Although it was agreed that this would not be achieved this year, Sarah Morley assured the Board that detailed discussion with the Healthy and Engaged steering group had been undertaken to identify whether all contributing elements are achievable. It was noted that sufficient consultation had been undertaken across the service and that this would be achievable a year from now.	

	Gareth Jones queried whether Welsh Government had been informed of the revised target and agreed the Trust's approach. Sarah Morley advised that future reports would include two figures and that the Trust would report to Welsh Government against Government targets. The Trust Board **APPROVED** an internal sickness absence target of 4.7% as a stepping stone towards improvement, while Welsh Government considers targets at a national level. The Trust will continue to submit data to Welsh Government against Welsh Government targets.	
3.6.0	**Public Quality, Safety & Performance Committee Highlight Report (14/09/2023)** In presenting the highlight report, Vicky Morris raised the following: • The September Quality, Safety & Performance Committee was unable to endorse / approve a number of Trust policies due to no evidence of completion of the Equality Impact Assessment process. It is essential that this is undertaken in advance of policies being provided to the Committee for endorsement / approval. • The Committee had received the Fuller Inquiry Action Plan (Body Storage) report, noting that all but 5 recommendations had been completed; however the assurance level of 6 was not reflective of the position and should be adjusted. The Chair urged the Executive team to check all policies for completed relevant Equality Impact Assessments prior to endorsement / approval. Sarah Morley suggested the inclusion of a formal EQIA process in Trust's internal process, suggesting that authors should explicitly note in the comments section of the cover paper should an Assessment not be required. This is to be communicated. Nicola Williams noted that this had been raised at a national level and that a local process had been implemented in the absence of a national process. The Trust Board **DISCUSSED** and **NOTED** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee, held on 14th September 2023.	
3.7.0	**Public Audit Committee Highlight Report (26/07/2023)** In presenting the highlight report, Martin Veale advised the following: • All items noted within the alert / escalate section had been addressed at the Board meeting held on 27th July 2023 (it was noted that Board took place only one day after Audit Committee and the highlight report had therefore not been prepared in time). • The Audit Wales Final Audit Plan had been received on the same date as the outcome of the final annual audit. This was considered inappropriate and concerns had been expressed to Audit Wales. No queries were raised and the Trust Board **NOTED** the content of the report and actions being taken.	
4.0.0	**PRESENTATIONS**	
4.1.0	**Integrated Radiotherapy Solution (IRS) –** *this item followed the Trust Assurance Framework due to timings*	

	Tony Millin provided an overview of the Integrated Radiotherapy Solution (IRS) and its purpose, noting the significant implementation programme for a robust and efficient system to meet anticipated demand and deliver high quality Radiotherapy for all patients over the next decade. It was recognised that Radiotherapy is a complex process involving a number of factors (imaging, planning, dosage) and systems; due to the complexity of Velindre's computer systems, it is anticipated that the IRS will simplify the solution by integration of systems to facilitate improved treatment quality and efficiency. The IRS encompasses the **Oncology Information System**, which will contain all patient data and transfer of this between the **treatment planning system**, **dosimetry system** and **treatment devices**. To date, the first phase of the implementation project has commenced and although anticipated timescales have been met, numerous complications will affect timescales going forward, namely complex IT relationships between systems, an ageing fleet of Linear Accelerators (all of which are currently beyond or at End of Life) and unexpected breakdowns as a result and an increase in patient numbers, waiting times and complexity of treatment due to COVID. Implementation will be facilitated via multiple workstreams and will include all data residing in a central database, allowing propagation of information and authorisation into all other dependent / national systems. Patient benefits will include reduced waiting times, increased quality of treatment and improved targeting of cancers. Staff benefits will include increased job satisfaction, less time on data entry / checking and duplication of work. This will also yield increased opportunity for Research and Development. The immediate challenge is to achieve implementation of the solution whilst simultaneously maintaining a high quality service. Current resources are scarce, with significant impact resulting from departure of key staff; as such, the considerable changes to work practices and systems is a significant ask for the service as a whole. A number of risks are posed by the programme, including dual running of new and current systems and ensuring appropriate and timely training and resources are in place. Jacinta Abraham congratulated the team on the achievements to date, noting how this change will enable the Trust to deliver improved patient care. Andrew Westwell requested further information around Radiotherapy demand and capacity to provide an understanding of staff resource requirements. It was advised that breast and prostate cancers comprise 50% of demand and although changes to processes during COVID had resulted in improvements for breast cancer patients, additional complexities in prostate cancer patients require further workaround to improve deliverability. The Trust is currently mapping out demand changes for other treatment sites and associated capacity changes and the IRS should enable the Trust to utilise a single solution to better manage and employ increased capacity. It was acknowledged that aside from 'machine time', sufficient time should also be afforded for doctors to address patients, scanning and drawing up of individual treatment pathways. Nicola Williams commended the leadership of the team to date despite very difficult circumstances.	

	The Trust Board **NOTED** the content of the presentation and it was agreed to revisit the position early next year.	
THE TRUST BOARD PAUSED FOR MEET AND GREET LUNCH WITH THE IRS TEAM		
5.0.0	**PLANNING & STRATEGIC DEVELOPMENT**	
	There were no items for discussion.	
6.0.0	**CONSENT ITEMS**	
6.1.0	**CONSENT FOR APPROVAL**	
6.1.1	**Health & Safety Management Annual Report 2022-2023** The Trust Board **APPROVED** the Trust's Health & Safety Management Annual Report 2022-2023	
6.1.2	**Quality Impact Assessment Tool** The Trust Board **APPROVED** the use of the national beta version of the Quality Impact Assessment Tool for all strategic decisions at Divisional, Executive and Board level and to request hosted bodies to also adopt the tool.	
6.1.3	**Lease for Approval** The Trust Board **APPROVED** the renewal of the lease with Toast (Mail Order) Limited.	
6.2.0	**CONSENT FOR NOTING**	
6.2.1	**Public Strategic Development Committee Highlight Report (05/09/2023)** The Trust Board **NOTED** the contents of the report and actions being taken.	
6.2.2	**Public Welsh Health Specialised Services (WHSSC) Committee Briefing (18/07/2023)** The Trust Board **NOTED** the contents of the report.	
6.2.3	**Emergency Ambulance Services Joint Committee (EASC) Briefing (18/07/2023)** The Trust Board **NOTED** the contents of the report.	
6.2.4	**NWSSP Wales Shared Services Partnership Committee - Assurance Report** The Trust Board **NOTED** the contents of the report.	
6.2.5	**NHS Wales Shared Services Partnership Audit Committee Assurance Report** The Trust Board **NOTED** the contents of the report.	
6.2.6	**Approved Policies Update** The Trust Board **NOTED** the policies which were approved during the period June to September 2023.	
6.2.7	**Trust Seal Approval Report – (May - September 2023)**	

	The Trust Board **NOTED** the contents of the report.	
6.2.8	**Wales Infected Blood Support Scheme (WIBBS) Annual Report 2022-23** The Trust Board **NOTED** the contents of the report.	
7.0.0	**ANY OTHER BUSINESS** The Chair had not received prior notice of any other business. Alan Prosser noted that the WIBBS annual report had indicated that the final report will be published during Autumn 2023, however it will now be published during Spring 2024. Vicky Morris reiterated the importance of the governance route in relation to the policies under item 6.2.6 and Carl James agreed to make any necessary amendments.	
8.0.0	**DATE and TIME of the next meeting** The next meeting of the Public Trust Board will take place on Thursday 30th November 2023.	
9.0.0	**CLOSE**	

VELINDRE UNIVERSITY NHS TRUST
PUBLIC TRUST BOARD MEETING 30th NOVEMBER 2023
ACTION LOG

No.	Action	Owner	Target Date	Progress to date	Status (Open / Closed)
ACTIONS ARISING FROM 28/9/2023					
2.2.0	Congratulations to be sent on behalf of the Board to Becky Bowie, celebrating her qualification as the Trust's first Assistant Practitioner.	Vice Chair	**30/11/2023**	**Update 08/11/2023** – Congratulations sent by Vice Chair by email on 08/11/2023.	**CLOSED**
3.1.0	Include detail in Trust Risk Register / reference information captured elsewhere in relation to how risks are being addressed and managed downwards (for assurance purposes).	Director of Corporate Governance & Chief of Staff	**30/11/2023**	**Update 06/11/2023** – Included in paper for November 2023 Trust Board.	**CLOSED**
3.1.0	Identify a method of informing Trust Board that risks with an impact rating of 5 are being monitored and managed via SLT meetings.	Director of Corporate Governance & Chief of Staff	**30/11/2023**	**Update 06/11/2023** – To be included in paper for January 2024 Trust Board.	**OPEN**
3.2.0	Seek approval of Trust Assurance Framework (TAF) via Chair's urgent action.	Director of Corporate Governance & Chief of Staff	**30/11/2023**	**Update 06/11/2023** – Approach agreed at Audit Committee and confirmed with Trust Board	**CLOSED**

TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING	30/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

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

ACRONYMS	
WBS	Welsh Blood Service
VCC	Velindre Cancer Centre

1. SITUATION / BACKGROUND

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

- AGM
- Board Development Sessions
- WBS Donor Awards Ceremony 18th / 19th October 2023 and 14th November 2023
- Veggies for Velindre visit 28th October 2023
- Retirement of Dr Tracey Rees – Welsh Blood Service 27th October 2023
- VCC Remembrance Service – 10th November 2023
- Winner of Employee Excellence Awards – 29th September 2023
- Introductory Meeting with Meeting with Llais Regional Ambassdor
- Defence Employers Recognition Scheme Awards – 23rd November 2023
- 15 step visit to the Welsh Bone Marrow Collection Team Department – 27th September 2023

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Annual General Meeting

The Chair led the AGM on 29th September which was held at Trust Headquarters. The annual accounts and twelve extraordinary days from 2023 were presented, to provide a flavour of achievements across the Trust over the course of the year.

2.2 Board Development Sessions

A Board Development Session was held on 24th October 2023. Topics discussed were:

- National Data Resource programme.
- Health Technology Wales: Ministerial priorities and collaboration the Welsh Blood Service.
- WBS Showcase items:
  - 5 minute service improvement initiative.
  - Development and progress of the National Blood Health Plan for Wales 2-24-2027.
  - WBS Transplantation Services – past, present and future.

2.3 WBS Donor Awards 18th / 19th October 2023 and 14th November 2023

The October Welsh Blood Service Donor Award ceremony took place over two evenings in Wrexham, celebrating donors from Wrexham and neighbouring areas for their commitment to those in need. The ceremony was also attended by the Chair of Betsi Cadwaladr University Health Board and was the first Wrexham donor award event since prior to the COVID-19 pandemic.

83 donors were welcomed to celebrate their 50th and 75th and whole blood donations, including 16 donors celebrating their 100th whole blood donations. Robert (Bob) Evans, pictured left, was recognised for his lifelong achievement of an exceptional 203 whole blood donations, having first donated in 1961.

The Director of the Welsh Blood Service, Alan Prosser and the Chair attended a donor clinic, met with staff who were presented with two gold awards – one for the Wrexham Collection team and one for the Hospital Services Stock Holding Unit.

The November ceremony, which the chair attended, took place in Haverfordwest, also showcasing local blood donors celebrating their 50th, 75th and 100th donations, demonstrating their commitment to the Welsh Blood Service.

2.4 Veggies for Velindre Visit 28th October 2023

The Chair and High Sheriff of Mid Glamorgan visited Seren and Morgan Lewis-Dawe and their 'Veggies for Velindre' initiative, presenting the siblings with the Trust's Volunteer award in recognition of their achievement. The High Sheriff was treated to a tour of the allotment the children had created, having transformed an abandoned space over many months.

2.5 Retirement of Dr Tracey Rees, Welsh Blood Service

Following 41 years of service at the Welsh Blood Service, Dr Tracey Rees, Chief Scientific Officer, retired at the end of October.

Having begun her journey in 1982 aged 18, as a trainee Medical Laboratory Scientific Officer and after gaining a number of qualifications and specialising in blood transfusion, Tracey changed disciplines to support transplantation services.

After working through several senior Scientist positions, Tracey became the Head of the Welsh Transplantation and Immunogenetics Laboratory (WTAIL), which also operates the Welsh Bone Marrow Donor Registry. During her time at the Welsh Blood Service, Tracey has been instrumental in shaping and improving the service which operates today.

The Trust Executive Team and Board wished Tracey well, following what has undeniably been an exceptional career.

2.6 VCC Remembrance Service – Friday 10th November

To mark Remembrance Day, a service was held outside the main entrance to the Cancer Centre at 11am. Our hospital chaplain, Rev Ben Tugwell officiated. The exhortation and Kohima Epitaph was read by Simon Lawrence and wreaths were laid at our cenotaph by Chair and colleagues from 203 (Welsh) Multi Role Regiment.

'The Last Post' was played by Alex James (former employee) and a two minute silence was observed. The service was attended by a number of staff.

2.7 Winners of Employee Excellence Awards – Friday 29th September

The 2023 Employee Excellence Awards saw a total of 16 awards presented to individuals and teams across the Trust. More than 180 nominations were received for the awards, including a number from members of the public.

Hannah Russon (pictured), Project Lead, was awarded the Chair and Chief Executive's Award for her contribution to developing and establishing the Velindre Oncology Academy. The Academy will provide accredited Oncology education, training and upskilling to Velindre University NHS Trust staff, Wales and wider.

2.8 Regional AMBASSADOR FOR Llais

The Chair and Chief Executive held an introductory meeting with Bamidele Adenipekun who is the newly appointed Llais Cymru Regional Ambassador for the Cardiff and Vale of Glamorgan region which covers Velindre University NHS Trust.

2.9 Defence Employers Recognition Scheme Awards – 23rd November 2023

The Chair, along with colleagues, attended the Defence Employers Recognition Scheme awards on the 23rd November 23. The Trust was awarded Gold recognition, one of only ten organisations in Wales to be recognised for their support of those who serve, reservists, veterans and cadets.

2.10 15 step visit to Welsh Bone Marrow Collection Team Department – 27th September 2023

The Chair and Director of Finance were pleased to visit the stem cell donor clinic at Velindre cancer centre. Chris Harvey, manager, together with Fariba Thompson and Lisa Hicks, clinical nurse specialists, together with a student nurse were present. We were fortunate to meet a donor who was making a stem cell donation and who was able to explain to us how straightforward the process had been and how supportive the staff were.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	This has been considered. No implications
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

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

TRUST BOARD

VICE CHAIR'S REPORT

DATE OF MEETING	30/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Stephen Harries, Vice Chair
PRESENTED BY	Stephen Harries, Vice Chair
EXECUTIVE SPONSOR APPROVED	
REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

Vice Chair's Update to Trust Board November 2023

This Report provides an update from the Vice Chair.

Employee Excellence Awards Ceremony

On 29 September 2023 I attended the Employee Excellence Awards ceremony and had the pleasure of presenting two of the awards to the chosen winners.

Trust Board & Committees

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

- Annual General Meeting – 29 September 2023
- Board Development Session – 24 October 2023
- Extraordinary Private Trust Board – 14 November 2023

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

- TCS Scrutiny Sub-Committee, Public Meeting – 12 October 2023
- TCS Scrutiny Sub-Committee, Public & Private Meetings – 26 October 2023
- Strategic Development Committee, Public and Private Meetings – 7 November 2023
- Extraordinary Strategic Development Committee, Private Meeting (single agenda item - to review contractual matters in relation to the Trust's Blood Establishment System) – 15 November 2023
- TCS Scrutiny Sub-Committee, Public & Private Meetings – 23 November 2023

I have attended the following Committee meetings:

- QSP Committee, Public and Private Meetings – 16 November 2023
- Remuneration Committee - 16 November 2023

External Meetings

On 2 October 2023, together with the Chair and a colleague IM, I attended a meeting with Marie Curie.

On 18 October 2023 I attended a Peer Group Meeting of Independent Members, Digital.

On 15 November 2023 I attended a Meeting of Vice-Chairs of Health Boards and Trusts.

Internal Meetings

On 25 October I met with the Trust's newly-appointed Clinical & Scientific Strategy Lead, as part of the wider engagement and consultation process.

On 31 October 2023 I met with the Chief Executive, Executive Director of OD & Workforce, and Deputy, in my role as the Trust's "*Speaking up Safely Board IM Champion*".

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

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	30/10/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

Matters addressed in this report cover the following:

- Joint Executive Team Meeting
- Update on new Velindre Cancer Centre
- Working Together staff sessions
- Clinical and Scientific arrangements update

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Joint Executive Team Meeting

The Trust's executive team met with the executive team of Health & Social Care in Welsh Government on 17th November. This was a mid-year 2023/24 meeting. The agenda covered:

- Organisational Reflections:
  - What's gone
  - What's to come
- Quality Delivery and Ministerial Priorities
- Governance, Risk Management and Trust Board
- Workforce: Developing a Sustainable Future
- Planning and Financial Decisions Under Consideration

The Trust's slide deck has been shared with Trust Board members and the successes summary is attached to this report for ease of reference. The teams had an excellent discussion and the formal feedback when received will also be shared with the Trust Board.

2.2. Update on new Velindre Cancer Centre

For the information of the Trust Board, the following update was shared with Trust staff on 22nd November:

"As you know, we are finalising the agreement with our consortium partner Acorn, who is developing the new cancer centre – an agreement which includes the final design, commissioning of the new centre and operating it for the next 25 years. We have progressed with pace over recent months and many of you have supported the project team. We are now in the final stage of the process. We would like to thank you for the tremendous effort put in to get us to this final stage.

The project team will continue to work with you to consider the alignment of the project's timelines and ongoing programmes of work at the cancer centre and other health boards, such as the Radiotherapy Satellite Unit at Nevill Hall.

We know that we have come this far on the basis of great teamwork. Thank you, everyone, for everything you continue to do for the staff, patients, families, carers and friends of the new Velindre Cancer Centre.

Steve Ham
Chief Executive Velindre University NHS Trust

David Powell
New Velindre Cancer Centre Project Director"

2.3 Working Together staff sessions

As referenced in the Chief Executive's report in the September Trust Board, the Chief Executive would like to confirm that the sessions have been progressing well. These are taking place across divisions and corporate services in the Trust as well as on-line, to provide an opportunity for staff to get together for discussion with the Executive Board and Senior Leadership Team members to discuss what it feels like to work for the Trust today.

The approach is part of the Building our Future Together organisational change approach, which the Trust Board signed off in March 2023. This will then become a regular way of engaging with staff across the Trust and the key themes, and action taken as a result, will be fed back through the Building our Future Together reporting. In addition, feedback videos are being shared with staff and where appropriate, specific follow up with different groups also being addressed.

2.4 Clinical and Scientific arrangements update

The Chief Executive would like provide an update the establishment of the Trust's Clinical & Scientific strategic infrastructure and the development of the Clinical & Scientific Strategy, which will set the strategic clinical and scientific direction for the Trust over the next five years.

The Chief Executive would like to welcome Joanna Doyle who joined the Trust in October on a secondment as Clinical and Scientific Strategy Lead. Joanna is a senior paediatric nurse with 28 years' experience working within operational and strategic roles and as a programme manager within the NHS. Since 2016 she has been leading the All-Wales Nurse Staffing Programme working within Health Education and Improvement Wales.

The first Clinical & Scientific Board has been held as well as significant engagement with stakeholders over the period. This includes Trust and national clinical and scientific leaders, as well as collaborating and engaging with front line staff to inform the development of the Clinical and Scientific Strategy. We are keen to ensure that all our stakeholders have an opportunity to share their views and ideas to help us inform the strategy.

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:
	Not required

EQUALITY IMPACT ASSESSMENT COMPLETED	
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

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

Successes Snapshot H1 2023/4

Ground-breaking trial at Velindre in the news - Clinical trial for glioblastoma patients features on BBC Wales 31 October 2023

Head and neck cancer trial passes incredible 1000 patient recruitment milestone

Intimate, inspiring documentary following Rhod Gilbert's treatment

A "pioneering" team based at Velindre have won a prestigious national award for their achievements.
The South East Wales Immunotherapy Toxicity Service took home a Macmillan Professionals Excellence Award at the annual ceremony

PRIDE IN VETERANS STANDARD
FIGHTING WITH PRIDE

Trust signed up to the Pride in Veterans Standard as part of its commitment to advocating and supporting those that are and have served within the Armed Forces.

The results of INTERLACE trial marks the biggest cervical cancer drug advance in 20 years

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

Successes Snapshot H1 2023/4

Continued Donor Awards across the country

Trust's first Assistant Practitioner, having advanced from being a Healthcare Support Worker to a Trainee Assistant Practitioner.

A major UK clinical trial to treat the most aggressive brain tumour has opened at the Velindre Cancer Centre

Welsh Blood Service were shortlisted for : Providing services in partnership across NHS Wales.
The project involved the development of an innovative new kidney transplant dashboard that has been launched by the Welsh Blood Services' Welsh Transplantation and Immunogenetics Laboratory (WTAIL).

SE Wales Acute Oncology Learning Portal Launched – key role

Sarah Morley, Executive Director of OD and Workforce, appointed as joint President of the Healthcare People Management Association (HPMA).

Successes Snapshot H1 2023/4

The VCC Paracentesis Team have been awarded a Chief Nursing Officer Excellence Award for their outstanding work.

Launch of digital prospectus of training courses being run by the School of Oncology

cilip
Chartered Institute of Library and Information Professionals

One of our library staff has been named on the list of the top 125 movers and shakers of the next generation of library and information specialist leaders.

At inaugural Vaccination Saves Lives (VSL) awards hosted by Public Health Wales at their 20th Welsh Immunisation Conference, the Welsh Blood Service has been awarded the Vaccination Saves Lives Team Award for its work supporting the national Covid-19 vaccination programme.

£3 million to launch the Advancing Radiotherapy Cymru Academy
An All-Wales radiotherapy initiative led by Velindre Cancer Centre

Llongyfarchiadau to all our winners this year

TRUST BOARD

BOARD CHAMPION (QUALITY & SAFETY) REPORT

DATE OF MEETING	30/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Vicky Morris, Independent Member
PRESENTED BY	Vicky Morris, Independent Member
EXECUTIVE SPONSOR APPROVED	
REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

QUALITY AND SAFETY CHAMPION REPORT TO THE BOARD - NOVEMBER 2023

Introduction

I commenced my role as independent member (Quality, Safety and Performance) in December 2021. In providing this champions report, I can demonstrate how I use a number of different approaches to triangulate the information received and provide assurance to the Board or indeed escalate issues if required. As a registered Nurse, I can use my clinical expertise and Board experience to quickly get to the core of issues having worked as a Director of Nursing/Chief Nurse for 18 years which included all aspects of Safety including Executive lead for Safeguarding and Infection prevention and control.

Focus

The Focus for this champions report is on Safeguarding (Adult and Child safeguarding), infection prevention and control and Safety walkabouts.

1. Infection, prevention and Control

An annual Report 2022-2023 was provided to Quality, Safety and Performance Committee and to the Board in July 2023. The executive summary provides a comprehensive overview of the Trust's infection prevention and control efforts conducted throughout the year. That report highlighted the key achievements, challenges and future directions to enhance infection prevention and control practices within the organisation. In summary the Trust implemented robust infection prevention and control measures to mitigate the risk of healthcare associated infections (HAIs).

- Rigorous hand hygiene protocols, comprehensive staff education and training programs and effective surveillance systems were put in place to monitor and respond to potential outbreaks.
- In addition to the workload generated by COVID-19 pandemic, the Infection Prevention and Control Team (IPCT) continued to oversee education, guidelines and practice to ensure risk of infection is minimised in the Trust.
- Exploring research and innovation opportunities, working with Transforming Cancer Services team for IPC design and finishes.

1.1 Key achievements

- VUNHST was the first organisation in Wales to achieve ANTT Gold accreditation which validates excellence
- 40% decrease in healthcare associated Clostridioides *dificile* infection compared to 2021-2022 figures
- There were no cases of Pseudomonas *aeruginosa* bacteraemia identified in 2022-2023, 100% reduction compared to 2021-2022 figures
- Zero Velindre-related case of MRSA bacteraemia since November 2013 (10 years) (The one initially recorded on our performance report following the RCA was confirmed as community-acquired)
- VUNHST Infection Prevention & Control Team successfully hosted an All-Wales Ventilation Study Day
- VUNHST first in Wales to achieve substantial compliance for water safety

Data contained within the annual report demonstrated that despite challenges posed by the ongoing COVID-19 pandemic, the IPCT continued to improve and sustain improvements in the reduction of healthcare associated infections at the Trust.

1.2 Governance

- The Infection Prevention and Control Management Group (IPCMG) is integral to the achievement of the Trust's infection, prevention and control objectives. This is chaired by the Executive Director of Nursing, AHPs and Health Science who is the Executive lead for infection prevention and control.
- The purpose of the Group is to ensure that Velindre University NHS Trust is:
  - adequately executing its responsibilities in relation to preventing and controlling infections and therefore taking all actions to prevent infection-related avoidable harm to patients.
  - to ensure ongoing compliance with the Health and Care Quality Standards (2023) for Infection Prevention and Control and Decontamination providing strategic leadership and direction on infection prevention and control activities across the Trust to ensure the risks posed by transmission of avoidable infections is minimised.
- Trust IPCMG (and VCC & WBC IPC Summit meetings) are held quarterly.
- Reporting and assurance arrangements - The IPCMG formally reports into the Trust's Executive Management Board and onto the Trust's Quality, Safety and Performance Committee which is chaired by myself as IM (Quality, Safety and Performance). A highlight report will be provided to QSP following each meeting supplemented by any papers identified as being required at the meeting. All such reports are approved by the IPCMG chair prior to submission.
- All members are expected to attend IPCMG each meeting. In the event of being unable to attend it is the member's responsibility to arrange for a deputy to attend who has full authority to act and make decisions on behalf of the member.

In my champion role, by attending the IPCMG at least annually I can see the IPCMG group in practice, with the expert chairmanship of the Executive Director of Nursing, AHPs and Health Science and the good attendance and contributions of all members. To date, I have attended at least twice since commencing my role. As the Champion for safety, it is important to attend this meeting to back up the triangulation of information received in the performance reports presented to QSP and to the Board and also to use the 15 step challenge process to get out and about to clinical areas to see and gain assurance (or not) on IPC practice, environmental cleanliness standards and environmental challenges which may constrain best practice. The QSP Committee can track any actions fed back to staff on these visits through a tracker which is being developed and enhanced in 2023. These actions are tracked through IPCMG and QSP if related to IPC/Decontamination. By being a member of the Audit Committee and QSP, I can receive Internal audit reports/Audit Wales reports as well as regulatory/Peer review visits and any related IPC issues which may arise.

2. Safeguarding

As in IPC, I have attended at least 2 Safeguarding meetings since joining the Trust and have seen first-hand the leadership and clinical expertise that we have in place. The leadership expertise and regional recognition of this enables Velindre University NHS Trust to connect to the national and regional safeguarding meetings and processes and ensures we can share safeguarding learning from both adult and child safeguarding reviews and multi-agency reviews. I have witnessed directly in meetings how requirements internally to support safeguarding are followed through and people are held to account to ensure systems, processes and policies are robust.

As Board champion, I work closely with the Executive Director through the 15 step challenges, following up on actions required through QSP and triangulating information provided in papers to QSP and to the Board. So, in summary:-

- Velindre University NHS Trust continues to fulfil all duties and statutory obligations to safeguard and support patients, donors, staff and the organisation.
- A workplan is in place to continue improvements within both Safeguarding and Vulnerable persons. Progress is monitored at the quarterly Safeguarding Vulnerable Adults Group. Attendance at the group is consistently high with a variety of representatives at a leadership

level from VCC & WBS. External scrutiny is provided by an independent corporate member and Designated Nurse for Safeguarding from PHW National Safeguarding Service.

- Assurances regarding safeguarding activity are provided through internal reporting to QSP and EMB meetings.
- The challenge of having expert leadership in place is that they subsequently gain promotion to wider Quality and Safety roles/professional leadership roles. As a result of recent successful promotion, the Trust has recently experienced a gap in a visible substantive named professional as the Head of Safeguarding, however the Exec lead and previous Safeguarding lead have maintained oversight until the successful Head of Safeguarding has commenced her role.
- Recent challenges in achieving the required levels of safeguarding related training is acknowledged due to the vacancy of the head of Safeguarding. The successful recruitment into this vacancy and another into the temporary MCA role is enabling the team to focus on areas of lowest compliance with targeted divisional discussions.
- So, the succession planning for safeguarding activity has been successful and external expertise brought in to head up this key part of safety work for the Trust. Workstream progress has continued over the summer and Autumn, notably with the Once for Wales pilot, the appointment of a Practice Educator for MCA training and ensuring the Trust provided responses for key Welsh Government safeguarding consultations and staff had access to safeguarding advice and supervision.

3. The 15-Step Challenge

A process introduced in Velindre University NHS Trust in 2022, the “15-Step Challenge” is an initiative introduced by the National Patient Safety Agency a number of years ago. The process looks at safety and risks in clinical areas. This process enabled me as an Independent Member of the Board to engage in undertaking visits to clinical areas to both engage with staff and listen to any key concerns/safety concerns that they may have. These were undertaken with the Director of Nursing, AHP and Health Science but could have been undertaken with any one of the Executive Directors.

By undertaking a safety walkabout within that clinical area, you could observe practice in real time and assess the clinical environment and raise any potential issues of concern or clarify any queries with staff.

Corporate administration support on site enabled key discussions and questions to be captured which could then be tracked through to completion.

Appendix 1 provides a summary of the visits that I have undertaken to date as IM and safety champion acknowledging that for a period of time (late 2022 into 2023) no 15-step challenges were booked through the corporate offices. This process has now recommenced and as outlined earlier in the paper, the 15-step challenge is an ideal opportunity to triangulate with key issues raised through the Governance arrangements across the Trust and to observe first-hand the excellent practice in place and where improvements could and should be made.

Vicky Morris

Independent Member (Quality, Safety and Performance)
November 2023

DATE OF CHALLENGE	LOCATION	PRESENT	DATE REPORT SENT	TO WHOM	DATE ACTION PLAN RECEIVED	CHASED	REPORT RECEIVED AT QSP	DIVISION
19/05/2022	Laboratories, WBS, Talbot Green	Nicola Williams, Executive Director of Nursing, Vicky Morris, Independent Member and Kyle Page, Business Support Officer	21/06/2022	Tracey Rees (Chief Scientific Officer), Alan Prosser (Director WBS), Peter Richardson (WBS QA Systems), Stephen Pearce (Head of Manufacturing & Distribution).	13/10/2022	Rec'd 2/9 but update chased 7/10 for QSP	10/11/2022	WBS
26/07/2022	Radiotherapy Department, VCC	Nicola Williams, Executive Director of Nursing and Vicky Morris, Independent Member	05/08/2022	Rachel Hennessy (Interim Director VCS), Kathy Ikin (Head of Radiation Services), Helen Payne (Radiotherapy Service Manager), Hayley Jeffreys (Infection Prevention & Control Nurse), Viv Cooper (Head of Nursing), Samantha Allen (Treatment Superintendent), Steven Floyd (Superintendent Radiographer).	17/10/2022	07/10/2022	10/11/2022	VCC
23/08/2022	Collections Team, Wrexham and HQ	Nicola Williams, Executive Director of Nursing, Vicky Morris, Independent Member, Kyle Page, Business Support Officer	06/09/2022	Jane Porter, (Operational Manager), Sally Gronow (WBS Deputy Head of Collections Services), Alan Prosser (Director WBS), Michelle Higgins (Senior Clinic Nurse).	12/10/2022	07/10/2022	10/11/2022	WBS
08/09/2022	First Floor Ward, VCC (Lauren Fear shadowing)	Nicola Williams, Executive Director of Nursing, Vicky	20/09/2022	Rachel Hennessy (Interim Director VCS), Cath O'Brien (Chief Operating Officer), Matthew Walters (Advanced	21/10/2022	07/10/2022	10/11/2022	VCC

		Morris, Independent Member, Kyle Page, Business Support Officer and Lauren Fear, Director of Corporate Governance & Chief of Staff		Nurse Practitioner, Viv Cooper (Head of Nursing) , Nigel Downes (Deputy Director of Nursing).				
24/10/2022	WBS Collections Team, UHW Cardiff	Nicola Williams, Executive Director of Nursing, Vicky Morris, Independent Member, Kyle Page, Business Support Officer	07/11/2022	Alan Prosser (Director WBS), Sally Gronow (Deputy Head of Collections WBS), Amanda Ewing (Collections), Cheryl Dodd (Donor Contact Centre Advisor)	09/12/2022	02/12/2022		WBS

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	30.11.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

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

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

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board – Run	02.11.2023
Quality, Safety and Performance Committee	16.11.2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The three key points highlighted to the Quality, Safety and Performance Committee in November were:

- Following Quality, Safety and Performance Committee, Audit Committee and Trust Board in previous cycle, there has been significant challenge at both Divisional and Executive Management level regarding the scoring and target scoring of risks.
- Approach to digital risk review was agreed – which is a separate paper to be brought back on the enterprise digital risk landscape to the January Committee meeting.
- It was highlighted that the Joint Executive Team Meeting included a section on risk.

During the meeting, further matters were raised:

- A key theme arising from the Committee papers was around issues with Administration systems and processes. This will be considered by the Divisional leadership teams and appropriate risk(s) articulated and scored.
- The two 15 level risks are related to workforce issues in Velindre Cancer Services. The Committee noted that this is currently not clear on the Workforce Risk 03 in the refreshed Trust Assurance Framework and again, this will be addressed for the next version.
- The Committee asked for further consideration of how the report can be clear in evidencing the active risk management over the period, as the current format of reporting provides the background and history of the risk also and therefore the current update can be unclear.
- It was discussed that the Datix information for risk 2515 required updating.

The October Audit Committee, following the last Trust Board, also discussed the risk register and framework development.

- Audit Committee were also challenging on ensuring a clear report on changes since the last period. - In addition, the Audit Committee discussed whether an Assurance Level of 2 was still appropriate. This is because the outcomes in Level 2 should show "measurable impact from actions taken." The static residual/ current scores over recent reporting cycle of many of the Trust Board reportable risks meant that the evidence for this was therefore not clear. The Audit Committee concluded, based on the assurance of the significant Executive review due for this cycle of reporting, to agree with the Level 2 but that this would be reassessed in the December meeting.

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

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR				2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.			

APPENDICES	
1	Current risk register data.
2	Risk data graphs

1. SITUATION

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

2. BACKGROUND

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

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 5 risks to report to Board and Committee on Datix 14, this includes 3 risks with a current score over 15, one of which is a private risk, and 2 risks with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Risk Register

- The risk register detail in Appendix 1 is for consideration by the Trust Board.
- To note all actions in the Datix action plan section have assigned owners – however given named individuals on the system, this is not included in reporting. If any member would like further details, this can be provided.
- Executive Management Board conducted a detail risk review on 6th November, following the October work. There was significant challenge on some scoring and also target scores. This has resulted in the target score on two risks being challenged and now will be reconsidered through Divisional governance prior to Executive Management Board sign off.

4.2 Risk Progress Updates

A summaries of progress against the public risks on the risk register have been drawn from the information held on Datix and included here.

Risk 2187
A comprehensive five year workforce plan is underway to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC.

The plan includes recruiting to the 13.5 posts within the satellite centre business case and additional posts for the IRS commissioning schedule at nVCC.

It has been identified that financial support of the workforce plan will be required in order to achieve the target risk rating.

A process of continual prioritisation of business critical tasks is in place and it is ensured that detailed project and resource plans are kept up to date.

Every occurrence when developmental/Integrated Radiotherapy Solution (IRS) work is put on hold to meet urgent radiotherapy treatment planning demand is being logged, as of 16.10.2023.

Risk 2515
All training previously identified is under implementation.
The options appraisal have been delayed until early 2024 due to the high current service demand.

There is an additional demand on current resources to the support the shift to a paperless radiotherapy service in readiness for the satellite centre. The service will be paperless by May 2024.

Risk 3001
A meeting of the Workforce and OD SLT and Executive Director took place to review the risk. Confirmation was made that the Healthy and Engaged Workforce Steering Group is the meeting to oversee this risk and it will be reviewed at the steering group on a quarterly basis.

Risk 2465
An email review has been undertaken. There was a delay in the proposed timeline due to the individual leading the review needing to prioritise Covid Inquiry requests. The ways of working recommendations are anticipated.

A Trust etiquette document is being finalised as part of this work.

Interim work has commenced to move to centralised email boxes by Sight Specific Teams for clinical issues.

Communications will she shared to highlight that all urgent requests should not use email as a means of communication, clarified with key areas such as SACT, medical secretaries roles and responsibilities and to not send emails ‘just in case’. October, which identified there were no digital risks reportable to Trust Board at this time.

4.3 Summary of Actions Taken/ In Plan from Recent Governance Cycle of Quality Safety & Performance and Audit Committee

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe
1	Risk scores and target risk scores	Following Executive Management Board review and Divisional Leadership Team work, a number of scores were challenged and are being reassessed through the December-January cycle	December-January reporting cycle
2	Digital Risks	Separate paper to be brought back on the enterprise digital risk landscape to the next Committee meeting.	January Quality, Safety & Performance Committee
3	Administration systems and processes	This will be considered by the Divisional leadership teams and appropriate risk(s) articulated and scored	December-January reporting cycle
4	15 level risks are related to workforce issues in Velindre Cancer Services – triangulated to TAF 03	Workforce Risk 03 will include this in next review	December-January reporting cycle
5	Formatting of report to be clear on active risk management in the period	New updates from Datix are included in this cover paper as well as in a separate column in the Risk Register appendix	Addressed in this paper
6	Datix information for risk 2515 required updating	Updated since November Quality, Safety & Performance Committee	Addressed in this paper
7a	Assurance level considerations by Audit Committee	Active risk management has resulted in a number of scores being reduced however not yet evidence of impact of actions on remaining risks – This will be further addressed and challenged in next period	December-January reporting cycle

		and explicit comment from the Executive Management Board (EMB) will be included for the next report – to demonstrate why EMB is comfortable with the current risk score or if not, what action is being taken.	
7b	Assurance level considerations by Audit Committee	In addition, any decrease in scores which result is no longer being currently reported at Trust Board level will be summarised for the next report in a separate table in the cover paper also.	December-January reporting cycle
8	Trust Board September action to include a method of informing Trust Board that risks with an impact rating of 5 are being monitored and managed via SLT meetings.	To agree approach with Divisional Leadership Teams and reflect in next reporting cycle.	December-January reporting cycle

4.4 Next Steps in Engagement and Embedding

- As of 25th October 2023 an Introduction to Risk training has a completion rate of 73.11% across VCS, WBS and Corporate.
- As we approach the six month initial completion deadline (end November) work is being undertaken with managers to ensure completion of level one training, as well as sharing the training through Trust wide communications.

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒	

. An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒ The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item. There are no direct well-being goal implications or impact in the current risks in this paper.

	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and / or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text. **Type of Funding:** Choose an item. **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text. **Type of Change** Choose an item. Please explain if 'other' source of funding selected: Click or tap here to enter text.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

	Click or tap here to enter text.

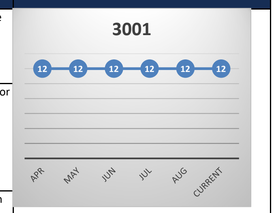
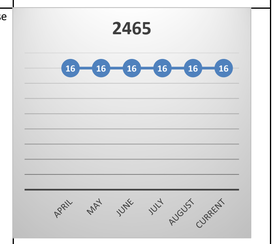
6. RISKS

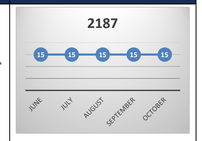
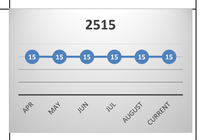
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require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

APPENDIX 1

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

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

ID	Risk Title - New	RR - Current Controls	Risk (in brief)	Progress Update since Last Governance Cycle	Risk Type	Opened	Amount of Days Open	Division	Is this a Private & Confidential Risk?	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (Current)	Impact (Current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Date Target rating will be achieved	Review date	Due date	Description	Trend Graphs
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	A meeting of the Workforce and OD SLT and Executive Director took place to review the risk. Confirmation was made that the Healthy and Engaged Workforce Steering Group is the meeting to oversee this risk and it will be reviewed at the steering group on a quarterly basis.	Safety	09/12/2022	321	Corporate Services	No	4	4	16	4	3	12	3	3	9	31/03/2024	31/12/2023	31/03/2024 09/12/2022 21/03/2023 22/12/2023 31/03/2024	Divisions/Departments should have proactive stress risk assessments Formal arrangements not in place for the Healthy and Engaged Steering Group to evaluate wellbeing interventions Steering Group This risk needs a SMART action plan Systemic factors that impact on levels of workforce stress to be described and associated actions plans developed Develop management training in managing stress	
2465	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	An email review has been undertaken. There was a delay in the proposed timeline due to the individual leading the review needing to prioritise Covid Inquiry requests. The ways of working recommendations are anticipated. A Trust etiquette document is being finalised as part of this work. Interim work has commenced to move to centralised email boxes by Sight Specific Teams for clinical issues. Communications will she shared to highlight that all urgent requests should not use email as a means of communication, clarified with key areas such as SACT, medical secretaries roles and responsibilities and to not send emails 'just in case'.	Safety	05/11/2021	720	Velindre Cancer Centre	No	4	4	16	3	4	12	2	2	4		29/12/2023	09/10/2023	IB to undertake an audit into the use of email within the medical directorate across VCC	

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Progress Update Since Last Governance Cycle	Risk Type	Opened	Amount of Days Open	Division	Is this a Private & Confidential Risk?	Likelihood (Initial)	Impact (Initial)	Rating (initial)	Likelihood (Current)	Impact (Current)	Rating (current)	Likelihood (Target)	Impact (Initial)	Rating (Target)	Date Target Risk Due to be	Review date	Due date	Actions	Trend Graphs
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks. Inadequate staffing may result in: - Patient treatment delay and breaches - Key projects not keeping to time with an impact on radiotherapy capacity e.g. commissioning and implementation of IRS systems, system upgrades of essential radiotherapy software and hardware - Suboptimal patient treatment - either due to lack of planning time or lack of developmental time - Radiotherapy treatment errors; individual patient errors or errors affecting multiple patients due to insufficient developmental, commissioning or training time, or too few staff with the specialist skills required. This staff group comprises highly trained, specialist scientific and technical staff key to ensuring quality and safety of radiotherapy treatments. The Engineering Section in particular is identified as an area of risk to the radiotherapy service, with 2 recent retirements and an additional 4 engineers due to retire within the next 4 years. Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. RTDS data submissions v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. The risk rating did reduce to 10 following recruitment of surge posts but has since increased to 15 as the number of Physics posts required for the implementation of the IRS is significantly greater than the posts recruited to, with the resource gap being filled by staff within the service.	A comprehensive five year workforce plan is underway to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC. The plan includes recruiting to the 13.5 posts within the satellite centre business case and additional posts for the IRS commissioning schedule at nVCC. It has been identified that financial support of the workforce plan will be required in order to achieve the target risk rating. A process of continual prioritisation of business critical tasks is in place and it is ensured that detailed project and resource plans are kept up to date. Every occurrence when developmental/IRS work is put on hold to meet urgent radiotherapy treatment planning demand is being logged, as of 16.10.2023.	Safety	14/09/2020	1137	Velindre Cancer Centre		5	5	25	3	5	15	2	5	10	31/10/2024	29/12/2023	31/10/2023	5 year workforce programme - Complete comprehensive 5 year workforce plan to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC.	
																					30/11/2023	Readvertise post which did not recruit - Re-advertise IRS implementation lead for the development of novel techniques.	
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	Brachytherapy Staffing Levels at Velindre are at varied levels of resilience across the service. Clinical Oncology: There is one ARSAC Practioner Licence holder in urology and two in gynaecology and this is recognised as position of low resilience. A Speciality Doctor was appointed from Prostate Expansion Business case is currently working with Breast SST Radiotherapy: Not all Brachytherapy Advanced Practioners can cover all tasks required within the section to provide resilient service cross cover. Time demands from DXR administration and treatments conflict with brachytherapy service provision and training. Theatre: One member of the team is currently on long term sick. Return to work due May 2023. Physics: Currently two Brachytherapy MPEs appointed. A recent resignation (April 2023) of a staff member in MPE training and one MPE due to start maternity leave in July 2023 has left the service vulnerable to a future MPE single point of failure. This could lead to service discontinuity.	Service provision across all specialties is managed by careful examination of rotas and managing leave within the teams. Clinical Oncology: One Consultant Oncologist in Urology is currently practicing under ARSAC Delegated Authority. Application for an ARSAC Practioner Licence is to be submitted. A locum Consultant Clinical Oncologist was appointed in Nov 2022 is currently in Brachytherapy training. Previous experience in brachytherapy will expedite local training. On completion she may practice under Delegated Authority (September 2023) with the aim to apply for an ARSAC Practioner Licence. Radiotherapy: Four Brachytherapy Advanced Practioners (3.2WTE) were appointed in October 2022 to address lack of resilience within the team. A training schedule for staff is in place to ensure increased resilience from cross cover of tasks. A plan for capacity/demand management and to handover DXR administration tasks to RT is under construction. Timeframe not established. DXR treatments to be handed over with introduction of nVCC. Theatre: Staffing hours have been increased (March 2023) to improve resilience of the service provision. Training plans are under consideration to further increase resilience through cross cover of tasks. Vacant HCA post was filled (March 2023). Physics: A training plan is under implementation to increase the number of Brachytherapy MPE and Registered Clinical Scientists competent to perform MPE duties under written guidelines and supervision. Resourcing this plan has been recognised within Radiotherapy Physics at the highest priority level to ensure a safe and continued service. Future Planning: An options appraisal is to be agreed through the Brachytherapy Operational Group (May-2023) to determine the most appropriate service model to meet forecast demand over a 1 to 5 year period. A workforce paper will be drawn up to staff the model to include resilience and succession planning. A business case will be submitted if required. Staff model completion due September 2023	All training previously identified is under implementation. The options appraisal have been delayed until early 2024 due to the high current service demand. There is an additional demand on current resources to the support the shift to a paperless radiotherapy service in readiness for the satellite centre. The service will be paperless by May 2024.	Performance and Service Sustainability	09/02/2022	624	Velindre Cancer Centre		4	5	20	3	5	15	2	5	10 - Challenged by EMB	31/12/2024	30/12/2023	30/09/2023	Brachy Workforce	
																					14/03/2023	The risk review is overdue	
																					28/03/2023	A SMART Action Plan needs to be developed	
																					31/07/2023	Insufficient brachy MPE	

TRUST BOARD

Trust Assurance Framework

DATE OF MEETING	30.11.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	A review of the Trust Assurance Framework, including a refresh of the Strategic Risks has been undertaken and this paper provides an update to the Executive Management Board, following Trust Board in September and Audit Committee in October.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the Trust Assurance Framework.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Shape	13.11.2023
Quality, Safety and Performance Committee	16.11.2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The three key points highlighted to the Quality, Safety and Performance Committee in November were:

- Of the refreshed Trust Assurance Framework risks, six of the eight are included in Appendix 1 on the new format. The remaining two were amended later in the review cycle and are being worked on at pace by Executive leads.

- The Chair of Quality, Safety and Performance Committee has raised some matters prior to the meeting, including the need to ensure that there was alignment to the Integrated Medium Term Plan goals and then triangulation against the progress on these goals is an important element of first line of defence assurance.

- It is important to note that embedding of the Trust Assurance Framework, as a valuable management tool, through the Divisional leadership teams and senior management across the organisation remains a priority for the next phase of the Governance, Assurance & Risk development.

During the meeting, further matters were raised:

- Specific feedback on individual risks was discussed, including: TAF 01: *"There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources."* requiring greater clarity on Velindre Cancer Services vs Welsh Blood Service references; TAF 02 required further detail and completion; *TAF 03 "There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives."* requires articulation to the Trust Risk Register (as also referenced in the Trust Risk Register Cover paper for Trust Board today). Any additional specific feedback on individual risks will be addressed in the December-January reporting cycles also.

- During reflections on triangulation at the end of the Committee meeting, it was agreed that increased service pressures across many aspects of performance were impacting on the risk of delivery of service. This was to be considered in the context of *TAF 01: "There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources."*

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	***Report for Noting***

APPENDICES	
1	Summary of Strategic Risk Refresh outcomes
2	New Trust Assurance Framework

1. SITUATION

A review of the Trust Assurance Framework (TAF) and Strategic Risks have been undertaken, following collaboration with the divisional Senior Leadership/Management Teams, Committee members, Executives and Independent members.

The new Strategic Risks are included in this paper for information, following a review process through divisional Senior Leadership Teams, Executive Management Board and committees.

The revised Trust Assurance Framework is appended for six of the eight of the strategic risks. These risks were considered at Executive Management Board on 13th November. The remaining two are:

TAF 07 - There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and

complex treatment regime, staffing challenges, and lack of consistent quality, outcome and mortality metrics.

TAF 08 - There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.

2. BACKGROUND

The Trust Assurance Framework (TAF) was established in 2020, detailing ten strategic risks. A dashboard was developed to record the TAF and support ongoing management by Executive Leads.

The Trust Assurance Framework template was reviewed, updated and discussed with Independent Members who sit on the Audit Committee who reviewed the template. The template was endorsed by the Executive Management Board ahead of Audit Committee approval in April 2023.

The Strategic Risk Refresh started with divisional teams, Velindre Cancer Service (VCS) Senior Leadership Team, also attended by some Executive colleagues, and Welsh Blood Service (WBS) with a core group of attendees. These sessions were an opportunity to review the current risks, their appropriateness from a service perspective and to gather suggestions of key areas for inclusion in the refresh. Similar discussions took place in the Executive Management Board and Strategic Development Committee.

The National Risk Register was published in August 2023, a review of which was undertaken and key areas highlighted of relevance to Trust have been considered as part of the Strategic Risk Refresh.

As background, it is important to note that Strategic Development Committee, Quality, Safety & Performance Committee and Trust Board have all expressed concern over recent months that during this review period, a Trust Assurance Framework was not operational for six months. Overarching lessons learnt from this has been discussed in various Committees and Trust Board, and is broadly two-fold:

- The refresh of strategic risks will take place annually going forwards, in line with the Integrated Medium Term Plan review. The Trust Assurance Framework guidelines are being updated to reflect this.
- During all subsequent reviews, the existing risks will be reported on until the refresh has taken place.

3. ASSESSMENT

3.1 Following the Strategic Risk Refresh the outcome has been shared with the Trust Board is included in Appendix 1.

The refreshed Strategic Risks have been populated on to the new Trust Assurance Framework Dashboard, which has previously been reviewed by this Committee and approved by the Audit Committee. The new template links with strategic frameworks, includes an area for reference to operational risk related to the strategic risk and have SMART action plans, alongside the core information around key controls, sources of assurance and gaps in controls.

3.2 Summary of Actions Taken/ In Plan from Strategic Development Committee, Quality Safety & Performance and Audit Committee:

	Matter raised through recent governance cycle	**Action Taken/ In plan**	**Timeframe**
1	Populate refreshed TAF on Bower BI template	Work completed in background on Power BI and refreshed information to be populated from next reporting cycle.	December-January reporting cycle
2	Finalise template for remaining two newest TAF risks – TAF 07 and 08	Work continued to progress well since Quality, Safety & Performance Committee with Executive leads.	December-January reporting cycle
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Good progress made since Quality, Safety & Performance Committee – with the Risk & Assurance lead working with the Planning team to map and then populate with Executive leads at next review.	December-January reporting cycle
4	Deep dive of two risks at Quality, Safety & Performance Committee going forwards	Following reporting of refresh framework of strategic risks, this will recommence from the next reporting cycle.	December-January reporting cycle

	Feedback on specific risks from Quality, Safety & Performance Committee – including triangulation of key themes	Addressed in next Strategic Risk review and update.	December- January reporting cycle
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may including further Board development time etc.	December- April, in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board are asked to:

- Consider and **NOTE** the Strategic Risk Refresh, as detailed in Appendix 1 of this report.
- **NOTE** the next steps, both in respect of governance and operationalisation, as detailed in section 3.2 of this report.
- **NOTE** the Trust Assurance Document.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** All Strategic Risks are related.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). All domains are relevant to this work, as the strategic risks span all areas of the Trust

	business and are imperative to quality and safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change**

	Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risks are detailed in the new Trust Assurance Framework dashboard.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Action plans for strategic risks are included in the Trust Assurance Framework Dashboard.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

SECTION 1

RISK ID		RISK TITLE		STRATEGIC GOAL		RISK SCORE TREND	
RISK LEADS				RISK THEME			

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	

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**	**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**

RISK ID	01	RISK TITLE	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	
RISK LEADS	Cath O'Brien	Rachel Hennessey	Alan Prosser	RISK THEME	Service Capacity		

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: 7 Levels of Assurance(see definitions tab)	RATING	PE	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH

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								
C1	Blood stock planning and management function between 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 to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
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 arrangements. Weekly meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plan please in time for Board.	PA	Welsh Government Quality, Planning and Delivery Review	PA
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and WBMDR.	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government EPRR for Health, Local Resilience Forum - SCG.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB Review.	PA	QSP committee and Board and external stakeholders if required.	PA

C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			**E**	Horizon scanning and representation at key forums including UK Forum, JPAC, SaBTO Regular liaison with Blood Policy and Tissue, Cells and Organs team in Welsh Government.	**Not Assessed**	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	**Not Assessed**	QSP, SDC	**Not Assessed**
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	**Not Assessed**	Performance Report - SLT, EMB, QSP and Board	**Not Assessed**	Welsh Government Quality, Planning and Delivery Review	**Not Assessed**
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	**Not Assessed**	Performance Report - SLT, EMB, QSP and Board	**Not Assessed**	Welsh Government Quality, Planning and Delivery Review	**Not Assessed**

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.**
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 require digital systems to be in place which are out of WBS control. Projects are progressing externally.		A1.1
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 inappropriate use of blood, which impacts demand.		A1.1

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3184	There is a risk to VCC as a result of no Lead Digital Pharmacist in post resulting in multiple risks for VCC and the trust. These include for example lack of Medicines management clinical leadership for the implementation and ongoing use of general medicines EMPA, update of current chemocare and implementation of new all wales SACT EMPA. Implementation of pharmacy robot nVCC.	20	Risk Increasing
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Stable/No Movement
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	15	Risk Decreasing

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
A1	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	**IA**	Jul-25	National oversight group is currently discussing with CAV in light of new supplier for All Wales LIMS soplution.	14.11.23	No current funding route idetified within LIMS and may be identified as a core recommendation through Infected Blood Inquiry (IBI).	
A1.1	Working with DCHW to support the Blood Transfution Model of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	**IA**		Discussions ongoing about funding solutions	14.11.23		

A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	**PA**		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including - preoptimisation of anaemia patients - Intraoperative cell salvage (ICS) - Quality insights QS138 Audit (NICE standard, ongoing audit tool to monitor patient blood management quality standards) - Appropriate use of OD neg red cells - Appropriate use of platelets	14.11.23	All Wales programmes which will ensure equity of care for patients.	

SECTION 1

RISK ID	02	**RISK TITLE**	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	**STRATEGIC GOAL**	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	**RISK SCORE TREND**	
RISK LEADS	**Carl James**	**Jacinta Abraham**	**Nicola Williams**	**RISK THEME**	Partnership Alignment		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	**LIKELIHOOD**	**IMPACT**	**TOTAL**	**12**	**CURRENT RISK**	**LIKELIHOOD**	**IMPACT**	**TOTAL**	**8**	**TARGET RISK**	**LIKELIHOOD**	**IMPACT**	**TOTAL**	**6**
	3	4				2	4				2	3		

SECTION 3

Overall Level of Effectiveness: **7 Levels of Assurance(see definitions tab)**	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL HAVE A GRAPH

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								
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	IA	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	IA	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

GAPS IN CONTROLS	**GAPS IN ASSURANCE**	**ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.**	
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		Need to enusre the gaps in assurance are refelcted in the action plan

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite			
DATIX RISK REF	**RISK TITLE**	**CURRENT RISK RATING**	**RISK TREND**
	There are currently no associated operational risks according to the risk appetite to include		

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	
1.4	Development of Phase 2 of PMF with additionalperfromance measures/quality metrics	Carl James		Mar-24	Design stage commenced		Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase	Progress update needed Action Plan needs strengthening to indicate how gaps in assurance are being managed Assurance level needs to be included progress update needs to be included
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce		Programme outputs to be confirmed	Programme established and staff on-boarded	09/11/2023	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase	
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)		tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc)	target date Feb 2024 (tbc by	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase	

SECTION 1

RISK ID	03	**RISK TITLE**	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	**STRATEGIC GOAL**	1 -Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Sarah Morley			**RISK THEME**	Workforce Supply and Shape		

SECTION 2

RISK SCORE (see definitions tab)

	LIKELIHOOD	IMPACT	TOTAL			LIKELIHOOD	IMPACT	TOTAL			LIKELIHOOD	IMPACT	TOTAL	
INHERENT RISK	4	**4**	**TOTAL**	**16**	**CURRENT RISK**	4	**3**	**TOTAL**	**12**	**TARGET RISK**	2	**3**	**TOTAL**	**6**

SECTION 3

Overall Level of Effectiveness: **definitions tab)**	**7 Levels of Assurance(see**	**RATING**	**PE**	**Overall Trend in Assurance**
				THIS WILL INCLUDE A GRAPH

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		PE						
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E	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			E	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
C3	Workforce planning - skills development	Susan Thomas	X			PE	Provide operational managers with skills and capabilities to undertake effective	IA	Joint finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	IA
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation sheets	IA	Joint finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	IA
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	IA	Joint finance and Workforce Report to QSP	PA	Wales Audit Workforce Planning National Review	IA
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 reports 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	PA	Internal Audit Reports	IA
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 - see comments below - programme now closed - updates on any future work progammes via EMB	PA	Policies and proceedures to be imbedded with Hybrid Working Principles	PA		

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite					
DATIX RISK REF	**RISK TITLE**	**INTIAL RISK RATING**	**CURRENT RISK RATING**	**TARGET RISK RATING**	**RISK TREND**
	There are currently no associated operational risks according to the risk appetite to include				

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
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	**IA**	Mar-24	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.	8.11.23	Plan is moniitoted via Health and Engaged Steering group and plan in palce to March 2024	
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	**IA**	Mar-23	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	8.11.23	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	**IA**	Mar-24	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB			
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	**IA**	Dec-23	A plan to implement the People Strategy will be presented to EMB in December.			
1.5	Development of a Strategic workforce plan	Susan Thomas	**IA**	Mar-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy			
1.6	Development of a Trust Retention Plan	Susan Thomas	**IA**	Feb-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly			
1.7	Review Exit Interview Process	Susan Thomas	**IA**	Jan-24	Task and Finish group to consider Exit interview process			

SECTION 1

RISK ID	04	**RISK TITLE**	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	**STRATEGIC GOAL**	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	**RISK SCORE TREND**	
RISK LEADS	Sarah Morley			**RISK THEME**	Organisational Culture		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	9	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	4
	3	4				3	3				2	2		

SECTION 3

Overall Level of Effectiveness: (7 Levels of Assurance(see definitions tab))	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL INCLUDE A GRAPH

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE
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
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
C4	Values to be reviewed and Behaviour framework to be considered	Susan Thomas	X			PE
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE
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
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Working group led by CJ		Trust Board reporting on strategy and controls via cycles of business		To be completed as per compliance/ reg tracker updates	
Education and training steering group		Trust Board reporting on strategy and controls via cycles of business		To be completed as per compliance/ reg tracker updates	
Education and training steering group					
Healthy and Engaged Steering Group and Education and Training Steering Group					
Healthy and Engaged Steering Group					
Health and Wellbeing Steering Group					
Executive Management Board					
PMF Workling Group					
SLT Meetings					
SLT Meetings and Educationa and Training Steering Group					

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include				

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
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		Mar-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message.	09/11/2023		
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey will be distilled to further develop our work programme	09/11/2023		
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley		Jan-24	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 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in	09/11/2023		
1.4	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. An initial exercise on Employee Voice is being undertaken to gain a baseline on speaking up safely which will link with the ongoing listening exercise within the Trust. An Independent Member Champion in this work has been identified to ensure effective scrutiny and oversight. The full implementation of the framework is expected by March 2024. Updates will be reported via EMB Run.	09/11/2023		

SECTION 1

RISK ID	05	**RISK TITLE**	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	**STRATEGIC GOAL**	5 - A sustainable organisation that plays it part in creating a better future for people across the globe	**RISK SCORE TREND**	
RISK LEADS	Carl James			**RISK THEME**	Digital Transformation		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	9
	4	4				3	4				3	3		

SECTION 3

Overall Level of Effectiveness: (7 Levels of Assurance(see definitions tab))	RATING	PE	Overall Trend in Assurance	
				THIS WILL BE A GRAPH

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								
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	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
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital Officer		X		E	Trust Digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	Not Assessed
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	IA	Wales Audit Office	Not Assessed
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback	IA	Feedback and progress working with universitues	IA	Wales Audit Office	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	Not Assessed
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office/ Centre for Digital Public Services	PA
C7	Digital inclusiion 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	IA	Wales Audit Office	PA
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	IA	Wales Audti Office	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA	Wales Audit Office	PA

Assurance ratings need to be added for all the sources of assurance. Ref the definitions tab

C11	Trust digital Governance	Carl James		X		PE	Trust Digital governance reporting	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audit Office	IA
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/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	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA	Wales Audti Office	Not Assessed

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Stable/ No Movement

SMART ACTION PLAN

Action Ref	Action Plan	Ownder	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	
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer		Nov-22	Digital Programme has now been established from Oct '23	Nov-23	As the Programme continues to develop the overall level of risk should reduce	The level of asurance should increase.	Dates need to be reviewed and updated progress notes need to be added any gaps in assurance need to be reference with an action plan
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer		Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The Digital Strategy has now been published and a draft insfrastructure strategy (reference architecture) is available.	Nov-23	As the Programme continues to develop the overall level of risk should reduce	The level of asurance should increase.	

SECTION 1

RISK ID	06	**RISK TITLE**	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**STRATEGIC GOAL**	1 - Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Lauren Fear			**RISK THEME**	Organisational and Clinical Governance		

SECTION 2

RISK SCORE (see definitions tab)

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

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)	THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS

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
SOURCES OF ASSURANCE												
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	E	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	CURRENT RISK RATING	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include		

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

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

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	*Board, Committee and Management Structures which receive evidence from*	*Recent internal audit reviews and levels of assurance*

Local management information / departmental management reporting	*Finance reports*	*External Audit coverage*
Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)	*KPI's and management information*	*Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews*
Operational planning / Business Plans - Delivery Plans and Action Plans	*Quality, Safety and Risk reports*	*Patient Feedback / Patient experience feedback*
Governance statements / self-certification	*Training records and statistics*	*Staff surveys / feedback*
Local procedures	*Performance reports*	*Comparative data, statistics, benchmarking*
Exceptions reporting	*BAF, VUNHS risk register*	
Targets, Standards and KPIs	*Policies and Procedures including Risk Management Policy*	
Incident Reporting	*Compliance against Policies*	
Staff Training Programmes		

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

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

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	Minor issues in establishing and maintaining effective relationships with internal and external stakeholders Minor misalignment of operational actions or strategic approach with system partners	Moderate issues in establishing and maintaining effective relationships with internal and external stakeholders Moderate misalignment of operational actions or strategic approach with system partners	Major issues in establishing and maintaining effective relationships with internal and external stakeholders Major misalignment of operational actions or strategic approach with system partners	Failure to establish and maintain effective relationships with internal and external stakeholders Severe 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 with collaborative working initiatives within our cancer and blood and transplant systems	Moderate issues with collaborative working initiatives within our cancer and blood and transplant systems	Major issues with collaborative working initiatives within our cancer and blood and transplant systems	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 / G&E*	Peripheral element of treatment or service suboptimal Informal complaint/enquiry Temporary insignificant impact upon process or performance with no impact on quality or safety of components produced. Donor/patient/staff discomfort	Overall treatment or service suboptimal Formal complaint (stage 1) Local Resolution Single failure to meet internal standards 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.	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Multiple failures to meet internal standards 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.	Non-compliance with national standards with significant risk to patients or donors if unresolved Multiple complaints/ independent review Multiple failures to meet national standards 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.	Non-compliance with national standards with severe risk to patients or donors if unresolved Inquest/ombudsman inquiry. Gross failure to meet national standards 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	Moderate injury requiring professional intervention Requiring time off work for 4-14	Major injury leading to long-term incapacity /disability Requiring time off work for >14	Incident leading to death Multiple permanent injuries or irreversible health effects

			Increase in length of hospital stay by 1-3 days	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	days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term 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

TRUST BOARD

AUDIT COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Gareth Jones, 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 19 October 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 19 October 2023:

ALERT / ESCALATE	**TRUST RISK REGISTER** The Audit Committee recognised the progress that had been made with risk mitigation but stressed the need to see the progress in between. The narrative of the paper needs to be made clear for high level risks about the mitigation actions that have been taken. The Committee noted this is being escalated and managed appropriately through Executive Management Board. The Committee agreed that on the basis of the assurance that came out of the Board meetings in September 2023 and the assurance that was provided in relation to management of the Trust Risk Register through Executive Management Board, risks will stay as a level two but with a strong message that unless things improve by the next Audit Committee, the Committee will be looking at reducing these to a one. **TRUST ASSURANCE FRAMEWORK** The Committee raised concerns about the join up between a Trust Board discussion about strategic objectives for this current year from the Integrated Medium-Term Plan (IMTP) and the agreement of risks against that. The lack of discussion in the last few months highlighted concerns about how the Trust Assurance Framework (TAF) would be delivered and managed proactively. Without a TAF, it was difficult to be confident about our delivery of our strategic objectives. The Committee felt there is a need to review the strategic risks and objectives to see whether the risks reflect their impact, which affect the Trust's ability to achieve those objectives. The Committee made a recommendation for the November 2023 Trust Board to have a formal discussion on the updated strategic risks which will reflect the discussion had in the September Trust Board. Need to link the strategic risks back to the strategic objectives in the Ten-Year Plan and then need to have an appropriate Trust Assurance Framework to review.
ADVISE	**AUDIT ACTION TRACKER** The AUDIT Committee **AGREED** the requested extension dates and **AGREED** to formally closing the 26 green/complete actions and these being changed to blue status. The Committee requested for future Committees a separate annex is to be included to assure the Committee that overdue actions are being addressed appropriately. **AUDIT POSITION UPDATE:** The Committee were informed of the plan to do work for the Charity accounts in December 2023 as the Charity Commission deadline is the end of January 2024. The Committee were informed the deadline should be achievable. **AUDIT WALES - FINANCIAL ACCOUNTS MEMORANDUM REPORT** This report contains the issues raised from the Audit Accounts report that was presented at the July 2023 Audit Committee. The Committee were informed that this comprises of three recommendations: one high and two medium priority.

	REVISION TO STANDING ORDERS / STANDING FINANCIAL INSTRUCTIONS The Committee **ENDORSED** the report for Board approval subject to minor changes including the updated Delegated Financial Limits Paper with changes in delegated limits of Chief Executive Officer and the Executive Director of Finance limit rising from £5,000-£25,000 be added and taken to the November 2023 Trust Board.
ASSURE	**GOVERNANCE ASSURANCE & RISK GOVERNANCE, ASSURANCE & RISK PROGRAMME OF WORK.** The Committee were informed the programme of work was introduced across the organisation for assurance and strategic development, recognising that the Board and Executive Teams were not fulfilling obligations to their full potential so the governance was re-structured to support in doing this. The Committee recognised the engagement across the work and the elements of this, involving significant engagement of staff. **PRIVATE PATIENT SERVICE REVIEW / PRIVATE PATIENT SERVICE DEBT POSITION** The Committee were informed that Private Patient Team is now up to full compliment. The Committee understood that the report also goes to Quality Safety & Performance Committee so the Audit Committee is only looking at the financial commercial aspects of the improvements. The Committee acknowledged the aged debt position which achieved a reduction from £1million to £250,000.
INFORM	**INTERNAL AUDIT REPORTS** The Committee received the following internal audit report: • Digital Strategy & Transformation Programme Audit Report **EXTERNAL AUDIT REPORTS** The Committee also received the following external audit report: • Audit Wales – Workforce Planning Report **OTHER BUSINESS:** The Committee also received written reports under the following agenda items: • Internal Audit Progress Update • Counter Fraud Progress Report Quarter 2 23/24 • Losses and Special Payments Report • Procurement Compliance Report; and • Declaration of Interests, Gifts, Sponsorship, Hospitality & Honoraria
APPENDICES	**NONE**

3. RECOMMENDATION

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

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Healthcare Science

REPORT PURPOSE	FOR DISCUSSION

1. PURPOSE

This paper is to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 16th November 2023.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. Following its annual review in October 2022, the Committee continues to mature, actively seeking opportunities for continuous improvement, together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHTS FROM THE MEETING HELD ON 16th NOVEMBER 2023

3.1 Triangulated themes

The work being undertaken to develop and further refine the risk register and Trust Assurance Framework was referenced throughout the meeting as new and continued risks and issues were being highlighted. In particular, the need to ensure that all emerging risks are being captured in real time in the Trusts risk register and that the strategic risks are adequately reflected in the Trust Assurance Framework.

The triangulated themes throughout a number of the papers included:

- Workforce issues, this was caused by a combination of staff sickness, increasing difficulty in recruiting into highly specialist as well as more generic roles. Fatigue and burnout were compounded further by increasing operational demands and infrastructure constraints such as lack of robust automated electronic pathway processes such as referral and booking and insufficient business intelligence capability. Although action is being undertaken to address these issues, to date, they are not having a tangible impact. The results of the national NHS staff survey are awaited as these will provide an opportunity to have an even greater understanding of the culture across the Trust and what it is like to work here for our staff and what actions can be taken to support them.

- The increasing service pressures at the Cancer Service and the associated impact on all areas of delivery was becoming increasingly evident. This was impacting as detailed above on staff wellbeing as well as the care experience and outcomes for our patients.

- It was also identified that further oversight is required in respect of how the seven levels of assurance framework is being implemented and how the assurance outcomes are being determined and reflected in the paper templates. Further training for Trust Officers is planned for November and December 2023.

- Business Intelligence capacity to meet the required needs of the service.

3.2 Further Information

Board members who are not members of the Committee and require further detail are able to access the agenda and papers for the November 2023 Quality, Safety & Performance Committee meeting at: https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-committee-2023/public-quality-safety-performance-committee-16112023/

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	• ***Quality and Safety Outcome Theme: Administrative processes at Velindre Cancer Service*** A number of papers identified an emerging theme in relation to patient administrative/pathway processes within the Cancer Service. These have been identified through an increase in patient concerns, patient feedback provided through the CIVICA system, incidents, nationally reportable incidents and duty of candour incidents. The processes relate to: o Referral mechanisms into the Cancer Service o SACT (chemotherapy) booking o General patient bookings o Not being answered / responded to when contacting the Cancer Service via telephone o Post-consultation letters The Cancer Service has undertaken immediate make-safe actions in respect of the above and medium-longer term changes to these areas are underway. The Committee will receive a high-level strategic plan for these with delivery dates at the next meeting. • ***Policy Management Review and Compliance Status: October 2023*** The Policy Compliance paper identified that 50% of policies were currently past their review date. Assurance was provided that targeted action is being taken to address this. A new Compliance Officer has commenced who will be working with Trust officers to prioritise policy governance. This will also be enhanced through the implementation of the new Trust-wide document management system. Timescales for addressing the work required is required for the next meeting.
ADVISE	• ***Risk Register*** The Risk Register update report including a summary of four of the five highest scoring risks which were discussed in detail (one risk was private). The risks included staffing levels within Radiotherapy Physics, staffing within Brachytherapy, work-related stress and

excessive clinical email traffic. Significant work had been undertaken to further refine the Risk Register although it was identified that further updating in respect of these four risks is required. The Committee requested that the new theme of administrative processes within the Cancer Service is added into the Risk Register and agreed to receive a comprehensive analysis of the digital risks (all individually scoring under 15) at the next meeting to identify is there an overarching higher level digital risk.

- ***Trust Assurance Framework (TAF)***
  The draft revised partially completed Trust Assurance Framework aligned with the Trusts strategic risks was received and discussed. Six of the eight revised strategic risks were described although further refinement is required. The Committee requested further work to align and include the current strategic objectives to enable the Committee to judge that the mitigating actions against the risks would support the delivery of the strategic objectives . The Committee were assured that the gaps into todays sections and the remaining elements of the TAF were being reviewed in EMT and would come to the November Board.

- ***Workforce Supply and Shape & Associated Finance Risks***
  The Committee received the report which further outlined the risks to the workforce as highlighted within the Risk Register and detailed the strategic interventions and operational plans put in place to mitigate them. The report also offers an insight into the impact of these actions and the Committee was pleased to note an overall downward trend in terms of vacancies, whilst recognising that “hot spots” remain within certain areas. Whilst the benefits of the longer-term arrangements were recognised, the Committee highlighted the importance of ensuring action is taken to mitigate the risks in the short to medium term.

- ***Workforce Planning Audit and Action Plan***
  The Committee received the ‘Review of Workforce Planning Arrangements’ Audit Wales report, and the action plan that had been developed to meet the identified recommendations. A number of the identified actions had already been completed in the months since the audit was conducted. Ongoing management of the audit recommendations and action plan will be conducted through working closely with senior leadership teams with regular reporting to the Executive Management Board and will be tracked via the Audit Committee.

The Committee were advised that an internal audit on recruitment and retention has recently been undertaken and higher reasonable assurance has been received. Details of this audit will also be reported to the next Committee.

- ***Quality & Safety Framework & Quality Priorities Update***
  14 out of the 26 (54%) of the quality framework implementation actions have been delivered. Of the remaining 2 (8%) will meet agreed timescales and 10 (38%) have needed revised timescales as there have been extended quality and safety team staffing gaps. The team is now fully resourced. The key exception was identified as being in relation to the development of the quality and harm measures which required dedicated Business Intelligence support and there had been no trajectory for completion of this work.

- ***Integrated Quality & Safety Group Highlight Report***
  The comprehensive Integrated Quality and Safety Group Highlight report from the meeting held on the 18th October 2023 was discussed. The focus of discussions included:

  - Good progress being made in relation to the five Safe Care Collaborative projects.
  - Work has commenced to determine the 2024/25 Trust Quality priorities.
  - The new AMaT Quality and Safety Action tracker - The actions had all been transferred over to the AMaT Inspection Module significantly enhancing governance, reporting and transparency. However, assurance could not yet be gained from the tracker that was presented as further work is being undertaken to ensure all action owners can use the system and keep the action status live.

    The Committee noted that although full assurance could not yet be gained from the report, significant strides have been made towards development and implementation of processes and a fuller, clearer picture is anticipated to be presented at the January Committee.

- ***Private Patient Service Improvement Group Highlight Report & Improvement Plan Update***
  The Committee received an update in relation to the private patient improvement plan and highlights from the Private Patient Improvement Group held on the 30th October 2023. The continuing prevalence of business intelligence support issues was highlighted

	to alert/escalate to the Committee. Ongoing discussions are taking place with Digital and an interim solution is being sought to facilitate timely and robust billing.
ASSURE	• ***Trust Performance Management Framework Report and Supporting Analysis for September 2023/24*** The Committee received a comprehensive Trust-wide September 2023 report. The following was highlighted: o Blood supply chain remains challenging with a further blue alert experienced at the end of the month. No imports were required although a number of recovery actions were necessary. National trends around blood shortages have been identified and are being further investigated. o One reportable event had been submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) around an error in screening for malaria. This was noted to be a widely experienced issue across blood services due to increasing complexities around the geographical Donor Risk Index and work is ongoing at a service and national level to look at potential changes to the donor questionnaire. o Progress in terms of radiotherapy performance was evident. Depressed demand for radiotherapy in August and September, although this was understood to be as a result of the annual leave period, with draft figures for October suggesting further improvement. o A review of the PADR process is to be undertaken to look at creating a more engaging process to meet the Welsh Government target of 85% rather than the current reported 74%. o One MRSA bacteraemia case - the first in seven years - had been identified. Following a full Root Cause Analysis it was established that the bacteraemia was community acquired and so not contributed to Velindre, although some opportunities for learning had been noted. • ***Velindre Cancer Service Quality & Safety Divisional Report*** A detailed report covering the period April 2023 to September 2023 was presented to the Committee and the following key points were noted: o Positive HIW inspection of radiotherapy undertaken. o No avoidable falls reported during the period.

- Challenges around service pressures and workforce vacances remain a recurring theme throughout the report.

It was noted that patient feedback via the CIVICA system had signalled patients were dissatisfied with waiting times. Work to refine the question on the CIVICA system is to be undertaken in order to be able to more clearly ascertain the detail around the specific areas of delays, although the Committee were made aware of lengthy waiting times within the Cancer Service as a result of capacity issues.

Patient feedback also highlighted an issue around communication in general - telephony issues, timely response to voicemail messages, ability to reach the required department, etc. as well as concerns raised around referrals and bookings both from SACT and outpatients. Some immediate remedial action has been taken to make safe and work is ongoing to address the pathway issues. A clear action plan with target dates will be provided at the next Committee.

An issue had been identified where there were delays beyond 30 days with non-urgent post clinic letters being sent out. A harm review has commenced. An initial screening of all completed and a further review of 79 has commenced. To date no harm had been identified.

An incident investigation had highlighted the lack of a single electronic referral processes into the cancer service. The Committee were advised that a link has been established with Digital Health Care Wales (DHCW) in relation to the national electronic referral system, with opportunities for a system to be in place anticipated for early next year, although an interim solution with the Cancer Network is currently being sought.

- ***Trust Integrated Medium Term Plan – Progress Against Quarterly Actions for 2023/2024 (Quarter 2)***
  An overall positive report covering the period July-September was received by the Committee and generally good progress over the last six months for both the Velindre Cancer Service and Welsh Blood Service was noted. The Committee's attention was brought to the two actions with an amber rating:

	o Implementation of the national Transforming Access to Medicines (TrAMS) Model o Implementation of the approved Full Business case for the development of the new Velindre cancer centre Both of these risks feature highly in the Trust Risk Register given their potential impact. Assurance was sought regarding the delivery of the high number of actions with a yellow progress rating (18 with remedial action plans). The Committee was advised that, with the systems in place and using past performance as an indicator of future performance, reasonable assurance can be given, although a more informed position will be demonstrated to the Committee in the next quarterly report. • ***Integrated Medium Term Plan - Accountability Conditions*** The Committee were advised that the Trusts 2023-2026 IMTP was approved on the 14th September 2023 and the accountability conditions letter was recieved on the 2nd October 2023. The report set out the key accountability conditions and accountable officer for each condition. • ***Anti-Racist Wales Action Plan - Progress Report*** An overview of compliance with the Trusts Anti-racist action plan was provided. Although progress had been made it was recognised that this is a first report and that much work is still to be done. It was agreed that the open actions would be transferred onto the Quality and Safety Tracker for ongoing high level monitoring by the Committee. • ***Finance Report for the Period Ended 30th September 2023 (Month 6)*** The month 6 finance report demonstrated that the revenue position remains in line with expectations, with a projected forecast outturn position of breakeven. The following was highlighted: o Key Performance Indicators show an on-target balance year to date and year end forecast for revenue and public sector payment. A deficit for Capital was noted, due to delays with Financial Close for the new Velindre Cancer Centre project, although this is being mitigated by a request to Welsh

Government for funding for the project, with the latest forecast being circa £2.9m.

- o Long Term Agreement contract income flows from commissioners - where a risk around whether sufficient income would be provided to cover the cost of investments made during COVID had previously been identified, it was now anticipated that, based on the latest forecasted income, these costs will be covered.
- o All known risks around Digital Health Care Record (DHCR) data capture issues noted within the month 6 report have since been resolved.
- o NHS Wales deficit - the Trust continues to look to identify further areas to support the financial system in terms of reduced costs. Details of areas already identified and submitted to Welsh Government are noted within the report.

- ***2023-24 Quarter 2 Quality & Safety Report***
  A comprehensive report covering the period 1st July 2023 to 30th September 2023 was discussed. The triangulation of data this quarter has identified a theme of increasing concerns and incidents relating to administrative processes at Velindre Cancer Service. The areas identified where wholescale changes are required relate to:
  - o Referral processes – there needs to be a single electronic referral
  - o mechanism into VCS,
  - o Clinical letter approval processes – need to ensure that patients' GPs and patients receive a letter following an appointment within a reasonable timescale (30 days is proposed), and
  - o Booking and appointment processes – a central automated booking process is required.

  A summary of the findings of a general positive Welsh Risk Pool audit of compliance with the operationalisation of the Putting Things Right procedures covering current policies, procedures, and practice was provided. There were four areas of substantial assurance: (claims, redress, learning from events and reimbursement, one of reasonable assurance: concerns and one of limited assurance: incidents. The Committee were provided with assurance that positive action has been completed to address the areas of deficit in relation mainly to the utilisation of the Datix system.

	• ***Duty of Quality NWSSP Update*** A comprehensive report detailing progress of the work undertaken by NWSSP around implementation of the Duty of Quality was presented to the Committee. The report was positively received and significant advancements in always on reporting were noted.
INFORM	• ***Velindre Cancer Service - Patient Story*** The Committee received an uplifting video interview of a patient who had received the Five Fraction Radiotherapy Regime for prostate cancer The Five Fraction Regime which utilises technology developed within the last few years, delivers a higher, more targeted dose of radiotherapy, sparing more organs at risk and patients can receive their treatment five times over ten days, rather than having to visit the Service 20 times over a four-week period. This has substantial benefits for both the patient and the Trust, as with an average of 30 patients per month, this brings a LINAC saving time of 62½ hours, significantly increasing the capacity to treat further patients. • ***Transforming Access to Medicine/Clinical Pharmacy Technical Services Update*** A comprehensive report was presented to the Committee. Further detail around the high levels of environmental contamination was sought. The Committee were informed that no further issues had been identified and full assurance had been received from the infection control for Public Health Wales and the Infection Prevention and Control team in relation to actions that were taken and risk reduction mitigations that were implemented. • **POLICIES/PLANS** o The **National Policy on Patient Safety Incident Reporting and Management** and the **Freedom of Information/Environmental Information Regulations Standard Operating Procedure** were approved for implementation across the Trust. o The **Trust Claims Policy, Handling Concerns Policy** and **NHS Wales Red Cell Shortage Plan** were endorsed for Trust Board approval.
APPENDICES	N/A

3.4 Meeting reflection

Committee members were asked to reflect on the meeting, complete the post-meeting survey, in particular given the size and complexity of the agenda, how this could be managed differently.

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 November 2023.

Trust Board

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

Date of meeting	30/11/23
PUBLIC OR PRIVATE REPORT	**Public**
IF PRIVATE PLEASE INDICATE REASON	**Not Applicable - Public Report**
REPORT PURPOSE	**INFORMATION / NOTING**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	**NO**
Prepared by	**Peter Gorin, Head of Strategic Planning and Performance Rachel Hennessy, Head of Operational Services and Delivery, Sarah Richards, Interim General Services Manager**
PRESENTED BY	**Cath O'Brien, Chief Operating Officer, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance**
APPROVED BY	**Carl James, Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**1. VELINDRE NHST PERFORMANCE MANAGEMENT FRAMEWORK (PMF) FOR THE PERIOD TO SEPTEMBER 2023/24** 1.1 This paper reports on the performance of our Trust for the month of September 2023, against a range of national targets, best practice standards and locally identified outcome measures for our cancer and blood and transplant services, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance. 1.2 The overview, in Section 2, draws attention to key areas of performance across the organisation as a whole, highlighting the interconnection between many of these areas 1.3 The Performance Management Framework (PMF) Scorecards, in Section 3, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care. 1.4 Each KPI is supported by data, in Appendices 1 to 3, that explain the current performance, using wherever possible, Statistical Process Control (SPC) Charts or other relevant information to allow the distinction to be made between 'natural variations' in activity, trends or performance requiring investigation. 1.5 Individual VCC and WBS PMF reports were presented initially to the respective VCC and WBS Senior Leadership Teams (SLT), followed by the Chief Operating Officer Divisional Performance Review meetings. 1.6 During 2023/24, the PMF Development Project Group will look to evaluate potential Business Intelligence solutions that automate KPI collection, analysis and reporting, and approach potential benchmarking partners for both tertiary cancer and blood services.

RECOMMENDATION / ACTIONS	**The Trust Board is asked to:** • **The Board is asked to NOTE the contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Appendices 1 to 3.** • **The new style PMF Performance reports continue to be developed by the PMF Project Group, with a number of potential new measures currently under consideration.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	**11 October 2023**
VCS SLT / Performance Review	**18 October 2023**
Executive Management Board – Run	**30 October 2023**
Quality Safety and Performance Committee	**16 November 2023**
Summary and outcome of previous governance discussions **The report has been considered and endorsed at the VCS and WBS Performance Review meetings, EMB Run and QSP Committee and is presented to the Trust Board for information and noting.**	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
1	**Velindre Cancer Services – PMF Supporting KPI Data Graphics and Analysis**
2	**Blood and Transplant Services – PMF Supporting KPI Data Graphics and Analysis**
3	**Trust-wide Services – PMF Supporting KPI Data Graphics and Analysis**

ACRONYMS	
VUNHST	**Velindre University NHS Trust**
QSP	**Quality Safety and Performance Committee**

EMB	**Executive Management Board**
SLT	**Senior Leadership Team**
PMF	**Performance Management Framework**
QSF	**Quality Safety Framework**
KPI	**Key Performance Indicators**
SPC	**Statistical Process Control Charts**

2. SITUATION AND BACKGROUND

VELINDRE NHST PERFORMANCE REPORT FOR SEPTEMBER 2023

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

2.1 Cancer Centre Services Overview

The reported improvement in radiotherapy performance observed in August was sustained in September. Compliance with the 21-day time-to-treatment target for scheduled radiotherapy treatment increased again from 81% in August to 88%. Further, compliance with the 7-day time-to-treatment target for urgent symptom control increased in September to 84% from 73% in the previous month. The sustained improvement in performance remains encouraging and can be attributed, in part, to detailed work to rationalise and shorten treatment pathways which has been undertaken throughout 2023 and targeted training delivered to clinical teams. Additionally, a new radiotherapy workflow system trialled in May 2023 has now been rolled out to all treatment sites. This new system has supported the delivery of marked efficiencies.

Maintaining radiotherapy treatment capacity continues to present challenges. It should be noted that the number of patients referred for radiotherapy treatment and those actually beginning treatment in September were lower than anticipated based on historical patterns of demand. Depressed demand for radiotherapy treatment was likely a contributing factor in the improved performance reported in August and September. Due to factors such the fragility of the fleet of linear accelerators, instances of downtime and lost capacity are being experienced. In these instances, extensions to the working day and week have been implemented to manage the capacity.

Compliance with the 21-day time-to-treatment target for new patients referred for treatment with SACT decreased marginally in September to 90% from 92% in the previous reporting period. Nursing and pharmacy workforce capacity remain significant challenges and a recruitment and resource plan intended to address these issues in a sustainable manner is in development.

Performance targets were met in September in the case of patient falls and pressure ulcers. There were two reported instances of non-compliance with the timely administration of the NEWS bundle, but no harm was reported to either of the patients. Two Healthcare Acquired Infections (HAI) were reported in September. Both instances will be the subject of a multi-disciplinary review facilitated by the Infection Prevention and Control team which will identify learning and inform any subsequent response. There were no instances of potentially avoidable Hospital Acquired Thrombosis (HAT) reported in September.

There were three Delayed Transfers of Care (DToC) in September. One patient's transfer to another local hospital site was delayed due to bed capacity challenges. Such challenges are being experienced across the wider healthcare system and impacts the ability of Velindre Cancer Centre to discharge patients without delay. A second patient required a nursing home placement and a third required a packaged of care to be developed prior to discharge. Velindre Cancer Centre nurse leads are active members of the all-Wales Pathways of Care Delays (PoCD) national group which is considering delayed discharges.

Discussions continue to take place with health board and community teams to realise improvements. The PoCD national group have scheduled visits at Velindre Cancer Centre to provide additional training on the Six Goals of Emergency Care to provide further support in facilitating patient discharge.

There were some instances of delayed access to Therapies services reported in September. Workforce capacity remains a challenge in the case of certain Therapy modalities, notably, dietetics and physiotherapy, which is reflective of the national position. Locum staff have been recruited in dietetics.

The data quality issues related to the implementation of the DH&CR continues to cause significant administrative challenges across Velindre Cancer Centre. The Medical Records team continue to make significant progress against the backlog of unprocessed outcomes through the support of additional resource.

To mitigate the data quality issues that have been experienced, a revised staff training plan, which meets the needs of individual users and groups in relation to their specific role, has been developed by the IT Applications Support Team and Operational Services.

2.2 Welsh Blood Service Overview

WBS have continued to perform well during September and all clinical demand was met, however, there was a Blue Alert for O negative for the period 20th September 2023 – 4th October 2023. Provision of red cells to hospitals was maintained and no mutual aid was required as a result of this.

Quality incident investigations closed within 30 days remains well above target (90%) at 95%. There was one reportable event submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in September.

- This event has arisen from the lookback exercise undertaken as a Corrective and Preventive Action (CAPA) for SABRE 106 Malaria residency risk incorrectly assessed. Root Cause Analysis investigation is complete, and the report is being written up (target date for confirmatory report submission to MHRA is 21/10/23). Any remedial actions / lessons learnt will be implemented.

Donor satisfaction met the 95% target in September. 6,896 donors were registered at donation clinics with no formal concerns and 2 informal concerns raised (0.03%).

Reference Serology performance is slightly below target (80%) at 70% for September. Training and development of junior members of staff will be completed between September 2023 and April 2024 and performance levels are expected to improve during this period. There was excellent performance during Quarter 2 for Antenatal -D & -c quantitation Turnaround Times within 5 working days. At 100% in September, performance averaged 99% for the quarter, meeting target and showing continued performance improvement in July, August & September.

The quarterly performance for Deceased Donor Typing / Cross Matching performance did not meet target. This target measures turnaround times of less than four hours and Quarter 2 performance was below target at 70%. This was attributed to delays in notification times by NHSBT Specialist Nurses and new staff joining the on-call rota. Work is now underway with NHSBT Specialist Nurses to ensure earlier notice for samples.

All clinical demand for platelets was met representing a strong performance against this metric. Platelet wastage just missed target in September (11% against a target of 10%). This is attributed to the significant weekly variance in platelet demand experienced in September. Work is underway to develop a Platelet Strategy to address issues being experienced.

Collection productivity performance reduced slightly in September and failed to meet target. Contributory factors influencing performance include reduced clinic donation slots due to sickness absence limiting donation capacity particularly in north Wales and the number of donors attending collection sessions in September who were unable to provide a completed donation.

At 1,262, the number of new donors did not meet the quarterly target of 2,750 in September. The requirement to intensify appointment management by donor blood type throughout a prolonged need for additional O Positive and O Negative blood in September, as well as one short-term blue alert, inhibited the recruitment of new donors. In addition, campaigns to optimise appointment uptake left fewer appointments for new donors, due to their unknown blood type status. At 90%, appointment uptake from existing donors was on target for the quarter. However, this success provides less opportunities for non-donors to book their first donation.

The total number of collections in September was 5 (all Peripheral Blood Stem Cell collections). The total cell provision for the service was 8 (5 collected and 3 imported for a Welsh patients). The service is seeing a gradual increase in activity for this year with a current projected outturn of 50-55 at year end (against a target of 80). The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment and will be managed under WBS Futures.

2.3 Workforce and Wellbeing

The ability of skilled people to provide the key services within the Trust remains one of the most significant risks for the Trust, alongside ensuring those we do employ are supported, valued and feel their wellbeing is central while in the workplace. The Trust's People Strategy ensures progress towards; a planned and sustained workforce with skilled and developed people who are healthy and engaged in the workplace. Alongside these work programmes there are key metrics the Trust analyses and evaluates to ensure the effective performance of the workforce.

Trust wide sickness absence data continues to remain high month on month with the current rolling absence of 5.75% to September 2023 which is still above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%.

Trust wide PADRs this month remains at 74% lower than the 85% target, whereas Statutory and Mandatory training remains above target at 87% and has been consecutively on target for the whole year to September 2023. Details of interventions can be found in the SPC's for these metrics and corresponding action plans.

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

2.4 Nursing and Quality

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

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

2.5 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys: 'Would you recommend us?' (95%) and 'Your Velindre experience?' (63%) both set against a 95% target. The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 97% that continues to meet the target.

2.6 Digital Services

Performance largely stable – no significant change in performance since August 2023.

Following a number of incidents in August 2023, the rolling 12-month position for the number of significant IT business continuity incidents has stabilised in September. Improved performance through early/mid-2023 should start to be reflected in reported 12-month performance towards end of 2023/24 financial year. Work ongoing to remove / replace legacy IT infrastructure and improve the resilience across both the WBS and VCC sites. This work will continue through 2023/24 and beyond.

Resolution timescales for service requests and incidents was unchanged in September 2023. Both remain under the 85% target for both indicators. Both 1st and 2nd line IT support teams are now fully established. Coupled with a new service improvement plan for the Digital Service Desk and 2nd line support teams, it is anticipated that improvements in performance will be observed through Q3/Q4 2023/24, with the aim of achieving target from the start of the 2024/25 financial year.

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

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role – this role was due to be filled in September 2023, but the candidate withdrew. Interviews for a replacement are scheduled for late-September 2023.
- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Delivery of routine reporting has been delayed due to competing priorities within the team.

2.7 Estates Infrastructure and Sustainability

The period through to September has seen consolidation of levels of compliance for PPM and reactive tasks which are currently listed as green. The technical issue with CAFM has been resolved and figures have been updated accordingly. This is expected to be resolved shortly and the PMF will be updated accordingly. Recruitment has seen appointment of a maintenance technician post with further vacancies re-advertised. Two H&S posts are progressing through the recruitment process Head of H&S out to advert and the H&S Technician currently with translation.

Energy management is intrinsically linked to Estates resourcing and will be improved with recruitment in the Estates Department, and implementation of the decarbonisation plan. Recent events have hindered the availability of utility data which is largely due to the introduction of Energy Bill Relief Scheme (EBRS) which continues to be an issue with reporting data. This month has seen similar issues and data will be uploaded once available.

Fire Safety and Health & Safety KPIs are at acceptable levels with the exception of training, which is a constant challenge. New initiatives have been rolled out working closely with Education and Development Colleagues which is having a positive impact on performance, there is now sufficient training capacity to meet the needs of the organisation.

Module C training (Violence and Aggression) is currently listed as red, due to this being new course which is currently being rolled out to relevant areas. It is anticipated that this figure will rise with availability of training moving forward, minor improvements are witnessed month on month.

Divisions have reinvigorated H&S meeting which will support improvement of training, by approaching issues at operational level, working with trainers and departments to tailor a package that meets departmental requirements, this is underpinned by support from SLT.

Patient manual handling figures for WBS have increased to acceptable levels as the training provision is captured in the reporting figures.

2.8 Finance

The overall position against the profiled revenue budget to the end of September 2023 is an underspend of £0.007m and is currently expecting to achieve an outturn forecast of Breakeven.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

The approved Capital Expenditure Limit (CEL) as at September 2023 is **£24.516m**. This represents all Wales Capital funding of **22.833m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to August '23 of £8.683m and is forecasting to remain within the CEL of £24.416m. A risk to delivery of the Capital programme exists where Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close, however this risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£2.7m.

During September '23 the Trust (core) achieved a compliance level of **97.7%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month , and a Trust position (including hosted) also of **97.8%** compared to the target of 95%.

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

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

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

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

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

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

3.2 Navigating our PMF Performance Report

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

Canolfan Ganser Felindre
Velindre Cancer Centre

Consolidated Performance Management Framework

Welsh Blood Service

Quality Safety & Performance (QSP) Committee Scorecard as at September (Month 06) 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 06 (September 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	87%	85%	87%	✓	↑	WOD.19
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	→	KPV.02
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓	↓	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa cumulative	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli	National	Monthly	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0	✓	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	99.6%	✓	→	KPV.08
	Number of National VCS Serious Untoward Incidents recorded with Welsh Government	National	Monthly	0	0	0	✓	→	KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	1	✗	↓	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	14	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	99.9 C/m3	85.3 C/m3	✓	→	EST.06

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 06 (September 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Number of Delayed Transfers of Care (DToCs)	National	Monthly	1	0	3	✗	🡻	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	95%	✗	🡻	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%	✓	🡹	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	121%	✓	🡹	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	11%	✗	🡹	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	5	✗	🡻	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.75%	✗	🡻	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	74%	✗	🡹🡻	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	95%	✓	🡺	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	95%	✓	🡹	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	🡺	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	N/A	✓	🡺	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)	National	Monthly	29% 47%	80% 100%	23% 88%	✗	🡺	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	National	Monthly	6% 50%	80% 100%	8% 84%	✗	🡺	KPV.15
	Emergency Radiotherapy Patients Treated 100% within 1 Day (COSC)	National	Monthly	94% 100%	100%	85% 95%	✓	🡹	KPV.16

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 06 (September 2023)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	National	Monthly	27% 32%	80% 100%	87% 91%	✗	→	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	90%	✗	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	↑	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	96%	✓	→	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	99%	✓	↑	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	(£0.007m)	✓	→	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	N/A	£11.326m	£11.326m	✓	→	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.50m	£0.117m	✗	↓	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£0.767m	£0.685m	✗	↓	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	→	FIN.60
Equitable	Diversity of Workforce – % of women in senior leadership positions (defined as Band 8 and above)	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people (based on Wales version of WRES)	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	TBA	TBA	TBA	✓	→	WOD.80
	% of Workforce declared Welsh Speakers at Level 1	National	Quarterly	TBA	TBA	TBA	✓	→	WOD.81

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

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text

	Scale of Change Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	PMF report is focused upon monitoring performance against statutory and local stretch targets
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

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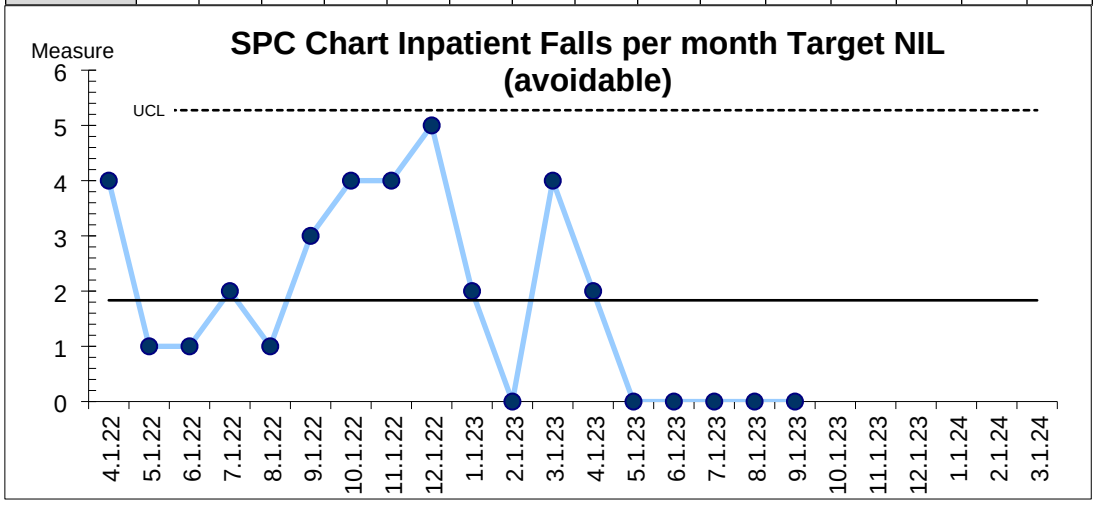
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul23	Aug 23	Sep 23
Actual Number	2	1	3	4	4	5	2	0	4	2	0	3	5	5	3
Avoidable Falls	2	0	1	2	2	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

Performance

No avoidable falls in September 2023.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.01

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Number of VCC Acquired Pressure Ulcers per month (Inpatients)

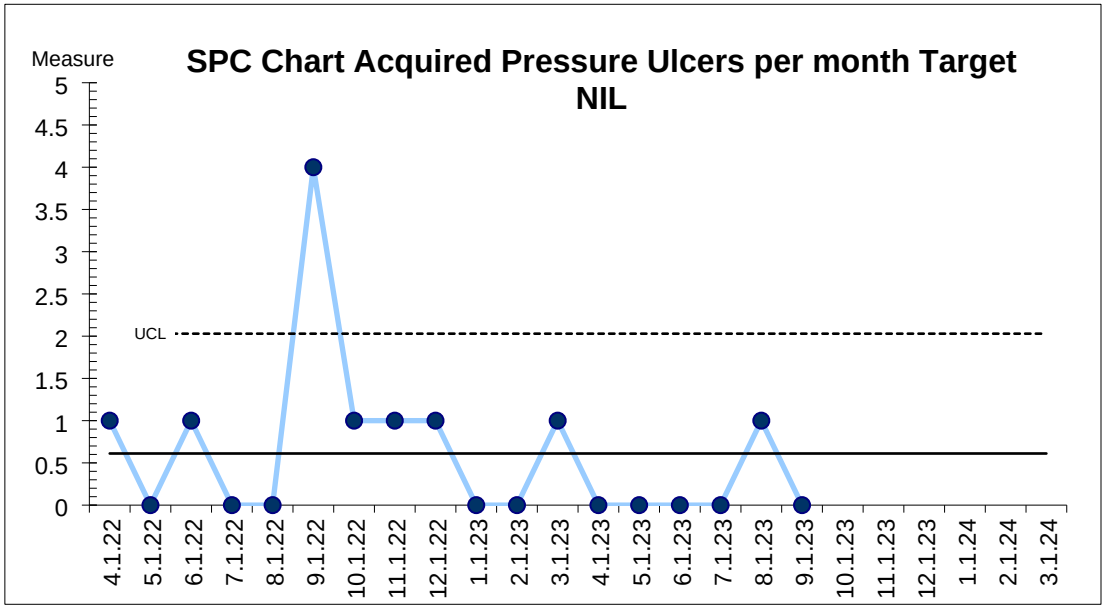
Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Performance

VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Actual Number	0	0	4	1	1	1	0	0	1	0	0	0	2	2	3
Avoidable Ulcers	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

The SPC chart shows common cause or normal variation, apart from Sept '22 over the last 15 months

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator WOD.19

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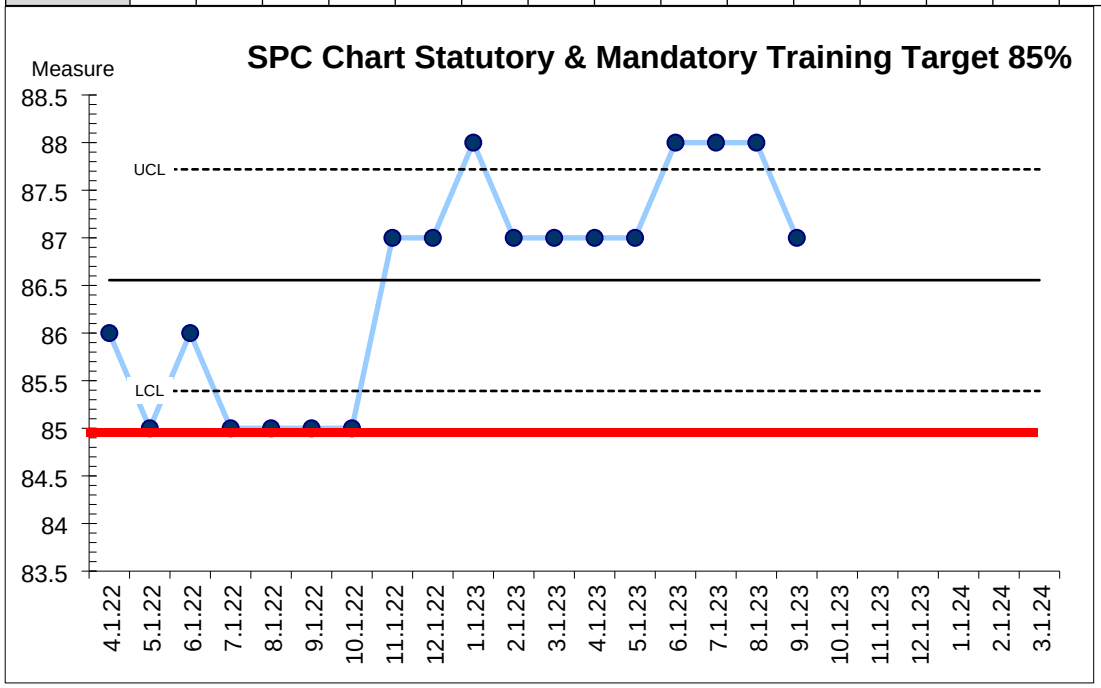
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

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



SPC Chart Analysis

The SPC chart shows common cause 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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

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

Risks to future performance

Set out risks which could affect future performance

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

KPI Indicator KPV.07

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

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

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

VCC	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Hospital Acquired Thromboses	1	0	0	0	0	0	0	0	2	1	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:

On target for the month

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.04

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Healthcare Acquired Infections (Inpatients)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Incidence of Healthcare Acquired Infections for the period February 2022 to April 2023

VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
C.diff	0	0	0	0	0	1	1	0	0	0	0	0	2	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
E.coli	1	0	0	0	0	1	3	1	0	1	0	0	1	0	1
Klebsiella	0	0	0	0	0	0	1	0	0	1	0	1	1	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	1	4	1	0	1	1	0	0	0	0

Performance

Assessment of current performance, set out key points:

- RCA for all reported infections in progress
- There is no evidence of VCC transmission in the RCA's to date.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.08

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

Target: 100%

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Jul 22	Au 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
VCS Hand Hygiene												100 %	100 %	99%	99.6 %
WBS Hand Hygiene												100 %	99.2 %	99%	
Trust Hand Hygiene												100 %	100 %	99%	
IPC Validation												100 %	100 %	100 %	99.4 %
Target l00%	0	0	0	0	0	0	0	0	0	0	0	100 %	100 %	100 %	100 %

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

Plus Infection Prevention Control Team Validation Audits % compliance

Performance

Assessment of current performance, set out key points:

- Performance is on target

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Weekly validation audit by IPCT		IPC

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.60

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

Target: NIL

SLT Lead:

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23
Actual															
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

[SUI data to be input]

Performance

Assessment of current performance, set out key points:

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

KPI Indicator KPI.30

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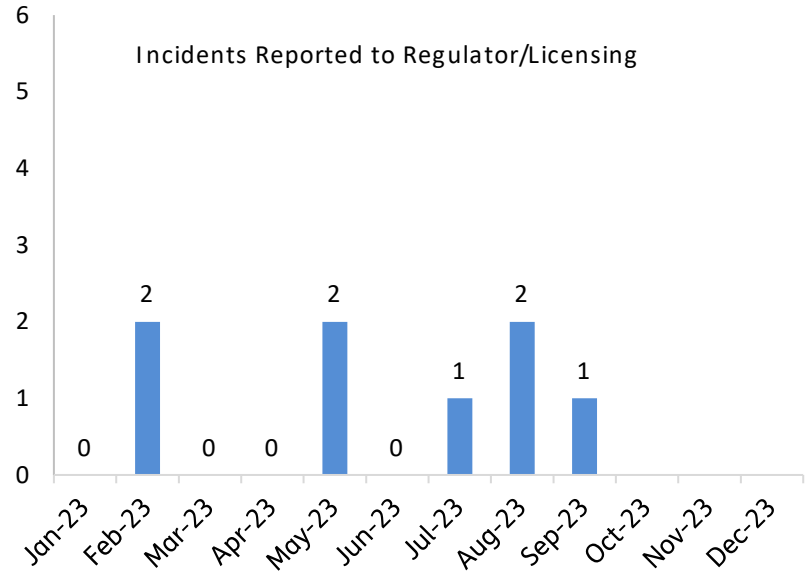
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23
Actual	1	1	0	0	0	2	0	2	0	0	2	0	1	2	1
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Performance

Assessment of current performance, set out key points:

There was one event submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in August:

- SABRE 110 - *Malaria positive donor archive sample*
  This event has arisen from the lookback exercise undertaken as Corrective and Preventive Action (CAPA) for SABRE 106 *Malaria residency risk incorrectly assessed.*
  Status: A Root Cause Analysis (RCA) investigation is complete, and the report being written up. A target date for the confirmatory report submission to MHRA is 21/10/23. Any remedial actions / lessons learnt will be implemented.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
The completion of Corrective Actions and Preventative Actions (CAPA), in respect of SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub	Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.	Peter Richardson

Expected Performance gain – immediate - N/A

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term - N/A

Risks to future performance

N/A

KPI Indicator H&S.55

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

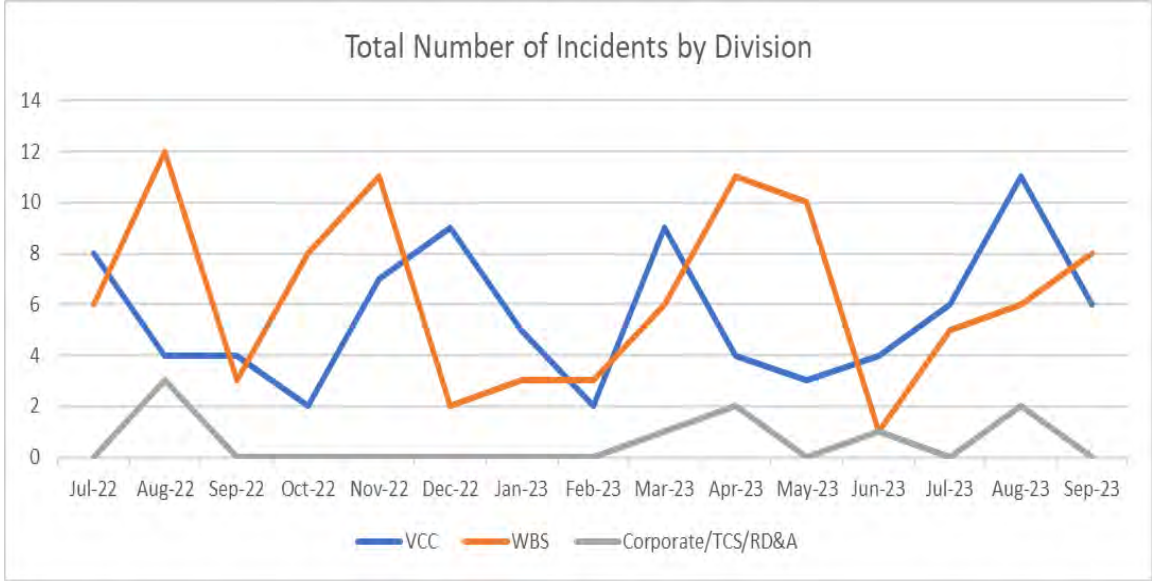
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
VCC	8	4	4	2	7	9	5	2	9	4	3	4	6	9	6
WBS	6	12	3	8	11	2	3	3	6	2	10	1	9	6	8
Corporate	0	2	0	0	0	0	0	0	0	2	0	1	0	2	0



Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incidents investigated. H&S incident investigation training complete	Q4 2022/23.

Expected Performance gain

Improved identification root causes VCC & Corporate

Improved data quality in incident records

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale:**

Expected Performance gain

Risks to future performance

Incomplete incident investigation – ongoing monitoring

KPI Indicator EST.06

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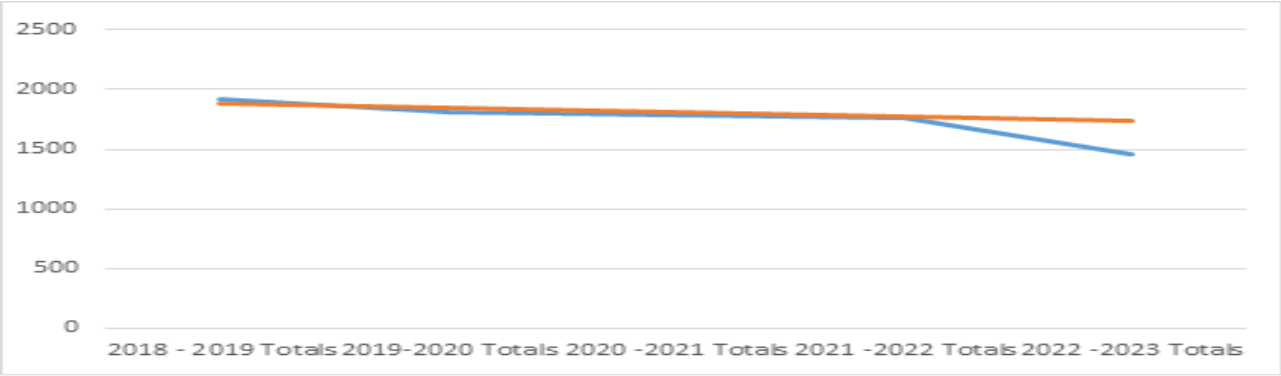
% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline

Target: -16% by 2025

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr23	May 23	Jun 23	July 23	Aug 23	Sept 23
Actual Number	103.01	95.85	102.66	122.08	172.82	155.55	212.01	179.31	187.06	130.20	111.83	86.13	85.33		
Target (-3% from previous year emissions)	110.6551	104.4917	104.8802	133.9711	190.288	201.7611	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858		



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

Performance

Assessment of current performance, set out key points:

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain – immediate

Ongoing communication and engagement with staff to reduce consumption.

Amendments to the BMS across all sites for better controls.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Reduced carbon footprint

Improvement across sites from the capital projects – namely nVCC and Talbot Green Infrastructure.

Risks to future performance

Set out risks which could affect future performance

•

EFFECTIVENESS

KPI Indicator KPV.05

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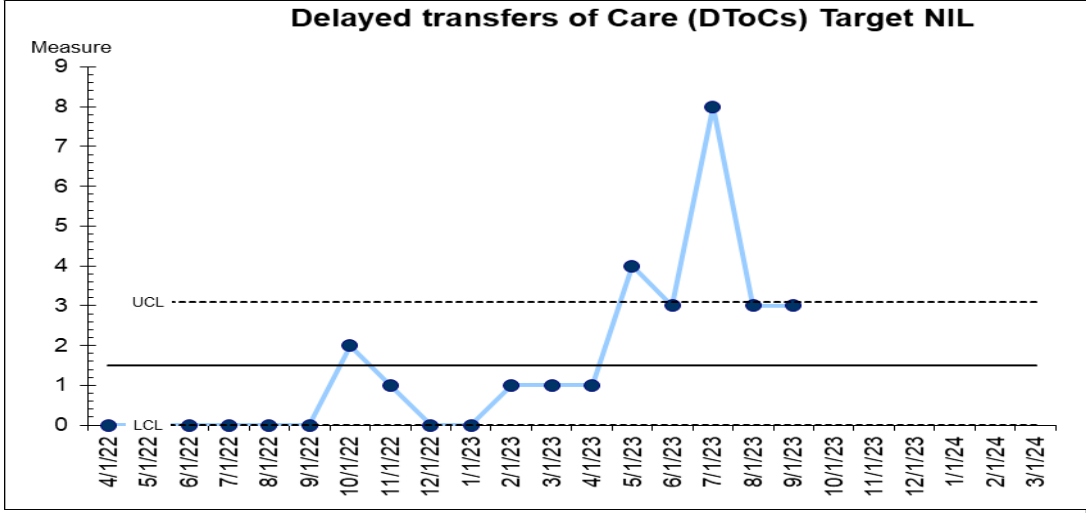
Number of Delayed Transfers of Care (DToC) Should we change this to the new WG descriptor i.e. Pathways of Care Delays (PoCD).

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Actual DToCs Number	0	0	0	2	1	0	0	1	1	1	4	3	8	3	3
Days Delayed													32	19	43
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

There were 3 pathways of care delays reported in September 2023.

There was 1 repatriation delay reported in September 2023.

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

There were 2 pathways of care delays reported in September 2023.

Patient 1: Awaiting Nursing Home Placement for discharge referred on 11/09/2023 causing a delay of 36 days.

Patient 2: Awaiting Package of Care for discharge referred on 10/10/2023 causing a delay of 7 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Data is now being uploaded nationally to the Pathways of Care Delays National system. Individual patient discussions are taking place daily with HB and community teams to progress any delays. It is acknowledged that there are bed pressures across the whole system which impacts on patient discharge/transfer. Pathways of Care NHS Executive team leads have visited VCC and provided additional training on the Six Goals of Emergency Care to further support and facilitate patient discharge.		Matthew Walters Operational Senior Nurse Matthew Walters Operational Senior Nurse

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Meeting with Llais Cymru to discuss/address delays affected by social services and how Llais may be able to support improvement work in this aspect.		Matthew Walters Operational Senior Nurse

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.04

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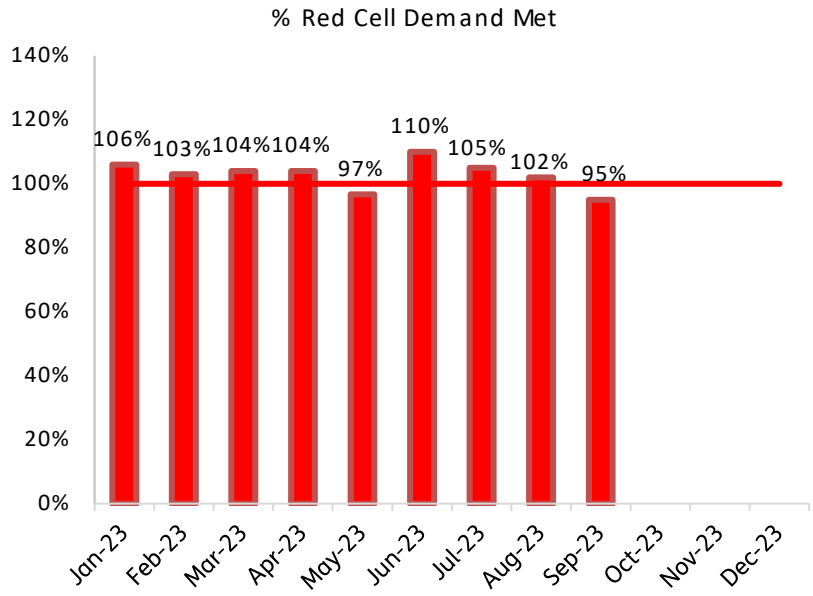
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Tracey Rees

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23
Actual %	107	112	105	115	115	94	106	103	104	104	97	110	105	102	95
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

Blood collection in September was lower than demand.
The average weekly demand in September was slightly higher than August at 1405 units per week in September compared to 1381 in August. **NOTE:** All hospital demand was met, but the service issued a Blue alert to hospitals for Group O negative red cells for 14 days in September. No mutual aid was required.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

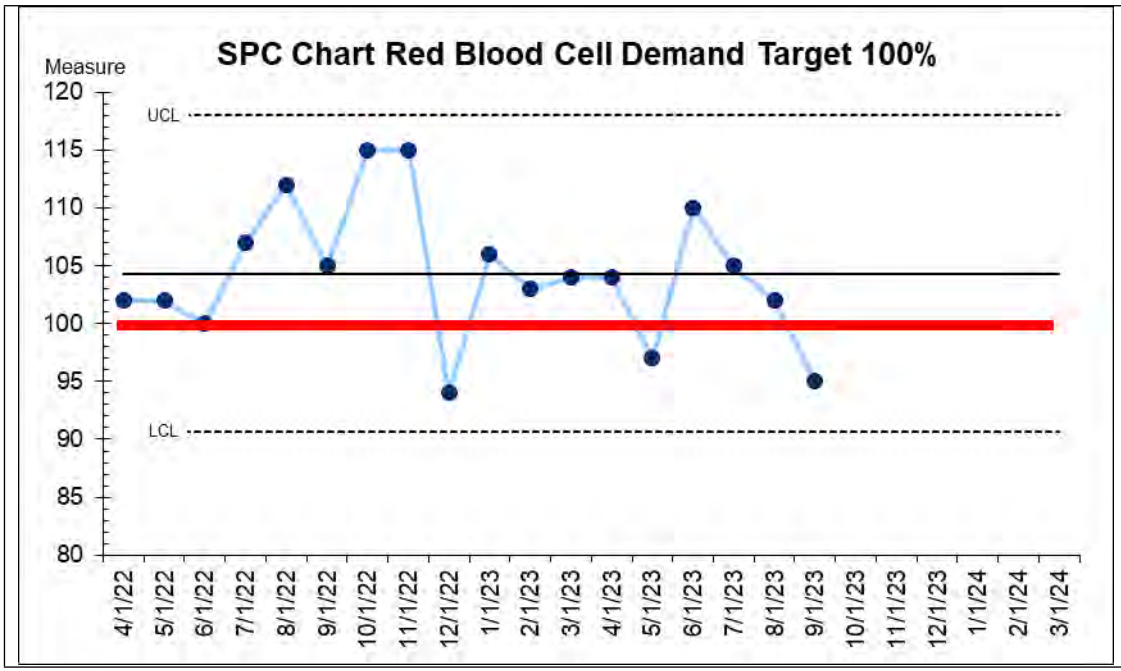
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term N/A

Risks to future performance

Set out risks which could affect future performance.
N/A



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

KPI Indicator KPI.26

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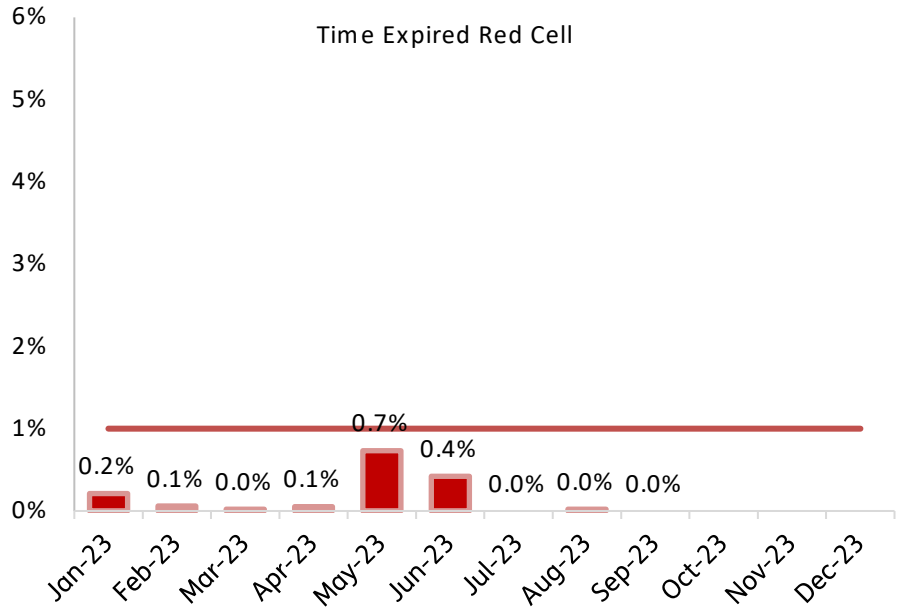
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	0.01	0.03	0.35	0.01	0.33	0.36	0.21	0.05	0.02	0.05	0.7	0.42	0	0.02	0
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance

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

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

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

Service Improvement Actions – Immediate (0 to 3 months)

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

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

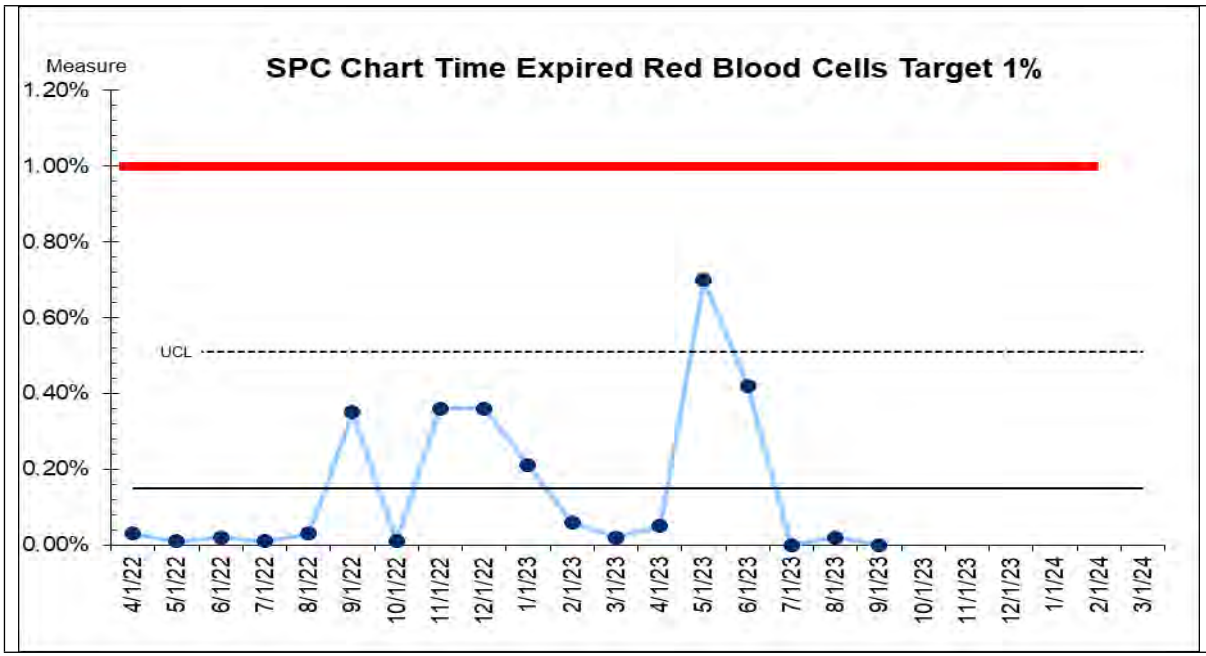
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

High stock levels lead to a risk of increased time expiry.



SPC Chart Analysis
The SPC chart shows common cause variation over the last 6-month period, with one 'special cause variation' in the month of May. However, the average performance of 0.15% remains well within the maximum 1%

KPI Indicator KPI.05

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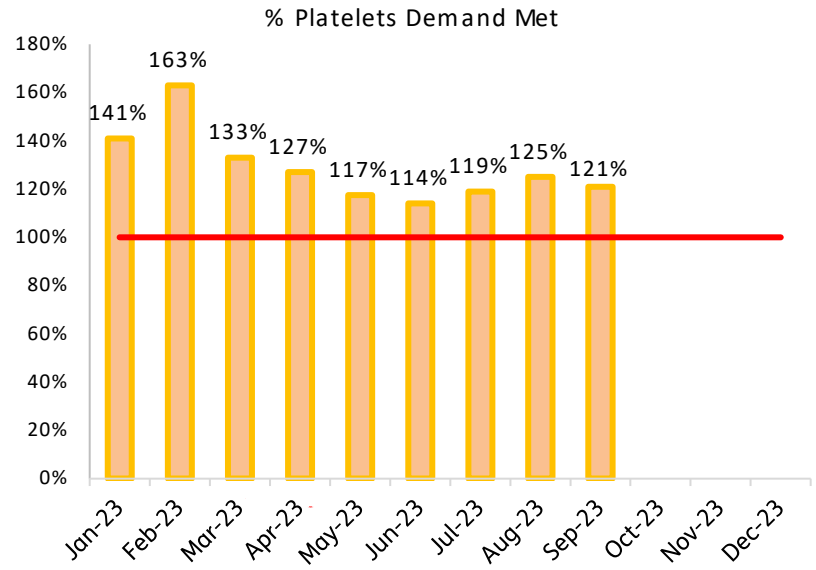
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23
Actual %	145	164	132	126	139	145	141	168	133	127	117	114	120	125	121
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



NB: A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.

Performance

Assessment of current performance, set out key points:
All clinical demand for platelets was met representing a continued strong performance against this metric in September.

Service Improvement Actions – Immediate (0 to 3 months)

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

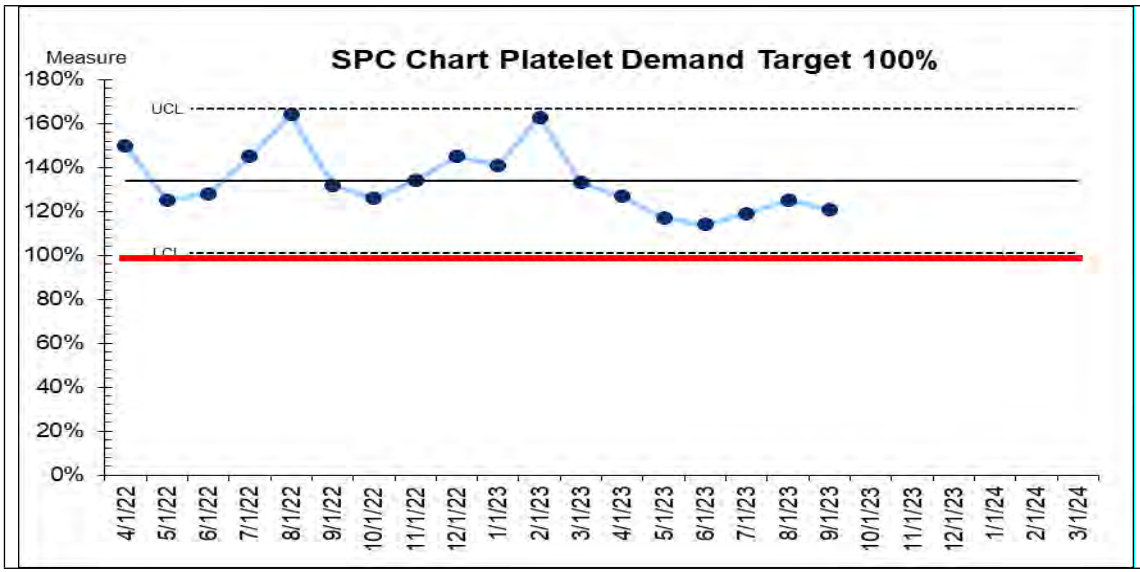
Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs. Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
Optimised clinic collection plan for Apheresis and a forecasting tool to inform decisions around pooled platelet manufacture.

Risks to future performance
Fluctuations in platelet demand.



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 138% consistently exceeding the 100% target.

KPI Indicator KPI.25

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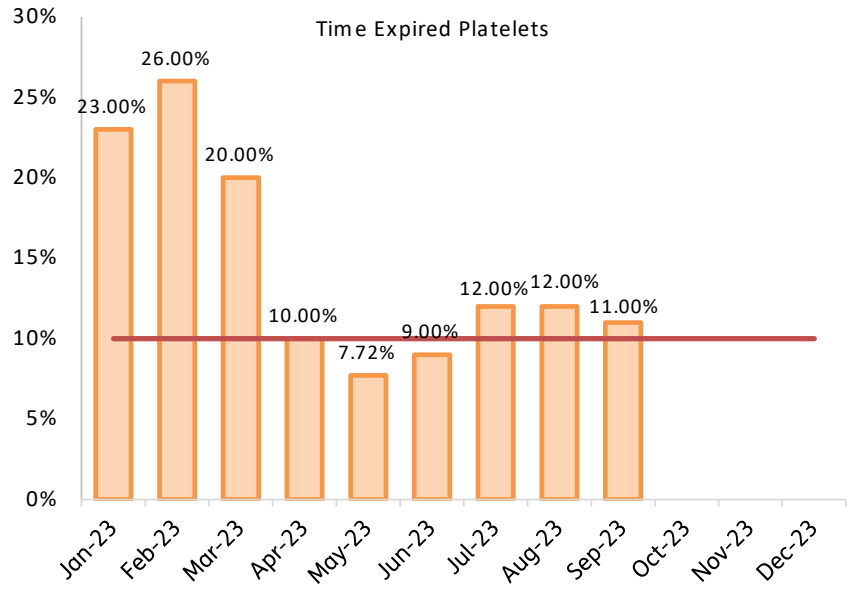
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	19	30	25	14	15	27	23	25	20	10	8	9	12	12	11
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 platelets 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:
At 11% performance was just above target for September with 87 units time expired, improving slightly on the performance for August.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

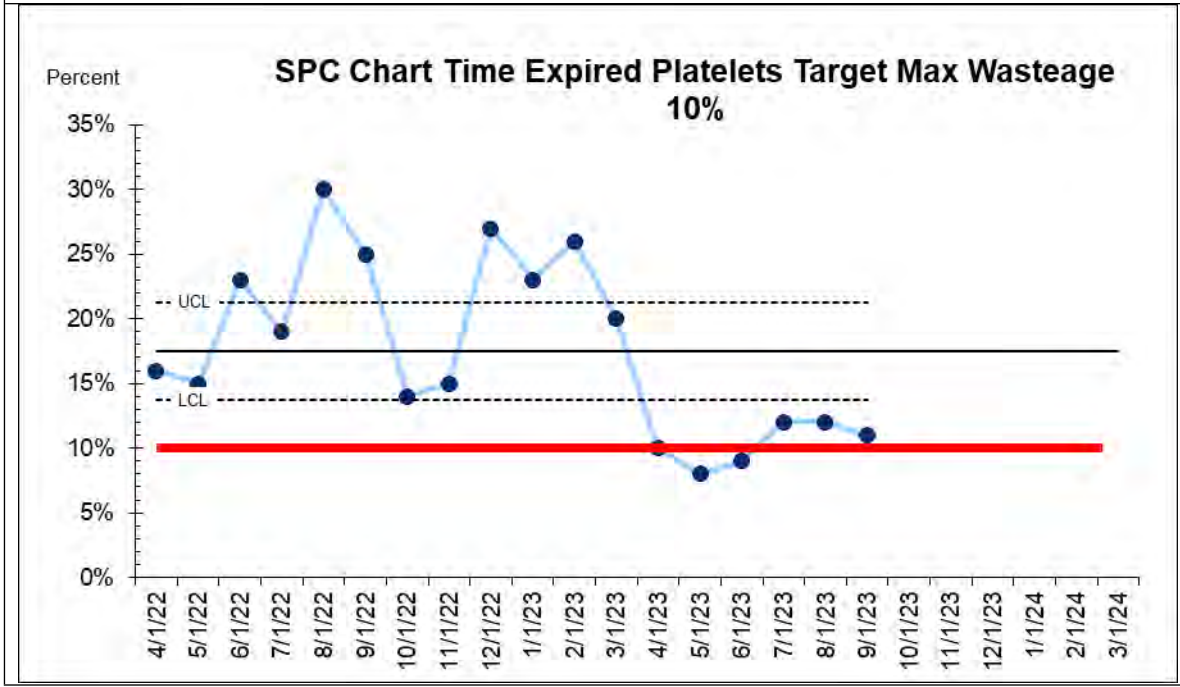
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
Platelet expiry reduction using a risk-based approach, balancing platelet expiry against ability to supply platelets for clinical needs.

Risks to future performance

Set out risks which could affect future performance.
Unexpected increases in clinical need - noting unexpected spike in demand may require imports.
Future Bank holidays.



SPC Chart Analysis

The SPC chart shows fluctuating special cause variation over 4 of the last 6- month period, with the beginnings of a favourable trend over the last four months. The average performance of 18% remains above the maximum wastage limit of 10%. Signifiicantly improved and sustained performance noted.

KPI Indicator KPI.13

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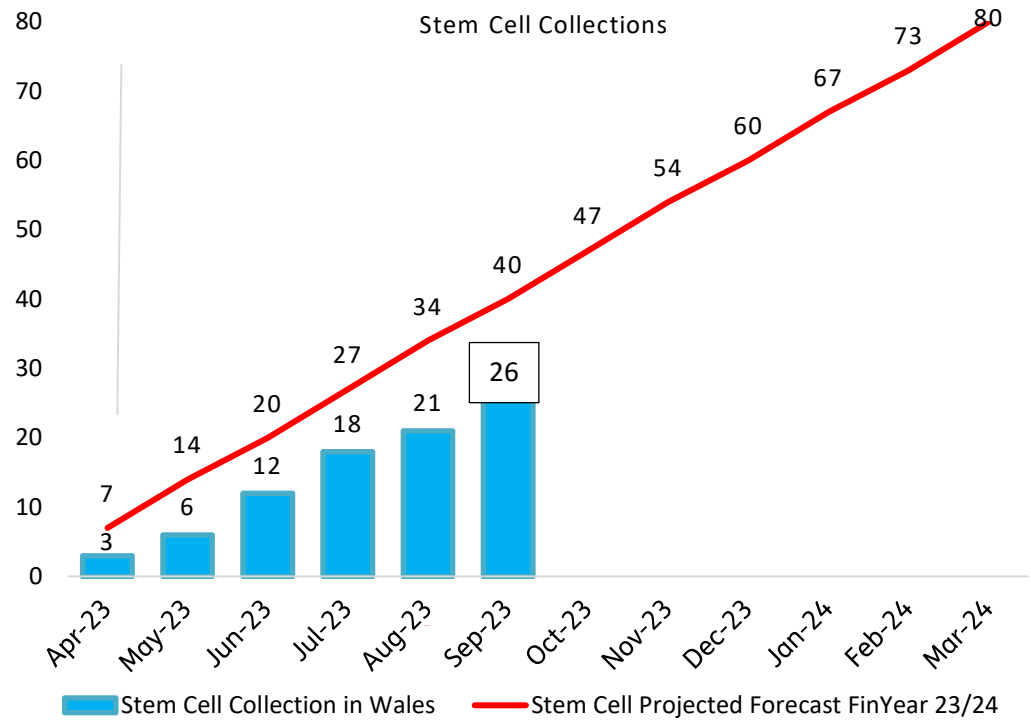
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jul 21	Aug 21	Sep 21	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Cumulative Actual	8	12	14	14	15	19	23	26	32	3	6	12	18	21	26
Cumulative Target p/a	28	35	42	49	56	63	70	77	84	7	14	20	27	34	40



Performance

The total cell provision for the service in September was 8 with 5 collections (Peripheral Blood Stem Cell) and 3 imported for a Welsh patient.

The Service continues to experience a cancellation rate of approx. 30%-40% compared to 15%-20% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

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

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:** / **Lead:**
The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being finalised to support the ongoing development of the WBMDR. This will form part of the WBS futures programme. A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collections see KPI.20	**Timescale:** Q3 **Lead:** Tracey Rees

Expected Performance gain - immediate.

	As above
	Service Improvement Actions – tactical (12 months +)
	Implementation of the five-year strategy. **Timescale:** 2024/25 **Lead:** Tracey Rees
	Expected Performance gain – longer-term. Improved recruitment of new donors to the Register which over time will increase the number of collections
	Risks to future performance
	Set out risks which could affect future performance. Identified risks are being managed.

KPI Indicator WOD.37

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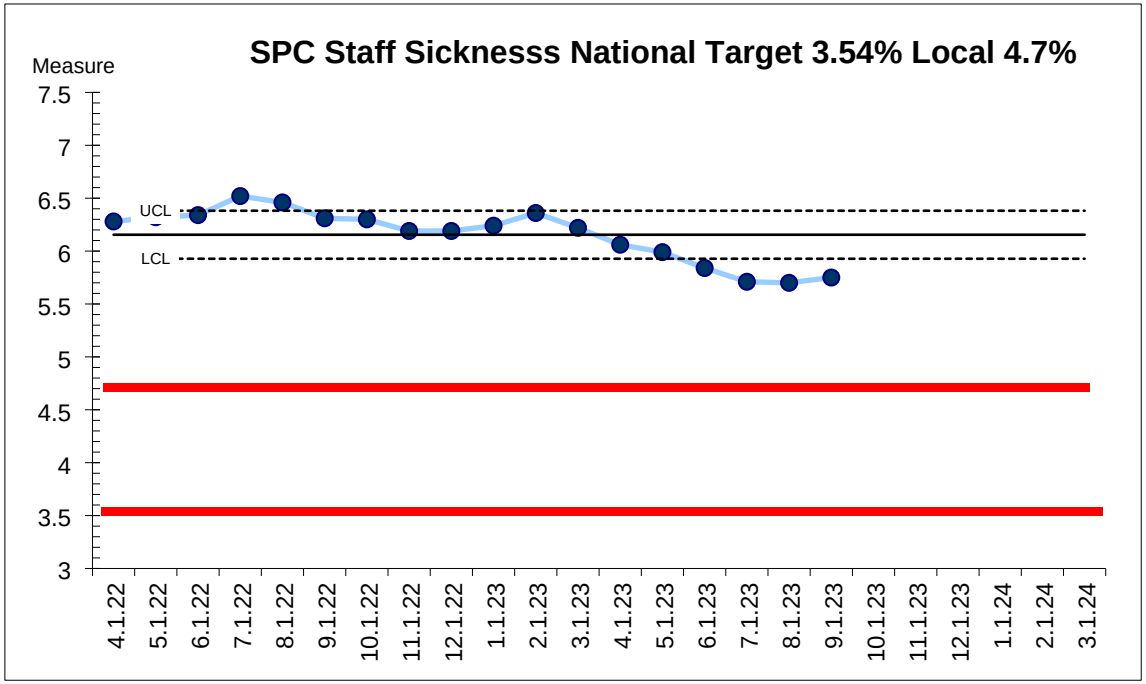
Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23
Actual %	6.53	6.50	6.36	6.30	6.19	6.19	6.24	6.36	6.22	6.06	5.99	5.84	5.71	5.70	5.75
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
National 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 an improving trend over the last 7 months. However, the overall average 6.2% sickness level remains higher than the 3.54% target

Performance

Assessment of current performance, set out key points:

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

Short-term absence remains relatively low across the Trust.

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

Anxiety/stress/depression/other psychiatric illnesses, remaining as highest reason for absence, both in month and on a rolling average.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Quarterly random sickness audits to be undertaken in: • ICT • RD&I • Private Patients (Closed)	01/09/2023 01/08/2023	Head of Workforce
Detailed analysis of anxiety/stress/depression and other psychiatric illness to be undertaken		Head of Workforce

Expected Performance gain - immediate

Regular monitoring against the application of the policy will ensure our staff are supported and encouraged to improve their health and areas where there are concerns are provided with immediate interventions to improve practice.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engagement sessions in Autumn 2022 the following actions are being taken over the coming 12 months • Staff wellbeing support survey • Developing a Menopause friendly culture	30/04/2024	Head of OD

	• Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation	Ongoing	Head of OD and Trust Board
	Expected Performance gain – longer-term The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.		
	Risks to future performance		
	Set out risks which could affect future performance • Not having enough staff available due to sickness absence could impact on delivery of services across the Trust • Staff who feel unsupported during absence may chose to leave the organisation increasing turnover		

KPI Indicator WOD.36

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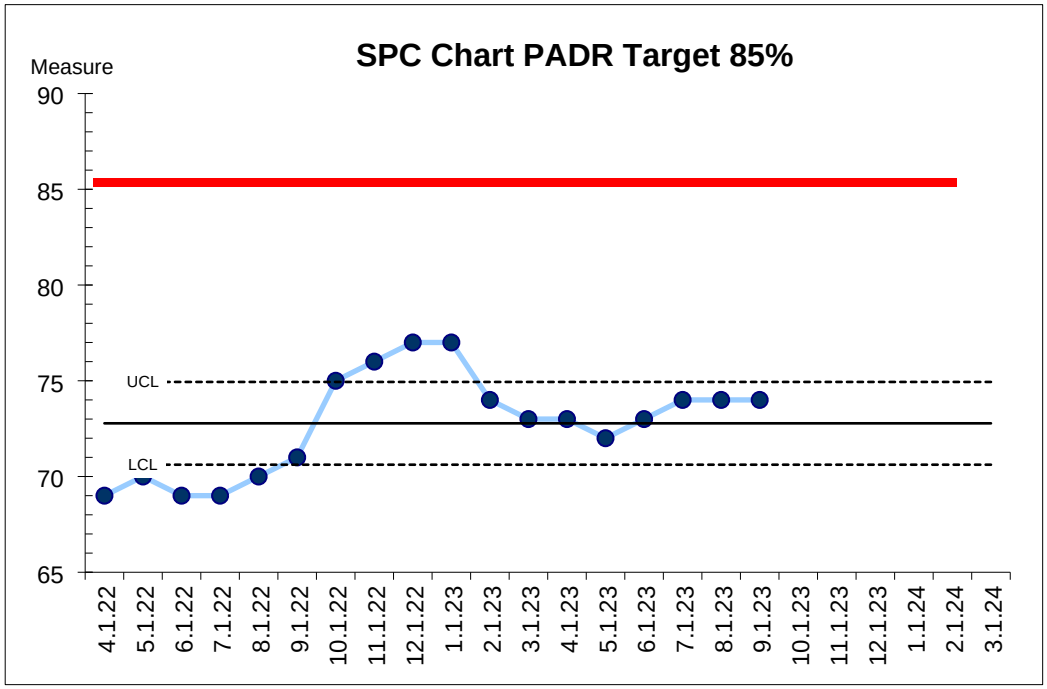
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23
Actual %	69	70	71	75	76	77	77	74	73	73	72	73	74	74	74
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

The SPC chart shows a stabilising trend over the last 7 months. However, averaging 72%, consistently falling short of the 85% target.

Performance

Assessment of current performance, set out key points:

As anticipated, there was short-term growth in PADR activity during the early implementation of the new Pay Progression Policy in Autumn 2022 however this remains significantly below the Welsh Government target. Transforming Cancer Services remains the biggest cause for concern reporting 8 months consecutively below 50%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Support TCS with improvement plan	01/09/2023	Senior BP Head of Workforce
Continue to monitor for hotspot areas of concern and provide interventions for improvement.	01/09/2023	

Expected Performance gain - immediate

With targeted interventions in hotspot areas that are continually preforming significantly below the expectations this should see a growth in the overall compliance within the Trust.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Ongoing Monthly	Business Partners alongside SMT/SLT

Expected Performance gain – longer-term

As regular monitoring and reviews of compliance is undertaken in the divisional operational meetings the Trust's compliance will improve.

Risks to future performance

Set out risks which could affect future performance

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

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

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

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Performance

VCC	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Would you recommend us? %		89	89	88	nda	nda	93	96	95	95	98	96	97	97	95
Your Velindre Experience? %					nda	nda	84	86	82	82	68	71	91	94	63
Target 85%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Assessment of current performance, set out key points:

There are two surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience'. The 'Would you recommend us?' survey uses categories such as Very good, good etc

Question 1: Overall, how was your experience of our service?

Survey: VCC - Friends and Family

Create new action

Available Answers	Responses	Score (%)
Very good	33	86.84%
Good	3	7.89%
Neither good nor poor	0	0.00%
Poor	1	2.63%
Very poor	1	2.63%
Don't know	0	0.00%
Total	**38**	**100%**

The Your Velindre experience survey uses 0-10 in the question about rating VCC

Question 10: Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

Create new action

Available Answers	Responses	Score (%)
10	4	50.00%
9	1	12.50%
8	3	37.50%
7	0	0.00%
6	0	0.00%
5	0	0.00%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	0	0.00%
0	0	0.00%
Total	**8**	**100%**

	Service Improvement Actions – Immediate (0 to 3 months)		
	Actions: what we are doing to improve Outcomes from CIVICA are reviewed monthly and form part of SLT Q&S highlight report and the QSP report Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback Directorates to develop plans to increase response rate. Q+S team to work with each directorate to provide further analysis on responses CIVICA working group established with attendees from each directorate Q+S team to review the difference in positive percentages for both surveys	**Timescale:** Ongoing Ongoing Ongoing	**Lead:** Head of Nursing/SLT SLT/Directorate Managers SLT/Directorate Managers Q+S manager
	Expected Performance gain – immediate A new Patient Experience and Concerns manager has been in post since June 2023 who is engaging with staff across teams to encourage patient feedback and the recording of compliments.		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve Patient Engagement Hub to work with Q&S team to continue to find new/different ways of engaging patients and seeking feedback.	**Timescale:** December 2023	**Lead:** Head of Patient Engagement
	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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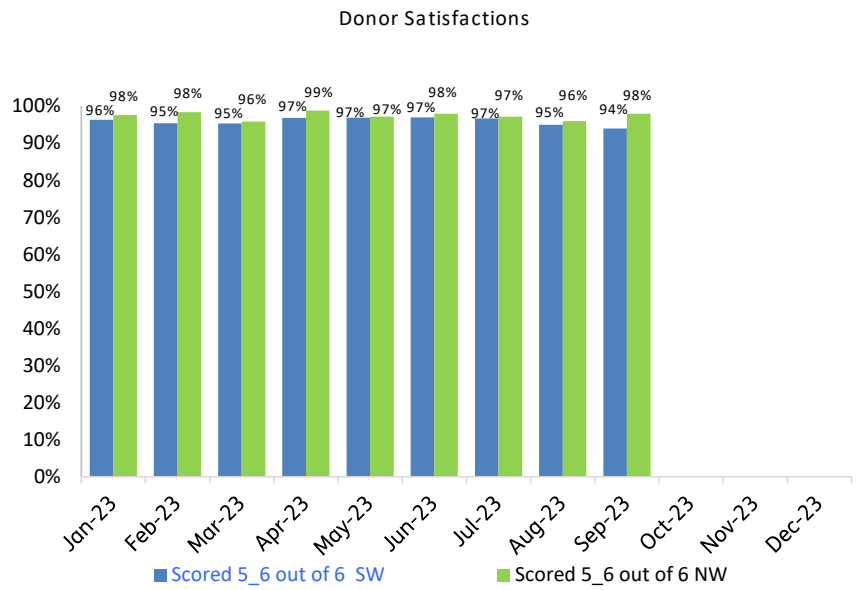
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	96	97	97	96	96	95	97	97	95	97	97	97	97	96	94.9
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 94.9%, is 0.1% off target for donor satisfaction in September. In total there were 1,092 respondents to the donor survey, 220 from North Wales (scoring satisfaction at 97.6%), and 976 from South or West Wales (scoring satisfaction at 94.2%).

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance.

N/A

KPI Indicator KPV.12

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Number VCC formal complaints received under Putting Things Right within 30 days

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

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

Performance

Assessment of current performance, set out key points:

- Target deadline has consistently been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

New Patient Experience and Concerns manager in post since June 2023 promoting instant access to deal with early resolutions or PTR concerns.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.03

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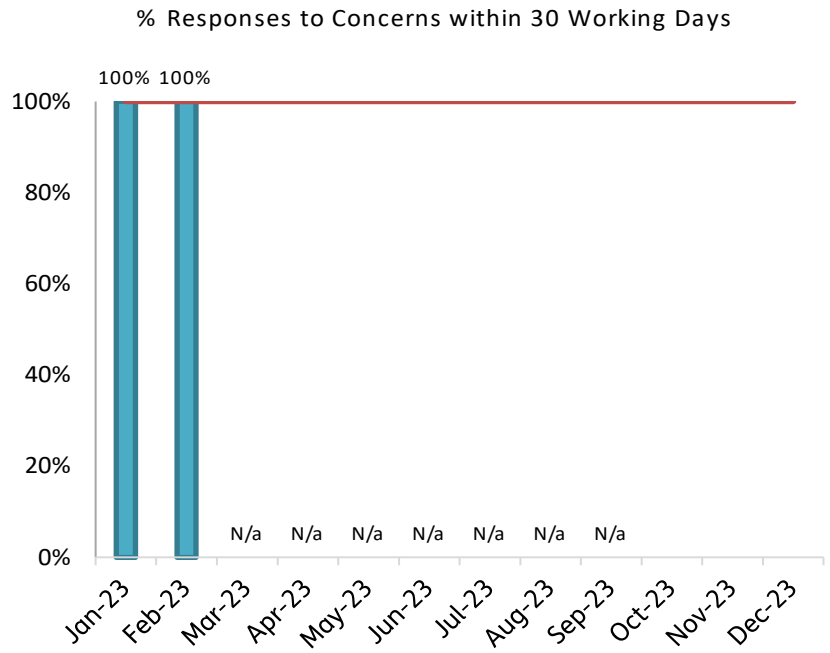
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	100	n/a	n/a	100	100	N/A	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



NB:
Performance against target only shown the month when a formal concern has been raised.
Under Putting Things Right (PTR) guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.

Performance

Assessment of current performance, set out key points:
There were no formal concerns raised or due for closure in September 2023.

NB: In September 2023, an enquiry was received by a Welsh Government Minister regarding a concern raised by a constituent relating to the environmental impact associated with a proposed change at the WBS. A response was issued to the Minister by VUNHST on 03/10/23.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:
– Continue to monitor this measure against the '30 working day' target compliance. – Continued emphasis of concerns reporting timescale to all staff involved in concerns management reporting. – Work closer with relevant departments to ensure proactive and thorough investigations and learning outcomes. – Adherence to Duty of Candour requirements.	Ongoing **Lead:** Edwin Massey

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance.

TIMELINESS

KPI Indicator KPV.14

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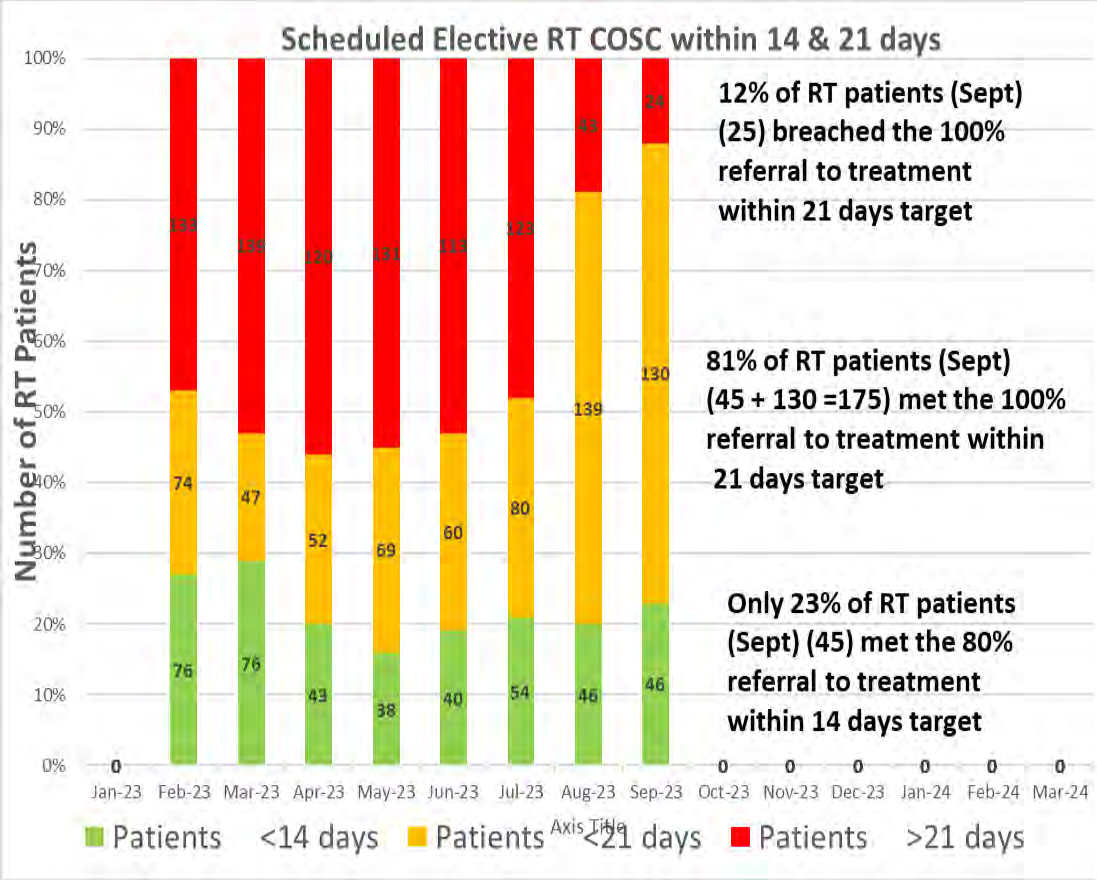
Scheduled Elective Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days (COSC)

Target: 80% within 14 Days and 100% within 21 Days (COSC)

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



SPC Chart Analysis

The SPC chart analysis is not possible until well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Performance

Assessment of current performance, set out key points:

Ongoing challenges post DHCR in establishing a fully validated position. Validation resources currently insufficient to address range of issues identified.

Number of referrals	200	
treated within 14 days of referral (80% target)	45	23%
treated within 21 days of referral (100% target)	175	88%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve		Lead:
Retraining for clinical teams to ensure categorising of the referrals is correct.	Ongoing	Helen Payne/Tom Rackley
Additional validation resources to be provided.	Ongoing Complete	Helen Payne Kathy Ikin
Care Path implemented and streamlining booking processes		

Expected Performance gain – immediate

Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Pathway change group in place to address changes in process to meet revised patient journey timings with SST leads.	October 2023	Tom Rackley

Expected Performance gain – longer-term

Changes to patient pathway in line with time to radiotherapy timings

Risks to future performance

Set out risks which could affect future performance

Linac replacement programme which has commenced

Sickness absence levels in radiotherapy workforce

KPI Indicator KPV.15

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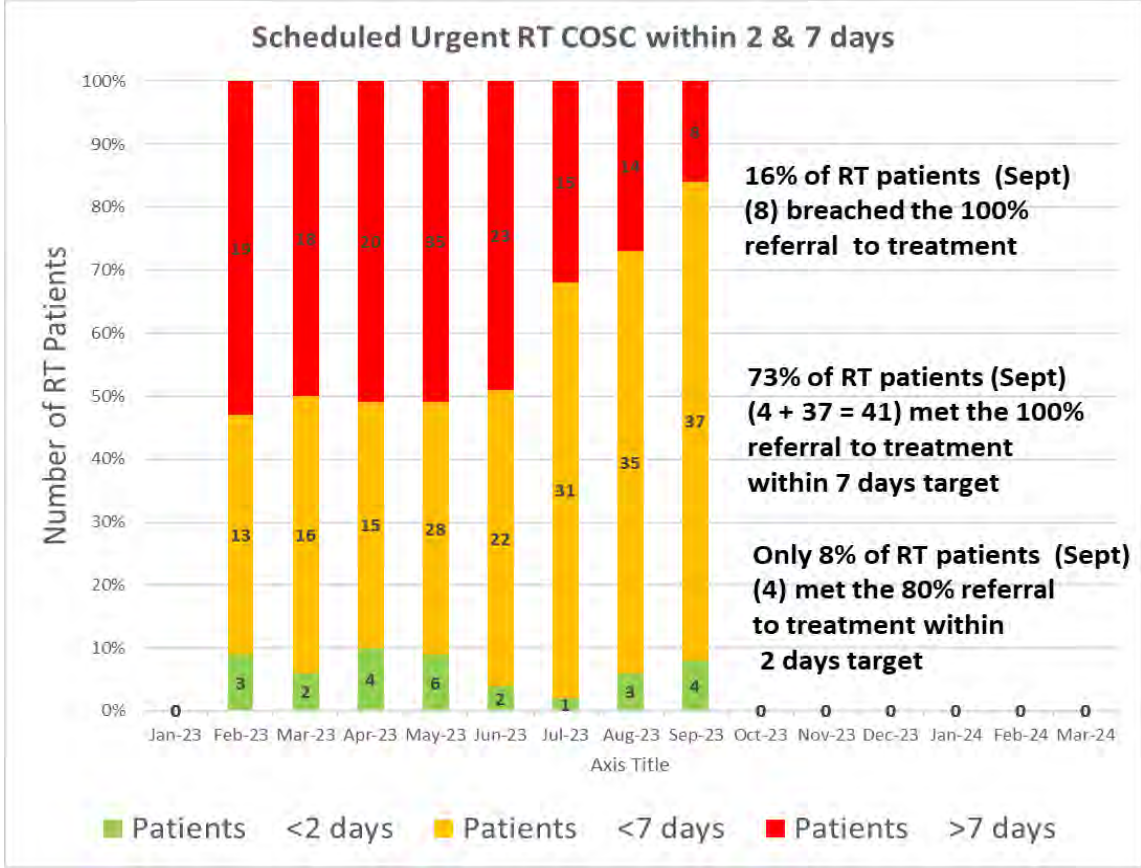
Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days (COSC)	
Target: 80% within 2 Days and 100% within 7 days (COSC)	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**



SPC Chart Analysis

The SPC chart analysis is not possible until we have well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	49	
treated within 2 days of referral (80% target)	4	8%
treated within 7 days of referral (100% target)	41	84%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		
• Implementation of revised Urgent Symptom Control definition	Helen Payne/ Thomas Rackley	November 2023

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.16

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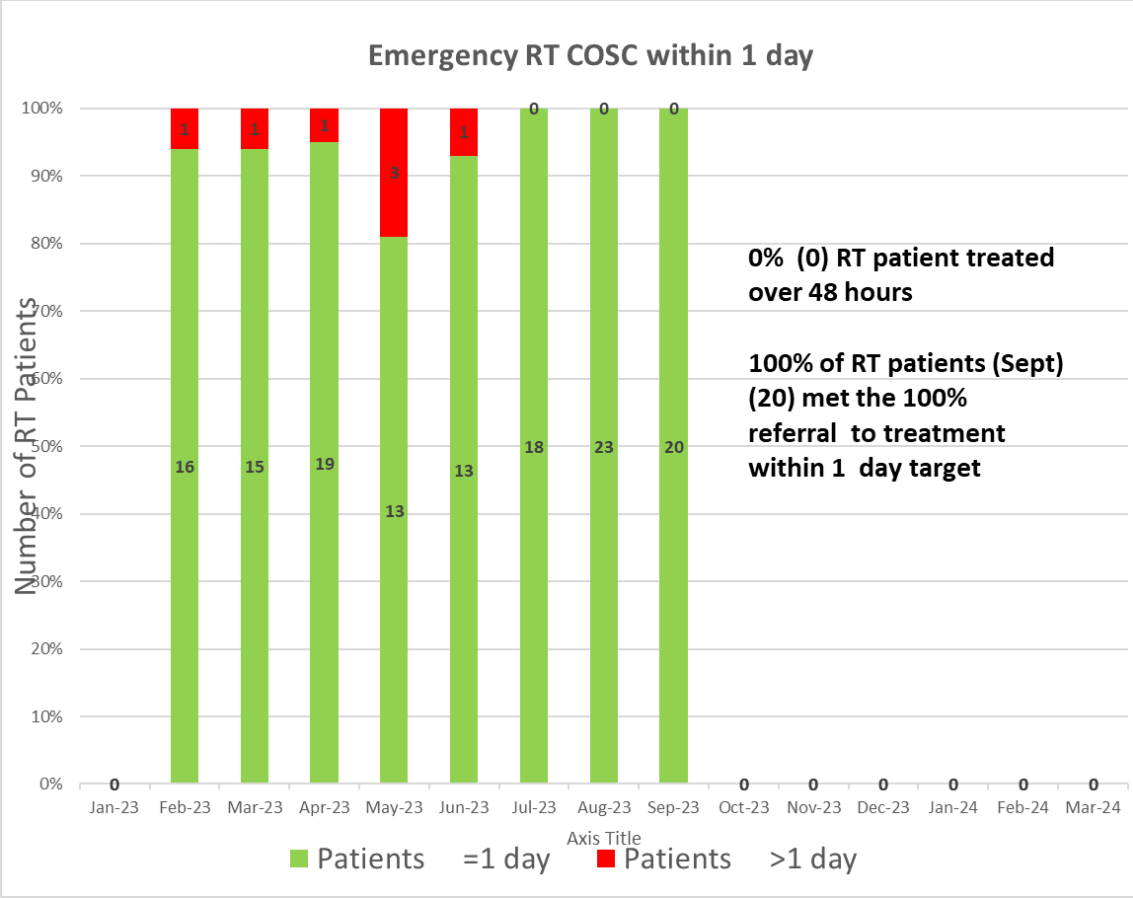
Emergency Radiotherapy Patients Treated Within 1 Day (COSC)	
Target: 100%	**SLT Lead: Head of Radiation Services / Clinical Director**

Current Performance against Target or Standard



SPC Chart Analysis

The SPC chart analysis is not possible until we well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Performance

Assessment of current performance, set out key points:

Target Achieved

Number of referrals	20	
85% treated within 24 hours of referral	17	85%
95% treated within 48hours of referral	19	95%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve • As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

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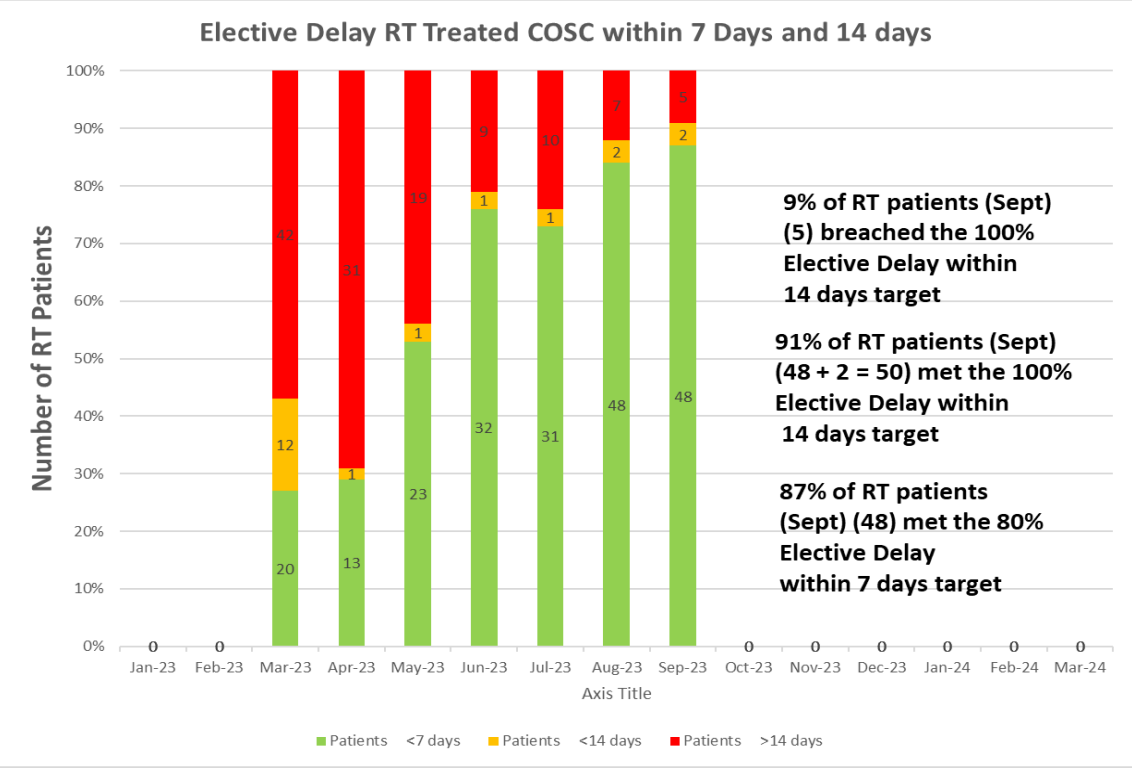
Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days (COSC)	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

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



SPC Chart Analysis

The SPC chart analysis is not possible until we well over 6 month's performance data available using the new COSC measures to ensure the results are statistically valid.

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	55	
treated within 7 days of referral (80% target)	48	87%
treated within 14 days of referral (100% target)	50	91%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve • As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve •		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.20

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Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23
Actual %	66	77	89	96	98	96	97	98	98	93	90	90	94	92	90
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days				14	6	12	9	9	8	26	40	40	25	32	35
Within 21 days				341	354	322	336	388	409	343	354	378	370	380	323

The number of patients scheduled to begin non-emergency SACT treatment in Sept 2023 was 358.

Parenteral Attendances (excludes patients on single agent oral SACT regimens)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,186	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,558	2486	2463	2572	2297	2455	2162	2557
2023/24 Attendances	2,220	2,545	2,622	2,483	2,679	2,453						

Performance

Of 358 non-emergency new patients started patients started, 35 patients waited over 21 days = performance of 90%. Target Not Achieved

Intent /Days -	22-28	29-35	36-42	43 da1ys +
Non-emergency (21-day target)	34	0	1	0

1 patient who waited > 28 days due to incorrectly being allocated to clinical trials by the prescriber.

SACT data lead in process of validating BI report which will enable such patients to be identified earlier by the bookings team

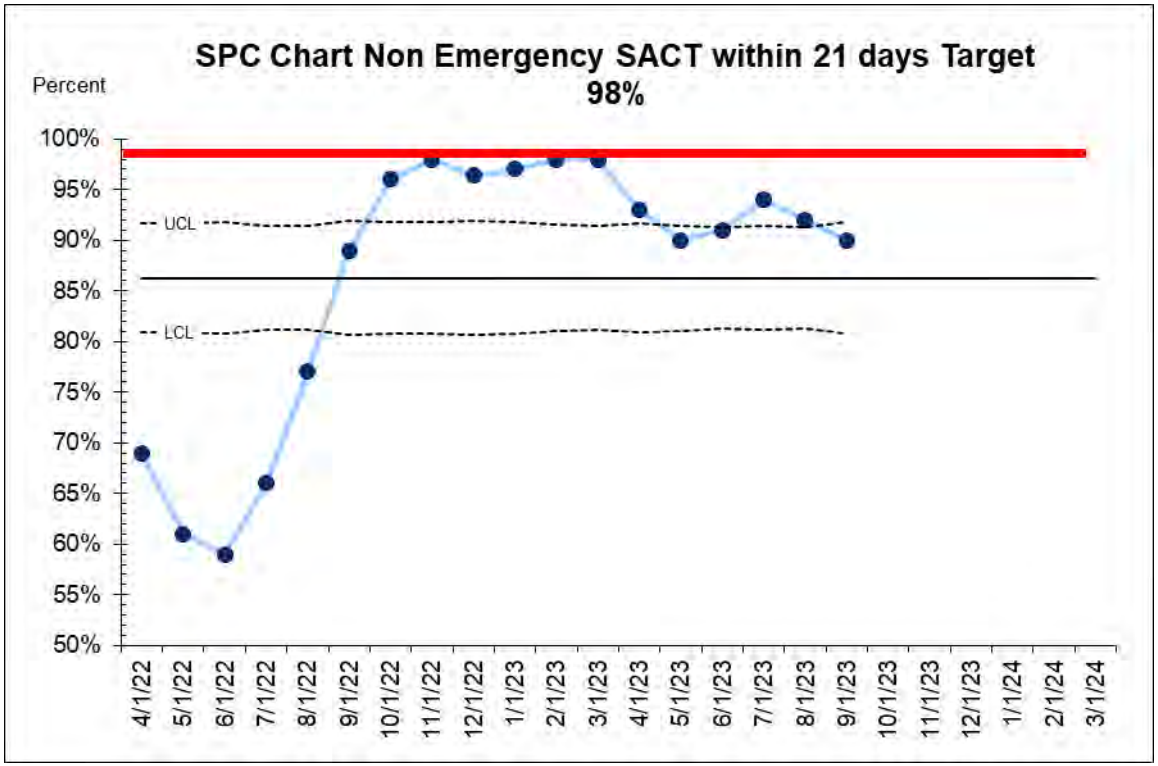
Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead
Continue to progress SACT nurse and booking review recommendations.	March 2024	Barbara Wilson
Validation of BI tool to identify incorrectly allocated patients	15/11/23	EH

Expected Performance gain – immediate

Reduction of breaches/lengths of wait due to systems/ human error

Service Improvement Actions – tactical (12 months +)



SPC Chart Analysis

The SPC chart shows an improvement trend, followed by stable performance close to the 98% target.

Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Re-determine the impact of continued growth in demand across SACT teams	**01/04/24**	
• Implement additional staff resources/ recruitment plan to meet revised forecasts across all staffing groups		BW
• Nursing: international nurse recruitment and perceptorship recruitment		BT
Pharmacy (as pharmacy capacity review recommendations, see below)		RM Outreach board
Booking: 0.5WTE identified through DHCR work, funding continues to be explored		
• Engage with HB partner to deliver on VCC strategy to deliver care closer to home		
Progress pharmacy capacity review: submitted to BPG and SLT Oct 2023.		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Staff recruitment and retention: nursing and pharmacy. Availability of suitably skilled workforce
- Financial ability to recruit ahead of increased demand, in order for training
- Timescales for on-boarding of HB partner outreach locations and available VCC accommodation capacity
- Overall capacity of aseptic services across SE Wales

KPI Indicator KPV.21

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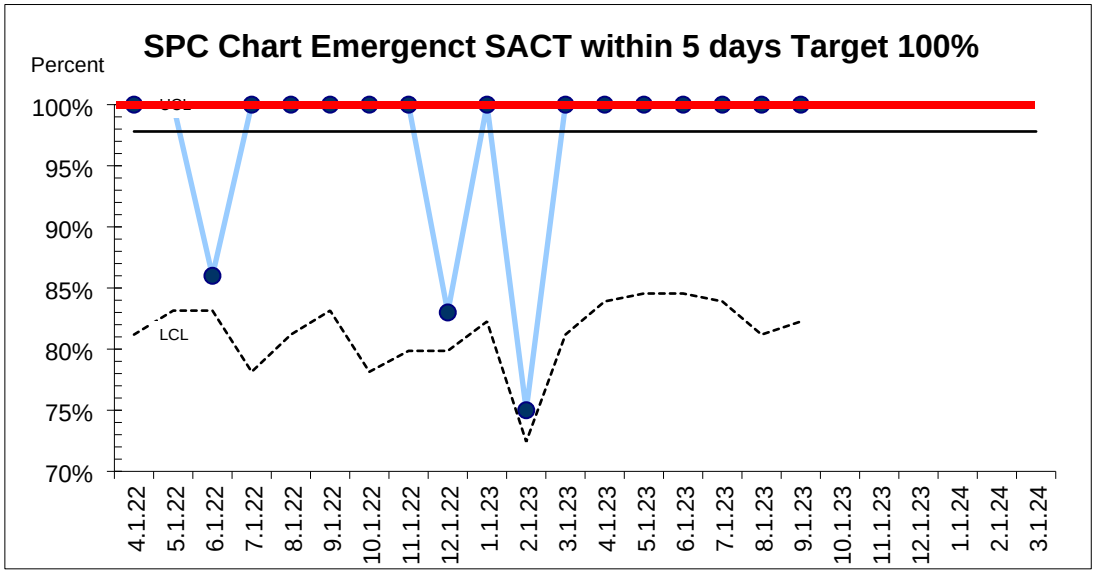
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Jul 22	Au2 2	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23
Actual %	100	100	100	100	100	83	100	75	100	100	100	100	100	100	100
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
More than 5 days	0	0	0	0	0	1	0	1	0	0	0	0	0	2	0
Within 5 days			0	5	6	5	8	3		5	0	12	10	5	8



SPC Chart Analysis

The SPC chart shows a fluctuating process starting to stabilize with average 97 % against the 100% target, however note small numbers involved.

Performance

8 patients referred for emergency SACT treatment were scheduled to begin treatment in Sept 2023. All waits were in line with clinical decision and thus were treated in target = 100% performance.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

		Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPI.18

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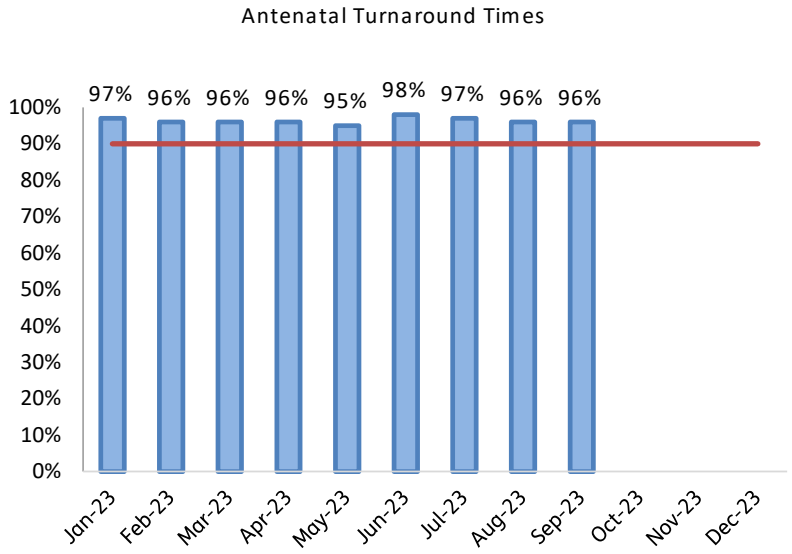
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	96	97	97	98	96	87	97	96	96	96	95	98	97	96	96
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Assessment of current performance, set out key points:
At 96% the turnaround time performance for routine Antenatal tests continued to exceed target in September 2023.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.	Ongoing	Tracey Rees

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

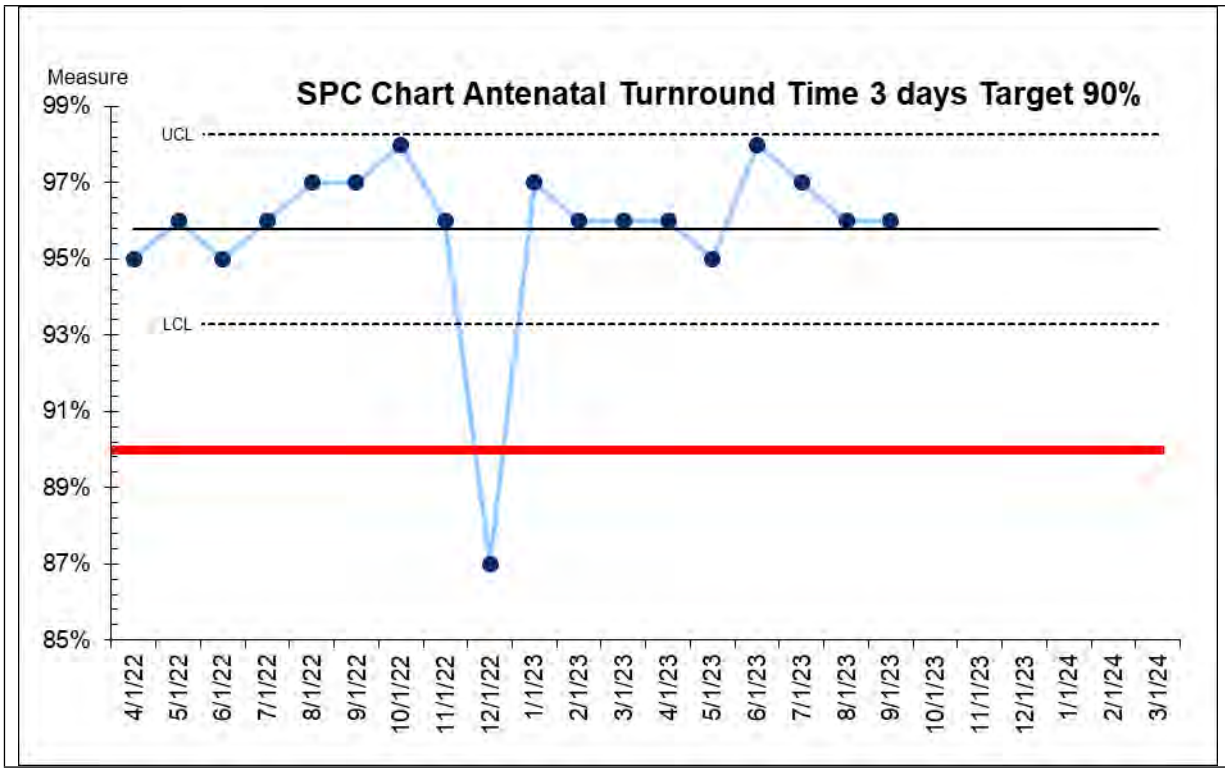
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance



SPC Chart Analysis
The SPC chart shows common cause or normal variation over the 15-month period. However, a special cause variation has occurred in December due to an IT incident The average performance of nearly 96% exceeds the 90% target.

KPI Indicator KPI.17

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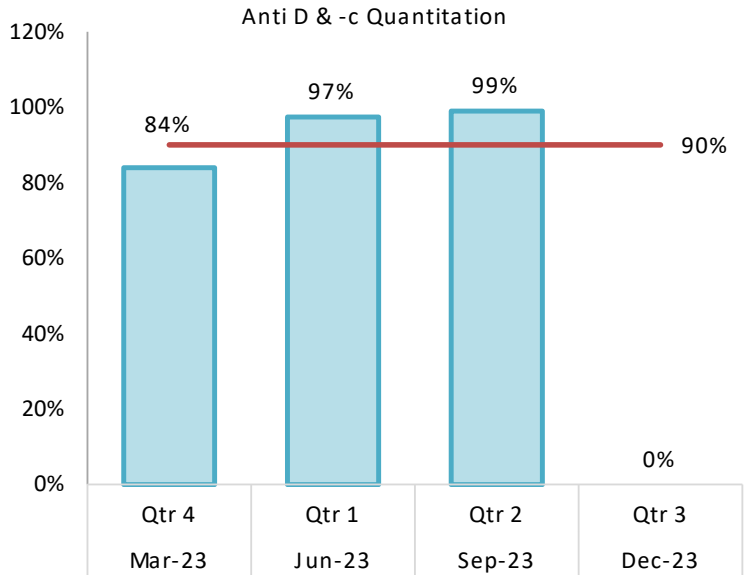
% Antenatal -D & -C quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Tracey Rees

Current Performance against Target or Standard

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23
Actual %	99	96	99	99	96	97	96	60	92	97	98	97	98	99	100
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Excellent performance during Quarter 2, met the target and continued to improve.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate.

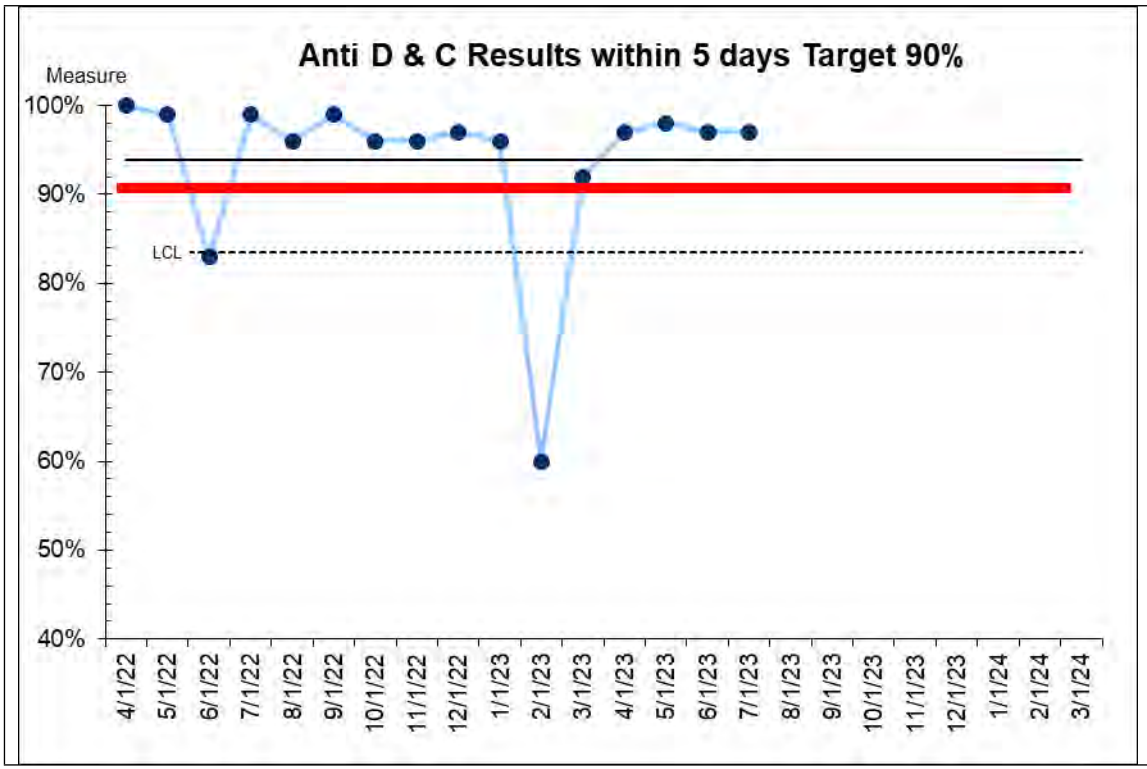
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.



SPC Chart Analysis
The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter four. However, the average performance of 94% exceeds the 90% target overall.

EFFICIENT

KPI Indicator FIN.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

Current Performance against Target or Standard

Trust Position (core)	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual £k	64	1	4	2	4	5	7						
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at September23

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(21.191)	(21.190)	0.001	(40.123)	(40.123)	0.000
RD&I	(0.538)	(0.538)	(0.000)	0.091	0.091	0.000
WBS	(11.065)	(11.066)	(0.000)	(21.532)	(21.532)	0.000
Sub-Total Divisions	**(32.795)**	**(32.794)**	**0.000**	**(61.564)**	**(61.564)**	**0.000**
Corporate Services Directorates	**(6.639)**	**(6.615)**	**0.024**	**(12.956)**	**(12.956)**	**0.000**
Delegated Budget Position	**(39.433)**	**(39.409)**	**0.025**	**(74.520)**	**(74.520)**	**0.000**
TCS	(0.386)	(0.404)	0.018	(0.744)	(0.744)	0.000
Health Technology Wales	(0.071)	(0.071)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	39.891	39.891	0.000	75.381	75.381	0.000
Trust Position	(0.000)	0.007	0.007	0.000	0.000	0.000

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

Performance

The overall position against the profiled revenue budget to the end of September 2023 is an underspend of £0.00m and is currently expecting to achieve an outturn forecast of Breakeven.

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all financial risks are mitigated during 2023-24.

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Further Non Delivery of recurrent savings plans

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.991**	

KPI Indicator FIN.73

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Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast

SLT Lead: Finance Director

Current Performance against Target or Standard

Performance

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual(Cum)	27.8	1.38 9m	1.63 7m	5.64 6m	10.3 33m	8.68 3m	11.3 26m						
Target £24.416m CEL		1.38 9m	1.63 7m	5.64 6m	10.3 33m	8.68 3m	11.3 26m						

Capital Position as at September 2023

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M6 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	7.508	0.000	3.388	10.896	0.000
nVCC - Project costs	0.000	1.573	0.000	(1.573)	2.856	(2.856)
nVCC - Advanced Works	3.800	0.000	0.000	3.800	3.800	0.000
Integrated Radiotherapy Solutions (IRS)	7.826	2.137	0.000	5.689	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.000	0.000	0.147	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Total All Wales Capital Programme	22.833	11.218	0.000	11.615	25.689	(2.856)
Discretionary Capital	1.683	0.108	0.000	1.575	1.683	0.000
Total	24.516	11.326	0.000	13.190	27.372	(2.856)

The approved Capital Expenditure Limit (CEL) as at September 2023 is **£24.516m**. This represents all Wales Capital funding of **£22.833m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.8m in respect of advanced design works in nVCC.

Following the delays in the opening of both the nVCC and Radiotherapy Satellite Centre in Nevill Hall the Trust returned £2.5m of funding on the IRS programme, and £1.2m on the RSC scheme to WG during this September, with the caveat that the funding will be re-provided in future years.

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

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

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

Performance to date

The actual expenditure to September 2023 on the All-Wales Capital Programme schemes was £11.218m, this is broken down between spend on the nVCC enabling works £7.508, nVCC Project Costs £1.573m, and the IRS £2.137m.

Spend to date on Discretionary Capital is currently £0.108m.

Year-end Forecast Spend

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a

request to WG for funding for the Project with latest forecast being c£2.9m as at the end of September.

All other schemes including the discretionary programme are at this stage expected to deliver to budget for 2023/24.

The CEL will be fixed by WG at the end of October, after this point the Trust is expected to internally manage any slippage on the Capital programme.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance • NVCC not securing the additional funding request from WG of c£2.m for project support costs.		

KPI Indicator FIN.72

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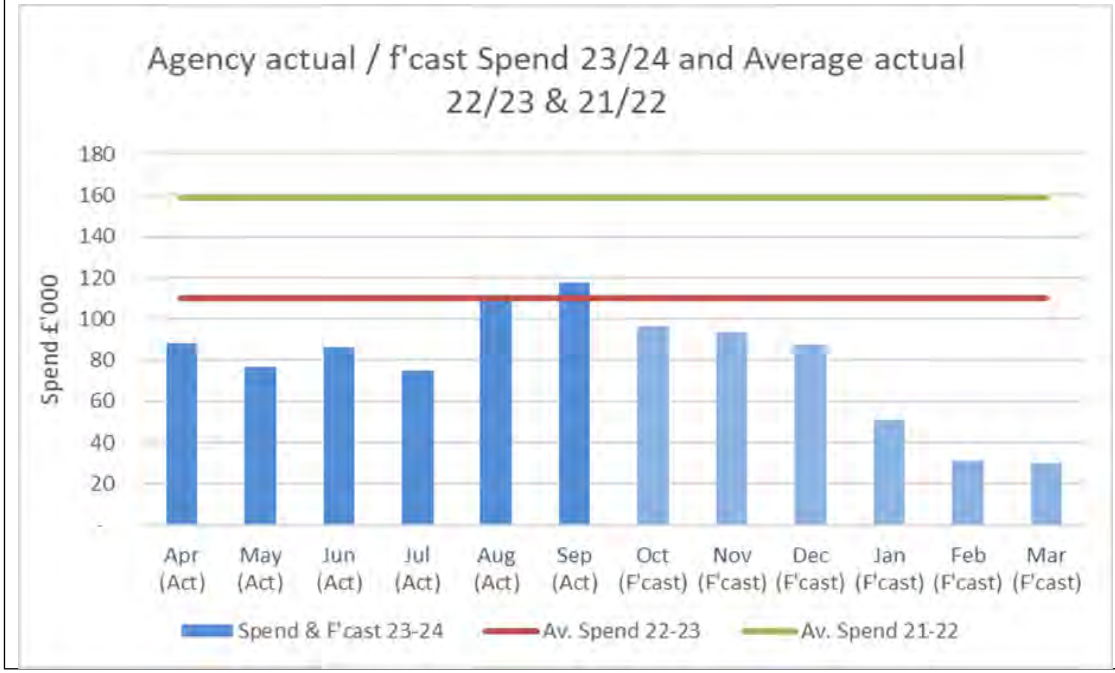
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.323	88	77	86	**75**	109	117						
Target (per IMTP) £0.543M Forecast		115	115	115	58	50	50	16	16	0	0	0	0



Performance

The spend on agency for Sept'23 was **£0.117m,** which gives a cumulative year to date spend of £0.552m and a current forecast outturn spend of circa **£0.940m** (£1.323m 2022/23).

Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Actions addressed via Divisional action plans		Matthew Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.74

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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

Performance

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.300	0.084m	0.108m	0.087m	**0.132m**	0.137m	0.137m						
Target £1.8M Forecast		0.084M	0.084m	0.084m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	0.172m	1.8M

Overall VUNHST Cost Improvement Programme £1.8M

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

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

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

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness
The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Whilst we don't expect delivery this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain.

There is a small year to date underachievement against the planned savings target with the commencement of two schemes expected later in the year.

KPI Indicator FIN.60

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

Target: 95%

SLT Lead: Finance Director

Current Performance against Target or Standard

	22/23	Apr 23	My 23.	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Trust Position													
Capital & Revenue Invoices	95	98	98	99	98	96	98						
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

During September '23 the Trust (core) achieved a compliance level of **97.7%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 6, and a Trust position (including hosted) also of **97.8%** compared to the target of 95%.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Work between Finance, NWSSP and the service will continue throughout 2023-24 in order to maintain performance.	31/03/2024	M Bunce

Expected Performance gain – longer-term.
Ensured compliance

Risks to future performance

Set out risks which could affect future performance

EQUITABLE

KPI Indicator WOD.81

Return to Top

% Workforce declared Welsh Speakers in Trust at Level 1

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

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

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

Total VUNHST headcount 1624

Welsh speakers 116 headcount (4%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator WOD.78

Return to Top

Diversity of Workforce (Gender) % of Women in Senior Leadership positions

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

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

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

Total VUNHST headcount 1624
Male 405 (25%)
Female 1219 (75%)
Senior positions (Band 8 +)
Male 94 (37%)
Female 159 (63%)

SPC Chart Analysis
The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.79

Return to Top

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

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

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

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

Total VUNHST headcount 1624

White 1424 (88%)

Black, Asian and Minority Ethnic people 200 (12%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.80

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Diversity of Workforce – People with a Disability

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

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

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

Total VUNHST headcount 1624

People with a Disability 70 (4%)

SPC Chart Analysis

The SPC chart shows

Performance

Assessment of current performance, set out key points:

- insert text
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 30TH SEPTEMBER (M6)

DATE OF MEETING	30/11/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of September 2023.
RECOMMENDATION / ACTIONS	**TRUST BOARD** is asked **NOTE** the contents of the September 2023 financial report and in particular the yearend financial performance which at this stage is reporting a **breakeven** position.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – EMB Run	30/10/2023
Quality, Safety & Performance Committee –	16/11/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS THE REPORT WAS NOTED AND DISCUSSED AT EMB AND QUALITY, SAFETY AND PERFORMANCE COMMITTEE	

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

APPENDICES	
	Trust Finance Report - September 2023
Appendix 1	TCS Finance Report – September 2023

1. SITUATION/ BACKGROUND

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

1.2 The financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as it is directly accountable to WG for its financial performance. The balance sheet (SoFP) and cash flow

provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 . Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.639	11.326	27.372
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.9%	97.8%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget remains in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of September'23 is an underspend of **£0.007m**, with an outturn forecast of **Breakeven** expected.

It is expected that cost pressures will be managed by budget holders in line with the Trust's budgetary control procedures to ensure the delegated expenditure control limits are not exceeded.

LTA Contract Performance

VCS Contract income has recovered to a level that sufficiently funds the capacity investments made to date. However, there remains a risk that planned growth for the period October to March may not transpire at the planned levels, compounded by potential

reporting issues due to the implementation of DHCR which is highlighted as a financial risk for the Trust.

NHS Wales Financial Pressures

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

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

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	1.991	

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2023-24.

2.3 Savings

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

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

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

2.4 PSPP Performance

PSPP performance for the whole Trust is currently 97.8% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently also achieving a target of 97.8% as at the end of September.

2.5 Covid Expenditure

Covid Programme Costs

In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast for 2023-24 reduced to £0.078m.

Covid Recovery and Planned Care Capacity

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

2.6 Reserves

The financial strategy for 2023-24 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These

reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

The Trust reserves and previously agreed unallocated investment funding continues to be on hold and under review following the letter received from Judith Paget with a request to support the overall NHS Wales Deficit.

2.7 **Financial Risks**

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

DHCR – Risk £0.500m / Likelihood – Medium

The Digital Health Care Record system was implemented in 2022-23. However, there have been challenges in the operational use and accurate data capture within the system. This means that activity data is not being fully captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team have reviewed the situation and put in place plans to address the issues. However, if these plans do not resolve the data capture issue there is a reduced risk that c£0.500m income related to unrecorded activity could be lost.

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

NEW RISK - Whitchurch Site Security – Risk £0.143m for 2023/24 (Medium)

The annual cost of maintaining security on the Whitchurch land is expected to be c£600k.The does not currently have any identified agreed funding route for these costs, but its expectation, based on discussions between Trust Officers and WG Officials, is that WG will funds these costs. The costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre from C&VUHB. The official transfer will be dependent on the WG formal process for transfer which is currently anticipated to take place in quarter 4, however this could be delayed into next financial year.

There are several opportunities has highlighted in the main body of the report including utilisation of the uncommitted reserve which would be used to support these risks should they crystallise.

2.8 Capital

All Wales Programme

During September the Trust was awarded £3.8m in respect of advanced design works in nVCC.

Following the delays in the opening of both the nVCC and Radiotherapy Satellite Centre in Nevill Hall the Trust returned £2.5m of funding on the IRS programme, and £1.2m on the RSC scheme to WG during this September, with the caveat that the funding will be re-provided in future years.

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£2.9m as at the end of September.

Other Major Schemes in development that are detailed in the main finance report will be considered during 2023-24 or beyond in conjunction with WG.

Discretionary Programme

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

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

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

The CEL will be fixed by WG at the end of October, after this point the Trust is expected to manage any slippage on the Capital programme.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐

<table>
<tr><td colspan="2">

- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐
- A beacon for research, development and innovation in our stated areas of priority ☐
- An established 'University' Trust which provides highly valued knowledge for learning for all. ☐
- A sustainable organisation that plays its part in creating a better future for people across the globe ☐

</td></tr>
<tr><td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: STRATEGIC RISK DESCRIPTIONS</td><td>Choose an item</td></tr>
<tr><td rowspan="2">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Yes -select the relevant domain/domains from the list below. Please select all that apply
Safe ☐
Timely ☐
Effective ☐
Equitable ☐
Efficient ☐
Patient Centred ☐</td></tr>
<tr><td></td></tr>
<tr><td rowspan="2">SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:
For more information:
https://www.gov.wales/socio-economic-duty-overview</td><td>Choose an item</td></tr>
<tr><td>N/A.

Click or tap here to enter text</td></tr>
<tr><td>TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT</td><td>Choose an item</td></tr>
</table>

	If more than one Well-being Goal applies please list below:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a financial position of **£0.007m** for September'23 which is in line with the IMTP
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A
WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
	N/A
All risks must be evidenced and consistent with those recorded in Datix	

Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED SEPTEMBER 2023/24

TRUST BOARD

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2023-24.

2. Background / Context

The draft Trust IMTP Financial Plan for the period 2023-2026 was set within the following context.

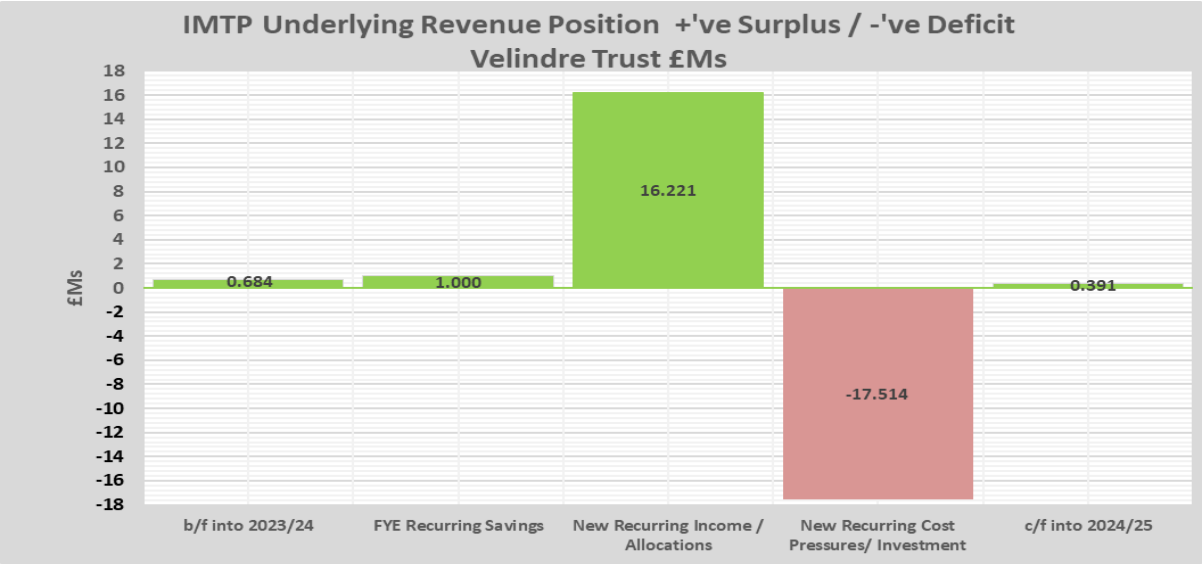
- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

- For 2023-24 the Plan included;
  - an underlying **Surplus of £0.684m** brought forward from 2022-23,
  - FYE **of new cost pressures / Investment** of -**£17.514m,**
  - offset by **new recurring Income** of **£16.221m,**
  - and Recurring FYE **savings schemes** of **£1.000m,**
  - Allowing **a £0.391m surplus position** to be carried into 2023-24.

- The Trust has a carry forward underlying surplus of £0.684m, which relates to the 2022-23 discretionary uplift funding that was held due to the uncertainty of WG funding support for the increase in energy prices and to cover the possible LTA income shortfall risk against the Covid capacity cost investment.

- The balance of the underlying surplus is forecast to reduce year-on-year as cost pressures increase over the 3-year planning period. IMTP planning assumptions assumed that a £0.391m underlying surplus will be c/fwd into 2024-25.

- **In order to achieve the c/fwd underlying surplus of £0.391m the savings target set for 2023-24 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2023/24	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.684	1.000	16.221	-17.514	0.391

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.002	0.007	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.639	11.326	27.372
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	95.9%	97.8%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	(0.035)	(0.082)	0.000

Revenue

The Trust has reported a **£0.002m** in-month underspend position for September'23, which gives a year to date cumulative underspend of **£0.007m** and an outturn forecast of **Breakeven**.

Capital

The latest approved Capital Expenditure Limit (CEL) as of September 2023 is **£24.516m**. This represents all Wales Capital funding of **£22.833m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to September'23 of £11.326m and is forecasting to remain within the CEL of £24.516m.

The Trust's current CEL and in year movement is provided below:

	£m Opening	£m Movement	£m Current
Discretionary Capital	**1.683**	**-**	**1.683**

All Wales Capital:			
nVCC - Enabling Works	10.896	-	10.896
nVCC - Advanced Works		3.800	3.800
IRS	10.326	(2.500)	7.826
Digital Priority Investment	0.164	-	0.164
RSC Satellite Centre	1.347	(1.200)	0.147
Total All Wales Capital	**22.733**	**0.100**	**22.833**
Total CEL	**24.416**		**24.516**

Following the delays in the opening of both the nVCC and Radiotherapy Satellite Centre in Nevill Hall the Trust returned £2.5m of funding on the IRS programme, and £1.2m on the RSC scheme to WG during September, with the caveat that the funding will be re-provided in future years.

During September the Trust was awarded £3.8m in respect of advanced design works in nVCC.

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£2.9m.

PSPP

During September '23 the Trust (core) achieved a compliance level of **97.7%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 6, and a Trust position (including hosted) also of **97.8%** compared to the target of 95%.

Efficiency / Savings

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

Revenue Position

Cumulative				Forecast		
£0.007m Underspent				**Breakeven**		
Type	**YTD Budget (£m)**	**YTD Actual (£m)**	**YTD Variance (£m)**	**Full Year Budget (£m)**	**Full Year Forecast (£m)**	**Forecast Variance (£m)**
Income	(94.627)	(95.599)	0.972	(194.655)	(194.655)	0.000
Pay	41.780	41.419	0.361	83.877	83.877	0.000
Non Pay	52.848	54.173	(1.325)	110.777	110.777	0.000
Total	**0.000**	**(0.007)**	**0.007**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of September 2023 is an underspend of **£0.007m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2023-24.

4.1 Revenue Position Highlights / Key Issues

NHS Wales Financial Pressures

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

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

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.491	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 6 there is a reduction of c£0.491m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	**1.991**	

Underlying Position

As highlighted above in the IMTP Financial plan the Trust brought forward a surplus of £0.684m from 2022-23 and is forecast to reduce year-on-year as additional cost pressures arise over the 3-year planning period.

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

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

Income Highlights / Key Issues

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises.

VCS and WBS overachievement from Private Patient, SACT Homecare and Plasma sales.

LTA Contract Performance

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

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Hywel Dda	0.283	(0.051)	0.232	-18%
Swansea Bay	0.294	(0.048)	0.246	-16%
Cardiff & Vale	15.036	1.447	16.483	10%
Cwm Taf Morgannwg	13.221	1.275	14.497	10%
Aneurin Bevan	17.344	1.301	18.645	8%
Powys	0.758	0.171	0.929	23%
WHSSC	2.633	(0.127)	2.506	-5%
	49.569	**3.969**	**53.539**	**8%**

VCS Contract income has recovered to a level that sufficiently funds the capacity investments made to date. However, there remains a risk that planned growth for the period October to March may not transpire at the planned levels, compounded by potential reporting issues due to the implementation of DHCR which is highlighted as a financial risk for the Trust.

Pay Highlights / Key Issue

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

The recently announced medical pay award of 5% is expected to be processed in October and back dated to April. The Trust is currently assuming that this will be fully funded by WG.

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

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work is continuing in VCS to understand the likely cancer activity demand and associated income, secure additional funding to support these posts and assessing options to migrate staff into vacancies to help mitigate the financial risk exposure.

On top of the savings plans VCS (£0.600m) and WBS (£0.450m) hold a vacancy factor target, which will need to be achieved during 2023-24 in order to balance the overall Trust financial position.

Non-Pay Key Issues

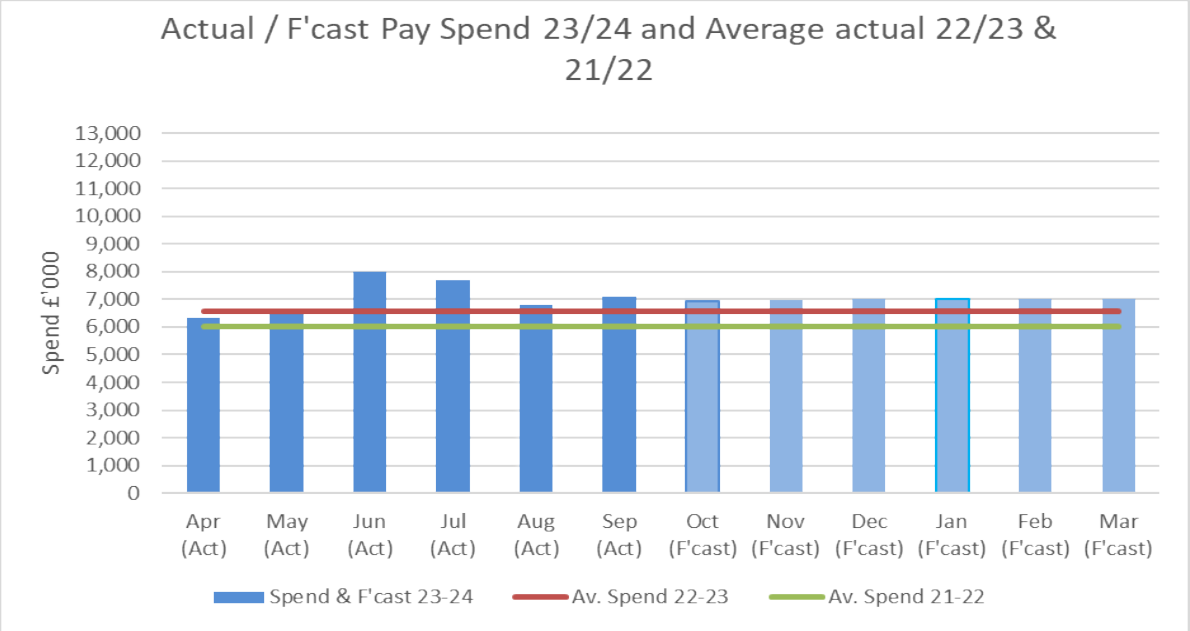
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust IMTP savings target for each division was set as VCS £0.950m, WBS £0.700m and Corporate £0.150m for 2023-24.

As part of the IMTP the Trust included £1.191m for the anticipated increase in energy prices during 2023-24. Latest projection from NWSSP suggests that the stepped increase will be c£0.700m. As above this potentially releases c£0.491m back into the system to support the NHS Wales Financial Pressures.

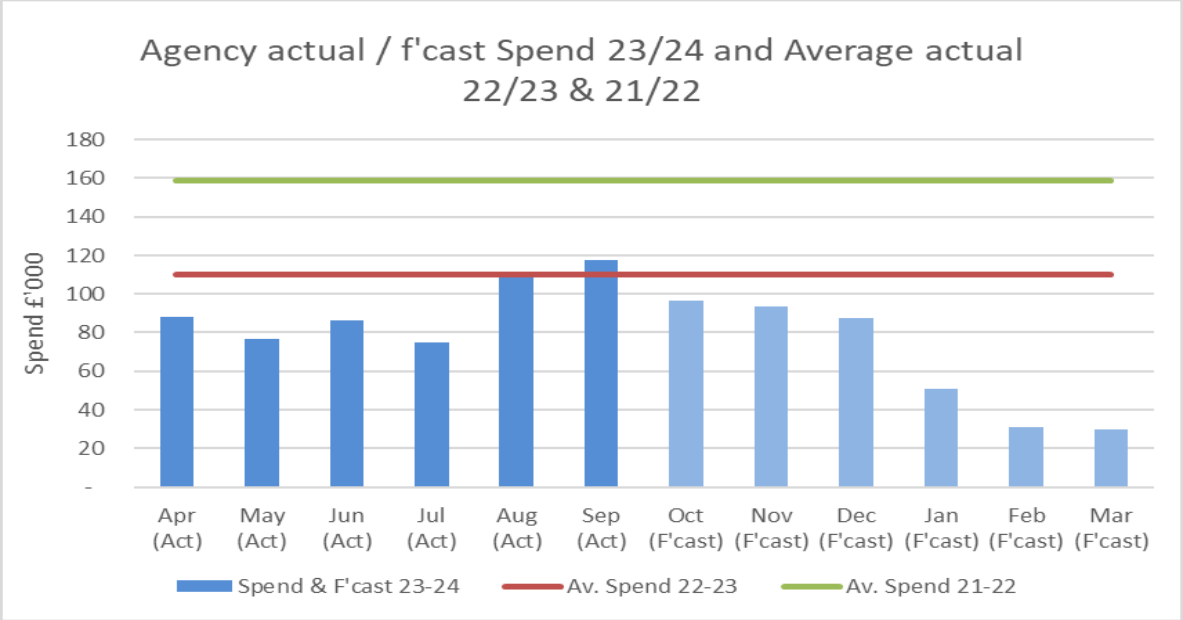
The Trust reserves and previously agreed unallocated investment funding continues to be on hold and under review following the letter received from Judith Paget with a request to support the overall NHS Wales Deficit. The budget for the reserves is held in month 12 and will be released into the position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

4.2 Pay Spend Trends (Run Rate)

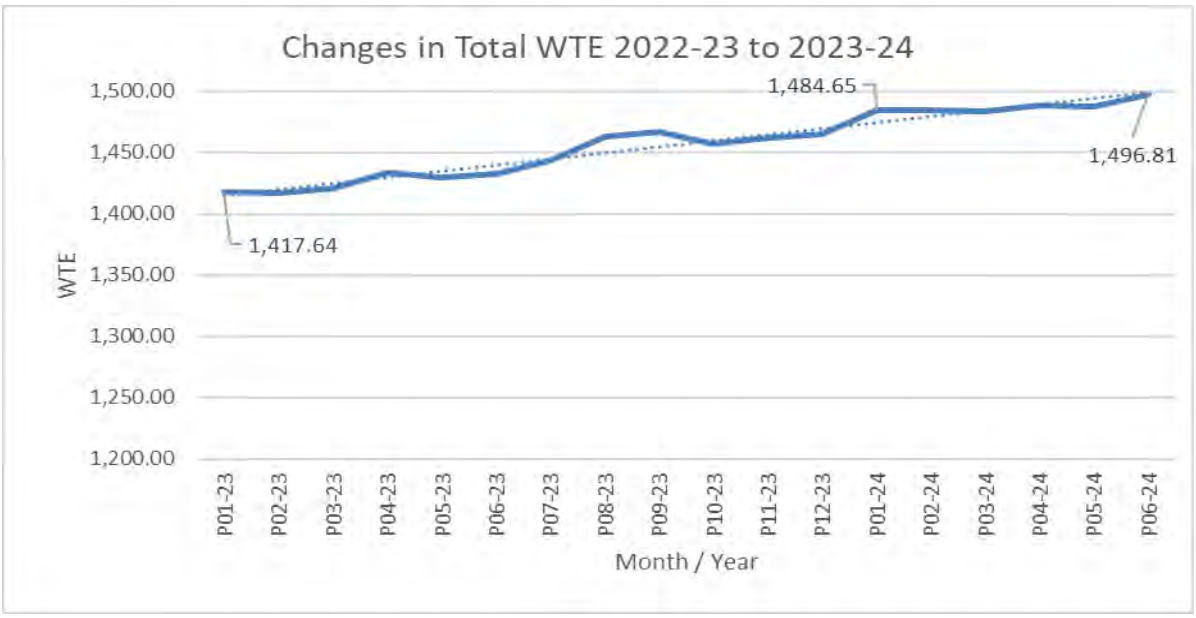
Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging.

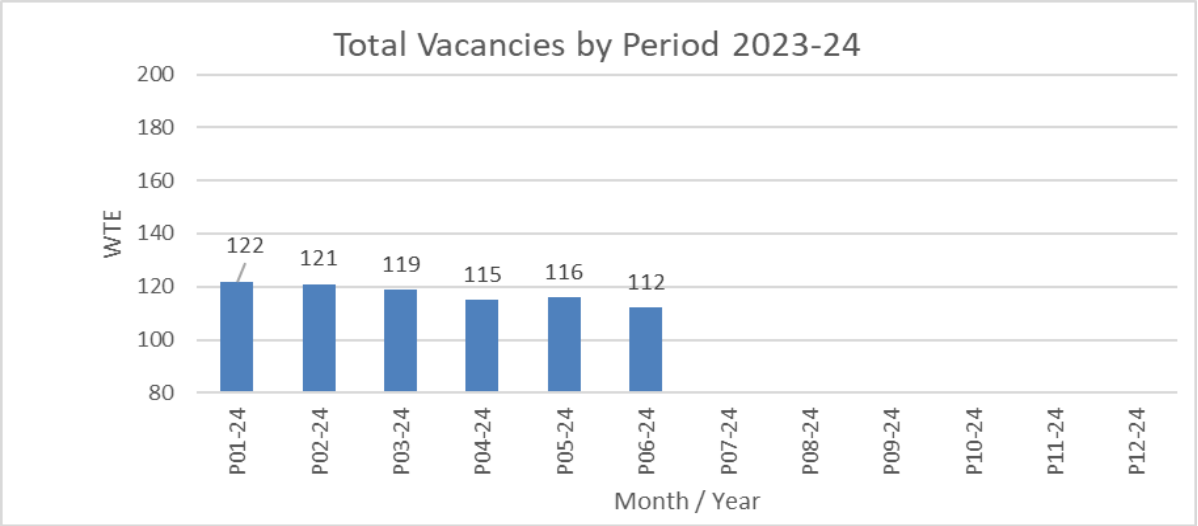


*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% consolidated pay award backdated to April 2023.



The spend on agency for Sept'23 was **£0.117m,** which gives a cumulative year to date spend of £0.552m and a current forecast outturn spend of circa **£0.940m** (£1.323m 2022/23).

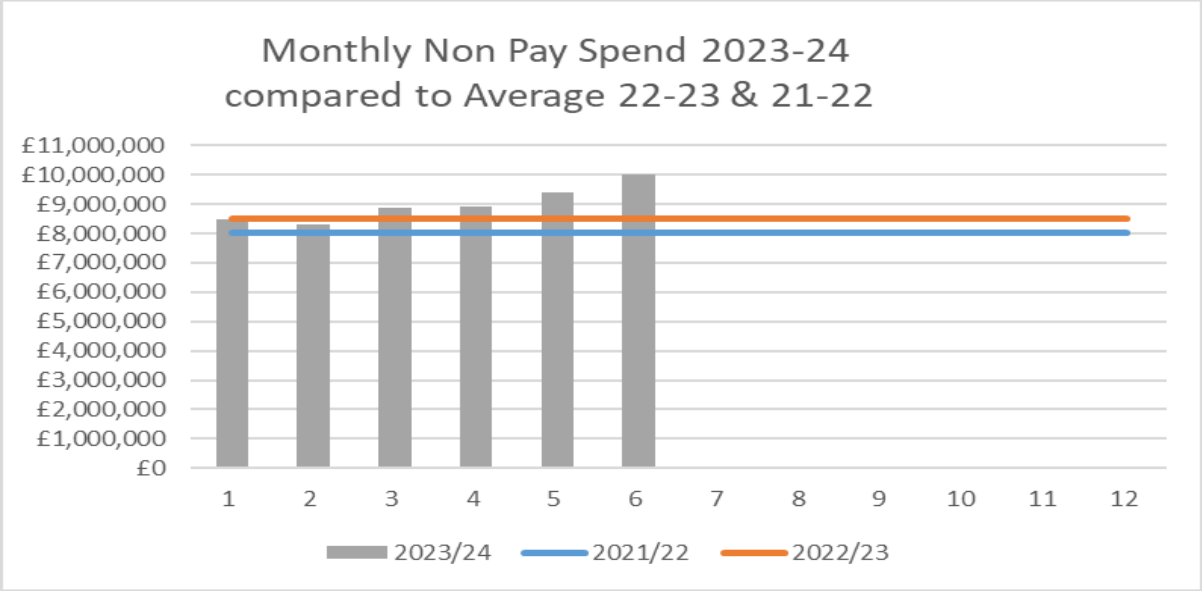




The total Trust vacancies as of September 2023 is 112wte, VCC (64wte), WBS (32wte), Corporate (9wte), R&D (3wte), TCS (2wte) and HTW (2wte).

4.3 Non-Pay

The average monthly spend for 2022-23 was £8.5m which was £0.5m higher than the reported monthly average spend for 2021-22. Most of the monthly average increase related to the WBS wholesaling costs, along with the growth in energy costs and general inflation. Average non-pay spend so far for 2023/24 is £9m per month which is a £0.5m increase from the previous whole year average. Largest movement is in drug spend which has increased by £4.9m ytd, or £0.8m average per month when compared with the previous year's spend for the same period. Energy costs have decreased by £0.141m ytd.



4.4 Covid-19

Covid Programme Costs

Last year there was clear expectation from WG that following issue of their Covid de-escalation letter that organisations would be extricating themselves from many of the Covid response costs. Therefore, WG have only committed to cover the financial costs of certain ongoing Covid response and national programme costs as set out in the Director General of Health & Social Services letter dated 22nd December 2022. These programme costs will include support towards mass vaccination, and the provision of PPE which will be funded to the Trust based on actual spend during 2023/24.

At present the Trust is only expecting to draw funding from WG towards PPE costs with the forecast requirement for 2023/24 as at September 23 being £0.078m, which is a reduction of £0.162m from the £0.240m requested as part of the IMTP. However, whilst unlikely if the Trust is required to support the HBs with the vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Covid Recovery and Planned Care Capacity

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

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24. The Trust's Medium-Term Financial Plan assumed that activity levels may not be high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position

is that the contract performance has recovered however full year position is reliant on forecast activity levels from Commissioners for Velindre Cancer Services. The activity levels and Commissioner demand for services will continue to be closely monitored over the coming months.

Whilst the year to date gap in funding has recovered since the IMTP planning stage work is continuing to review all Covid recovery investment within Velindre Cancer Services, with a view to understanding the direct capacity related benefits and mitigations such as reducing, removing or repurposing these costs.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

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

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

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

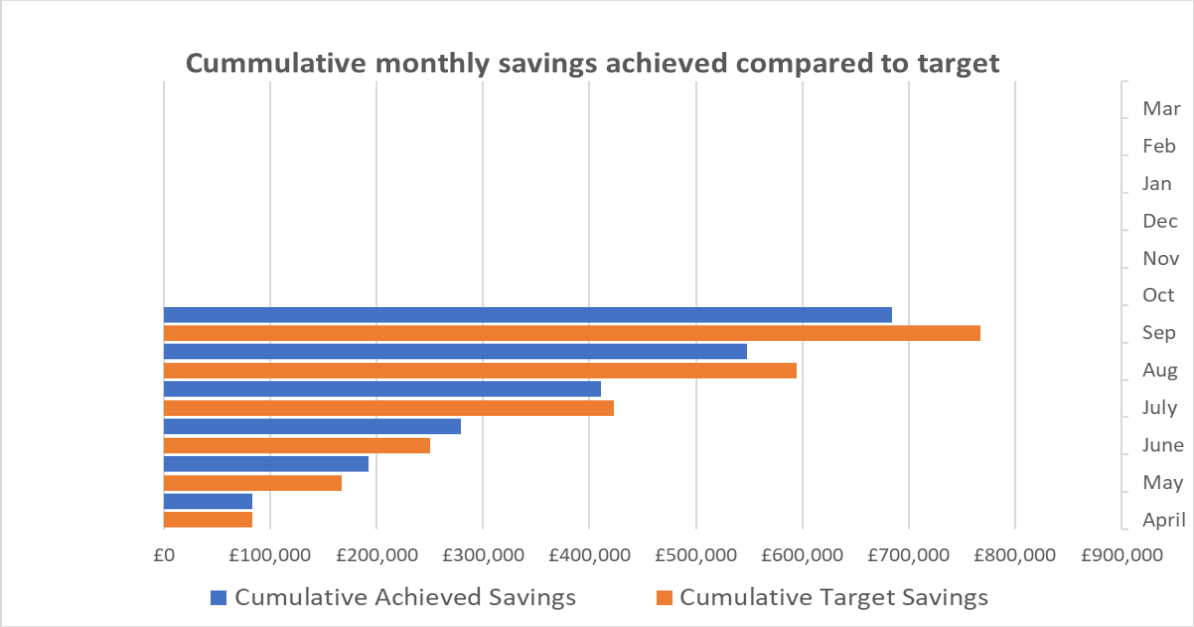
The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Whilst we don't expect delivery this year work will continue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

There is a small year to date underachievement against the planned savings target with the commencement of two schemes expected later in the year.

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented, or mitigations put in place to ensure that the Savings target is met for 2023-24.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**950**	**396**	**415**	**19**	**950**	**0**
			105%		**100%**	
WBS TOTAL SAVINGS	**700**	**296**	**195**	**(101)**	**700**	**0**
			66%		**100%**	
CORPORATE TOTAL SAVINGS	**150**	**75**	**75**	**0**	**150**	**0**
			100%		**100%**	
TRUST TOTAL SAVINGS IDENTIFIED	**1,800**	**767**	**685**	**(82)**	**1,800**	**0**
			89%		**100%**	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes							
Establishment Control (N/R) (Corporate)	Green	75	38	38	0	75	0
Procurement Supply Chain (R) (WBS)	Red	100	33	0	(33)	0	(100)
Collection Team Costs Reduction (R) (WBS)	Green	10	5	5	0	10	0
Collection Team Costs Reduction (NR) (WBS)	Green	8	4	4	0	8	0
Establishment Control (R) (WBS)	Green	60	30	30	0	60	0
Reduced use of Nitrogen (R) (WBS)	Red	55	18	0	(18)	0	(55)
Reduced Research Investment (R) (WBS)	Green	25	13	0	(13)	25	0
Stock Management (NR) (WBS)	Green	125	63	63	0	125	0
Reduced Transport Maintenance (NR) (WBS)	Green	30	10	0	(10)	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	Green	137	46	0	(46)	137	0
Service Workforce Re-design (R) (VCS)	Red	50	17	0	(17)	0	(50)
Establishment Control (NR) (VCS)	Green	175	58	77	19	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	Green	150	50	50	0	150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	Green	125	63	63	0	125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	Green	50	25	25	0	50	0
Procurement Supply Chain (R) (VCS)	Red	100	33	0	(33)	0	(100)
Total Saving Schemes		**1,275**	505	354	(151)	970	(305)
Income Generation							
Bank Interest (R) (Corporate)	Green	75	38	38	0	75	0
Sale of Plasma (R) (WBS)	Green	150	75	75	0	150	0
Expand SACT Delivery (R) (VCS)	Green	200	100	100	0	200	0
Private Patient Income (R) (VCS)	Green	50	25	25	0	50	0
Private Patient Income (N/R) (VCS)	Green	50	25	25	0	50	0
NEW Medicines at Home (N/R) (VCS)	Green		0	50	50	150	150
NEW Sale of Plasma (NR) (WBS)	Green		0	18	18	155	155
Total Income Generation		**525**	263	331	68	830	305
TRUST TOTAL SAVINGS		**1,800**	**767**	**685**	**(82)**	**1,800**	**0**
				89%		**100%**	



5. Reserves

The financial strategy for 2023-24 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.522m.

As highlighted earlier further allocation of the reserves is currently on hold and continues to be under review in conjunction with the overall Trust position which is in response to the letter received from Judith Paget with a request to support the overall NHS Wales Deficit.

6. End of Year Forecast / Risk & Opportunities Assessment

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

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

Risks

DHCR activity data income risk – *Risk £0.500m / Likelihood – Medium*

The Digital Health Care Record system was implemented in 2022/23. However, there have been challenges in the operational use and accurate data capture within the system. This means that activity data is not being fully captured and consequently Commissioners are not being charged based on the correct activity levels. The VCS operational team have reviewed the situation and put in place plans to address the issues. However, if these plans do not resolve the data capture issue there is a reduced risk that c£0.500m income related to unrecorded activity could be lost.

Management of Operational Cost Pressures – *Risk £0.500m / Likelihood - Low*

There are several cost pressures that are already within the service divisions which are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a risk that these current pressures may be beyond divisional control which is being recognised.

In addition, new cost pressures may materialise over the period which may be beyond divisional control or ability to manage through the overall Trust funding envelope.

NEW RISK - Whitchurch Site Security – Risk £0.143m for 2023/24 (Medium)

The annual cost of maintaining security on the Whitchurch land is expected to be c£600k.The Trust does not currently have any identified agreed funding route for these costs, but its expectation, based on discussions between Trust Officers and WG Officials, is that WG will funds these costs. The costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre from C&VUHB. The official transfer will be dependent on the WG formal process for transfer which is currently anticipated to take place in quarter 4, however this could be delayed into next financial year.

SDEC Funding 2024/25 – *Risk £0.935m / Likelihood - Medium*

At time of submission of its Business Cases the Trust received assurance from WG Officers that the SDEC funding was recurrent in nature, however the Trust is yet to receive written confirmation to confirm the recurrent funding. Whilst the funding has been confirmed for the current financial year, if this is not secured recurrently it would impact the Trust's underlying position to be carried into 2024/25.

Opportunities

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

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

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

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

Vacancy Turnover – *Opportunity / Likelihood - Low*

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

Contract Currency Review – *Opportunity / Likelihood - Low*

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

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

7. CAPITAL EXPENDITURE

Administrative Target

- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *To ensure the Trust does not exceed its External Financing Limit*

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M6 £m	Full Year Foreast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	7.508	0.000	3.388	10.896	0.000
nVCC - Project costs	0.000	1.573	0.000	(1.573)	2.856	(2.856)
nVCC - Advanced Works	3.800	0.000	0.000	3.800	3.800	0.000
Integrated Radiotherapy Solutions (IRS)	7.826	2.137	0.000	5.689	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.000	0.000	0.147	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Total All Wales Capital Programme	22.833	11.218	0.000	11.615	25.689	(2.856)
Discretionary Capital	1.683	0.108	0.000	1.575	1.683	0.000
Total	24.516	11.326	0.000	13.190	27.372	(2.856)

The approved Capital Expenditure Limit (CEL) as at September 2023 is **£24.516m**. This represents all Wales Capital funding of **£22.833m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.8m in respect of advanced design works in nVCC.

Following the delays in the opening of both the nVCC and Radiotherapy Satellite Centre in Nevill Hall the Trust returned £2.5m of funding on the IRS programme, and £1.2m on the RSC scheme to WG during this September, with the caveat that the funding will be re-provided in future years.

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

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

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

Performance to date

The actual expenditure to September 2023 on the All-Wales Capital Programme schemes was £11.218m, this is broken down between spend on the nVCC enabling works £7.508, nVCC Project Costs £1.573m, and the IRS £2.137m.

Spend to date on Discretionary Capital is currently £0.108m.

Year-end Forecast Spend

Capital funding has not been allocated to the nVCC Project with costs being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project with latest forecast being c£2.9m as at the end of September.

All other schemes including the discretionary programme are at this stage expected to deliver to budget for 2023/24.

The CEL will be fixed by WG at the end of October, after this point the Trust is expected to internally manage any slippage on the Capital programme.

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund. The financial year cash flows for many of these schemes including the IRS and IRS Satellite projects require re-profiling due to delays in the nVCC project and RSC project. This is currently being worked on. The TCS nVCC cash flows will be revised due to the VCC project delays for inclusion in the final FBC. The Digital and Digital scanning infrastructure schemes are also being revised with expectation that costs will now land in future years. All schemes will be reviewed and updated as part of the IMTP process which is underway.

The schemes included within the IMTP for 2023-24 are provided below:

All Wales Approved and Unapproved Capital Schemes	2023-24 £m	2024-25 £m	2025-26 £m	2026-27 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works	10.896	0.000	1.547			12.443
Integrated Radiotherapy Solution (IRS)	10.326	14.697	6.150			31.173
IRS Satellite Centre	1.347	10.065				11.412
Digital Priority Fund - WHIAS Project	0.167					0.167
Total Approved Capital Schemes	**22.736**	**24.762**	**7.697**	**0.000**	**0.000**	**55.195**
All Wales Unapproved Schemes						
TCS nVCC	7.168	34.132	7.147			48.447
TCS nVCC Enabling works	1.000					1.000
WBS HQ	0.120	1.016	12.808	9.996	10.961	34.901
Plasma Fractionation (under development)						0.000
WBS Fleet Replacement		1.400				1.400
WTAIL Lims Case	0.826	0.066				0.892
WBS Blood Establishment Computer System (BECS) (under development)						0.000
WBS Blood Group Analyser Replacement		0.480				0.480
WBS Asset Replacement		0.300	0.400	0.500		1.200
VCC Replacement Brachytherapy Applicators			0.300			0.300
Digital Services	0.650	0.400	0.400	0.400		1.850
Digital Scannining infrastructure	2.536	0.536				3.072
Total Unapproved Capital Schemes	**12.300**	**38.330**	**21.055**	**10.896**	**10.961**	**93.542**
Total All Wales Capital Plans	**35.036**	**63.092**	**28.752**	**10.896**	**10.961**	**148.737**

8. BALANCE SHEET (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 23	Closing Balance End of Aug-23	Movement from 1st April Aug-23	Forecast Closing Balance End of Mar 24
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	170.418	175.583	5.165	175.583
Intangible assets	11.194	11.062	(0.132)	11.062
Trade and other receivables	1,107.047	1,111.830	4.783	1,111.830
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,288.659	1,298.475	9.816	1,298.475
Current Assets				
Inventories	34.070	31.280	(2.790)	31.280
Trade and other receivables	565.742	540.982	(24.760)	551.792
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	31.136	21.210	(9.926)	10.400
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	630.948	593.472	(37.476)	593.472
TOTAL ASSETS	1,919.607	1,891.947	(27.660)	1,891.947
Current Liabilities				
Trade and other payables	(226.254)	(202.382)	23.872	(202.382)
Borrowings	(1.123)	0.00	1.123	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(392.525)	(432.039)	(39.514)	(432.039)
Current Liabilities sub total	(619.902)	(634.421)	(14.519)	(634.421)
NET ASSETS LESS CURRENT LIABILITIES	1,299.705	1,257.526	(42.179)	1,257.526
Non-Current Liabilities				
Trade and other payables	(3.092)	(3.092)	0.000	(3.092)
Borrowings	(2.421)	0.00	2.421	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,108.919)	(1,069.028)	39.891	(1,069.028)
Non-Current Liabilities sub total	(1,114.432)	(1,072.120)	42.31	(1,072.120)
TOTAL ASSETS EMPLOYED	185.273	185.406	0.133	185.406
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	34.708	34.833	0.125	34.833
PDC	131.461	131.047	(0.414)	131.047
Retained earnings	19.104	19.526	0.422	19.526
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	185.273	185.406	0.133	185.406

9. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

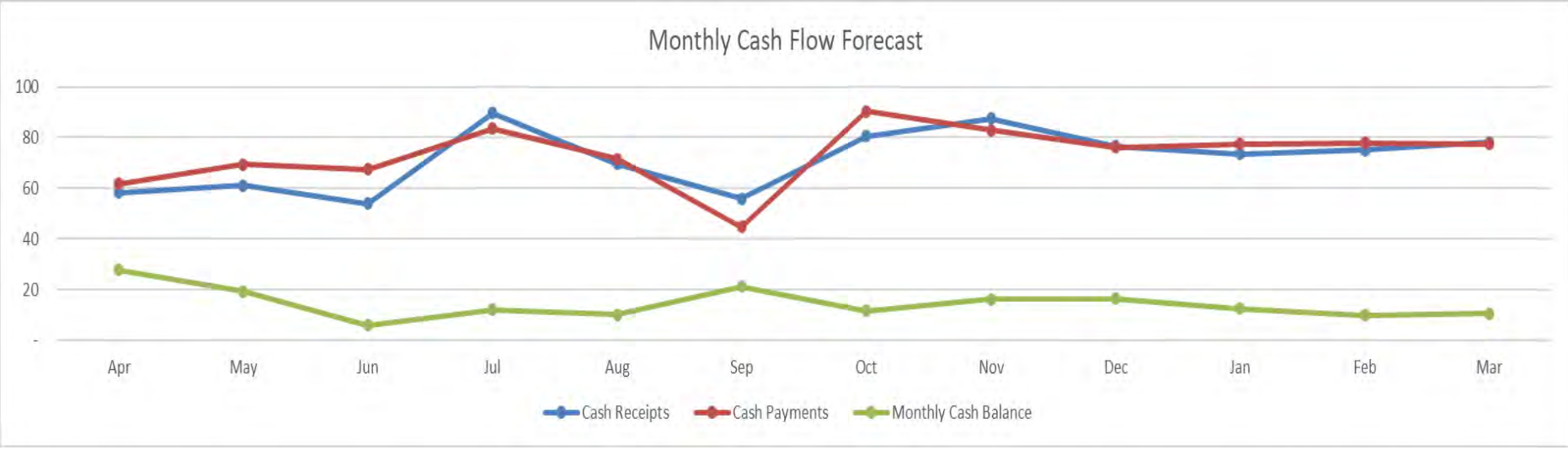
As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the ongoing uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however have now issued the additional stock and the £4.5m was repaid to WG during February '23.

In order to support interim cash flow pressures the Trust has agreed with WG and drawn down on the forecast £8.881m of PDC for 2023/24. The Trust cash position has been further escalated recently following announcement that the medical pay award will be processed in October which is in addition to the impact of the AFC pay award and has been carried since July. The Trust is yet to receive funding for either of these pay awards which will leave a negative cash flow of c£13m as at the October pay date.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	Income from other Welsh NHS	37.581	38.378	41.097	40.905	41.581	41.028	40.500	40.980	42.697	43.602	43.277	43.835	495.460
2	WG Income	14.460	18.799	9.707	42.966	22.143	2.138	24.832	40.325	27.825	23.486	25.525	24.800	277.006
3	Short Term Loans													0.000
4	PDC							8.881					0.000	8.881
5	Interest Receivable	0.149	0.162	0.143	0.126	0.106	0.117	0.060	0.060	0.060	0.060	0.060	0.060	1.163
6	Sale of Assets													0.000
7	Other	6.156	3.753	2.953	5.651	5.886	12.689	6.300	6.150	6.050	6.350	6.250	9.325	77.512
8	TOTAL RECEIPTS	**58.346**	**61.092**	**53.900**	**89.648**	**69.716**	**55.971**	**80.573**	**87.515**	**76.632**	**73.498**	**75.112**	**78.020**	**860.022**
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	38.993	34.802	34.922	34.500	41.566	36.088	36.110	36.138	36.154	36.109	431.903
10	Non pay items	28.883	34.362	26.186	46.813	35.820	9.253	42.005	43.500	38.500	39.600	39.450	37.602	421.974
11	Short Term Loan Repayment											0.000		0.000
12	PDC Repayment		0.000											0.000
14	Capital Payment	1.122	0.394	2.160	1.949	0.824	1.094	6.651	3.411	1.639	1.783	2.185	3.669	26.881
15	Other items													0.000
16	TOTAL PAYMENTS	**61.807**	**69.477**	**67.339**	**83.564**	**71.566**	**44.847**	**90.222**	**82.999**	**76.249**	**77.521**	**77.789**	**77.380**	**880.758**
17	Net cash inflow/outflow	(3.461)	(8.385)	(13.438)	6.085	(1.850)	11.124	(9.649)	4.516	0.383	(4.023)	(2.677)	0.639	
18	Balance b/f	31.136	27.675	19.290	5.851	11.936	10.086	21.210	11.561	16.077	16.460	12.438	9.761	
19	Balance c/f	27.675	19.290	5.851	11.936	10.086	21.210	11.561	16.077	16.460	12.438	9.761	10.400	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(21.191)	(21.190)	0.001	(40.123)	(40.123)	0.000
RD&I	(0.538)	(0.538)	(0.000)	0.091	0.091	0.000
WBS	(11.065)	(11.066)	(0.000)	(21.532)	(21.532)	0.000
Sub-Total Divisions	**(32.795)**	**(32.794)**	**0.000**	**(61.564)**	**(61.564)**	**0.000**
Corporate Services Directorates	**(6.639)**	**(6.615)**	**0.024**	**(12.956)**	**(12.956)**	**0.000**
Delegated Budget Position	**(39.433)**	**(39.409)**	**0.025**	**(74.520)**	**(74.520)**	**0.000**
TCS	(0.386)	(0.404)	0.018	(0.744)	(0.744)	0.000
Health Technology Wales	(0.071)	(0.071)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	39.891	39.891	0.000	75.381	75.381	0.000
Trust Position	(0.000)	0.007	0.007	0.000	0.000	0.000

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**36.040**	**36.596**	**0.556**	**74.333**	**74.333**	**0.000**
Expenditure						
Staff	**25.017**	**24.923**	**0.094**	**48.838**	**48.838**	**0.000**
Non Staff	**32.214**	**32.864**	**(0.650)**	**65.619**	**65.619**	**0.000**
Sub Total	**57.231**	**57.787**	**(0.556)**	**114.457**	**114.457**	**0.000**
Total	**(21.191)**	**(21.191)**	0.000	**(40.123)**	**(40.123)**	**0.000**

VCS Key Highlights/ Issues:

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

Income at Month 6 represents a surplus of **£0.556m**. Overachievement on Private Patients drugs due to both activity and the VAT savings from delivery of SACT homecare, which is offsetting and providing a significant surplus above the divisional management savings target. Other small income overachievements in areas such as Catering which are offset with non pay costs.

VCS have reported a year to date underspend of **£0.094m** against staff. The division continues to have high levels of vacancies, sickness, and maternity leave across several services and

particularly across Nursing budgets, this along with recruitment challenges, is largely offsetting both the vacancy savings target and the requirement to support posts appointed into without funding agreement i.e. Advanced recruitment and Capacity investments. The international recruitment scheme is being explored within Nursing to help fill current vacancies.

Non-Staff Expenditure at Month 6 was **£(0.650)m** overspent which is a result of increased activity pressures which can be linked to contract performance and in areas such as PICC and SACT following treatment returning to Nevill Hall.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**13.433**	**13.511**	**0.077**	**27.085**	**27.085**	**0.000**
Expenditure						
Staff	**9.352**	**9.255**	**0.096**	**18.389**	**18.389**	**0.000**
Non Staff	**15.147**	**15.320**	**(0.173)**	**30.228**	**30.228**	**0.000**
Sub Total	**24.499**	**24.575**	**(0.077)**	**48.617**	**48.617**	**0.000**
Total	**(11.065)**	**(11.065)**	0.000	**(21.532)**	**(21.532)**	**0.000**

Key Highlights/ Issues:

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

Income overachievement of **£0.077m** to month 6. Targeted income generation on plasma sales through increased activity which is exceeding planned expectations and creating opportunities for consideration. This is being partly offset by lower than planned Bone Marrow activity.

There has been a lack of growth in the bone marrow registry which was largely impacted during the pandemic and is still yet to see signs of recovery. WBS have previously run campaigns to try and grow the panel in sites such as schools and universities, however the year to date target is currently underachieving by c35%.

Staff reported a **£0.096m** underspend to September. Vacancies are helping to offset the overspend from posts supported without identified funding source. This includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured.

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

Non-Staff reported an overspend of **£(0.173)m** to September. Energy price rises which we be funded centrally by the Trust as agreed at the IMTP planning stage, along with venue hire costs pressures previously funded by WHSSC, are being partly offset by reduced spend from lower activity.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**1.252**	**1.555**	**0.303**	**2.126**	**2.126**	**0.000**
Expenditure						
Staff	**6.042**	**5.874**	**0.168**	**11.735**	**11.735**	**0.000**
Non Staff	**1.849**	**2.296**	**(0.446)**	**3.347**	**3.347**	**0.000**
Sub Total	**7.891**	**8.169**	**(0.278)**	**15.082**	**15.082**	**0.000**
Total	**(6.639)**	**(6.615)**	0.024	**(12.956)**	**(12.956)**	**0.000**

Corporate Key Highlights / Issues:

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

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

For staff the expectation is that vacancies within the division will help offset the cost of use of agency and the divisional savings target.

Non pay overspend largely relates to the divisional savings target and the increased running costs associated with the ageing hospital estate.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.971**	**1.009**	**0.038**	**3.247**	**3.247**	**0.000**
Expenditure						
Staff	**1.398**	**1.403**	**(0.005)**	**2.891**	**2.891**	**0.000**
Non Staff	**0.111**	**0.144**	**(0.033)**	**0.264**	**0.264**	**0.000**
Sub Total	**1.509**	**1.548**	**(0.038)**	**3.155**	**3.155**	**0.000**
Total	**(0.538)**	**(0.538)**	0.000	**0.091**	**0.091**	**0.000**

RD&I Key Highlights / Issues

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

Trials Income fluctuations expected throughout the year.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.000**	**0.260**	**0.260**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.376**	**0.371**	**0.005**	**0.730**	**0.730**	**0.000**
Non Staff	**0.010**	**0.293**	**(0.283)**	**0.015**	**0.015**	**0.000**
Sub Total	**0.386**	**0.664**	**(0.278)**	**0.744**	**0.744**	**0.000**
Total	**(0.386)**	**(0.404)**	(0.018)	**(0.744)**	**(0.744)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of September 2023 is **£(0.018)m** overspent with a forecasted outturn position of **Breakeven.**

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

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.771**	**0.768**	**(0.003)**	**1.677**	**1.677**	**0.000**
Expenditure						
Staff	**0.769**	**0.766**	**0.003**	**1.545**	**1.545**	**0.000**
Non Staff	**0.073**	**0.073**	**0.000**	**0.248**	**0.248**	**0.000**
Sub Total	**0.842**	**0.839**	**0.003**	**1.794**	**1.794**	**0.000**
Total	**(0.071)**	**(0.071)**	(0.000)	**(0.117)**	**(0.117)**	**0.000**

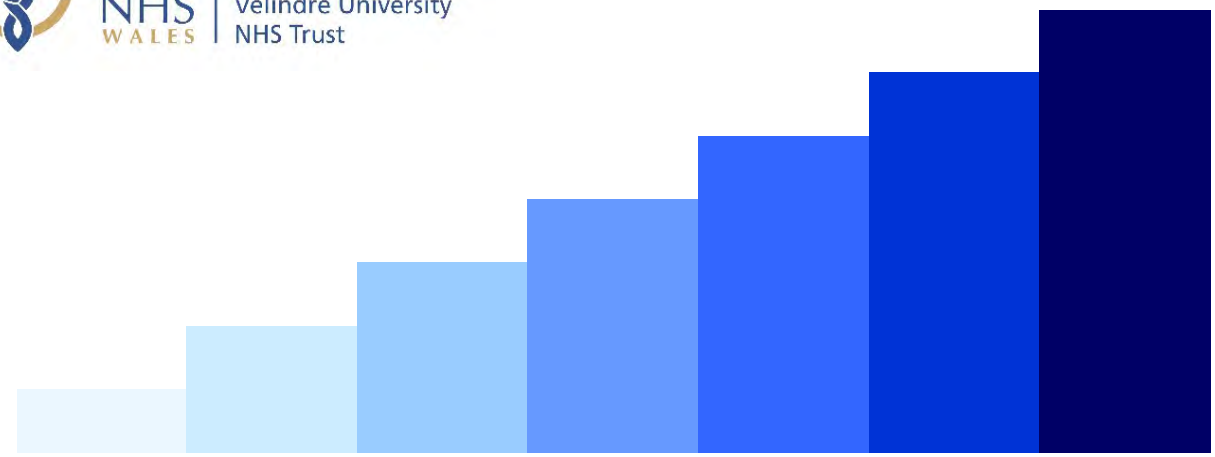
HTW Key Highlights / Issues

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

HTW programme costs are funded directly by WG.

The pay award is to be funded via the Trust allocation for 2023/24.

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



TCS PROGRAMME
FINANCE REPORT 2023-24

Period Ending 30th September 2023

Contents

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 2023-24, outlining spend against budget as at 30th September 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 2023-24 as at 30th September 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	2023-24 Full Year		
		Budget	Forecast	Variance
Capital	£9.082m	£10.896m	£13.749m	-£2.853m
Revenue	£0.404m	£0.744m	£0.785m	-£0.041m
Total	**£9.486m**	**£11.641m**	**£14.534m**	**-£2.894m**

2.2 The overall forecast outturn for the Programme is an overspend of £2.894m for the financial year 2023-24 against a budget of £11.641m.

2.3 Capital funding has not been allocated for the OBC phase of the nVCC Project for this financial year, resulting in the aforementioned overspend. A funding request for c£2.800m has been made to WG.

2.4 Capital funding of £3.882m has been allocated to the nVCC Project by WG for advanced works for the FBC stage, to be confirmed by letter in October 2023. Both the funding and spend will be reported from October onwards, with an expected break even position for this financial year.

2.5 No revenue funding has been allocated for Project Deliver and Judicial Review elements of the nVCC project for this financial year. A funding request of £0.041m is being made to the Trust.

2.6 There are currently three financial risks associated with TCS:

- The Enabling Works Project may be required to provide financial support to the nVCC Project due the current lack of funding for 2023-24 for the latter. This risk is being mitigated as previously noted.
- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.000m. Ministerial approval will be sought for this additional funding.
- Capital funding has not been allocated to the nVCC Project, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of £2.800m.

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 2023, the Welsh Government (WG) had provided a total of £42.377m funding (£40.084m capital, £2,293m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.380m non-recurrent revenue funding.

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

3.4 The current funding provided to support the TCS Programme in 2023-24 is £10.896m capital and £0.689m revenue, as outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding

Initial Allocation (as at 1st April 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£0	£0
Total	**£10.896m**	**£10.896m**

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Total	**£0**	**£0**

Current Allocation (as at 30th September 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£0	£0
Total	**£10.896m**	**£10.896m**

Sources of Revenue Funding

Initial Allocation (as at 1st April 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.024m	£0.060m	£0	£0.084m
nVCC Project	£0	£0	£0	£0
SDT Project	£0.180m	£0.131m	£0	£0.311m
Total	**£0.204m**	**£0.204m**	**£0**	**£0.395m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.216m	£0	£0.028m	£0.244m
nVCC Project	£0	£0	£0.096m	£0.096m
SDT Project	£0	£0	£0.009m	£0.009m
Total	**£0.216m**	**£0.204m**	**£0.133m**	**£0.349m**

Current Allocation (as at 30th September 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Total Funding
PMO	£0.240m	£0.060m	£0.028m	£0.328m
nVCC Project	£0	£0	£0.096m	£0.096m
SDT Project	£0.180m	£0.131m	£0.009m	£0.320m
Total	**£0.420m**	**£0.204m**	**£0.133m**	**£0.744m**

4. CAPITAL POSITION

4.1 The current capital funding for 2023-24 is outlined below:

- Enabling Works Project £10.896m
- nVCC Project £0

Total **£10.896m**

4.2 The capital position as at 30th September 2023 is outlined below, with a forecast overspend of £2.853m for 2023-24 against a budget of £10.896m. This is due to the lack of capital funding being allocated to the nVCC Project for this financial year.

Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£7.509m	£10.896m	£10.893m	£0.004m
nVCC Project	£1.574m	£0	£2.856m	-£2.856m
Total	**£9.082m**	**£10.896m**	**£13.749m**	**-£2.853m**

4.3 A funding request has been made to WG for c£2.700m for the nVCC Project.

4.4 There are three new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £1.150m. This additional capital funding will require Ministerial approval.

5. REVENUE POSITION

5.1 The revenue funding for 2023-24 is outlined below:

- PMO £0.328m
- nVCC Project £0.096m
- SDT Project £0.320m

Total £0.744m

5.2 The revenue position as at 30th September 2023 is outlined below, with a forecast overspend of £0.041m for 2023-24 against a budget of £0.313m. This is due to the lack of funding for the nVCC revenue non-pay costs for this financial year.

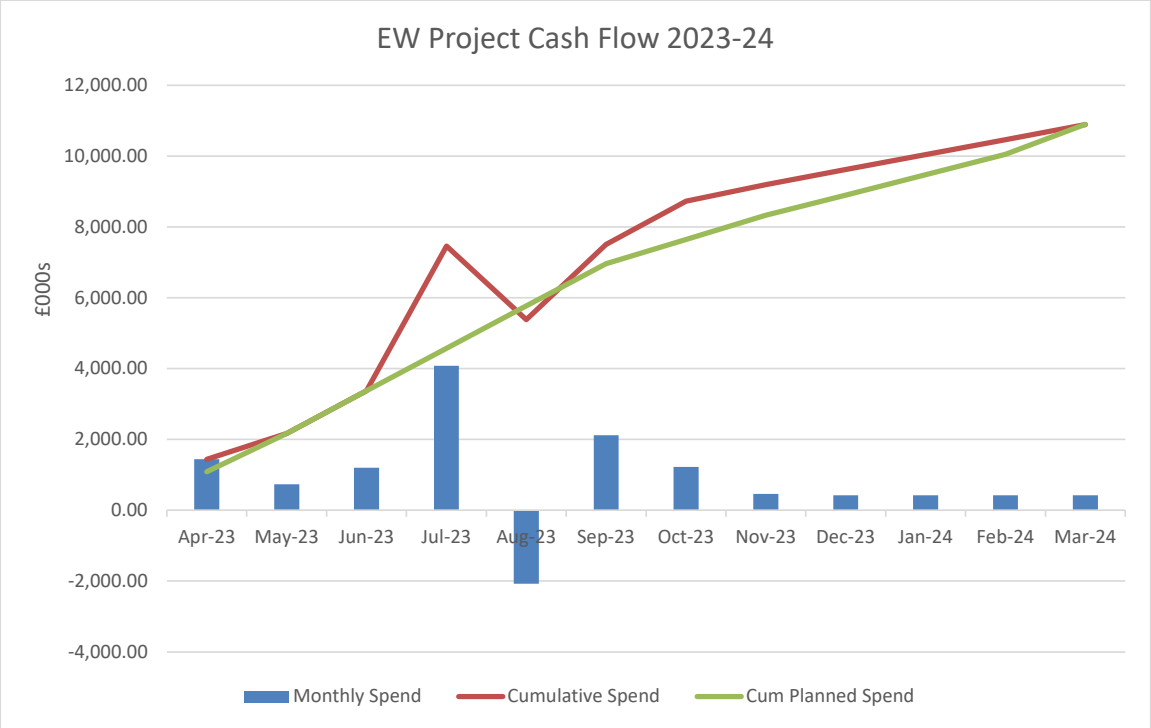
Revenue Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
PMO	£0.165m	£0.328m	£0.328m	£0
nVCC Project	£0.082m	£0.096m	£0.137m	-£0.041m
SDT Project	£0.156m	£0.320m	£0.320m	£0
Total	**£0.404m**	**£0.744m**	**£0.785m**	**-£0.041m**

5.3 A revenue funding request for £0.041m for 2023-24 is being made to the Trust for the Project Delivery and Judicial Review elements of the nVCC Project.

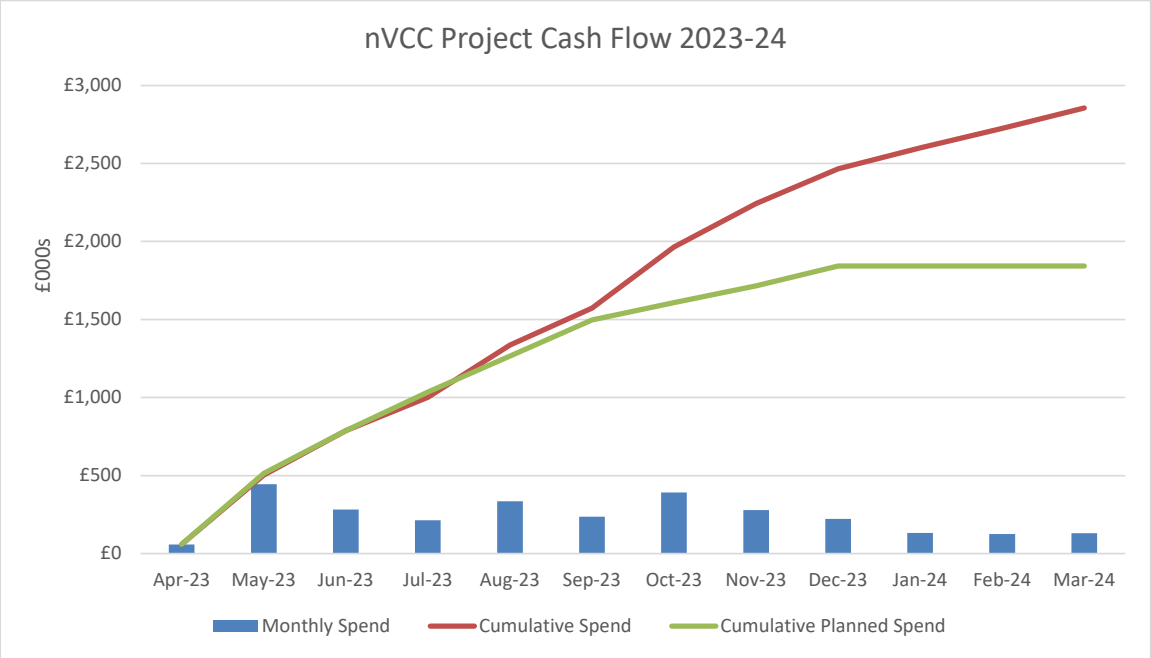
5.4 The 2022-23 one-off recovery payment was paid out in June 2023, with funding provided by WG in June 2023 via the Trust. Funding has also been provided by WG to cover the recurrent pay award for 2023-24 paid out in August 2023.

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The run rate indicates that the majority of costs will have been incurred within the first half of the financial year.



6.2 The capital cash flow for the **nVCC Project** is outlined below. Actual spend is higher in the second half of the financial year, which reflects the delay in financial close.



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 current revenue funding for the PMO for 2023-24 is £0.328m. £0.240m of this has been provide from NHS Commissioners' funding, £0.060m from the Trust Reserves, and £0.028m from WG 2022-23 for pay awards.

7.3 There has been no capital funding requirement for the PMO in 2023-24.

7.4 The revenue position for the PMO as at 30th September 2023 is shown below, showing a forecast breakeven positon for the year against a budget of £0.328m.

PMO Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.164m	£0.327m	£0.327m	£0
Non Pay	£0.001m	£0.001m	£0.001m	£0
Total	**£0.165m**	**£0.328m**	**£0.328m**	**£0**

7.5 There are currently no financial risks associated with the PMO for 2023-24.

Enabling Works Project

7.6 In February 2022, the Minister for Health and Social Services approved the Enabling Works FBC. This has provided capital funding of £28.089m in total, with £10.896m provided in 2023-24.

7.7 The Project's financial position for 30th September 2023 is shown below. The forecast position reflects an expected underspend of £0.004m for this financial year.

Enabling Works Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.162m	£0.230m	£0.277m	-£0.047m
Non-Pay	£7.346m	£10.667m	£10.616m	£0.051m
Total	**£7.509m**	**£10.896m**	**£10.893m**	**£0.004m**

7.8 There are three new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.000m. This additional capital funding will require Ministerial approval. The elements are:

- Water Main Diversion £0.850m inc VAT
- S278 Works – Longwood Drive £0.900m inc VAT
- Off Site Habitat Creation £0.250m inc VAT

Total **£2.000m inc VAT**

7.9 The Project spend relates to the following activities:

Enabling Works FBC Project Capital Budget & Spend Summary 2023-24

Description		Year to Date Budget Sep-23 £	Year to Date Spend Sep-23 £	Year to Date Variance Sep-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY							
Project 1b - Enabling Works FBC		140,382	162,431	-22,049	229,841	276,741	-46,900
Pay Capital Total		**140,382**	**162,431**	**-22,049**	**229,841**	**276,741**	**-46,900**
NON-PAY							
EF02	Utility Costs	1,546,163	1,091,385	454,779	2,873,927	2,641,385	232,542
EF03	Supply Chain Fees	175,000	379,302	-204,302	375,000	537,802	-162,802
EF04	Non Works Costs	156,253	75,095	81,158	312,505	231,347	81,158
EF05	ASDA Works	1,906,946	2,336,191	-429,245	3,813,893	3,036,343	777,550
EF06	Walters D&B	3,033,982	3,463,634	-429,652	3,033,982	4,033,634	-999,652
EFQR	Quantified Risk	6,247	512	5,735	257,245	135,512	121,733
EFRS	Enabling Works FBC Reserves	0	0	0	0	0	0
Enabling Works FBC Project Capital Total		**6,824,591**	**7,346,119**	**-521,528**	**10,666,552**	**10,616,023**	**50,529**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**6,964,973**	**7,508,550**	**-543,576**	**10,896,393**	**10,892,763**	**3,629**

7.10 There are currently two financial risks associated with the Enabling Works Project:

- Financial support may be required to the nVCC Project. As at September 2023 the financial support is c£1.600m, with a total requirement of c£2.800m. The nVCC Project has made an interim capital funding request to WG for c£2.800m.

- There are three new elements that require additional funding as noted above, totalling £2.000m. Ministerial approval will be sought for this additional funding.

New Velindre Cancer Centre Project

Capital

7.11 The nVCC Project has not been allocated capital funding for this financial year. A funding request has been made to WG for c£2.800m.

7.12 The capital financial position for the nVCC Project for 30th September 2023 is shown below, with a forecast overspend of £2.856m. This is due to the delay of the nVCC Financial Close into 2023-24 with no funding for the Project at this stage.

nVCC Capital Expenditure	Year to Date Spend	2023-24 Full Year		
		Budget	Forecast	Variance
Pay	£0.562m	£0	£1.186m	-£1.186m
Non-Pay	£1.012m	£0	£1.670m	-£1.670m
Total	**£1.574m**	**£0**	**£2.856m**	**-£2.856m**

7.13 The spend relates to the following activities:

nVCC OBC Project Capital Budget & Spend Summary 2023-24

Description	Year to Date Budget Sep-23 £	Year to Date Spend Sep-23 £	Year to Date Variance Sep-23 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC OBC	0	105,521	-105,521	0	213,143	-213,143
Project 2a - New Velindre Cancer Centre OBC	0	456,370	-456,370	0	972,953	-972,953
Pay Capital Total	**0**	**561,890**	**-561,890**	**0**	**1,186,097**	**-1,186,097**
NON-PAY						
nVCC OBC Project Delivery	**0**	**20,855**	**-20,855**	**0**	**64,000**	**-64,000**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	0	881,819	-881,819	0	1,344,735	-1,344,735
VC10 Legal Advice	0	17,398	-17,398	0	24,898	-24,898
VC11 S73 Planning	0	14,437	-14,437	0	14,437	-14,437
VC12 nVCC FBC	0	57,687	-57,687	0	147,687	-147,687
VCRS nVCC OBC Reserves	0	19,480	-19,480	0	74,480	-74,480
nVCC Project Capital Total	**0**	**990,821**	**-990,821**	**0**	**1,606,236**	**-1,606,236**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**1,573,566**	**-1,573,566**	**0**	**2,856,333**	**-2,856,333**

7.14 The current risk to the Project is the lack of funding, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of c£2.800m.

Revenue

7.15 The current revenue funding for the nVCC Project for 2023-24 is £0.096m, provided from WG 2022-23 for pay awards. A funding request is

7.16 The revenue financial position for the nVCC Project for 30th September 2023 is shown below, reflecting a current overspend of £0.041m for the year against budget of £0.096m.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.057m	£0.096m	£0.096m	£0.000m
Project Delivery	£0.014m	£0	£0.030m	-£0.030m
Judicial Review	£0.011m	£0	£0.011m	-£0.011m
Total	**£0.082m**	**£0.096m**	**£0.137m**	**-£0.041m**

7.17 The Judicial Review matter is now closed, with the final costs being submitted in July 2023. The final cost in 2023-24 is £0.011m, with a total cost for this matter of £0.138m.

7.18 The only revenue financial risk associated with the nVCC Project at present is the lack of funding, which is being mitigated with a funding request to the Trust.

Service Delivery and Transformation Project

7.19 The revenue funding for the Project for 2022-23 is £0.180m from NHS Commissioners' funding, £0.131 from Trust reserves, and £0.009m from the WG 2022-23 one-off recovery payment funding. The resulting budget is £0.320m for this financial year.

7.20 There is no capital funding requirement for the Project in 2023-24.

7.21 The SDT Project revenue position for 2023-24 is shown below, showing a forecast breakeven positon for the year against a budget of £0.320m.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.150m	£0.306m	£0.306m	£0
Non-Pay	£0.007m	£0.013m	£0.013m	£0
Total	**£0.156m**	**£0.320m**	**£0.320m**	**£0**

7.22 There are currently no financial risks associated with the Project for 2023-24.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 There are currently three financial risks associated with TCS:

- The Enabling Works Project may be required to provide financial support to the nVCC Project due the current lack of funding for 2023-24 for the latter. This risk is being mitigated as previously noted.

- There are three new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.000m. Ministerial approval will be sought for this additional funding.

  Capital funding has not been allocated to the nVCC Project, with a current overspend as costs are still being incurred due to the delay of Financial Close. This risk is being mitigated by a request to WG for funding for the Project of £2.800m.

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 produced.

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 as at 30th September 2023

TCS Programme Budget & Spend 2023-24

CAPITAL	Year to Date Budget Sep-23	Year to Date Spend Sep-23	Year to Date Variance Sep-23	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	01-Aug	£	£	£	£	£
PAY						
Project Leadership nVCC OBC	0	105,521	-105,521	0	213,143	-213,143
Project 1b - Enabling Works FBC	140,382	162,431	-22,049	229,841	276,741	-46,900
Project 2a - New Velindre Cancer Centre OBC	0	456,370	-456,370	0	972,953	-972,953
Capital Pay Total	**140,382**	**724,321**	**-583,939**	**229,841**	**1,462,837**	**-1,232,996**
NON-PAY						
nVCC OBC Project Delivery	0	20,855	-20,855	0	64,000	-64,000
Project 1b - Enabling Works FBC	6,824,591	7,346,119	-521,528	10,666,552	10,616,023	50,529
Project 2a - New Velindre Cancer Centre OBC	0	990,821	-990,821	0	1,606,236	-1,606,236
Capital Non-Pay Total	**6,824,591**	**8,357,794**	**-1,533,203**	**10,666,552**	**12,286,259**	**-1,619,708**
CAPITAL TOTAL	**6,964,973**	**9,082,115**	**-2,117,142**	**10,896,393**	**13,749,096**	**-2,852,704**

REVENUE	Year to Date Budget Sep-23	Year to Date Spend Sep-23	Year to Date Variance Sep-23	Financial Year Annual Budget	Financial Year Annual Forecast	Financial Year Annual Variance
	£	£	£	£	£	£
PAY						
nVCC Pay Award	57,423	57,423	0	96,408	96,408	0
Programme Management Office	164,571	163,787	785	326,890	327,095	-205
Project 6 - Service Change Team	153,983	149,850	4,134	306,290	306,290	0
Revenue Pay total	**375,978**	**371,059**	**4,918**	**729,589**	**729,793**	**-205**
NON-PAY						
nVCC OBC Project Delivery	0	14,029	-14,029	0	30,000	-30,000
nVCC OBC Judicial Review	0	11,000	-11,000	0	11,000	-11,000
Programme Management Office	1,410	1,481	-71	1,410	1,205	205
Project 6 - Service Change Team	9,000	6,522	2,478	13,340	13,340	0
Revenue Non-Pay Total	**10,410**	**33,032**	**-22,622**	**14,750**	**55,546**	**-40,796**
REVENUE TOTAL	**386,388**	**404,092**	**-17,704**	**744,339**	**785,339**	**-41,000**

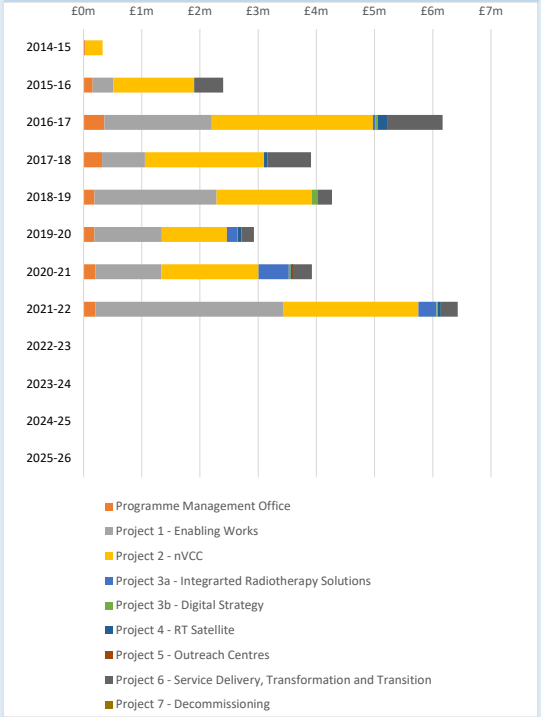
APPENDIX 2: TCS Programme Funding for 2022-23

Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0**	**£0.328m**
Commissioner's Funding		£0.240m
Trust Revenue Funding		£0.060m
WG One Off Pay Award 2022/23 Funding		£0.006m
WG Recurrent Pay Award Funding		£0.022m
Enabling Works FBC	**£10.896m**	**£0**
2022-23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£10.896m	
New Velindre Cancer Centre OBC	**£0**	**£0.096m**
WG One Off Pay Award 2022/23 Funding		£0.019m
WG Recurrent Pay Award Funding		£0.077m
Radiotherapy Satellite Centre	**£0**	**£0**
No funding requested or provided for this project to date		
SACT and Outreach	**£0**	**£0**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0**	**£0.320m**
Commissioner's Funding		£0.180m
Trust Revenue Funding		£0.131m
WG One Off Pay Award 2022/23 Funding		£0.002m
WG Recurrent Pay Award Funding		£0.007m
VCC Decommissioning	**£0**	**£0**
No funding requested or provided for this project to date		
Total	**£10.896m**	**£0.744m**

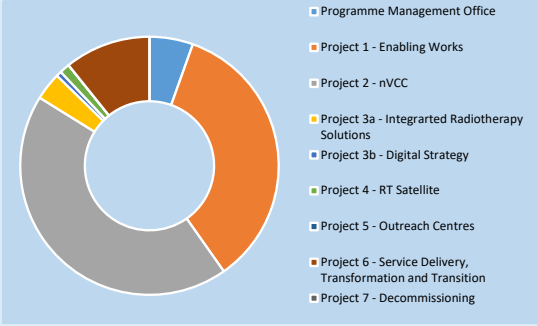
APPENDIX 3: TCS Cumulative Spend Report to 31st March 2022

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

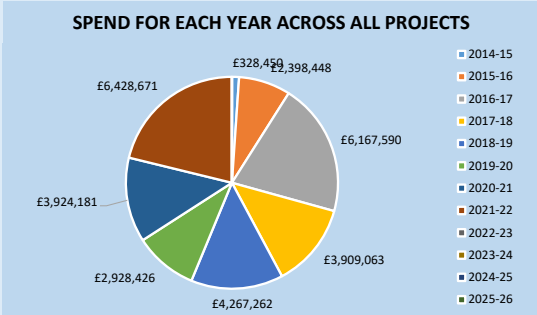
SPEND PER PROJECT PER YEAR



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

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2023 / 2024 (QUARTER 2)

Date of meeting	30/11/23

PUBLIC OR PRIVATE REPORT	**Public**

IF PRIVATE PLEASE INDICATE REASON	**Not Applicable - Public Report**

REPORT PURPOSE	**INFORMATION / NOTING**

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	**NO**

Prepared by	**Peter Gorin, Head of Strategic Planning and Performance**
PRESENTED BY	**Phil Hodson, Deputy Director of Planning and Performance**
APPROVED BY	**Carl James, Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**1. VELINDRE NHST IMTP PROGRESS 2023/24** 1.1 This report provides an update (position as of 25th October 2023) of progress against the actions (July – September 2023) which were included within the IMTP for 2023/24 as at Quarter 2. 1.2 These updates are provided in the form of the monitoring templates for WBS and VCS (See Appendix 1 and Appendix 2). 1.3 Good progress has been made again against IMTP actions as at Quarter 2.

RECOMMENDATION / ACTIONS	**The Trust Board is asked to:** • **The Board is asked to NOTE the progress made in the delivery of the agreed IMTP (2023 – 2026) actions as at Quarter 2 for both the Velindre Cancer Service and the Welsh Blood Service.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SLT / Performance Review	**19 October 2023**
VCS SLT / Performance Review	**20 October 2023**
Executive Management Board Run	**30 October 2023**
Quality Safety and Performance	**16 November 2023**
Summary and outcome of previous governance discussions: **The report has been considered and endorsed at the VCS and WBS Performance Review, EMB Run and QSP meetings and is presented to the Trust Board for information and noting.**	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
1	**Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/10/2023.**
2	**Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/10/2023.**

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

2. SITUATION/BACKGROUND

2.1 The Integrated Medium Term Plan (IMTP) 2023/24-2025/26 was submitted to the Welsh Government on 31st March 2023. Integral to the successful delivery of our IMTP were a number of actions to support the delivery of the Trust's Strategic Aims, across both cancer services and blood and transplant services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The timing of the end of Quarter 2 (July to September 2023), has given the time for a detailed assessment of progress against IMTP actions and has been prepared for the QSP Committee and Trust Board meetings to be held on 16th and 30th November 2023 respectively.

3.2 The table below gives a high-level overview of progress made in the delivery of actions at Q2 for WBS and for VCS.

BRAG Rating	Progress Categories Definitions	Welsh Blood Services IMTP 2023/24 Actions	Velindre Cancer Services IMTP 2023/24 Actions
BLUE	Action successfully completed with benefits being realized		
GREEN	Satisfactory progress being made against action in line with agreed timescale	**8 Q actions**	**9 Q actions**
YELLOW	Issues with delivery identified and being resolved with remedial actions in place	**7 Q actions**	**11 Q actions**
AMBER	Delays in implementation / action paused due to external issues beyond our control		**2 Q actions**
RED	Challenges causing problems requiring recovery actions to be identified		
Total IMTP 2023/23 Quarterly Actions		**15 Q actions**	**22 Q actions**

3.3 WBS are making satisfactory progress, categorised as '*green or yellow*', against all 15 of their actions as at Q2.

3.4 VCS are making satisfactory progress, categorised as '*green or yellow*', against 20 of their 22 actions.

3.5 However, two actions that remain assessed as 'amber'. This is defined as *'Delays in implementation / action paused due to external issues beyond our control*'. These two actions are:

- Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Service (pg.24)
- Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025) (pg. 32)

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organization that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarized here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text

	Type of Change Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1

Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/10/2023.

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
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.	**Donor Data Recovery Plan** - introduced new semi-automated process where donors who are unsuccessfully sent an SMS receive an email requesting they update mobile details. Appointment system portal concept has been successfully piloted, implementation will continue into Q3. Donor Contact Centre integrated communication platform procurement underway. Work progressing to establish a donor forum.	
	Develop and implement strategy for sustained growth and retention of the	• Increased stem cell donor panel • Increase in stem cells supply	Develop strategy. Engagement with key stakeholders.	Formal sign off of strategy. Communication plan developed and approved.	Launch and implement strategy.	Post implementation review.	Development of strategy has commenced and is now being taken forward as part of the WBS Futures initiative.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2023/24.	• Improved resilience in stem cell supplies • Improved clinical outcomes in Wales/globally • Increased income levels		Develop implementation plan.			Timelines have been reappraised as part of the WBS Futures initiative.	
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.	Final draft strategy developed, awaiting sign off prior to initiating a review of systems and processes.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• 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 blood products.	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.	Preoperative anaemia standards have been agreed by all NHS Wales preoperative services & agreed implementation of the All-Wales pathway across Health Boards for all surgical specialties. Pre-op anaemia reports have been benchmarked against standards, resulting in recommendations to optimise services. Bilingual preoperative anaemia toolkit resources have been	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Compliance with the NICE guidance. • Improved efficiency • Cost efficiencies.					created and are hosted on BHNOG website. Patient Blood Management (PBM) training is now included for all 'Foundation' doctors across Wales. Work is ongoing with DHCW to create live data dashboard for the initial data set.	
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	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.	'Tours' for North Wales are still being scoped to better understand capacity return/viability. Powys 'tours' have been adjusted to increase capacity by approx.400 appointments. There has been an increase in the number of mobile donation clinics in Q2 creating approx. 600 extra appointments.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		Donor Registry						
	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.	The OCP implementation is completed in North and West Wales. A phased implementation in South Wales is due to begin in January 2024. Preliminary work has been initiated in respect of the new clinically led collection team model. This work is being taken forward as part of the WBS Future initiative.	
	Develop and implement a platelet strategy by 2024/25.	• Improved levels of efficiency • Improved alignment between capacity and demand • Reduction in avoidable waste	Establish a platelet strategy group under the Laboratory Modernisation Programme to coordinate the work. Complete development of	Planning tool developed and in routine use. Review the clinic collection plan for Apheresis to ensure the clinic times are	Clinical and Scientific roadmap established to predict future trends e.g., cold platelets. Begin development	Continue development of the platelet strategy.	The Platelet Strategy Group (established as part of WBS Futures initiative) will meet in October and will align work around the development of the planning tool and the review of the clinic collection plan for Apheresis.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Reduce wastage.	platelet planning tool.	optimised.	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.	Procurement has been delayed, due to WG query regarding alternative funding routes, but expected to commence by October 2023.	
	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	Post-engagement days & supplier engagement is ongoing. User Requirements Specification in development, and discussions are being held across the WBS Senior Leadership Team and Executive Team to consider options regarding the shape and	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							structure of procurement process. The funding position is currently unconfirmed.	
	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.	The project is running to plan, in compliance with SaBTO recommendations and the approach agreed by the 4 UK nations. Data is being collated as our contribution to the planned SaBTO review. SaBTO have not confirmed a report date for this review as yet.	
	Establish a quality assurance modernisation programme to develop and implement strategy which supports more	• Maintain compliance with regulatory standards • Improved quality • Improved safety	Complete reconfiguration of the Regulatory Assurance and Governance Group to create	Validation and deployment of eQMS. Review document hierarchy structure.	6 month review of Quality Hub delivery. Implementation of eQMS.	Review pilot of electronic signatures and implement learnings. Review eQMS Implementation and	An initial review of the electronic signatures pilot is underway. The eQMS procurement is behind schedule. Currently awaiting Trust Board approval before the contract is awarded.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	efficient and effective management of regulatory compliance and maximises digital technology by 2023/24.	• Improved donor experience.	the Divisional Quality Hub. 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	Adapt change management process to support Continuous Improvement culture.	Review amended Change Management process	functionality.	The Document Hierarchy work will be paused until the eQMS procurement is complete. Initial change management process changes are in place, and a Continuous Improvement approach is underway.	
	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.	On track to award tender in October 2023. The 'Go live' date has been agreed by Programme Board as 13th May 2024.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Improved patient experience • Reduction in avoidable waste/costs						
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.	• Secure 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.	Diagnostic Plasma contract prices have been renegotiated, and the Plasma Project Brief has been written. WBS is awaiting notification of WG position on funding. The National Fractionation contract has been awarded, with commercial details received and a benefits scenario model developed. A High-level costing model for apheresis has been prepared. The Business Case for investment in	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							Leucodepletion kits has been submitted.	
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.	Decision to integrate phase 1 (sustainability elements) & phase 2 (laboratory space utilisation) into one OBC. Awaiting updated programme and associated costs from Supply Chain Partner.	
SP7 Develop great people and a great place to work	Develop a sustainable workforce model which provides leadership,	• Enhanced workforce capacity & capability to meet need.	Consult on new Senior Leadership Team (SLT) workforce model	Permanently recruit to remaining SLT roles where there are	Permanently recruit to remaining SLT roles where there are	Review of newly implemented SLT workforce model.	Senior Leadership Team (SLT) Recruitment is progressing. All SLT posts are aimed to be appointed to by	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)	resilience and succession planning by 2025/26.	• Enhanced Leadership capacity & capability • Improved staff satisfaction • Improved staff well-being • Improved service quality, safety and donor satisfaction.	and recruit to roles where there are substantive job holders.	currently only seconded post holders. Scope out new WBS workforce model for Clinical Services. Laboratory Services Modernisation Programme determine requirements for future workforce in Laboratory Services.	currently only 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.	31.12.23, with the potential for start dates early in 2024 where external appointments are made. The Clinical Services delivery model scoping has concluded, and a new model has been recommended. The WBS SLT & Workforce Business Manager are evaluating recommendations. The Laboratory Services Modernisation Programme has been initiated as part of the WBS Futures initiative.	

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

APPENDIX 2

Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/10/2023

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
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 patient satisfaction	Complete recruitment to any additional posts identified in workforce plan. Review SLAs. Review operational model	Undertake staff training. Deploy communications plan. Review SLAs	Development of a transition and implementation plan to support the move to the Satellite Centre in 2024/25 Installation of 2 standard linear accelerators and a CT Sim at the centre.	Complete recruitment to any additional posts identified in workforce plan Develop stakeholder communication plan .	• Working group established in conjunction with ABUHB to design service specification and SLA.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Integrated Radiotherapy Solution Programme by 2026/27**	• Improved patient outcomes • Improved quality of care	Clinical commissioning of first replacement linear accelerator at the existing VCS	Realise initial pathway improvements. Initiate digital implementation and develop	Decommissioning and removal of second linear accelerator. Bunker refurbishment commenced in	Installation and commissioning of second replacement linear accelerator at VCS	• All aspects of phase 1 (year 1) delivered on-time and on-budget.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• 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	First patient treatment (June 2023)	benefits realisation plan.	advance of installation of second replacement linear accelerator.		• Planning for phase 1 (year 2) in development.	
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.	Business case to be completed (if required) to address additional resource requirement.	Continue to implement local actions.	• Work on the peer review action plan has been paused during summer months following the resignation of a Brachytherapy MPE. Now	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• 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	Continue to implement local actions. In conjunction with CAV review processes and flows aligned to Brachy theatre utilisation	Continue to implement local actions		single handed MPE focused activity on Clinical Commissioning and training additional MPE to maintain operational service. • Action plan to be reviewed in October, when MPE capacity should be improved subject to training and competence assessment of clinical scientist in training.	
Trust Strategic Goals 1, 2 3 and 4	**Implement Radiology Informatics System (RISP) and participate in RISP -**	• Improved diagnostics information	Continue to engage with DHCW facilitated project board		Development of a local implementation plan to support	Development of a local implementation plan to support	• Local deployment order approved by Executive	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	Radiology Informatics System Procurement.	• Better information sharing and enhanced clinical decision-making • Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction			National implementation	National implementation	• Management Board and to be considered by the Trust Board (September 2023). • Full implementation plan to be developed. Work to commence in September 2023.	
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre**	• Improved patient outcomes • Improved quality of care		Complete phase 2 of SDEC programme			**Ambulatory Care-:** • Established Internet page for ACU/PSU patients	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	Cancer Services by Q4 2024/25	• Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Reduction in avoidable admissions • Improved patient satisfaction		Develop business case to secure ongoing funding			• Review of nursing resources and potential requirement for extra staff • Recruitment of ACU Ward Manager to manage SDEC Ambulatory service **IO Service-:** • Audit of IO toxicity clinics to capture complexity of calls, referrals, prescription • Specialist Consultant SLAs for Lung, Gastro & Neuro • Review of job title and role of IO MDT Coordinator and workload	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
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 VCS to support delivery of functions of QMS Develop and implement revised governance structure	Fully implement QMS	Establish patient engagement hub	• Work to describe governance structure advanced (to conclude September 2023).	
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 Completion of review	Review and evaluate impact of implementation	• Capacity and demand review at a tumor site by tumor site level progressing and due to conclude in September 2023. • CNS competency	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							framework complete. • Job descriptions for band 6 and 7 CNS roles revised and redrafted.	
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	• Continued engagement with national teams. Local work progressing and initial round of Pilot 3 complete (further rounds now to be progressed) however, National TrAMS Service Model is not yet defined to enable significant change of	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
							practices to be implemented locally. For this reason, work around local compounding of materials has been rescheduled for 24/25	
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.	• Data collected. in early stages of analysis to determine unmet demand.	
Trust Strategic Goals 1, 2 and 5	**E-prescribing implementation of phases 1 and 2 for E-prescribing for general medicines in line with**	• Improved quality • Improved patient safety • Improved information (access to and sharing of)	Establish engagement with ePMA suppliers, arrange demonstrations and identify preferred supplier	Develop local procurement specification Identify resource required for implementation	Recruit VCS system implementation team	Recruit to VCS System Implementation Team (if staff additional to Pre-implementation Team required)	• System specification at local approval stage. • Engagement with health board partners	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	national timeframes	• Improved levels of efficiency and productivity • Reduction in carbon emissions	Map business processes and consider the effects ePMA will have on ways of working	team Develop business case to support recruitment of implementation team Develop project plan for implementation			focused on identifying potential collaboration opportunities.	
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	Progress continues: • Nursing - 8/17 recommendations completed / closed • Bookings - 4/6 recommendations completed / closed • Pharmacy - 2/7 recommendations completed / closed	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
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 Revise guidelines for escalation of calls.	Develop guidelines for audit. Conduct audit process	SACT treatment helpline fully implemented	Respond to audit findings Ensure the SACT triage line is achieving agreed VCS standards in accordance with the VCS Generic Patient Enquiry implementation action plan	• Triage tool updated and launched. • UKONS tool digitalised and launched.	
Trust Strategic Goals 1, 2 and 4	**Implementation of pathway programme to support optimisation of cancer pathway and transition to nVCC by Q4**	• Improved quality • Improved patient safety • Reduced waiting times • Improved access • Improved clinical outcomes	Establish governance structure, develop work plan and define timelines (programme to encompass a number of work streams which will include a	Establish work streams to support the delivery of the pathway programme to include RRTT Develop action plan in response to support work	Develop supporting business case(s) where required to support new delivery models, identifying funding stream. Implementation	Develop and implement revised processes / pathways. Implementation of service delivery model for Attend Anywhere	• Project management resource in post. Work plan identifies initial focus on Cwm Taf Morgannwg UHB / Velindre lower GI pathway.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
	2024/25	• Reduced waiting times • Improved patient experience	focus on supporting improved system-wide Suspected Cancer Pathway compliance. Improving compliance against new radiotherapy time-to-treatment (previously COSC) targets and improved flow and performance in Outpatients) Identify two tumour sites to commence pathway work. Set up workshop to map sessions and agree key processes and treatment	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 service and delivery model for Attend Anywhere.	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 pathways for MSSC and SACT telephone helpline Implementation of services delivery model for Attend Anywhere	Continued engagement in Safe Care Collaborative Programme Identify new ways of working and opportunities for workforce reconfiguration	• Work to define new radiotherapy pathway performance indicators undertaken. • Safe Care Collaborative project teams established. Continued engagement with national programme. Baseline data trawls and process mapping undertaken.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			specific pathways for focus Identify service improvements / opportunities for change aligned to best practice / national standards Gather and review baseline data sets Establish Task and Finish Group to identify service improvement opportunities within outpatients department and medical records/medical secretaries					

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			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, secure approval to proceed Establish project group					

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
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	• Project group yet to be established.	
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 • Improved clinical outcomes	Continue engagement with Prehab to Rehab south-east Wales collaborative and WCN national prehabilitation group Establish local governance structure, develop work plan and define	Establish task and finish group to develop prehabilitation website for VCS patients	Introduce prehabilitation (self-management) website for VCS patients Introduce physical activity prehabilitation group sessions.	Introduce virtual physical activity programme Develop local service improvement plan	• Project management support assigned to project. • Project board established. • Working group set up and Terms of Reference and Project	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Improved patient experience	timelines Review funding streams and commissioning models to facilitate prehabilitation service development.				Initiation Document developed and approved. RAID and project benefits logs established.	
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 • Reduction in carbon emissions	Secure FBC approval from the Welsh Government Secure full planning permission Complete clinical design Ground clearance works Continued engagement between nVCC project team and VCS.	Achieve financial close Ground clearance works Continued engagement between nVCC project team and VCS.	Commence nVCC construction Continued engagement between nVCC project team and VCS.	nVCC construction Revise/refine delivery plans Develop plans to support the transition of services from VCS to the nVCC Finalise clinical models to be implemented to support nVCC.	• Full Business Case remains under development and awaits Welsh Government approval.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Reduced staff sickness						
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	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 Ongoing discussions with CTMUHB to determine model and next steps.	Service model developed and agreed with both CTMUHB and C&VUHB	• Strategic planning assumptions and baseline data reviewed. • Internal project board to re-start (end of September 2023).	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
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 VCS and identification of required next steps	Develop communication strategy Develop AOS framework for VCS and service model	Undertake engagement on service model for nVCC	• Regional activity temporarily paused pending recruitment of new operational manager. • Velindre specific acute oncology project progressing with particular focus on pathways, processes and transport issues.	
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	Develop agreed costed model for palliative radiotherapy Identify opportunities for workforce	Collaborate with Cardiff and Vale University Health Board to explore options for regionalised chronic pain service	Develop business case to support palliative radiotherapy model if required	• Palliative radiotherapy workshop scheduled (for November 2023) to consider options for	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			radiotherapy within VCS and as part of a regional model.	redesign and develop associated workforce plan Identify possible funding options	Review and develop agreed costed model for palliative radiotherapy Identify opportunities for workforce redesign and develop associated workforce plan		resourcing clinic sustainably. • CIVICA-based palliative patient experience launched facilitating the collection of experience and outcome data.	
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	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service	Finalise the priority of implementation of key treatments where external funding is required and agree timescales Determine requirement for additional funding and	Identify preferred service model and any additional resource requirement. To support delivery of partial breast and axillary radiotherapy for eligible patients with breast cancer	Identify additional resource required to implement partial breast and axillary radiotherapy and develop business case for consideration by commissioners	• Working group established to plan introduction of IMN and other breast cancer treatments. Group will identify any resource implications which will inform the development of	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Enhanced organisational reputation for quality of 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 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	where appropriate commence business case developments for agreed treatments in phased approach according to priority and timetable agreed 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	Develop strategy and service model to support adoption of motion management	Expand SRS service to support the routine treatment of patients with more than 3 metastases Identify additional resource required to support the expansion of the SRS service and develop business case, if required	a business case to support introduction of new techniques. • Hyperarc phantoms procured to support testing of SRS treatment solutions.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			neuroendocrine tumours Identify additional resource required to expand HDR brachytherapy boost treatments for eligible patients with prostate cancer. Develop business case for WHSSC to support expansion of HDR brachytherapy boost service Develop service model and associated pathways to support delivery	with prostate cancer if required Identify additional resource required to implement extreme hypofractionated radiotherapy for eligible patients with prostate cancer and 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				

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			of new indications for Stereotactic Ablative Radiotherapy (SABR)	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 Identify super users/champions for each service group to continue to support implementation Establish revised governance, reporting and delivery structure for	Review learning from phase 1 Establish revised governance structure	Clarify scope and service delivery requirements	Develop work plan to support implementation.	• Phase 1 closure report and benefits realisation review developed. Lessons learned exercise undertaken. • Revised programme governance structure to be implemented from September 2023.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
			VCS agreed scope and prioritisation of phase 1b (VCS 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 tackle key issues • Creation of knowledge economy and innovation across Wales	Workshop to be held to scope CFCL and ways of working Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway	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 improved engagement and pathway delivery between and with primary and community	• The CCfLI, Velindre Oncology Academy and ARC Academy collaborative scoping work has been completed to inform the workshop. • CCfLI collaborative workshop has been scheduled and	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q2**	**Progress Rating**
		• Physical space to support innovation and development working across the region/Wales/wider	delivery between and with primary and community care and Velindre			care and Velindre	next steps to be agreed.	

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

INTEGRATED MEDIUM TERM PLAN – ACCOUNTABILTY CONDITIONS

DATE OF MEETING	30th November 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital.
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The Trust, on 14th September 2023, received confirmation from the Welsh Government that it's IMTP for 2023 / 24 – 2025 / 26 had been approved. Following the approval of the IMTP the Trust received an accountability conditions letter, on 2nd October 2023, from the NHS Wales Chief Executive. The key accountability conditions are summarised in section1 (*situation*). A stated requirement within the accountability conditions letter was for the Trust to report Progress against

	the conditions on a quarterly basis from quarter 3 (2023/24).

RECOMMENDATION / ACTIONS	The Trust Board is asked to: • Note the Welsh Government accountabilities conditions • Note the approach for reporting against the Welsh Government conditions

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Run	**30/10/2023**
Quality, Safety and Performance Committee	**16/11/2023**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The approach for reporting against the accountability conditions was approved by the Executive Management Board and Quality, Safety and Performance Committee.	

7 LEVELS OF ASSURANCE – NOT APPLICABLE

1. SITUATION

1.1 The Trust, on 14th September 2023, received confirmation from the Welsh Government that it's IMTP for 2023 / 24 – 2025 / 26 had been approved.

1.2 Following the approval of the IMTP the Trust received an accountability conditions letter, on 2nd October 2023, from the NHS Wales Chief Executive. The key accountabilities are listed below with the Trust accountable officer(s) for each condition also identified:

- Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risk (Chief Operating Officer (supported by Executive and Divisional Directors)).

- Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance (Chief Operating Officer (supported by Executive and Divisional Directors)).

- Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID (Chief Operating Officer (supported by Executive and Divisional Directors)).

- Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible (Executive Director of Finance)

2. BACKGROUND

2.1 Within the Welsh Government Accountability Conditions letter it was stated that there was an expectation that:

"*The Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year*".

3. ASSESSMENT

3.1 To ensure robust delivery of the IMTP for 2024 / 25 – 2026 / 27 and to discharge the Welsh Government IMTP accountability conditions it is recommended, from November 2023, that a quarterly progress report is submitted to:

- The Executive Management Board (Run)
- The Quality, Safety and Performance Committee
- The Velindre University NHS Trust Board

Note: we currently report progress against the actions included within the Trust IMTP on a quarterly basis. This proposal is specific to the four Welsh Government accountability conditions.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Trust Board is asked to:

- Note the Welsh Government accountabilities conditions
- Note the approach for reporting against the Welsh Government conditions

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Not applicable
	Not Applicable
	The purpose of this paper is to outline the approach for reporting against the Welsh Government IMTP accountability conditions.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the approach outlined within the paper or attached appendices.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A - There are no Trust Well-Being goal implications or impact linked directly to the

	approach outlined within the paper.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	The purpose of this paper is to initiate a discussion in relation reporting requirements against the Trust IMTP accountability conditions. However, there will be a requirement to undertake an IMTP Equality Impact Assessment I support of the development of the Trust IMTP for 2024/25 – 2026/27.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

TRUST BOARD

OPTIONS FOR PROCUREMENT OF A BLOOD ESTABLISHMENT COMPUTER SYSTEM

DATE OF MEETING	30/11/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Carl Taylor, Chief Digital Officer Elin Griffiths, Interim Head of Digital Programme Claire Salisbury, NWSSP, Assistant Director of Procurement Services Alan Prosser, Director Welsh Blood Service Peter Richardson, WBS Head of Quality, Safety and Regulatory Compliance
PRESENTED BY	Alan Prosser, Director Welsh Blood Service
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The Blood Establishment Computer System (BECS) is a business-critical system and without it the Welsh Blood Service (WBS) would not be able to operate causing both direct patient harm and leaving NHS Wales without the capability to

	supply blood and blood products, to the patients and services of Wales. The current contract with MAK-SYSTEM expires in November 2024, with an additional extension available until November 2025 to allow for the transition to a new system/supplier. The BECS system is coming to the end of its current contractual arrangements. The BECS Project was established in Jan '23 and continues to work on the future options, this has included a Prior Information Notice process with the market. In addition to BECS, the Trust Board recently approved support to implement the Digital Transplantation programme for the Welsh Histocompatibility and Immunogenetics Service (WHAIS), this commercial product is a complex digital transformation for the transplantation laboratories within Welsh Blood Service (WBS) and has been an outstanding high risk for the service for a number of years. The environment in which the BECS Project is operating remains challenging due to the need to: implement 2 new and highly complex digital systems within a truncated time period; manage the risk that essential system failure will result in harm to donors and/or patients through loss of cross matching or other test data, or the loss of vein to vein traceability between donors and patients; demonstrate to regulators that digital systems are maintained in a safe, validated and fully supported state; and manage the risk that essential system failure will result in an inability to deliver core activities in a sustainable and resilient way. The BECS Project is, therefore, exploring options for future BECS provision and these are set out in the corresponding Private Trust Board paper due to commercial sensitivity.

RECOMMENDATION / ACTIONS	The Trust Board are asked to **NOTE** this update on the BECS Project, the challenges and strategic context and that options for the future provision are being explored.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Extra-ordinary Private Strategic Development Committee (endorsed for approval)	15/11/23
Private SDC (2 Independent Members) Formative discussion	09/11/23
EMB Shape	16/10/23
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS TWO WORKSHOPS HELD WITH WBS SENIOR LEADERSHIP TEAM A REFINED OPTIONS PAPER HAS BEEN PREPARED AND CONSIDERED BY WBS SLT ON 11TH OCTOBER AND WAS PRESENTED TO EMB ON 16TH OCTOBER AND ENDORSED FOR APPROVAL. THE DISCUSSIONS AND SDC/TRUST PAPER ARE COMMERCIALLY SENSITIVE AND ARE INCLUDED IN THE PRIVATE TRUST BOARD PAPERS.	

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

APPENDICES	
Appendix 1	AW092 BECS Final Published VEAT

1. SITUATION

1.1 The Blood Establishment Computer System (BECS) Project has been established to manage the procurement and implementation of a new BECS on behalf of the

Welsh Blood Service. BECS is a business-critical system and without it the Welsh Blood Service (WBS) would not be able to operate causing both direct patient harm and leaving NHS Wales without the capability to supply blood and blood products, to the patients and services of Wales.

1.2 In addition to BECS, the Trust Board recently approved support to implement the Digital Transplantation programme for the Welsh Histocompatibility and Immunogenetics Service (WHAIS), this commercial product is a complex digital transformation for the transplantation laboratories within Welsh Blood Service (WBS) and has been an outstanding high risk for the service for a number of years due to the many manual workarounds that are currently in place within this operation, the legacy system currently supporting the service and the shortage of IT expertise in supporting this system.

1.3 The WHAIS system is critical to patient safety and underpins the Quality Management Framework which is required by UK and international regulations governing the storage and processing of human tissues.

1.4 Requirements for the use of computer systems in Blood and Tissue establishments are set out in the Council of Europe Good Practice Guidance (GPG). Of particular relevance, is the requirement for digital systems to be validated before use, and to be maintained in a validated state throughout useful life. Validations include the software itself, it's deployment to the specific hardware platform and local configurations.

1.5 These standards are enforced through regular inspections by national regulators and competent authorities such as the Human Tissue Authority (HTA) or the Medicines and Healthcare Products Regulatory Agency (MHRA). The WBS Quality Management framework is subject to regular audit by both the HTA and the MHRA. In order to maintain our HTA licence and Blood Establishment Authorisation (BEA), any significant changes, such as the deployment of a new digital platform, are subject to detailed independent oversight by the regulator, and require approval before final deployment depending on the assessed level of risk. Failure to demonstrate compliance with the regulations would result in regulatory sanction and may risk suspension of the HTA licence, or Blood Establishment Authorisation.

1.6 For BECS, the current contract with the incumbent supplier (MAK-SYSTEM) is due to expire in November 2024, with an additional one-year extension available until November 2025.

1.7 The BECS system is therefore coming to the end of its current contractual arrangements. The BECS Project was established in Jan '23 and continues to

work on the future options, this has included a Prior Information Notice process with the market.

1.8 In line with current procurement legislation, Public Contract Regulations 2015 (PCR 2015), Velindre University NHS Trust (VUNHST) must undertake a compliant process to provide a BECS system.

1.9 The environment in which the BECS Project is operating remains challenging due to the:

- The risk that devoting resource to the procurement and deployment of 2 new and highly complex digital systems within a truncated time period will leave insufficient skilled resource to deliver essential activities needed to maintain current clinical systems leading to system degradation and possible failure.
- The risk that essential system failure will result in harm to donors and/or patients through loss of cross matching or other test data, or the loss of vein to vein traceability between donors and patients**.**
- The risk that failure to demonstrate to regulators that digital systems are maintained in a safe, validated and fully supported state could lead to significant regulatory sanction.
- The risk that essential system failure will result in an inability to deliver core activities in a sustainable and resilient way.

1.10 The future BECS system must be affordable in the current and future financial climate.

1.11 Work is being done by the BECS Project to identify and explore options to manage these challenges within the strategic context.

2. BACKGROUND

2.1 In 2009, WBS entered into a 5+1+1 contract with MAK-SYSTEM (for ePROGESA) with operational use commencing in May 2015. This is the current BECS. Due to the level of complexity and statutory/regulatory nature of a BECS it took the WBS approximately five years to fully implement following contract award, during this time the BECS was an “asset under construction”, with some of the functionality yet to be fully optimised in 2023.

2.2 In July 2019, the Trust Board approved a request to take up the option of the 2-year (1+1) extension of the existing contract.

2.3 In June 2022, Welsh Government was informed of the Trust's intention to extend the contract of the current supplier: MAK-SYSTEM. The new contract covers from the 1st November 2022 – 31st October 2024, with a further optional 12-month extension available (2+1). This extension was covered by a Voluntary Ex Ante Transparency (VEAT) notice which has been included at Appendix 1.

2.4 The VEAT placed for the BECS indicated a contract value of £1,200,000 exc. VAT.

2.5 In Jan '23 WBS initiated the BECS Project to manage the forward procurement of a BECS system. This project is ongoing and continues to make progress.

2.6 The first multi-disciplinary BECS Procurement Group was held in January 2023, which subsequently developed a Prior Information Notice (PIN) issued to the market. The PIN also outlined a high-level scope, including both the current and future needs of the service aligned with the delivery of the new WBS 5 Year Strategy. Following SLT approval, the PIN was issued on 10th March 2023.

2.7 A number of suppliers responded to the PIN: this was followed by supplier engagement sessions, in May 2023. Following the engagement sessions, the suppliers were asked to provide high-level indicative costs.

3. ASSESSMENT

3.1 Work is being done by the BECS Project to identify and explore options around the future procurement of the BECS system. Several key considerations are provided below, which have been used to inform the options.

3.2 Four key considerations are provided below, which support the setting out of the options. These are:

- BECS is a critical clinical system and needs contractual stability and security to safeguard the capability to supply blood and blood products, to the patients and services of Wales. The current system is safe and can be maintained and updated.

- A large-scale BECS procurement within the current prescribed timescales (implementation complete by November 25), could severely impact the WBS WHAIS Transplantation Digital programme, in terms of workforce capacity and regulatory assurance.

- The competitive market maturity and support for national NHS Wales and Welsh Government Cloud ambitions.

- The funding and procurement route need to be established.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1. As described, NHS Wales cannot operate without the WBS provision of blood and blood products. This is dependent on a BECS system. The Trust Board are asked to **NOTE** this update on the BECS Project, the challenges and strategic context and that options for the future provision are being explored and are set out in the corresponding Private Trust Board paper due to commercial sensitivities.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development, and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	06 - Quality and Safety In addition, a number of strategic risks are impacted upon including demand and capacity and finance

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). BECS is a business-critical system and needs stability and on-going investment, to safeguard the blood product supply for Wales and any interruption to our blood supply chain will impact patient safety and the population we serve. **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why)
	Not completed at this stage but will be for the main business case **Click or tap here to enter text**

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:

	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated.
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: Additional funding may be required for any new BECS from commissioners/WG and has yet to be agreed. Unable to determine final costs until contractual arrangements are confirmed. **Type of Funding:** **Revenue and Capital Funding** **Type of Change** **Major Programme** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not yet completed - Include further detail below why
	Will be completed for the business case
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text

	Without an approved BECS WBS would be unable to operate legally and will be in breach of regulatory and statutory duties.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Quality and Financial Sustainability domains
WHAT IS THE CURRENT RISK SCORE	Risks for the BECS options explored are set out in the Private Trust Board paper due to commercial sensitivities.
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The actions outlined in this paper do not mitigate the financial risk to the organisation in the short term but do mitigate the quality and safety of service provision. The Private Trust Board paper outlines the options considered to mitigate the current risk.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	This will be determined following discussions with Trust Board, our commissioners and Welsh Government in relation to an agreed procurement route and funding route being confirmed.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
	Dependant on Board approval of the option to be taken forward for BECS project.
All risks must be evidenced and consistent with those recorded in Datix	

EN

Voluntary ex ante transparency notice

Directive 2014/24/EU

Section I: Contracting entity

I.1) Name and addresses

NHS Wales Shared Services Partnership-Procurement Services (hosted by Velindre University NHS Trust)

4-5 Charnwood Court,, Heol Billingsley, Parc Nantgarw

Cardiff

CF15 7QZ

UK

E-mail: ProcurementServicesenquiries@wales.nhs.uk

NUTS: UK

Internet address(es)

Main address: http://nwssp.nhs.wales/ourservices/procurement-services/

Address of the buyer profile: https://www.sell2wales.gov.wales/search/Search_AuthProfile.aspx?ID=AA0221

I.4) Type of the contracting authority

Body governed by public law

I.5) Main activity

Health

Section II: Object

II.1) Scope of the procurement

II.1.1) Title

Blood Establishment Computer System (BECS)

Reference number: AW101

II.1.2) Main CPV code

72268000

II.1.3) Type of contract

Services

II.1.4) Short description

Procurement of a 'rights to use license' to continue to access the Blood Establishment Computer System. Plus license maintenance and support. Associated project management and consultancy.

II.1.6) Information about lots

This contract is divided into lots: No

II.1.7) Total value of the procurement

Value excluding VAT: 1 200 000.00 GBP

II.2) Description

II.2.2) Additional CPV code(s)

72263000

72267000

II.2.3) Place of performance

NUTS code:

UKL

Main site or place of performance:

Welsh Blood Service, Talbot Green, Llantrisant.

II.2.4) Description of the procurement

Procurement of a ‘rights to use’ software license for the on-premise provision of the Blood Establishment Computer System (BECS) via its ‘ePROGESA’ platform and associated modules including but not limited to the eDRM (Electronic Donor Records Management) service – a module of ‘ePROGESA. Maintenance and support of the software, upgrades, project management and consultancy fees to support implementation of functionality and the delivery of functional enhancements.

II.2.11) Information about options

Options: Yes

Description of options:

Option to extend for a further 12 months.

II.2.13) Information about European Union funds

The procurement is related to a project and/or programme financed by European Union funds: No

II.2.14) Additional information

See VI.1)

Section IV: Procedure

IV.1) Description

IV.1.1) Type of procedure

Negotiated procedure without prior publication

Justification for selected award procedure:

The works, supplies or services can be provided only by a particular economic operator for the following reason: absence of competition for technical reasons

Explanation:

WBS intended to run a new competition for this requirement during 2020 and for a new agreement to commence with a ‘go live’ service date during 2022. The running of the competitive exercise was significantly delayed due to the resources within the WBS being redirected to support the NHS Wales response to the Covid-19 pandemic.

The Authority therefore needs to replan this competition and intends to publish a Prior Information Notice (PIN) during the autumn of 2022 to commence the process.

To ensure contractual arrangements remain in place to maintain the continuity of this critical service, the Authority intends to use the negotiated procedure without prior publication in accordance with the use of Public Contract Regulations 2015 32 (2)(b)(ii) and (iii), competition is absent for technical reasons and (2)(b)(iii) - the protection of exclusive rights, including intellectual property rights.

IV.1.8) Information about Government Procurement Agreement (GPA)

The procurement is covered by the Government Procurement Agreement: Yes

Section V: Award of contract/concession

Contract No: AW092

V.2 Award of contract/concession

V.2.1) Date of conclusion of the contract/concession

10/08/2022

V.2.2) Information about tenders

The contract has been awarded to a group of economic operators: No

V.2.3) Name and address of the contractor

MAK-SYSTEM

35 square de Meeus

Brussels

1000

BE

Telephone: +33 646121360

Fax: +33 000000000

NUTS: BE

Internet address(es)

URL: www.mak-system.com

The contractor is an SME: No

V.2.4) Information on value of the concession and main financing terms (excluding VAT)

Total value of the concession/lot: 522 362.00 GBP

V.2.5) Information about subcontracting

Section VI: Complementary information

VI.3) Additional information

The Authority intends to award an agreement to MAK-System for a period of up to 2 years, plus an option to extend for a further period of up to 12 months for the reasons provided in this notice.

Should this extension need to be executed, it will be conditionally upon the Authority having run the new procurement and be in the implementation stage of the new agreement.

It is also the intention of the Authority to publish a new Prior Information Notice for a new competition in the autumn of 2022.

(WA Ref:120596)

VI.4) Procedures for review

VI.4.1) Review body

High Court

Royal Courts of Justice, The Strand

London

WC2A 2LL

UK

Telephone: +44 2079477501

VI.4.3) Review procedure

Precise information on deadline(s) for review procedures:

NHS Wales Shared Services Partnership on behalf of Welsh Blood Service – being a division of Velindre University NHS Trust, will apply a minimum 10 calendar day standstill period between notifying the award decision and awarding the contract.

Should additional information be required it should be requested of the addressee in section I.1). Aggrieved parties who have been harmed or are at risk of harm by breach of the procurement rules have the right to take action in the High Court (England and Wales). Any such action is subject to strict time limits in accordance with the Public Contracts(Amendments).

VI.4.4) Service from which information about the review procedure may be obtained

As in section I.1)

Cardiff

UK

VI.5) Date of dispatch of this notice

26/08/2022

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 30 November 2023 to 30 January 2024

DATE OF MEETING	30 November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	FOR BOARD **APPROVAL**

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	This report details the Trust Board decisions required for Commitment of Expenditure exceeding the Chief Executive's Limit (£100k), for the period **30/11/2023** – **30/01/2024**. Four items of expenditure are required for Board Approval during this period:- 1. Provision of Oncotype Testing. 2. Renewal of All Wales Blood Derived Products Contract. 3. Primary Care Services (PCS) – Provision of Multi-Functional Devices (MFD) and Professional Printing Devices (PPD) 4. Health Courier Services – Vehicle Replacement Programme

	All items of expenditure have been reviewed and approved by Trust Procurement.

RECOMMENDATION / ACTIONS	The Trust Board is requested to **AUTHORISE** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices **and AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

GOVERNANCE ROUTE	
EXECUTIVE MANAGEMENT BOARD (RUN)	**Appendix 1 - 02/10/2023**: Provision of Oncotype Testing. **Appendix 2 – 30/10/2023:** Renewal of All Wales Blood Derived Products Contract.
WBS FPPG	**Appendix 2 - 20/10/2023:** Renewal of All Wales Blood Derived Products Contract.
WBS Senior Management Team	**Appendix 2 – 11/10/2023:** Renewal of All Wales Blood Derived Products Contract.
NWSSP / NHS Wales Shared Services Partnership Committee	**Appendix 3 – 23/11/2023:** Primary Care Services
NWSSP / NHS Wales Shared Services Partnership Committee	**Appendix 4 – 23/11/2023:** Health Courier Services and Supply Chain.

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Appendix 1 & 2 - The Executive Management Board has reviewed and **APPROVED** the Commitment of Expenditure for the provision of Oncotype Testing.

Appendix 2 - The Welsh Blood Service (WBS) Finance & Procurement Planning Group (FPPG), WBS Senior Management Team and Executive Management Board have reviewed and **APPROVED** the Commitment of Expenditure for the Renewal of All Wales Blood Derived Products Contract.

Appendix 3 & 4 - The NWSSP Committee have reviewed and approved the Primary Care Services Commitment of Expenditure for the Provision of Multi-Functional Devices (MFD) and Professional Printing Devices (PPD) and Health Courier Services – Vehicle Replacement Programme.

7 LEVELS OF ASSURANCE – N/A

APPENDICES
Appendix 1 - Provision of Oncotype Testing
Appendix 2 - Renewal of All Wales Blood Derived Products Contract.
Appendix 3 - Primary Care Services (PCS) – Provision of Multi-Functional Devices (MFD) and Professional Printing Devices (PPD)
Appendix 4 - Health Courier Services – Vehicle Replacement Programme

1. SITUATION/ BACKGROUND

1.1 Velindre University NHS Trust (VUNHST) has a Scheme of Delegation, as set out in its Standing Orders, together with its Standing Financial Instructions (SFIs), which ensures that there are effective governance arrangements in place for the delegation of financial authority.

1.2 Financial limits apply to the commitment of expenditure. If expenditure is greater than an individual's financial limit, and is more than the limit delegated to the VUNHST Chief Executive, the planned expenditure will require VUNHST Board approval. For extensions of existing contracts in place, this only applies if the provision for extension was not included in the original approval granted by the Trust Board.

1.3 The decisions expected during the period **30/11/2023** – **30/01/2024** are highlighted in this report.

1.4 In line with the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are received by the Executive Management Board to ensure Executive oversight and scrutiny, to provide the Board with supporting recommendations and additional assurance.

2.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendices 1 - 4** for the detailed appraisals undertaken of the expenditure proposals that the Trust Board is asked to **APPROVE**

2.2 The table below provides a summary of the decisions sought from the November 2023 meeting of the VUNHST Board:

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (Inc. VAT)
Appendix 1	Velindre Cancer Service	Provision of Oncotype Testing	Start: 01/12/2023 End: 30/11/2025 Option to extend: 12 months (01/12/2025 - 30/11/2026)	£1,025,460
Appendix 2	Welsh Blood Service	Renewal of All Wales Blood Derived Products Contract.	Start: 01/05/2024 End: 30/04/2027 Option to extend: 12 month extension	£165,295
Appendix 3	NHS Wales Shared Services Partnership	Primary Care Services	Start: 18/02/2024 End: 17/02/2027 Option to extend: N/A	£266,000
Appendix 4	NHS Wales Shared Services Partnership	Health Courier Services – Vehicle Replacement Programme	Start: 01/12/2023 End: 30/11/2026 Option to extend: Two x 12 months Optional Extensions.	£2,364,000

3 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)	06 - Quality and Safety

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - ***Further details are provided in Appendix 1-4 of this report***
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required, undertaken on a case by case basis, as part of the procurement process.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	If applicable, as identified in each case as part of the service design/procurement process.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	PROVISION OF ONCOTYPE TESTING
DIVISION / HOST ORGANISATION	VCC
DATE PREPARED	20th September 2023
PREPARED BY	Sophie Stacey, Senior Procurement Business Manager
SCHEME SPONSOR	David Osbourne, Head of Finance Business Partnering

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The Oncotype DX Breast Recurrence Score Test analyses the activity of a group of genes that can affect how an early-stage breast cancer is likely to behave and respond to treatment. The Oncotype DX Breast Recurrence Score Test is used in two ways:

- to help doctors figure out a person's risk of early-stage, estrogen-receptor-positive breast cancer coming back in a part of the body away from the breast (distant recurrence)
- to help figure out if a person will benefit from chemotherapy

The results of the Oncotype DX Breast Recurrence Score Test, combined with other features of the cancer, can help patients make a more informed decision about whether or not to have chemotherapy to treat early-stage, hormone-receptor-positive, HER2-negative breast cancer.

Therefore, the Oncotype DX Breast Recurrence Score Test is both a prognostic test, since it provides more information about how likely (or unlikely) the breast cancer is to come back, and a predictive test, since it predicts the likelihood of benefit from chemotherapy or radiation therapy treatment. Studies have shown that Oncotype DX Breast Recurrence Score Test is useful for both purposes.

The current contract provision is in place until 30th November 2023. This paper is to request approval to renew the contract with the incumbent supplier for a further 2 years with an option to extend for a further 12 months.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/12/2023
Expected End Date of Contract	30/11/2025
Contract Extension Options **(E.g. maximum term in months)**	12 months (01/12/2025-30/11/2026)

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

If not, please explain the reason for this in the space provided.

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Currently there is only one provider, Exact Sciences, that can provide Oncotype Testing. The Trust were advised by the Cancer Network that there were no alternative providers in a position to supply the services required. In addition, the NHSSC Framework confirmed that Exact Sciences are the only supplier awarded to the current framework that can provide breast cancer assays.

Other providers are considering entering into the market to supply the test and Cardiff & Vale UHB were also considering establishing a Oncotype testing service, however, none of these alternative suppliers are yet included on the Framework or in the position to supply.

The options for the Trust to consider are as follows;
Option 1 - Do Nothing – If the contract is not renewed then the Trust would no longer be able to offer breast cancer patients this test.
Option 2 – Approve a new contract for 2 years plus a one year extension option
Procurement Recommendation
Procurement Services recommend option 2 as this will allow the Trust to provide continuity of services whilst allowing the market to develop in its maturity and hopefully ensuring a more competitive process in the next two years.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

Oncotype DX testing, together with other prognostic tests, can help the medics determine how a patients' cancer will act and whether the benefits of chemotherapy or radiation therapy outweigh the side effects and costs. The test score can be interpreted with other markers such as age and tumor grade and size.

Studies have reported Oncotype DX testing altering the decision to administer chemotherapy in as many as 30% of doctors treating people with ER-positive and HER2-negative breast cancer.

Oncotype DX testing may be most beneficial for people with medium-risk cancer, where it's unclear if chemotherapy or radiation therapy would increase the chances of survival.

In the large TAILORx clinical trial, researchers compared the benefit of chemotherapy guided by gene testing in a group of 9,719 women with ER-positive and HER2-negative breast cancer. In women over age 50 with medium Oncotype DX scores, the researchers found no significant difference in overall survival between women who:

- received hormone therapy alone
- received hormone therapy and chemotherapy together

The researchers found some benefit of adding chemotherapy to treatment in women under age 50 with a medium score.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
The risks associated by not renewing the contract will lead to patients with early-stage, hormone-receptor-positive, HER2-negative breast cancer being treated with chemotherapy unnecessarily.	There is no mitigation to not providing this test. Potentially up to 30% patients with early-stage, hormone-receptor-positive, HER2-negative breast cancer will undergo SACT treatment with no significant benefit in overall survival .

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.

Competition		Single source	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

Direct award via NHS Supply Chain Pathology and Point of Care Testing, Associated Equipment, Instruments, Consumables and Accessories and Managed Services (2019/S 212-519575) Framework will be awarded to Exact Science for a period of 2+1 years.

6.3 What is the approximate time line for procurement?

Procurement Services have engaged with NHSSC Framework and received a renewal quote from the incumbent supplier, Exact Sciences. Exact Sciences have agreed to hold the current cost per test at £1350 for further two years. The renewal of this contract poses no cost pressures to the Trust.

The new contract will be awarded by 1st December 2023.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Emma Lane (Assistant Head of Operational Procurement)
Signature:	E Lane On behalf of Claire Salisbury, Assistant Director of Procurement Services and Executive Procurement Lead, C&V
Date:	28/09/2023

Maximum expected whole life cost relating to the award of contract	**£854,550.00 Excluding VAT (£k)** ***This includes the extension option**	**£1,025,460.00 Including VAT (£k)**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Cost Per Test	Annual Value (exc. VAT) £k	Total (2+1 Years) (exc.VAT) £k	Total (2+1 Years) (inc. VAT) £k
Overall Total	£1350.00	£284,850.00	£854,550.00	£1,025,460.00

Please note that the annual value has been determined based on estimated annual usage of 211 tests. The cost per test has not increased from previous years, resulting in no cost pressures.

Laboratory services including testing are VAT exempt. The VAT accounting will be confirmed.

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	N/A This test is part of VCS clinical pathways and standard service offering. There are no specific management arrangements required.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Matthew Bunce
Signature:	MBunce
Service Area:	Finance
Date:	28th September 2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
EMB RUN	02/10/2023

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	RENEWAL OF ALL WALES BLOOD DERIVED PRODUCTS CONTRACT
DIVISION / HOST ORGANISATION	WELSH BLOOD SERVICE
DATE PREPARED	19/09/2023
PREPARED BY	CERI WHITE
SCHEME SPONSOR	ALAN PROSSER

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Provision of Blood Derived Medicinal Products

The Welsh Blood Service (WBS) holds a Wholesale Distribution Authorisation Licence (WDA) and acts as the wholesaler for blood derived medicinal products for all of Wales. The supply of blood derived commercial products is managed by the All-Wales Human Blood Derived contract PAD-OJEU-43181.

This contract will expire on 30/04/2024 and is therefore being reviewed.

Blood derived medicinal products covered by this contract, are either held by WBS as stock or ordered on an ad hoc request basis to cover specific patient needs.

How stock holding of Blood Derived Medicinal products are managed.

For blood derived medicinal products held at WBS as stock, the minimum holding is based on a calculation incorporating the average monthly issuing quantity, along with an additional quantity to ensure resilience. As the monthly average in calculated over a 12-month period, ensuring WBS hold sufficient stock to supply hospitals when requests exceed the average must also be considered. Therefore, with most calculations, the target stock holding is calculated at 1.5 or 2 months. This also provides WBS with sufficient resilience to ensure patient demand is met, should the suppliers inform of potential delays.

The Human Blood Derived Products Contract contains IV and Subcutaneous Immunoglobulin products whereby the provision of such products for patients in Wales is closely managed by

the All Wales Immunoglobulin Strategy Group (WBS representatives form part of this Strategy Group). These products are required for the long term management of many Immune-related conditions. The strategy group provides detailed advice to the clinical areas on the administration of these products via the Product Selection Guide.

Procurement and Distribution of Blood Derived Medicinal Products

WBS procure the Blood Derived Medicinal Products monthly on behalf of the Hospital Blood Banks, Pharmacies and Haemophilia Centre's. Order for the products is then requested and distributed via the Hospital Services department. There is no limit to their ordering capacity and is solely based on patient demand.

WBS then invoice the requesting Hospital Blood banks, Pharmacies and Haemophilia centres' for the products they have ordered.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/05/2024
Expected End Date of Contract	30/04/2027
Contract Extension Options **(E.g. maximum term in months)**	12

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐

Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☒
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
If not, please explain the reason for this in the space provided.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES

This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information									
Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Alternative Option WBS could dissolve the All Wales Human Blood Derived Products contract and request incorporation into the CMU Framework. However, as a separate contract, Wales have the ability to negotiate pricing and product allocation, separately from other Nations. Incorporating into the CMU Framework this would prevent the All Wales Immunoglobulin Strategy Group from managing patients IV/ SC Immunoglobulin treatments in Wales independently. **Do nothing** If WBS do nothing the contracts will expire and prevent purchase of the Blood Derived Medicinal Products covered by the contract. This would result in the depletion of current stock holding, prevention of future procurement and the inability to supply Welsh patients with lifesaving medicinal products.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
- Continued procurement of Human Blood Derived commercial products managed within Wales ensuring proficient and prudent healthcare support for patients throughout Wales. - WBS can more actively negotiate product allocations with suppliers as the contract is specific to Wales. - Ensures resilience of product availability. - Assists in more individualized management of patients within Wales.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Inability to supply Welsh Health Boards with products covered by the All-Wales Human Blood Derived Products contract.	Incorporation into the CMU equivalent of the Human Blood Derived Products Framework for other UK Nations. There would be an initial delay in procurement of these products in the interim.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.

Competition		Single source	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☒	All Wales contract	☒

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

It is the recommendation of Procurement Services that a competitive Find a Tender Service (FTS) tender be undertaken by means of Open procedure. The upcoming agreement will be for a 3-year period with an option for a 1-year extension, this will allow for a period of stability

and provide the flexibility to take advantage of any changes in market conditions should they arise. It is the intention to put in place Framework Agreement which will allow for multiple suppliers to be awarded, to ensure that all suitable product options are available to the clinicians in each Health Board.
6.3 What is the approximate time line for procurement?
Following approval of the Procurement Services Briefing Paper (by week commencing 13th November) and the Trust Board Paper (meeting 30th November), it is the intention to publish the tender by 01/12/2023. This will allow the tender to be evaluated and the appropriate award governance sought prior to the planned start date of 01/05/2024.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Wyn Owens
Signature:	W.Owens
Date:	04/10/23

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £165,295	**Including VAT (£k)** N/A
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		

If you have selected 'Other' – please provide further details below:

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (12 month extention) (exc. VAT) £k	Total Expenditure if all 4 years are invoked (exc.VAT) £k	Total (inc. VAT) £k
Human Blood Derived Products	£35,616	£39,178	£43,096	£47,405	£165,295	n/a
Overall Total	£35,616	£39,178	£43,096	£47,405	£165,295	n/a

Note: A 10% increase in yearly expenditure has been incorporated based on projected increases in demand. All products on contract are exempt from VAT.

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	N/A

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	ALAN PROSSER
Signature:	
Service Area:	WELSH BLOOD SERVICE
Date:	24/10/2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
WBS Finance and Procurement Planning Group	20/10/2023
Divisional Senior Management Team	11/10/2023
Executive Management Board	
Trust Board Meeting	

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	
HTW – Senior Management Team	

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	PRIMARY CARE SERVICES (PCS) - PROVISION OF MFD'S AND PPD'S
DIVISION / HOST ORGANISATION	NWSSP – Primary Care Services
DATE PREPARED	9th November 2023
PREPARED BY	Ed Evans, Primary Care Services
SCHEME SPONSOR	Andrew Evans, Director of Primary Care Services

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The purpose of the contract is intended to provide replacement Multi-Functional Devices (MFD's) and Professional Printing Devices (PPD'S) which will be located across NWSSP PCS sites across Wales. The three locations are, Cwmbran House, Alder House, and Brecon House. Additionally, three Professional Printing Devices (PPD's) are also required, the location of all three printers will be at Cwmbran House, Mamhilad. The service currently leases two colour printers and one mono printer which will be the requirement going forward.

The current MFD's and PPD's have been used to support Primary Care Services (PCS) with their printing and scanning needs. PCS is reliant on these devices' as they enable the service to conveniently print and scan key documents and produce publications on mass for patients and staff.

The ICT & OE sourcing team took over the management of the MFD's and PPD's in August 2022. Due to limited time and resource the machines have been on a 6-month rolling contract with Konica with no secure agreement in place.

To best deliver value for money the team are now looking to address the MFD's and PPD's position by securing a 3-year contract through a mini competition. Two frameworks were assessed with the superior framework being hosted by Crown Commercial Services, 'RM6174 - Lot 2', which provided more competitive pricing when compared to Welsh Governments, National Procurement Services, 'NPS-ICT-0104-20'. A further review of MFD's has recently been undertaken, reducing PCS's requirement by 3 copiers utilising 2 surplus copiers from NWSSP Companies House.						
1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	18/02/2024
Expected End Date of Contract	17/02/2027
Contract Extension Options **(E.g. maximum term in months)**	N/a

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐

Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
If not, please explain the reason for this in the space provided.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES

This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Do Nothing - Unable to provide an All Wales print service to stakeholders, Health Boards, customers and internal printing requirements

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
To continue to provide an All-Wales print service to stakeholders, Health Boards, customers and internal printing requirements with modern up to date printing equipment.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
No capacity for service growth or development, service costs will grow overtime due to inefficiencies. Unable to provide an All-Wales print service to stakeholders, Health Boards, customers and undertake internal NHS printing requirements.	N/a

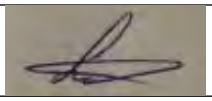
6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☒	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			

6.2 Please outline the procurement strategy
Two frameworks were assessed with the superior framework being Crown Commercial Service (CCS) 'RM6174' Lot 2, which provided more competitive pricing when compared to the Welsh Government's - National Procurement Service (NPS) 'NPS-ICT-0104-20'. A mini competition was published on Bravo which contained two specifications (one for MFD's and one for PPD's), as well as a commercial response template. The specification outlined the stakeholder's requirements for the machines, and the commercial response contained a pricing template where the bidder could state their costs. The costs were to capture rental charge and estimated copy charges (black and colour). The winning bidder was solely based on price once it was established that the suppliers proposed machines meet the stakeholder's requirements. A full ratification paper outlining the evaluation that took place is available upon request.

6.3 What is the approximate time line for procurement?	
Planning Approval	30/11/2023
Award Contract	01/12/2023
Contract Commencement	18/02/2024

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Lena Boghossian
Signature:	
Date:	14.11.2023

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k) £222**	**Including VAT (£k) £266**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Operational costs (met by existing budget)	74	74	74		222	266
Overall Total	74	74	74		222	266

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*N/a*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Andrew Evans
Signature:	
Service Area:	Primary Care Services
Date:	13/11/23

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	N/A
Divisional Senior Management Team	N/A
Executive Management Board	N/A

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	23 November 2023
HTW – Senior Management Team	

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	HEALTH COURIER SERVICE – VEHICLE REPLACEMENT PROGRAMME
DIVISION / HOST ORGANISATION	NWSSP - Health Courier Services and Supply Chain
DATE PREPARED	14th November 2023
PREPARED BY	Gregg Roberts, NWSSP Procurement
SCHEME SPONSOR	Tony Chatfield, National Clinical Logistics Manager, NWSSP

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Contract for the Lease of Heavy Goods Vehicles (HGV's) used in the Distribution of NHS Wales Supply Chain and Consumables, and for its Laundry Service. Existing contract for the old HGV Fleet is expiring, and this opportunity allows us to replace/add to those vehicles with more modern lower emission vehicles.

HCS vehicle replacement programme covers a total of 15 vehicles and is as follows:

- 12 x 15t/16t Chassis with Shorter Box Body Conversions in line with the set specification
- 3 x 18t Longer Box Body Conversions to required Standard in line with the set specification to include capability for the engine to operate on HVO/Bio Diesel

Suppliers have also been asked to provide indicative pricing for

- 2 x 22ft Box Conversations

to operate on Alternative Fuels with options to include:

- Bio Gas
- Hydrogen/Hydrogen Cell
- Electric

1.1 Nature of contract:						

Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/12/2023
Expected End Date of Contract	30/11/2026
Contract Extension Options **(E.g. maximum term in months)**	Two x 12 months Optional Extensions.

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☐

If not, please explain the reason for this in the space provided.

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Other frameworks were considered and investigated but they were either a single supplier or pointed back to the CCS framework, which is what we used.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Benefits of the replacement fleet, include: • More Modern Powered Vehicles, capable of operating with reduced emissions and also capable of operating on alternative fuel (HVO); • Larger Body Vehicles for larger loads, helping reduce the number of journeys required; • Standardisation of the HGV's utilised in Laundry Services in line with NWSSP's Fleet; and • Improved Vehicle Design, to improve staff environment and reduce handling.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Requirement to find alternate route to market or outsourcing of staff/service.	Non-Approval will mean the need to use short term hire arrangements which will: 1. Cost Significantly more 2. Still require recording under IFRS16 to meet financial governance 3. Risk ability to deliver the service if Hire Fleet isn't available

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☒	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

Crown Commercial Services (CCS) RM6268 Lot 2b - Lease of commercial vehicles 7.5 tons was the preferred option due to the scope of the framework. A mini competition was published on Bravo which contained the specification requirement, as well as a commercial response template. The specification outlined the stakeholders' requirements for the vehicles and the commercial response contained a pricing template where the bidder could include their costs. Costs were captured for both monthly rental charge and any additional option, for example extended warranty on the vehicles. The winning (and only) bidder was based on a combined technical and commercial outcome, ensuring that the supplier could meet the technical requirement of the vehicles.

6.3 What is the approximate time line for procurement?

Briefing paper / Estimates return – September 2023
Further Competition Issue – September 2023
Tender Return – October 2023
Evaluation – October 2023
Ratifications Out / Return – October 2023
Award Approval – November 2023
Welsh Government Notification – November 2023
Publish Award – November 2023

Contract Start – November 2023

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Wyn Owens
Signature:	W.Owens
Date:	14.11.23

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £1,970	**Including VAT (£k)** £2,364
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Operational Cost	394	394	394	788	1,970	2,364

Overall Total	394	394	394	788	1,970	2,364

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*N/A*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Jonathan Irvine
Signature:	
Service Area:	Procurement Services
Date:	17.11.23

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	N/A
Divisional Senior Management Team	N/A
Executive Management Board	N/A

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	23 November 2023
HTW – Senior Management Team	N/A

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	30th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	**CONSIDER** and **ENDORSE**

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	This report details Chair's Urgent Action taken between the **20/09/2023** – **22/11/2023**. • 4 urgent items of business for the Trust Board were considered via Chairs Urgent Action during this period:- 1. Signing of Lease – Du Pont & Cwmbran Buildings, Mamhilad. 2. Storage & Restoration of Health Records Held in Freezer Storage at Harwell Restoration Ltd. 3. Cardiff & Vale University Health Board Utilities Deed of Variation. 4. Provision of an Electronic Quality Management System • No objections to approval were received in respect of the items of business considered.

	• A number of queries were raised and subsequently addressed, these are detailed in the report.

RECOMMENDATION / ACTIONS	To **CONSIDER** and **ENDORSE** the Chairs Urgent Action taken between the **20/09/2023** – **22/11/2023.**

GOVERNANCE ROUTE	
Trust Board Members – Via Email	**19/10/2023**: Signing of Lease – Du Pont & Cwmbran Buildings, Mamhilad.
Trust Board Members – Via Email	**19/10/2023:** Storage & Restoration of Health Records Held in Freezer Storage at Harwell Restoration Ltd.
Trust Board Members – Via Email	**19/10/2023:** Cardiff & Vale University Health Board Utilities Deed of Variation.
Trust Board Members – Via Email	**19/10/2023:** Provision of an Electronic Quality Management System
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Trust Board **APPROVED** each item of business considered via Chairs Urgent Action.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES – N/A

1. SITUATION

This paper provides the Trust Board with an overview of key decisions and outcomes considered via Chairs Urgent Action between the **20/09/2023** – **22/11/2023**.

2. BACKGROUND

2.1 In accordance with the 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.

2.2 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.

3.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following is a summary of the key outcomes from the items of business considered by the Trust Board via Chairs Urgent Action since the last formal meeting of the Trust Board at the end of September 2023:

3.1.1 Signing of Lease – Du Pont & Cwmbran Buildings, Mamhilad:

The Trust Board were sent an email and Chair's Urgent Action Report on the **19/10/2023** regarding the Signing of Lease – Du Pont & Cwmbran Buildings, Mamhilad for NHS Wales Shared Services Partnership (NWSSP) that required urgent approval.

The Trust Board were asked to:

- To **APPROVE** the signing of the lease for the renewal of the arrangement for the Cwmbran Building.

- To **APPROVE** entering into a new lease on the Du Pont building to replace the previous arrangement for Brecon House.

In response to a query raised, it was subsequently confirmed that the other buildings on the Mamhilad Estate had been checked for Reinforced autoclaved aerated concrete (RAAC) and none found.

Following satisfactory confirmation and assurance provided the below approvals were received:

Recommendation Approved by:

- Donna Mead OBE, Trust Chair
- Steve Ham, CEO
- Stephen, Harries, Vice Chair
- Vicky Morris, Independent Member
- Professor Andrew Westwell
- Matthew Bunce, Executive Director of Finance

3.1.2 Storage & Restoration of Health Records Held in Freezer Storage at Harwell Restoration Ltd.

The Trust Board were sent an email and Chair's Urgent Action Report on the **19/10/2023** regarding the Storage & Restoration of Health Records Held in Freezer Storage at Harwell Restoration Ltd that required urgent approval.

The Trust Board were asked to:

- To **AUTHORISE** the Chief Executive to **APPROVE** the financial commitment to be awarded as summarised within the attached papers and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements where appropriate.

There were no queries raised and the following approvals were received:

Recommendation Approved by:

- Donna Mead OBE, Trust Chair
- Steve Ham, CEO
- Stephen, Harries, Vice Chair
- Vicky Morris, Independent Member
- Professor Andrew Westwell
- Matthew Bunce, Executive Director of Finance

3.1.3 Cardiff & Vale University Health Board (CVUHB) Utilities Deed of Variation

Further to the discussion at the September Trust Board, the Trust Board were sent an email and Chair's Urgent Action Report on the **19/10/2023** regarding the CVUHB Deed of Variation that required urgent approval.

The Trust Board were asked to:

- To **APPROVE** that the Trust enters into a Deed of Variation with C&VUHB.

- To **DELEGATE** the signing and sealing of the legal agreement to the Chair and CEO.

There were no queries raised and the following approvals were received:

Recommendation Approved by:

- Donna Mead OBE, Trust Chair
- Steve Ham, CEO
- Stephen, Harries, Vice Chair
- Vicky Morris, Independent Member

- Professor Andrew Westwell
- Matthew Bunce, Executive Director of Finance

3.1.4 Provision of an Electronic Quality Management System

The Trust Board were sent an email and Chair's Urgent Action Report on the **19/10/2023** regarding the provision of an Electronic Quality Management System that required urgent approval.

The Trust Board were asked to:

- To **AUTHORISE** the Chief Executive to **APPROVE** the financial commitment to be awarded as summarised within the attached paper and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements where appropriate.

There were no queries raised and the following approvals were received:

Recommendation Approved by:

- Donna Mead OBE, Trust Chair
- Steve Ham, CEO
- Stephen, Harries, Vice Chair
- Vicky Morris, Independent Member
- Professor Andrew Westwell
- Matthew Bunce, Executive Director of Finance

3 IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	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.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial impact was captured within the documentation considered by the Board.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

REVISIONS TO THE MODEL STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS FOR NHS TRUSTS; AND MODEL STANDING FINANCIAL INSTRUCTIONS

DATE OF MEETING	30/11/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	This report advises the Trust Board of: • The further revisions to the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales have been undertaken by Welsh Government. The changes are: a) Linked to the establishment of **Llais (Citizen Voice Body)**.

	b) Linked to **Notifying and equipping Board members**, the number of calendar days for Board members to be sent an agenda and a complete set of supporting papers **has reduced to 7 calendar days** before a formal Board meeting. • The Welsh Government review of the Model Standing Financial Instructions, which are Schedule 2.1 of the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales. The changes are: c) Updated hyperlinks for the Governance e-Manual, which is now on the NHS Wales Shared Services Partnership external website. d) Updated contact information for Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. e) Update to 6.2 in relation to the Chief Executive responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement. f) Updated Schedule 1 – Revised General Consent to Enter Individual Contracts. • The Charitable Funds Committee and Audit Committee endorsement of the: g) Revisions to the Financial Limits in relation to the Trust's Charitable Funds, as follows: a. Increase the delegated approval limit for both the Chief Executive and Executive Director of Finance to £25,000. b. The entry level at which approval from the Charitable Funds Committee is required increases from £5,000 to £25,001.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Model Standing Financial Instructions.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run	02/10.2023
Charitable Funds Committee	07/09/2023
Audit Committee	16/10/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board **ENDORSED** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Model Standing Financial Instructions for submission to the Audit Committee for endorsement to submit to the Trust Board for approval.

The Charitable Funds Committee **ENDORSED** for submission to the Audit Committee, the following revisions to the Financial Limits in Schedule 1 Model Scheme of Reservation and Delegation Powers as follows:

- To Increase the Trust's Charitable Funds delegated approval limit for both the Chief Executive and Executive Director of finance to £25,000.
- The entry level at which approval from the Charitable Funds Committee is required increases from £5,000 to £25,001.
- To specifically write into the Trust's Charitable Funds Procedure for the Scheme of Delegation and Stages for the Purchasing and Authorisation of Good and Services (CFC01) that if any pre-approved project expenditure exceeds approval but is less than 10% of the original project cost **AND** no greater than £10,000, then approval can be sought from either the Chief Executive or Executive Director of Finance. If the additional spend is greater than either of these limits, then approval will be required from the Charitable Funds Committee.

The Audit Committee **ENDORSED:**

- The following revisions to the Financial Limits in Schedule 1 Model Scheme of Reservation and Delegation Powers as follows:
  - To increase the Trust's Charitable Funds delegated approval limit for both the Chief Executive and Executive Director of finance to £25,000.
  - The entry level at which approval from the Charitable Funds Committee is required increases from £5,000 to £25,001.
  - To specifically write into the Trust's Charitable Funds Procedure for the Scheme of Delegation and Stages for the Purchasing and Authorisation of Good and Services (CFC01) that if any pre-approved project expenditure exceeds approval but is less than 10% of the original project cost **AND** no greater than £10,000, then approval can be sought from either the Chief Executive or Executive Director of Finance. If the additional spend is greater than either of these limits, then approval will be required from the Charitable Funds Committee.

- For the Trust Board to **APPROVE** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and revised Model Standing Financial Instructions.

7 LEVELS OF ASSURANCE - N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1	Revised Model Standing Orders, Reservation and Delegation of Powers for Velindre University NHS Trust
Appendix 2	Schedule 1 Revised Model Scheme of Reservation and Delegation of Powers
Appendix 3	Schedule 2 Key Guidance, Instructions and Other Related Documents
Appendix 4	Schedule 3 Board Committee Arrangements
Appendix 5	Schedule 4 Advisory Groups Terms of Reference and Operating Arrangements

1. SITUATION

Velindre University National Health Service Trust is a statutory body that came into existence on 1st December 1993 under the Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838), as amended, "the Establishment Order".

Velindre University NHS Trust has a duty under Regulation 19(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990 to make Standing Orders for the regulation of their proceedings and business. It is important to note that the Trust is able to vary or suspend its own Standing Orders, providing that it is able to satisfy that it complies with the relevant regulations.

2. BACKGROUND

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales. All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

3. ASSESSMENT

The Welsh Government has undertaken further revisions to the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales, since they were presented to the Trust Board in July 2023.

The changes are:

a) Linked to the establishment of **Llais (Citizen Voice Body)**;
b) Linked to **Notifying and equipping Board members**, the number of calendar days for Board members to be sent an agenda and a complete set of supporting papers **has reduced to 7 calendar days** before a formal Board meeting.

The Welsh Government has also undertaken a review of the Model Standing Financial Instructions, which are Schedule 2.1 of the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales.

The changes are:

c) Updated hyperlinks for the Governance e-Manual which is now on the NHS Wales Shared Services Partnership external website.
d) Updated contact information for Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts.
e) Update to 6.2 in relation to the Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.
f) Updated Schedule 1 – Revised General Consent to Enter Individual Contracts.

The Charitable Funds Committee at its meeting held on 7th September 2023 considered and endorsed the following revisions to the Financial Limits in relation to Trust's Charitable Funds, as follows:

g) Increase the delegated approval limit for both the Chief Executive and Executive Director of Finance to £25,000.
h) The entry level at which approval from the Charitable Funds Committee is required increases from £5,000 to £25,001.

The Audit Committee at its meeting on 19th October 2023 endorsed the revisions to the Financial Limits as outlined above and the revisions to both the model Standing Orders and Model Standing Financial Instructions for approval by the Trust Board.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to **APPROVE** the adoption of the revised Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Model Standing Financial Instructions.

Following Trust Board approval, these changes will be enacted with immediate effect and published on the Trust website.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.

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

6. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

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

Model Standing Orders

Reservation and Delegation of Powers

Velindre University NHS Trust

Foreword

These Model Standing Orders are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. National Health Service Trusts ("NHS Trusts") in Wales must agree Standing Orders (SOs) for the regulation of their proceedings and business. When agreeing SOs Trusts must ensure they are made in accordance with directions as may be issued by Welsh Ministers.

They are designed to translate the statutory requirements set out in the National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024) as amended] into day to day operating practice, and, together with the adoption of a Schedule of decisions reserved to the Board of directors; a Scheme of decisions to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework GC03 Standards of Behaviour Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Trust's Director of Corporate Governance will be able to provide further advice and guidance on any aspect of the Standing Orders or the wider governance arrangements within the Trust.

Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/.

Contents

Section A – Introduction

Statutory framework

i) Velindre University National Health Service Trust ("the Trust") is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838),** as amended, "the Establishment Order".]

ii) The principal place of business of the Trust is –
Velindre University NHS Trust Headquarters, 2 Charnwood Court, Parc Nantgarw, Cardiff, CF15 7QZ

iii) All business shall be conducted in the name of Velindre University National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee.

iv) NHS Trusts are corporate bodies and their functions must be carried out in accordance with their statutory powers and duties. Their statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

v) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (S.I. 1990/2024)**, as amended ("the Membership Regulations") set out the membership and procedural arrangements of the Trust.

vi) Sections 18 and 19 of and Schedule 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give directions about how they exercise those functions. NHS Trusts must act in accordance with those directions. The NHS Trust's main statutory functions are set out in their Establishment Order, but additional functions may also be contained in other legislation, such as the NHS (Wales) Act 2006.

vii) **The Health and Social Care (Quality and Engagement) (Wales) Act 2020 (2020 asc 1)** (the 2020 Act) makes provision for:

- Ensuring NHS bodies and ministers consider how their decisions will secure an improvement in the quality of health services (the Duty of Quality);
- Ensuring NHS bodies and primary care services are open and honest with patients, when something may have gone wrong in their care (the Duty of Candour);
- The creation of a new Citizens Voice Body for Health and Social Care, Wales (to be known as Llais) to represent the views of and advocate for people across health and social care in respect of complaints about services; and
- The appointment of statutory vice-chairs for NHS Trusts.

The act has been commenced at various stages with the final provision, relating to the preparation and publication of a code of practice regarding access to premises coming into effect in June 2023.

NHS Trusts will need ensure they comply with the provisions of the 2020 Act and the requirements of the statutory guidance.

The Duty of Quality statutory guidance 2023 can be found at https://www.gov.wales/duty-quality-healthcare

The NHS Duty of Candour statutory guidance 2023 can be found at https://www.gov.wales/duty-candour-statutory-guidance-2023

viii) The Well-being of Future Generations (Wales) Act 2015 also places duties on LHBs and some Trusts in Wales. Sustainable development in the context of the Act means the process of improving economic, social, environmental and cultural well-being of Wales by taking action, in accordance with the sustainable development principle, aimed at achieving the well-being goals.

ix) In exercising their powers NHS Trusts must be clear about the statutory basis for exercising such powers.

x) In addition to directions the Welsh Ministers may from time to time issue guidance which NHS Trusts must take into account when exercising any function.

xi) NHS Trusts work closely with the seven Local Health Boards (LHBs) in Wales. The chief executive of the Trust is an associate member of the following joint committees of the LHBs:

- The Welsh Health Specialised Services Committee, and
- The Emergency Ambulance Service Committee.

xii) **The Welsh Health Specialised Services Committee (Wales) Directions 2009 (2009/35)** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of specialised and tertiary services and for the purpose of jointly exercising those functions will establish the Welsh Health Specialised Services Committee ("WHSSC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Welsh Health Specialised Services Committee (Wales) Regulations 2009 (S.I. 2009/3097)** which make provision for the constitution and membership of the WHSSC including its procedures and administrative arrangements.

xiii) **The Emergency Ambulance Services Committee (Wales) Directions 2014 (2014/8 (W.08))** as amended by the **Emergency Ambulance Services (Wales) Amendment Directions 2016 (2016/8 (W.8))** provide that the seven LHBs in Wales will work jointly to exercise functions relating to the planning and securing of emergency ambulance services and for the purpose of jointly exercising those functions will establish the Emergency Ambulance Services Committee ("EASC"). Under powers set out in paragraph 4 of Schedule 2 to the NHS (Wales) Act 2006, the Minister has made **The Emergency Ambulance Services Committee (Wales) Regulations 2014 (2014/566)** which make provision for the constitution and membership of the EASC including its procedures and administrative arrangements.

xiv) **The Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012) (as amended) require the Trust to establish a Shared Services Committee and prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

xv) **The National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993)** have effect as made under section 33 of the NHS (Wales) Act 2006 enable LHBs, NHS Trusts and Local Authorities to enter into any partnership arrangements to exercise certain NHS functions and health-related functions as specified in the Regulations. The arrangement can only be made if it is likely to lead to an improvement in the way in which NHS functions and health-related functions are exercised, and the partners have consulted jointly with all affected parties, and the arrangements fulfil the objectives set out in the Area Plan developed in accordance with the **Social Services and Well-being (Wales) Act 2014.**

xvi) Section 72 of the NHS Act 2006 places a duty on NHS bodies to co-operate with each other in exercising their functions. NHS bodies includes

NHS bodies in England such as the NHS Commissioning Board, NHS Trust and NHS Foundation Trust and, for the purposes of this duty, also includes bodies such as NICE, the Health and Social Care Information Centre and Health Education England.

xvii) Section 82 of the NHS Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

xviii) The Welsh Language (Wales) Measure 2011 makes provision with regard to the development of standards of conduct relating to the Welsh Language. These standards replace the requirement for a Welsh Language Scheme previously provided for Section 5 of the Welsh Language Act 1993. The Welsh Language Standards (No.7) Regulations 2018 (2018/411) came into force on the 29 June 2018 and specifies standards in relation to the conduct of NHS Trusts. The Trust will ensure that it has arrangements in place to meet those standards which the Welsh Language Commissioner has required by way of a compliance notice under section 44 of the 2011 Measure.

xix) Paragraph 18 of Schedule 3 to the NHS (Wales) Act 2006 provides for NHS Trusts to enter into arrangements for the carrying out, on such terms as considered appropriate, of any of its functions jointly with any Strategic Health Authority, Local Health Board or other NHS Trust, or any other body or individual.

xx) NHS Trusts are also bound by any other statutes and legal provisions which govern the way they do business. The powers of NHS Trusts established under statute shall be exercised by NHS Trusts meeting in public session, except as otherwise provided by these SOs.

NHS framework

xxi) In addition to the statutory requirements set out above, NHS Trusts must carry out all business in a manner that enables them to contribute fully to the achievement of the Welsh Government's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Welsh Government's Citizen Centred Governance principles. These principles provide the framework for good governance and embody the values and standards of behaviour that are expected at all levels of the service, locally and nationally.

xxii) Adoption of the principles will better equip NHS Trusts to take a balanced, holistic view of their organisations and their capacity to deliver high quality, safe healthcare services for all its citizens within the NHS framework set nationally.

xxiii) The overarching NHS governance and accountability framework incorporates these SOs; the Scheme of Reservation and Delegation of Powers; SFIs together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework*; the Health and Care Quality Standards 2023, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

* The NHS Wales Values and Standards of Behaviour Framework can be accessed via the following link: https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/living-public-service-values/values-and-standards-of-behaviour-framework/

xxiv) The Welsh Ministers, reflecting their constitutional obligations, and legal duties under the **Well-being of Future Generations (Wales) Act 2015 (2015/2)**, have stated that sustainable development should be the central organising principle for the public sector and a core objective for the NHS in all it does.

The Trust is considered a public body under the Act.

xxv) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of NHS Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

NHS Trust framework

xxvi) Schedule 2 provides details of the key documents that, together with these SOs, make up the NHS Trust's governance and accountability framework. These documents must be read in conjunction with these SOs and will have the same effect as if the details within them were incorporated within the SOs themselves. The Standing Financial Instructions form Schedule 2.1 of these SOs.

xxvii) NHS Trusts will from time to time agree and approve policy statements which apply to the Trust's Board of directors and/or all or specific groups of staff employed by Velindre National Health Service Trust and others. The decisions to approve these policies will be recorded and, where appropriate, will also be considered to be an integral part of the Trust's SOs and SFIs. *Details of the Trust's key policy statements are also included in Schedule 2.*

xxviii) NHS Trusts shall ensure that an official is designated to undertake the role of the Director of Corporate Governance (the role of which is set out in paragraph xxxvi) below).

xxix) For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors shall be referred to as Executive Directors and Independent Members respectively; and the Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance – SO 1.1.2 refers.

Applying Standing Orders

xxx) The SOs of NHS Trusts (together with SFIs and the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy), will, as far as they are applicable, also apply to meetings of any formal Committees established by the Trust, including any sub-Committees and Advisory Groups. These SOs may be amended or adapted for the Committees as appropriate, with the approval of the Board. *Further details on committees may be found in Schedule 3 of these SOs.*

xxxi) Full details of any non-compliance with these SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Corporate Governance, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non-compliance to the Director of Corporate Governance as soon as they are aware of any circumstance that has not previously been reported.

xxxii) **Ultimately, failure to comply with SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

Variation and amendment of Standing Orders

xxxiii) Although these SOs are subject to regular, annual review by the NHS Trust, there may, exceptionally, be an occasion where it is necessary to vary or amend the SOs during the year. In these circumstances, the Director of Corporate Governance shall advise the Board of the implications of any decision to vary or amend SOs, and such a decision may only be made if:

- The variation or amendment is in accordance with regulation 19] of the Membership Regulations and does not contravene a statutory provision or direction made by the Welsh Ministers;

- The proposed variation or amendment has been considered and approved by the Audit Committee and is the subject of a formal report to the Board; and

- A notice of motion under Standing Order 7.5.14 has been given.

Interpretation

xxxiv) During any Board meeting where there is doubt as to the applicability or interpretation of the SOs, the Chair of the Trust shall have the final say, provided that his or her decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair shall take appropriate advice from the Director of Corporate Governance and, where appropriate the Chief Executive or the Director of Finance (in the case of SFIs).

xxxv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SOs when interpreting any term or provision covered by legislation.

The role of the Director of Corporate Governance

xxxvi) The role of the Director of Corporate Governance is crucial to the ongoing development and maintenance of a strong governance framework within NHS Trusts, and is a key source of advice and support to the NHS Trust Chair and other Board members. Independent of the Board, the Director of Corporate Governance acts as the guardian of good governance within NHS Trusts. The Director of Corporate Governance is responsible for:

- Providing advice to the Board as a whole and to individual Board members on all aspects of governance;
- Facilitating the effective conduct of NHS Trust business through meetings of the Board, its Advisory Groups and Committees;
- Ensuring that Board members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- Ensuring that in all its dealings, the Board acts fairly, with integrity, and without prejudice or discrimination;
- Contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- Monitoring the NHS Trust compliance with the law, SOs and the governance and accountability framework set by the Welsh Ministers.

As advisor to the Board, the Director of Corporate Governance's role does not affect the specific responsibilities of Board members for governing the organisation. The Director of Corporate Governance is directly

accountable for the conduct of their role to the Chair in respect of matters relating to responsibilities of the Board, its Committees and Advisory Groups, and reports on a day to day basis to the Chief Executive with regard to the wider governance of the organisation and their personal responsibilities.

Further details on the role of the Director of Corporate Goverance within Velindre University NHS Trust, including details on how to contact them, is available from the Trust by contacting the Trust on 02920 196161 or visiting the Trust's public internet site.

Section B – Standing Orders

1. THE TRUST

1.0.1 The Trust's principal role is to:

(a) to own and manage Velindre Hospital, Velindre Road, Whitchurch, Cardiff CF4 7XL and associated hospitals and premises, and there to provide and manage hospital accommodation and services;

(b) to own and manage Welsh Blood Service Headquarters, Ely Valley Road, Talbot Green, Pontyclun CF72 9WB and associated premises, and there to provide and manage services relating to the collection, screening and processing of blood and its constituents and to the preparation and supply of blood, plasma and other blood products;

(c) services relating to prescribing and dispensing;

(d) to manage and provide Shared Services to the health service in Wales;

(e) to own or lease the premises associated with the provision of the services in paragraph (d), and

(f) to manage and administer the Wales Infected Blood Support Scheme in accordance with directions issued by the Welsh Ministers.

1.0.2 The Trust was established by, and its functions are contained in, the **Velindre National Health Service Trust (Establishment) Order 1993** (S.I. 1993/2838), as amended. The Trust must ensure that all its activities are in exercise of those functions or other statutory functions that are conferred on it.]

1.0.3 To fulfil this role, the Trust will work with all its partners and stakeholders in the best interests of its population.

1.1 Membership of the Trust

1.1.1 The membership of the Trust shall comprise the Chair, Vice-Chair, 6 non-executive directors and 6 executive directors.]

1.1.2 For the purposes of these SOs, the Trust Board of directors shall collectively to be known as "the Board" or "Board members"; the executive and non-executive directors (which will include the Chair) shall be referred to as Executive Directors and Independent Members respectively. The

Chief Officer and the Chief Finance Officer shall respectively be known as the Chief Executive and the Director of Finance. All such members shall have full voting rights.

1.1.3 The Minister for Health and Social Services shall appoint the Chair and non-officer members of the Trust.

1.1.4 The Trust will appoint a Committee whose members will be the Chair and non-executive directors of the Trust whose function will be to appoint the Chief Executive as a director of the Trust.

1.1.5 The Trust will appoint a Committee whose members will be the chair, the non-executive directors and the Chief Executive whose function will be to appoint the executive directors other than the Chief Executive.

Executive Directors

1.1.6 A total of 6, appointed by the relevant committee, and consisting of the Chief Executive, the Director of Finance, a medical or dental practitioner (to be known as the Medical Director), a registered nurse or registered midwife (to be known as the Nurse Director) and 2 others. Executive Directors may have other responsibilities as determined by the Board and set out in the scheme of delegation to officers.]

Non-executive directors [to be known as Independent Members]

1.1.7 A total of 6 (excluding the Chair and Vice-Chair) appointed by the Minister for Health and Social Services, which will include:

- A person appointed from Cardiff University.

1.1.8 In addition to the eligibility, disqualification, suspension and removal provisions contained within the Membership Regulations, an individual shall not normally serve concurrently as a non-officer member on the Board of more than one NHS body in Wales.

Use of the term 'Independent Members'

1.1.9 For the purposes of these SOs, use of the term 'Independent Members' refers to the following voting members of the Board:

- Chair
- Vice-Chair
- Non-Executive Directors

unless otherwise stated.

1.2 Joint Directors

1.2.1 Where a post of Executive Director of the Trust is shared between more than one person because of their being appointed jointly to a post:

(i) Either or both persons may attend and take part in Board meetings;
(ii) If both are present at a meeting they shall cast one vote if they agree;
(iii) In the case of disagreement, no vote shall be cast; and
(iv) The presence of both or one person will count as one person in relation to the quorum.

1.3 Tenure of Board members

1.3.1 The Chair and Independent Members appointed by the Minister for Health and Social Services shall be appointed as Trust members for a period specified by the Welsh Ministers, but for no longer than 4 years in any one term. These members can be reappointed. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term**.**]

1.3.2 Executive Directors' tenure of office as Board members will be determined by their contract of appointment.

1.3.3 All Board members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements, so far as they are applicable, as specified in the Membership Regulations. Any member must inform the Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office. The Chair will advise the Minister in writing of any such cases immediately.

1.3.4 The Trust will require Board members to confirm in writing their continued eligibility on an annual basis.

1.4 The Role of the Trust, its Board and responsibilities of individual members

Role

1.4.1 The principal role of the Trust is set out in SO 1.0.1. The Board's main role is to add value to the organisation through the exercise of strong leadership and control, including:

- Setting the organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims and objectives through

effective challenge and scrutiny of the Trust's performance across all areas of activity.

Responsibilities

1.4.2 The Board will function as a corporate decision-making body, Executive Directors and Independent Members being full and equal members and sharing corporate responsibility for all the decisions of the Board.

1.4.3 Independent Members who are appointed to bring a particular perspective, skill or area of expertise to the Board must do so in a balanced manner, ensuring that any opinion expressed is objective and based upon the best interests of the health service. Similarly, Board members must not place an over reliance on those individual members with specialist expertise to cover specific aspects of Board business and must be prepared to scrutinise and ask questions about any contribution that may be made by that member.

1.4.4 NHS Trusts shall issue an indemnity to any Chair and Independent Member in the following terms: "A Board [or Committee] member, who has acted honestly and in good faith, will not have to meet out of their personal resources any personal liability which is incurred in the execution of their Board function. Such cover excludes the reckless or those who have acted in bad faith".

1.4.5 All Board members must comply with their terms of appointment. They must equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes, engaging fully in Board activities and promoting the Trust within the communities it serves.

1.4.6 **The Chair** – The Chair is responsible for the effective operation of the Board, chairing Board meetings when present and ensuring that all Board business is conducted in accordance with these SOs. The Chair may have certain specific powers delegated by the Board and set out in the Scheme of Delegation.

1.4.7 The Chair shall work in close harmony with the Chief Executive and, supported by the Director of Corporate Governance, shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

1.4.8 **The Vice-Chair** – The Vice-Chair shall deputise for the Chair in their absence for any reason and will do so until either the existing chair resumes their duties, or a new chair is appointed.

1.4.9 **Chief Executive** – The Chief Executive is responsible for the overall performance of the executive functions of the Trust. They are the

appointed Accountable Officer for the Trust and shall be responsible for meeting all the responsibilities of that role, as set out in their Accountable Officer Memorandum.

1.4.10 **Lead roles for Board members** – The Chair will ensure that individual Board members are designated as lead roles or "champions" as required by the Welsh Ministers or as set out in any statutory or other guidance. Any such role must be clearly defined and must operate in accordance with the requirements set by the Trust, the Welsh Ministers or others. In particular, no operational responsibilities will be placed upon any Independent Member fulfilling such a role. The identification of a Board member in this way shall not make them more vulnerable to individual criticism, nor does it remove the corporate responsibility of the other Board members for that particular aspect of Board business.

2. RESERVATION AND DELEGATION OF TRUST FUNCTIONS

2.0.1 Subject to any directions that may be given by the Welsh Ministers, the Board shall make arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the Board must set out clearly the terms and conditions upon which any delegation is being made.

2.0.2 The Board's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

(i) Schedule of matters reserved to the Board;
(ii) Scheme of delegation to committees and others; and
(iii) Scheme of delegation to officers.

all of which must be formally adopted by the Board in full session and form part of these SOs.

2.0.3 The Trust retains full responsibility for any functions delegated to others to carry out on its behalf. Where Trusts and Local Health Boards have a joint duty, the Trust remains fully responsible for its part, and shall agree the governance and assurance arrangements for the partnership, setting out respective responsibilities, ways of working, accountabilities and sources of assurance of the partner organisations.

2.1 Chair's action on urgent matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the Board need to be taken between scheduled meetings, and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and the Chief Executive, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board - after first consulting with at least two other

Independent Members. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification.

2.1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

2.2 Delegation of Board functions

2.2.1 The Trust shall delegate its Shared Services functions (that is, the provision and management of Shared Services to the health services in Wales) to the Shared Services Partnership Committee which they are required to establish and confer such functions on in accordance with the Shared Services Regulations.

Subject to Standing Order 2.2.2 the Board may agree the delegation of any of their functions, except for those set out within the 'Schedule of Matters Reserved for the Board' within the Model Standing Orders (see paragraph 2.0.2 (i), to Committees and others, setting any conditions and restrictions it considers necessary and in accordance with any directions or regulations given by the Welsh Ministers. These functions may be carried out:

(i) By a Committee, sub-Committee or officer of the Trust (or of another Trust); or
(ii) By another LHB; NHS Trust; Strategic Health Authority or Primary Care Trust in England; Special Health Authority; or
(iii) With one or more bodies including local authorities through a sub-Committee.]

2.2.2 The Board may agree and formally approve the delegation of specific executive powers to be exercised by Committees or sub-Committees which it has formally constituted.

2.3 Delegation to officers

2.3.1 The Board may delegate certain functions to the Chief Executive. For these aspects, the Chief Executive, when compiling the Scheme of Delegation to Officers, shall set out proposals for those functions they will perform personally and shall nominate other officers to undertake the remaining functions. The Chief Executive will still be accountable to the Board for all functions delegated to them irrespective of any further delegation to other officers.

2.3.2 This must be considered and approved by the Board (subject to any amendment agreed during the discussion). The Chief Executive may

periodically propose amendments to the Scheme of Delegation to Officers and any such amendments must also be considered and approved by the Board.

2.3.3 Individual Executive Directors are in turn responsible for delegation within their own directorates/departments/localities in accordance with the framework established by the Chief Executive and agreed by the Board.

3. COMMITTEES

3.1 NHS Trust Committees

3.1.1 The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees. The Board shall, wherever possible, require its Committees to hold meetings in public unless there are specific, valid reasons for not doing so.

Use of the term "Committee"

3.1.2 For the purposes of these SOs, use of the term 'Committee' incorporates the following:

- Board Committee
- sub-Committee

unless otherwise stated.

3.2 Sub-Committees

3.2.1 A Committee appointed by the Board may establish a sub-Committee to assist it in the conduct of its business provided that the Board approves such action. Where the Board has authorised a Committee to establish sub-Committees, they cannot delegate any executive powers to the sub-Committee unless authorised to do so by the Board.

3.3 Committees established by the Trust

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds *[as appropriate]*;

- Remuneration and Terms of Service; and
- Mental Health Act requirements *[as appropriate]*.

3.3.2 In designing its Committee structure and operating arrangements, the Board shall take full account of the need to:

- Embed corporate standards, priorities and requirements, e.g., equality and human rights across all areas of activity;
- Maximise cohesion and integration across all aspects of governance and assurance.

3.3.3 Each Committee established by or on behalf of the Board must have its own SOs or detailed terms of reference and operating arrangements, which must be formally approved by the Board. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others (including the Board**,** its Committees and any Advisory Groups);
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

3.3.4 In doing so, the Board shall specify which aspects of these SOs are not applicable to the operation of the Committee, keeping any such aspects to the minimum necessary.

3.3.5 The membership of any such Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements, directions or regulations made by the Welsh Ministers. Depending on the Committee's defined role and remit, membership may be drawn from the Board, its staff (subject to the conditions set in Standing Order 3.4.6) or others not employed by the Trust.

3.3.6 Executive Directors or other Trust officers shall not be appointed as Committee Chairs, nor should they be appointed to serve as members on any Committee set up to review the exercise of functions delegated to officers or to review Mental Health Tribunals (in accordance with the Mental Health Act 1983). Designated Trust officers shall, however, be in attendance at such Committees, as appropriate.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

3.4 Other Committees

3.4.1 The Board may also establish other Committees to help the Trust in the conduct of its business.

3.5 Confidentiality

3.5.1 Committee members and attendees must not disclose any matter dealt with by or brought before a Committee in confidence without the permission of the Committee's Chair.

3.6 Reporting activity to the Board

3.6.1 The Board must ensure that the Chairs of all Committees operating on its behalf report formally, regularly and on a timely basis to the Board on their activities. Committee Chairs' shall bring to the Boards specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.0.1 From 1 June 2012 the function of managing and providing Shared Services to the health service in Wales was given to Velindre NHS Trust. The Trust's Establishment Order has been amended to reflect the fact that the Shared Services function has been conferred on it.

4.0.2 The **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012** (S.I. 2012/1261 (W.156)) ("the Shared Services Regulations") require the Trust to establish a Shared Services Committee which will be responsible for exercising the Trust's Shared Services functions. The Shared Services Regulations (as amended) prescribe the membership of the Shared Services Committee in order to ensure that all LHBs, Trusts and Special Health Authorities in Wales have a member on the Shared Services Committee and that the views of all the NHS organisations in Wales are taken into account when making decisions in respect of Shared Services activities.

4.0.3 The Director of Shared Services will be designated as Accountable Officer for Shared Services.

4.0.4 These arrangements necessitate putting in place a Memorandum of Co-operation Agreement and a Hosting Agreement between all LHBs, Trusts and Special Health Authorities setting out the obligations of NHS bodies to participate in the Shared Services Committee and to take collective responsibility for setting the policy and delivery of the Shared Services to the health service in Wales. Responsibility for the exercise of the Shared Services functions will not rest with the Board of Velindre NHS Trust but will be a shared responsibility of all NHS bodies in Wales.

4.0.5 The Shared Services Committee is to be known as the Shared Services Partnership Committee for operational purposes.

5. ADVISORY GROUPS

5.0.1 The Trust may and where directed by the Welsh Ministers must, appoint Advisory Groups to the Trust to provide advice to the Board in the exercise of its functions.

5.0.2 *Details of the Trust's Advisory Groups, their membership and terms of reference are set out in Schedule 4.*

5.0.3 The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out by others to advise it in the conduct of its business. The Board shall, wherever possible, require its Advisory Groups to hold meetings in public unless there are specific, valid reasons for not doing so.

5.1 Advisory Groups established by the Trust

5.1.1 The Trust has established the following Advisory Groups:

- Local Partnership Forum

5.2 Terms of reference and operating arrangements

5.2.1 The Board must formally approve terms of reference and operating arrangements in respect of any Advisory Group it has established. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role, responsibilities and accountabilities, and terms and conditions of office) and quorum;
- Meeting arrangements;
- Communications;
- Relationships with others (including the Board, its Committees and Advisory Groups) as well as other relevant local and national groups;
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

5.2.2 In doing so, the Board shall specify which of these SOs are not applicable to the operation of the Advisory Group, keeping any such aspects to the minimum necessary. The detailed terms of reference and operating arrangements for the Trust's Advisory Groups are set out in Schedule 4.

5.2.3 The Board may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the Board approves such action.

5.3 Support to Advisory Groups

5.3.1 The Trust's Director of Corporate Governance, on behalf of the Chair, will ensure that Advisory Groups are properly equipped to carry out their role by:

- Co-ordinating and facilitating appropriate induction and organisational development activity;
- Ensuring the provision of governance advice and support to the Advisory Group Chair on the conduct of its business and its relationship with the Trust Board and others;
- Ensuring the provision of secretariat support for Advisory Group meetings (for specific arrangements relating to Local Partnership Forum see 5.7 and Schedule 4);
- Ensuring that the Advisory Group receives the information it needs on a timely basis;
- Ensuring strong links to communities/groups/professionals as appropriate; and
- Facilitating effective reporting to the Board

enabling the Board to gain assurance that the conduct of business within the Advisory Group accords with the governance and operating framework it has set.

5.4 Confidentiality

5.4.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

5.5 Advice and feedback

5.5.1 The Trust may specifically request advice and feedback from the Advisory Group(s) on any aspect of its business and they may also offer advice and feedback even if not specifically requested by the Trust. The Group(s) may provide advice to the Board:

- In written advice;
- In any other form specified by the Board

5.6 Reporting activity

5.6.1 The Board shall ensure that the Chairs of all Advisory Groups report formally, regularly and on a timely basis to the Board on their activities. Advisory Group Chairs shall bring to the Board's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

5.6.2 Each Advisory Group shall also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub-groups it has established.

5.6.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

5.7 The Local Partnership Forum (LPF)

Role

5.7.1 The LPF's role is to provide a formal mechanism where the Trust, as employer, and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust - achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

5.7.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

5.8 Relationship with the Board and others

5.8.1 The LPF's main link with the Board is through the Executive members of the LPF.

5.8.2 The Board may determine that designated Board members or Trust staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Board members or Trust staff, subject to the agreement of the Trust Chair.

5.8.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

5.8.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

5.8.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

Refer to Schedule 4 for detailed Terms of Reference and Operating Arrangements.

6. WORKING IN PARTNERSHIP

6.0.1 The Trust shall work constructively in partnership with others to plan and secure the delivery of an equitable, high quality, whole system approach to health, well-being and social care for its citizens. This will be delivered in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

6.0.2 The Chair shall ensure that the Board has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the Trust through:

- The Trust's own structures and operating arrangements, e.g., Advisory Groups; and

- The involvement (at very local and community wide levels) in partnerships and community groups – such as Public Service Boards – of Board members and Trust officers with delegated authority to represent the Trust and, as appropriate, take decisions on its behalf.

6.0.3 The Social Services and Well-Being (Wales) Act 2014 sets out duties for working in partnership with local authorities complementing existing duties under section 82 of the NHS Act 2006 (duty to cooperate with local authorities) and sections 10 (arrangements with other bodies) and 38 (duty to make services available to enable the discharge of local authority functions) of the NHS (Wales) Act 2006. An advice note on partnership working – implications for health boards and NHS Trusts from the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015 has been published and it can be found here: https://socialcare.wales/cms_assets/hub-downloads/Partnership-working-–-implications-for-health-boards-and-NHS-Trusts.pdf

6.0.4 The Board shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6.1 The Citizen Voice Body for Health and Social Care, Wales (known as Llais)

6.1.1 Part 4 of the **Health and Social Care (Quality and Engagement) (Wales)**

Act 2020 (2020 asc 1) (the 2020 Act) places a range of duties on Trusts in relation to the engagement and involvement of Llais in its operations.

6.1.2 The 2020 Act places a statutory duty on the Trust to have regard to any representations made to them by Llais. Statutory Guidance on Representations has been published to guide NHS bodies, local authorities and Llais in how these representations should be made and considered.

The Statutory Guidance on Representations made by the Citizen Voice Body can be found at https://www.gov.wales/sites/default/files/publications/2023-04/statutory-guidance-on-representations-made-by-the-citizen-voice-body.pdf

6.1.3 The 2020 Act also places a statutory duty on the Trust to promote awareness of Llais and make arrangements to engage and co-operate with Llais with the view to supporting each other in the exercise of their relevant functions. Promoting and facilitating engagement between individuals and Llais through access to relevant premises can help strengthen the public's voice and participation in shaping the design and delivery of services. The Trust must have regard to the Code of Practice on Access to Premises and Engagement with Individuals (so far as the code is relevant)

The Code of Practice on Access to Premises and Engagement with Individuals can be found at

https://www.gov.wales/code-practice-llais-accessing-premises-and-engaging-people

6.1.4 In discharging these duties, and given the all-Wales nature of the Trust's functions, the Board shall work constructively with the Board of Llais to ensure that regional offices of Llais are involved, as appropriate, in:

- The planning of the provision of its healthcare services;
- The development and consideration of proposals for service change and the way in which those services are provided;
- The Board's decisions affecting the operation of those healthcare services that it has responsibility for; and
- Engaging, formally consulting and working jointly with Llais on any proposals for substantial development or change of the services it is responsible for, in line with the Guidance on Changes to Health Services in Wales 2023 .

The Guidance on Changes to Health Services can be found at https://www.gov.wales/guidance-changes-health-services

6.1.5 The Board shall ensure Llais is provided with the information it needs on a timely basis to enable it to effectively discharge its functions.

Relationship with the Board

6.1.6 The Board may determine that a designated Llais representative (s) shall be invited to attend Board meetings.

6.1.7 The Board shall ensure arrangements are in place for regular meetings between Trust officers and representatives of Llais.

6.1.8 The Board's Chair shall put in place arrangements to meet with the Chair or Deputy Chair and/or representatives of Llais on a regular basis to discuss matters of common interest.

7. MEETINGS

7.1 Putting Citizens first

7.1.1 The Trust's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens, community partners and other stakeholders. The Trust, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- Active communication of forthcoming business and activities;
- The selection of accessible, suitable venues for meetings when these are not held via electronic means;
- The availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read (where requested and required) and in electronic formats;
- Requesting that attendees notify the Trust of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g., arranging British Sign Language (BSL) interpretation at meetings; and
- Where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh,

in accordance with legislative requirements, e.g., Disability Discrimination Act, as well as its Communication Strategy and provisions made in response to the compliance notice issued by the Welsh Language Commissioner under section 44 of the Welsh Language (Wales) Measure 2011.

7.1.2 The Chair will ensure that, in determining the matters to be considered by the Board, full account is taken of the views and interests of the Trust's citizens and other stakeholders, including any views expressed formally to the Trust, e.g., through Llais.

7.2 Annual Plan of Board Business

7.2.1 The Director of Corporate Governance, on behalf of the Chair, shall produce an Annual Plan of Board business. This plan will include

proposals on meeting dates, venues and coverage of business activity during the year, taking account that ordinary meetings of the Board will be held at regular intervals and as a minimum six times a year. The Plan shall also set out any standing items that will appear on every Board agenda.

7.2.2 The plan shall set out the arrangements in place to enable the Trust to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing Board members to contribute in either English or Welsh languages, where appropriate.

7.2.3 The plan shall also incorporate formal Board meetings, regular Board Development sessions and, where appropriate, the planned activities of the Board's Committees and Advisory Groups.

7.2.4 The Board shall agree the plan for the forthcoming year by the end of March, and this plan will be published on the organisation's website.

Annual General Meeting (AGM)

7.2.5 The Trust must hold an AGM in public no later than the 31 July each year. [Note : this will be no later than 30 September in 2023 to take account of the timetable for audit and laying of the Accounts by Audit Wales.] At least 10 calendar days prior to the meeting a public notice of the intention to hold the meeting, the time and place of the meeting, and the agenda, shall be displayed bilingually (in English and Welsh) on the Trust's website.

The notice shall state that:

- Electronic or paper copies of the Annual Report and Accounts of the Trust are available, on request, prior to the meeting; and
- State how copies can be obtained, in what language and in what format, e.g. as Braille, large print, easy read etc.

7.2.6 The AGM must include presentation of the Annual Report and audited accounts, together with (where applicable), an audited abridged version of the annual accounts and funds held on trust accounts and may also include presentation of other reports of interest to citizens and others.

7.2.7 A record of the meeting shall be submitted to the next ordinary meeting of the Board for agreement.

7.3 Calling Meetings

7.3.1 In addition to the planned meetings agreed by the Board, the Chair may call a meeting of the Board at any time. Individual Board members may also request that the Chair call a meeting provided that at least one third of the whole number of Board members, support such a request.

7.3.2 If the Chair does not call a meeting within seven days after receiving such a request from Board members, then those Board members may themselves call a meeting.

7.4 Preparing for Meetings

Setting the agenda

7.4.1 The Chair, in consultation with the Chief Executive and Director of Corporate Governance, will set the Agenda. In doing so, they will take account of the planned activity set in the annual cycle of Board business; any standing items agreed by the Board; any applicable items received from the Board's Committees and Advisory Groups; and the priorities facing the Trust. The Chair must ensure that all relevant matters are brought before the Board on a timely basis.

7.4.2 Any Board member may request that a matter is placed on the Agenda by writing to the Chair, copied to the Director of Corporate Governance, at least 12 calendar days before the meeting. The request must set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12-day notice period if this would be beneficial to the conduct of board business.

Notifying and equipping Board members

7.4.3 Board members shall be sent an Agenda and a complete set of supporting papers at least **7** calendar days before a formal Board meeting. This information may be provided to Board members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided, after this time provided that the Chair is satisfied that the Board's ability to consider the issues contained within the paper would not be impaired.

7.4.4 No papers will be included for consideration and decision by the Board unless the Chair is satisfied (subject to advice from the Director of Corporate Governance, as appropriate) that the information contained within it is sufficient to enable the Board to take a reasonable decision. This will include evidence that appropriate impact assessments have been undertaken and taken into consideration. Impact assessments shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the Board, and the outcome of that assessment shall accompany the report to the Board to enable the Board to make an informed decision.

7.4.5 In the event that at least half of the Board members do not receive the Agenda and papers for the meeting as set out above, the Chair must

consider whether or not the Board would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

7.4.6 In the case of a meeting called by Board members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

7.4.7 Except for meetings called in accordance with Standing Order 6.3, at least 10 calendar days before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- On the Trust's website, together with the papers supporting the public part of the Agenda; as well as
- Through other methods of communication as set out in the Trust's communication strategy.

7.4.8 When providing notification of the forthcoming meeting, the Trust shall set out when and how the Agenda and the papers supporting the public part of the Agenda may be accessed, in what language and in what format, e.g., as Braille, large print, easy read, etc.

7.5 Conducting Board Meetings

Admission of the public, the press and other observers

7.5.1 The Trust shall encourage attendance at its formal Board meetings by the public and members of the press as well as Trust officers or representatives from organisations who have an interest in Trust business. The venue for such meetings shall be appropriate to facilitate easy access for attendees and translation services; and shall have appropriate facilities to maximise accessibility.

7.5.2 The Board and its committees shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g., business that relates to a confidential matter. In such cases the Chair (advised by the Director of Corporate Governance where appropriate) shall schedule these issues accordingly and require that any observers withdraw from the meeting. In doing so, the Board shall resolve:

> *That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with*

7.5.3 In these circumstances, when the Board is not meeting in public session it shall operate in private session formally reporting any decisions taken to the next meeting of the Board in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a Board meeting held in public session.

7.5.4 The Director of Corporate Governance, on behalf of the Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

7.5.5 In encouraging entry to formal Board Meetings from members of the public and others, the Board shall make clear that attendees are welcomed as observers. The Chair shall take all necessary steps to ensure that the Board's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting.

7.5.6 Unless the Board has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the Board, its Committees and Advisory Groups

7.5.7 The Board will decide what arrangements and terms and conditions it feels are appropriate in extending an invitation to observers to attend and address any meetings of the Board, its Committees and Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the Board will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the Trust, (whether directly or through the activities of bodies such as Llais and the Trust's Advisory Groups representing citizens and other stakeholders) and to demonstrate openness and transparency in the conduct of business.

Chairing Board Meetings

7.5.8 The Chair of the Trust will preside at any meeting of the Board unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and vice-chair are absent or disqualified, the Independent Members present shall elect one of the Independent Members to preside.

7.5.9 The Chair must ensure that the meeting is handled in a manner that enables the Board to reach effective decisions on the matters before it. This includes ensuring that Board members' contributions are timely and relevant and move business along at an appropriate pace. In doing so,

the Board must have access to appropriate advice on the conduct of the meeting through the attendance of the nominated Director of Corporate Governance. The Chair has the final say on any matter relating to the conduct of Board business.

Quorum

7.5.10 At least one-third of all Board members, at least one of whom is an Executive Director and one is an Independent Members, must be present to allow any formal business to take place at a Board meeting.]

7.5.11 If the Chief Executive or an Executive Director is unable to attend a Board meeting, then a nominated deputy may attend in their absence and may participate in the meeting, provided that the Chair has agreed the nomination before the meeting. However, Board members' voting rights cannot be delegated so the nominated deputy may not vote or be counted towards the quorum. If a deputy is already a Board member in their own right, e.g., a person deputising for the Chief Executive will usually be an Executive Director, they will be able to exercise their own vote in the usual way but they will not have any additional voting rights.

7.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e., any decisions to be made. Any Board member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting and must be noted in the minutes.

Dealing with motions

7.5.13 In the normal course of Board business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a Board member may put forward a motion proposing that a formal review of that service area is undertaken by a Committee of the Board. The Director of Corporate Governance will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the Board unless moved by a Board member and seconded by another Board member (including the Chair).

7.5.14 **Proposing a formal notice of motion –** Any Board member wishing to propose a motion must notify the Chair in writing of the proposed motion at least 12 days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the Chair has determined that the proposed motion is relevant to the Board's business, the matter

shall be included on the Agenda, or, where an emergency motion has been proposed, the Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

7.5.15 The Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of Board business.

7.5.16 **Amendments -** Any Board member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the Board alongside the motion.

7.5.17 If there are a number of proposed amendments to the motion, each amendment will be considered in turn, and if passed, the amended motion becomes the basis on which the further amendments are considered, i.e.., the substantive motion.

7.5.18 **Motions under discussion –** When a motion is under discussion, any Board member may propose that:

- The motion be amended;
- The meeting should be adjourned;
- The discussion should be adjourned, and the meeting proceed to the next item of business;
- A Board member may not be heard further;
- The Board decides upon the motion before them;
- An ad hoc Committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

7.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

7.5.20 **Withdrawal of motion or amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconder and the Chair.

7.5.21 **Motion to rescind a resolution –** The Board may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six months unless the motion is supported by the (simple) majority of Board members.

7.5.22 A motion that has been decided upon by the Board cannot be proposed again within six months except by the Chair, unless the motion relates to the receipt of a report or the recommendations of a Committee/Chief Executive to which a matter has been referred.

Voting

7.5.23 The Chair will determine whether Board members' decisions should be expressed orally, through a show of hands, by secret ballot or by recorded vote. The Chair must require a secret ballot or recorded vote if the majority of voting Board members request it. Where voting on any question is conducted, a record of the vote shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the Minutes shall record the name of the individual and the way in which they voted.

7.5.24 In determining every question at a meeting, the Board members must take account, where relevant, of the views expressed and representations made by individuals or organisations who represent the interests of the Trust's citizens and stakeholders. Such views will usually be presented to the Board through the Chair*(s)* of the Trust's Advisory Group*(s)* and the Llais representative(s).

7.5.25 The Board will make decisions based on a simple majority view held by the Board members present. In the event of a split decision, i.e., no majority view being expressed, the Chair shall have a second and casting vote.

7.5.26 In no circumstances may an absent Board member or nominated deputy vote by proxy. Absence is defined as being absent at the time of the vote.

7.6 Record of Proceedings

7.6.1 A record of the proceedings of formal Board meetings (and any other meetings of the board where the Board members determine) shall be drawn up as 'minutes'. These minutes shall include a record of Board member attendance (including the Chair) together with apologies for absence and shall be submitted for agreement at the next meeting of the Board, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

7.6.2 Agreed minutes shall be circulated in accordance with Board members' wishes, and, where providing a record of a formal Board meeting shall be made available to the public both on the Trust's website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g., Data Protection Act 2018, the General Data Protection Regulations 2018, and the Trust's Communication Strategy and Welsh language requirements.

7.7 Confidentiality

7.7.1 All Board members together with members of any Committee or Advisory Group established by or on behalf of the Board and Trust officials must respect the confidentiality of all matters considered by the Trust in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the Chair of the Board or relevant Committee, as appropriate, and in accordance with any other requirements set out elsewhere, e.g., in contracts of employment, within the Values and Standards of Behaviour framework GC03 Standards of Behaviour Policy or legislation such as the Freedom of Information Act 2000, etc.

8. VALUES AND STANDARDS OF BEHAVIOUR

8.0.1 The Board must adopt a set of values and standards of behaviour for the Trust that meets the requirements of the NHS Wales Values and Standards of Behaviour framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the Trust, including Board members, Trust officers and others, as appropriate. The framework adopted by the Board is the Trust's Standards of Behaviour Policy (GC03) and will form part of these SOs.

8.1 Declaring and recording Board members' interests

8.1.1 ***Declaration of interests –*** It is a requirement that all Board members must declare any personal or business interests they may have which may affect or be perceived to affect the conduct of their role as a Board member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the Board's business. Board members must be familiar with the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy and their statutory duties under the Membership Regulations. Board members must notify the Chair and Director of Corporate Governance of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as Board members.

8.1.2 Board members must also declare any interests held by family members or persons or bodies with which they are connected. The Director of Corporate Governance will provide advice to the Chair and the Board on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g., the Values and Standards of Behaviour framework. If individual Board members are in any doubt about what may be considered as an interest, they should seek advice from the Director of Corporate Governance. However, the onus regarding declaration will reside with the individual Board member.

8.1.3 ***Register of interests –*** The Chief Executive, through the Director of Corporate Governance will ensure that a Register of Interests is

established and maintained as a formal record of interests declared by all Board members. The register will include details of all Directorships and other relevant and material interests which have been declared by Board members.

8.1.4 The register will be held by the Director of Corporate Governance, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by Board members. The Director of Corporate Governance will also arrange an annual review of the Register, through which Board members will be required to confirm the accuracy and completeness of the register relating to their own interests.

8.1.5 In line with the Board's commitment to openness and transparency, the Director of Corporate Governance must take reasonable steps to ensure that the citizens served by the Trust are made aware of and have access to view the Trust's Register of Interests. This may include publication on the Trust's website.

8.1.6 ***Publication of declared interests in Annual Report –*** Board members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in the Trust's Annual Report.

8.2 Dealing with Members' interests during Board meetings

8.2.1 The Chair, advised by the Director of Corporate Governance, must ensure that the Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual Board members must demonstrate, through their actions, that their contribution to the Board's decision making is based upon the best interests of the Trust and the NHS in Wales.

8.2.2 Where individual Board members identify an interest in relation to any aspect of Board business set out in the Board's meeting agenda, that member must declare an interest at the start of the Board meeting. Board members should seek advice from the Chair, through the Director of Corporate Governance before the start of the Board meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Board minutes.

8.2.3 It is the responsibility of the Chair, on behalf of the Board, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions made by the Welsh Ministers. The range of possible actions may include determination that:

(i) The declaration is formally noted and recorded, but that the Board member should participate fully in the Board's discussion and decision, including voting. This may be appropriate, for example

where the Board is considering matters of strategy relating to a particular aspect of healthcare and an Independent Member is a healthcare professional whose profession may be affected by that strategy determined by the Board;

(ii) The declaration is formally noted and recorded, and the Board member participates fully in the Board's discussion, but takes no part in the Board's decision;

(iii) The declaration is formally noted and recorded, and the Board member takes no part in the Board discussion or decision;

(iv) The declaration is formally noted and recorded, and the Board member is excluded for that part of the meeting when the matter is being discussed. A Board member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the Board.

8.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a Board member is compatible with an identified conflict of interest.

8.2.5 Where the Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the Board.

8.2.6 In all cases the decision of the Chair (or the Vice Chair in the case of an interest declared by the Chair) is binding on all Board members. The Chair should take advice from the Director of Corporate Governance when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

8.2.7 ***Members with pecuniary (financial) interests –*** Where a Board member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the Board, including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The Board may determine that the Board member concerned shall be excluded from that part of the meeting.

8.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SOs must be interpreted in accordance with these definitions.

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[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other.

8.2.9 ***Members with Professional Interests -*** During the conduct of a Board meeting, an individual Board member may establish a clear conflict of interest between their role as a Trust Board member and that of their professional role outside of the Board. In any such circumstance, the Board shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the Director of Corporate Governance.

8.3 Dealing with officers' interests

8.3.1 The Board must ensure that the Director of Corporate Governance, on behalf of the Chief Executive, establishes and maintains a system for the declaration, recording and handling of Trust officers' interests in accordance with the Values and Standards of Behaviour Framework.

8.4 Reviewing how Interests are handled

8.4.1 The Audit Committee will review and report to the Board upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

8.5 Dealing with offers of gifts[2], hospitality and sponsorship

8.5.1 The Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy approved by the Board prohibits Board members and Trust officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

8.5.2 Gifts, benefits or hospitality must never be solicited. Any Board member or Trust officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a Trust Board member or officer. Failure to observe this requirement may result in disciplinary and/or legal action.

8.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the Director of Corporate Governance as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems

[2] The term gift refers also to any reward or benefit.

than those which could result in a contractual relationship, in which case accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the Trust;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g., diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the Trust; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it should always be declined.

8.5.4 A distinction may be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

8.6 Sponsorship

8.6.1 In addition, gifts and hospitality individuals and the organisation may also receive sponsorship. Sponsorship is an offer of funding to an individual, department or the organisation as a whole from an external source whether in cash, goods, services or benefits. It could include an offer to sponsor a research or operational post, training, attendance at a conference, costs associated with meetings, conferences or a working visit. The sponsorship may cover some or all of the costs.

8.6.2 All sponsorship must be approved prior to acceptance in accordance with the Values and Standards of Behaviour Framework GC03 Standards of Behaviour Policy and relevant procedures. A record of all sponsorship accepted or declined will also be maintained.

8.7 Register of Gifts, Hospitality and Sponsorship

8.7.1 The Director of Corporate Governance, on behalf of the Chair, will maintain a register of Gifts, Hospitality and Sponsorship to record offers of gifts, hospitality and sponsorship made to Board members. Executive Directors will adopt a similar mechanism in relation to Trust officers working within their Directorates.

8.7.2 Every Board member and Trust officer has a personal responsibility to volunteer information in relation to offers of gifts, hospitality and sponsorship, including those offers that have been refused. The Director of Corporate Governance, on behalf of the Chair and Chief Executive, will ensure the incidence and patterns of offers and receipt of gifts, hospitality and sponsorship are kept under active review, taking appropriate action where necessary.

8.7.3 When determining what should be included in the Register with regard to gifts and hospitality, individuals shall apply the following principles, subject to the considerations in Standing Order 8.5.3:

- **Gifts:** Generally, only gifts of material value should be recorded. Those with a nominal value, e.g., seasonal items such as diaries/calendars would not usually need to be recorded.

- **Hospitality:** Only significant hospitality offered or received should be recorded. Occasional offers of 'modest and proportionate[3]' hospitality need not be included in the Register.

8.7.4 Board members and Trust officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the Trust;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

8.7.5 The Director of Corporate Governance will arrange for a full report of all offers of Gifts, Hospitality and Sponsorship recorded by the Trust to be submitted to the Audit Committee (or equivalent) at least annually. The Audit Committee will then review and report to the Board upon the

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[3] Examples of 'modest and proportionate' hospitality that need not be included in a Hospitality register include a working sandwich lunch or a buffet lunch incidental to a conference or seminar attended by a variety of participants.

adequacy of the Trust's arrangements for dealing with offers of gifts, hospitality and sponsorship.

9. SIGNING AND SEALING DOCUMENTS

9.0.1 The common seal of the Trust is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board or Committee of the Board.

9.02. Where it is decided that a document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other authorised independent Member) and the Chief Executive (or another authorised individual) both of whom must witness the seal.

9.1 Register of Sealing

9.1.1 The Director of Corporate Governance shall keep a register that records the sealing of every document. Each entry must be signed by the persons who approved and authorised the document and who witnessed the seal. A report of all sealings shall be presented to the Board at least bi-annually.

9.2 Signature of Documents

9.2.1 Where a signature is required for any document connected with legal proceedings involving the Trust, it shall be signed by the Chief Executive, except where the Board has authorised another person or has been otherwise directed to allow or require another person to provide a signature.

9.2.2 The Chief Executive or nominated officers may be authorised by the Board to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) where the subject matter has been approved either by the Board or a Committee to which the Board has delegated appropriate authority.

9.3 Custody of Seal

9.3.1 The Common Seal of the Trust shall be kept securely by the Director of Corporate Governance.

10. GAINING ASSURANCE ON THE CONDUCT OF TRUST BUSINESS

10.0.1 The Board shall set out explicitly, within a Risk and Assurance Framework, how it will be assured on the conduct of Trust business, its governance and the effective management of the organisation's risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in

accordance with any requirements determined by the Welsh Ministers.

10.0.2 The Board shall ensure that its assurance arrangements are operating effectively, advised by its Audit Committee (or equivalent).

10.0.3 Assurances in respect of services provided by the NHS Wales Shared Services Partnership shall primarily be achieved by the reports of the Director of Shared Services to the Shared Services Partnership Committee and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the Trust.

10.0.4 Whilst the Trust is not a member of WHSSC or EASC the Chief Executive does attend the Committees as an Associate Member. Assurances in respect of the functions discharged by WHSSC and EASC shall achieved by the reports of the respective Joint Committee Chair and reported back by the Chief Executive.

10.0.5 Arrangements for seeking and providing assurance is respect of any other services provided on behalf of or in association with the Trust shall be clearly identified and reflected within the practice of the organisation and within the relevant agreements.

10.1 The role of Internal Audit in providing independent internal assurance

10.1.1 The Board shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

10.1.2 The Board shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the Board. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);
- Ensure the HIA communicates and interacts directly with the Board, facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the Board on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

10.2 Reviewing the performance of the Board, its Committees and Advisory Groups

10.2.1 The Board shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Committees and Advisory Groups. Where appropriate, the Board may determine that such evaluation may be independently facilitated.

10.2.2 Each Committee and, where appropriate, Advisory Group must also submit an annual report to the Board through the Chair within 6 weeks of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-Committees it has established.

10.2.3 The Board shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Board Development Programme, as part of an overall Organisation Development framework; and
- the Board's report of its alignment with the Welsh Government's Citizen Centred Governance Principles.

10.3 External Assurance

10.3.1 The Board shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on the Trust's operations, e.g., the Auditor General for Wales and Healthcare Inspectorate Wales.

10.3.2 The Board may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the Board itself may commission specifically for that purpose.

10.3.3 The Board shall keep under review and ensure that, where appropriate, the Trust implements any recommendations relevant to its business made by the Welsh Government's Audit Committee, the Senedd Cymru/Welsh Parliament's Public Accounts Committee or other appropriate bodies.

10.3.4 The Trust shall provide the Auditor General for Wales with any assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities.

11. DEMONSTRATING ACCOUNTABILITY

11.0.1 Taking account of the arrangements set out within these SOs, the Board shall demonstrate to the communities it serves and to the Welsh Ministers a clear framework of accountability within which it:

- Conducts its business internally;
- Works collaboratively with NHS colleagues, partners, service providers and others; and
- Responds to the views and representations made by those who represent the interests of citizens and other stakeholders, including its officers and healthcare professionals.

11.0.2 The Board shall, in publishing its strategic and operational level plans, set out how those plans have been developed taking account of the views of others, and how they will be delivered by working with their partners.

11.0.3 The Board shall also facilitate effective scrutiny of the Trust's operations through the publication of regular reports on activity and performance, including publication of an Annual Report.

11.0.4 The Board shall ensure that within the Trust, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

12. REVIEW OF STANDING ORDERS

12.0.1 The Director of Corporate Governance shall arrange for an appropriate impact assessments to be carried out on a draft of these SOs prior to their formal adoption by the Board, the results of which shall be presented to the Board for consideration and action, as appropriate. The fact that an assessment has been carried out shall be noted in the SOs.

12.0.2 These SOs shall be reviewed annually by the Audit Committee [or equivalent], which shall report any proposed amendments to the Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SOs, including the appropriate impact assessments.

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

CONTENTS

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

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

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance

The Director of Corporate Governance will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Director of Corporate Governance and Chief of Staff of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are detailed in Schedule 2.
3	FULL	GENERAL	Approve the Trusts Governance Framework.
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the Trust's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the Trust's Values and Standards of Behaviour Framework Policy.
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Director of Corporate Governance
11	FULL	STRATEGY & PLANNING	Determine the Trust's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
13	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
14	FULL	STRATEGY & PLANNING	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
15	FULL	STRATEGY & PLANNING	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
16	FULL	OPERATING ARRANGEMENTS	Approve the Trust's framework and strategy for performance management.
17	FULL	STRATEGY & PLANNING	Approve the Trust's framework and strategy for risk management and assurance.
18	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
19	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
20	FULL	STRATEGY & PLANNING	Approve the Trusts patient, public, staff, partnership and stakeholder engagement and co-production strategies.
21	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
22	NO – Remuneration and Terms of Service Committee (For Chief Executive Committee to consist of Chair and non-Officer Members, for all other Officer members as above and to include Chief Executive)	ORGANISATION STRUCTURE & STAFFING	Appointment of the Chief Executive and Executive Directors (officer members of the Board)
23	NO – Remuneration and Terms of Service Committee (see above)	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance
24	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
28	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
29	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
31	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
32	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property
33	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
34	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers
35	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Trust
36	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
37	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions
38	FULL	PERFORMANCE & ASSURANCE	Approve the Trust's audit and assurance arrangements

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
39	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
40	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate.
41	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales, etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
42	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
43	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
44	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Trusts performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
45	FULL	REPORTING	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
46	FULL	REPORTING	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. An Independent Member will be identified to be represented as members on the Board Committees/Sub Committees as outlined in Schedule 3.
	VICE CHAIR		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. An Independent Member will be identified to be represented as members on the Board Committees/Sub Committees as outlined in Schedule 3.
	CHAMPION/ NOMINATED LEAD		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. Independent Members will be identified as Champions/Leads for the following areas: • Armed Forces and Veterans • Digital • Hosted Organisations • Infection Prevention • Mental Health • Patient Information • Patient and Donor Engagement and Experience • Performance Framework • Research, Development and Innovation • Sustainable Development and Design • University Trust • Violence and Aggression • Vulnerability • Welsh Language

DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

The Board has delegated a range of its powers to the following Committees and others:

- Remuneration & Terms of Service Committee
- Audit Committee
- Quality, Safety & Performance Committee
- Strategic Development Committee
  - Transforming Cancer Services Programme Scrutiny Sub-Committee
- Charitable Funds Committee
  - Charitable Funds Investment Performance Review Sub-Committee
  - Research, Development & Innovation Sub-Committee
- Advisory Consultants Appointment Committee (to be established for each consultant medical staff appointment as appropriate to the specialist nature of the post, in accordance with guidance from Welsh Government)
- Academic Partnership Board
- NHS Wales Shared Services Partnership Committee (established as a direct result of Welsh Government regulations)
  - NHS Wales Shared Services Partnership Audit Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, set out in **[insert details]**, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Directors	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Executive Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	Directors	Yes	Authorisation matrix. Financial policies & procedures
Reimbursement of patient monies	Directors	Yes	Authorisation matrix. Financial policies & procedures
Management of Grant Agreements	Executive Director of Finance	No	Not Applicable.
Management of Legacy Income	Executive Director of Finance	No	Not Applicable.
Engagement of staff within funded establishment	Directors	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Chief Executive	Nominated deputy	In absence of Chief Executive
Staff re-grading and awarding of incremental points	Executive Director of Organisational Development & Workforce	Yes	Written authority to suitably qualified HR staff

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of overtime	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of compassionate leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of leave without pay	Directors	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Reserved for Board Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Executive Director of Organisational Development & Workforce	No	
Approval of relocation costs	Executive Director of Organisational Development & Workforce	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • Directors • Other staff	Reserved for Board Directors / Divisional Directors	No	

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of redundancy, early retirement and ill-health retirement	Chief Executive	Yes	Authorisation matrix. HR policies & procedures
Dismissal of staff	Executive Director of Organisational Development & Workforce	Yes	Authorisation matrix. HR policies & procedures
Management of clinical and other operational capacity	Directors	Yes	Authorisation matrix. Annual Operating Framework and operational plans
Approval to procure goods and services within budget	Directors	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Chief Executive	Nominated deputy	In absence of Chief Executive
Approval to commission healthcare services from other NHS bodies	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission healthcare services from voluntary sector	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission healthcare services from private and independent providers	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval to amend the drugs formulary	Executive Medical Director	No	
Approval to prescribe drugs outside the formulary	Executive Medical Director	Yes	Prescribing policies & procedures
Authorisation of sponsorship	Chief Executive	No	Sponsorship policies & procedures
Approval of clinical trials	Executive Medical Director	Yes	Clinical policies & procedures
Approval of research projects	Chief Executive	Yes	Research policies & procedures
Management of complaints	Executive Director of Nursing, Allied Health Professionals & Clinical Scientists	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	Director of Corporate Governance	Yes	Communication policies & procedures
Investment of charitable funds	Executive Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval for use of charitable funds	Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose equipment	Directors	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation (except for personal effects)	Directors	No	Within authorised limits set by WG.

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	 Small claims panel Director of Finance Chief Executive Approval by WG	 No No No No	
Approval of Clinical negligence and personal injury claims	Executive Director of Nursing, Allied Health Professionals & Health Sciences	Yes	Authorisation matrix and within limits set by WG.
Approval of staff tenancy agreements	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of capital expenditure	Chief Executive / Executive Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	Executive Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Chief Executive	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Executive Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Service Directors.
The calling down of new public dividend capital as identified in the Trust's External Financing Limit (EFL).	Executive Director of Finance	Yes	Further delegations subject to authorisation matrix. Financial policies and procedures.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Standing Financial Instructions detail the requirements for Budgetary Control, including:

- Budget Setting
- Budgetary Delegation
- Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Chief Executive will delegate the following Income and Expenditure budgetary responsibility:

- Velindre Cancer Centre budgets to Velindre Cancer Centre Divisional Director
- Welsh Blood Service budgets to Welsh Blood Service Divisional Director

In addition the Income and Expenditure budgetary responsibility for hosted organisations are delegated to the relevant Director/Senior Manager.

The Chief Executive and Divisional Directors will, in turn, delegate budgetary responsibility to other Directors and managers. The detailed schedule of this second tier delegation will be reviewed, revised and reapproved on an annual basis by the Executive Board as part of the annual Financial Strategy and Budget Setting process.

Within the budgetary delegation there are delegated powers of budget virement

- Budget virements between Divisions must be approved by the Chief Executive.
- Budget virements between budgets within the same Division must be approved by the Divisional Director.
- Budget virements between staff and non-staff within the same budget must be approved by the Budget Holder.
- These delegated powers of virement, from the Chief Executive to Divisional Directors and Budget Holders, assume that the Trust is achieving its financial targets and can be revised, in year, by the Chief Executive in the light of adverse financial performance.
- Budget virements within Divisions can be authorised by Divisional Director and Director of Finance up to the limit of £60,000.

FINANCIAL LIMITS

(All values exclude VAT)

Financial Limits	Revenue £'000	Capital £'000	Charitable Funds £'000
Corporate Services:			
Trust Board	No Limit	No Limit	0
Charitable Funds Committee	0	0	>25
Delegated Charitable Fund Holders	0	0	5
Chief Executive or Executive Director of Finance	100	100	25
Cancer Services:			
Director of Cancer Services, Director of Operations & Chief Pharmacist – for Pharmaceuticals	150	0	0
Blood Wholesale Products Chief Executive Executive Director of Finance WBS Director WBS Medical Director WBS Deputy Director WBS Assistant Director of Operations	800	0	0

Further delegated financial limits which are **less than £100k** will be agreed by the Chief Executive and the Executive Management Board.

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF DELEGATION

Please refer to the Shared Services Partnership Committee Standing Orders contained within Schedule 5.

LOSSES & COMPENSATION LIMITS

NB All amounts are exclusive of VAT.	DELEGATED LIMITS							
	Trust Limit	Trust Board	Chief Executive	Director of Nursing	Director of Finance	Divisional Directors	Claims Manager / Q&S Manager	Small Claims Panel
	£	£	£	£	£	£	£	£
1. LOSSES OF CASH DUE TO:-								
a) Theft, Fraud etc.	50,000	50,000						
b) Overpayment of Salaries, Wages, Fees & Allowances	50,000	50,000						
c) Other causes, including un-vouched or completely vouched payments, overpayments other than those included under 1b; physical losses of cash and cash equivalents e.g. stamps due to fire (other than arson), accident and similar cause	50,000	50,000						
(2) FRUITLESS PAYMENTS (including abandoned capital schemes)	250,000	250,000						
(3) BAD DEBTS AND CLAIMS ABANDONED:-								
(a) Private Patients	50,000		50,000		10,000			
(b) Overseas Visitors	50,000		50,000		10,000			
(c) Causes other than a) – b)	50,000		50,000		10,000			
(4) DAMAGE TO BUILDINGS, THEIR FITTINGS, FURNITURE AND EQUIPMENT AND LOSS OF EQUIPMENT AND PROPERTY IN STORES AND IN USE DUE TO:-								
(a) Culpable causes e.g. theft, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000	50,000						
(b) Other causes	50,000	50,000						
(5) COMPENSATION PAYMENTS UNDER LEGAL OBLIGATION	FULL	FULL	100,000					
(6) EXTRA CONTRACTUAL PAYMENTS TO CONTRACTORS	50,000	50,000						
(7) EX GRATIA PAYMENTS:-								
(a) To patients and staff for loss of personal effects	50,000		50,000	50,000	10,000			1,000
(b) For Clinical Negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 (Inc. Plaintiff Costs)	>100,000 – 1,000,000	100,000	100,000	5,000	5,000		
(c) For Personal Injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 (Inc. Plaintiff Costs)	>100,000 – 1,000,000	100,000	100,000	5,000	5,000		
(d) Other clinical negligence and personal injury claims including Putting Things Right Arrangements - Concerns	50,000		50,000	50,000			5,000	
(e) Other, except cases of maladministration where there was no financial loss by the claimant	50,000		50,000	50,000				
(f) Maladministration where no financial loss by claimant	Nil							
(g) Patient referrals outside UK and EEA guidelines	Nil							
(8) EXTRA STATUTORY AND EXTRA REGULATIONARY	Nil							

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

Trust framework

The Trust's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs*** *(see Schedule 2.1 below)*
- ***Standards of Behaviour Framework Policy***
- ***Trust Assurance Framework***
- ***Key policy documents***

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by the Trust intranet site or from the Director of Corporate Governance.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR NHS TRUSTS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders (incorporated as Schedule 2.1 of SOs)

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Schedule of decisions reserved to the Board and a Scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the Trust. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

Contents

Velindre University NHS Trust

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by **Velindre University National Health Service Trust** "the Trust". They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Director of Finance and Audit Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non compliance to the Director of Finance and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of NHS Trusts

1.3.1 The financial provisions and obligations for NHS Trusts are set out under Schedule 4 to the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the Trust meets its statutory obligation to perform its functions within the available financial resources.

1.3.2 The financial obligation as set out in paragraph 2 of Schedule 4 is as follows:

(1) Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

(2) Each NHS trust must achieve such financial objectives as may from time to time be set by the Welsh Ministers with the consent of the Treasury and as are applicable to it.

(3) Any such objectives may be made applicable to NHS trusts generally, or to a particular NHS trust or to NHS trusts of a particular description.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall income;

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and Trust officers, and Trust committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated to committees or sub-committees that the Trust has established or to an officer of the Trust in accordance with the 'Scheme of delegation' document adopted by the Trust.

2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that financial provisions, obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and Trust officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the Trust's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and

d) Without prejudice to any other functions of the Trust, and Board members and Trust officers, the duties of the Director of Finance include:

(i) the provision of financial advice to other Board members and Trust officers, and to Trust committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.

2.4 Board members and Trust officers, and Trust Committees

2.4.1 All Board members and Trust officers, and Trust committees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and Trust officers, and Trust committees who carry out a financial function, the form in which financial records are kept and the manner in which Trust Board members and officers, and Trust committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.
nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,

- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the Trust;

c) Access at all reasonable times to Board members and officers;

d) The production of any cash, stores or other property of the Trust under a Board member or a Trust official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the Trust. The Auditor General may nominate his representative to represent him within the Trust and to undertake the required audit work. The cost of the audit is paid for by the Trust. The Trust's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised

with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual report and accounts, is central to the core work of the Audit Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor

[1] The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs, that relate to the exercise of many of his core functions, including his statutory audits of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the Trust and its officers and staff, but also to, among others, suppliers to the Trust.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the Trust (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the Trust may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements

- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public

interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the Trust and other public sector bodies. At the Trust he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 (as amended).

https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

3.5.3 The LCFS shall report to the Trust Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Director of Finance and Audit Committee, at least annually, on proactive and reactive counter fraud work within the Trust.

3.5.5 The Trust must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The Trust should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on

NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Trust has two statutory financial duties, to:

- First Duty - A breakeven duty, to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period
- Second Duty - A duty to prepare a plan to secure compliance with the first duty and for that plan to be submitted to and approved by the Welsh Ministers

The first duty is provided for under paragraph 2(1) of Schedule 4 of the National Health Service (Wales) Act 2006, although this should be read in conjunction with 'Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts' which sets out the duty to break even over a three-year period. The second duty arises as a result of the Welsh Ministers' powers to set financial objectives for the Trust under paragraph 2(2) of Schedule 4 of the National Health Service (Wales) 2006 Act. The planning requirement, which by virtue of being set as a financial objective becomes a statutory financial duty, was previously set by the Welsh Ministers and has been retained by Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. Further details of the WHC can be obtained from the HSSG Director of Finance' hywel.jones38@gov.wales

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Trust has a statutory duty to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period, that is to breakeven over a 3-year rolling period.

4.2.2 Trusts must ensure their boards approve balanced revenue and capital plans before the start of each financial year.

4.2.3 The Director of Finance of the Trust will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total funding received, assumed in-year funding and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary funding are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year funding to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial funding and the application of such funds.

4.2.4 The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Trust has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs Trusts to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context within which the Trust will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,
  - establishing preventative approaches across all care and services
- demonstrate how the Trust will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plans should be based on a reasonable expectation of future income, service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning

document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the Trusts response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Trust plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the Trust and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1 Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focussed on delivery of safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioner, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced or specified funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents);

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

j) Identify potential risks and opportunities.

5.2 Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the

form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Director of Finance will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:
- Understand the current and forecast financial position
- Evaluate risks and opportunities
- Use insight to make informed decisions
- Be consistent with other Board reports

As a minimum the reports will cover:
- Current and forecast year end position on statutory financial duties
- Actual income and expenditure to date compared to budget and showing trends and run rates
- Forecast year end positions
- A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
- Explanations of material variances from plan
- Capital expenditure and projected outturn against plan
- Investigations and reporting of variances from financial, activity and workforce budgets.
- Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
- Statement of performance against savings targets
- Key workforce and other cost drivers
- Income and expenditure run rates, historic trends, extrapolation and explanations
- Clear assessment of risks and opportunities
- Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and SFI 9.1.

5.4 Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the Trust's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the Trust. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.

6.3 The Director of Finance, on behalf of the Trust, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The Trust's annual accounts must be audited by the Auditor General for Wales. The Trust's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The annual report must also be sent to the Welsh Ministers. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. NHS Trusts are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Director of Finance is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Trust business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the Trust's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the Trust. No officer other than the Director of Finance shall open any account in the name of the Trust or for the purposes of furthering Trust activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the Trust and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Director of Finance will review banking arrangements of the Trust at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Director of Finance is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

e) Ensuring effective control systems are in place for the use of payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in

writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Director of Finance will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The Trust shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

9.1.2 The Trust can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The Trust should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Director of Finance when overpayment of salary or expenses have been made, in

order that recovery can be made.

9.4.3 The Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability

10.1.1. The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2. The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the Trust's scheme of delegation.

10.1.3. The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice

(whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or Trust officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

10.3.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the Trust's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Trusts must consult with NWSSP Procurement Services, Director of Finance and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Trust's Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the Trust, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money

- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Trust. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the Trust, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Contract Notification Arrangements, included as **Schedule 1** of these SFIs.

11.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Procurement Principles

11.3.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the Trust to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.3.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Equal treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Proportionality: requirements and conditions in the procurement should be reasonable in proportion to the object of procurement and measures taken should not go beyond what is necessary;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

11.4 Legislation Governing Public Procurement

11.4.1 There are a range of EU Directives which set out the EU legal framework for public procurement. These EU Directives have been implemented into UK law by statutory regulations which govern public sector procurement, the primary statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.' From 1 January 2021, all aspects of EU law in respect of the EU Directives relating to public procurement, except where expressly stated otherwise by domestic legislation, will continue to govern public sector procurement, although further amendments or developments of EU related procurement law following this will not be incorporated into domestic law. The Welsh Government policy framework and the Wales Procurement Policy Statement (WPPS) also govern this area. One of the key objectives of governing legislation is to ensure public

procurement markets are open and that there is free movement of supplies, services and works. Legislation, policy and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs.

11.4.2 The main Regulations (the Public Contracts Regulations 2015 No. 102) cover the whole field of procurement, including thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Regulations are understood and fully implemented. The protocols set out in the Regulations, and any Procurement Policy Notices, are the model upon which all formal procurement shall be based.

11.4.3 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Trust and Procurement Services e.g. Engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.4.4 Other relevant legislation and policy include:

- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Policy Framework
- The Wales Procurement Policy Statement (WPPS)

11.5 Procurement Procedures

11.5.1 To ensure that the Trust is fully compliant with UK Procurement Regulations, EU Procurement Directives and Welsh Ministers' guidance and policy, the Trust shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;
d) Evaluation and scoring methodologies
e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures shall reflect the Welsh Ministers' guidance and the Trust's delegation arrangements and approval processes.

11.6 Procurement Consent and Notification

11.6.1 Paragraph 14(2) of Schedule 3 to the National Health Service (Wales) Act 2006 allows the Trust to:

- Acquire and dispose of property;
- Enter into contracts; and
- Accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the NHS trust or for any purpose relating to the health service).

11.6.2 **Schedule 1** details the requirement process for contract notification for Trusts.

Planning

11.7 Sustainable Procurement

11.7.4 To further nurture the Welsh economy, in support of social, environmental and economic regeneration, Trusts must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible. The principles of the Well-being of Future Generations (Wales) Act 2015 (WBFGA 2015) should be adopted at the earliest stage of planning. Procurement solutions must be developed embracing the five ways of working described within the Act and capture how they will deliver against the seven goals set out in the Act.

11.7.2 The WBFGA 2015 requires that bodies listed under the Act must operate in a manner that embraces sustainability. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

11.7.3 The 7 Wellbeing goals are:

- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

These goals have been put in place to improve the social, economic, environmental, and cultural well-being of Wales.

11.7.4 Public bodies need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. The Act expects them to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place.

11.7.5 The Trust is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on Ethical Employment in supply chains which commit public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.

11.7.6 The Trust shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The Trust shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the Trust shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with Welsh Government commitments policy set out in the current WPPS and subsequent versions of this statement, the Trust shall ensure that it provides opportunities for these organisations to quote or tender for its business.

11.9 Planning Procurements

11.9.1 Trust must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks governing public procurement and the requirement of open competition.

11.9.2 Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine:

- the likely financial value of the procurement, , including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process.
- That the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement**.**

11.9.4 Where free of charge services are made available to the Trust, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Trust does not unintentionally commit itself to a single provider or longer term commitment. Regular reports on free of charge services provided to the Trust should be submitted by Board Secretary to Audit Committee.

11.9.5 Trusts are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Trust's approved

catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the table below. Trust's must ensure the value of their requirement considers cumulative spend across the Trust for like requirements and opportunity for collaboration with other Trusts and Health Boards:

11.10.3 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SO 11.6.

11.11.2 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.3 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable
- Specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks;
  - include robust performance measures to effectively measure and manage supplier performance; and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price;
- consider cost of change where relevant;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all Wales competition/National strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;

- An acceptable level of assurance is available before presentation for approval in line with the Trust Scheme of Delegation; and
- An “or equivalent” test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly.

11.13.5 As SQA/ STAs are only used in exceptional circumstances, the Trust, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent recurrence by the Trust.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Trust to attend Audit Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training; or
- Take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA’s not endorsed by Procurement or any exceptional matters.

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Trust making use of any agreements covering the disposal of such items.

11.14.3 The Trust must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the operational service of the Trust. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records;
- Monitoring contract performance measures;
- Engaging suppliers to ensure performance delivery;
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Trust budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Trusts compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract, the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Trust will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official Orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the Trust's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Trust by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Chief Executive is responsible for ensuring the Trust enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for its provision of health care services.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the Trust by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables NHS Trusts to commission certain healthcare services. Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Board reports on quality and financial performance.

13. GRANT FUNDING

It is a matter for Trusts to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the Trust's functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the Trust has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement:

Grant v Procurement.doc

13.2 Policies and procedures

13.2.1 The Trust shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Minister's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

13.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, Trusts should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money. The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on Trusts or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;

- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, Trusts should ensure principles of good practice, available from a number of external sources, are considered and reflected in grant programmes.

13.4.1 Trusts must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.2 For grant programmes that span a number of financial years, the Trust is responsible for evaluating the programmes to ensure they are fit for purpose, are achieving required outcomes and continue to provide value for money.

13.4.3 Trusts are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.4 Trusts are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the Trust to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.5 The Trust must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the Trust should ensure principles of good practice, available from a number of external sources, are considered and reflected.

13.4.6 The Trust is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs, the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment, if appropriate, approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The Trust will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e, the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or Trust official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development has responsibility for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
   - reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation);

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

14.5.3 The Chief Executive is responsible for:

a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The capital plan and programmes must be delivered within Welsh Government capital external financing limit.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the external financing limit, as set out by Welsh Government (WG) for the year, and the Trust must not exceed the external financing limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) https://gov.wales/nhs-wales-infrastructure-investment-guidance
- Better business cases: investment decision-making framework https://gov.wales/better-business-cases-investment-decision-making-framework

15.2.2 The Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Trust's Scheme of Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three year Capital Plan, and detailed annual Capital Programme is adopted by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the Trust's SOs.

15.4.7 The Director of Planning and Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure

benefits set out in the business case supporting the investment are delivered. The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The Trust must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the Trust's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each

disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior Trust officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and Trust officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as Trust property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements including records for receipt, issues, and returns of goods to stores and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals

and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset and goods, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Director of Finance;

b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the assets and good are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately

inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The Trust must obtain the Health and Social Services Group Director General's approval for special severance payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the Trust for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology .

18.1.2 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the Trust digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the Trust's digital systems and data for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information Systems Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information Systems Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Director of Finance

18.3.1 The Director of Finance shall need to ensure that new financial data and systems and amendments to current financial data and systems are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for:

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Informatics and Digital shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the Trust arising from the use of data, information and IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 NHS Trust Responsibility

19.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Trust will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 All business shall be conducted in the name of Velindre University National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee. SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the Trust's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The Trust shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

20.2.3 The Trust shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018 and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

Schedule 1

REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales, HEIW and DHCW

Our Ref: SE&IG/

Date: 31 March, 2022

Dear All,

This letter supercedes the consent guidance issued in our joint letter on 30 November 2020.

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

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Steve.elliot@gov.wales
Gwefan • website:
www.gov.wales

LHBs and HEIW
Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts
Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

Entering into contracts
Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;

- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

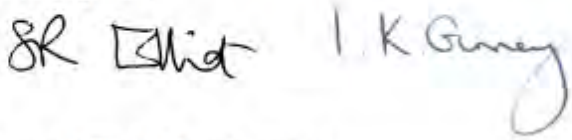
The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,



Steve Elliot & Ian Gunney
Cyfarwyddwr Cyllid dros dro - Interim Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group

Schedule 3

BOARD COMMITTEE ARRANGEMENTS

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

CONTENTS

Quality, Safety and Performance Committee

Terms of Reference &

Operating Arrangements

Reviewed:	November 2022
Approved:	January 2023
Next Review Due:	November 2023

1. INTRODUCTION

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

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide:

- Evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:
  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects regarding the workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021) and the Duties of Quality and Candour;

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance

arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes / outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.

- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are

maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

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

Authority

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

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

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

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

Access

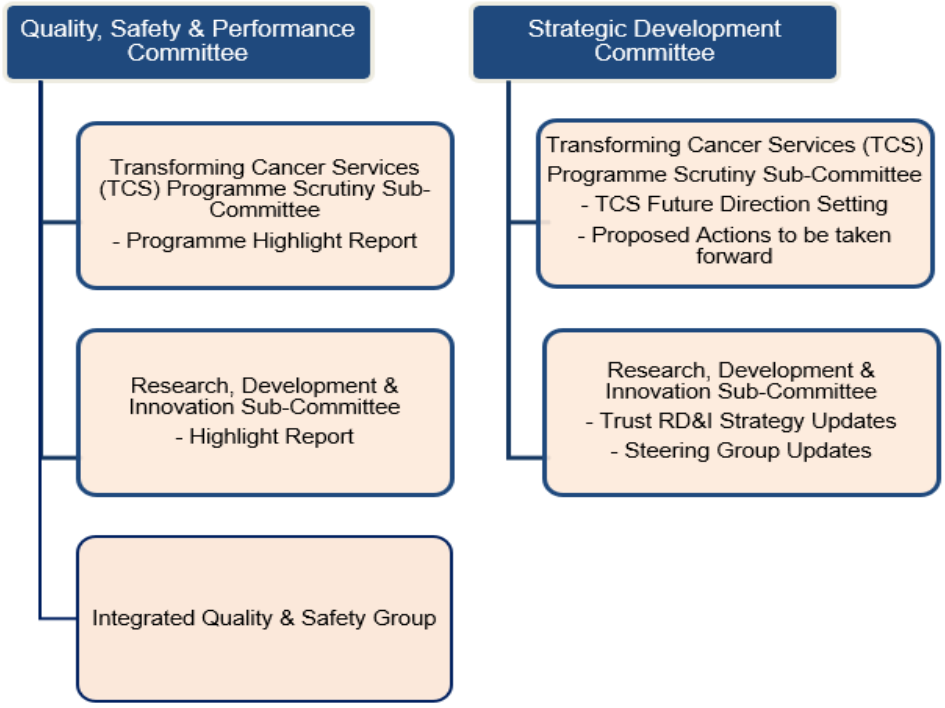
3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the:
- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.
- Integrated Quality & Safety Group.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at ***Annex 2***.

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



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

4. MEMBERSHIP

Members

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

Chair — Independent member of the Board (Non-Executive Director)
One independent member of the Board (Non-Executive Directors)

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

4.2 **Attendees:**

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- Welsh Blood Service and Velindre Cancer Centre Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Deputy Director of OD & Workforce
- Chief Digital Officer (*also cyber/data outages/performance)*
- Head of Quality, Safety & Assurance
- Head of Corporate Governance

4.3 **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.
The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

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

Secretariat

4.4 Secretary - as determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

Support to Committee Members

4.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure the provision of a programme of development for Committee members as part of the Trust's overall OD programme.

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

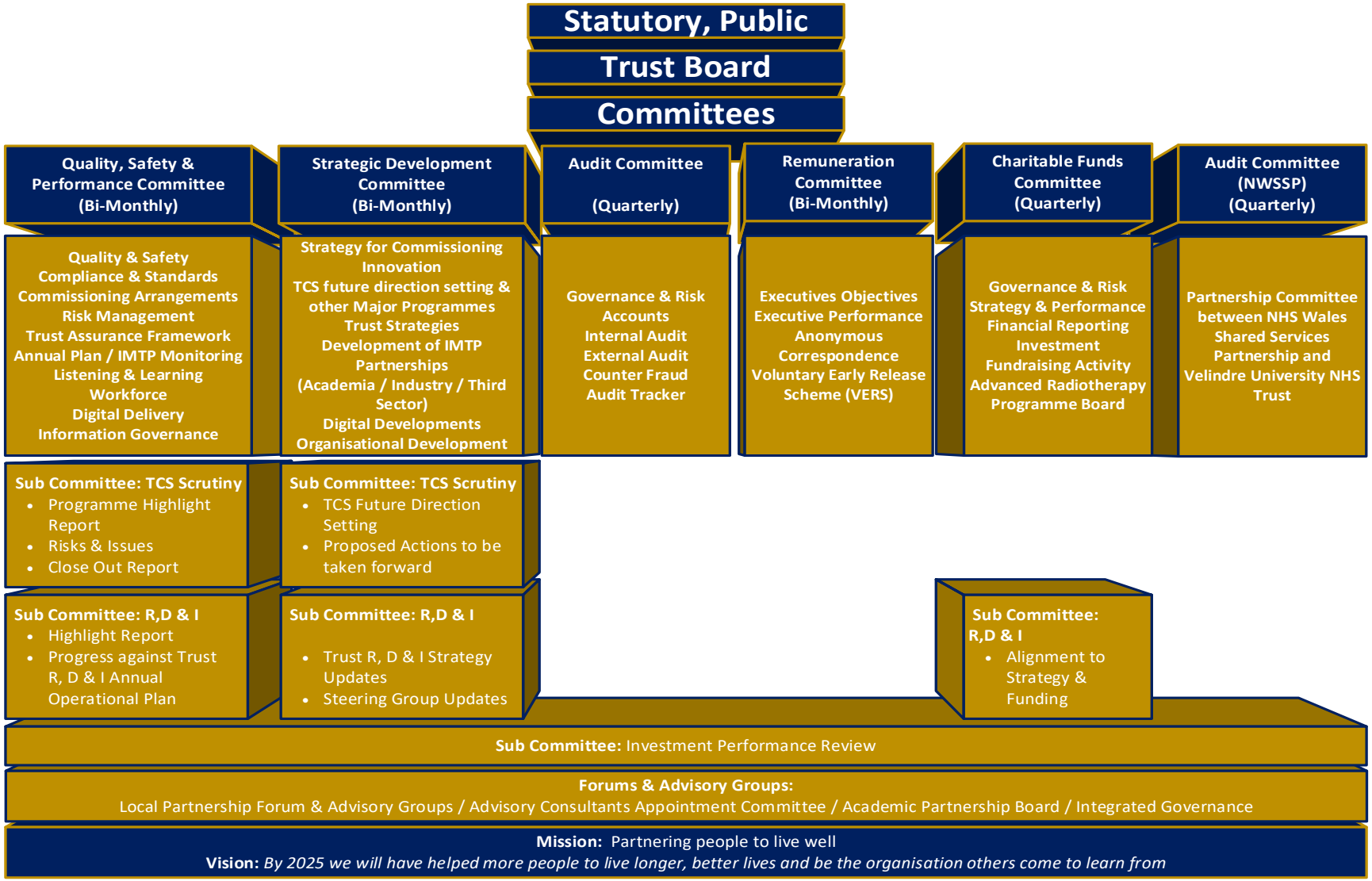
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

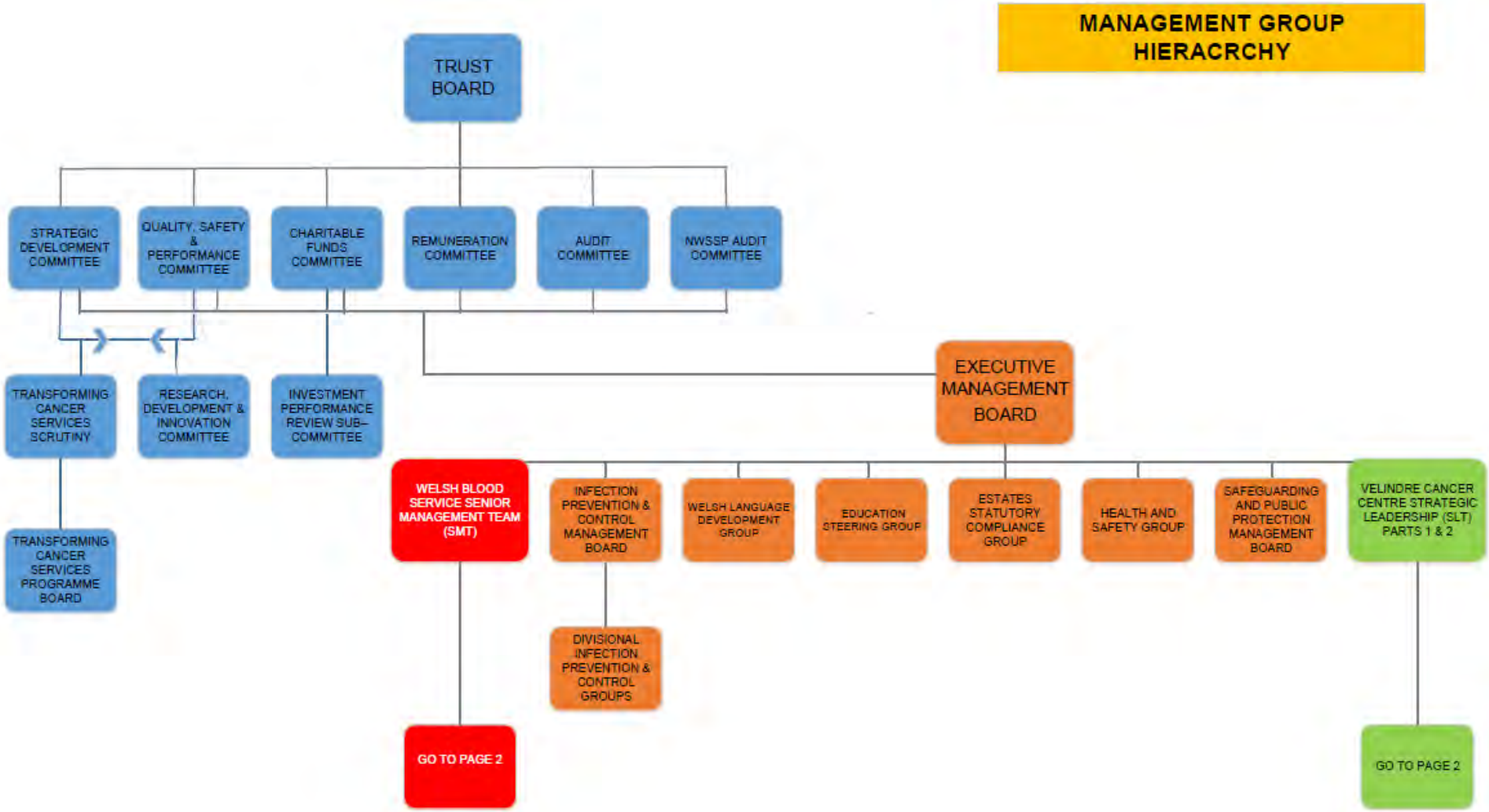
10. CHAIR'S ACTION ON URGENT MATTERS

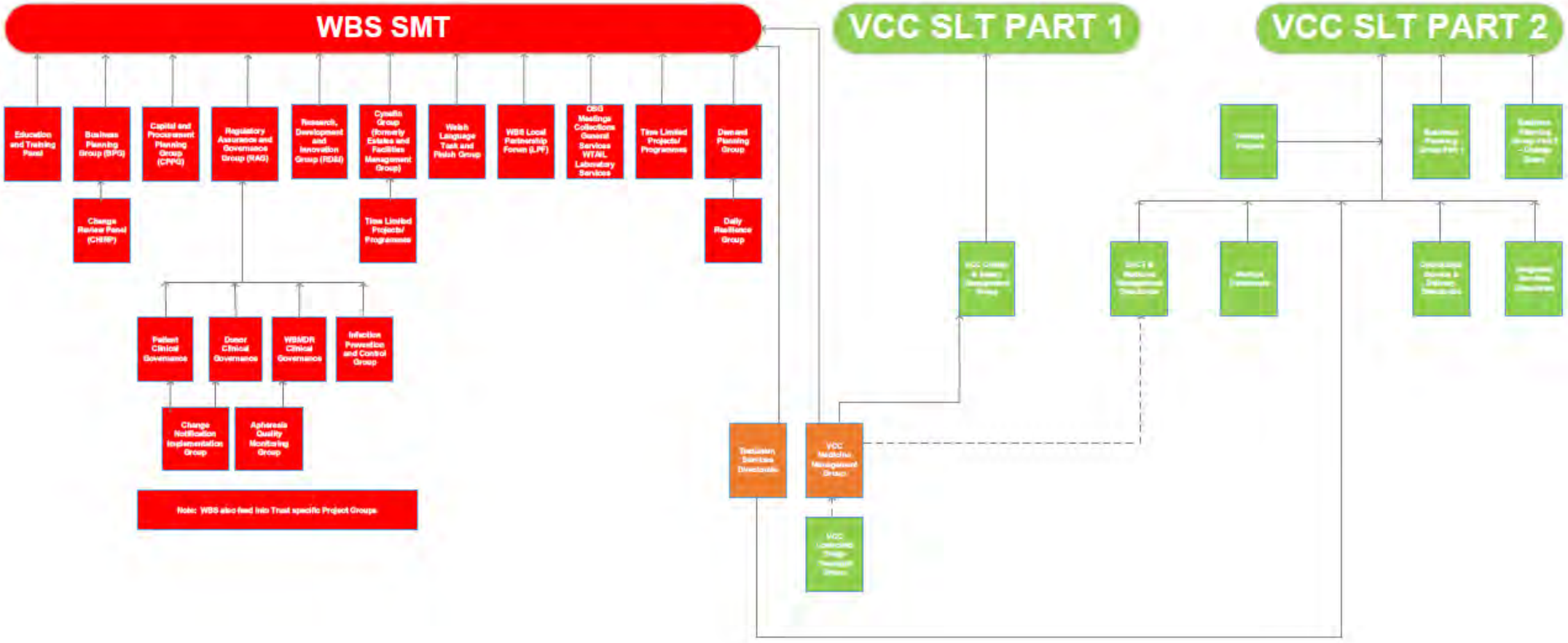
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf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

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

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK




MANAGEMENT GROUP HIERACRCHY
TRUST BOARD
STRATEGIC DEVELOPMENT COMMITTEE
QUALITY, SAFETY & PERFORMANCE COMMITTEE
CHARITABLE FUNDS COMMITTEE
REMUNERATION COMMITTEE
AUDIT COMMITTEE
NWSSP AUDIT COMMITTEE
TRANSFORMING CANCER SERVICES SCRUTINY
RESEARCH, DEVELOPMENT & INNOVATION COMMITTEE
INVESTMENT PERFORMANCE REVIEW SUB–COMMITTEE
EXECUTIVE MANAGEMENT BOARD
TRANSFORMING CANCER SERVICES PROGRAMME BOARD
WELSH BLOOD SERVICE SENIOR MANAGEMENT TEAM (SMT)
INFECTION PREVENTION & CONTROL MANAGEMENT BOARD
WELSH LANGUAGE DEVELOPMENT GROUP
EDUCATION STEERING GROUP
ESTATES STATUTORY COMPLIANCE GROUP
HEALTH AND SAFETY GROUP
SAFEGUARDING AND PUBLIC PROTECTION MANAGEMENT BOARD
VELINDRE CANCER CENTRE STRATEGIC LEADERSHIP (SLT) PARTS 1 & 2
DIVISIONAL INFECTION PREVENTION & CONTROL GROUPS
GO TO PAGE 2
GO TO PAGE 2


WBS SMT
Education and Training Panel
Business Planning Group (BPG)
Capital and Procurement Planning Group (CPPG)
Regulatory Assurance and Governance Group (RAG)
Research, Development and Innovation Group (RD&I)
Cymdeithas Group (formerly Estates and Facilities Management Group)
Welsh Language Task and Finish Group
WBS Local Partnership Forum (LPF)
OBG Meetings Collections General Services WTAL Laboratory Services
Time Limited Projects/ Programmes
Demand Planning Group
Change Review Panel (CHRP)
Time Limited Projects/ Programmes
Daily Resilience Group
Patient Clinical Governance
Donor Clinical Governance
WBMDR Clinical Governance
Infection Prevention and Control Group
Change Notification Implementation Group
Apheresis Quality Monitoring Group
Note: WBS also feed into Trust specific Project Groups
VCC SLT PART 1
VCC SLT PART 2

Strategic Development Committee

Terms of Reference & Operating Arrangements

Reviewed:	October 2021
Approved:	January 2022
Next Review Due:	October 2022

1. INTRODUCTION

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

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Strategic Development Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Strategic Development Committee "the Committee" is to provide:

- Evidence based and timely **advice** to the Board to assist it in discharging its functions and responsibilities with regard to the:
  - strategic direction
  - strategic planning and related matters
  - organisational development
  - digital services, estates and other enabler services
  - sustainable development and the implementation of strategy through the spirit and intention of the Well Being of Future Generations Act
  - investment in accordance with Value-based healthcare

- **Assurance** to the Board in relation to strategic decision-making, ensuring it is supported with a robust understanding of risks in relation to the achievement of organisational goals and strategic objectives.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board on strategic direction and organisational development, the Committee will:

- Oversee the development of the Trust's strategies and plans which set out how plans the delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.

- Regularly review whether the Trust is developing a strategic approach, which provides it with the greatest opportunity to fulfil its duties under the Well-being of Future Generations (Wales) Act 2015 by means of the application of the Act's Sustainable Development Principle.

- Review the arrangements and contents of key plans to ensure alignment with the Trusts strategic goals and objectives, including the Trust's Integrated Medium-Term Plan (IMTP) in accordance with above.
- Review the Trust's Capital Plan to ensure alignment with key Trust strategies, plans (IMTP) and sustainable development principles.

- Review Trust developments involving significant investment or modernisation.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

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

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

Authority

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

- Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee, or group set up by the Board to assist it in the delivery of its functions.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

- To approve policies relevant to the business of the Committee as delegated by the Board.

Access

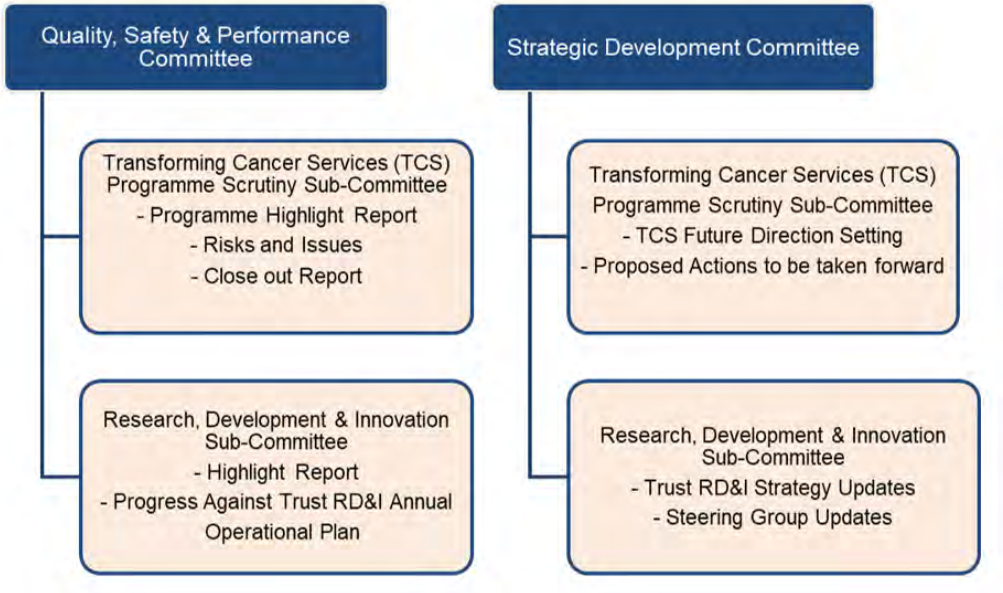
3.4 The Chair of the Strategic Development Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

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

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

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



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

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

4. MEMBERSHIP

4.1 **Members**

A minimum of two (2) members comprising:

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

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

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

4.2 **Attendees:**

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

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

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

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

4.3 **Secretariat**

As determined by the Director of Corporate Governance and Chief of Staff.

4.4 **Member Appointments**

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

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

4.5 **Support to Committee Members**

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

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

5.1 **Quorum**

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

5.2 **Frequency of Meetings**

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

5.3 **Withdrawal of individuals in attendance**

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

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

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

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

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports.

- Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

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

10. CHAIR'S ACTION ON URGENT MATTERS

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

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

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	January 2023
Next Review Due:	November 2023

1. INTRODUCTION

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

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference as detailed in the NHS Wales Audit Committee Handbook June 2012.

2. PURPOSE

2.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

2.3 A separate Audit Committee is in operation for the NHS Wales Shared Services Partnership (NWSSP) which has its own Terms of Reference.

3. DELEGATED POWERS AND AUTHORITY

3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:

- The adequacy of the Trust's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:

  - the organisation's ability to achieve its objectives,

  - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and other directions and requirements set by

the Welsh Government and others,

- the reliability, integrity, safety and security of the information collected and used by the organisation,

- the efficiency, effectiveness and economic use of resources, and

- the extent to which the organisation safeguards and protects all its assets, including its people to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);

- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;

- The Schedule of Losses and Compensation;

- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);

- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;

- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and

- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

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

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances), prior to endorsement by the Board;

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and

- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by the NHS Counter Fraud Authority.

3.3 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

3.4 This will be evidenced through the Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Committee to review and form an opinion on:

- The comprehensiveness of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non-clinical; and

- The reliability and integrity of these assurances.

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

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the Board and the Accountable Officer through the Committee;

- There is an effective counter fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the Committee;

- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;

- The work carried out by key sources of external assurance, in particular, but not limited to the Trust's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;

- The work carried out by the whole range of external review bodies is brought to the attention of the Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;

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

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

Authority

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

- Employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.

3.7 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives shall have unrestricted and confidential access to the Chair of the Audit Committee at any time, and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

3.10 The Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist without the presence of officials on at least one occasion each year.

3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

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

4. MEMBERSHIP

Members

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

Chair	Independent member of the Board (Non-Executive Director)
	Two independent members of the Board (Non-Executive Directors) *[one member should be a member of the Quality, Safety & Performance Committee]*
	The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.
	The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

4.2 In attendance:

Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.)*
Executive Director of Finance
Director of Corporate Governance and Chief of Staff
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation — The Committee Chair may invite:

- the Chair of the organisation
- any other Trust officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

4.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

Support to Committee Members

4.6 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

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

5 COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

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

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

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

7 REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year;

- Bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against

relevant standards. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

8 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *[as per section on Committee meetings]*

Cross reference with the Trust Standing Orders.

9 REVIEW

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

10 CHAIR'S ACTION ON URGENT MATTERS

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

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

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2021
Approved:	January 2022
Next Review due:	October 2022

1. INTRODUCTION

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

1.2 In accordance with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. CONSTITUTION

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

2.2 The purpose of the Committee" is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

3. SCOPE AND DUTIES

3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the Charitable Funds in accordance with their respective governing documents.

3.2 To ensure that the Trust policies and procedures for Charitable Funds investments are followed. To make decisions involving the sound investment of Charitable Funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The terms outlined in the Velindre NHS Trust Charity's Governing Documents

3.3 At least twice a year, receive highlight reports from the Executive Director of Finance in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.

3.4 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.5 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

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

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

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

5. AUTHORITY

5.1 The Committee is empowered with the responsibility for:

- Overseeing the day to day management of the investments of the Charitable Funds in accordance with the investment strategy set down from time to time by the Trustees and the requirements of the Trust's Standing Financial Instructions.
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power the Committee must ensure that:

  a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
  b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
  c) The performance of the person or persons exercising the delegated power is regularly reviewed.

d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2012.
Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

- Ensuring that the banking arrangements for the Charitable Funds are kept entirely distinct from the Trust's NHS funds.

- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.

- Obtaining appropriate professional advice to support its investment activities.

- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

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

5.4 **Sub Committees**

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

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

The Charitable Funds Committee is also supported by the Velindre Charity Senior Leadership Group, whose purpose on behalf of the Board of Trustees is to support the development of the strategic direction, take forward strategic delivery and operational management of all Charitable Funds held within the Trust.

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

6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

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

Attendees

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

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

By invitation, The Committee Chair may invite:

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

Secretariat

6.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

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

6.6 In order to demonstrate that there is a visible independence in the consideration of decisions and management of charitable funds from the Trust's core functions, the Board should consider extending invitations to the Charitable Funds Committee to individuals outside of the Board. One option might be to seek representation from the Patient Liaison Group.

Support to Committee Members

6.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

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

7. COMMITTEE MEETINGS

Quorum

7.1 At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member and one must be the Executive Director of Finance or Nominated Representative.

Frequency of meetings

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

Withdrawal of individuals in attendance

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

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

8.1 The Committee will only consider Research and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation Sub-Committee. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.

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

8.3 The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and appropriate sharing of information in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in their capacity as Trustees. This may include, where appropriate, a separate meeting with the Board.

9.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year.

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

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum

Cross referenced with the Trust Standing Orders.

11. REVIEW

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

12. CHAIR'S ACTION ON URGENT MATTERS

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

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

Charitable Funds Investment Performance Review Sub Committee

Terms of Reference & Operating Arrangements

Reviewed:	June 2022
Approved:	November 2022
Next Review Due:	June 2023

1. INTRODUCTION

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

1.2 The Charitable Funds Committee was established by the Board to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

1.3 As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

2. PURPOSE

2.1 The purpose of the Investment Performance Review Sub Committee ("the Committee") is to undertake the following tasks on behalf of the Committee:

- Ensure that when investing charitable funds Trustees achieve an appropriate balance for the Charity between the two objectives of:

  a) Providing an income to help the Charity carry out its purposes effectively in the short term; and

  b) Maintaining and, if possible, enhancing the value of the invested funds, so as to enable the Charity to carry out its purpose in the longer term.

- Ensure that the following standards as defined in **the Trustee Act are followed**, whether they are using the investment powers in that Act or not:

  a) 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.

  b) Secondly, that the Charity is complying with the following **specific duties**:
     - Trustees must consider the **suitability** for the 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 the Charity They also have a duty to consider whether a particular investment of that type is a suitable one for the Charity to make, based on the overall investment policy set by the Charitable Funds Committee 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.

- 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. A review of the investments should be carried out at least once a year.

- Trustees must monitor the overall performance of the portfolio and, in so far as it is possible, compare the rate of return with returns achieved by other similar organisations. The rate of return will need to be reported annually to the Charitable Funds Committee as part of its annual report.

- 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.

3. DELEGATED POWERS AND AUTHORITY

The Committee has delegated responsibility to the sub-committee to review the performance and strategy for the Investment Portfolio in the context of the general and specific duties set out above and has delegated the authority to investigate all relevant aspects relating to this function.

4. MEMBERSHIP

Members:

The membership of the Charitable Funds' Investments Performance Sub Committee is as follows:

- Two Independent Members of the Board (Non Executive Director)
- The Chief Executive
- The Executive Director of Finance.

One of the independent members will be Chair of the Sub-Committee.

An invitation to attend these Sub Committee meetings has been given to representatives of the Trust's Investment Management Service Provider.

Attendees:

In attendance	The Committee may require the attendance for advice, support and information routinely at meetings from: • Deputy Director of Finance • Investment Advisors

Secretariat

The Sub Committee shall be serviced by a Secretary who shall not be a member of the Sub Committee with agendas and papers circulated at least 10 working days before meetings.

5. COMMITTEE MEETINGS

Quorum: At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member.

The Sub Committee should meet every six months or as required.

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

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

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

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

The Sub-Committee Chair shall arrange for a report formally, regularly and on a timely basis to the Charitable Funds Committee on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports following each meeting.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Sub Committee, other than in relation to the quorum requirements as specified in 5.1 above.

9. REVIEW

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

Remuneration & Terms of Service Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2023
Approved:	November 2023
Next Review Due:	November 2024

1. INTRODUCTION

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

1.2 In line with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Remuneration & Terms of Service Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Remuneration & Terms of Service Committee "the Committee" is to provide:

- ***advice*** to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government; and

- ***assurance*** to the Board in relation to the Trust's arrangements for the remuneration and terms of Service, including contractual arrangements, for *all staff*, in accordance with the requirements and standards determined for the NHS in Wales.

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

3. DELEGATED POWERS AND AUTHORITY

3.1 The Board had delegated the following specific powers to the Committee;

- To consider and ratify Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.

3.2 With regard to its role in providing advice and assurance to the Board, the Committee will comment specifically upon the:

- remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by the Welsh Government are applied consistently;

- objectives for Executive Directors and other VSMs and their performance assessment;

- performance management system in place for those in the positions mentioned above and its application;

- proposals to make additional payments to consultants to include any additional sessions or allowances payable to Senior Medical Staff for managerial duties; and

- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Welsh Government guidance.

Authority

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

- employee (and all employees are directed to cooperate with any reasonable request made by the Committee); and

- any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.

3.4 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

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

Sub Committees

3.6 The Committee may, subject to the approval of the Trust Board, establish Sub Committees or task and finish Groups to carry out on its behalf specific aspects of Committee business. The following Sub Committees/task and finish Groups have been established:

None currently.

4. MEMBERSHIP

Members

4.1 A minimum of two (2) members, comprising:
Chair or Vice Chair of the Board (Non-Executive Director)
At least one other independent member of the Board (Non-Executive Director)

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

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

In attendance

4.2 By invitation The Committee Chair may invite:

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

Secretariat

4.3 Secretariat as determined by the Director of Corporate Governance

Member Appointments

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

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

Support to Committee Members

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

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability in relation to its role as Corporate Trustee.

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

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

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

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

6.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- report formally and on a timely basis to the Board on the Committee's activities, in a manner agreed by the Board;
- bring to the Board's specific attention any significant matter under consideration by the Committee;
- ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the

Trust.

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

7.3 The Committee shall provide a written, annual report to the board on its activities. The report will also record the results of the Committee's self- assessment and evaluation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *[cross reference with the Standing Orders]*

9. REVIEW

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

Transforming Cancer Services Programme Scrutiny Sub-Committee

Terms of Reference & Operating Arrangements

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

1. INTRODUCTION

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

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

1.3 As part of their functions, the Quality Safety and Performance Committee and the Strategic Development Committee are supported by the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee to scrutinise the programme governance arrangements for the TCS Programme, which extends to its constituent projects. At a project level the Sub-Committee will examine, Project arrangements, the application and project management methodologies, monitor project performance, risk management, progress and provide assurance to the Quality, Safety and Performance Committee. Assurance on development or proposed changes to the programme scope will be provided to the Strategic Development Committee.

1.4 The detailed terms of reference and operating arrangements set by the Quality, Safety and Performance Committee and Strategic Development Committee in respect of this Sub-Committee are set out below.

2. PURPOSE

2.1 The purpose of the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee is to:

- Provide assurance that the leadership, management and governance arrangements are sufficiently robust to deliver the outcomes and benefits of the programme.
- Scrutinise the progress of the programme and provide the Trust Board with assurance that implementation is effective, efficient and within the budget available.
- Undertake any other scrutiny activity relating to the TCS Programme as directed by the Trust Board or Senior Responsible Owner (SRO).
- Seek advice and guidance from appropriate Technical Advisors as well as the MIM Transactor (if relating to the nVCC Project) to assist the Committee with their scrutiny of the TCS Programme.
- Provide assurance to the Trust Board on all aspects of the TCS Programme in relation to approvals sought on all decisions reserved for the full Board.

- Receive all audit, gateway and assurance reviews pertaining to the programme or its constituent projects and provide assurance (or otherwise) to the Trust that the programme is being delivered in accordance with all professional, financial and Trust standards.

- Provide assurance to the Trust Board and support to the Senior Responsible Officer in signalling the TCS closure activities once it has met its objectives.

2.2 Where appropriate, the Committee will advise the Trust Board and the Accountable Officer on where, and how, its system of assurance in relation to the TCS Programme may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

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

3.1 Strategy and Policy Development

- Scrutinise programme and project documentation to ensure the direction of the TCS Programme remains within the scope and parameters set by the Trust Board and its alignment with the external commissioner and political environment.

- Scrutinise and provide assurance that the Programme and its constituent projects are conducted in line with the Trust's requirements on policy and legislative compliance, best practice and within the Trust's governance framework.

3.2 Governance, Monitoring and Review

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

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

- Provide assurance that Programme and Project governance arrangements are appropriately designed, proportionately applied and implemented and are operating appropriately to ensure the provision of a high quality programme and project management delivery.

- Undertake scrutiny and assurance of the Programme progress against the master programme plan, seeking explanations and remedies for any deviation from Programme timelines. It will report any concerns to the Trust Board as and when appropriate and necessary.

- Undertake scrutiny and assurance of Programme risks, issues and mitigating actions to satisfy itself that they can be placed back under the required levels of control.

- Scrutinise all sources of independent assurance in relation to the delivery of the Programme (e.g. Internal/External Audit, Independent Reviews, Gateway Reviews, CAP etc.) and scrutinise and monitor the organisation's response to independent reviews.

- Provide assurance that there are robust monitoring and management arrangements in place to identify important enablers and dependencies between the programmes projects, as failure to do so could impact on the programmes critical path.

- Scrutinise and assure that the Programme and Project expenditure against the budget allocated is appropriate and managed effectively.

3.3 **Authority**

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

- Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and

- Other Committee, sub Committee, or group set up by the Board (including the Project Board) to assist it in the delivery of its functions.

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- Provide assurance that any proposals /actual amendments to delegated limits as necessary in relation to the all TCS Projects are in accordance with the Trust Boards direction and it's Standing Orders and Statutory Financial Instructions.

- The Sub-Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.4 **Access**

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

4. MEMBERSHIP

Members

4.1 A minimum of three (3) members to include:

Chair	Independent member of the Board (Non-Executive Director)
	Two (2) other Independent members of the Board (Non-Executive Director)
	Other Trust Board members are extended an open invitation to attend all/any meeting

Attendees

4.2 **Core Attendance**;

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

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

- Project Executive Project 1
- Project Executive Project 2
- Project Executive Project 3
- Project Executive: Project 4
- Project Executive: Project 5
- Project Executive: Project 6

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

Secretariat

4.4 As determined by the Director of Corporate Governance.

Member Appointments

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

Members shall be appointed for a maximum of 3 consecutive years before formally

reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

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

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

5. COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

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

Withdrawal of individuals in attendance

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

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

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

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

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

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

In doing so, contributing to the integration of good governance across the Organisation,

ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Quality, Safety and Performance Committee, the Strategic Development Committee Board and the Accountable Officer on the Sub-Committee's activities. This includes verbal updates on activity and the submission of written highlight reports by exception throughout the year and an annual Committee report.

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees/Groups of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum – as per section 5.1 above. Cross referenced with the Trust Standing Orders.

9. REVIEW

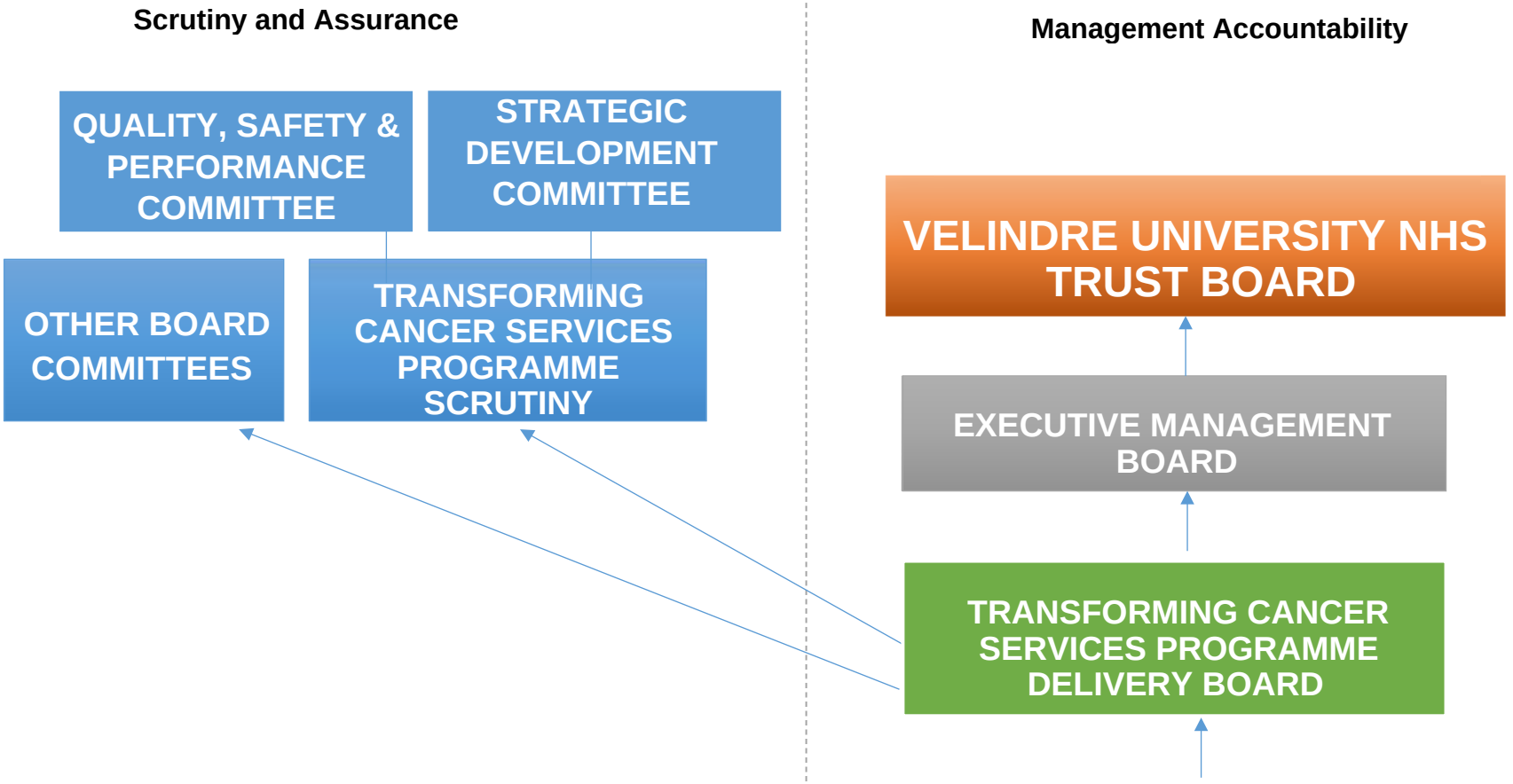
9.1 These Terms of Reference shall be reviewed annually by the Sub-Committee with reference to the Trust Board.

10. CHAIR'S ACTION ON URGENT MATTERS

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

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

Structure and governance arrangements



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

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	November 2022
Next Review Due:	October 2023

1. INTRODUCTION

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

1.2 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.

1.3 As part of the aforementioned Committee functions, the **Research, Development & Innovation (RD&I) Sub-Committee** has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:

- oversee and maintains oversight of the RD&I Strategy on behalf of the Strategic Development Committee.
- oversee the development of an annual implementation plan that operationalises the Strategy and monitor the Division's performance and delivery on behalf of the Quality, Safety & Performance Committee.
- review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.

1.4 Research, Development and Innovation are defined as follows:

- **Research and Development**, from a healthcare perspective - refers to systematic investigation and study to generate new knowledge and insight to drive improved patient care.
- **Innovation**, from a healthcare perspective - refers to the application of original research into new or improved health policies, practices, systems, products and technologies, services or delivery methods for improved patient outcomes.

2. PURPOSE

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

- Provide strategy and policy oversight for RD&I activities undertaken by the Trust reporting to the Strategic Development Committee.

- Provide assurance on the performance of RD&I activity reporting to the Quality, Safety & Performance Committee.

- Promote and encourage a RD&I ethos and culture which is integral to the Trusts vision, mission and values including the identification of new and enhanced funding opportunities to grow the significance and reach of the Trust's RDI activities.

- Provide assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the UK Policy Frameworks for Health & Social Care Research as amended from time to time.

- Consider relevant matters with reference to the parameters identified for risk appetite in relation to RD&I as set by the Board.

- The RD&I Sub-Committee is underpinned and informed through the work of a number of Management Groups and Assurance Processes as set out in ***Appendix 1***.

3. DELEGATED POWERS AND AUTHORITY

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

3.1 Strategy & Policy Development

- Promote and encourage a RD&I ethos and culture within the Trust.

- Oversee the development of all RD&I strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of RD&I activity.

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.

- Ensure that matters of strategic development are escalated as appropriate to the Trust Strategic Development Committee and on to Trust Board for assurance and approval as required.

3.2 Strategy & Policy Approval

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

- Scrutinise RD&I Business cases for any legal and / or ethical implications that need to be considered, access, finance and ensure alignment with the Trust overarching ten year strategy ***'Destination 2032'*** including the benefit / impact it will make for patients / donors / staff and service users. The Committee is also supported by the Advancing Radiotherapy Fund (ARF) Programme Board, (established to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales), in scrutinising bids for funding for business case proposals and will assess, review and advise as appropriate.

3.3 **Monitoring and Review**

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

- To achieve this, the Sub-Committee will need assurance that the following aspects of RD&I are being effectively managed:

    - The safety, rights, dignity and wellbeing of participants in Innovation and Research development projects is above all other considerations.

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

    - The diversity of the organisation's patients, service users, donors and staff are valued and that their active involvement in the development of Research, Development and Innovation as appropriate.

    - There is close collaboration with partner Organisations in higher education to improve quality, promote joint working for best RD&I outcomes and avoid unnecessary duplication of functions. In this respect, the work of RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board.

    - The organisation ensures compliance with appropriate legislation and regulation such as the, UK Policy Framework for Health and Social Care Research 2017 the EU Clinical Trials Directive 2004 as amended, Good Laboratory Practice, Good Manufacturing Practice in manufacturing products for clinical trials and Good Clinical Practice in the conduct of all clinical Research and Innovation activities as appropriate.

    - Systems are in place to monitor compliance with regulatory requirements of the Trust as well as organisational standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Research and Innovation activity.

    - Research and Innovation investment and expenditure is accounted for and complies with audit requirements as well as the requirements of external funders or sponsors as appropriate.

    - The Committee will scrutinise research and/or innovation proposals and/or business cases that are seeking charitable funding PRIOR to submission to the Charitable Funds Committee, in order to provide assurance on the quality and safety of RD&I related activity.

    - When research or innovation findings have commercial potential, the Trust takes action to protect and exploit them in collaboration with its Research and Innovation partners and where appropriate commercial Organisations.

3.4 **Access**

The Chair of the RD&I Sub-Committee shall have reasonable access to Executive Directors and other relevant senior staff.

4. MEMBERSHIP

Members

4.1 A minimum of two (3) members to include:

Chair — Independent member of the Board (University) or delegated Independent Board member
Two Independent Members of the Board

Attendees

4.2 In attendance

- Executive Director with responsibility for RD&I currently Medical Director
- Executive Director of Finance or nominated officer with RD&I funding responsibilities
- Associate Medical Director with responsibility for R&D
- Clinical Director (or Nominated Deputy) – Velindre Cancer Centre
- Executive Director of Nursing AHP and Health Sciences
- Director of Corporate Governance
- Trust Head of Innovation
- Head of Velindre Cancer Research Strategy
- Trust Head of Research & Development
- Research Delivery Manager
- Research, Development and Innovation Finance Business Partner
- Representative - Velindre Cancer Centre Strategic Leadership Team
- Representative – Welsh Blood Service SMT Lead for RD&I
- Representative – Welsh Blood Service Lead Clinician for RD&I
- WBS RD&I Facilitation Lead
- Service User/Lay Representatives

4.3 **By invitation**

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

- Head of Information Governance (in advisory capacity)
- Divisional Directors
- Representatives of stakeholder organisations

As well as others internal or external to the Organisation who the Sub-Committee consider should be in attendance, taking account of the matters under consideration at each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

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

4.6 **Support to Committee Members**

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

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

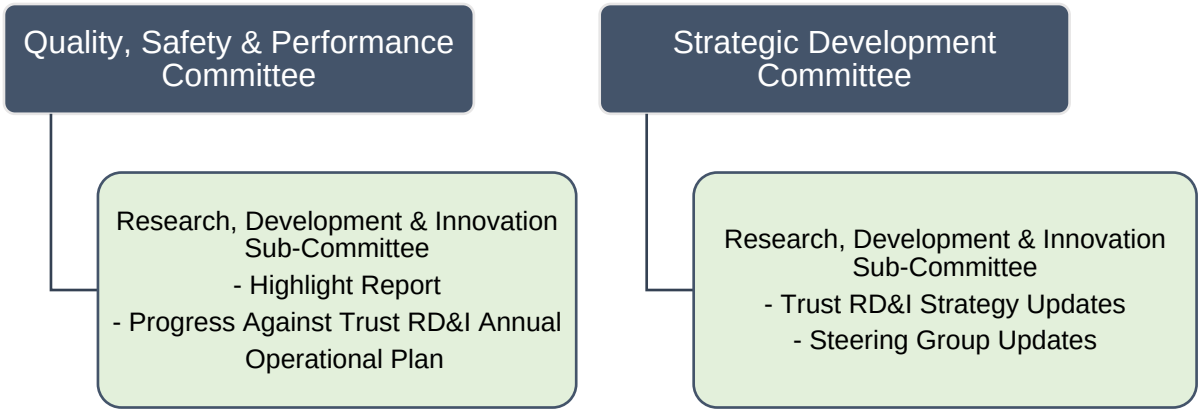
- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. SUB-COMMITTEE MEETINGS

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

- Research, Development & Innovation Sub-Committee

The Sub-Committee will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as follows :



Although the Research, Development & Innovation Sub-Committee, is a sub-committee with dual reporting lines, it will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee is also accountable to the Trust Charitable Funds Committee in relation to ensuring business cases are aligned with RD&I strategy and Trust's strategic objectives. Further details are set out in each of the respective Terms of Reference. In addition, the wider governance and accountability reporting arrangements in place at a divisional level that feed upwards into the RD&I Sub-Committee structure are also summarised at **Appendix 1.**

5.1 **Quorum**

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

5.2 **Frequency of Meetings**

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

5.3 **Withdrawal of individuals in attendance**

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

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

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

6.2 The Sub-Committee is directly accountable to the Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee for its performance in exercising the functions set out in these terms of reference.

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

a. The Committee Chair shall:

Report formally, to the:

i. Quality, Safety & Performance Committee on the performance and delivery of RD&I quarterly.
ii. Strategic Development Committee Board on strategic development and updates to the RD&I Strategy quarterly and

iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives.

7.2 The Sub-Committee shall receive:

i. A briefing from the Executive Medical Director with responsibility for RD&I
ii. A quarterly RD&I Integrated Performance Report (following presentation at EMB)
iii. A quarterly Highlight Report from the Advancing Radiotherapy Fund Programme Board on the activity of the programme.

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

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

9. REVIEW

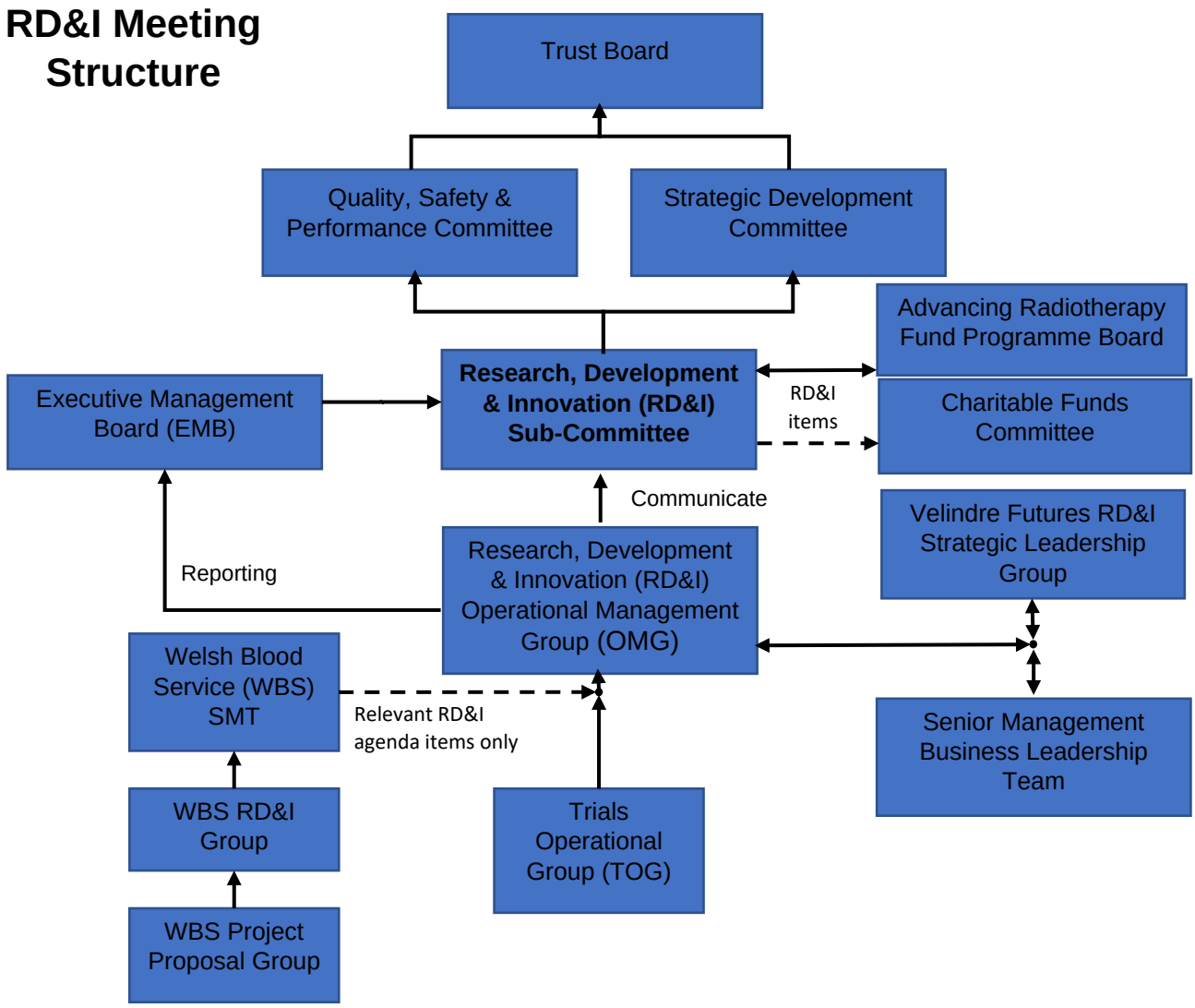
a. These terms of reference and operating arrangements shall be reviewed annually by the Sub-Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

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

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

APPENDIX 1


RD&I Meeting Structure
Trust Board
Quality, Safety & Performance Committee
Strategic Development Committee
Advancing Radiotherapy Fund Programme Board
Executive Management Board (EMB)
Research, Development & Innovation (RD&I) Sub-Committee
RD&I items
Charitable Funds Committee
Communicate
Velindre Futures RD&I Strategic Leadership Group
Reporting
Research, Development & Innovation (RD&I) Operational Management Group (OMG)
Welsh Blood Service (WBS) SMT
Relevant RD&I agenda items only
Senior Management Business Leadership Team
WBS RD&I Group
Trials Operational Group (TOG)
WBS Project Proposal Group

Schedule 4

ADVISORY GROUPS

Terms of Reference and Operating Arrangements

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

Terms of Reference and Operating Arrangements for;

- Local Partnership Forum
- Advisory Consultants Appointment Committee
- Academic Partnership Board

CONTENTS

Local Partnership Forum

Terms of Reference & Operating Arrangements

Reviewed:	August 2023
Approved:	September 2023
Next Review Due:	September 2024

1. INTRODUCTION

1.1 The Trust's standing orders provide for the establishment of a Local Partnership Forum (LPF) and that the Board must formally approve terms of reference and operating arrangements for the LPF.

The LPF will also operate in accordance with the Trade Union Congress (TUC) six principles of partnership working, namely;

- A shared commitment to the success of the organisation.
- A focus on quality of working life.
- Recognition of the legitimate roles of the employer and trade union.
- A commitment by the employer to employment security.
- Openness on both sides and willingness by the employer to share information and discuss future plans of the organisation.
- Adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees.

1.2 The detailed terms of reference and operating arrangements set by the Board in respect of this forum are set out below.

2. PURPOSE

2.1 The purpose of the Local Partnership Forum (LPF) is;

To provide a formal mechanism where the Trust, as employer and trade unions/professional bodies representing Trust employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the Trust – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the Trust's workforce.

2.2 It is the forum where the Trust and staff organisations will engage with each other to inform, debate and seek to agree local priorities on workforce and health service issues; and inform thinking around national priorities on health matters.

2.3 The Trust may specifically request advice and feedback from the LPF on any aspect of its business and the LPF may also offer advice and feedback even if not specifically requested by the Trust. The LPF may provide advice to the Board:

- In written advice or
- In any other form specified by the Board.

3. MEMBERSHIP

Joint Chairs

3.1 The LPF shall have two Chairs on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff Representative and Management Representative Chairs;
- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the Board.

The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by the Trust.

Joint Vice Chairs

3.2 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

Each Vice Chair shall deputise for their Chair in that Chair's absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

3.3 Membership of the LPF comprises;

	Staff Representative	**Management Representative**
Joint Chair	TBC	Executive Director of Organisational Development & Workforce (WF&OD)
Joint Vice Chair	TBC Staff Rep	Chief Executive
	All accredited staff reps within the Trust	Deputy Director of OD & Workforce
		Executive Director of Finance
		Executive Director of Nursing, Allied Health Professionals and Health Science
		Chief Operating Officer
		Director VCC
		Director WBS

All members of the LPF are full and equal members and collectively share responsibility for its decisions.

All members must:

- Be prepared to engage with and contribute to the LPFs activities and in a manner that upholds the standards of good governance set for the NHS in Wales.
- Comply with their terms and conditions of appointment.
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes and
- Promote the work of the LPF within the professional discipline they represent.

Members of the LPF who are unable to attend a meeting may send a deputy, providing such deputies are eligible for appointment to the LPF and their attendance has been agreed by the Joint Chairs/Vice Chairs prior to the meeting.

Appointment and Terms of Office

3.4 Management representative members shall be determined by the Board.

Staff representatives shall be determined by the staff organisations recognised by the Trust, subject to the following conditions:

- Staff representatives must be employed by the Trust and accredited by their respective trade union and
- A member's tenure of appointment will cease in the event that they are no longer employed by the Trust or cease to be a member of their nominating trade union.

The Management Representative Chair shall be appointed by the Board.

The Staff Representative Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Chair's term of office shall be for one (1) year.

The Management Representative Vice Chair shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

The Staff Representative Vice Chair shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The Staff Representative Vice Chair's term of office shall be for one (1) year.

A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

Removal, suspension and replacement of members

3.5 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from officer unless they are satisfied that:

(a) The absence was due to a reasonable cause and
(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

If the LPF considers that it is not conductive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

3.6 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

3.7 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4. SUB FORA

4.1 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas: and or
- Detailed discussion in relation to a specific issue(s).

Sub fora that have been established;

- The LPF Policy Sub-Group.

5. MEETINGS

Quorum

5.1 At least two members must be present to ensure the quorum of the LPF, one of whom should be the Management Chair or Vice Chair or the staff representative Chair or Vice Chair.

Frequency of Meetings

5.2 Meetings shall be held quarterly or otherwise as the Joint Chairs deem necessary. Where joint Chairs agree, an extraordinary meeting of the LPF may be scheduled with 7 calendar days notice.

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

6.1 The LPF's main link with the Board is through the Executive Members of the LPF.

6.2 The Board may determine that designated Trust Members or staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of Trust members or staff, subject to the agreement of the Trust Chair.

6.3 The Board shall determine the arrangements for any joint meetings between the Board and the LPF's staff representative members.

6.4 The Board's Chair shall put in place arrangements to meet with the LPF's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

6.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

7. SUPPORT TO THE LPF

7.1 The LPF's work shall be supported by two designated Secretary's one of whom shall support the staff representative members and one shall support the management representative members.

7.2 The Director of Workforce and OD will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

7.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representatives.

7.4 Both Secretaries shall work closely with the Trust's Board Secretary who is responsible for the overall planning and co-ordination of the Trust's programme of Board business, including that of its Committees and Advisory Groups.

8. REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Joint Chairs shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the LPF's activities. This includes verbal updates on activity and the submission of written Highlight Reports.
- The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation
- bring to the Board and the Accountable Officer's specific attention any significant matters under consideration by the LPF;
- ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

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

9. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum – as per section 5.1 above.

Cross referenced with the Trust Standing Orders.

10. REVIEW

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

11. CHAIR'S ACTION ON URGENT MATTERS

11.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings.

In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

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

Appendix 1

Six Principles of Partnership Working

- a shared commitment to the success of the organisation
- a focus on the quality of working life
- recognition of the legitimate roles of the employer and the trade union
- a commitment by the employer to employment security
- openness on both sides and a willingness by the employer to share information and discuss the future plans for the organisation
- adding value – a shared understanding that the partnership is delivering measurable improvements for the employer, the union and employees

Appendix 2

Code of Conduct

A code of conduct for meetings sets ground rules for all participants:

- Respect the meeting start time and arrive punctually
- Attend the meeting well-prepared, willing to contribute and with a positive attitude
- Listen actively. Allow others to explain or clarify when necessary
- Observe the requirement that only one person speaks at a time
- Avoid ‘put downs’ of views or points made by colleagues
- Respect a colleague’s point of view
- Avoid using negative behaviours e.g. sarcasm, point-scoring, personalisation
- Try not to react negatively to criticism or take as a personal slight
- Put forward criticism in a positive way
- Be mindful that decisions have to be made and it is not possible to accommodate all individual views
- No ‘side-meetings’ to take place
- Respect the Chair
- Failure to adhere to the Code of Conduct may result in the suspension or removal of the LPF member.

Appendix 3

List of Recognised Trade Unions/Professional Bodies referred to as ‘staff organisations’ within these Standing Orders

- British Medical Association (BMA)
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCN)
- UNISON
- UNITE
- GMB
- British Orthoptic Society
- Society of Radiographers
- British Dental Association
- Society of Chiropodists and Podiatrists
- Federation of Clinical Scientists
- Chartered Society of Physiotherapy (CSP)
- British Dietetic Association
- British Association of Occupational Therapists (BAOT)

Advisory Consultant Appointment Committee

Terms of Reference and Operating Arrangements

1. INTRODUCTION

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

1.2 In accordance with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Advisory Appointment Committees (AACs)** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

1.3 These Terms of Reference and Operating Arrangements are based on and compliant with the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005.

1.4 Due to the nature of the business considered by the Committee, all relevant paperwork will be kept confidential and not routinely published.

2. PURPOSE

2.1 The arrangements for appointments to NHS Consultant posts are stipulated in statutory regulations: "The NHS (Appointment of Consultants) Regulations 1996", as amended. These are supported by "The National Health Service (Appointment of Consultants) Regulations Good Practice Guidance", published by the Department of Health in January 2005.

2.2 The regulations provide for appointments to be made via Advisory Appointments Committees (AACs).

3. DELEGATED POWERS AND AUTHORITY

3.1 The Trust Board has delegated to the Committee the authority to make decisions on all appointments and for appointments to be reported to the Trust Board at a subsequent meeting where the decision to appoint is unanimous. Cross reference section 5.5 and Annex B of the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005

3.2 If the Committee cannot make a unanimous decision, the majority recommendation will be referred to the Trust Board for ratification, before an offer of appointment is made.

4. MEMBERSHIP

4.1 The NHS (Appointment of Consultants) Regulations 1996 set out the governing membership for the AAC. In meeting these provisions the Trust should seek to secure a balanced Committee.

4.2 An outgoing consultant should not be a member of the Committee set up to select his/her successor.

4.3 Particular care needs to be taken in relation to Committee membership when appointing to posts across two or more Trusts, or to appointments made in conjunction with universities. For example, it is possible to contract an employee jointly between two Trusts. When constituting the AAC in such cases, the requirements in the Regulations for joint appointments will need to be met.

4.4 Trusts must ensure that no close relative of any candidate or candidate's partner serves on the Committee. If it becomes apparent during the short-listing of candidates that any member of the Committee is a close relative or partner of a candidate, that member should be invited to stand down and a replacement nomination sought.

4.5 Occasionally, one of the candidates will be well known to the 'local' members of the Committee. Such prior experience must not be allowed to interfere with an objective assessment of the candidates. A member may also have provided a reference for a candidate. On such occasions, the member must declare an interest and be careful not to show a bias.

4.6 The core membership of the Committee, as specified in Regulations, is set out below:

Chair	Chairman of the Board (Independent Member)
Members	Chief Executive Officer

Medical Director (Clinical Director to deputise in their absence)

Clinical Director or Consultant from relevant specialty as their deputy.

External Professional Assessor from the College or University.

4.7 The Trust is free to add additional members, but the balance of the Committee must continue to have local and a medical majority. The Trust must seek to ensure that the size of the Committee is, in all cases, kept to a minimum.

Attendees

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

- Faculty Consultant Lead
- Executive Director of Workforce & Organisational Development
- Trust Secretary
- Assistant Director of Research & Development

Secretariat

4.9 Secretary as determined by the Medical Director or the Executive Director of Workforce & Organisational Development who is involved in the recruitment procedure. Cross-reference section 4.9 of the National Health Service *(Appointment of Consultants Regulations)*, Good Practice Guidance – January 2005.

Member Appointments

4.10 Appointed Independent Members shall hold office for a period that corresponds with their appointment to the Trust Board.

Support to Committee Members

4.11 The Executive Director of Workforce & Organisational Development, on behalf of the Committee Chair, shall:

- Ensure all Committee members receive the NHS Appointment of Consultants Regulations outlining their individual and collective role on the Committee.

- Retain all records and documents in connection with the short-listing and interviewing, including formal records of the decision and informal notes taken by members of the Committee, for a minimum of five years,

confidentiality being secured in case an applicant were to bring a claim against the Trust (e.g. alleging discrimination), as an employment tribunal may require these papers.

- Ensure all members of the Committee will have received appropriate training. It is the responsibility of the Trust to ensure that training has been provided. This should cover all aspects of the appointments process and concentrate on those areas where difficulties may arise:
    - Equal opportunities (refer to Annex E of the guidance)
    - Matters which should not be discussed at the interview other than in exceptional circumstances.

4.12 The role of the Board Secretary shall be to:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and

- Ensure and co-ordinate the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Organisational Development & Workforce.

5. COMMITTEE MEETINGS

Quorum

5.1 The Committee may not proceed if any core member (or their appointed deputy) is not present.

5.2 Prospective members of the Committee should notify the Trust immediately they become aware they are no longer able to attend the Committee on the set date. The Trust should then find an appropriate replacement.

Frequency of meetings

5.3 Meetings shall be held as required to ensure support to the timely recruitment of consultants and otherwise as the Committee Chairs deems necessary.

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

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

6.2 The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and

- appropriate sharing of information

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

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 A brief report of the Committee should be prepared and signed by the Chair.

7.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board via the Workforce & Organisational Development Committee and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of Committee minutes and written reports as necessary throughout the year.

7.2 The Trust Secretary, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

7.4 Formal records of the decision made by the Committee should be retained for a minimum of five years, confidentiality being secured.

7.5 Due to the nature of the business considered by the Committee, all relevant paperwork will be kept confidential and not routinely published.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum
- Chairs Action on Urgent Matters

Cross reference with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the NHS (Appointment of Consultants) Regulations and the Board.

Academic Partnership Board

Terms of Reference and Operating Arrangements

1. INTRODUCTION

1.1 The Trust's Establishment (Amendment) Order, 2018 no.887 (W.176) established Velindre NHS Trust as Velindre University NHS Trust. This development acknowledges the Trust as *'…having a significant teaching commitment by virtue of paragraph 5(3)(b) of Schedule 3 to the National Health Service (Wales) Act 2006'.*

1.2 The Trust is committed, by way of holding University Status, to ensure one of the Non-Executive Directors (Independent Members) is appointed from Cardiff University.

1.3 The Trust has made a commitment to recognise the importance of partnership working across all academic partners and has established an **Academic Partnership Board (APB)** to support these partnerships and hereby sets out the formal terms of reference and operating arrangements.

1.4 The APB will provide a formal mechanism whereby a strategic approach will be taken to steer future operational collaboration with academic partners. The collaboration, overseen by the APB should be of mutual benefit and support in order to promote the health, wellbeing, education and economic regeneration to the benefit of the Trust's service users and the wider population of Wales.

1.5 The collaboration will be driven by a shared commitment to ensure excellent health, medical care, research, innovation, wellbeing and health care education. The parties recognise that there are synergies between them that will allow the development and promotion of the Trust's University status and provide positive opportunities for collaboration which potentially exceed the traditional University Hospital model.

1.6 The APB will operate in accordance with the following principles;

- Commitment to facilitate discussion

- Create an environment to identify, support and allow collaboration to flourish
- Realise opportunities in partnership working to enhance;

    - education, research and development across all disciplines (including engineering, maths, business, medicine, health sciences and biosciences);
    - translating research and learning into practice;
    - continuing professional development (CPD);
    - audit;
    - innovation and commercialisation;
    - modernisation and service improvement including technological developments;
    - international bench-marking;
    - wealth creation;
    - funding and grant capture; and
    - workforce modernisation/reconfiguration and training/education for newly emergent roles

2. PURPOSE

2.1 The Partnership Board is responsible for strategic collaboration between Velindre University NHS Trust and academic partners to provide and strengthen safety and quality and gain an international reputation for excellence and innovation.

2.2 The purpose of the APB is to:-

2.2.1 Ensure that the Memorandum of Understanding between the parties to which these Terms of Reference form an Annex, is fully enacted to support the services provided by the Trust achieve the highest standards of health, clinical care, research, innovation and health care education and training.

2.2.2 Promote collaborative efforts to improve the health, wellbeing, education and wealth of patients, service users and the population.

2.2.3 Review the strategic aims and objectives of each of the partners and where those aims and objectives appear to be usefully aligned, to optimise the benefits to patient care and health care service delivery through an inclusive and supportive approach.

2.2.4 Accelerate the translation of discoveries to drive improvements in quality and productivity.

2.2.5 Become a national and international exemplar for effective strategic and operational collaboration between the local health service and its partner universities.

2.2.6 Provide a broad horizon-scanning function in those areas of activity for which the APB has responsibility.

2.2.7 Foster a forward-looking organisational culture across all partners which: -

a) promotes quality improvement across all activities;
b) is rich in educational activities and staff development opportunities;
c) helps attract and retain the very best staff, including internationally leading clinical academics;
d) facilitates research grant capture by clinicians and academics and the translation of research findings into practice;
e) encourages innovation and modernisation;
f) encourages multi-disciplinary work and access to new and emergent fields of research and evidence based practice;
g) builds capacity for translational research that allows all parties to compete at an international level;
h) integrates education, research and practice that looks beyond targets and entrenched ways of working, fostering a culture of learning and innovation;
i) facilitates wealth and economic growth in the region and beyond;
j) Supports the capture and analysis of the service user experience;
k) Develops health informatics opportunities to achieve their potential;
l) Supports strategic planned lines of enquiry enabling knowledge creation.

2.2.8 Receive assurance that projects in which the parties are currently collaborating have appropriate agreements which detail the projects and clearly reflect the responsibilities of the parties. Depending on the nature of the projects the risk to the parties should be understood and the appropriate mitigated action taken.

2.2.9 The work of the Board will focus on healthcare professional education and training, continuing professional development, scholarly enquiry and research, audit and evaluation.

3. ROLE

3.1 The Partnership Board will;

3.1.1. Explore opportunities for the further development of collaborative activities between the members of the partnership - especially in relation to clinical services, research, teaching, innovation and improvement, providing advice thereon to appropriate decision- making bodies;

3.1.2. Advise on matters relating to resources for existing or potential collaborative activity;

3.1.3. Build on existing work in developing opportunities for widening access and

increasing participation in health and social care education amongst local communities;

3.1.4. Explore opportunities for the development of collaborative activities in relation to research and to promote and plan for synergy in research;

3.1.5. Maximise the benefits of shared resources and expertise;

3.1.6. Monitor and facilitate the delivery of all aspects of undergraduate teaching and postgraduate training as delivered by the members of the partnership;

3.1.7. Promote excellence in education and training to develop a workforce with the capability and commitment to transform healthcare;

3.1.8. Build capacity for translational research across the integrated patient pathway that allows the University Trust to compete at an international level;

3.1.9. Promote an outward-facing culture eager to build external links nationally and internationally with other clinical, academic and industrial partners;

3.1.10. Establish systems to recognise and reward innovation in education, research and practice, sharing best practice for stakeholders to learn from each other and facilitating the promotion of NHS clinicians to academic titles and academics to honorary clinical titles;

3.1.11. Establish specific task and finish groups, as necessary, to take forward any relevant initiatives;

3.1.12. Agree a forward work programme annually.

4. MEMBERSHIP

4.1. Membership of the APB will include;

- Chair, Velindre University NHS Trust (**CHAIR**)
- Executive Medical Director
- Executive Director Of Nursing, Allied Health Professions & Health Sciences
- Chief Operating Officer
- Executive Director of OD & Workforce (or their deputy)
- Clinical Director lead for Education
- Clinical Director lead for Research and Innovation
- Independent Board Member (in addition to the Chair)
- Cardiff University Nominated Representative
- Cardiff Metropolitan University Nominated Representative
- Swansea University Nominated Representative
- University of South Wales Nominated Representative

- Plus other University Representatives as the Chair of the Partnership Board and Trust Chief Executive determines.

4.2. The APB may require the attendance for advice, support and information routinely at meetings from other colleagues/bodies as appropriate, to be determined by the Partnership Board Chair.

4.3. The Partnership Board may extend invitations to staff of any partner organisation to attend meetings as required and establish any of the following in support of their business;

4.3.1. Task and Finish Groups

Secretariat

4.4. As determined by the Director of Corporate Governance

Member Appointments

4.5. The membership of the Partnership Board shall be determined by the Velindre University NHS Trust Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Partnership Board's remit.

4.6. Withdrawal of individuals in attendance

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

5. MEETINGS

Support to APB Members

The Director of Corporate Governance will;

5.1 ensure the provision of secretariat support for meetings, including that the appropriate notice of a meeting of the Board is given, accompanied by an agenda and copies of any papers to be discussed at the meeting;

5.2 ensure that the Academic Partnership Board receives the information it needs on a timely basis;

5.3 facilitate effective reporting to the respective organisation(s);

5.4 oversee a process of regular and rigorous self assessment and evaluation of the Academic Partnership Board's performance and operation.

5.5 The Chair of the Academic Partnership Board will be required to report upon the activities at public meetings of the University Trust or to community partners and other stakeholders, where this is considered appropriate.

5.6 Members of the Academic Partnership Board may nominate a suitably briefed senior officer on rare occasions to attend meetings in their absence.

Frequency of meetings

5.7 Meetings shall be held as required as the APB Chair deems necessary, aiming to meet 3 times a year as a minimum.

Quorum

5.8 A quorum shall be 2 Independent Members and 1 Executive Director of Velindre University NHS Trust, and at least 2 of the academic partner organisations listed in section 4 above (membership).

Frequency of Meetings

5.9 Meetings shall be held as required as the APB Chair deems necessary, aiming to meet 3 times a year as a minimum.

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

6.1 The APB, through its Chair and members, shall work closely with the Velindre Trust Board and academic partners through the:

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

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

6.2 The APB will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Trust Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

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

7. REPORTING ARRANGEMENTS

7.1 A highlight report will be produced and presented to the University Trust Board at subsequent meetings, presented by the APB Chair.

7.2 All parties will ensure that reporting arrangements are in place to report through the appropriate structures within their respective organisations.

8. REVIEW

8.1 These terms of reference and operating arrangements shall be reviewed annually by the APB with reference to the Velindre University NHS Trust Board.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

UPDATED CLAIMS POLICY
(Clinical Negligence and Personal Injury Litigation)

DATE OF MEETING	30th November 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable Public Meeting
REPORT PURPOSE	APPROVE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Quality
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	To ensure the Trust discharges its responsibilities regarding the management of negligence claims made against the Trust. The Claims Policy has been reviewed and updated to ensure alignment with: • Welsh Risk Pool Procedures • The National Health Service (NHS) Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended in April 2023 • The Health and Social Care (Quality and Engagement Act) (Wales) 2020 • The Civil Procedural Rules 1998, as amended by the Civil Procedure (Amendment) Rules 2020

RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the revised Claims Management Policy (Clinical Negligence and Personal Injury Litigation): QS04a.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	26th September 2023.
Executive Management Board	30th October 2023
Quality, Safety & Performance Committee	16th November 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Revised policy Endorsed by all.	

7 LEVELS OF ASSURANCE	
NA as a policy	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** ***Not required***

APPENDICES	
1.	Revised Claims Management Policy (Clinical Negligence & Personal Injury Litigation): QS04a.

1. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The revised Claims Management Policy is attached in ***Appendix 1***.

This policy has been reviewed and amended to ensure alignment with the legislative requirements of the Health and Social Care (Quality and Engagement) (Wales) (2020) Act, The National Health Service (NHS) Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended in April 2023 and The Civil Procedural Rules 1998, as amended by the Civil Procedure (Amendment) Rules 2020.

2. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	All 6 domains of quality are positively impacted by this policy.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream

	There are financial requirements in respect of executing responsibilities within this policy relating to Clinical Negligence and Personal Injury Litigation
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Click or tap here to enter text. Equality Impact completed and agreed on 25th September 2023.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	This policy ensures Trust compliance with legal responsibilities relating Claims Management.

CLAIMS MANAGEMENT POLICY (CLINICAL NEGLIGENCE & PERSONAL INJURY LITIGATION)

Ref QS 04a

Executive Sponsor & Function:	Director of Nursing, Allied Health Professionals and Health Science
Document Author:	Jayne Rabaiotti, Claims Manager
Approved by:	The Integrated Quality and Safety Group
Approval Date:	26th September 2023
Date of Equality Impact Assessment:	March 2011.
Equality Impact Assessment Outcome:	The Equality Impact Assessment completed in March 2011 and September 2023 continues to be relevant
Review Date:	1st September 2026

Version	9

DOCUMENT CONTROL SHEET

Purpose of document	This Policy describes the claims management process for the timely and cost effective management of claims, including learning from claims to prevent re-occurrence and monitors the effectiveness of relevant procedures. The Policy extends to the importance of supporting staff during the investigation of a claim or other legal proceedings and compliance with the requirement of the Welsh Risk Pool.
Dissemination	The Policy must be disseminated to all services within the Trust and will be made available on the staff intranet.
Implementation	Senior Managers are required to bring the Policy to the attention of all staff.
Review	The Policy is required to be updated 3 years or earlier, depending on new national guidance or legislation.
Equality and Diversity Impact Assessment	Completed and agreed 25th September 2023.

INDEX

1. Introduction

1.0 This policy describes the Velindre University NHS Trust Policy for the management of negligence claims made against the Trust.

1.1 The Policy mirrors the objectives of openness, transparency and timelines, as part of the legislative reforms introduced by the Civil Justice System in April 1999, following recommendations made by Lord Woolf.

1.2 It is recognised that both the human and financial cost involved in a claim are powerful incentives for effective risk management. Funds that are spent on addressing and compensating could otherwise contribute to the continuous improvements of healthcare services and working environments. This policy therefore forms an integral part of the Trust's Risk Management Strategy and is intrinsically linked with the Trust's system for the management and learning from concerns.

1.3 The Trust is committed to ensuring:

- timely and effective investigation, response and management of any claim, which includes allegations of clinical negligence or personal injury made against the Trust
- learning from claims to prevent recurrence
- supporting staff throughout the investigation of a claim
- ensuring that any healthcare governance issue which may emerge, is addressed promptly and the outcome used to facilitate wider organisational learning.
- this policy complies with relevant legislation and procedures, including Welsh Risk Pool Procedures, the National Health Service (NHS) Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended in April 2023, the Health and Social Care (Quality and Engagement Act) (Wales) 2020 and the Civil Procedural Rules 1998, as amended by the Civil Procedure (Amendment) Rules 2020. Any future change in procedures implemented by the Welsh Risk Pool will be followed, and may supersede the procedures laid down in this document.
- each claim will be assessed on its own merits, taking advice from legal advisers, where appropriate, for resolution of the case.

2. Purpose

2.0 This Policy has been developed in order to fulfil the Trust's commitments, as described in Section 1 above, and to ensure compliance in the management and handling of all claims.

2.1 All members of staff are expected to co-operate fully in the investigation of a claim and implement lessons learnt where required.

2.2 The Trust will follow the requirements of the Welsh Risk Pool in the management of all claims in a manner consistent with the guidance of being open, honest and transparent.

3. Scope

3.0 This Policy is to be used by all Trust employees involved in the claims process which applies to the management of the following types of claim:

- Clinical Negligence
- Personal Injury
- Redress Scheme

3.1 The Policy provides additional guidance and direction for seeking advice in respect to Inquests.

3.2 The Trust has a legal duty of care towards those it treats. This duty of care is extended to visitors, staff and third parties. The Trust may be held vicariously liable for the acts or omissions of its staff, visitors and third parties.

3.3 Those who consider they have suffered harm from a breach of duty in care can make a claim for compensation and damages against the Trust. For a claim to be successful, it must be proved that:

- the duty of care was owed;
- the duty of care was breached;
- the breach of duty caused, or materially contributed to the harm caused and
- there were consequences and effects that resulted from the harm.

If a claim is successful, an injured person has a right to financial compensation for the harm sustained, the amount of which is assessed in accordance with the principles of common law, case law and statute.

3.4 The Trust acknowledges the importance of the claims management process within its organisation and will ensure that the appointed Claims Manager has sufficient seniority and profile as required by the Welsh Health Circular (WHC) (97)17 and the Putting Things Right Guidance (2013) Part 8, revised in April 2023. The Trust and relevant nominated committees will support and promote these objectives, including the provision of support through an approved escalation procedure as set out in the Trust's claims management processes.

3.5 The Trust is committed to learning lessons from claims to ensure the continuous improvement in standards of patients and staff safety and services. Incidents and/or feedback/complaints reporting are crucial elements in the claims process, as this is often the first key indicator of a potential claim. Recording and preserving evidence is crucial in determining if the Trust can defend a claim. All staff are required to be aware of the importance of recording and preserving evidence.

3.6 The Claims Manager will support directors, key managers and staff in the claims process and will ensure that where an investigation identifies the need to learn lessons, that appropriate recommendations are made and remedial action taken to prevent future occurrence.

3.7 In addition to the Putting Things Rights Regulations, the Trust is equally committed in complying with the Health and Social Care (Quality and Engagement Act) (Wales) 2020 and the principles of the Duty of Candour and Duty of Quality, which aligns to the Putting Things Right Regulations of being open and transparent in the investigation and management of claims.

3.8 The Act places an onus on all Welsh NHS organisations to be open and honest with service users when things go wrong and put in place learning to prevent a recurrence. The Trust is committed to enhancing service user safety and providing an efficient and effective person-centred, timely and equitable health care system in the context of a learning environment.

3.9 The Trust will have due regard to the Wellbeing of Future Generations (Wales) Act 2015, the Equality Act 2010 and various legislation, that support the Trust's plan in meeting its objectives by promoting a fairer and safe healthcare organisation.

3.10 Due to the complex nature of healthcare, a claim may involve more than one defendant organisation, e.g. acute hospital or GP practice. It is important that notification of a claim is made to the Claims Manager promptly, in order that discussions can take place with the Claimant's solicitor, NHS providers or other external organisations within a timely manner.

3.11 Claims arising from the treatment provided by contracted practitioners are not indemnified and do not form part of the Welsh Risk Pool Scheme. The Trust has no delegated authority to make admissions of liability in respect to such claims or authorise payments in relation to damages or costs.

3.12 This policy does not extend to cases involving procedures for submitting a claim for loss or damage of property and does not apply to claims for reimbursement from the Welsh Risk Pool relating to the Human Rights Act 1998, claims for unlawful imprisonment arising from the activities of Mental Health Services and employment issues.

3.13 The Trust is liable for the actions of all its employees and volunteers, during the legitimate course of their employment and volunteering services. The content of this policy applies to all employees and extends to volunteers acting on behalf of the Trust.

3.14 The Trust will adopt a common and standardised approach in dealing with claims for both clinical negligence and personal injury. The Trust will gather all evidence as expeditiously as possible and, when liability is admitted, will seek to negotiate settlement in a timely fashion to prevent unnecessary delay and increased litigation costs.

3.15 The Trust will make every effort to resolve a claim before the issue of court proceedings and will explore the option of alternative dispute resolution methods, where appropriate. Where formal legal action or Court proceedings are unavoidable, the Trust will ensure that it conducts its defence of the claim in a fair and timely manner, ensuring that legal costs are appropriate and proportionate.

3.16 The Trust will comply with the Pre-Action Protocols laid down by the Civil Procedural Rules in dealing with all claims and will ensure a constructive and open approach is taken with the aim of reducing delays and preventing, where possible, formal legal proceedings from commencing.

3.17 The Trust is responsible for complying with the Welsh Risk Pool (WRP) (the National Health Service (NHS) Welsh organisation indemnifier), to ensure that the Trust complies with its statutory and obligatory duties as outlined by the Welsh Risk Pool All Wales Indemnity and Insurance Policy and Scope document revised and effective from 1st September 2023, and guidance on the management of claims.

3.18 Nuisance Claims

The Trust will not settle claims of doubtful merit, however small, purely on a value basis. Similarly, claims of this nature will be defended as appropriate.

The decision to settle a claim will always be based upon an assessment of the Trust's legal liability and the risks and costs associated with the defence of that claim.

4. Objectives

4.0 The Trust acknowledges that its duty is to ensure that the appropriate financial and risk management systems are in place and that any loss is minimised. In seeking to manage risk effectively, the objectives of this Policy are to ensure:

- the timely and effective management of claims
- a systematic approach is adopted and takes account of legal and best practice requirements for risk management
- that the Trust learns from claims to prevent an occurrence
- that Trust staff are supported, directed and guided throughout the investigation of a claim and advice provided on other legal matters as and when required e.g. inquests.
- there is accountability and responsibility for the management of all claims against the Trust, which are clearly defined
- that the Trust complies with the requirements of the Welsh Risk Pool and also with the requirements of the Pre-action Protocol for the Resolution of Clinical Disputes and the Pre-action Protocol for Personal Injury, thereby avoiding the cost penalties associated with non-compliance.
- external agencies are involved in the investigation of a claim or legal matter when required
- adequate procedures are in place for monitoring the effectiveness of the policy and the claims process.

5. Definitions

5.0 The definition and meaning of a "concern", relate to complaints, incidents and claims, where a significant litigation risk is presented. The definition for clinical negligence and personal injury negligence claims are outlined below as follows:-

Clinical/Medical Negligence

"*A breach of duty of care by members of the health care professions employed by NHS bodies or by others consequent on decisions or judgements made by members of those professions acting in their professional capacity in the course of employment and which are admitted as negligent by the employer or are determined as such through the legal process."*

Personal Injury

"*Any disease or impairment of a person's physical or mental health condition."*

5.1 **Claim** – a demand for compensation made following a clinical negligence claim and/or adverse incident resulting in damage or loss and/or personal injury, which carries significant litigation risk for the Trust.

5.2 **Claimant** – Any patient or their representative, a member of the public, or employee who instructs solicitors to act on their behalf to pursue a claim against the Trust, or who enters into legal proceedings against the Trust to pursue compensation.

5.3 **Clinical Negligence** – A claim based on an allegation that care fell below a reasonable medical or clinical acceptable standard (care which is less than best practice may still be 'acceptable' in the legal definition and may not be considered 'negligent').

5.4 **Personal Injury** – Harm caused to a patient, staff, or visitor, arising from a breach of common law or statutory duty to take reasonable care to provide safe premises, systems of work, equipment and competent staff.

5.5 **Employer Liability** – In accordance with common law and statutory duty, the Trust is required to ensure that there is reasonable care to provide competent staff, safe plant and equipment, safe premises and safe systems of work. The Trust may be liable to pay compensation to any employee for any injury or loss suffered if a breach

of these responsibilities is established. These circumstances may also give rise to criminal liability.

5.6 **Public Liability** – The Trust is under a duty to take reasonable care in all circumstances to make safe any visitor to its premises. The Trust may be liable to pay compensation to any visitor who sustains injury or loss, as a result of a breach of duty, to take reasonable precautions to protect the visitor or third party.

5.7 **Human Rights** – A claim made against a public body by an individual for a breach of Human Rights legislation.

5.8 **Ex-gratia** – Ex-gratia payments are the responsibility of the Trust and sit outside the remit of the Claims Policy. Further information in relation to ex-gratia payments can be found in Appendix 3

5.9 **Judicial Review** – An action taken to bring court proceedings in which a judge reviews the lawfulness of a decision or action taken by a public body.

5.10 **Conditional Fee Agreements (CFAs)** – Commonly referred to as a 'no win, no fee' agreement in which the Claimant enters into a contract with their legal representative. In the event of a successful claim against the Trust, the court will normally make an order to pay the Claimant's legal costs. For CFAs entered on or after the 1st April 2013 (where the insurance policy was signed on or after that date), with a few exceptions, success fees and insurance premiums will be paid by the claimant not the defendant. A 'success fee' may form part of a CFA. This is an uplift on the solicitor's basic costs that can be recovered from successful claimant damages.

5.11 **Qualified One-Way Costs Shifting -** From the 6th April 2023, claims issued after this date, will see a change in the costs rules relating to recovery of Defendant costs from a Claimant. This means that costs orders made against a Claimant will be enforceable not only against orders for damages under the Civil Procedural Rules
44.14 but against "*any orders for damages or agreements to pay or settle a claim for, damages costs and interest made in favour of the claimant*".

5.12 **Compensation Recovery Unit (CRU)** – The introduction of the social benefits recovery scheme came into effect on the 6th October 1997, following the Social Security (Recovery of Benefits) Act 1997. In recent years, further legislation has been introduced, including the Health, and Social Care (Community Health and Standards) Act 2003. The scheme places the onus of liability to repay social security benefits (known as NHS charges) on the compensator rather than the injured person. The

Department of Works and Pension govern the NHS charges and CRU payments. When a claim is made against the Trust or a concern is considered under the Redress arrangements of the Putting Things Right Regulations, the Trust is legally obligated to inform the Compensation Recovery Unit. The aim of the Compensation Recovery Unit is to seek to recover the NHS charges incurred as a consequence of an act of negligence on the part of an NHS provider and ensures that a Claimant is not reimbursed twice.

5.13 **Duty of Candour** There is a requirement on all NHS organisations to be open and honest, transparent, fair and impartial.

5.14 **Duty of Quality** There is an obligation for the Trust to provide safe, effective, patient- centred, timely, efficient and equitable health services.

6 Responsibilities

6.0 Subject to the provisions of the Limitation Act 1980, the Trust will be responsible for managing claims that fall within its scope.

6.1 **Chief Executive** – The Chief Executive is the accountable officer for the proper and effective handling of claims for the Trust with overall responsibility for claims management. The Chief Executive is required to ensure that there is a designated Executive Director Lead with clear responsibility for the management of claims. The Chief Executive delegates responsibility to the Executive Director of Nursing, Allied Health Professionals (AHPs) and Health Science in overseeing the function and management of claims.

6.2 **Executive Director of Nursing, Allied Health Professionals (AHPs) and Health Science** – The Executive Director of Nursing, AHPs and Health Science is the Board member/Executive Lead responsible for claims management and for issues affecting clinical negligence, personal injury claims and Redress matters. The Executive Director of Nursing, AHPs and Health Science, is also responsible for ensuring that the Executive Management Board and Trust Board are kept informed of any significant and major developments as they arise.

6.3 **Director of Finance** – The Director of Finance is responsible for maintaining the Losses and Special Payments Register (LaSPaR) and ensuring that any major developments or concerns that pose a financial risk to the Trust, are highlighted to

the Board and relevant Committees accordingly, to safeguard and/or ensure that such financial risk or concern is actioned appropriately.

6.4 **Medical Director** – The Medical Director is responsible for ensuring that medical quality and safety is paramount and has responsibility for providing medical leadership and support in achieving the aims and objectives as set out in this policy.

6.5 **Deputy Director of Nursing, Patient Experience and Corporate Services –** The Deputy Director is required to act upon and oversee the claims function in the absence of the Executive Lead Director of Nursing, AHPs and Health Science, and is assigned reasonable delegated authority to comply with the efficient and timely management of the claims procedures and processes.

6.6 **Divisional Directors** – All divisional directors and service managers have a delegated accountability and responsibility within their divisions for the implementation and adherence to this policy.

6.7 **Trust Head of Quality, Safety and Assurance –** The Trust Head of Quality, Safety and Assurance is accountable to the Director of Nursing, AHPs and Health Science in the implementation of procedures and guidance on quality and safety assurance matters, including monitoring and performance. The Trust Head of Quality, Safety and Assurance is required to deputise in the absence of the Deputy Director of Nursing.

6.7 **Trust Deputy Head of Quality, Safety and Assurance** – In the absence of the Claims Manager, the Trust Deputy Head of Quality, Safety and Assurance is responsible for overseeing the claims management and its function, and will have relevant experience and qualifications, in addition to demonstrating continual professional development, in the management and responsibility of the day to day operation of claims management, including participating in relevant networks and meetings to advance the profile and management of claims and will be responsible for implementing any new procedures, legislation and guidance that will affect the governance arrangements in place for claims management and its functions. The Deputy Head of Quality, Safety and Assurance will also be responsible for ensuring that the Once for Wales Cymru databases, are consistent across all modules (Incidents, Complaints, Claims, Risk Management and Patient Experience), for the purpose of learning lessons and monitoring.

6.8 **Claims Manager -** The Trust is committed to employing a Claims Manager who has the relevant experience and qualifications in the management of claims.

6.8.1 The Claims Manager will be required to demonstrate ongoing continuing professional development in the area of claims management.

6.8.2 The Claims Manager is required to hold sufficient seniority and profile as required by Welsh Health Circular (97)17 and the Putting Things Right Guidance (2013) Part 8 and is accountable to the Director of Nursing, Allied Health Professionals and Health Science, for ensuring compliance with this Policy and for securing the most cost- effective resolution of claims.

6.8.4 The Claims Manager is responsible for taking an active part in the quarterly All Wales Claims Management, Redress and Inquest Networks, to ensure that the claims processes and any new procedures are discussed and implemented in accordance with the Trust's commitment to the Welsh Risk Pool's obligations.

6.8.4 The Trust and relevant nominated committees are required to support and promote the objectives and scope of this policy by ensuring that an appropriate escalation process is in place to achieve equitable, efficient and timely managed claims.

6.8.6 The Claims Manager is required to ensure that throughout the progress of the claim, staff are kept up-to-date on the status and progress of the claim and its outcome.

6.9 Employees, responsibilities, support and guidance

6.9.1 The Trust recognises that the co-operation of staff involved in a claim is crucial and acknowledges that the litigation process can be a difficult, daunting and anxious experience. The process can also be time consuming, slow and lengthy, with some cases taking years rather than months to conclude. The Trust accepts that staff may find this a stressful time and encourages staff to access well-being support and occupational health resources when needed. It is vital that staff are provided the relevant access to services to assist them throughout the litigation period, if required.

6.9.2 A manager who has responsibility for a staff member involved in a claim, owes a duty of care to ensure that there is appropriate support in place. Managers who have concerns, should signpost staff to confidential counselling and wellbeing support when required and/or to Occupational Health for additional support, if necessary. advice and guidance should also be sought from Workforce and Organisational Development when there are concerns relating to any staff member.

6.9.3 The Trust is required to ensure that guidance is provided to staff who are involved in the claims process and that they have access to training and guidance, at a level appropriate to their role and responsibilities.

6.9.4 There is a duty on staff to ensure that early collation of evidence is appropriately captured on the RL Datix Once for Wales' incident/feedback modules with provision to escalate to directorate leads and managers as appropriate. It is also a requirement that staff members ensure that evidence is preserved and good record keeping maintained, as this will be fundamental in the investigation of a claim.

6.9.5 Staff are required to engage with the Claims Manager and co-operate fully to ensure that the cost of a claim is minimised. This includes reporting adverse incidents promptly to allow early investigation of potential claims and providing witness accounts and statements, when required, within a timely manner.

6.9.6 Any staff member receiving written notification of a claim or potential claim must not enter into direct correspondence or communication with the claimant or their legal representative. All such notifications are to be directed to the Claims Manager who will take the required action at the earliest available opportunity to avoid any adverse costs consequences.

6.9.7 The Trust will take full responsibility for managing and, where appropriate, settling claims, meeting all financial obligations and will not seek to recover any costs from health professionals, save in exceptional cases, where the health professional was legally found to be acting outside of his/her remit.

6.9.8 Should a case go to trial, staff giving witness evidence will receive support from the Claims Manager and legal advisers, both in conference and prior to attending court. Staff have the option of being accompanied by their union representative should they wish to exercise this right.

6.9.9 It is not the intention of the claims investigation to assess whether employment action against an individual member of staff should be considered. However, if, as a result of the investigation there is prima facia evidence of a breach of the law or professional misconduct, further action may need to be considered. In these circumstances, the appropriate senior manager will determine whether Workforce and OD employment policies should be invoked. Staff should also be aware that in exceptional circumstances their actions might give rise to personal criminal liability and referral to their professional body.

7. Limitation Act 1980

7.0 Subject to the provisions of the Limitation Act 1980, the Trust will be responsible for managing all Trust related claims. The Limitation Act 1980 requires that claims are made within three years of the date of the incident or three years from the date a Claimant became aware of the incident, or from the date when the Claimant could reasonably have been expected to know. For minors, the three-year limitation period will commence on the minor attaining the age of 18. The limitation period will not usually apply to a Claimant incapable of managing and administering their own affairs. In certain circumstances, Courts have discretion to waive the limitation period when necessary.

7.1 A Human Rights Act claim is to be made within one year of the act being committed, or its failure to act.

7.2 A Judicial Review application should be made within three months of the act or the omission.

7.3 The Trust will comply with the requirements of the Welsh Risk Pool in notifying other organisations and bodies of claims arising from service provision and will retain day- to-day management of such claims unless otherwise instructed.

8. Welsh Risk Pool (WRP)

8.1 The Trust will comply with various rules and procedures relating to the Welsh Risk Pool, including its revised Welsh Risk Pool Procedures and All Wales Indemnity and Insurance Policy and Scope Document.

8.2 The WRP currently provides the means by which all Trusts and Health Boards are able to fund their risk exposure for all risks, such as employers and third party liability, including that for clinical negligence.

8.3 The WRP has responsibility for reimbursement of claims handled under the NHS Indemnity, which exceed £25,000. The cases reimbursed mainly relate to clinical negligence and personal injury matters, although the scope of the WRP includes buildings and, in exceptional circumstances, equipment, where an excess of £50,000 is applied.

8.4 The role of the WRP was expanded in 2018, to include responsibility for the appropriate reimbursement of permitted costs and damages arising from Redress cases. Redress cases, introduced in 2011 through the 'Putting Things Right' arrangements, deal with matters where there is a qualifying liability arising from complaints and healthcare reported incidents. Effective use of the Redress process has a direct impact on litigation costs for each organisation, with savings in claimants' costs. Further guidance on the extent of the WRP indemnity is found in the revised All Wales Policy on Insurance, NHS Indemnity and Related Risk Management for/ Potential Losses and Special Payments and Scope of Welsh Risk Pool. The Trust will ensure there is a comprehensive and robust governance framework in place for dealing with the financial management of potential losses and special payments when they do arise and make any necessary changes and updates as required by the Welsh Risk Pool.

8.5 The Welsh Risk Pool Scope document sets out the types of losses arising from legal obligations (with the exception of contractual claims) and losses defined by the losses and special payment manual. For the effective management of the claims function the Trust will have:-

1. Up-to-date procedures, contract documentation and management practices for the provision and commissioning of healthcare and other services to ensure that they are consistent with the key principles set out in the All Wales Indemnity and Insurance Policy.
2. Ensure there is indemnity or insurance arrangement which provides appropriate cover for all activities which fall outside of the scope of NHS Indemnity
3. Ensure there are clear, written policies, procedures and financial arrangements for meeting liabilities arising from negligence claims which are fully consistent with the All Wales Welsh Risk Pool Indemnity and Insurance Policy and the risk pooling arrangements of the Welsh Risk Pool and associated Technical Notes.

8.6 Of note, the Policy has replaced the Welsh Health Circular (WHC) (98) 08 and incorporates the requirements of WHC (2000) 04, which outlines the risk pooling arrangements made for clinical negligence claims received from those person to whom the health body owes a duty of care. It does not, however, apply to other types of legal claims that might be made in respect of purely commercial or employment contracts and specifically excludes any payments made for harm sustained where there is no negligence (i.e. personal accident cover).

8.7 The Welsh Risk Pool All-Wales Indemnity and Insurance Policy now contains an addendum (WHC 04 (2000)) which specifically allows personal accident cover to be purchased where a health body considers it relevant or appropriate to do so, for

example, the Policy does not extend to losses arising from non-emergency vehicles for which the health body is permitted under WHC 04 (2000) to purchase commercial insurance. The decision to enter into agreements for cover for non-negligent harm rests with individual health bodies and cannot be recouped from the Welsh Risk Pool.

8.8 Other losses, including building, equipment and consumable losses, are dealt with under the Welsh Risk Pool Indemnity and Insurance Policy and Scope document, outlined in the Insurance and Indemnity Arrangements section**.**

8.9 The Trust is assessed annually against the Welsh Risk Pool Standard for Claims Management and is responsible for complying with the procedures, as captured in the Welsh Risk Pool Indemnity and Case Reimbursement Procedures. The procedures were introduced in October 2019 and revised following consultation throughout NHS Wales. The revised Welsh Risk Pool Procedures will come into effect from the 1st September 2023. Guidance on the procedures, including revisions and updates are periodically provided by the Welsh Risk Pool and are implemented in accordance with the Trust's governance requirements.

8.10 The review and auditing of claims management is recognised as an essential component of the Trust's risk management systems and governance processes in place. Periodic claims reviews and audits are compulsory and are undertaken both by internal and external auditors, including the Welsh Risk Pool. Following notification of a review or audit, the co-operation of Trust staff will be required, if called upon, to ensure compliance has been achieved and is maintained.

8.11 The Claims Manager is responsible for monitoring the nature and type of claims received to ensure that any claims, which are novel, contentious or repercussive, are reported in advance of settlement to the WRP and, any required approvals are obtained at relevant stages. These may include claims involving some unusual and new features. If not correctly handled, these claims might set an unfortunate precedent for other NHS litigation and might represent test cases for a potential class action, or cases not formally part of a class action but might appear to be similar in kind to concurrent claims against other NHS bodies. In such cases, the Claims Manager will contact the WRP and, where appropriate, NWSSP Legal and Risk Services for advice regarding the further management of the claim.

9. Learning

9.0 The Trust is committed to identifying opportunities for learning and continuous improvement from all events that arise from claims and is responsible for ensuring that a process exists to support its learning by ensuring that there is adequate monitoring of implementation of lessons learned, evaluation of the efficacy of lessons learnt and auditing of learning to prevent and minimise a future occurrence.

9.1 It is important that all directorates involved in a claim capture lessons learnt and the actions of evidence following an event, incident or near miss, regardless if it is the subject of a claim. The basis for this is to diminish the risk of future events. This includes learning lessons from any report issued by the Public Ombudsman for Wales and/or His Majesty's Coroner, following the issue of a Preventable Future Deaths Report.

9.2 Each directorate lead has responsibility for liaising with appropriate staff and ensuring any identified and agreed actions are implemented and monitored.

9.3 The Claims Manager will highlight the potential for 'learning lessons' from claims as they arise through the reporting and governance mechanisms in place and will share learning with the approved management boards and relevant Committees.

10. Delegated Financial Authority

10.0 The Welsh Government has delegated its responsibility for the settlement of claims up to a limit of £1m. The Trust is required to exercise discretion when settling a claim, ensuring that this is within the legal advice provided, and conforms to the Trust's governance arrangements in place for the settlement of cases, including the criteria set out by the Welsh Risk Pool. The levels of financial delegated authorities approved by the Trust are set out in the Trust's Scheme of Delegation (Appendices 2 & 3).

10.1 For claims where the sum exceeds that of the Chief Executive/or nominated Executive Director financial delegated limits, the Trust Board is required to agree the settlement of the claim up to the value of £1m.

10.2 In situations where a decision is necessary and it is not possible to comply with the financial delegated limits because of time constraints, the Chief Executive, or nominated Executive Director, will contact the Trust's Chairperson, or nominated

Independent Member and recommend a course of action (known as a Chairperson's Action). Any action taken in accordance with the Chairperson's Action will be reported at the next available meeting of the Trust Board where retrospective approval will be obtained.

10.3 In accordance with the Welsh Government's delegation to the WRP, the Claims Manager will ensure that when damages in a claim are estimated to exceed that of the Trust's delegated authority of £1m, such claims are reported to the WRP, prior to any decisions taken in the claim.

10.4 The Trust is required to exercise its discretion in settling claims by ensuring that:-

a) It adopts a clear policy for the handling of claims that satisfies the requirements of Section 8 of the National Health Service Putting Things Right – Guidance on dealing with NHS concerns - thereby ensuring that there is clarification upon which the Trust will manage and settle claims. The requirements of which the Guidance will form the basis of the procedure for the day-to-day management of claims
b) Appropriate Welsh Risk Pool (WRP) approvals and settlements under the delegated authorities provision, are obtained
c) Appropriate checklists are completed for every settlement authorised by the Trust within its delegated limit
d) Promotion of good economic practice in the management of claims
e) Assurance is provided from learning from events with the objective of improving standards in patient safety and with the aim of diminishing risk.

11. Legal Advisers – NWSSP Legal and Risk Services

11.1 In accordance with the WRP procedures, the Trust is responsible for instructing NWSSP Legal & Risk Services in the defence or settlement of clinical negligence and personal injury claims.

11.2 Where NWSSP Legal and Risk Services' advice is sought, the Trust will retain the responsibility to direct its solicitors in respect of liability, admission, defence, settlement and general authorities associated with a claim e.g. approval for instruction of an external expert report. However, the Trust will always take due account of qualified legal advice in making such decisions. Legal advice will cover:

- Liability and causation;

- An assessment of the strength of the available defence and probability of success;
- The likely valuation of quantum of damages including best- and worst-case scenarios; and
- Estimates of legal costs for claimant and defence.

11.3 The final decision to settle a claim or continue with its defence, requires approval by the Executive Director of Nursing, AHPs and Health Science, or by the Chief Executive and/or the Board, taking into consideration the delegated financial limits, as appropriate. Any decision taken to settle a claim or continue with its defence is captured within the quarterly reporting in accordance with the governance processes in place or alternatively, by briefings as directed by the Executive Director of Nursing, AHPs and Health Science.

11.4 The Trust will ensure that, when appropriate, advice is sought from NWSSP Legal and Risk Services, with appropriate expertise, when required to do so, and where there is an indication of a possible risk to the Trust or the Trust's reputation if legal advice is not sought. Advice may be sought in the following circumstances:

- Coroners Inquests
- Responses to Serious Incidents
- Complaints
- General legal advice of a nature that requires legal expertise or specialism

11.5 In all eligible cases, the Claims Manager will work in collaboration with NWSSP Legal & Risk Services in obtaining the necessary legal advice as required.

11.6 Authority to seek legal advice will be required from the Executive Director of Nursing, AHPs and Health Science in the first instance, as the cost of such instruction is not recoverable and will be borne by the Trust.

12. Reporting Requirements & Structure

12.1 The Claims Manager is required to prepare a claims analysis report on a quarterly basis that will form part of the Putting Things Right quarterly report and annual report. The report outlines information regarding claims, including details of new claims, settled and closed claims within each quarter, the number and aggregate value of compensation claims in progress, including their outcome and any remedial action taken or proposed. Learning undertaken in relation to new, settled and closed claims,

and any resultant changes in practice which have occurred, or which might be needed.

12.2 Claims are escalated through governance arrangements routinely. Any case requiring escalation will be raised with the Deputy Head of Quality, Safety and Assurance in the first instance.

12.3 **The Executive Management Board** (EMB) is responsible for

a) promoting a climate of openness
b) ensuring prompt incident reporting and investigation
c) being assured that clear explanations are provided to patients who have concerns or complaints
d) ensuring directorate compliance regarding claims to comply with WRP reporting requirements.

12.4 Trust Quality, Safety and Performance Committee

The Committee receives quarterly reports on the management and status of all claims activities against the Trust in the format specified by section 8 of the Putting Things Right Guidance and WRP guidance, which includes updates on the learning undertaken to prevent recurrence and future risk to the Trust.

12.5 Trust Integrated Quality and Safety Group

Provides oversight to support the Board, Executive Team and Divisional senior Leadership Teams in meeting their Quality and Safety responsibilities and helps to ensure quality is at the centre of decision making across the Trust.

12.6 Trust Health, Fire and Safety Management Board

The Trust's Health, Fire and Safety Management Board reviews health and safety claims as part of the Trust's health and safety governance processes. Any health and safety event, which could potentially result in a claim, is highlighted to the Board as part of the Trust's governance requirements. Learning that is implemented following a decision taken to settle a health and safety claim is captured in the quarterly reporting and cascaded down to the Health and Safety Management Group.

12.7 Audit Committee

The Director of Finance is responsible for updating and reporting the value and incidences relating to the Special Losses and Compensation payments to the Audit Committee.

13. Claims Management Process/Procedures

13.1 The Claims Manager will ensure that claims management processes/procedures are developed which supports and embraces the objectives contained in this Policy and the Putting Things Right Guidance.

13.2 The Claims Management Procedure will set out the processes for the day-to-day operational and practical management of claims and associated matters.

13.3 The Executive Management Board delegates the authority for the approval of the Compensation Claims Management Policy to the Quality & Safety Performance Committee.

14. Databases & Systems

14.1 The Trust will maintain the following databases in compliance with the governance and risk framework as outlined below:-

14.2 **The RL Datix Once for Wales (OfW) Claims, Inquests and Redress Modules**
The Once for Wales Concerns Management System has been designed to bring consistency to the use of electronic tools used by all NHS Wales health bodies. The system is a cloud-based platform adopted by the Trust to comply with best practice in relation to cyber security and has the benefit of an All Wales approach in adopting integrated functions.

The modules encompass wider functionality and delivers extensive specifications for incorporating integration across Welsh NHS organisations. These modules form the Trust's Claims management database and captures up-to-date information relating to claims, inquests and redress.

Staff are required to ensure that they submit timely incidents or near misses on the Incident Module and, where concerns are raised, for these to be reported via the Feedback Module. All relevant information is required to be uploaded and all fields completed to allow for a seamless, effective co-ordination and management of the claims handling function.

14.3 The Losses and Special Payments Register (LaSPaR)
LaSPaR is a computerised database previously introduced by the Welsh Government to replace previous paper based systems with a national standardised format for actioning write-offs or special payments approval. All NHS organisations are required to have procedures in place to record details of losses incurred by the Trust and any

special payments made. The register is required to capture all payments, including details of the reason to make the payment. The register forms part of the Trust's annual accounts and is subject to scrutiny by auditors and the Trust's Audit Committee. The main objectives of LaSPaR are to:

- Ensure that health bodies monitor all aspects of losses and special payments, from initial registration to final outcome, on a case by case basis;
- Allow health bodies and the Welsh Government to identify settlement/claimant costs, provisions, and defence or other administration costs provisions, and to action any subsequent adjustments; and
- Ensure that all payments and income recoveries are identified separately and that analyses can be performed on all transactions

14.4 Detailed guidance on the management of losses and special payments are provided within the losses and special payments chapter within the NHS Wales Manual for Accounts. The Trust is required to ensure that arrangements are in place for compliance with the requirements of the manual and the Welsh Risk Pool procedures and All-Wales Indemnity and Insurance Policy and Scope document. In particular the Losses and Special Payments Manual requires that health bodies throughout NHS Wales have effective systems for:-

a) The control and safe custody of health service property
b) Administration of property including that of patients, and
c) Recording, reporting and investigating losses and special payments

14.5 Compensation claims (including redress settlements), are captured on the LaSPaR database spreadsheet and updated by the Claims Manager and authorised staff, to ensure that relevant financial information is up-to-date and complies with auditing requirements. These payments are monitored closely to ensure that any trends or potential risk is analysed, highlighted and reported and escalated within the Trust's governance framework.

14.6 The Trust is responsible for ensuring that patient and staff confidentiality is maintained when accessing the databases outlined above and that staff comply with the Trust's information governance policies and procedures, as required.

14.7 The Trust requires any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately

inform the Chief Executive and the Director of Finance or inform an officer charged with appropriately informing the Director of Finance and/or Chief Executive.

14.8 The procedure for submitting a claim for loss or damage of property is found in the Trust's document "Procedure for Submitting a Claim for Loss or Damage of Property". The procedure provides guidance to Trust staff in relation to claims concerning loss of damage of personal property.

Losses and Compensation claims are defined as;
"Losses, damage to/or loss of personal belongings through no fault of the individual".

14.9 The "Procedure for Submitting a Claim for Loss or Damage of Property" outlines the responsibilities of the accountable directors and panel members, and sets out the process to be followed in the event of losses involving staff and service users.

14.10 The differences between a Loss and Special Payment is outlined below:-

Loss
Relates to the loss of money or property belonging to the Trust (e.g. theft, damage to buildings, loss of cash, bad debts and loss or obsolescence of stock). Pharmacy Stock is defined as drugs kept on Trust's premises.

Special Payments
Special Payments are made outside the normal day-to-day business of the Trust (e.g. compensation payments for clinical negligence and employer's liability claims, to staff for loss/damage to personal property whilst on Trust premises).

14.11 Appendices 3 and 4 outline the financial authorities delegated in accordance by the Welsh Government and includes the Trust's Model Standing Orders – Reservation and Delegation of Powers 2021.

15. Link between Claims, Incidents & Complaints (Concerns)

15.1 The Trust will be committed to ensuring that there is need for a close connection between complaints, incidents, claims (collectively known as concerns) and other risk related information.

15.2 The triangulation of concerns are dealt with under a collective governance arrangement and meet the requirements of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as updated in April 2023, to

ensure an effective concerns process is in place that identifies risks and trends through the analysis, gathering and scrutiny of data collection.

15.3 Claims may be identified as a result of an incident, complaint, request for records or correspondence from a claimant or solicitor indicating that a claim is being considered. There may be further circumstances that also indicate a potential claim, examples of which are outlined below:-

- Where a Serious Incident Investigation or Coroner's Inquest identifies a breach in the duty of care owed
- Where there has been an allegation of professional misconduct
- Where a response to a complaint implies acceptance of liability of a potential claim.

15.4 The outcome of all investigations are reviewed through the appropriate forum i.e. by the relevant divisional management group, to ensure that any lapse in action/provision of service identified during the investigation is acted upon and monitored to ensure that lessons are learnt and evaluated to improve services with the aim of preventing a future occurrence.

15.5 Adverse incidents or outcomes, which could lead to a claim for negligence, should be reported to the Claims Manager to consider the likelihood of a potential claim. The following information should be supplied:-

- Details of the potential claimant
- Date and details of incident/outcome, giving rise to a potential claim
- Names and contact details of relevant members of staff involved in witnessing the incident
- Statements by such relevant members of staff and witnesses
- Any further documentation which is considered relevant.

16. Putting Things Right (PTR) Redress Scheme

16.1 The Trust adopts a pro-active stance to the management and resolution of potential claims identified through the 'Putting Things Right' process.

16.2 The Deputy Head of Quality, Safety and Assurance will work with the Claims Manager and concerns/investigation leads within divisions to highlight concerns where identified breaches in the legal duty of care are established.

16.3 When a concern handled via the Putting Things Right Regulations identifies that a breach of duty has potentially caused/or has caused harm which does not exceed the PTR threshold, and the breach or breaches in the duty of care has been approved by the Putting Things Right Panel, followed by a Regulation 26 response issued to the service user or representative, the matter is transferred to the Claims Manager to investigate further under the Redress Scheme with a view to determining a qualifying liability.

16.4 As part of the Putting Things Right process, the Claims Manager will be responsible for liaising with relevant staff to obtain in-house comments as part of the investigation process, including comments from clinicians, nursing leads and professionals within their capacity and speciality when considering causation. When it is not possible to establish causation, the Claims Manager will liaise with the Claimant, or the Claimant's clinical negligence accredited solicitor, to instruct a suitably qualified expert on a joint basis, with a view to seeking an opinion to determine qualifying liability.

16.5 When a qualifying liability is established the Claims Manager will be responsible for evaluating, assessing and quantifying Redress cases. Where there is difficulty in quantifying the case, the Claims Manager will seek advice from NWSSP Legal and Risk solicitors following approval by the Executive Director of Nursing, AHPs and Health Science.

16.6 Prior to making an admission in relation to qualifying liability and making an offer of compensation in matters where the value of a Redress case is less than the PTR threshold of £25,000, the Claims Manager will be responsible for convening a Putting Things Right Redress Panel and bringing the matter before the Panel to consider liability and the offer of compensation. This may also include seeking approval on one or more of the remedies available under the Putting Things Right Regulations e.g. the associated cost of remedial treatment.

16.7 Where a Redress case is considered to be in excess of the PTR threshold of
£25,000, if a qualifying liability were to be determined, the matter must not proceed under the Putting Things Right Regulations. The Claims Manager will, instead, be required to inform the service user or their representative to seek independent legal advice.

16.8 The Claims Manager will be responsible for obtaining a Compensation Recovery Unity (CRU) Certificate from the Department of Works and Pension (DWP), in accordance with legislative requirements, and will be required to obtain approval, within the financial delegated limits set, for settling any NHS/CRU charges incurred as part of a financial compensation settlement. The Claims Manager will be responsible for providing the outcome to the CRU on all Redress matters. Where CRU exceeds that of £3,000, in accordance with the Welsh Risk Pool Procedures, the matter will be referred to NWSSP Legal and Risk Services for advice.

16.9 The Deputy Head of Quality, Safety and Assurance will direct the nature and involvement of the Claims Manager in any subsequent investigation of an incident or reported concern that involves a potential breach of the legal duty of care by the Trust.

16.10 The Trust is to ensure that there is an appropriate forum to enable lead members of staff for complaints, risk and claims to meet on a regular basis to discuss risk and ensure that the identification of any trends and/or remedial action that may be required are highlighted and signposted for action accordingly.

17. Payments made under the Putting Things Right Regulations - NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

17.1 The Trust is required to ensure that all requests for compensation associated with a possible negligence claim, should only be made in the event of the Trust being liable for the claimant's loss. Payments requiring financial compensation arising out of any episode of negligence must satisfy the requirements of the Welsh Government's delegated authority and WRP guidance as follows:-

17.2 Concerns involving a qualifying liability in tort are to be resolved by the settlement of damages up to a maximum of £25,000 under Redress

17.3 Concerns (i.e. claims for negligence) exceeding £25,000 and formal claims for negligence below £25,000 are to be resolved in accordance with the relevant Pre-Action Protocols and Civil Procedure Rules.

18. The Putting Things Right Panel

18.1 Following an investigation into a PTR concern, in accordance with the Trust's Terms of Reference, the Putting Things Right Panel will convene and make a decision on one or either of the following:-

- breach of duty has occurred
- causation (harm) that has resulted in a qualifying liability

Authorisation is required by the PTR Panel before making any admissions on breach of duty and causation, including any financial offers of compensation and/or remedial treatment to put the Claimant back into the position he/she would have been in, but for the negligence

18.2 The Putting Things Right Panel is chaired by the Executive Director of Nursing, AHPs and Health Science and consists of the Deputy Director of Nursing, Clinical PTR Lead, Clinical Director and/or Medical Director, Nursing leads, Directorate leads, the Trust's Head of Quality, Safety and Assurance and Deputy Head of Quality, Safety and Assurance and Claims Manager in addition to members of staff invited to attend.

18.3 Approval is authorised by the Chair and is based upon the following considerations:

- the strength and merits of the case
- the remedies available under the Redress Scheme
- the likelihood/requirement of settling the case and its associated cost
- Any lessons learnt

18.4 If a decision is made to proceed with a financial offer and that offer is subsequently accepted, correspondence will state that the payment is made in full and final settlement of the concern.

18.5 The complainant is advised that they will be unable to pursue a claim for the same matter, as outlined by the Putting Things Right procedures.

18.6 The relevant Divisional Director has responsibility for liaising with appropriate staff, ensuring any identified and agreed learning and actions arising from the Panel, are implemented and monitored.

19. Inquests

19.1 Inquests are legal inquiries into the cause and circumstances of a death, and are limited, fact-finding inquiries.

19.2 The Coroner will consider both oral and written evidence during the course of an inquest. Inquests are public hearings and can be held with or without juries - both are considered equally valid. Under Rule 8 of the Coroners (Inquest) Rules 2013, Coroners are required to complete an inquest within 6 months of the date on which the Coroner is made aware of the death, or as soon as is reasonably practicabl

19.3 Coroners are independent judicial officers, appointed by the local authority, and are either doctors or lawyers responsible for investigating the cause of deaths in accordance with the Coroners and Justice Act 2009.

19.4 Under section 5 of the Act, a Coroner is responsible for determining:

- who the deceased was;
- how, when and where the deceased came by his or her death; and,
- the particulars (if any) required by the Births Deaths and Registrations Act 1953 to be registered concerning the death.

19.5 A coroner is obliged to investigate deaths where there is a reasonable suspicion that the deceased has:-

- died a violent or unnatural death,
- where the cause of death is unknown or
- if the deceased died while in custody or state detention as defined by section 1(2) of the Coroners and Justice Act 2009.

19.6 The Coroner will also investigate where the deceased has not been seen by the doctor issuing the medical certificate, or during the last 14 days before the death.

19.7 The Coroners and Justice Act 2009 conferred on Coroners the power to require a witness e.g. a clinician, nurse, police officer etc. to provide a written statement and to call a witness to appear at an inquest, and to determine the evidence to be heard.

19.8 The Claims Manager will liaise with the Coroner following notification of an inquest and will liaise accordingly with staff to provide a written statement, providing guidance as required.

19.9 If a staff member is informed of an inquest direct by a Coroner, Coroner's Officer or Police Officer and a witness statement or information is requested in relation to a death, it is the responsibility of the staff member to ensure that it is reported to the Claims Manager immediately. The Claims Manager will, on behalf of the staff member, liaise thereafter with the Coroner and co-ordinate the statement and/or any information that is required.

19.10 When a staff member is called upon to attend an inquest, the Claims Manager and an appropriately appointed senior manager will attend the inquest in a supporting capacity.

19.11 In instances where there are concerns involving the Trust's reputation, failings in service or care, likelihood of a possible Prevention of Deaths Report being issued or if Article 2 is invoked by the Coroner, the Trust will be required to consider seeking legal assistance from NWSSP Legal and Risk to represent the Trust at the inquest hearing.

20. Information Governance /Confidentiality

20.1 The Trust is responsible for ensuring that staff are aware of their obligations and duties to ensure that information, records and disclosure are processed and managed in accordance with applicable legislation, codes of practice, standards and Trust policy.

20.2 There is a requirement for all staff to process sensitive personal data, information, documents and records in accordance with the legislation contained within the Data Protection Act 2018, the retained EU General Data Protection Regulations 679/2016 (UK GDPR), Access to Health Records Act 1990, The Freedom of Information Act 2000, Environmental Information Regulations 2004 and the Caldicott Principles. The Trust Data Protection and Confidentiality Policy contains further information.

20.3 Staff are required to pay particular attention when transferring and/or communicating any sensitive data, information, documents and records that form part of a concern and must take the utmost care to ensure information is, at all times, safe and protected. When a need exists to exchange any information that forms part of a claim, it is the responsibility of Trust staff to maintain security and confidentiality in order to minimise the risk of loss at all times.

20.4 Staff are required to comply with legislation, codes of practice, standards and relevant Trust Policies together with applicable divisional/associated organisational directions and/or guidance, to ensure that suitable precautions are taken to protect against any accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to data, information, documents and records whether employee or patient, donor or service user, held on a computer or held manually, regardless of the method of communication, which includes verbal, electronic or written.

20.5 Reports and correspondence which do not have, as their sole or dominant purpose, actual or prospective litigation, are likely to be disclosable to parties with or without authorisation from the data subject. This will include incident reports and investigations, complaints or investigations and any associated e-mails.

20.6 Trust staff who are requested to disclose records to any legal representative or where the intention to pursue a claim has been indicated by an individual should notify the Claims Manager.

20.7 The Claims Manager is responsible for ensuring that all relevant records and information relating to a claim are obtained and protected. Records protection will usually include the clinical record and any supplementary documents (e.g. incident and complaint investigations).

20.8 The Claims Manager is responsible for maintaining claims information via the Datix Management System. Access to the database is restricted; any claims that are reported to the Executive Management Board, Quality, Safety and Performance Committee, or sub-committees, are anonymised to protect the confidentiality of data.

20.9 Closed files are to be placed in archive storage for a minimum period of 10 years

21. Equality and Impact Assessment

21.1 The Trust is committed to ensuring that the Trust does not discriminate against individuals or groups.

21.2 The Trust has undertaken an Equality Impact Assessment to ascertain if the Policy and procedures outlined in this document will directly impact on any group in respect to gender, including maternity and pregnancy, marriage or civil partnership issues, race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or any other protected characteristics.

21.3 The assessment has found that there is no likely impact to the equality groups highlighted above. Where impact is likely this has been assessed in accordance with national guidance and statute. Where appropriate, the Trust will take action to minimise any direct impact on equality and will ensure that it meets its responsibilities in accordance with human rights legislation.

22. External Agencies

22.1 The Trust's Deputy Head of Quality, Safety and Assurance will determine if external agencies should be involved in the claim investigation process as follows:-

- Where the circumstances give rise to a suspicion of an unlawful act, an Executive Director will be responsible for the decision as to whether the matter should be reported to the Police.

- Where the circumstances give rise to concerns in relation to professional conduct, the appropriate professional lead will be responsible for reporting the matter to the relevant professional body.

- The Trust Deputy Head of Quality, Safety and Assurance will advise if the matter should be reported to Health Inspectorate Wales (HIW), or other regulatory or statutory body.

22.2 NHS Executive

From the 1st April 2023, the Welsh Government has introduced the NHS Executive made up of the following component organisations:

- Delivery Unit

- Finance Delivery Unit
- Improvement Cymru
- Health Collaborative

The key purpose of the NHS Executive is to drive improvements in the quality and safety of care to achieve better, fairer healthcare outcomes for the people of Wales. The Claims Manager will liaise with the NHS Executive, when required, and will comply with any reporting requirements to fulfil the claims and inquests management function. This will include submitting any reports that could potentially impact upon the Trust's reputation. The Trust is required to ensure that the NHS Executive is made aware of any potential reputational impact from media or press coverage e.g. inquests.

23. Monitoring

23.1 The effectiveness of this policy will be reviewed on an annual basis by the monitoring arrangements in place in relation to claims management and the compliance with the WRP Reimbursement Procedures. The Quality and Safety Performance Committee will monitor claims performance via the quarterly Putting Things Right reports and the Trust's Putting Things Right Annual Report, highlighting the position in respect of all claims and the learning identified.

23.2 The Claims Policy will be received by the Integrated Quality and Safety Group, Executive Management Board and Quality and Safety Performance Committee for approval and noting.

24. The Duty of Candour

24.1 Following the introduction of the Health and Social Care (Quality and Engagement) (Wales) Act 2020, the Duty of Candour is now a statutory requirement which comes into force from the 1st April 2023. It underpins the Welsh Government's commitment to openness and learning, vital for the provision of safe, effective and person-centred health and social care. The aim of the Act is designed to improve accountability, promote responsibility through the development of safer systems, engage staff in the improvement of services, strengthen the delivery of quality care and create an enhanced service user experience, built on trust and mutual understanding.

Although the statutory duty applies specifically to NHS organisations, individual healthcare staff are predominantly representatives of the NHS and are therefore

responsible for their interactions with service users, their families and advocates and are required to follow relevant procedures and policies.

The statutory duty of candour places a requirement on NHS bodies to follow a set process, evidencing the series of prescribed actions undertaken when the duty of candour is triggered. It works alongside current governance processes involving:-

- **Management of concerns (both formal and informal)**
  The duty is aligned with the Putting Things Right Regulations, updated in 2023. These Regulations will exist alongside the Duty of Candour and will continue to support the Trust's culture of openness and transparency.

- **Compliance with fundamental care quality standards and relevant statutory regulation e.g. Health Care Inspectorate Wales.**

  Monitoring and assurance of the Trust's process will continue as a fundamental priority. Where inefficiencies are found in the delivery of care and quality, rapid remedial action will be taken to address deficiencies. This will not only improving our services but put in place necessary safeguards to minimise future risk to the Trust's service users and staff.

- **Effective investigation of, and learning from, concerns**

  In compliance with the statutory Duty of Candour and Putting Things Right Regulations, proportionate investigation and learning will remain at the heart of the Trust's commitment to improve the Trust's services and enable learning to be shared. This not only encourages better outcomes across NHS Wales but also ensures staff are able to raise concerns in a safe and protected environment.

- **Statutory and professional duty of candour**

  There are two types of duty that involve candour:-
  - professional
  - statutory

  Professional Duty - Healthcare professionals are required to comply with their professional duty of candour**,** which states:
  "*Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress".*

Statutory Duty - NHS organisations are responsible for regulating the statutory duty of candour, while regulators of specific healthcare professions, such as the General Medical Council (GMC), Nursing (RCN), and Midwifery Council (NMC) will oversee the professional duty.

The new statutory duty compliments the existing professional duty of candour and has the same aims – to encourage openness and learning to improve the quality of our care.

The statutory duty of candour also encompasses specific requirements for 'notifiable safety incidents'. When a notifiable safety incident occurs, the professional duty alone will no longer be sufficient to meet the requirements.

24.2 Definitions

Statutory Duty of Candour	To act with openness and honesty with service users or their families/advocates, when a service user is harmed by the provision of healthcare, regardless if a concern is raised.
Professional Duty of Candour	The individual duty professionally owed.
Concern	Refers to a claim, complaint, incident or enquiry.
Openness	Free to express concerns and questions answered honestly.
Transparency	Sharing a true account of performance and outcomes with staff, service users, the public and regulators.
Notifiable adverse outcome	An adverse event which caused, or has the potential to cause, harm to a service user which may be a factor in the duty of candour being triggered.
Apology	Saying sorry. An expression of meaningful sorrow or regret.
Harm	More than minimal harm. Level of harm is defined as: death, severe harm or moderate harm, includes psychological harm.
Healthcare	Provision provided in Wales under virtue of the National Health Service (Wales) Act 2006 for or in connection with:- a) the prevention, diagnosis or treatment of illness;

	b) the promotion and protection of public health;
Illness	Includes any disorder or disability of the mind and any injury or disability requiring medical or dental treatment, nursing or therapy.
Service user	Person to whom healthcare is given by an NHS organisation/provider.
Review	Clarification of an incident and an assessment as to the level of harm that has occurred or could occur to the service user when considering if the threshold for triggering the duty of candour has been met.
Investigation	In-depth analysis and enquiries made to understand what has happened. This may involve a number of investigative techniques and methodologies including, 5 whys, root cause analysis, fish bone tool etc. The investigation will require the need to identify learning.
Once for Wales Datix Cymru	A reporting and management digital platform for concerns, comprising claims/inquests, incidents, redress, feedback (complaints) modules.

24.3 When does the Duty of Candour apply?

Every event is likely to be different and, at times, complex. Two conditions must be met in order for the duty to be triggered:-

1. A service user experiences, or could experience, unintended or unexpected harm, that is more than minimal.
2. The provision of healthcare was or may have been a factor.

It is important to note that the duty is triggered not only when harm is known to have occurred, but also in cases where the circumstances are such that a person could experience harm from an incident or occurrence, at some point in the future.

24.4 Harm that is unintended or unexpected

The Duty of Candour requires that harm must be unintended or unexpected.

Many interventions come with inherent risks. These risks should be identified and discussed with a service user as part of the consenting process. If, for example, a medication has a known risk of adverse reaction, the Duty of Candour will not be triggered in the event that the risk materialises and the service user has consented to the risk. In this sense, “unexpected harm” has not been identified because the risk is one which was expected as part of the consequence of treatment.

In situations regarding side effects and adverse reactions to medications, the harm threshold of more than minimal, has to be met to trigger the Duty of Candour. The materialisation of a known risk will not trigger the duty. However, complications associated with care that was not discussed as a risk of the healthcare provided, may meet the requirements to activate the trigger.

24.5 Grading Harm

The concept of “more than minimal” harm is not defined in law. The level of harm framework under the Putting Things Right Regulations will apply when determining if the duty of candour is triggered. The trigger will occur when moderate harm or above is identified, or likely, at some time in the future, to cause or potentially cause moderate harm or above, to the service user. The duty will be triggered on:-

- Death
- Severe Harm
- Moderate Harm, including psychological harm.

Further information in relation to the Duty of Candour can be found in the Handling Concerns Policy.

25. Resources

25.1 The implementation and management arrangements associated with this policy will give rise for the release of investigators to investigate a claim.

26. Implementation

26.1 The function of this policy will be maintained by the Corporate Quality & Safety Team.

27. Policy Conformance / Non Compliance

27.1 In the event any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered as gross misconduct.

28. Distribution

28.1 The policy will be available via the Trust Intranet Site and the Claims Manager. Where staff do not have access to the intranet, the staff member's line manager must ensure that their staff have access to a copy of this policy.

29. Review

29.1 The Claims Manager will review the operation of the policy as necessary and at least every 3 years

30. Contact Information

30.1 The Claims Manager can be contacted as follows:- Jayne.Rabaiotti@wales.nhs HandlingConcernsVelindre@wales.nhs.uk.
Contact telephone number: 02920196161

31. References and Legislation

31.1 This Policy complies with:-

- PTR Guidance – Clinical Negligence and Personal Injury Litigation: Claims Handling: Putting Things Right – Guidance on dealing with concerns – Clinical Negligence and Personal Injury Litigation: Structured Settlements
- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- The Civil Procedure Rules 1998

- Welsh Health Circular (WHC) (2000) 04 replacing the Welsh Health Circular (WHC) (98) 08
- WHC(99)128 – Handling Clinical Negligence Claims: Pre-Action Protocol
- Welsh Health Circular addendum (WHC 04 (2000))
- The Welsh Risk Pool Services Concerns and Compensation Claims Management Standard
- The Welsh Risk Pool Protocols and procedures including the Case Reimbursement Procedures and periodic reimbursement updates and Welsh Risk Pool Indemnity provisions
- The Trust's Standing Orders and Standing Financial Instructions
- Protocol for Referring Clinical Negligence Claims to Legal & Risk
- Duty of Candour
- The Welsh Risk Pool revised All-Wales Indemnity and Insurance Policy and Scope Document effective from 1st September 2023
- Welsh Risk Pool Procedures (revised)

Appendix 1

RESPONSIBLIITY AND ACCOUNTABILITY FRAMEWORK – Velindre University NHS Trust

Appendix 2

SCHEME OF DELEGATION

Matter Delegated	Approving Officer
Approving individual losses and special payment claims in accordance with current Assembly guidance and Velindre University NHS Trust Model Standing Orders - Reservation and Delegation of Powers 2021: Please see Appendix referred to below	
• Up to £5,000	Claims Manager & Quality, Senior Quality and Safety Assurance Managers
• up to £100,000	Chief Executive/Executive Director of Nursing Allied Health Professionals and Health Science
• Over £100,000 and up to £1,000,000	Trust Board
• Over £1,000,000	Welsh Government/Welsh Risk Pool
Notes: These limits relate to damages and/or costs payable	

Appendix 3

Extract from Velindre University NHS Trust Model Standing Orders – Reservation and Delegation of Powers 2021:

TRUST BOARD

HANDLING CONCERNS POLICY

DATE OF MEETING	30th November 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Zoe Gibson, Interim Corporate Head of Quality, Safety and Assurance
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Quality
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	To ensure the Trust discharges its responsibilities regarding concerns handling the Trust Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour) QS03 has been reviewed and updated to ensure alignment with: • The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour). • National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011). • The Putting Things Right Guidance (PTR) (2023). • Public Service Ombudsman for Wales Act (2019). • Duty of Candour Procedure (Wales) (2023).

	• NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).
RECOMMENDATION / ACTIONS	The Trust Board are asked to **APPROVE** the revised version of the Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour): QS03.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	25th July 2023.
Executive Management Board	31st July 2023
Quality, Safety & Performance Committee	16th November 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Policy endorsed for onward approval.	

7 LEVELS OF ASSURANCE	
NOT REQUIRED AS A POLICY FOR APPROVAL	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance** Not required

APPENDICES	
1.	Revised Trust Handling Concerns Policy

1. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The revised Handling Concerns Policy is attached in ***Appendix 1***. This policy has been extensively reviewed and amended to ensure alignment with the legislative requirements of the Health and Social Care (Quality and Engagement) (Wales) (2020) Act, the requirements of the Duty of Candour procedures (2023) and updated Putting Things Right Guidance (2023).

2. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒

• A beacon for research, development, and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	All 6 domains of quality are positively impacted by this policy.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not applicable
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There are financial requirements in respect of executing responsibilities within this policy relating to NHS redress procedures.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Click or tap here to enter text.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal requirements to comply with Duty of Quality, Duty of Candour and Putting Things Right Regulations. This policy ensures Trust

	compliance with these legal responsibilities from a handling of concerns perspective.

Ref QS03

Handling Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour)

Executive Sponsor & Function:	Executive Director Nursing, Allied Health Professionals and Health Science
Document Author:	Corporate Head of Quality, Safety and Assurance
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
Equality Impact Assessment Outcome:	
Review Date:	
Version:	5

TABLE OF CONTENTS

1. Executive Summary

This policy has been developed to ensure that Velindre University NHS Trust (the Trust) discharges its statutory responsibilities for the robust, effective, and timely handling of concerns (complaints, claims, and patient safety incidents) through ensuring organisation wide learning and continuous improvement, in line with the requirements set out within:

- The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour).
- National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011).
- The Putting Things Right Guidance (PTR) (2023).
- Public Service Ombudsman for Wales Act (2019).
- Duty of Candour Procedure (Wales) (2023).
- NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).

2. Policy Statement

The Trust fully acknowledges that, as a provider of specialist and complex healthcare services, there will be occasions where things will go wrong.

When such occasions occur the Trust will ensure a robust response that is in line with the key principles and statutory requirements of Health and Social Care Quality and Engagement (Wales) Act (2020), the Duty of Quality (2020), the Duty of Candour (2022) and National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011), to ensure an open and transparent concerns handling, with and a strong focus upon learning and continuous improvement, required to ensure the provision of safe, timely, effective, efficient, equitable and person centred care.

2.1 Policy Key Principles

A culture of psychological safety, openness, and transparency.	**Robust & proportionate Investigations.**	**Local procedures will be in place to support delivery in line with the requirements of National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations (2011). Putting Things Right Guidance.**
Staff will be equipped with role appropriate concerns handling knowledge and information.	**Individuals raising concerns will be engaged in the handling process.**	**Staff involved in a concern will be able and encouraged to access support.**
Consistent concern management and reporting Systems in place across the Trust.	**Continuous improvement through learning.**	**A bi-lingual service will be provided through an active Welsh Language offer.**
Learning will be shared across the Trust.	**Early resolution of concerns will be promoted, and unnecessary escalation avoided.**	**Concerns will be managed in a timely manner in line with Putting Things Right Regulations.**

3. Scope of Policy

This policy applies to all people engaged in work for the Trust and host organisations, including those employed on a contract of employment and those working on a bank or agency contract

There is an acknowledgement that the Putting Things Right Regulations and Duty of Candour may not apply in their entirety to some hosted organisations, however, the principles and requirements of the Regulations should be adopted where appropriate as good practice.

The Policy relates to concerns regarding:

- Services, care, and treatment provided by the Trust.
- Services provided by the Trust's employed staff.
- Services provided by independent contractors.
- Services provided by independent or voluntary sector(s) funded by the Trust.

This policy ***does not*** apply to concerns relating to:

- Clinical services provided privately, even when provided within Trust premises.
- Staff contract of employment, e.g., concerns raised though the Respect and Resolution Policy or The Procedure for NHS Staff to Raise Concerns (whistleblowing).
- Public Services Ombudsman investigations.
- Alleged failure of the Trust to comply with a request for information under the Freedom of Information Act (2000).
- Trust disciplinary proceedings arising from the investigation of a concern.
- Civil Proceedings.
- Individual Patient Funding Request (IPFR).
- Police criminal investigations.

If a concern raised is excluded from the scope of Putting Things Right Regulations (PTR) the Trust will advise the complainant, in writing as soon as reasonably practicable of the reason(s) for the decision. If any excluded matter forms part of a wider concern, the issues within scope of the Putting Things Right Regulations can be managed under this policy.

4. Aims & Objectives

The Trust is committed to dealing with concerns in a timely, open, honest, transparent, accessible, and equitable manner, with a strong focus upon ensuring that organisational learning and continuous improvement takes place, in accordance with the NHS Wales Duty of Candour.

The aim of this Policy is to:

- Ensure the Trust has robust arrangements in place for the effective handling and monitoring of concerns.
- Provide assurance to the Board and external bodies of the commitment to implement the requirements of the regulations National, the Health and Social Care Quality and Engagement (Wales) Act 2020 and Duty of Candour Procedure (2023).
- Define concern handling roles, responsibilities, and processes.

5. Definitions

Adverse event/incident	An event which causes or has the potential to cause unexpected or unwanted effect involving the safety of the patients, users, or other persons.
Claim	Allegations of negligence and/or demand for compensation made following an untoward incident resulting in clinical negligence or personal injury to a member of staff, patient, member of the public or damage to property.
Complainant	A person notifying the concern/complaint.
Complaint	Any expression of dissatisfaction.
Concern	Any complaint, claim or reported patient/ donor incident to be handled under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.
Duty of Candour	A requirement to ensure healthcare providers are open and transparent with people who use services when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
Duty of Quality	A legal responsibility for Welsh Ministers and NHS bodies secure improvements in the quality of services they provide, supporting the achievement of ever higher standards of person-centered care services in Wales.
Early Resolution	Concerns that could potentially be resolved to the complainant's satisfaction either immediately or within 2 working of receipt.
External body / Agency	An organisation that has an official advisory or regulatory role that has been mandated to regulate the corporate and professional activities of NHS Trusts.
Investigation	A formal approach of gathering information in a systematic and methodical way.
Nationally Reportable Incident	A patient or donor safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff, or members of the public, during NHS funded healthcare.
Never Event	Serious Incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.
Near Miss	An occurrence, which but for the luck or skilful management would in all probability have become an incident.

Qualifying Liability	A liability in tort owed in respect of, or consequent upon, personal injury or loss arising out of or in connection with breach of duty of care owed to any person in connection with the diagnosis of illness, or in the care or treatment of any patient/ donor/ service user in consequence of any act or omission by a health care professional and which arises in connection with the provision of qualifying services.
Redress	The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability in tort; the giving of an explanation; the making of a written apology and the giving of a report on the action that has been, or will be, taken to prevent similar occurrence
Root Cause Analysis	A process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence or possible occurrence of a sentinel event.

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6. Roles and Responsibilities

In line with the Regulations the roles and responsibilities for Concern Handling at VUNHST are:

6.1 Chief Executive Officer

The Trust Chief Executive Officer has overall responsibility for dealing with concerns and ensuring investigations are undertaken in an appropriate manner, within appropriate timescales and that lessons learned are implemented within the Trust.

6.2 Responsible Officer

The Responsible Officer is accountable for the effective day to day operation of the Trust's arrangements for dealing with concerns in an integrated manner. The Director of Nursing, Allied Health Professionals and Health Science is the Responsible Officer for the Trust and ensures arrangements are in place to:

- Deal with concerns in line with the Regulations.
- Ensure a Duty of Candour is applied where appropriate.
- Allow for the consideration of qualifying liabilities; and
- For incidents, complaints and claims to be dealt with under a single governance arrangement.

6.3 Strategic Oversight

A nominated Independent Member is responsible for maintaining a strategic overview of the Putting Things Right arrangements and the Duty of Candour and their operation, including:

- Overseeing how organisational arrangements are operating at a local level.
- Ensuring that concerns are dealt with in compliance with the regulations.
- Ensuring the Duty of Candour is triggered where relevant.
- Ensuring arrangements are in place to review the outcome of all investigated concerns to ensure that any failure in provision of service identified during the investigation are acted

upon, learnt from, and monitored to prevent recurrence. The nominated Independent Member is the individual with responsibility for the Quality, Safety & Performance Committee.

6.4 Corporate Quality and Safety Team

The Corporate Quality & Safety team is responsible for ensuring the Trust has appropriate policies, procedures, support, and training in place for the management of Concerns across the organisation through.

- Receipting and grading PTR Concerns and providing acknowledgement letters within required timescales.
- Developing Concerns / Putting Things Right/ Duty of Candour related policies and procedures.
- Providing/sourcing concerns handling, investigation and Datix Cymru training to ensure staff across the organisation are equipped with the knowledge and skills to undertake their role in concerns handling and investigation.
- Overseeing appropriate divisional investigative processes and adherence with national timescales
- Leading on 'Serious Harm' investigations
- Leading on all Public Services Ombudsman Reviews / investigations
- Leading on all Redress processes
- Leading on all Duty of Candour reporting
- Leading on Vexatious Concerns Management
- Auditing compliance with Putting Things Right and Duty of Candour
- Oversight of learning and dissemination of learning
- Development of Concern reports for Executive Management Board, Quality, Safety & Performance Committee and Trust Integrated Quality and Safety Group
- Development and Publishing Trust Annual Concern Report
- Leading on liaison and meeting requirements of other external bodies such as: Coroner's Office; Shared Services – Legal and Risk, Police; and Citizen Voice Body for Health and Social Care, Wales
- Representing the Trust at National Concern related meetings.

6.5 Executive Management Board

The Executive Management Board is responsible for overseeing the Trust's Concerns Management process and outcomes, including policies, procedures, and reporting in line with legislative and national requirements; training provision and compliance; identification of and compliance with key performance indicators; meaningful analysis; investigative processes; audit and operational assurance mechanisms; ensuring that remedial action is taken; Duty of Candour mechanisms are in place; and appropriate lessons are identified and shared.

6.6 Quality Safety and Performance Committee

The Quality, Safety and Performance Committee provide assurance reports to the Trust Board in relation to how the Trust is meeting its responsibilities under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations ('the Regulations) (2011) and Duty of Candour Procedure (Wales) (2023), whilst highlighting any exceptions, risks, or potential risks in respect of this. The Committee's oversight includes ensuring the provision of appropriate training,

policies, procedures, and reports in line with legislative and national requirements; identification of and compliance with key performance indicators; meaningful analysis. investigative processes; audit and operational assurance mechanisms; ensuring remedial action is taken and appropriate learning identified, addressed, and shared

6.7 Corporate Head of Quality, Safety and Assurance

The Head of Quality, Safety and Assurance is responsible as the Senior Investigations Manager (SIM) for the Trust in line with the requirements of the PTR regulations, and is responsible for:

- Oversight of the handling and consideration of concerns in accordance with this policy.
- Auditing Trust and Divisional concern handling arrangements.
- Ensuring robust interface arrangements with the Divisions are in place to ensure effective divisional concern handling processes and outcomes.
- Development, integration and embedment of a comprehensive concern investigation and redress systems.
- Embedment of robust Duty of Candour processes and procedures.
- Providing assurance to the Executive Management Board (EMB) and Quality, Safety and Performance Committee on the Trust concern management performance.
- Ensuring mechanisms are in place for learning, and continuous improvement initiatives to be shared across the Trust.

6.8 Service Directors (including hosted Organisations)

(Corporate / Divisional Directors, Clinical Directors, Medical Directors, Chief Scientific Officers, and Heads of Nursing.)

Service Directors are responsible for achieving compliance with the Regulations, the Duty of Candour, and this policy through ensuring:

- The provision of robust local concern handling arrangements across all provided and commissioned services.
- Concerns are managed within required timescales and performance measures.
- Datix Cymru is the primary repository for all concerns and associated documentation
- All investigations are fully and accurately recorded and stored in Datix Cymru.
- A culture of openness, transparency, psychological safety, learning, improvement is promoted, encouraged, and embedded into practice.
- Employees receive role appropriate concerns handling training
- Employees understand their individual roles and responsibilities in concerns handling.
- Cross-divisional and Trust wide approach to concern handling, communication, co-ordination, liaison, and reporting.
- Adequate and appropriate support is available and offered to employees who are involved in, or are the subject of a concern
- Availability and release of employees trained in investigations analysis to support required investigations.
- All identified learning is addressed and shared to enable continuous improvement to prevent re-occurrence of issues arising and optimise quality and safety of service provision.

6.9 Departmental Managers

All managers across the Trust are responsible for ensuring:

- Employees and volunteers are aware of this policy and their roles and responsibilities within it.
- A culture of openness, transparency, psychological safety, empowerment, learning, improvement, and timely concerns handling is promoted, encouraged, and sustained in practice.
- Processes are in place to ensure effective management of concerns and discharge responsibilities in line with Putting Things Right Guidance and Duty of Candour Procedure.
- Ensuring all concerns and associated communications and documentation are recorded at time of report and stored within Datix Cymru system.
- Provision of robust and timely feedback of concern outcomes, lessons learnt and improvement opportunities with colleagues.
- Employees are provided with role specific training for both concerns handling and operation of Datix Cymru system.
- Display and provision of relevant patient/ donor concern reporting information and sign posting within clinical areas e.g. 'How to raise a concern' and Llais (Citizen Voice Body for Health and Social Care).
- All identified lessons learnt, and improvement actions are addressed, implemented, or escalated as appropriate.

6.10 Putting Things Right Panel

The Trust Putting Things Right panel are responsible for the consideration and progress of Regulation 26 concerns where a breach in the duty of care has been identified. Responsibilities identified include:

- Determination and or validation of whether a breach of duty has occurred.
- Determination of whether the breach of duty described has caused harm.
- Consideration of engaging an independent clinical expert if a decision on breach of duty cannot be reached.
- Consideration of engaging of an independent clinical expert in collaboration with the person raising the concern where causation is in question or further clarity as to the degree of harm is required.
- Agreement of communication pathways to communicate the decision of the panel to both the person raising the concern and staff affected by the concern.
- Agreement of award of financial compensation in cases where a Redress remedy applies.
- Ensuring robust systems to capture and record decision making processes and outcomes.

6.11 Responsibility of all Staff

All staff must ensure:

- Adherence to this policy, divisional/ departmental concerns, and Duty of Candour procedures.
- All individuals notifying/reporting concerns are treated with honesty, transparency, respect, and courtesy.
- All concerns are treated confidentially.
- Understanding of their individual role and responsibilities for reporting, handling and

escalating concerns, incidents, and near misses.
- Awareness of available supportive resources.
- Co-operation and engagement in investigation processes.
- All concerns are addressed or escalated at time of report.
- Role specific concern management and Datix Cymru training and education is undertaken.
- Report all near misses, safety incidents and concerns in line with divisional and departmental processes.

7. Duty of Candour

The Trust will adhere to the legal requirements and discharged its responsibilities in line with the Health and Social Care (Quality and Engagement) (Wales) Act (2020) and Duty of Candour Procedure (Wales) (2023).

7.1 When does the Duty of Candour apply?

For the Duty of Candour to be triggered the following two conditions must be met:

- **A service user experienced, or may have experienced, unintended, or unexpected harm (physical or psychological harm or in the case of an individual that is pregnant, loss or harm to the unborn child) that is "more than minimal." Although there is no legal definition of minimal harm, in practice this relates to moderate harm or above:**

  ''Moderate Harm: A service user experiences a moderate increase in treatment and significant but not permanent harm, e.g., being given medication, that they have a known allergy to, and this leads to a significant reaction requiring 4 or > days in hospital before recovery.'

  'Severe Harm: A service user experiences a permanent disability or loss of function e.g., being given medication, that they have a known allergy to, and this leads to brain damage or other permanent organ damage.'

  'Death: A service user dies e.g., being given medication, they have a known allergy to, and this leads to their death.'

- **The provision of healthcare "was" or "may have been" a factor in the patient or donor suffering that outcome.**

To ensure appropriate consideration of the Duty of Candour requirements the Trust will consider each event upon an individual basis and determine whether a 'notifiable adverse outcome' has occurred, and the Duty triggered.

7.2 Requirements of Duty of Candour

- The trust is legally required to adhere to the conditions of the Duty of Candour and will therefore ensure that Duty of Candour Procedure (Wales) 2023 is followed.

7.3 Duty of Candour Procedure

- To ensure the Trust fulfils its legal obligations it will ensure the following robust process is in place:

7.3.1 Stage 1 – Rapid Review- Identification of a 'Notifiable Adverse Outcome'

Incidents or Concerns graded at moderate harm or higher will receive a rapid review that is undertaken within 48 hours of report to determine whether a notifiable adverse outcome has occurred, and the Duty of Candour triggered. All rapid reviews will be recorded in the Datix Cymru system in line with Trust Incident Reporting policy and processes.

7.3.2 Stage 2 – 'In Person Notification'

The Trust will ensure that the 'In Person Notification is undertaken in line with the Duty of Candour procedure (2023), by a suitably trained and skilled individual, either in person, via telephone or audio visually, and completed at the time the Trust first become aware the Duty of Candour procedure has been triggered.

The in-person notification will consistently include:

- A meaningful apology
- An explanation of the actions and further enquiries that the Trust will undertake to investigate the circumstances of the notifiable adverse outcome
- Details of the nominated point of contact,
- An offer of support and details of any appropriate support information
- If the in-person notification is made later than 30 working days after the Trust first became aware of the notifiable adverse outcome an explanation for delay should be included.

7.3.3 Stage 3 - Written Communication

The Trust will ensure a formal letter is issued by the Service Director or nominated deputy to the service user/ person acting on their behalf within five working days of the "in-person" notification.

The formal letter will include:

- Reiteration of the verbal apology
- Date of notification
- An account of the incident to date and explanation of the actions that the organisation will take as part of the procedure and the investigation
- Point of Contact details
- Details of available support
- If "in-person" notification was later than 30 days after the date on which the incident occurred, an explanation of the reason for the delay is required.

7.3.4 Stage 4 - The Review/Investigation

The division in collaboration with the service user or person acting on their behalf will conduct an open, transparent, and proportionate investigation of the incident in accordance with the Regulations and Duty of Candour procedure (2023). Once complete the investigation outcome will be

communicated to the service user or their representative in accordance with regulation 24 or regulation 26 and 31, where the Redress arrangements apply.

7.4 Record Keeping

The Trust will ensure that all correspondence, decisions made, actions and relevant documents are kept in accordance with the Duty Candour Procedure within Datix Cymru. Documentation should include but is not limited to:

- Outcomes of Rapid Review to establish whether the duty has been triggered.
- Notification of the Duty.
- Attempts to contact the service user/person acting on their behalf.
- Any decision by the service user/person acting on their behalf not to be contacted in relation to the Duty of Candour
- Investigation of the notifiable adverse outcome, which is undertaken by the Trust, including the response or interim report issued under regulations 24, 26 or 31 of the 2011 Regulations.

7.5 Consent

The Trust will ensure that relevant consent procedures are followed in line with the Putting Things Right guidance and Duty of Candour procedure. In cases where a representative is acting on behalf of a service user with capacity, consent for the representative to act will be obtained from the service user and will be kept under review throughout the process.

In situations where the service user/person acting on their behalf indicate that they do not wish to engage or communicate with the Trust, the individuals wishes should be respected, but investigation of the incident must continue so that lessons can be learned, and quality improvements made.

7.6 Serious Case Reviews

In the event of adverse outcomes effecting large numbers of patients/ donors are identified following retrospective serious case reviews, or following a decision made by the medical examiner service or a coroner's inquest, where the cause of death attributed was not known at the time of the incident, the Trust will ensure Duty of Candour Procedures are followed for all affected individuals.

7.7 Incidents that occurred before 1st April 2023

The Duty of Candour is not intended to operate in respect of adverse outcomes which occurred before the 1st of April 2023.

7.8 Reporting to External Bodies

The Trust will fulfil its external reporting responsibilities in line with the requirements of the Health and Social Care (Quality and Engagement) (Wales) (2020) ((Duty of Quality and Duty of Candour), National Serious Incident reporting procedure, regulators, Medical Examiner Service, His Majesty's Coroner and Welsh Government.

7.9 When more than one NHS organisation is involved in the Duty of Candour Procedure

In situations where the Trust is part of an episode of care with other NHS Organisation(s) in which the Duty of Candour is triggered, the Trust will fulfil its responsibilities in line with the Duty of Candour procedures (Wales) (2023).

8. Concerns Management

8.1 Early Resolution Concerns

The Trust will manage Early Resolution Concerns in line with The Putting Things Right Guidance, ensuring resolution achieved to the satisfaction of the complainant within 2 working days from receipt. In circumstances where resolution has not been achieved within this period, but the complainant does not wish to raise a formal concern, the Trust will aim to resolve the concern(s) within 5 working days from receipt. If following this time, the concern remains unresolved, the concern(s) will be managed in line with the regulations as a formal concern.

8.2 Concerns Notified by a Third Party

The Trust will ensure that concerns notified by a third party acting as a representative on behalf of another are handled in line with the Regulations ensuring a best interest assessment is completed and proportionate response considered.

8.3 Concerns Received from Assembly Members/Members of Parliament

The Trust will ensure that concerns received from the Welsh Government, an Assembly Member, Member of Parliament, or other elected members on behalf of their constituent, are dealt with as soon as possible and a response provided at the earliest opportunity. For the sharing of personal data, the Trust will adhere to the requirements of The Data Protection (Processing of Sensitive Personal Data) (Elected Representatives) Order (2002).

8.4 Concerns Relating to Children and Young People.

Where a concern is notified by a child or young person, the Trust will ensure it meets its support, assistance, and advocacy responsibilities in line with the Welsh Government's 'Model for Delivering Advocacy Services to Children and Young People in Wales.'
In the event of concerns being received on behalf of a child or young person the Trust will determine whether the child or young person wishes to raise a concern themselves, or if they are happy for the person who raised the concern to represent them. In cases where the child or young person is not willing to allow the concern to be investigated, the Trust will assess the individual situation and where appropriate seek specialist advice to support decision making. In any circumstance where safeguarding issues are identified the Trust will evoke the Wales Safeguarding procedures.

8.5 Concerns Raised by Prisoners

The Trust will handle and investigate concerns raised by prisoners in the same manner as all concerns, in accordance with the Regulations and with the offer and right of access to advocacy services provided by Llais, Social Care or mental health services as appropriate.

8.6 Concerns raised by individuals Lacking Capacity or Vulnerable Adults

The Trust will ensure that all concerns raised by individuals lacking capacity or vulnerable adults and handled in an equitable and accessible manner with reasonable adjustments and enhanced support and advocacy services provided as required.

In circumstances where concerns regarding mental capacity are raised the Trust will ensure all assessments align with the requirements of Mental Capacity Act (2005). During this process, if any safeguarding and public protection issues are identified the Trust will evoke the All-Wales Safeguarding Procedures.

8.7 Concerns raised through Advocacy Services

The Trust will work in collaboration with Advocacy services and ensure that concerns raised on behalf of patients/ donors are managed in line with the Regulations.

8.8 Concerns from Solicitors / Intention to Litigate /Requests for Compensation

The Trust will ensure that concerns, litigation intents and compensation requests are managed by the Corporate Quality and Safety Team, in accordance with the governance and framework of the regulations, with exception of a concern in respect of which court proceedings have already been issued, including the pre-action stage of those proceedings which should not be further investigated.

8.9 Concerns from people with a Disability

In line with the Equality Act (2010), the Trust will make reasonable adjustments to ensure that the concerns process is accessible, and reasonable adjustments provided for service users who have a disability.

8.10 Concerns and British Sign Language (BSL)

The Trust recognises BSL as a recognised language and will ensure the concerns process is accessible to service users who communicate through BSL through the provision of services and reasonable adjustments as appropriate.

8.11 Concerns from Blind and Partially Sighted Individuals

The Trust will ensure that it has in place alternative methods for communication, including access to Braille and large print versions to support and enable concerns to be raised by individuals who are blind or partially sighted.

8.12 Concerns involving Contracted Services

The Trust will ensure that all contracted services are aware of and understand this policy, its application in practice, and their role and responsibilities in concerns management and adherence with the Regulations.

9. Welsh Language

When dealing with concerns the Trust will take account of its statutory duties in relation to the provision of services in Welsh and will ensure compliance with the duties set under the Welsh Language (Wales) measure (2011) and Welsh Language Standards. All concerns received in Welsh will be responded to in Welsh under the regulations and the Trust will ensure:

- All written communication is provided in Welsh.
- Welsh interpretation for telephone or face-to-face meetings.
- Provision of bilingual information resources.
- Adopt a proactive approach to language choice and need in Wales.
- Ensure Welsh Language Needs are met.

10. Reporting Concerns

In line with the Regulations, the Trust has a single point of contact for raising a concern:

Executive Director Nursing AHP's & Health Science Velindre Trust Head Quarters
2 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Email: handlingconcernsvelindre@wales.nhs.uk

Telephone: 029 20196161

10.1 Management and Investigation of Concerns

The Trust will ensure that concerns are managed and investigated in the most relevant, proportionate, efficient, and effective way in line with the Regulations, Duty of Candour Procedure, this policy, and local procedures.

10.2 Acknowledging PTR Concerns

The Trust will ensure that all concerns managed under the Regulations and Duty of Candour Procedure with acknowledgement being issued in writing within 5 working days of receipt and will include:

- Point of Contact details
- An offer of a meeting or discussion to review and discuss their concern and the concerns process.
- The opportunity to meet with relevant staff involved in relation to the concern/s raised.
- Response timescales.
- Details of advocacy and support services.
- Information advising that a patient's clinical records will need to be accessed as part of the investigation.
- A copy of the Putting Things Right leaflet.

10.3 Formal Response Timescales limit

The Trust will provide a full and comprehensive response/interim report within 30 working days from the date the concern is received, if the Trust is unable to comply with this standard, the Trust will:

(a) notify the service user, outline the reason for the delay, and advise when the response will be available; and
(b) send the comprehensive response/interim report as soon as reasonably practicable and within 6 months, or 12 months for concerns being handled under Regulation 33 of the Regulations.

10.4 Concerns received from Medical Examiners

The Trust will ensure robust corporate procedures are in place to receive and respond to concerns received from the Medical Examiner's office.

10.5 Concerns Referred to Coroner's Inquest

The Trust will ensure that robust procedures are in place to investigate concerns referred to HM Coroners Service in line with the Regulations.

10.6 Consent to Investigate Concerns

The Trust will ensure that the consent policy is followed, and patient/ donor consent obtained for all concern investigations that require access to medical records, if the patient/donor does not provide consent the Trust will take a view on whether an investigation without access to the medical records would be possible and beneficial.

10.7 Consent Involving Other Organisations

Where the Trust is notified of a concern that involves the functions of more than one responsible body/organisation, it will firstly seek the consent of the complainant (within 2 working days of concern receipt), Within 2 days of consent receipt the Trust will contact all relevant organisations and the lead organisation will be identified in discussions with the complainant and involved organisations.

11. Time limits for notification of a Concern

The Trust aligns the time limits for notification of a concern with the Regulations and requires concerns to be notified no later than 12 months from the date on which the concern occurred, or if later,12 months from the date the person raising the concern realised they had a concern. Concerns received after these timescales will be considered by the Trust to determine the reason for the delay in reporting and the possibility of investigation being thorough and fair due to the time lapse.

12. Withdrawal of Concerns

The Trust acknowledges that a concern can be withdrawn at any time by the complainant, with such withdrawal requests can be provided in writing or verbally and will be acknowledged in writing by the trust. Despite withdrawal the Trust will ensure the concern continues to be investigated.

13. Nationally Reportable Incidents

The Trust will ensure a concern raised by a complainant that has already been reported and investigation commenced as a nationally reportable incident will be managed in accordance with the Regulations, with the investigation progressing in line with Nationally Reportable Incident policy, ensuring the person raising the concern is kept informed of investigations and outcomes.

Where a concern is received, and it becomes apparent that there has been a serious incident that the Trust was previously unaware of, the Trust will ensure the incident is reported within Datix Cymru system and the National Reportable incident process followed, whilst informing the complainant of the process, the potential that 30-working day response timeframe will not be achieved, and details of expected timing of response.

13.1 No Qualifying Liability – Regulation 24

The Trust will ensure that requirements of the Regulations and associated investigations and reporting requirements are met.

In events where further correspondence is received from the person raising the concern, expressing dissatisfaction, the Trust will ensure the concern is l be reopened, investigated, and acknowledged within 2 days. If a complainant is dissatisfied with their response and there are no new issues to investigate, the Trust will manage in accordance with the Regulations with the concern not being reopened and a meeting with the complainant offered, if the complainant remains dissatisfied following this the Trust will advise the complainant to refer their concerns to the Public Services Ombudsman of Wales.

13.2 Interim Report (Regulation 26) – When a Breach of Duty is identified, and harm has, or likely to have occurred, resulting in a possible qualifying liability

- The Trust will ensure compliance with the Regulations, in cases where the Trust considers following investigation that both breaches in the duty of care have been identified and potential for harm, or actual harm identified in line with the requirements of establishing a qualifying an interim report under Regulation 26 will be issued within 30 working days from whichever is the later from: The day upon notification of the concern was received or
- Where the Duty of Candour is triggered, the day upon which the “in person” notification under Regulation 4(1) of the Duty of Candour Regulations was given.

The Trust will ensure that i in cases where a breach in the duty of care is identified that the case will be progressed and considered by the Trust’s Putting Things Right Panel to inform the interim Regulation 26 response, ensuring the inclusion of the following detail:

- A summary of the nature and substance of the issues contained in the concern.
- A description of the investigation undertaken to date
- A description of why in the opinion of the Trust there is or may be a qualifying liability.
- A copy of any relevant medical records.
- An explanation of how to access legal advice without charge.
- An explanation of advocacy and support services which may be of assistance.
- An explanation of the process for considering liability and Redress.
- Confirmation that the full investigation report will be made available to the person seeking Redress.

- An offer of an opportunity to discuss the contents of the interim report with appropriate staff.
- The interim report should receive final approval and signed off by the Executive Director Nursing, AHP's and Health Science.

If it is not possible to issue a Regulation 26 interim response within the required 30 working day timeframe, the Trust will ensure the person raising the concern will be informed of the reason for the delay and the interim response sent within 6 months of whichever is the later, either:

- The day upon notification of the concern was received or
- Where the Duty of Candour is triggered, the day upon which the "in person" notification under Regulation 4(1) of the Duty of Candour Regulations was given.

Once the interim response is issued, the Trust will ensure the matter is forwarded to the Trust Claims Manager for further investigation under the Redress arrangements as referenced within the Regulations.

13.3 Post Closure contact - Public Service Ombudsman of Wales

The Trust will ensure compliance with the Public Services Ombudsman (Wales) Act (2019) and inform any individuals that are dissatisfied with the Trust final response of their right to contact the Public Service Ombudsman for Wales, who will review the matter on their behalf.

The Ombudsman's contact details are: Phone: 0300 790 0203
E-mail: ask@ombudsman.wales Website: www.ombudsman.wales
Address: Public Services Ombudsman for Wales
1 Ffordd yr Hen Gae
Pencoed
CF35 5LJ

13.4 Investigation by the Public Service Ombudsman of Wales (PSOW) - timeframes

On receiving a complaint from the PSOW, the Trust will provide an acknowledgement of receipt to the PSOW within 5 days and will investigate and respond to the PSOW within 20 days. If for any reason required timescales are difficult to achieve the Trust will request an extension from PSOW.

In response to conclusions received from the PSOW the Trust will ensure that identified opportunities for learning and improvement are actioned and shared.

13.5 Redress

The Trust will ensure compliance with the Redress requirements of the Regulations, including.

- The making of an offer of compensation in satisfaction of any right to bring civil proceedings in respect of a qualifying liability.
- The giving of an explanation.
- The making of a formal apology.
- The provision of a report on the action/s which has been, or will be, taken to prevent a similar occurrence from arising.
- Care/remedial treatment.

Following an opinion from an independent expert, the report findings are shared with the appropriate division and relevant staff members involved in the investigation, as required. If a breach of duty exists, a Regulation 26 response is issued, and the matter is referred to the Trust Claims Manager for ongoing management of the concerns under the Redress arrangements.

In circumstances when a person is seeking Redress, the Trust will ensure findings of the investigation are recorded in an investigation report in accordance with Regulation 31, with the report that contains:

- copies of any independent expert advice used to determine whether there is a liability.
- a statement by the Trust confirming whether there is a liability and
- the rationale for the Trust decision.

The Trust will ensure the report is provided in line with the Regulations to the person who raised the concern.

Where an investigation report cannot be provided within the set 12-month timescale, the Trust will inform the person raising the concern of both the reason for the delay and expected date for response.

13.6 Regulation 33 Response

The Trust will ensure compliance with Regulation 33 ensuring that when financial compensation is due, a Regulation 33 response will be completed by the Trust Concern Manager, to provide an appropriate financial offer to settle the matter on a full and final basis with approval from the Executive Director of Nursing, Allied Health Professionals and Health Science. Following the issue of this response the person raising the concerns will have six months to accept the offer, If, after that time, no response is received, the concern will be closed within 9 months.

13.7 CRU Certificate

The Trust Claims Manager is responsible for requesting a CRU certificate from the Department of Work and Pensions where it is established that harm may have occurred. This is in accordance with the Trust's statutory obligation. Where harm is found to have occurred in relation to the NHS Charges/recoverable benefits (CRU), the Trust Claims Manager will arrange the appropriate payment and discharge of the CRU Certificate, as necessary. Where the NHS charges/CRU amounts to over £3,000 the matter is passed to NWSSP Legal and Risk Services for advice in accordance with the Welsh Risk Pool guidance.

14. Behaviour, Conduct and Unreasonable Demands during a Concerns Investigation

The Trust will ensure that people raising concerns are heard, understood, and respected. On occasions there may be times when persons raising the concern acts out of character and become determined, forceful, angry and make unreasonable demands of staff, in such circumstances the Trust has a zero-tolerance policy on unreasonable, unacceptable abusive or aggressive, or violent behaviour.

For the purpose of this policy, unreasonable, unacceptable, abusive, or aggressive, or violent behaviour is considered as:

- Behaviour that produces damaging or harmful effects, physically or emotionally on other

people.

- Persistent unacceptable behaviour is demonstrated on several occasions within a given period of time.

Examples of unacceptable or aggressive or abusive behaviour recognised by the Trust include:

- Verbal threats unsubstantiated allegations or offensive statements can also be termed as abusive violent behaviour.
- Threatening remarks e.g., both written and oral.
- Demands for responses within unrealistic timescales, repeatedly phoning, writing, or insisting on speaking to particular members of staff.

15. Monitoring Arrangements

The Trust will ensure a record is held of the following matters:

- Each concern notified.
- The outcome of each concern.
- The time taken to investigate the concern.
- The reasons where any investigation exceeded the 30-day time period.

The Trust will ensure that this information, and comprehensive analysis of concerns activity and learning will be reported to the Executive Management Board and Trust Quality and Safety Performance Committee on a quarterly basis. The Trust Integrated Quality &Safety group will provide oversight for the quarterly reports and will ensure the triangulation and robust analysis of data.

The Trust will prepare and publish an annual PTR report annually by the 31st of October regarding the delivery of the Regulations and application of the Duty of Candour in line with the requirements of the Regulations, Duty of Candour, and PTR Guidance, and will be clearly displayed on the Trusts internet site.

16. Learning from Concerns

The Trust will ensure that it has arrangements in place to review and assess the outcome of any concern that has been subject to an investigation under the Regulations, to ensure that any deficiencies in its actions or its provision of services, identified during the investigation, are:

- Recognised, acknowledged, owned, and acted upon
- Where improvement requires embedding, an improvement plan will be developed using the template action plan within the complaint's manual
- Identify learning for wider sharing across the Trust and share as appropriate, including the means to share across the wider NHS sector if suitable.
- Reviewed and reported regularly within the service divisions and Trust wide to ensure improvements are established minimising the risk of reoccurrence.
- Ensure that learning is used to target any problem areas and consider if there is potential to improve policies, procedures, and services.

17. Supporting Staff

17.1 Staff involved in Concerns

The Trust will ensure it discharges its responsibilities for staff involved in concerns and will provide a psychologically safe environment for staff involved in Concerns investigations through:

- Actively promote an open and fair culture that fosters peer support and discourages the attribution of blame. Velindre University NHS Trust will work towards a culture where human error is understood to be a consequence of flaws in the systems, not necessarily the individual.
- Providing ongoing support via Line Managers, Clinical Supervisors, Workforce department, Occupational health colleagues and Trade Union representatives.
- Ensuring the provision of mentorship and coaching as required.
- Signposting staff to their Employee Wellbeing Service/Occupational Health/Employee Assistance Programmes.
- Providing and maintaining up to date information on the support systems currently available for staff including counselling services offered by professional bodies.

17.2 Concerns Containing Allegations against Staff

Where concerns raised contain allegations against a staff member(s), the Trust will ensure relevant staff member/s receive a copy of the key issues identified at the beginning of the investigation and provide support as required throughout the process.

18. Concerns and Disciplinary Procedure

Any Disciplinary Proceedings undertaken in relation to a concern will be managed under the Trust Disciplinary policy. Equality Impact Assessment

This policy has been screened for relevance to equality. No potential negative impact has been identified so a full equality impact assessment is not required.

The Trust will develop an understanding of why some members of the community who may wish to raise a concern might not feel able to do so. This may be due to cultural, social, gender and other reasons, including sensory loss, any of which might result in ineffective communication. Staff should be mindful of the issues which might act as a barrier to people raising a concern and look for ways to assure people that it is safe for them to raise an issue.

19. Policy Compliance

The Trust and its Divisions will ensure adherence to this policy and will provide role specific concern and Duty of Candour training to enable staff to possess the required knowledge to fulfil both their concern management roles and responsibilities and compliance with the Regulations and Duty of Candour procedure.

20. Information Governance

The Duty of Confidentiality is an important aspect in relation to concerns handling. All Trust Staff are required to maintain the complainant's confidentiality and are required to protect personal data as outlined by legislation including the Common Law Duty of Confidentiality and the Data Protection Act 2018 which includes the retained EU GDPR 679/2016 (known as UK GDPR). UK GDPR sets out the key data protection principles, rights of individuals (known as Data Subjects), and obligations for processing personal information.

The Trust acts as a “Data Controller” in respect of personal data as defined in Article 4 UK GDPR. Staff responsible for processing personal data are to follow the 'seven data protection principles' which are contained in Article 5 UK GDPR, this means that whenever they process Personal Data, they must do so; lawfully, fairly and transparently; Only process it for specific, explicit and legitimate purposes; Ensure that in relation to the purposes of processing that the data is adequate, relevant and limited for that purpose; Ensure that the data processed is accurate, kept up to date and stored in a format which permits the data subject to be identified and kept for no longer than is absolutely necessary. Staff must also ensure that when the data is processed that appropriate technical and organisational measures are in place to protect the integrity and confidentiality of the Data. The final data protection principle is accountability; all Staff are accountable for the data that they process. The obligation to comply with the data protection principles sits alongside the eight Caldicott principles, Section 8 of the Human Rights Act 1998, Section 40 of the Freedom of Information Act 2000, and Section 13 of the Environmental Information Regulations 2004.

Information in relation to complaints should not be disclosed/copied/ shown to any external agency without the permission of the Responsible Officer or nominated deputies on a “need to know basis.”

All requests for access to such information should be directed in the first instance to the appropriate manager or nominated deputy or service lead for the subject of the concern.

The Trust has adopted the NHS Wales Records Management Code of Practice Health and Social Care 2022, as well as supporting the development of the Wales Accord on the Sharing of Personal Information (WASPI) as a legally binding framework.

All staff are bound by their Contractual Duty of Confidentiality regardless of their role and are required to respect the personal data and privacy of others. All staff must not access information about any individual who they are not providing care or treatment for, or in relation to the administration of services unless in a professional capacity. They are not permitted to access their own data, any request for their own personal data must be made as a Subject Access Request. The Trust Head of Information Governance can provide further information and advice if required in relation to access rights and the lawful sharing of personal data.

The Information Commissioner’s Office (ICO) has detailed guidance on data sharing on its website and has issued a data sharing code of practice, the Code of Practice can be accessed https://ico.org.uk/for-organisations/guide-to-data-protection/ico-codes-of-practice/data-sharing-a-code-of-practice/

It must be noted that the threshold for reporting a data breach to the Information Commissioner is much higher than that contained within the Duty of Candour, this is because Article 33(1) UK GDPR states:

> "In the case of a personal data breach, the controller shall without undue delay and, where feasible, not later than 72 hours after having become aware of it, notify the personal data breach to the Commissioner, unless the personal data breach is unlikely to result in a risk to the rights and freedoms of natural persons. Where the notification under this paragraph is not made within 72 hours, it shall be accompanied by reasons for the delay".

The Trust Head of Information Governance must be contacted where a data breach has occurred so that an assessment of risk to the rights and freedoms of the natural person (data subject) can be made, this is to ensure alignment between Duty of Candour and Data Protection legislation requirements.

Advice and guidance in relation to any aspect of Information Governance considerations can be obtained from the Trusts Head of Information Governance.

VelindreInformationGovernance@wales.nhs.uk

21. Managing Media Interest / Media Communications

The management of media interest/ in relation to incidents, either individually or generally, will be undertaken by the Trust's Communications Department.

22. References

- The Health and Social Care (Quality and Engagement) (Wales) (2020) (Duty of Quality and Duty of Candour).
- National Health Service (Concerns, Complaints and Redress Arrangements) 6+lesgulations ('the Regulations) (2011).
- The Putting Things Right Guidance (PTR) (2013).
- Putting Things Right Guidance update (2023)
- Public Service Ombudsman for Wales Act (2019).
- Duty of Candour Procedure (Wales) (2023).
- NHS Wales National Policy on Patient Safety Incident Reporting & Management (2023).
- Civil Procedural Rules

TRUST BOARD

NWSSP – REGISTRATION AUTHORITY POLICY

DATE OF MEETING	30th November 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	IAN BEVAN, HEAD OF INFORMATION GOVERNANCE / CERI EVANS, HEAD OF TRANSACTION SERVICES NWSSP
PRESENTED BY	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	NWSSP has acted as the Registration Authority for the issue of smart cards predominantly in its own organisation but also for Public Health Wales in order to support cervical and breast screening services. Historically this is a small amount of cards being processed (about 180 cards) With the advent of ePMA , the requirement for the cards will increase and will include Primary Care and Community Pharmacies. The

	processing will increase to approximately 20,000 cards. The change has necessitated that NWSSP establishes a Registration Authority Policy and inter-organisational agreement which requires endorsement by EMB and if appropriate approval by the Quality, Safety and Performance Committee. The Trust as the legal entity for NWSSP is the signatory for the Agreement and its governance.

RECOMMENDATION / ACTIONS	It is recommended that the Trust Board: • **APPROVE** the attached Registration Authority Policy for approval by the Quality and Safety Performance Committee. • **APPROVE** the attached Agreement for the Provision of Registration Authority Services between NHS Wales Shared Services Partnership and Velindre University NHS Trust for approval by the Quality and Safety Performance Committee.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
NWSSP PCS Senior Management Team	14/06/2023
Executive Management Board	31/08/2023
Quality Safety & Performance Committee (via Chair's Urgent Action)	25/10/2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ENDORSED	

7 LEVELS OF ASSURANCE
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance *N/A*

APPENDICES	
One	Registration Authority Policy
Two	Agreement for the Provision of Registration Authority Services between NHS Wales Shared Services Partnership and Velindre University NHS Trust

1. SITUATION

The purpose of this paper is to seek the approval of the Trust Board in relation to the proposed changes governing the use of Smartcards by NHS Wales Shared Services Partnership (NWSSP) Primary Care Services and in particular the requirement to establish a policy to support the rollout of Electronic Prescription Services in Wales and the increased volume of issued Smartcards required in NHS Wales. In consideration of the All-Wales impact of the rollout of the Smartcards linked to the fact that NWSSP is a hosted body, this policy requires approval by Velindre University NHS Trust prior to implementation.

2. BACKGROUND

The NHS Care Records Service (NHS CRS) and related National Programmes use a common approach to protect the security and confidentiality of every patient's personal and health care details.

NWSSP and its predecessor organisations have acted in the capacity as Registration Authority (RA) since circa 2008. This role has supported the issuing and management of Smartcards to users predominantly in NWSSP as well as Public Health Wales for the purposes of cervical and breast screening services and some to Digital Health and Care Wales (DHCW). The number of Smartcards currently in use equates to small numbers that have seen steady volumes managed and held by users (circa 180 Smartcard users). Smartcards are issued for the purposes of accessing applications linked to the NHS spine, i.e., Patient Demographic Services (PDS).

With the introduction of Electronic Prescribing Services (EPS) in Wales, the requirement for the application and use of Smartcards will further extend to Primary Care providers across Wales (GP practices and Community Pharmacies). This extension of use will significantly broaden the capture of demographic data and greatly increase the number of Smartcard users. It is

therefore both timely and necessary to ensure that policy and agreement that are fit for purpose are in place to govern the use of such applications.

3. ASSESSMENT

In accordance with NHS England's (formerly NHS Digital) Registration Authority Policy, it is a mandatory requirement that organisations that run local RA activity have in place a policy that outlines their management of Registration Authority activities.

A Registration Authority Policy has been prepared for approval and an Inter Organisational Agreement has been updated which will be presented for signature by the Trust once the Policy has been approved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The following is a summary of matters which is intended to support the recommendation at Paragraph 5 of this paper.

- The current smartcard service will no longer be fit for purpose once the new ePMA is in place in Wales
- There will be a significant increase in card processing which requires the implementation of;
    - A new Registration Authority Policy that enables the governance of the smartcard process to be robust and timely, which be further supported by;
    - A Service Level Agreement that sets out the obligations of NWSSP in managing the Smartcard process

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated areas of priority	☐

• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒ *The adoption of the Policy will ensure that [Please include narrative to explain the selected domain in no more than 3 succinct points].* The approval and adoption of the Policy will ensure that the Trust is compliant with NHS England's Registration Authority Policy, this means that it meets the domains of Safe, Timely and Effective. Furthermore as it is linked to the delivery of the All-Wales ePMA it meets the domain requirement of Patient Centered care and improves Efficiency.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required *[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed].* The approval and adoption of the policy meets a regulatory requirement which does not require the consideration of socio-economic duty for EMB prior to consideration of approval.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Other (please explain) Please explain if 'other' source of funding selected: Funding to be sourced from the Digital Medicines Transformation Portfolio **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Equipment/Hardware - £12k Resource - £106,505 **Type of Change** **Service Development** Please explain if 'other' source of funding selected: N/A

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Completed by NWSSP, embedded at Section 8 of the NWSSP Registration Authority Policy.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	EPS is included in the Welsh Government's agenda with delivery expected in 2023. Without NWSSP having an up-to-date Registration Authority Policy in place, NHS England will not want to delegate authority for Welsh GP practices and community pharmacies to NWSSP meaning that the Electronic Prescription Service cannot be rolled out in Wales.
WHAT IS THE CURRENT RISK SCORE	Risk captured in the Digital Medicine Transformation Portfolio RAID Log – Score 20 (Red)
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Enables delegated authority
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Policy required to enable programme delivery commencing September 2023
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No

	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

THIS AGREEMENT

Is made on ……

BETWEEN

NHS Wales Shared Services Partnership (NWSSP) whose registered office is situated at:

Corporate Headquarters, Unit 4/5 Charnwood Court, Parc Nantgarw, Nantgarw, Cardiff. CF15 7QZ

And

Velindre University NHS Trust ("the Trust"), whose registered office is situated at:

Corporate Headquarters, Unit 2 Charnwood Court, Parc Nantgarw, Nantgarw, Cardiff. CF15 7QW

For the provision of Registration Authority services in accordance with NHS England (formerly NHS Digital) Registration Authority Policy include the *Registration Authorities: Governance Arrangements for the NHS Organisations* (Gateway Reference Number 6244):

1. Background

It is of paramount importance that patients of the NHS are confident that their medical records are being appropriately kept secure and confidential and accessed appropriately in line with the NHS Care Records Guarantee. To achieve this objective, all NHS Care Records Service compliant applications require healthcare professionals/workers who require access, to be registered and issued with a Smartcard and have appropriate access profile(s) managed for their specific job role.

The registration process is operated at a local level by a Registration Authority ("RA"). The NWSSP has been an RA since 2008 for a small, specific number of Smart Cards.

All NHS organisations who are responsible for the registration of NHS Care Records Service users, including staff employed by independent contractors, independent providers, voluntary organisations and other public bodies need to ensure that a governing policy, procedure and guidance around the process is in place and administered effectively.

2. Aim of the Agreement

This Agreement is intended to outline the arrangement between the Parties for the delivery and management of Smartcards to NHS Care Record Service users employed by NHS Wales Shared Services Partnership (NWSSP) (hosted by Velindre University NHS Trust) and furthermore concerning the issuing and

management of smartcards to specified locations (including General Medical Practices) by NWSSP, whilst ensuring compliance with all statutory requirements as well as guidance adopted by NHS Wales in relation to Registration Authority protocol.

3. Duration

This Agreement shall continue for the term of three years commencing upon the date hereof and shall continue from year to year thereafter, unless determined in accordance with clause 14.

4. Interpretation

4.1. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted whether before or after the date of this Agreement from time to time and shall include any provisions of which there are re-enactments whether with or without modification.

5. Complete Agreement

This Agreement embodies the Agreement between NWSSP and the Trust and supersedes all other understandings and written agreements relating to the matters referred to herein.

6. Appointment of RA Sponsors

6.1. NWSSP Primary Care Services (PCS) will nominate suitable members of staff to be appointed as RA Sponsors (Appendix A). Provided the NWSSP RA Manager is satisfied that these individuals are suitable to undertake their respective nominated roles, the NWSSP RA Manager will duly appoint them and arrange for Smartcards to be issued to each of them, as necessary.

6.2. The NWSSP RA Manager reserves the right to terminate any or all of the RA Sponsor appointments for any reason and at any time.

7. Obligations of NWSSP RA Sponsors

The NWSSP RA Sponsors:

7.1. Are responsible for sponsoring users, in respect of NHS Care Record Service, on behalf of the agreed service providers (Appendix A), including validating the users' identify to e-GIF level 3[1] and assessing the appropriate level of access.

7.2. Ensure that Smartcards are only issued to those members of staff employed by the agreed service providers (Appendix A) and who have a clinical and/or administrative need to access NHS patient records.

[1] The verification of identify for NHS smartcard registrations is subject to the inter-governmental standard known as eGIF Level3. This provides assurance that the identity is valid across any organisation an individual works within.

7.3. Ensure that Smartcards are not issued to persons not employed by the agreed service provider.
7.4. Be responsible for alerting the NWSSP Information Governance Manager (as first point of contact) and the NWSSP RA Manager of all known or suspected breaches of security, confidentiality and/or any misuse of Smartcard(s).
7.5. Provide to the organisation, a list of current Smartcard users employed by agreed service provider whenever requested to do so by the NWSSP.
7.6. Be responsible for arranging cancellation of Smartcards where necessary and appropriate, for example, cancellation in respect of those who leave or terminate employment in a specific role within the NHS, those who move to another role and do not require a Smartcard and any Smartcards that are lost or stolen.

8. Obligation of the NWSSP Information Governance Manager

The NWSSP Information Governance Manager shall conduct periodic internal audits, not less that once every quarter, to ensure the Registration process is being appropriately and competently delivered and managed in accordance with ISO9001. Each internal audit shall include verification of a random sample of at least three Smartcard users and a written report setting out the findings of each internal audit shall be promptly forwarded to the Trust.

9. Obligations of the NWSSP

The NWSSP shall:

9.1. Be responsible for ensuring those members of the staff nominated to the NWSSP for the position of RA Sponsor are suitable and competent to undertake their respective roles.
9.2. Be responsible for ensuring the NWSSP RA Sponsors comply with their obligations as stated in clause 7 above.
9.3. Be responsible for ensuring that all RA Sponsors are provided with appropriate training, resources and supervision to properly discharge their respective duties.
9.4. Assist with all oral and written enquiries submitted by the Trust in respect of the Registration process and assist with any audits undertaken.
9.5. Ensure compliance with all applicable legislation, all application Department of Health guidance, including all RA policies and procedures, Information Governance and confidentiality policies.
9.6. Ensure compliance with the UK Data Protection legislation and the NHS Confidentiality Code of Practice.
9.7. Immediately inform the NWSSP Information Governance Manager (as first point of contact) in writing of any concerns or investigations or disciplinary action taken against any employee or other individual in relation to breaches of security, confidentiality and/or any misuse of Smartcard(s).
9.8. Immediately arrange for the revocation of Smartcard(s) from NWSSP user(s) upon written instructions from the NWSSP Information Governance Manager.

10. Partnership

Nothing in this Agreement shall be deemed to constitute a partnership between the Parties nor constitute any Party with the agent of the other Party.

11. Employment Status

The agreed service providers that nominate RA Sponsors will, at all times, remain in the employment of the agreed service provider and nothing in this Agreement shall be deemed to confer any employment relationship between the Trust and those individuals.

12. Indemnity

The Trust hereby undertakes to indemnify and keep indemnified the NWSSP and its successors and servants and agents against all direct, indirect or consequential losses, damages, costs, expenses, liabilities, claims, actions, demands or proceedings which may be taken or made against the NWSSP arising out of or in connection with this Agreement by any person howsoever arising whether under any statute or common law caused by negligence, omission, default or breach by the Trust or any of its servants, employees or agents. This clause 12 shall survive expiry or termination of this Agreement howsoever arising.

13. Freedom of Information

13.1. The Trust recognises that the NWSSP is subject to legal duties which may require the release of information under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004 or any other applicable legislation or codes governing access to information and that the NWSSP may be under an obligation to provide information on request. Such information may include matters relating to or arising out of or under this Agreement in any way including without limitation information provided by or relating to the Trust.

13.2. Notwithstanding anything in this Agreement to the contrary, in the event that the NWSSP receives a request for information under any applicable code or legislation governing access to information, the NWSSP shall be entitled to disclose all information and documentation (in whatever form) as the NWSSP considers necessary to respond to that request. The NWSSP shall be under no obligation to inform or consult the Trust, although the Trust has reasonable expectations that appropriate communication will be made. The NWSSP shall be entitled to include any such information as part of its publication scheme as it deems appropriate.

14. Termination

14.1. This Agreement may be terminated by either Party for any reason at any time by either Party giving the other at least 7 days written notice of termination,

such notice to be served at the address of the Party set out on the front page of this Agreement.

14.2. The Trust shall arrange for all Smartcards issued to Trust employees pursuant to this Agreement to be revoked upon the date of termination or expiry of this Agreement and shall provide written confirmation to the NWSSP that this clause 14.2 has been duly complied with.

Signed for and on behalf of the NHS Wales Shared Services Partnership:

Signature ……..

Name ……..

Full title/position ……..

Witnessed by:

Signature ……..

Name ……..

Full title/position ……..

Signed for and on behalf of Velindre NHS Trust:

Signature ……..

Name ……..

Full title/position ……..

Witnessed by:

Signature ……..

Name ……..

Full title/position ……..

GP practices (Wales) *Variable addresses*	Digital Health & Care Wales (DHCW) Technium 2 Swansea Waterfront Innovation Quarter Kings Road Swansea SA1 8PH
Pharmacy Contractors (Wales) *Variable addresses*	Digital Health & Care Wales (DHCW) 17 Oldfield Road Bocam Park Pencoed CF35 5LJ
Public Health Wales Headquarters Screening Division 4th Floor, 2 Capital Quarter Tyndall Street Cardiff CF10 4BZ	Digital Health & Care Wales (DHCW) 1st Floor, Cwmbran House Mamhilad Park Estate Pontypool NP4 0YP
Cervical Screening Wales 18 Cathedral Road Cardiff CF11 9LJ	Digital Health & Care Wales (DHCW) Tŷ Glan-yr-Afon 21 Cowbridge Road East Cardiff CF11 9AD
Cervical Screening Wales 1st Floor, Matrix House Northern Boulevard Matrix Park Swansea Enterprise Park SWANSEA SA6 8DP	Digital Health & Care Wales (DHCW) Media Point – Unit 3 Mold Business Park Mold CH7 1XY
Cervical Screening Wales Preswylfa Hendy Road Mold Flintshire CH7 1PZ	Breast Screening Wales 18 Cathedral Rd Pontcanna Cardiff CF11 9LJ
Breast Screening Wales Maesdu Road Llandudno LL30 1QY	Sandra Williams, RA Manager NWSSP-Primary Care Services 3rd Floor, Matrix House Northern Boulevard Matrix Park Swansea Enterprise Park SWANSEA

	SA6 8DP
Kelly Dixon, RA Manager NWSSP-Primary Care Services 1st Floor, Cwmbran House Mamhilad Park Estate Pontypool NP4 0YP	Sandra Williams, RA Manager NWSSP-Primary Care Services Alder House Alder Court St Asaph Business Park St Asaph LL17 0JL
Kelly Dixon, RA Manager NWSSP-Primary Care Services 3rd Floor, Companies House Crown Way Cardiff CF14 3UB	

Registration Authority Policy

NHS Wales Shared Services Partnership

May 2023

Version Number: 0.1	Issue/approval date:
Status: Draft	Next review date:

Document Control

Document Name:	Registration Authority Policy		
Version:	0.1	Status:	DRAFT
Approvals	NWSSP PCS Senior Management Team		14th June 2023
	Executive Management Board, Velindre NHS Trust		
	Quality, Safety & Performance Committee, Velindre NHS Trust		

Version Control

Date	Author	Version	Page	Reason for change

Reviewers/contributors

Name	Position	Version Reviewed & Date

Contents

1. INTRODUCTION

The purpose of this policy is to provide guidance to all NHS Wales Shared Services Partnership (NWSSP) staff on Registration Authority (RA) issues.

The NHS Care Records Service (NHS CRS) and related National Programmes use a common approach to protect the security and confidentiality of every patient's personal and health care details.

It is essential that everyone who is given access to patient information within NHS Wales and the following national applications has been through the same rigorous identity checks.

The NHS has set out the principles that govern how patient information is held in the NHS CRS and the way it is shared. This is further to the already pre-defined organisational Information Governance policies and procedures that is already established within NWSSP that provides a set of working practices that complement the culture of confidentiality within the organisation.

To access the NHS CRS users require a Smartcard to access the national applications linked to the NHS spine (these include patient demographic services (PDS), electronic prescriptions) and the issuance of Smartcards to access these systems is governed by the Registration Authority (in this case, NWSSP) policy and process.

2. SCOPE AND DEFINITIONS

Scope

It is the responsibility of all NWSSP staff including those working full or part time, on temporary or honorary contracts, bank or agency staff, work placements, apprenticeships and students to comply with this policy, and associated RA Operating Guidance and procedures.

This policy applies to those members of staff directly employed by NWSSP and for whom the NWSSP has legal responsibility. For those staff covered by a letter of authority/honorary contract or work experience, the organisation’s policies governing confidential information and use of such are also applicable whilst undertaking duties for or on behalf of NWSSP.

Definitions

Smartcard: NHS smartcards can be likened to chip and PIN bank cards; they enable healthcare professionals to access identifiable (clinical, patient and personal) information appropriate to their role.

A Registration Authority: is a function, usually within an NHS organisation, which carries out the identity checks of prospective smartcard users and assigns an appropriate access profile to the staff members role as approved by the employing organisation. Staff member is defined as a health professional, department manager,

team leader, patient information officer and other staff roles that require access to identifiable patient information.

Care Identity Service: Registration authorities use the Care Identity Service (CIS) to control NHS smartcard access for the NHS Spine's 800,000+ smartcard users. It is a unified application that provides a single location for all registration authority activities.

3. DETAILS OF THE REGISTRATION AUTHORITY (RA) POLICY

NWSSP Registration Authority (RA) will:

- Produce quarterly reports
- Identify how RA services are delivered (e.g., partner with other organisations to provide RA services, etc.) and the nature of the service delivery (which sites, what hours, etc.) This will include provision of RA services to non-NHS organisations where appropriate
- Identify to the NWSSP Senior Leadership Group, for approval, any proposed agreement with another organisation to provide RA services (this includes other NHS and non-NHS organisations)
- Develop the procedure guidelines for issuing of Smartcards by NWSSP Registration Authority staff
- Ensure the necessary support functions are in place and are aligned with the needs of the RA including training and awareness raising, IT, IG, HR and RA support
- Ensure the national policies and procedures for RA are considered when developing the arrangements within NWSSP for Information Governance purposes (these include assessment and advice as and when required)
- Ensure an annual review of the RA policy and procedures is undertaken and updated as required
- Establish and update the incident and risk management register and report on this on an annual basis to the NWSSP Senior Leadership Group.

RA Managers

- The RA Managers will be responsible for ensuring the adherence to policy and governance related to the RA, for the efficient day-to-day operation and capacity planning of the RA services.

RA Agent(s)

- The RA Agent(s) will be responsible for ensuring RA services are delivered in accordance with the RA procedures and governance to users of RA services.

RA Sponsors

- The Sponsors will be responsible for approving the registration and access profiles granted to users. Additionally, they may be responsible for resetting of Passcodes – all subject to agreed RA procedures and governance for internal control of access.

4. ROLES AND RESPONSIBILITIES

Overall accountability for policy documents across the organisation lies with the NWSSP Managing Director who has responsibility for meeting all statutory requirements and adhering to guidance issued in respect of policy documents.

NWSSP Primary Care Services are responsible for Registration Authority services provided to all customers in accordance with this policy.

Overall responsibility for the Registration Authority Policy lies with Registration Authority Managers who have delegated responsibility for managing the development and implementation of Registration Authority policy and procedural documents.

All NHS employees, contractors and other staff who have been issued with Smartcards for use in their work with the NHS are responsible for their Smartcards and must abide by all current Terms and Conditions of use.

Failure to adhere to national RA Policy and guidance may lead to revocation of the Smartcard and/or disciplinary procedures.

The principles of the Registration Authority procedures are to ensure that:

- All Smartcards are issued in accordance with the relevant NWSSP procedures
- All Users issued with a Smartcard are made aware of their roles and responsibilities for the use of their Smartcard and comply with those requirements
- All Users comply with the guidance in the RA Operating Guidance
- NWSSP audit of Smartcard use is conducted in accordance with the RA Operating Guidance in conjunction with customer organisations

5. TRAINING

The Registration Authority Team will ensure training opportunities are provided in the use of the Care Identity System and application of this policy and underpinning processes, procedures and standards.

6. MONITORING COMPLIANCE AND EFFECTIVENESS

Performance against Key Performance Indicators will be reviewed on an annual basis and used to inform the development of future policy and procedural documents. The Registration Authority Manager will monitor service performance and provide reports to IT Services Senior Leadership Team.

This policy will be reviewed on an annual basis and in accordance with the following, as and when required:

- Legislative changes

- NHS good practice guidance
- Significant incidents reported
- Changes to organisational infrastructure
- Changes to national Registration Authority Policy

7. REVIEW

The policy will be reviewed at least annually by NWSSP Primary Care Services.

8. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment was undertaken (embedded below) which involves assessing the likely or actual effects of decisions, policies or services on people in respect of age, disability, gender and racial equality, pregnancy and maternity, race, religion or belief, sex and sexual orientation. It helps us to make sure the needs of people are taken in to account when we develop and implement a new policy or service or when we make a change to a current policy or service.

Approved EQIIA
Registration Author

9. REFERENCES AND ASSOCIATED DOCUMENTS

National Registration Authority Policy can be found here:
https://digital.nhs.uk/services/registration-authorities-and-smartcards#registration-authorities

TRUST BOARD

NHS Wales Red Cell Shortage Plan

DATE OF MEETING	30/11//2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	LEE WONG, BLOOD HEALTH TEAM LEAD - WBS
PRESENTED BY	Alan Prosser, Director WBS
APPROVED BY	Cath O'Brien, Chief Operating Officer

EXECUTIVE SUMMARY	The NHS Wales Red Cells Shortage Plan is a collaborative document produced by WBS in conjunction with transfusion committees and subject matter experts across all health boards in Wales. The plan defines the actions to be taken in the event of a blood shortage including roles and responsibilities for both WBS and hospitals. The Plan underwent full consultation in July 2023 (please see below for details) and will be submitted for adoption at the Blood Health

	National Oversight Group (BHNOG) meeting in December 2023. Th plan has been amended to align with other UK Blood Services in terms of trigger levels and alert nomenclature and was informed by a national “Dim Gwaed” table top exercise within NHS Wales.

RECOMMENDATION / ACTIONS	***The Trust Board are asked to Approve the plan.***

GOVERNANCE ROUTE	
	Date
Quality Safety and Performance Committee	16/11/2023
Executive Management Board - Run	02/10/2023
Hospital Transfusion Committees/Teams (HTC/HTT) in each HB	(01/08- 01/09/2023)
Blood Health National Oversight Group (BHNOG)	(01/08 – 01/09/2023)
Emergency Planning Advisory Group (EPAG)	(01/08 - 01/09/2023)
Welsh Blood Service SLT	(01/08 – 01/09/2023)
Emergency Medical Retrieval & Transfer Services (EMRTS)	(01/08 – 01/09/2023)

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The NHS Wales Blood Shortage Plan was issued for consultation via transfusion and emergency planning networks in August 2023.

Relevant comments and amendments have been incorporated into the plan as part of the consultation process.

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

	*Please see refer to **Appendix 1** for the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels*

APPENDICES	
1	NHS Wales Red Cell Shortage Plan

1. SITUATION

The NHS Wales Red Cell Shortage Plan identifies the actions, roles and responsibilities of all Health Boards and the WBS in the event of a blood shortage. The Plan identifies the different levels of alerts and actions that should be taken in each alert level. It provides Health Boards with a framework on which they can further develop their own protocols and procedures should a blood shortage occur.

2. BACKGROUND

The Plan identifies the strategic approach that NHS Wales should take if there was a blood shortage. The plan defines each of the alert levels and the actions for both the WBS and the Health Boards. It also defines trigger levels for each alert level.

3. ASSESSMENT

See above

4. SUMMARY OF MATTERS FOR CONSIDERATION

To note new trigger levels (days stock) have been adopted for alert levels to Wales and new nomenclature for alerts, namely BLUE alert is being replaced with PRE-AMBER alert.

This helps align Wales with other UK services shortage plans.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** Service Delivery
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☒

	[Please include narrative to explain the selected domain in more than 3 succinct points]. This plan help ensure the safety and sufficiency of supply within Wales is maintained and managed at times of demand/supply pressure across NHS Wales.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. **Click or tap here to enter text**

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	EQIA plan undertaken and signed off by EQIA lead on 14/11/2023.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1

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

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

NHS Wales Red Cell Shortage Plan

The following plan has been drafted by Welsh Blood Service (WBS) in collaboration with NHS Wales Hospital Transfusion Teams and the Blood Health National Oversight Group (BHNOG)

Executive Summary

1.1 This document sets out the plan in the event in a shortage of allogeneic (i.e. donor) red blood cells and has been produced by the WBS, in collaboration with Hospital Transfusion Committees/Teams (HTC/HTT) across Wales, Emergency Planning Advisory Group Leads (EPAG) and the Blood Health National Oversight Group (BHNOG).

1.2 Hospitals and the WBS should work together to reduce the risk of red cell shortages through the effective management of both the supply and demand for blood. This includes use of Patient Blood Management (PBM) principles and appropriate conservation strategies.[1]

1.3 This document updates the integrated plan for blood shortages originally published by Welsh Government (WG) in the 2009 document '*CONTINGENCY PLANNING - AN INTEGRATED PLAN FOR THE MANAGEMENT OF BLOOD SHORTAGES*[2]' and builds on the principles of the original and subsequent plans.

1.4 It identifies actions to be taken by both the WBS and hospitals/Health Boards (HBs) in the event of a potential or actual red cell shortage. The latest version incorporates feedback received as a result of the blood shortage tabletop exercise run in October 2022.

1.5 The plan ensures that patients who need blood receive a transfusion regardless of their geographical location.
The arrangements are designed to ensure that:

- Access to red cells is equitably available for all essential transfusions to patients.
- Overall red cell usage is managed so that the most urgent cases receive sufficient red cells for their needs.

1.6 A shortage of red cells may be associated with a platelet shortage. Please refer to the WBS Platelet Shortage Plan[3] for further information.

1.7 The Red Cell Shortage Plan describes four phases dependent on WBS red cell stock levels - Green, Pre-Amber, Amber and Red. The green phase is focused on the implementation of Patient Blood Management (PBM) principles to ensure blood is used appropriately and prudently.

1.8 In each HB/hospital there are established business continuity planning arrangements, within services which would be activated to manage red cell shortages in the Amber and Red phases. Should the situation deteriorate to such an extent, command & control measures should be activated as detailed in Major Incident Plans/Business Continuity and other Emergency Response Plans

1.9 The Pre-Amber alert is used specifically by the WBS when stocks risk falling into Amber phase. Hospital staff will receive a Pre-amber notification of a potential shortage, which has not yet breached the Amber threshold. This phase has been introduced to encourage greater collaborative working between hospitals and the WBS e.g. agreed reduction in stock levels, negotiation of orders etc. to actively manage the national supply chain and alleviate the necessity to progress to a more formal alert level thereby averting more severe shortages. This is business continuity management and will be managed via the respective Pathology Business Continuity process.

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2.0 Background

2.1. The Civil Contingencies Act[4] (2004) (Ref) requires NHS organisations to demonstrate that they can deal with disruptive incidents while maintaining services. As part of Emergency Preparedness, Resilience and Response (EPRR), there is a requirement for services to develop business continuity plans to respond to supply issues such as a shortage within the blood supply chain, and to ensure the effective use of available blood components when blood stocks fall below pre-determined levels[4]. These plans will be critical to ensuring transfusion support remains available for the patients who need it most.

2.2 Although severe red cell shortages are rare in Wales and the UK generally recent experiences such as the COVID 19 pandemic and industrial action have exposed the fragility of the blood supply chain. This has sometimes resulted in prolonged periods of shortage as several multi factorial issues are managed.

2.3 The original integrated plan for the management of red cell shortages incorporated a framework to manage shortages in a variety of situations, including but not exclusive to:

- Short-term shortages, caused by, for example, adverse weather.
- Very acute shortages caused by, for example, security issues, which stop donors donating.
- Prolonged blood shortages, which could result from a number of circumstances e.g. the introduction of further measures to reduce the risk of disease transmission by transfusion or a pandemic.
- Unexpected increases in demand e.g. mass casualty incidents

3.0 Planning Principles

3.1 The following plan is designed to ensure that the WBS, together with Transfusion Services and the wider hospitals/HBs in Wales work in a collaborative process, to provide an integrated approach to manage red cell supply avoid shortages and minimise any impact on patients as far as possible.

3.2 The plan is designed to operate routinely even when there is no shortage. Where there are modest reductions in the blood supply, for example <10% reduction, appropriate use of blood conservation strategies (PBM) together with the active management of the blood supply chain should avoid the activation of formal blood shortage arrangements.

3.3 The appropriate use of donor blood and the use of effective alternatives to blood are important public health and clinical governance issues. This plan is designed to build on actions taken by hospitals/health boards (HBs) to improve transfusion safety and effectiveness in accordance with the Blood Health Plan[5].

4.0 Plan Structure

4.1 The plan is structured to provide a framework of actions for WBS and hospitals/HBs at four phases (refer Fig. 1 below). A summary table of the Blood Shortage categories & actions is shown in Appendix 1.

Green Alert Target blood stocks maintained; supply aligned to demand
Pre - Amber Alert Forecasts indicate that stock(s) are under pressure, requests for stock reductions and negotiations for stock management are likely to occur
Amber Alert Reduced availability of blood for a prolonged period with limited ability to recover stocks
Red Alert Severe and/or prolonged shortages or imminent threat to the blood supply

Fig. 1

4.2 During the Green phase, the WBS will maintain normal operations, target blood stocks are maintained, and supply is aligned to demand. Hospital/HBs will be encouraged to advocate PBM principles for prudent and appropriate use.

4.3 In the Pre-Amber phase, the WBS will issue a Pre-Amber alert notification to hospitals informing them of potential pressures on the supply chain and negotiating with hospitals to take appropriate action to protect supply. Activation of this alert will follow the guidance defined in **WBS SOP /BCM- 001: Blood Shortage Alert - Distribution and Testing arrangements**. Recipients will be requested to distribute this alert notification to relevant clinical and management teams across their health board this will include escalation through Pathology business continuity response routes to familiarise themselves with actions in Amber should this be necessary. This action is intended to prevent the requirement to move to Amber phase. This alert may apply to either a single blood group or a number or all of the blood groups.

4.4 The WBS will actively manage stock to minimise the risk of blood shortages. However, if red cell stocks fall lower than the pre-determined level then shortage plans may be activated and communications to move to an Amber phase will be issued. These will follow guidance as for Pre-Amber alert but will also be escalated to the Welsh Government. This may apply to either a single blood group or to a number or all of the blood groups.

4.5 Should the WBS identify a severe, imminent threat to the blood supply then, they will communicate a move directly to the Red phase. This will follow guidance as for Pre-Amber and Amber alerts in addition to the guidance for Red.

4.6 Each hospital/HB are required to have, as part of their overall emergency planning, an escalation process through their established governance structures to respond to alerts from the WBS. This will be via the respective service Business Continuity Management process, where there are escalation processes articulated. The response may require a reduction in both blood stocks and red cell use. It is recommended that use of red cells should be prioritised according to the guidance in Appendix 2.

5.0 WBS Actions

5.1 Stock levels are reviewed daily through WBS Resilience meetings and collection/manufacturing activities are monitored to ensure stock levels are kept at the pre-determined target levels. Monthly Capacity/Demand Planning meetings are used to set strategic direction. However, if these measures are unable to support the stock position, then either a divisional Emergency Planning meeting or a Trust meeting using the bronze/silver/gold command structure will be established and several additional actions may be taken.
These actions include but are not limited to:

- Calling more donors or targeting donors of a specific blood type. This might also mean deferring donors of blood groups that are plentiful and replacing with those of the group under pressure. This will be at the discretion of the Collections Manager/Donor Engagement Manager
- Extending shifts in the manufacturing/testing departments to increase manufacturing.
- Extending the opening times of current scheduled donor sessions/establish new donor sessions.
- Increased monitoring of stock ensuring it is distributed according to age and group mix, to keep wastage to a minimum.
- Utilising our mutual aid arrangements with other UK blood services.
- Activation of the BHNOG Blood Shortage Group (BSG) (Refer to Appendix 5 for Terms of Reference)

If these actions prove to be unsuccessful, WBS will declare a red cell shortage and invoke WBS Standard Operating Procedure (SOP) /BCM- 108: Business Continuity Plan – Blood Shortage. This will be communicated via the Shortage Alert process and escalated to the appropriate phase.

6.0 Hospital Business Continuity Response

6.1 Each hospital/HB should have the ability to set up appropriate operational, tactical and strategic business continuity arrangements to respond to, and deal with blood supply chain issues.

6.2 Blood component shortages in the Amber and Red phases would need to be escalated in this way in the same way as staffing shortages (e.g. strikes) fuel shortages, shortages of oxygen or any other critical service disruption for the care of patients. This is business continuity management. For the purposes of an Amber or Red blood shortage alert the appropriate Business Continuity command and control structures will be established and should include key staff in the organisation including, key staff supporting blood transfusion will be subject matter experts to assist in the decision-making process during the shortage.

Business Continuity Response
Essential
Consultant Haematologist responsible for Transfusion
Hospital Transfusion Committee Chair (or equivalent)
Transfusion Laboratory Manager
Transfusion Practitioner
As appropriate stakeholders from:
Clinical Directors of departments which are high blood users, in particular those with urgent/emergency need for blood e.g. critical care, acute medicine, accident and emergency, anaesthesia, surgery, obstetrics & paediatrics,

6.3 The responsibility of the hospital business continuity management process and associated command and control structures, if an escalated state is to provide strategic guidance and formulate arrangements to manage the appropriate use of red cells in both the Amber and Red operational phase, as part of their existing business continuity and emergency response arrangements.

6.4 Proposed generic actions for hospitals at Green, Pre-Amber, Amber and Red are defined in Appendix 3. The actions are dependent on the local case mix and configuration of services within each HB. These should be included within Pathology Service business continuity plans.

6.5 Routinely, Business Continuity Plans should clarify the roles and responsibilities of staff and give clear guidance for internal communication. Consideration should be given to centralising hospital/HB stock and modification of surgical lists.

6.6 Once the arrangements have been agreed the documentation should be managed by the Hospital Transfusion Team (HTT) and senior clinical staff representing the main users of blood.

6.7 Should the alert move from Pre-Amber to Amber and a red cell shortage occur, WBS will activate their emergency plan and notify HTTs to implement their business continuity incident response arrangements. In an Amber or Red shortage, actions within hospitals may need to be reviewed daily by relevant clinical service leads and the Chair of tactical group as appropriate.

6.8 It is recommended that each HB response should have senior hospital management support i.e. from the Chief Executive and/or Medical Director's teams to ensure their effectiveness. If in Red alert, there will be a strategic and tactical command and control arrangements and Clinical staff should be aware of their responsibilities as appropriate and be willing to accept that a decision-making process, is necessary when the supply of red cells is limited.

6.9 If an Amber alert is declared all requests to the transfusion laboratory should be reviewed by senior laboratory staff and referred to the hospital Haematology Specialist Registrar or consultant if request does not comply with current British Society Haematology (BSH) guidance.

6.10 If a Red alert is activated all requests to the transfusion laboratory should be reviewed by hospital Haematologists (registrar or Consultant) for appropriateness before the order is placed with WBS.

6.11 If the WBS are unable to meet a request (except in an emergency) and no suitable alternative is available then the request will be referred to a WBS Consultant for advice.

6.12 It is recommended that hospitals/HBs refer to the Welsh Blood Service (WBS) Red Cell Shortage Plan – Summary Document (https://wbs-intranet.cymru.nhs.uk/bht/policies-guidance-forms/policies/) for practical use during a red cell shortage.

7.0 Indications for Transfusion

7.1 The indications for transfusion are taken from UK national guidelines for the use of blood components and are provided in the '*Indication Codes for Transfusion: an Audit Tool*[6]'. Whilst it is acknowledged that clinical judgement plays an essential part in the decision to transfuse or not, the purpose of drawing available transfusion guidelines together into a single resource is to help clinicians prioritise the use of blood transfusion. It is recommended that the national indication codes for blood transfusion are used to document the indication for transfusion. These are available on the transfusion request form, as a QR code on the All-Wales Transfusion record and as an app for use on IOS & Android phones.

7.2 It is recognised practice that patients undergoing elective surgical operations should not require transfusion support if their Haemoglobin (Hb) concentration is pre-optimised before surgery. Assuming normovolaemia has been maintained, the Hb can be used in conjunction with clinical assessment to guide the appropriate use of red cell transfusion.

7.3 Patient Blood Management (PBM) measures to avoid the use of blood transfusion include pre-operative iron replacement for iron deficiency anaemia, and the use of tranexamic acid for surgical patients likely to have at least moderate blood loss (>500ml) or >10% blood volume loss in children and patients weighing less than 50kg.

7.4 Overreliance on group O D negative red cells may have a negative impact on the management of this scarce resource. Blood services worldwide encounter recurrent shortfalls of O D negative red cells. It is important that patients are prioritised with respect to their transfusion needs to identify those where the use of O D negative cells is essential. Group O D positive red cells may be used for individuals of non-childbearing potential where no anti-D is detectable. Hospitals are directed to the Management and Use of O D Neg Red Cells guidance[7].

7.5 The provision of O D negative red cells for use in the pre-hospital setting should also be retained for individuals of child-bearing potential. The emergency service currently advocates the use of O D Positive for individuals of non-childbearing potential but the service provision to supply may need to be reviewed to determine its suspension or reduction in units provided. This will need to be a multidisciplinary decision.

7.6 Ensure that unused blood is returned to stock in a timely manner to avoid time expiry/out of temperature wastage.

8.0 Operation of the Plan

8.1 Green

8.1.1 All routine operations should be undertaken. Collections and manufacturing activities will be performed in accordance with anticipated demand.

8.1.2 Hospitals are requested to send daily stock levels to WBS and to review optimum stock levels on a 12 monthly basis in collaboration with WBS.

8.1.3 WBS manage red cell collections to maintain appropriate stock levels across all groups as necessary.

8.1.4. Hospitals/HBs will develop their Business Continuity Blood Management Arrangements and integrate into their business continuity response structures.

8.1.5 Implementation of PBM principles incorporating the prudent and appropriate use of blood is advocated (ref Appendix 6).

8.2 Pre-Amber Alert

WBS Actions

8.2.1 Hospitals/HBs will be advised via the Pre- Amber alert notification that WBS blood stocks are under pressure with negotiations on orders of component(s) likely to occur.

8.2.2 The WBS will maintain clear communications and logistics plans to support hospitals as effectively as possible during shortages. Communications will be sent out on a clear schedule ensuring everyone in the supply chain is informed. This will include invoking the shortage alert protocol.

8.2.3 The WBS will review hospital/HB stock levels and compare with total stock. Demand forecasting will be used to inform allocation strategies.

8.2.4 The WBS will follow their internal Business Continuity Plan

Hospital Transfusion Team Actions

8.2.5 For the blood groups subject to alert hospital transfusion teams should aim to maintain stocks at their optimum level or 10% below this if possible.

8.2.6 Hospitals transfusion teams are requested to send daily stock updates to the WBS by 9.30 a.m.

8.2.7 Conserve O D negative red cells for O D negative patients and individuals of childbearing potential in an emergency.

8.2.8 Review stock holding age range and accept shorter dated blood where there is an opportunity to use it. Where possible avoid requesting fresh red cells for stock.

8.2.9 Establish communications with key clinical teams in high use areas about a potential move to Amber alert and the implication of this.

8.2.10 Ensure clear and effective communication of the pre-Amber alert both within the transfusion team and to key stakeholders.

Hospital Clinical Team Actions

8.2.11 Use of red cells should be in accordance with appropriate use and prudent Patient Blood Management (PBM) principles (Appendix 6).

8.2.12 Review triggers for red cell use by using a restrictive transfusion programme where identified in PBM guidance.

8.2.13 Use tools available to support decisions to transfuse including alternatives to transfusion e.g. intraoperative cell salvage, IV iron for anaemia and use of the NBTC Blood Components App to guide decisions.

8.2.14 Ensure clear and effective communication of the pre-Amber alert to relevant clinical colleagues.

8.2.15. Clinical teams must familiarise themselves with the requirements of an Amber alert and prepare for the establishment of a tactical Business Continuity Response Group as appropriate.

8.3 Amber Alert

8.3.1 In addition to the measures in the Pre Amber phase, the following measures will be added:

8.3.2. If stocks fall to a pre-determined level or an imminent threat to the blood supply is identified, the WBS will communicate a move to the Amber phase. This may apply to either a single blood group or to a number of blood groups or to all of the blood groups.

8.3.3 Hospitals will be expected to inform and convene their Business Continuity Response tactical Group and if necessary, escalate and integrate this with emergency incident command and control arrangements. The Business Continuity tactical Response Group will define which members of staff will participate in the shortage management and how a reduction in usage will be achieved.

8.3.4 Information from the WBS about blood shortages will be communicated to hospitals by sending the relevant Blood Shortage Alert message. The information will include the nature of the shortage and any actions, which need to be taken by hospitals as part of their business continuity response.

8.3.5 This information will also be forwarded to the Welsh Government.

8.3.6 Hospitals may be required to revise their usage and stockholding further. This will be agreed in discussion and consultation with each HB ensuring no risk to patient safety because of reductions.

8.3.7 Requests for blood may go through a WBS Consultant if considered inappropriate.

8.3.8 Transfusion teams will be asked to consider

- Reduction in reservation periods
- Reduction of stocks in remote fridges
- Reduction of irradiated stock ordering more as and when required.
- Limiting requests for phenotyped units for stock and ordering on a named patient basis

8.3.9 Initiation of the BHNOG Blood Shortage Group by WBS (ref Terms of Reference Appendix 4).

8.3.10 If patient care is adversely affected by the red cell shortage this must be communicated to the patient by the Consultant in charge of their care as defined in Duty of Candour regulations. WBS consultants will provide advice as required. Any adverse incident must be reported to the Serious Hazards of Transfusion (SHOT) haemovigilance monitoring scheme.

8.3.11 If, stocks continue to fall, the WBS may communicate that a greater reduction in usage is required. This may be within the Amber phase or be accompanied by the escalation of a move to the Red phase.

8.4 Red Alert

8.4.1 WBS will declare a Red alert if there is a severe shortage of red cells, or if an imminent severe threat to the supply of red cells is identified.

8.4.2 WBS will communicate with hospitals as in the Amber phase and will include all the actions identified in Amber.

8.4.3 In addition to the alert notifications WBS will chair an all-Wales meeting to include representatives from Velindre Exec. Board, each HB, the BHNOG Blood Shortage Group and Welsh Government.

8.4.4 Velindre will be required to provide a 'No Surprises' communication to Welsh Government

8.4.5 Actions will include a further reduction in stockholding and a reduction in usage to be agreed with hospital teams.

8.4.6. There will be a requirement to consider appropriate transfusions (Appendix 2) and emergency framework for blood rationing[8].

8.4.7 All requests for red cells will need to be agreed with WBS medical consultants prior to issue.

8.4.8 Hospitals/HBs are directed to the National Blood Transfusion Committee (NBTC) guidance and triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage[8]. This has been adapted from Canadian guidance[9] for UK practice and aligns with guidelines used by other UK Blood Services e.g. NHS Blood & Transplant (NHSBT). Appendix 4a & 4b outlines the algorithm for triaging patients in the context of a severe national shortage.
This will include a strategic, tactical and operational command and control structure.

9.0 Impact and monitoring of shortages

9.1 Most declared shortage scenarios will need to be accompanied by a reduction in red cell usage by hospitals/HBs.

9.2 Where the required reduction in usage is quite small it is anticipated that hospitals/HBs will be able to achieve this through the implementation of PBM/ conservation/ appropriate use measures. However, hospitals may also have to consider cessation of procedures in Category 3 (Appendix 2) to achieve the required reductions in usage.

9.3 In a prolonged shortage this will inevitably have an impact on elective surgery and waiting lists. In a more severe shortage reductions in usage will need to be achieved by cessation of some or all procedures in Category 2 (Appendix 2).

9.4 In a more severe shortage where, for example, 50% or more of the red cell supply becomes unavailable it is likely that only patients in Category 1 (Appendix 2) would be treated.

9.5 Hospitals/HBs should report adverse incidents in patients with the operation of this plan through local governance systems, SHOT, Serious Adverse Blood Reactions and Events (SABRE) and to the WBS as appropriate. SHOT reporting criteria can found on the SHOT UK website.[10]

9.6 During shortages the WBS will work collaboratively with hospitals/HBs to monitor red cell usage. It is recognised that hospital caseload and case-mix will vary but where hospitals are unable to meet the recommended reductions in stockholding and use, the haematologist with responsibility for blood transfusion and/or the Transfusion Laboratory Manager will be expected to discuss the hospital needs with a WBS Consultant.

9.7 The WBS Blood Health Team (BHT) will work closely with the Hospital Transfusion Teams, and HBs to support and share PBM and prudent management principles.

10.0 Recovery from shortages

10.1 The WBS will use the Blood Shortage Alert protocol to communicate changes in red cell stock levels and inform when hospitals can move to Amber, Pre-Amber or Green status. The recovery alert should be communicated to all relevant staff.

10.2 The Hospital Transfusion team will disseminate the information as above. The WBS Emergency Planning Group (EPG) and the HB Business Continuity tactical Response Group should convene at the earliest opportunity to review the effect of the blood shortage and amend the local arrangements as necessary.

10.3 Recommendations, lessons learnt, or impacts experienced during the shortage alerts should be collated and a debrief should be held with hospitals to discuss. The report should also be fed back through the Hospital Transfusion Committees as appropriate.

10.4 All hospital SHOT reports submitted as a result of blood shortages should be reviewed for recommendations and lessons learnt.

11.0 References

1. Health Board Blood conservation measures letter: https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2021/12/Conservation-letter-Final-Nov-21.pdf
2. CONTINGENCY PLANNING - AN INTEGRATED PLAN FOR THE MANAGEMENT OF BLOOD SHORTAGES
3. Platelet Shortage plan – In Progress
4. Civil Contingencies 2004 https://www.legislation.gov.uk/ukpga/2004/36/contents
5. Blood Health Plan: https://gov.wales/sites/default/files/publications/2021-09/nhs-wales-blood-health-plan.pdf#:~:text=The%20Blood%20Health%20Plan%20%28BHP%29%20has%20been%20developed,strategic%20aims%20can%20be%20defined%20as%20follows%3A%201.
6. NBTC Ind codes (https://www.transfusionguidelines.org/uk-transfusion-committees/national-blood-transfusion-committee/responses-and-recommendations & NBTC Blood Component App: *https://apps.apple.com/gb/app/blood-components/id1221434626*
7. Management and Use of O D Neg Red Cells: https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2022/01/All-Wales-Guidance-for-the-Management-Use-of-O-D-Neg-Red-Cells_v2_Dec-2021.pdf
8. Doughty, H., Green, L., Callum, J. and Murphy, M. (2020). Triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage: guidance from the National Blood *Transfusion Committee. British Journal of Haematology.* *https://onlinelibrary.wiley.com/doi/10.1111/bjh.16736*
9. National Advisory Committee on Blood and Blood Products, Canada. https://nacblood.ca/resources/shortages-plan/emergency-framework-final.pdf
10. SHOT UK*: https://www.shotuk.org/reporting/*

12.0 Useful Documents

Hunt, B., Allard, S., Keeling, D., Norfolk, D., Stanworth, S. and Pendry, K. (2015). A practical guideline for the haematological management of major haemorrhage. https://b-s-h.org.uk/guidelines/guidelines/haematological-management-of-major-haemorrhage/

South Wales Trauma Network (2020). Damage Control Resuscitation (Adult Major Trauma Patients): Clinical Guideline CG07.

Emergency preparedness, resilience and response guidance for UK hospital transfusion teams https://pubmed.ncbi.nlm.nih.gov/32020684/

Preoperative patient blood management during the SARS – CoV-2 pandemic https://b-s-h.org.uk/guidelines/guidelines/gpp-preoperative-patient-blood-management-during-the-sars-cov-2-pandemic/

Clinical Guide to surgical Prioritisation from Federation of Surgical Specialty Association *https://fssa.org.uk/userfiles/pages/files/covid19/prioritisationmaster280122.pdf*

13.0 APPENDICES

Appendix 1	Summary of Blood Shortage Categories and Actions
Appendix 2	Indication for Transfusion
Appendix 3	Proposed Actions for HBs/hospitals at each Alert Phase
Appendix 4a	Emergency Framework for Blood Rationing in the context of severe national shortage – Algorithm for Triage Team (Part 1)
Appendix 4b	Emergency Framework for Blood Rationing in the context of severe national shortage – Algorithm for triage Team (Part 2)
Appendix 5	BHNOG Blood Shortage Group Terms of Reference
Appendix 6	PBM guidance

Appendix 1: Summary of Blood Shortage Categories & Actions

WBS STATUS LEVEL	WBS BUSINESS STATUS	RISK to WBS SERVICE	WBS CONTINUITY PLAN	WBS COMMUNICATIONS	HEALTH BOARD (HB)/HOSPITAL RESPONSE / ACTION
GREEN >7 days	**Normal operations -** Target blood stocks maintained	Collections & manufacturing in line with anticipated demand	**Supply aligned to demand.** Monitor blood stocks and increase specific 'blood group' collections to maintain stock levels where necessary.	WBS activate donor communications in line with targeted groups	Normal operational status. Hospitals expected to send daily stock updates to WBS
PRE - AMBER <3 days	**Hospitals notified of anticipated shortage**	Forecasts indicate that stock will come under pressure; negotiations for stock management may occur to avoid increased pressure and escalation to an amber alert	**Pre-Amber shortage declared.** Review stock levels held in Health Boards. Compare total stocks with forecast demand and inform HBs of position negotiating where appropriate. WBS will supply targeted information on usage. Emergency Planning blood shortage group meeting held, monitored/escalations via daily Resilience Meetings Increase targeted publicity / recruitment activity. Targeted information on usage will be supplied by WBS. Discuss mutual aid with other UK services	Blood shortage alerts to be sent to: Hospital/HB Transfusion teams via agreed alert procedure Internal WBS contacts HB Emergency Planning Leads Medical Directors CEO/MD VUNHST	HBs are advised that WBS stocks are under pressure. Hospitals should aim to maintain stocks at their optimum levels or aim for a reduction of 10% if possible. Negotiations on orders of components under pressure are likely to occur. Hospitals are required to send daily stock updates to WBS by 9.30 am. Follow advice on pre-Amber alert including implementation of patient blood management and appropriate use principles
AMBER <2 days	**Blood Stock(s) depleted.** WBS has reached 2 days or less in (A & O) blood groups	Unable to recover or increase collection capacity to meet demand in coming days. No ability to import.	**Amber Shortage declared.** Increase publicity / recruitment activity. Hold additional or extended blood collection clinics where possible. Extend shifts in laboratories to increase manufacturing/testing as appropriate. Discuss mutual aid with other UK Blood Services Increased monitoring of stock ensuring distribution by age to reduce wastage. Issues/requests may be triaged by WBS consultants. Daily Emergency Planning group meetings The BHNOG BSG to review and agree stock holding levels for major trauma centres	Alerts to be sent to: Hospital/HB Transfusion Teams via agreed alert procedure & weekly meetings Internal WBS Contacts HB Emergency Planning Leads Medical Directors Welsh Government CEO/MD VUNHST	Hospitals should aim for a minimum reduction of 10% in optimum stock levels. Hospitals should conserve stocks and WBS will review orders. Rationing may be applied. HBs should convene a Business Continuity tactical Response Group to manage blood shortages. Hospitals are required to send daily stock updates to WBS by 9.30 am. Follow advice on Amber alert including implementation of patient blood management and appropriate use principles
RED <1 day	**Stock(s) in critical position or Major Incident disruption.**	Severe prolonged shortages or imminent threat to the blood supply	**Red Shortage declared.** As for Amber alert WBS will chair an all-Wales meeting to include representatives from Velindre Exec board, health board representatives and Welsh Government	Alerts to be sent to: As for Amber alert Daily updates to hospitals	As for Amber alert Hospitals are required to send daily stock updates to WBS by 9.30 am. Hospital orders will be managed by consultant discussions and prioritised. A HB Business Continuity tactical Response Group will be activated and respond to notifications from WBS.

Appendix 2: Indication for Transfusion

To simplify the management of patients in a general red cell shortage a prioritisation system has been created using three broad patient categories. This is to assist hospitals with prioritising patients to achieve the required reduction in red cell usage. It is recognised that clinical judgement is an essential part of decision-making for individual patients.

Non

<table>
<tr><th colspan="2">OPTIMISE ALL PATIENT BLOOD MANAGEMENT STRATEGIES</th></tr>
<tr><td rowspan="3"><u>Category 1</u>
These patients will remain highest priority of transfusion.

RED Phase</td><td>Resuscitation
Resuscitation of life-threatening / on-going blood loss including trauma. If ongoing major haemorrhage with expected poor prognosis review appropriateness of continuing transfusion support

Transfusion- dependent anaemias including thalassaemia.
Review the need for transfusion and delay if not symptomatic with anaemia.
Haemoglobinopathy patients on regular transfusion programmes follow amber alert guidance but also increase interval between red cell exchanges or consider using transfusion as interim measure.</td></tr>
<tr><td>Surgical support[1]
If less than 0.5 days stock
Priority 1a: *procedures can be supported with donor blood with exceptions**
Priority 1b: emergency procedures cannot be supported with donor blood.
These should be reviewed on an individual case basis taking into account blood group and correction of anaemia.
Non-surgical anaemias
Continue to transfuse in
a. life threatening anaemia including patients requiring in-utero support and high dependency care/SCBU.
b. Stem cell transplantation or chemotherapy already commenced***
Review cadaveric organ transplants and delay, if possible, particularly if large volume of blood is required e.g. liver/cardiac.</td></tr>
<tr><td>Surgical support[1]
If 0.5 - 1 day's stock
Priority 1a & 1b: procedures can be supported which are likely to require donor blood support. These should be reviewed on an individual case basis taking into account blood group and correction of anaemia.
Delay starting:
a. Stem cell transplantation, or chemotherapy
b. Living related organ transplantation
Delay prophylactic transfusion:
a. In severe bone marrow failure syndrome if patient not symptomatic with anaemia</td></tr>
</table>

Category 2 These patients will **not** be transfused in the RED phase.	*Surgery/Obstetrics* Cancer surgery (palliative); Symptomatic but not life-threatening post-operative or post-partum anaemia; Urgent*** surgery
	Priority 2 and 3 surgeries Consider postponing if likely to require blood. Support on an individual case basis taking into account blood group and correction of anaemia
	Non-surgical anaemias Symptomatic but not life-threatening anaemia
Category 3 These patients will **not** be transfused in the AMBER	*Surgery* Consider postponing priority 4 surgeries if likely to require blood. Support on an individual case basis considering blood group and correction of anaemia
	Chronically transfused patients 1. Haemoglobinopathy: Patients on Red Cell Exchange (RCE) programme – a. Reassess use of red cells during previous exchanges to ensure optimising red cell component usage. b. If available, use the depletion mode in the apheresis machine if safe to do so and results in less blood use. c. Consider increasing interval for RCE. d. Consider top-up red cell transfusion post partial exchange to reduce number of red cells required. 2. All Patients: (including haemato-oncological patients receiving chemotherapy) Reduce transfusion threshold to 70g/l if no contraindication. 3. Maximise Use of all PBM measures: i.e. use of Tranexamic acid, use of cell salvage, optimisation of pre-op anaemia, minimise iatrogenic anaemia by limiting blood sampling

1 Clinical Guide to surgical Priortisation from Federation of surgical Specialty Association

* Emergency – patient likely to die within 24 hours without surgery.
** With the exception of poor risk aortic aneurysm patients who rarely survive but who may require large volumes of blood.
*** Urgent – patient likely to have major morbidity if surgery not carried out.
**** Planned haemopoietic stem cell transplant or chemotherapy may be deferred if possible.

Appendix 3: Proposed Actions for hospitals/HBs at each Alert phase

Green Alert/Phase

Ensure use of Patient Blood Management and the appropriate use of blood as follows:

- Ensure appropriate membership and functioning of Hospital Transfusion committee (or equivalent) and Hospital Transfusion team.
- Ensure that effective blood transfusion policies for the appropriate use of red cells are in place, implemented & reviewed.
- Ensure that education and training is provided to all staff involved in the blood transfusion process and is included in induction programmes for new staff as appropriate.
- Send daily stock levels to WBS.
- Consider the establishment of stock sharing between hospital transfusion laboratories to utilise stocks more effectively across HBs.

Ensure the appropriate use of blood and effective alternatives in clinical situations where blood is used as follows:

- Implement relevant guidance on the appropriate use of blood and alternatives.
- Ensure that guidance is in place for the medical and surgical use of red cells and other blood components such as platelets and fresh frozen plasma (FFP)
- Establish local protocols to empower blood transfusion laboratory staff to query clinicians about the appropriateness of requests against local/national guidelines for use.
- Ensure procedures to empower transfusion laboratory staff that appropriate clinical information is provided with requests for blood.
- Implement regular monitoring and audit of usage of red cells, platelet & FFP in all clinical specialities.
- Schedule internal blood shortage exercises and extend the operational response to involve clinicians and decision making.
- In liaison with BHT and Blood Stocks Management System (BSMS) agree optimal and minimal stock holding

Pre-Amber Alert/Phase

- Ensure Business Continuity response arrangements are in place and that the group can be convened quickly if a potential Amber alert is called.
- Review haemoglobin triggers for red cell transfusions in accordance with PBM guidance.
- Use tools e.g. NBTC Indication codes app for guidance on appropriateness of transfusion, to support clinical decision making and consider transfusion alternatives.
- Support supply chain if requested by WBS to advertise local donation clinics.

All patients

- Minimise iatrogenic anaemia (reduce frequency and volume) of samples from patients. Only take if it affects their clinical management.
- Use a restrictive red cell transfusion threshold (Hb 70g/l) unless patient is bleeding, has acute coronary syndrome or is on a chronic transfusion programme.
- Advocate single unit transfusion (or equivalent volumes for children from 1 year or adults with low body weight) in patients who are not bleeding or on chronic transfusion programmes. Reassess the patient clinically after each unit and perform Hb test to determine if further transfusion is required.

Surgical Patients

- Ensure patients with anaemia scheduled for elective surgery are properly diagnosed and treated prion to surgery.
- Ensure early pre-assessment of patients in priority Categories 2 & 3 (Ref. appendix 2). Treat deficiencies with appropriate supplements.

- Optimise care of patients in Category P1 with IV iron infusions pre-operatively
- Review pre-op Hb level and expected blood loss. Use tranexamic acid and intraoperative cell salvage (ICS), unless contraindicated in adults if pre-op HB low or intraoperative blood loss greater than 500ml. Record any contraindications.
- Advocate the use of ICS including ensuring access to ICS equipment and appropriately trained staff.
- Use point-of care coagulation testing to guide intraoperative blood component management.
- Consider use of post-operative IV and/or oral iron in anaemic patients to avoid transfusion.

Patients requiring chronic transfusion programmes.

- Use alternatives to transfusion where appropriate (refer relevant guidelines)
- Review protocols for transfusion used to maintain Hb levels above a target level during curative radiotherapy.

Transfusion Laboratory Teams

- Hospitals should aim to maintain stocks at their optimum levels or aim for a reduction of 10% if possible.
- Conserve O D Neg red cells for O D Neg patients in accordance with guidelines
- Transfuse group specific red cells wherever possible.
- Ensure regular monitoring and audit of red cells in all clinical specialities.
- Enter hospital stock levels to the WBS daily by 09.30 a.m.
- Accept shorter dated red cells where you are confident, they can be used.
- Start communications with high users about a potential move to Amber and likely consequences of this.
- Actively manage stockholding for optimum use, consider if safe:
    - Reducing reservation period
    - Reducing stock levels in remote fridges
    - Reducing levels of irradiated stock and ordering as required
    - Limiting requests for stock phenotyped units, ordering on a named patient basis
    - Stock sharing across health boards
- Report any delays /incidents to SHOT.

Amber Alert/Phase

All Patients

- Decision to transfuse should be consultant led unless it is an emergency.
- Where component use is prolonged e.g. major haemorrhage, trauma or pre-hospital setting. Review transfusion support to consider the appropriateness of continued treatment.
- Clinical team should liaise with transfusion laboratory to consider supply of components.
- Consideration should be given to reviewing the transfusion trigger for all patients particularly in haemato-oncology or critical care unless contra-indicated.

Surgical

- Continuation of elective surgery will depend on current stock levels and anticipated demand.

Patients requiring chronic transfusion programmes.

- As for pre-Amber

Transfusion Laboratory Teams

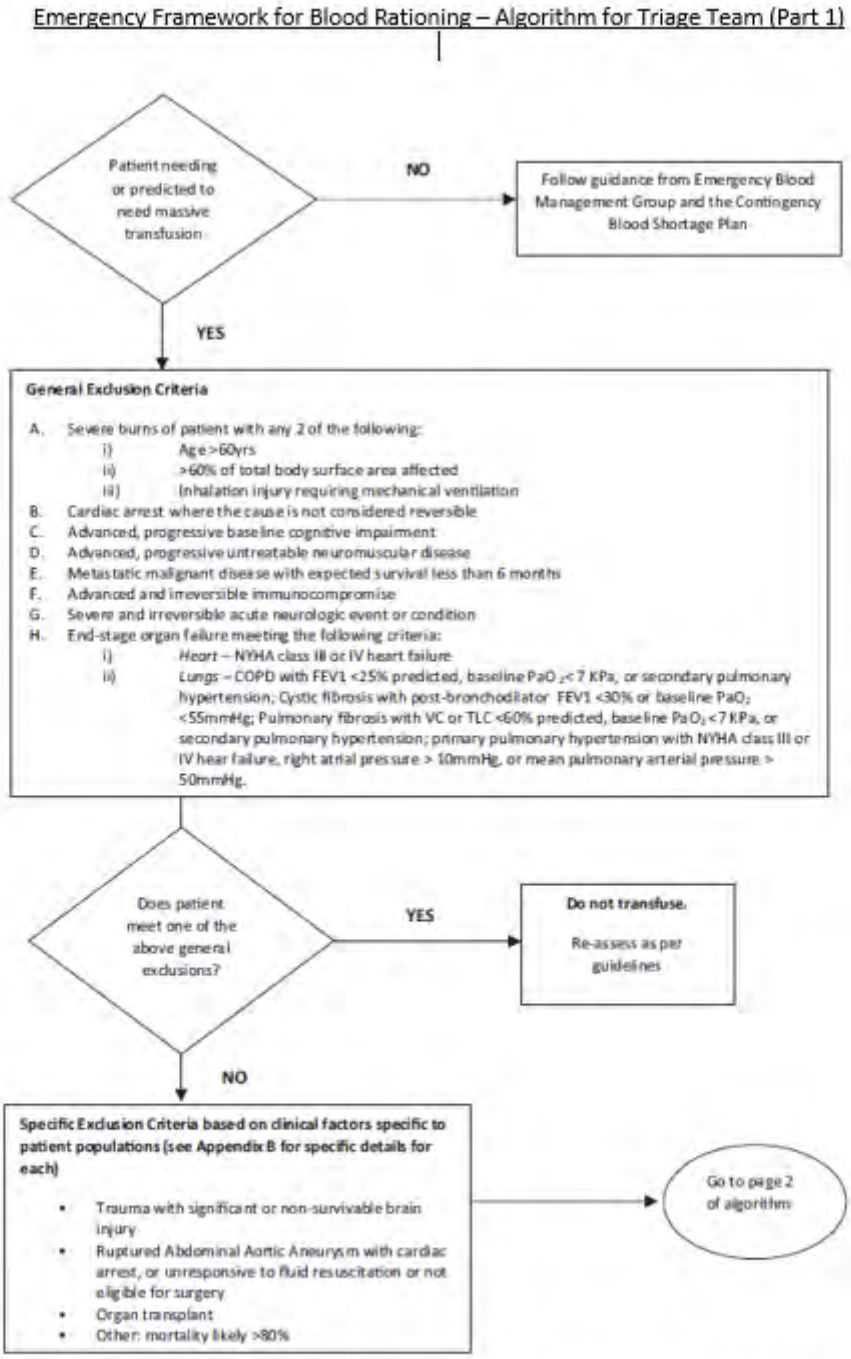
- As for pre-Amber and:
- Reduction of the reservation period wherever possible
- Consider the use of temperature loggers in blood transport boxes where appropriate to reduce wastage because of uncertainty in the cold chain
- Consider further reduction or removal of stock in remote issue fridges especially those used for elective surgery.
- Weekly meetings held with Hospital Transfusion Teams/EMRTS/Business Continuity tactical Response Group/EPRR leads as appropriate.

Red Alert/Phase

- As for Amber and:
- **Mandatory** entry of daily stock levels by 09.30am
- Reduce stockholding to the level agreed with WBS.
- Reduce usage to the level agreed in collaboration with the WBS.
- Daily review of the blood shortage and impact on patient care by Business Continuity Response Group.
- Assessment of all requests by a Consultant Haematologist to minimise inappropriate requests.
- Consider removal of all red cell stock from remote issues fridges except for emergency units and issue components directly from laboratory
- Sites with no staff on site laboratory will need to consider transport arrangements to ensure adequate blood component availability.
- Order of priority based on clinical need. Clinical teams are advised to follow the NBTC guidance and triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage[8] which outlines the algorithm.
- Establishment of stock sharing between hospital transfusion laboratories to utilise stocks more effectively across HBs.
- The enactment of a predetermined policy on dealing with major bleeding that should utilise guidance in this document on when to stop blood component support.

N.B. In both the Amber & Red phases of alert unless the request is an emergency if WBS is unable to meet a blood request and where no alternative can be found, this will be referred to a WBS Medical Consultant.

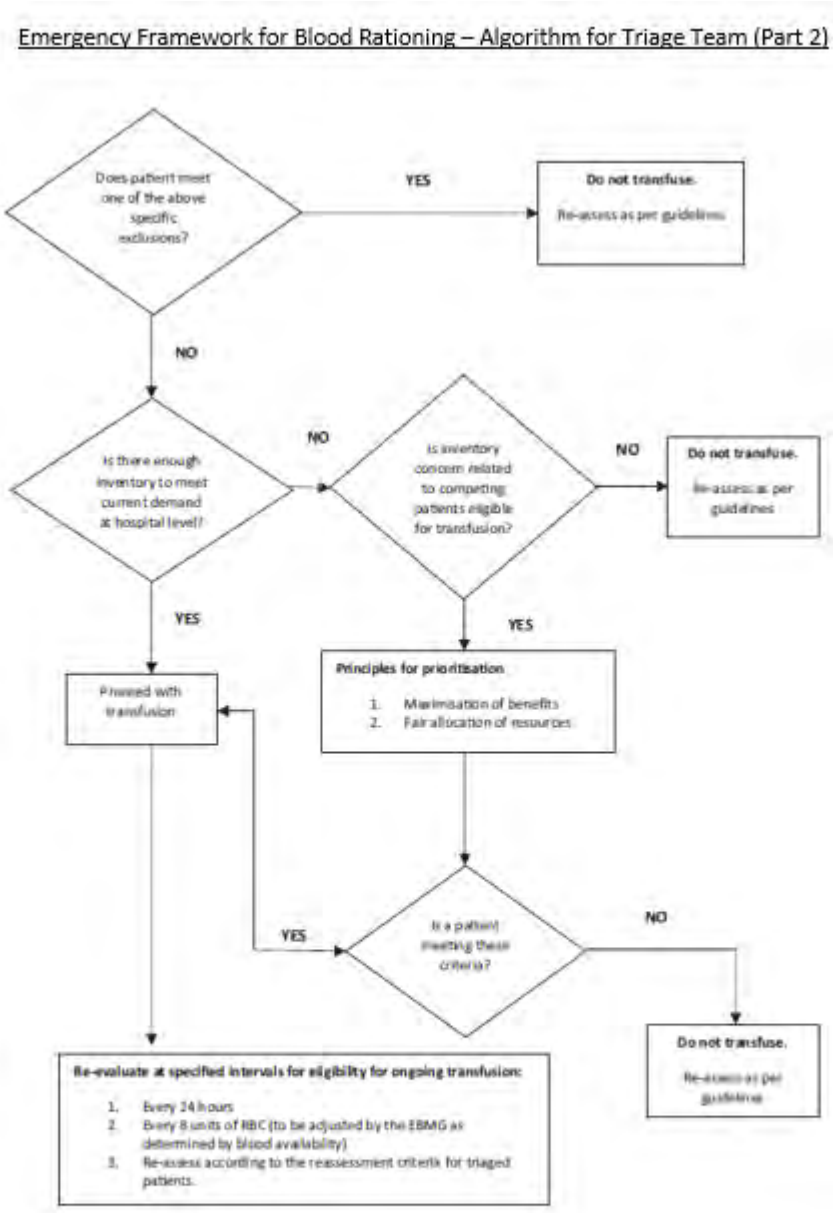
Appendix 4a: Emergency Framework for Blood Rationing in the context of severe national shortage – Algorithm for Triage Team (Part 1)



'Specific Exclusion Criteria Based on Clinical Factors' in the box above – further details on this can be found in the full guidance document at https://onlinelibrary.wiley.com/doi/10.1111/bjh.16736

Reproduced from Appendix B of *Triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage: guidance from the National Blood Transfusion Committee.*

Appendix 4b: Emergency Framework for Blood Rationing in the context of severe national shortage – Algorithm for triage Team (Part 2)



Reproduced from Appendix B of *Triage tool for the rationing of blood for massively bleeding patients during a severe national blood shortage: guidance from the National Blood Transfusion Committee.*

Appendix 5: BHNOG Blood Shortage Group Terms of Reference

1. Purpose

The Blood Health National Oversight Group (BHNOG) Blood Shortage Group (BSG) was established in response to ongoing challenges within the blood supply chain. These have been particularly evident over the last 12 – 18 months with both the Welsh Blood Service (WBS) and other UK services facing significant challenges securing supply to meet demand.
This resulted in the establishment of a group at a national level, comprising of key stakeholders, to facilitate management of the blood supply chain including the appropriate use of blood. Building on established structures and recognising that BHNOG already comprised much of the required membership, the establishment of the BSG, was agreed with reporting to BHNOG.
The purpose of the BSG is to work with key stakeholders to ensure the appropriate use of blood using patient blood management principles. If a pre-Amber alert or escalation to an Amber or Red phase / alert does occur that this is effectively communicated and managed within the Health Boards (HBs) using relevant shortage documentation[1].

2. Aim

The aim of the BSG is to escalate, communicate and manage any challenges to the blood supply chain in collaboration with other key stakeholders to avoid blood shortages. This can be applied to any blood components but excludes blood products which would be managed by the Intravenous Immunoglobulin (IVIG) Group. The BSG will ensure any shortages are effectively managed and communicated to clinical colleagues ensuring blood is given to those patients most in need.

3. Governance

The BSG is accountable to BHNOG and follows recognised governance pathways defined in the BHNOG ToR[2].

4. Chair

The BSG group will be chaired by current BHNOG chair. A Deputy chair will also be selected from within the group's membership.

5. Membership

BHNOG Chair
Director Welsh Blood Service (WBS)
Consultant with BHP responsibility/Medical Director WBS
BHNOG Work Stream Leads
Blood Health Team (BHT) Lead
BHNOG Rep for Transfusion Lab Manager Forum
Welsh Government Representative

The representatives identified in the membership table above will be defined as core members of the BSG. Other members may be co-opted as necessary onto the group at the agreement of the Chair.

6. Meeting Frequency

The BSG will meet on an ad-hoc basis and will depend on:

- Information regarding current and predicted stock levels both within in Wales and rest of the UK. This will include analysis of demand, collection activity, availability of mutual aid.
- Any critically identified issues within Wales that could impact on national supply
- Extended alerts or threats to the blood supply with limited ability to improve national stocks.
- Meetings will be convened by the WBS Director or nominated Deputy in liaison with the BHNOG Chair when one of the criteria above has been reached.
- Extraordinary meetings may be convened at the discretion of the WBS director.

Administrative Support
BSG is hosted by the WBS, which supports the administration of the meetings. These arrangements allow for organisation of meetings; documenting and maintaining records of all meetings held; and effective communication on behalf of the committee.

7. Documentation Required

- Notes of the preceding meeting & action log
- Documentation supporting agenda items e.g. resilience data, demand data, wastage and issuing data etc.

8. Remit

- The BSG will work with BHNOG work stream leads and other key stakeholders strategically across Wales to support the blood supply chain both within the transfusion community and across the wider clinical setting
- Work with relevant large blood user clinical groups to support individualised patient blood management in appropriate care pathways; this will encompass developing practices to support safety and minimise the avoidable use of blood transfusion
- If escalation to a pre-Amber, Amber or Red alert does occur that this is effectively communicated and managed within the Health Boards using relevant shortage documentation and established routes of escalation.
- Ensure any shortages are effectively managed and communicated to clinical colleagues ensuring blood is given to those patients most in need.

9. References

1. WBS Blood Shortage plan: https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2020/08/WBS-Red-Cell-Shortage-Plan_July-2020_final.pdf

2. BHNOG TOR: https://bhnog.wales.nhs.uk/wp-content/uploads/2021/12/BHNOG-Approved-ToR.pdf

Appendix 6: Patient Blood Management Principles

1. Implement best practice conservation measures	
a. Reduce the need for blood	
i. Pre-habilitate- (where time allows)	Where expected blood loss >500ml **OR** the transfusion risk is >10% **OR** the patient requires a group & save then complete the following: ✓ Full Blood Count to check for anaemic status ✓ If Haemoglobin (Hb) <130g/l check haematinics as per All Wales preoperative Anaemia Pathway ✓ Consider intravenous iron if < 8 weeks to surgery.
ii. Reduce intra-operative blood loss	✓ Give Tranexamic acid where indicated ✓ Monitor clotting state (where available) using Point of Care coagulation management (e.g. ROTEM/TEG) ✓ Measure blood loss and use alternatives wherever possible ✓ Use interventions, such as permissive hypotension, determined by patient and procedure. ✓ Use cell salvage to achieve a target post-op Hb & reduce allogeneic transfusion
b. Give blood only when needed	
➢ Use the NHSBT Blood Component App. Document the rationale for all transfusions given above guidance threshold (available IOS & Android free of charge) *https://www.bloodcomponents.org.uk/* ➢ Use the British Society of Haematology (BSH) Platelet Summary Guidance ➢ *https://b-s-h.org.uk/media/17121/summary-bcsh-platelet-guideline-appendix-1-final- reviewed-may-2019.pdf* ➢ Comply with the All Wales use of O D Negative Red Cells Summary Guidance ➢ *https://wbs-intranet.cymru.nhs.uk/bht/wp-content/bht-uploads/sites/4/2020/05/O-D-Neg-Guidance- Summary-final.pdf* ➢ Implement weight adjusted red cell guide to prescribe the minimum no. units for non-bleeding adults to achieve a target threshold. This will support single red cell transfusion strategy. ➢ Review requirements for transfusion dependant patients	
2. Match demand with supply	
➢ Clinical areas must work in close collaboration with their Senior Management Teams, Hospital Transfusion Teams (HTT) and the WBS to ensure continuity of supply ➢ Clinical teams must consider the potential for blood loss, before embarking on any procedure and plan management. Where blood will be required despite the prudent measures outlined above, do not proceed without confirmation that transfusion services can meet requirements. ➢ It is recommended this is specifically addressed in all WHO checklist, pre-operative briefings.	

Education material to support this guidance is available using the Blood Assist App (available on IOS & Android free of charge) *https://www.bloodassist.co.uk/*

Further information can be provided by contacting the Blood Heath Team *wbs.bloodhealthteam@wales.nhs.uk* and at the *https://wbs-intranet.cymru.nhs.uk/bht/*

TRUST BOARD

RENEWAL OF NWSSP NANTGARW HQ LEASE

DATE OF MEETING	30 November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	PETER STEPHENSON, HEAD OF FINANCE & BUSINESS DEVELOPMENT, NWSSP
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The 10-year lease of NWSSP'S HQ site in Nantgarw has expired and a new lease has been re-negotiated with the landlord. The contract will need to be signed and sealed by Velindre University NHS Trust, however in accordance with the Standing Orders, the lease must first be considered and approved by the Trust Board.

RECOMMENDATION / ACTIONS	The Trust Board is asked to approve the renewal of the lease between NWSSP and the Treforest Trustee (Jersey) Limited.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
N/a	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS This paper has not been through other governance discussions as it relates solely to the renewal of a lease of NWSSP's Headquarters site. The reason for requiring Trust Board approval is due to the lease needing to be formally signed and sealed by the Trust.	

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

APPENDICES	

1. SITUATION

This paper is prepared to seek the approval of the Trust Board for the signing and sealing of a (renewal) lease in relation to NWSSP's headquarters in Nantgarw.

2. BACKGROUND

The lease renewal between NWSSP and the Treforest Trustee (Jersey) Limited, as landlord, has been re-negotiated and the new lease is to be executed, by NWSSP's hosted Statutory Body - Velindre University NHS Trust. It requires two

authorised signatories, which in this case is the Chair and Chief Executive of Velindre University NHS Trust who are to formally sign the contract and affix with a common seal. Both signatories are also required to add their initials to the plans.

3. ASSESSMENT

The lease between NWSSP and the landlord, Treforest Trustee (Jersey) Limited will need to be signed by the Trust as the legal entity. In accordance with the Standing Orders, this must first be considered and approved by the Trust Board.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Approval is needed for the Trust to formally sign the lease on behalf of NWSSP.

The main terms of the lease renewal are set out below-

- **Lease Term** – 5 years from 30th April 2023.
- **Break Option** – Tenant only option to terminate the lease on 31st October 2024 subject to 6 months' prior written notice.
- **Rent** – £100,820 per annum.
- **Incentives** – 2 months' rent free from lease commencement date. Additional 5 months' rent free if break option is not exercised.
- **Landlord & Tenant Act 1954 –** lease to be within the protection of 1954 Act.

The deadline to complete the renewal lease was **27 November,** but due to the limited timescales given, our legal representative is liaising with the landlord to agree an extension to allow the lease to be approved by the Trust Board, however they are not obliged to do this and if they do not agree to an extension an application would need to be made to the court to ensure that the organisations security of tenure is not lost.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: N/a **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** N/a
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ N/a
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	**Choose an item** This paper has been produced for the sole purpose of gaining approval from the Trust in accordance with Standing Orders.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item** If more than one Well-being Goal applies please list below:

	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: This arrangement relates to the receipt of income rather than the commitment of expenditure. **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: The cost of the lease is consistent with that we already pay. **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	N/a for reasons given above.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	**Choose an item**
	Click or tap here to enter text

	The signing of the lease has legal implications for the landlord and tenant. However, Legal and Risk Services have helped to draw up the lease document which is a renewal of an existing lease.

6. RISKS

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

TRUST BOARD

TRUST WIDE POLICIES UPDATE

DATE OF MEETING	30/11/2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR NOTING
PREPARED BY	Kay Barrow, Corporate Governance Manager Fay Sparrow, Freedom of Information & Compliance Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Trust Board regarding the status of the Trust wide policies and to advise of those that have been approved during the period **October 2023 to November 2023.**
RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **NOTE** the progress being made regarding the Policy Compliance Status for Trust wide Policies. • **NOTE** the policies that have been approved during the period **October 2023** to **November 2023**.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	30/10/2023
Quality, Safety and Performance Committee	16/11/2023

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board:

- **REVIEWED** the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.
- **NOTED** the Quality, Safety and Performance Committee Policies Extract Compliance Report as of **October 2023.**
- **ENDORSED** the Policy Extract Compliance Report for submission to the November 2023 Quality, Safety and Performance Committee.

The Quality, Safety and Performance Committee:

- **REVIEWED** the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.
- **NOTED** that 50% of policies were currently past their review date and received assurance that targeted action is being taken to address this. To facilitate this, a new post has been established within the Corporate Governance Team for a Freedom of Information and Compliance Officer whose remit will encompass working with Trust officers to prioritise policy governance. In addition, it was also noted that a refresh of the Equality Impact Assessment (EIA) Toolkit is being taken forward that will strengthen the EIA policy process. It was further noted that a procurement is underway to facilitate a Trust-wide document management system, this will enable tracking and recording of policy compliance more effectively and efficiently.

7 LEVELS OF ASSURANCE	
N/A	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
Appendix 1	(QS01) National Policy on Patient Safety Incident Reporting

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy and Procedure for the Management of Trust wide Policies 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 through the Trust governance process and approved during the period **October 2023 to November 2023.**

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 As part of the governance approval process for those policies that have been formally approved during this reporting period, the following key points were highlighted in response to scrutiny and assurance undertaken at the November Quality, Safety and Performance Committee (QSPC):

- In relation to the extant basis of policies whilst policies are being reviewed, it was clarified that **section 13.4 of GC01 Policy and Procedure for the Management of Trust wide Policies and Other Written Control Documents** states: *"Until a document is reviewed, it will remain the extant policy document of the Trust until replaced. It is the responsibility of the policy author to ensure that documents are reviewed in line with their review dates. Therefore, the extant policy remains approved by the original approving body and is only superseded once a new version has been formally approved*."

- In relation to the timetable for all overdue policies, it was confirmed that the new Freedom of Information and Compliance Officer is prioritising policy governance and liaising with all policy authors on the expected governance approval process for policies past their review date. This will also ensure that all policies have an Equality Impact Assessment (EIA) in line with the new toolkit that has been established. In addition, where there is an existing EIA that it has been reviewed as part the refreshed EIA process.

  The QSPC will receive an updated policy compliance position in March 2024 and will also receive an annual status review in May 2024.

- In respect of the policy compliance status for the following Corporate, it was confirmed that:
  - IG08a Freedom of Information/Environmental Information Regulations Standard Operating Procedure was passed its review date, however, was approved by QSPC at the November meeting.
  - IG04 Information Security Policy and IG09 Information Governance Policy are NHS Wales policies and are currently being reviewed by the NHS Wales Information Governance Management and Advisory Group.
  - IG03 Email Use Policy and IG07 Internet Use Policy are NHS Wales policies and are currently being reviewed by the NHS Wales Information Governance Management and Advisory Group.
  - IG10 Staff Mobile Phone Policy was transferred from Corporate Communications into Digital Services and is currently undergoing a comprehensive review.
  - A number of Workforce and Organisational Development policies past their review dates are due to be reviewed imminently in line with the launch of the new EIA Toolkit/process for completeness.

2.2 As a result of a number of areas highlighted during the robust policy compliance audit review, the overarching Policy Framework GC01 will be undergoing an early review to incorporate a number of areas of continuous improvement such as the refreshed EIA Toolkit, strengthening the policy review process and reporting arrangements for policy compliance in respect of the Trust's Hosted Organisations.

2.3 Since the last Trust Board, the QSPC **APPROVED** the policy below which has been uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
(QS01) National Policy on Patient Safety Incident Reporting	Executive Director of Nursing, Allied Health Professionals and Health Science	Quality, Safety & Performance Committee (This national policy was endorsed for implementation in place of Trust Policy QS01: Incident Reporting and Investigation)	11th May 2023	**1**

2.4 The QSPC also **ENDORSED** the following policies for **APPROVAL** at the November Trust Board, which are included separately under agenda item **6.1.4** for this meeting:

Policy Title	Policy Lead / Function	Endorsing Body
(QS04a) Claims Management Policy (Clinical Negligence & Personal Injury Litigation)	Executive Director of Nursing, Allied Health Professionals and Health Science	Quality, Safety & Performance Committee
(QS03) Handing Concerns Policy (Complaints, Claims, Patient Safety Incidents and Duty of Candour)	Executive Director of Nursing, Allied Health Professionals and Health Science	Quality, Safety & Performance Committee
NWSSP Registration Authority Policy	Executive Director of Finance	Quality, Safety & Performance Committee

3. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents has an associated EIA. Each policy will be individually assessed to ensure compliance with EIA requirements.
ADDITIONAL 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.

4. RISKS

The Policy Compliance Audit is a continuous review of the status of Trust wide policies to ensure compliance with GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents.

Undertaking a continual policy review cycle will ensure a collaborative and inclusive approach to ensure policies do not go past their review date.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**
All risks must be evidenced and consistent with those recorded in Datix	

NHS Wales

National Policy on

Patient Safety Incident Reporting

& Management

Date to be reviewed:	31 March 2024	**No of pages:**	23
Document author & owner:	NHS Wales Executive		
Contact email:	PatientSafety.Wales@wales.nhs.uk		
Approved by:	Welsh Government		
Approval date:	4 May 2023		
Effective date (live):	11 May 2023		
Version:	v2.0		

Contents

Supporting sections:

1. Changes from previous version

- Merged the content of the policy and the guidance document into a single document
- Removed references to “Phase 1” and “Phase 2” of policy implementation. Phase 2 related to the establishment of systems to thematically analyse incident data, this work has been superseded by the plans to undertake thematic analysis at a national level through the use of the Once for Wales Concerns Management system (Datix Cymru)
- Clarification of the scope of applicability of the policy, particularly with regard to independent service providers
- Improved clarity of roles & responsibilities of all organisations involved in policy delivery, alongside use of more inclusive terminology throughout the document
- Improved clarity on the requirements of the initial assessment process following identification of a patient safety incident
- Strengthened references to the use of Datix Cymru for the reporting and management of patient safety incidents, including the use of the in-built Yorkshire Contributory Factors Framework tool
- Clarified the principles for NHS organisations to consider in determining whether an incident should be nationally reported
- Incorporated the NHS Wales Never Events list
- Endorsement of the just culture guide as a supporting tool
- New/strengthened sections on:
    - Duty of Candour, including alignment of harm definitions
    - Joint safety incident investigations
    - Incidents occurring in relation to commissioned services
- Clarification of accountability for completion (closure) of an incident investigation
- Provision of introductory guidance relating to the use of Safety-II thinking into current incident management processes
- Updated guidance and definitions in relation to specific incident types based on feedback throughout 2021/22 including:
    - patient & service user falls to be retrospectively reported where the investigation has determined the fall was avoidable
    - alignment of reporting requirements associated with maternal & perinatal and infant deaths to National Confidential Enquiry (MMBRACE-UK) definitions
- Clarity on the relationship between Nationally Reportable Incident (NRI) reporting and Welsh Government (WG) Early Warning Notifications

2. Introduction

Patient safety incident reporting is changing across Wales. Historically, incident reporting has been used as a key safety indicator in healthcare to attempt to understand where things go wrong to learn and improve safety, experience and outcomes for future patients and service users. As a nation, our understanding of how to best use intelligence from incident data is continuing to evolve. New conceptual approaches to safety, such as Safety-II, will help us shift the narrative from focusing purely on "what went wrong?" and balance this line of inquiry alongside "what goes right, and how can we learn from that as well?" (see Supporting Section 5 for more information on Safety-II). These new approaches require us to think differently and consider how incident reporting is one component of a whole safe system of care. We must continue to ensure our national processes and approaches to this complex and sensitive area of healthcare are aligned to maximise learning opportunities for the benefit of patients, service users, their families, carers and loved ones, staff and our NHS organisations.

To achieve these ambitions, our national processes must support a just culture for organisations and staff to feel supported to identify, report and learn from patient safety incidents, without the fear of punitive response or action throughout all levels of NHS Wales.

The previous version of this policy (in effect from 14 June 2021) aimed to empower organisations to think differently about what should be reported, taking more ownership and accountability for incident reporting and management. Through this updated version of the Policy, the NHS Wales Executive will take these aims further and continue to work collaboratively with NHS Wales organisations and other key stakeholders in delivering a new system for collecting and analysing incident data which is for the NHS, by the NHS.

3. Purpose of this policy

A patient safety incident occurs when an unintended or unexpected incident could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare.

While many incidents will not result in significant harm to an individual, the exploration of incident reports can help provide a source of intelligence which can be used by healthcare providers for a variety of purposes, including:

- to **learn** from what has gone wrong and what could have been done differently, by using the incident as a prompt to undertake an investigation and take action in order to make changes to improve the safety of patients;
- to identify and address **emerging risks** by looking for trends, themes and patterns of incident reports; and
- as a mechanism for oversight and **assurance** particularly where significant harm has occurred in the delivery of healthcare, in line with *The National Health Services*

(Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011- also known as 'Putting Things Right' (referred to forthwith as 'the Regulations').

Incident reports can be a valuable signal to healthcare providers about where to focus resource and attention to improve patient safety. However, they are only one part of the puzzle and should be examined in the wider context of other sources of safety intelligence. This includes triangulation with other data sources (for example, patient experience and complaint data) as well as looking at what goes well the majority of the time, and what we can learn from that (e.g. Safety-II). Throughout 2023 and beyond, the NHS Wales Executive will be working to improve how this triangulation of multiple data sources is undertaken at a national level.

The purpose of this Policy is to set out clear expectations for patient safety incident reporting and management across NHS Wales. It supersedes and replaces the section on "Serious Incidents" within the 2013 'Putting Things Right' (PTR) guidance document.

4. Strategic policy context

The following national programmes and concepts provide context to this Policy:

- **Health and Social Care (Quality and Engagement) (Wales) Act 2020**, which underpin the statutory **Duties of Candour and Quality**:
    - The **Duty of Candour** is intrinsically linked to incident management. The Duty focusses on the need to be open with patients and service users and anyone acting on their behalf when things go wrong, building on the requirements already set out in the Regulations.
    - The **Duty of Quality** has two aims – to improve the quality of services, and to improve outcomes for people in Wales.
- **Quality & Safety Framework: learning and improving**: the overarching national Framework setting out the national ambitions for Wales in relation to quality and safety in the NHS. In particular, this Policy relates to Action 4 – **the development of a new National Incident Reporting Framework focussing on maximising and sharing learning from incidents**.
- **National Clinical Framework: A Learning Health and Care System**: the overarching national Framework setting out the national ambitions for Wales in relation to the development of clinical services across NHS Wales.
- **NHS Wales Executive**: in fulfilment of an objective set down in A Healthier Wales, a number of organisations have brought together under the banner of the NHS Wales Executive from 1 April 2023. National systems for incident reporting will be established, maintained and developed by the NHS Wales Executive.

- **National Quality Management System (NQMS)**: a visionary system for NHS Wales which will ultimately bring together data from a number of sources, including patient safety incidents, for triangulation and to inform a range of activities in relation to learning and assurance.
- **Once for Wales Concerns Management System**: the national IT system enabling consistent approaches to a range of processes across NHS Wales. In relation to incident reporting and management, this system is also known as **Datix Cymru.**
- **COVID-19 pandemic & the National Nosocomial COVID-19 Programme (NNCP):** NHS Wales is still recovering from the effects of the COVID-19 pandemic and this must continue to be taken into consideration in relation to patient safety incident reporting and management. Importantly, learning and changes to process which were brought about by the pandemic must be capitalised on, including in particular learning from the NNCP, which will be incorporated into this and future versions of the policy as applicable.

5. Scope of Policy

This Policy applies to **all** services directly provided or managed by a Health Board, Trust or Special Health Authority in NHS Wales.

NHS Wales organisations that contract, agree or arrange for care to be provided by a non-NHS Wales provider (independent provider) on their behalf, retain responsibility for national incident reporting. This is in keeping with position outlined in the *Health and Social Care (Quality and Engagement) (Wales) Act 2020* for Duty of Candour reporting. The requirement to report extends to Primary Care services providing care as part of NHS Wales.

6. References and related documents

- Health and Social Care (Quality and Engagement) (Wales) Act 2020
- The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 as amended by National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2023
- The Duty of Candour Procedure (Wales) Regulations 2023
- The Duty of Candour Statutory Guidance 2023
- Putting Things Right guidance document (v3, 2013)

7. Aims and objectives of this policy

- Provide a clear and consistent national approach to incident reporting, management and investigation across NHS Wales.
- Provide clear guidance on what types of incident should be nationally reported, and how this should occur.

8. Responsibilities in relation to this policy

Welsh Government:

- Setting legislation, statutory guidance and government policy.
- Ensuring that intelligence and learning derived from the outputs of this policy are taken into account in setting legislation, statutory guidance and government policy.
- Publishing official statistics based on reported incidents.

NHS Wales Executive:

- Oversee and deliver national policy and processes in relation to reporting, management and investigation of safety incidents.
- Identification of cross-system learning, ensuring that learning is disseminated.
- Ensuring consistency of application of this policy, including provision of assurance mechanisms in relation to incident reporting, management and investigation.
- Provide national analysis on nationally reported incident data.
- Provide advice, guidance and support to organisations in relation to implementation of this policy, including the reporting, management and investigation of safety incidents.

Health Boards, NHS Trusts and Special Health Authorities

- Accountable for the quality and safety of care and services provided to their respective populations, including care that they contract, agree or arrange for their populations.
- Implementing this policy including endorsement through their Quality & Safety governance framework.
- Ensuring there are appropriate governance and assurance mechanisms in place, facilitating a flow of information across all parts of the organisation.

- Ensuring local systems and processes for incident reporting are in place and embedded.
- Ensuring that there are systems and processes for incident reporting, management and learning for any health care they contract, agree or arrange on behalf of their populations.
- Undertaking analysis of locally reported incidents, including identifying trends and themes from incident data.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.
- Ensuring staff are familiar with the requirements of this Policy.

Primary Care (General Medical Services) contractors in NHS Wales

- Accountable for the quality and safety of care and services provided to their respective populations
- Required to locally report incidents that have occurred within their organisations using the Datix Cymru system. The Health Body whose system they report into is responsible for assessing whether incidents have met the NRI threshold and undertaking any subsequent reporting.
- Primary Care Contractors must notify the relevant Health Board of occurrences where the Duty of Candour is triggered in respect of the health care they provide under a contract or other arrangement.
- Establishing mechanisms to extract and share learning from incidents, and taking action to reduce the risk of recurrence and improve patient and service user safety, experience and outcomes.

Once for Wales Concerns Management System programme:

- Responsible for overseeing the development and delivery of relevant Datix Cymru modules to support the implementation of this Policy.

9. Key Definitions

General definitions:

Policy Term	Applicable Definition
Concern	As defined in the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) (Amendment) Regulations 2011,* a concern is any complaint, claim or reported patient safety incident
Patient Safety Incident	An unintended or unexpected incident that could have or did lead to harm for one or more patients or service users receiving NHS-funded healthcare Note: the term "patient safety incident" refers to an incident occurring in the course of the delivery of healthcare. It is recognised that this may not always be to a patient but can also affect other service users in receipt of NHS-funded healthcare. The language throughout this document has been updated where possible to reflect this but for the avoidance of doubt, the definition of a patient safety incident applies equally to a service user in receipt of NHS funded healthcare even if they are not classified as a patient.
Patient or Service user	A person to whom healthcare is or has been provided Healthcare includes services for the prevention, diagnosis or treatment of illness as well as the promotion and protection of public health. It also includes NHS staff accessing treatment and care through wellbeing/occupational health services
Action	Something done intentionally or unintentionally
Inaction	Something **not** done intentionally or unintentionally including as a result of indecision, unnecessary delay, failure to act
Nationally Reported Incident (NRI)	A patient safety incident which is nationally reportable in line with this policy
"Must report"	A sub-set of Nationally Reportable Incidents where national reporting is mandated through this Policy

Harm definitions

The following definitions align with the definitions set out in the Duty of Candour Statutory Guidance

No harm	Any patient safety incident that had the potential to cause harm but impact resulted in no harm having arisen
Low harm	Any patient safety incident that resulted in a minor increase in treatment and which caused minimal harm to one or more persons receiving NHS-funded care
Moderate harm	Any significant but not permanent harm, or harm that requires a 'moderate increase in treatment' relating to the incident. A 'moderate increase in treatment' is further defined as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient or transfer to another treatment area such as intensive care
Severe Harm	The permanent lessening of the bodily, sensory, motor, physiologic or intellectual functions, including the removal of the wrong limb or organ or brain damage, which is related directly to the incident and not related to a natural course of the service user's illness or underlying condition
Death	A death caused or contributed to by a patient safety incident, as opposed to a death which occurs as a direct result of the natural course of the patient or service user's illness or underlying condition

10.Governance & assurance requirements

Organisations must ensure they have robust systems and processes in place in relation to local and national incident reporting, including:

- systems and processes to enact this policy in all areas of the organisation;
- all incidents should be reviewed within an appropriate governance framework to determine required risk management activities as well as any national reporting requirement. Whilst advice and support can be sought from the NHS Wales Executive, it will be expected that organisations are responsible and accountable for their judgements and decisions in line with the policy;
- integration with other relevant clinical and corporate governance processes e.g. management of complaints and claims, mortality review processes etc.;
- internal oversight, scrutiny and quality assurance of all incident reporting and investigation processes, including Executive level sign off on national incident notification and investigation outcome forms;
- clear and demonstrable lines of reporting across all parts of the organisation, including through relevant Committees of the Board;

- mechanisms for ensuring joint investigations with other responsible bodies and external agencies where applicable and appropriate;
- mechanisms for recording the outcomes of decisions around national reporting and investigation, including decisions on appropriate investigation methodology. In particular, organisations must ensure they keep robust records around the decisions not to report/investigate incidents as this will be needed for quality assurance purposes;
- mechanisms for capturing and demonstrating shared learning;
- mechanisms for ensuring engagement with any affected patient or service user or anyone acting on their behalf, in line with the legal Duty of Candour.

11. Local incident reporting, management & investigation requirements

11.1. Context

Patient safety incidents can be single isolated events, or multiple recurring events which can signal more systemic failures in care or demonstrate system weaknesses. They can also include events which indirectly impact patient safety or an organisation's ability to deliver a service, such as a failure of an IT system. Consequently, there is no definitive list of what constitutes a patient safety incident and accordingly NHS organisations will need to apply judgment when considering what should be reported, both at a local and a national level.

11.2. Systems and processes

All organisations are required to ensure that they have systems and processes for local incident reporting, management and investigation in line with this Policy. This must include systems and processes to analyse incident data, extract learning and disseminate it throughout the organisation, with relevant actions taken to improve patient and service user safety, outcomes and experience.

Organisations should also have systems in place for monitoring and nationally reporting incidents that occur within services that are provided on their behalf by non-NHS Wales providers.

These processes must include the use of Datix Cymru where available to ensure a consistent national approach to data collection and analysis. These processes should be sufficient to capture and analyse data from across all parts of the patient or service user pathway, including (but not limited to):

- secondary and acute care settings
- primary and community care, including community pharmacy, optometry, dentistry services

- urgent and emergency services including emergency departments & ambulance services
- out of hours' services
- public health services
- relevant IT services
- prisons
- commissioned services, and
- incidents identified through the course of other clinical and corporate governance processes, for example Medical Examiner and Mortality Reviews.

The systems and processes must fully align with the organisation's governance and assurance mechanisms, ensuring clear reporting across the entire organisation for relevant information.

Organisations must ensure local processes are reviewed, amended and/or adapted to incorporate the requirements of this Policy.

11.3. Initial assessment to determine risk management activities and next steps

All patient safety incidents will require an initial assessment in order to assess the circumstances, identify the relevant make safe actions required, and determine the next steps to manage the incident. This initial assessment should take place as soon as practicable after the incident has occurred or otherwise been identified.

This initial assessment must include:

- review of known information about the incident and consideration of further information to be obtained to inform the next steps;
- assessment of risk and determination of make safe actions in relation to:
    - all patient(s) or service user(s) affected by the incident, and
    - the organisation, or other safety systems, to prevent recurrence in similar circumstances;
- determination of the depth and parameters of an appropriate investigation;
- consideration of engagement with the patient or service user and anyone acting on their behalf as appropriate. This assessment will need to balance the desire to engage transparently and compassionately with all affected by the incident whilst having due regard for legal matters of consent and capacity.

- consideration and, where required, escalation e.g.:
    - as a Nationally Reported Incident (NRI);
    - through to relevant national frameworks (e.g. multiagency safeguarding processes); and/or
    - through to relevant external bodies;
- any relevant communications handling required;
- next steps in terms of incident management.

The depth of the initial assessment will vary depending on the circumstances of the incident. The initial assessment must be undertaken by someone of sufficient seniority and experience in incident management proportionate to the circumstances of the incident, and in many cases will require a multi-disciplinary approach. In some cases, including where the incident requires reporting as an NRI, this may require Executive level oversight.

Depending on the circumstances of the incident, this may be the point at which the organisation considers whether the Duty of Candour has been triggered and if so, who should make the initial "in person" notification – see Section 4 of the Statutory Guidance.

11.4. Use of Datix Cymru

All patient safety incidents should be reported through Datix Cymru (part of the Once for Wales Concerns Management System) in line with the applicable User Guide operational at the date of reporting.

Employees of Health Boards, Trusts and Special Health Authorities should have access to report directly into their employer's Datix Cymru system.

Primary Care Contractors in NHS Wales are required to report incidents that have occurred within their organisations. More information can be obtained from the Primary Care Wales Incident Reporting - NHS Wales Shared Services Partnership website.

11.5. Welsh Government Early Warning Notifications (EWN)

Early Warning Notifications (EWN) (previously No Surprise Reporting) is a communication function established by Welsh Government. Its purpose is to provide rapid information to Welsh Government on a range of issues, which may or may not relate to patient safety incidents.

The EWN process is independent of the incident reporting systems described in this Policy, which are overseen and managed by the NHS Wales Executive.

For clarity, where a patient safety incident meets both the requirements of a EWN and a NRI, then both processes must be followed.

12. National incident reporting requirements

12.1. Context

A subset of patient safety incidents will require national reporting to the NHS Wales Executive. The reporting of patient safety incidents at a national level:

- provides oversight and assurance relating to incidents that cause the most harm to patients and service users during healthcare;
- provides oversight and assurance relating to incidents that cause high levels of service impact, disruption or risk;
- enables the identification of organisational and/or system risks; and
- informs learning and action, including e.g. development of patient safety alerts and notices, policies and improvement programmes, national priorities, outcome measures and potential service reforms.

Building on the foundation of the previous version of the Policy, there is a need to move away from prescriptive "trigger list" approaches to determining what incidents require national reporting. This is because of the complexity of healthcare and the incidents that can occur, it would never be possible to determine and list all the types of incidents which should be reported.

Accordingly, NHS organisations must have systems and processes in place to review all incidents on an individual basis and apply judgement to determine what should be reported nationally.

12.2. Nationally Reportable Incidents (NRIs)

As part of the initial assessment process described above, NHS organisations will need to consider whether an incident requires reporting nationally, taking the following principles into account:

Principle 1 - 'Must reports'

Incidents related to the following are always nationally reportable (please see Supporting Section 3 for more guidance on definitions):

- Never Events, as specified within this Policy, even where no harm has occurred. The current NHS Wales Never Event list can be found in Supporting Section 1 of this Policy;
- suspected mental health homicides;
- suspected suicide or self-inflicted death
    - in any clinical setting; or

    - during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge; and

- maternal, perinatal and infant deaths.

Principle 2 - outcome/harm

A safety incident should be nationally reported if it is **assessed or suspected** an **action or inaction** in the course of a patient or service user's treatment or care, in any healthcare setting, **has**, or **could have caused or contributed** to their **severe harm** or **death**.

It will not always be possible to rapidly determine the extent to which a safety incident caused or contributed to the harm or death of a patient or service user within seven working days. In this case, organisations should nationally report the incident, specifying that the position is unclear and/or investigations are ongoing. Incidents can be downgraded at a later date.

Acts and inactions can relate equally to human interactions, technical failures and/or delays in systems and processes.

Principle 3 - number of patients or service users involved

Special consideration must be given to incidents where the numbers of patients or service users affected is significant, even where direct harm has not been, or is difficult to, identify. This includes but is not limited to incidents involving significant:

- screening services;
- IT failures;
- data breaches;
- national system failures; and/or
- service disruptions.

Principle 4 - learning opportunities

Incidents should be nationally reported where they present new learning opportunities, particularly where a similar risk may be present in other NHS organisations. This may include:

- near misses and/or no or low harm incidents where the learning would be beneficial to be shared nationally with other organisations to help raise awareness and mitigate risks for other patients or service users; and/or

- incidents may present which are unusual, unexpected or surprising, where seriousness of the incident requires it to be nationally reported and the learning would be beneficial for others.

Principle 5 - joint decision making around reporting and investigation

Some patient safety incidents will require joint investigation with another organisation. Early consideration must be given to involving relevant stakeholders in any discussions around incidents potentially requiring joint investigation, to ensure relevant information is obtained from all sources in order to inform the discussion. Guidance on the joint investigation process can be found in Supporting Section 4.

12.3. Reporting process

A patient safety incident will be nationally reported to the NHS Wales Executive within seven working days from the date of knowledge of the incident.

The reporting process is set out in Supporting Section 2.

13. Duty of Candour

The provisions of the statutory Duty of Candour, as set out in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 came into effect on 1 April 2023. This is an organisational duty on all NHS bodies and primary care providers. More information on the Duty of Candour, including the statutory guidance, can be found on the Welsh Government website.

Incident reporting, management and investigation is intertwined with the principles of *Being open: communicating patient safety incidents with patients and their carers* and must adhere to the Duty of Candour, so in practice these activities should be fully integrated. In preparation for the Duty of Candour, NHS organisations have been reviewing their systems and processes in relation to concerns and incident reporting, investigation, and management to ensure that they are aligned as far as possible, in order to provide a seamless patient or service user experience.

The Duty of Candour is triggered when:

- an adverse patient safety event (usually an incident) occurs, and the service user sustains or could sustain harm which is
    - unintended or unexpected, and
    - more than minimal e.g., moderate, severe or death, and
- the provision of healthcare was or could have been a factor in that harm occurring.

At the point the incident is reviewed, and it is recognised that the above triggers for the Duty of Candour have been met, the organisation becomes 'aware'. It is at this point that the Duty of Candour procedure should be initiated.

The Duty of Candour is not intended to operate retrospectively and therefore will only apply where the conditions triggering the Duty of Candour as set out in Section 3 of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 occur after the date on which Section 3 was brought into force (i.e. 1 April 2023). In practical terms, this means that the provision of health care and the harm which ensued, must have taken place after 1 April 2023.

For the avoidance of doubt, the Duty of Candour may be triggered following a retrospective case review but that the conditions which gave rise to the notifiable adverse outcome must have occurred after Section 3 was brought into force.

14. Patient safety incident investigations

14.1. Legislation

All concerns reported in NHS Wales, including patient safety incidents, must be subject to an appropriate and proportionate investigation in line with the *NHS Wales (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*. In particular,

Regulation 23 outlines the requirements of the investigation to be undertaken and requires the organisation to undertake the investigation in the manner that appears, to that organisation, to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently.

14.2. Methodologies

NHS organisations must have systems and processes for determining the appropriate and proportionate investigation to be undertaken in response to each reported safety incident, taking into account considerations such as scale, complexity and type of incident.

Organisations should therefore ensure they have access to a range of suitable investigation approaches/tools to support a proportionate approach across a range of outcomes. It will not be appropriate to conduct in-depth investigations for all incidents, and so it is important to determine as accurately as possible from the outset what will be proportionate in the circumstances.

Methodologies in use by an organisation should ensure the involvement throughout the investigation of appropriate staff and patient, service user or a person acting on their behalf.

For certain incident types, to support a consistent national approach there are a number of focussed review tools built into Datix Cymru, which should be used where they are available. This includes safety incidents relating to:

- Falls
- Pressure damage
- Extravasation

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

14.3. Use of Yorkshire Contributory Factors Framework

The Yorkshire Contributory Factors Framework (YCFF) has been built into Datix Cymru to support a consistent approach to the analysis of incidents, including the identification of cross-cutting themes to enable targeting of improvement activities.

Accordingly, the use of the YCFF is required for NRIs and encouraged for other patient safety incidents.

14.4. Just culture guide

Staff who have been involved in a patient safety incident should be treated in a consistent, constructive and fair way.

NHS Wales endorses the use of the NHS England just culture guide as a tool to support the fair treatment of staff who have been involved in an incident. It supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

The just culture guide should **not** be used as a routine or integral part of a patient safety investigation – it should only be used when consideration needs to be given to whether an individual member of staff requires support or management to work safely.

The just culture guide, along with supporting reference materials, can be found on the NHS England website - https://www.england.nhs.uk/patient-safety/a-just-culture-guide/

14.5. Joint investigations

Some safety incidents will require joint investigations, including between:

- different departments within the same organisation;
- where patients have been moved between organisations, including patient handovers at emergency departments; and

- where services have been commissioned, including relating to social care.

NHS organisations should have systems and processes in place to manage these types of investigations.

For joint investigations involving multiple organisations, please refer to the joint investigation process in Supporting Section 4.

15. Investigation of incidents occurring to a patient or service user while in receipt of commissioned services

Whilst the reporting of patient safety incidents at a national level remains the responsibility of the NHS Wales organisations that provided, managed or commissioned the care at the time of the incident, guidance on the investigation of such incidents is provided within the *The National Health Services (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011* ("the Regulations"). The Regulations require all 'responsible bodies' to investigate incidents which occur to services users in receipt of NHS funded care.

A responsible body is defined under the Regulations as:

- a Welsh NHS body:
  - a Health Board;
  - an NHS Trust managing a hospital or other establishment or facility wholly or mainly in Wales;
  - a Special Health Authority
- a primary care provider; or
- an independent provider:
  - a person or body who provides healthcare in Wales under arrangements made with a Welsh NHS body; and is not an NHS body or a primary care provider.

When a patient safety incident occurs, Regulation 23 states that "the responsible body must investigate the matters raised in the notification of a concern in the manner which appears to that body to be most appropriate to reach a conclusion in respect of those matters thoroughly, speedily and efficiently, having particular regard to additional criteria set out in the Regulations". The Regulations also detail what actions responsible bodies must take in terms of *redress*[1], when harm is deemed to have been 'caused' to a patient or service user through a 'breach in duty of care' to that patient or service user.

When healthcare is funded by another Welsh NHS body (Health Board or Trust), the Regulations require a full investigation up to and including consideration of qualifying

[1] Redress is a range of actions which include an apology, learning lessons, and/or in certain circumstances, financial compensation.

liability (QL). Organisations are required to undertake a joint investigation with a lead organisation agreed.

There are however distinct differences in how the Regulations are applied when healthcare provision has not been provided by a 'Welsh NHS body' (Health Board or Trust) through NHS funding arrangements. The degree in variation is predicated on which other type of 'responsible body' provided the healthcare, and particularly when the healthcare has been provided outside of Wales.

The way in which the Regulations vary can be divided into two categories;

1. NHS Wales funded healthcare provided by another UK NHS provider, i.e.:
    - NHS England; or
    - NHS Scotland; or
    - NHS Northern Ireland; and
2. NHS Wales funded healthcare provided by an 'independent provider', either:
    - provided in Wales under arrangements made with a Welsh NHS body and is not an NHS body or a primary care provider; or
    - provided outside of Wales.

NHS Wales funded healthcare provided by another UK NHS provider

When the Regulatory duty is applied to other UK NHS organisations through cross-border and other commissioning arrangements, it is anticipated that local procedures for managing concerns and investigations will be of a sufficient standard to support investigations in keeping with the Regulations. The Regulations require other UK nations to consider a qualifying liability (QL) and refer the matter back to the NHS Wales commissioning organisation where they consider a QL **does**, or **may** exist. However, there is no requirement on other UK NHS organisations to inform an NHS Wales commissioning organisation where they **do not** consider a QL exists.

NHS Wales funded healthcare provided by an 'independent provider'

The Regulations state any responsible body, who provides healthcare **in Wales** under arrangements made with a Welsh NHS organisation, and who is not an NHS Wales Health Board or Trust, must have arrangements in place to manage and undertake investigations when a concern, including a patient safety incident, is raised.

The first element to highlight is that the Regulations do not apply to private provision of healthcare *outside* of Wales.

The second element relates to private provision *within* Wales. In this regard, this will include healthcare provision in care and residential home settings through continuing healthcare

(CHC) and funded nursing care (FNC) arrangements, including local authority managed, third sector/charitable/not for profit sector, and private business. This also extends to any other privately provided healthcare which is NHS funded.

Responsibility to Investigate

Whilst the Regulations require an investigation to be undertaken when a patient or service user is subject of a concern during funded provision of healthcare, there are two key differences when a concern is raised in this regard:

1. the investigation is to be **undertaken by the provider** and not the NHS commissioning organisation, in keeping with the requirement on them to have arrangements in place to do so; and
2. there is no requirement on the provider to consider a QL as part ofthe investigation process.

Joint investigations in relation to commissioned services

Although the Regulations require the provider to undertake investigations when a concern is raised (including a patient safety incident), it is envisaged that when a concern is raised both in respect of the commissioned healthcare provider, and the commissioning organisation, it will be for the NHS Wales organisation to lead a joint investigation. The Regulations still however limit the independent provider element of the investigation to a factual response and not as far as considering QL, but the NHS element of the investigation is required to consider QL.

Post discharge

Concerns which occur during healthcare provision by an NHS Wales body prior to, or during a transfer of care to an independent provider through NHS funding arrangements, will remain the responsibility of NHS commissioning organisation to manage and investigate, fully in keeping with the Regulations up to and including consideration or QL.

16.Investigation outcomes

16.1. Learning from incident investigations

A fundamental part of undertaking incident investigations is to learn from previous experience in order to identify areas for improvement to reduce the risk of similar incidents occurring in the future.

NHS organisations should ensure they have robust systems and processes in place to support the extraction and dissemination of learning from incident investigations throughout the organisation, and include key learning as part of sharing investigation outcomes with the NHS Wales Executive.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

16.2. Completing (closing) an incident investigation

The accountability for completing (closing) an incident investigation sits with the NHS organisation who undertook the investigation.

NHS organisations must ensure there are robust processes in place to ensure the timely completion of incident investigations in line with this policy, which incorporate processes for patient or service user involvement, quality assurance, and Executive sign off.

To allow Boards to be assured that incidents within their organisation have been dealt with appropriately, all NHS organisations must ensure robust processes are in place to inform and assure their Boards that:

- the quality of their investigation processes is of a high standard;
- investigations are being undertaken and completed in a timely manner;
- patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and
- appropriate actions are being taken and learning is being shared across the organisation.

16.3. Process for reporting outcomes of an investigation into an NRI

Detailed guidance on the process for reporting NRI investigation outcomes to the NHS Wales Executive is in Supporting Section 2.

16.4. NHS Wales Executive's role in relation to investigation outcomes

The NHS Wales Executive does not "close" incident investigations related to NRIs. As stated above, the completion of an incident investigation is the responsibility and accountability of the NHS organisation who undertook the investigation.

The NHS Wales Executive has an assurance function to ensure that the information shared in relation to the investigation outcomes is of good quality, using a suitable approach, and undertaken in a timely manner. This is to support a patient or service user focussed approach, as patients or service users affected by safety incidents and people acting on their behalf require good quality information to be provided to them in a timely manner. Where gaps in assurance are identified, the NHS Wales Executive will liaise with the relevant NHS organisation to seek further assurance.

In addition to the extraction and utilisation of learning from incidents, data and intelligence from NRIs will be used to inform local and national assurance activities.

17. Future thinking in relation to incident reporting and analysis

As described in the introduction section, new conceptual approaches to safety including resilience in healthcare and Safety-II, will be increasingly considered by the NHS Wales Executive to determine how these new ways of thinking can help support continual improvement and evolution of our safety management systems in healthcare.

Some preliminary guidance on how to incorporate elements of Safety-II thinking into current incident management practices is included in Supporting Section 5.

This section will be expanded during 2023 in line with the NHS Wales Executive's work.

18.Getting Help

Please contact PatientSafety.Wales@wales.nhs.uk if help and support in application of this policy is required.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	30/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Commercially Sensitive

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Vice - Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Executive Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
		Choose an item.

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee 7th November 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 were no items identified for Alert / Escalation to the Trust Board.
ADVISE	There were no items identified to advise the Trust Board.
ASSURE	**Capital Plan** Following approval, delivery of the discretionary programme is managed by the Capital Planning & Delivery group. At this stage of the year the Discretionary programme is expected to deliver to budget. Whilst the discretionary programme is expected to deliver to budget Capital leads have been tasked to prepare a list, in priority order, of any schemes which could be delivered by the financial year end should any new capital funding become available, but also in preparation of the programme being re-imbursed for the £340k ringfenced to support the delivery of the nVCC project. Within the Capital Programme under the heading Planning / Estates there are salaries included within the Capital Programme. It was queried why they are within the programme and not within revenue. It was confirmed if certain staff are working on capitalisation schemes, the capital accounting manual allows the Trust to capitalise certain staffing costs related to capital projects and schemes, of which this is. In the end-of-meeting Review, it was proposed that a paper brought to the Trust Board in due course, to remind the Independent Members of the process by which capital is agreed within the Trust and the governance process behind this. It was flagged as a concern the extent of the cost to the provision of the ventilation to the first floor ward. It was highlighted this has been an ongoing challenge due a number of factors including COVID. The estimated cost of works has come approximately £250,000 higher than originally costed. The Estates Department are working through the details with two suppliers, and it is hoped to get the target cost reduced. As per the Trust Board request we will be moving forward with a reduced ventilation scheme to improve air temperature and also

assist with improving the air quality but this doesn't address our statutory obligations completely.

The Strategic Development Committee were made aware that options are being reviewed about if it would be possible to sell on the equipment once the move to the new hospital takes place.

The Strategic Development Committee **NOTED** the Capital Plan paper.

Integrated Medium Term Plan

Board Development sessions will be held in due course. These priorities discussed within the Board Development sessions will be brought together for the Executive Management Board and further discussions with the Strategic Development Committee and Trust Board. This will allow for the Integrated Medium Term Plan to be drafted. It was requested that sufficient time is allocated for the Independent Members to read the Integrated Medium Term Plan.

Concerns raised about the increasing demands on the Charitable Funds. It was highlighted there will be a method / mechanism whereby the posts that are currently funded by charitable funds will be considered within the Integrated Medium Term Plan.

The Strategic Development Committee:

- **NOTED** the approach to the development of the IMTP for 2024 / 25 – 2026 / 27 (*see Appendix 1)*
- **NOTED** the work from Directors of organisational and service functions regarding key priorities and activities to deliver requirements by 2027 / 2028
- Receive further reports and information for discussion and endorsement at the appropriate junctures.

WBS TGI Programme Progress Update

The Programme Business Case sets out a programme of strategic developments in relation to improvements in the infrastructure at Welsh Blood Service (WBS) was approved by Welsh Government in March 2021. The Programme Business Case outlined the phases of the programme as follows:

- **Phase 1: Sustainable Infrastructure**
- **Phase 2: Laboratory Modernisation**

Based upon the original scope, the Welsh Government allocated £150,000 to support development of the Outline Business Case for the Sustainable Infrastructure Phase 1, which is nearing completion.

	The TGI Programme Board will be held on Friday 10th November where the programme from the supply chain which will progress from an Outline Business Case to Full Business Case. Once funding is secured, regular progress updates will be brought to the Strategic Development Committee. A large programme of work is required, the Strategic Development Committee were assured that any type of refurbishment will ensure Welsh Blood Service are able to maintain services as well as ensure we have enough internal resources to support the project this size. CJ to confirm with Independent Members outside of the Strategic Development Committee what the funding implication and impact is. The paper states the revenue and/or capital impact is £190K (excluding VAT) but previously the papers have stated £127K (excluding VAT). The Strategic Development Committee **NOTED**: - The progress made in developing the TGI scheme Highlight Report (appendix 1) **People Strategy: - All Wales Retention Programme and Nurse Retention Plan** The paper informs the Strategic Development Committee of the national programme of work being undertaken by the All Wales Retention Programme under HEIW remit and to provide further information in relation to the Nurse Retention Plan as part of the wider strategy. The paper also informs the Strategic Development Committee of the HEIW funding for a Retention Lead within the Trust to fully implement the strategy, starting with the Nurse Retention Plan. DM highlighted that she is pleased to see stay interviews are now included. Previously there has been emphasis on why people leave and not sufficient emphasis on why they stay. It was highlighted to the Strategic Development Committee this is the first time the Trust have done international recruitment for nurses. SM confirmed the Trust will be partnering with other colleagues in other organisations to support each other and create a buddy and mentor system for when the international recruits arrive. A member of the workforce and OD team will facilitate this whole process. Updates will be brought back to every Strategic Development Committee going forward.

	The Strategic Development Committee **NOTED** the People Strategy: - All Wales Retention Programme and Nurse Retention Plan.
INFORM	**Digital Strategy** The digital team have progressed with the establishment of the Digital programme as the route to deliver the digital strategy. The initial digital programme board was held on 5th October and will meet on a bi-monthly basis. An audit on the Digital Strategy has also taken place alongside the work outlined above. NWSSP completed the internal audit, they gave a reasonable assurance rating. One of the findings was relating to the fact the Trust haven't published the strategy. All Strategies including the Digital Strategy have since been launched since the audit took place. The position for Assistant Director of data and insight has successfully been appointed. They will be starting on 3rd January 2024. It was highlighted that initially from the outset it looks like all the emphasis is on the process for the digital strategy, but assurance was provided to the Strategic Development Committee the digital team are also concentrating on the outcomes. Further discussions will be held outside of the Strategic Development Committee regarding what are the processes for engaging meaningfully with patients, carers and donor. The Strategic Development Committee **NOTED** Digital Strategy paper. **Clinical and Scientific Strategy Update** An update was delivered to the Strategic Development Committee regarding the Clinical and Scientific Strategy. A Clinical and Scientific Board is being established, as well as advisory groups to help develop the Clinical and Scientific Strategy. The strategy will set the clinical direction for the Trust over the next five years based on Clinical and Scientific priorities. The Strategic Development Committee will be kept updated of developments on the developing Strategy. The Strategic Development Committee **NOTED** the Clinical and Scientific Strategy Update.

	Cardiff Cancer Research Hub – Strategic Investment Proposal The report summarises the strategic case in relation to the Cardiff Cancer Research Hub - Strategic Investment Case. The content within the paper reflects the number of workshops that have been held in person with all three organisations (Velindre University NHS Trust, Cardiff and Vale University Health Board and Cardiff University). These events were very well attended with a high degree of engagement. Further consideration will be taking to review what innovation ways we can facilitate the movement of staff between organisations without further VAT consequences of secondments. There is no reference that a Memorandum of Understanding is required within the documentation within the Strategic Case. It was flagged to the Committee there needs to be legal documentation that governs the relationship of all parties within the Cardiff Cancer Research Hub. CJ confirmed a Memorandum of Understanding and other legal documentation has been drafted. “Without the CCRH, the research that VUNHST is able to deliver will be limited, and will exclude a significant cohort of patients who will not be able to access new/ novel therapies and treatments that may require access to specialist and/ or intensive care.” This statement within the Strategic Investment Case was highlighted as a concern as this potentially could be perceived as a negative criticism for Velindre, it was suggested for this to be reviewed. JA confirmed currently without specialist and/ or intensive care facilities we cannot deliver certain studies on our site. The ambition is to do more, expand our research portfolio. It was confirmed the above statement will be reviewed. The Strategic Development Committee **NOTED** the Strategic Case for the overall Strategic Investment Case for the Cardiff Cancer Research Hub. **Blood Establishment Computer System (BECS)** The current contract with MAK-SYSTEM expires in November 2024, with an additional extension available until November 2025. The BECS system is coming to the end of its current contractual arrangements. The BECS Project was established in January 2023 and continues to work on the future options, this has included a Prior Information Notice process with the market. The external environment in which the BECS Project is operating remains challenging due to the current financial climate and the pace of technological developments in the BECS market especially with the strategic move to cloud-based system and a

	future BECS provision must be in line with WBS five year strategy and Futures programme. The BECS Project is exploring options for future BECS provision, and these are explored in the corresponding Private SDC paper due to commercial sensitivity. The Strategic Development Committee are asked to **NOTE** this update on the BECS Project, the challenges and strategic context and that options for the future provision are being explored. **Welsh Blood Futures Programme Report** Welsh Blood Futures has been established to be the vehicle to deliver the WBS vision and to shape services for the future by working in partnership and driving a culture of excellence and continuous improvement. It will support delivery of both the WBS 5 Year Strategy and the Integrated Medium-Term Plan (IMTP). This paper outlines the update on the initiation of WBS Futures, progress to date and future reporting arrangements. The Strategic Development Committee were made aware that the implementation team are mapping out the programme of work to ensure they have enough resources to support the project developments. The Strategic Development Committee **NOTED** the contents of the Welsh Blood Futures Programme Report. **Velindre Futures Programme Report** The Strategic Development Committee decided it was most appropriate to withdraw and present this paper in January Strategic Development Committee. The Strategic Development Committee **NOTED** the Velindre Futures paper on the basis the paper is developed and restructured and brought back to the January Strategic Development Committee. **Value Based Healthcare** This report provides an overview of the development of the Value Based Healthcare programme of work. It presents some key considerations and matters in relation to governance and decision making for Strategic Development Committee to note as the Value Based Healthcare programme moves forward. Funding has been secured from Welsh Government for the Value Intelligence Centre is at the moment largely a centralised resource, but

	to be deployed to help the service move forward in terms of value based healthcare. The Strategic Development Committee **NOTED**: • The Terms of Reference (ToRs) for the VBH Steering Group, including reporting lines and budget management. • The Terms of Reference for the Value Intelligence Centre (VIC), including proposed handling of SLAs for utilizing VIC resources. **Trust Assurance Framework** The Trust Assurance Framework paper was delivered to the Strategic Development Committee. The Strategic Development Committee previously endorsed six of the eight proposed Strategic Risks. Agreement was made that following further discussion and agreement the Strategic Development Committee were content with being advised of the final Strategic Risks. The Quality, Safety and Performance Committee further discussed the risk review, following further work which had been undertaken since the Strategic Development Committee and endorsed all eight risks for Trust Board approval. A review of the Trust Assurance Framework has been undertaken including a refresh of the Strategic Risks. These are outlined within the paper. The Committee is asked to **NOTE** the outcome of the Strategic Risk Refresh.
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Charitable Funds Committee at its Public meeting held on the 7th September 2023.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Charitable Funds Committee held on the 07 September 2023:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**FUNDRAISING** The Charitable Funds Committee **NOTED** the changes to the Fundraising team, events currently being worked on and events that have taken place as well as the range of legacies currently being dealt with by the Fundraising team: • Paul Wilkins was appointed as the Director of the Velindre Charity as well as recruitment of three Charity Fundraising Support Officers. Recruitment to fill the vacancies in the Fundraising Officer roles is being progressed. • Up and coming events include: Rhod Gilbert's 'Hoof Cancer Where It Hurts Gig', France World Cup Bike Ride, Morocco Trek and the Key West Bike Ride. • The Velindre Big Swim event took place in Barry in August 2023. • 12 legacies are being considered and dealt with, an estimated income of £1.9 million to be received. **FINANCIAL POSITION** The Charitable Funds Committee **NOTED** the financial performance of the Charity for the period ending 31st July 2023, and the current position and performance of the Charity's investment portfolio. **Income Performance:** • Total income for period ending 31st July 2023 was £1.551million (£1.182million from fundraising & donations and £0.369million from legacies), which is a £0.560m (c50 %) overachievement against a plan of £0.991million. £0.047million of this was an overachievement against the unrestricted funds. The Trust has received £0.300m of funding from the Moondance Foundation, the first of 5 years match funding to implement the Advancing Radiotherapy Cymru (ARC) Academy Project. Forecast income in 2023-24 from further legacies notified to the Trust is circa £1.9million. **Expenditure Performance**:

- Forecast expenditure position to July '23 is £0.763m lower than planned £1.125 million. A significant proportion of the underspend relates to delays in recruiting to the Integrated R&D development project.
- Current indicative forecast for overhead costs with an expected outturn of £188,000 for the year.

Balance Sheet:

- Funds held at the end of July 2023 have increased by £220,000 to £9.963 million.
- Forecast net expenditure against the charitable funds of £2.881 million for the year of 2023/2024. Forecast for the Charity is an outturn fund balance of £6.862 million.
- Charity holding significant cash balances. Benefiting from greater returns due to increase in interest rates and further options will be explored to increase interest income post onboarding of the Charity's new Investment Advisors.

BUSINESS CASE AND EXPENDITURE PROPOSALS

The Charitable Funds Committee **APPROVED one** Business Case and Expenditure proposal:

- **Consultant Practitioner Urology Business Case**

The Charitable Funds Committee **AGREED** to **APPROVE** the Business Case which was drawn together following a generous donation of £160,000 from a benefactor who requested for a proposal for improvement in a urology service within radiotherapy. This will help provide Ionising Radiation (Medical Exposure) Regulations (IRMER) Training. The Business Case composed of two posts: Consultant Practitioner and Advanced Practitioner.

BUSINESS CASE ANNUAL EVALUATIONS

The Charitable Funds Committee **APPROVED five** Business Case Annual Evaluations:

- 2021-04 Improving the Effectiveness or Research, Development & Innovation through Enhanced Clinical Leadership
- 2019-63 Professor in Nursing & Interdisciplinary Cancer Care & Clinical Research Fellow
- 2019-59 Advanced Practitioner Physiotherapist in Oncology Gynaecological Pelvic Health
- 2022-02 Early Phase Trial: Medical Session for the Future

	• 2022-10 Pearl Clinical Trial: Extension of Consultant Clinical Lead Sessions The Charitable Funds Committee were content with the outcomes achieved. The Committee were pleased to note the overall improved quality of the evaluation reports that demonstrated good stewardship of the distributed funds.
ASSURE	There were no items required to report for assurance to the Trust Board.
INFORM	**DELEGATED FINANCIAL LIMIT REVIEW** The Charitable Funds Committee (CFC) **DISCUSSED** the recommendations following the delegated financial limit review. Current position: • All expenditure commitments over £5,000 need to be presented to the Charitable Funds Committee as a Business Case. • Anything under £5,000 can be approved by the Chief Executive. The service is looking to increase the limit for Chief Executive and Executive Director of Finance to £25,000. This paper was taken to the June Committee but brought back to the September meeting to provide further assurance. The Delegated Financial Paper was **APPROVED** on the basis an ongoing tally will be provided to Committee Members between CFC meetings of what has been committed by the Chief Executive or Executive Director of Finance with the ability for a Board Trustee to step in and propose delegation be ceased pending a review of the position if several awards of £25.000 are made in between meetings. It was agreed that the Delegated Financial Limit will be reviewed after 2 years. An analysis of all the commitments of expenditure up to £25,000 made by the Executive Officers will also be included CFC Financial Report on a quarterly basis.

3. RECOMMENDATION

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

Trust Board

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	30th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 12th October 2023.

1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
ADVISE	There were no items to advise Trust Board.
ASSURE	There were no items to assure to Trust Board.
INFORM	**Communications & Engagement** The Communication and Engagement paper was delivered to the TCS Programme Scrutiny Sub-Committee. The team were thanked for the Summer Jamboree. NG highlighted another Jamboree is being arranged for 31st October. Information will be circulated. The TCS Programme Scrutiny Sub-Committee **noted** the Communications and Engagement Paper. **TCS Programme Finance Report** The TCS Programme Finance Report was delivered to the TCS Programme Scrutiny Sub-Committee. This report outlines the financial position as of August 2023. The overall forecast outturn for the programme is an overspend of £2.7153m for the financial year 2023 – 2024 against a budget of £11.641m. It was highlighted that no capital funding has been allocated to the nVCC Project for this financial year, resulting in the aforementioned overspend. A funding request for c£2.700m has been made to Welsh Government. No revenue funding has been allocated for Project Delivery and Judicial Review elements of the nVCC project for this financial year. A funding request of £0.041m is being made to the Trust. It was highlighted that the Trust is not anticipating further judicial review costs for this year. Further clarity is also being sought in relation to the £0.041m. LF to clarify directly with Independent Members exactly what the £0.041m is relating to. The TCS Programme Scrutiny Sub-Committee **noted** the financial position for the TCS Programme and associated projects for 2023 – 2024 as at 31st August 2023.

APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	30th November 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 26th October 2023.

1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Trust Board.
ADVISE	**TCS Programme Finance Report** The TCS Programme Finance Report was delivered to the TCS Programme Scrutiny Sub-Committee. The purpose of the report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2023-2024, outlining spend to date against budget as at Month 06 and the current full year forecast. The overall forecast for the Programme is an overspend of £2.894m for the financial year 2023-2024 against a budget of £11.641m. Capital funding has not been allocated for the Outline Business Case phase of the nVCC Project for this financial year, resulting in the aforementioned overspend. A funding request for c£2.800m has been made to Welsh Government. MB provided assurance to the TCS Programme Scrutiny Sub-Committee that he is confident that capital funding will be returned from Welsh Government. SA highlighted to the committee from a public perspective, the current financial situation being faced by the NHS is significant. It was queried based on the current situation, will the project slow down as a result of the current financial position the NHS Wales is in? It was explained that the majority of the investment Welsh Government are making is capital. The new Velindre Cancer Centre costs have been reflected in the Welsh Government capital plans. MB does not envisage issues in terms of Welsh Government capital funding for this project at this point in time. The TCS Programme Scrutiny Sub-Committee **noted** the financial position for the TCS Programme and Associated Projects for 2023-24 as at 30th September 2023. **Programme Director's Report** The Programme Directors Report was delivered to the TCS Programme Scrutiny Sub-Committee. The reporting period for the Programme Director's Report covers from 7th September – 6th October 2023. If the mitigating actions do not deliver a positive outcome in this timeframe, it is possible that the Delivery Confidence Assessment (DCA) rating would change to Amber/Red in the next reporting period. A number of issues required to achieve financial close. These include: • Technical/Design matters • Commercial construct agreed with WG/Acorn • Agreement of governance timetable with Welsh Government • Confirmation of Gateway Review dates • Completion of the FBC

- Clearance of site

- **Project 3a Integrated Radiotherapy Solution (IRS) and Project 4: Radiotherapy Satellite Centre:**

The Neville Hall Project is approximately 10 weeks behind schedule, it is hoped to claw back some time. RAAC has been identified within the Neville Hall Estate.

A more detailed update will be provided on Radiotherapy during the November TCS Programme Scrutiny Sub-Committee.

- **Project 5 Outreach:**

It has been identified that there is a requirement for 32.5 SACT Chairs by 2025 / 2026. This is calculated by identifying what the overall system requirement would be for the number of SACT chairs across the region to meet that level of expected demand.

The clinical operational model has identified ideally 10% of services will be delivered at home, 45% delivered within Outreach and 45% delivered within the new Velindre Cancer Centre which equals the total capacity of chairs.

Assurance was provided to the TCS Programme Scrutiny Sub-Committee that SACT and Outreach Services are running from Neville Hall Hospital. During COVID the SACT Services were not operating from Neville Hall but these services are since operating again.

The TCS Programme Scrutiny Sub-Committee **noted** the Programme Directors Report.

Tranche Report

The Tranche Report was delivered to the TCS Programme Scrutiny Sub-Committee.

As SHam couldn't attend the October TCS Programme Scrutiny Sub-Committee, the meeting Chair indicated that he and the Members would prefer that the Chief Executive Officer be present when discussing the Tranche Report in detail. Therefore only an initial view on the paper was sought in this meeting

It was decided following the initial conversation a refreshed version of the Tranche Report will be brought back to the November Committee subject to the Independent Members comments and feedback which will be emailed across to CJ.

The initial comments have been received and Tranche Report was **noted**.

ASSURE	There were no items to assure the Trust Board.
INFORM	**Communications & Engagement** The Communication and Engagement paper was presented to the TCS Programme Scrutiny Sub-Committee. The report details the work to promote the nVCC project, detail the communications issued and highlight the engagement activities carried out recently. It was brought to the Committees attention within paragraph 1.3 correspondence, the key figures within the Communication paper states there are 27 correspondences received and 8 have been responded to. NG assured the TCS Programme Scrutiny Sub-Committee there is no delay in responding to the correspondence. Sometimes due to the nature of the correspondence there is a need to collate the information prior to responding which is why they are held up. The TCS Programme Scrutiny Sub-Committee **noted** the communication and engagement paper. **Nuffield Update** The Nuffield paper outlines the collective assessment of where we are against the Nuffield Trust recommendations. The following key points were highlighted to the TCS Programme Scrutiny Sub-Committee: - The agreed regional approval process for this collective report is via the Collaborative Cancer Leadership Group (CCLG). However, it has been agreed by the SE Wales Chief Executives to place the CCLG into the South East Wales Programme Portfolio programme from August 2023 to support its ongoing progress. As such, the report was received at the Portfolio Delivery Board on 5th October. - A single regional Cancer Programme Board will be established to reinvigorate the strategic system leadership that the CCLG first created. It will be chaired by the Chief Executive of Aneurin Bevan University Health Board and have a dedicated clinical lead, programme manager and supporting administration. - It is envisaged that a Cancer Programme will be developed through the same process adopted by the other regional programmes. This is likely to include a series of collaborative regional workshops to design, develop, articulate and prioritise the future cancer programme to anticipated to commence late 2023. Progress against the Nuffield

	recommendations will also inform these discussions and programme design. The TCS Programme Scrutiny Sub-Committee **noted** the collective South East Wales progress update against the Nuffield Trust recommendations.
APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE Private Remuneration Committee

DATE OF MEETING	16.11.2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Prof Donna Mead OBE, Velindre University NHS Trust Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Private Remuneration Committee on 16.11.2023.

1.2 Key highlights from the meeting are reported in section 2.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There are no items for escalation to the Trust Board.
ADVISE	There are no items for advising the Trust Board.
ASSURE	There are no items for assurance for the Trust Board.
INFORM	The Remuneration and Terms of Service Committee **APPROVED** the following: • The Terms of Reference for the Committee pending two minor amendments. • A pay band re-evaluation. The Remuneration and Terms of Service Committee **NOTED** the following: • The Pay Arrangements of Staff on Medical and Dental Terms and Conditions • The plan to exercise flexibilities available under the NHS Pension Scheme arrangements for two members of staff to retire and return.
APPENDICES	N/A.

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

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	30/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mel Findlay, 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

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
		Choose an item.

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 7th September 2023.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Wagestream** The Local Partnership Forum did not approve of the case for implementing Wagestream within the Trust at this time. **Social Partnerships** Members of the Local Partnership Forum expressed disappointment with the Trust in not processing the Social Partnerships arrangements quickly enough, although it was noted that the work has been completed and an options paper was being presented to October's EMB.
ASSURE	**Employee Relations Review** The Local Partnership Forum **DISCUSSED** and **NOTED** the Employee Relations Review Paper and welcomed the work to improving these processes for employees. **Trust 's Nursing Strategy** The Local Partnership Forum **DISCUSSED** and **NOTED** the Trust's Nursing Strategy **National Standardisation of Progression Process** The Local Partnership Forum **DISCUSSED** and **NOTED** the National Standardisation of Progression Process and implementation of the changes within the Trust for Band 5 and Band 6 Biomedical Scientists.
INFORM	The Local Partnership Forum **NOTED** the following reports: • Performance Report • Finance Report The Local Partnership Forum **APPROVED** the following: • Local Partnership Terms of Reference
APPENDICES	**NOT APPLICABLE**

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 19 SEPTEMBER 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 19 September 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings
The minutes of the meetings held on the 18 July 2023 & 1 August 2023 were approved as a true and accurate record of the meeting.

2. Action log & matters arising
Members noted the progress on the actions outlined on the action log.

3. Genomics Update
Members received a presentation on how the All Wales Medical Genomics Service (AWMGS) is leading the way in many areas of genomics (Rare Disease, Cancer, Pharmacogenomics, and Mental Health) covering prevention, diagnosis and targeted treatments where was clinically needed and cost effective.

Members noted the Genomics Delivery Plan for Wales 2022-2025, how genomics was transforming cancer diagnostics and drug prescriptions; and how the AWMGS was delivering equitable genomic testing for improved outcomes in cancer and rare disease enabling precision medicine and reducing adverse drug reactions.

Members noted the presentation.

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

- Appointment of a Vice Chair - To ensure effective business continuity for WHSSC and the Joint Committee it was proposed that Chantal Patel, Independent Member (IM), WHSSC is appointed to the unremunerated role of Vice Chair for the Joint Committee, in accordance with the WHSSC Standing Orders (SOs),
- Establishment of WHSSC/EASC Vacancy Control Panel – Following receipt of a letter to WHSSC on behalf of the CEOs,

WHSSC and EASC have established a joint Vacancy Control Panel, aligned with that of CTMUHB but responsive to the needs of both functions,

- Chair of the Individual Patient Funding Request (IPFR) Panel Further to the Extraordinary Joint Committee meeting held on 1 August 2023, which supported the request to take forward the urgent recruitment of the WHSSC Individual Patient Funding Request (IPFR) panel Chair and approved the proposed remuneration package, the post has now been advertised following earlier delays. The aim is to appoint a substantive IPFR Chair by the end of October 2023. Interim arrangements have been put in place to cover October; and
- Key meetings attended.

Members (1) Noted the report, (2) Noted the update on the recruitment of the Chair of the Independent Patient Funding Request (IPFR) Panel; (3) Noted the establishment of the WHSSC/EASC Vacancy Control Panel and (4) Approved the appointment of Chantal Patel as Vice Chair of the WHSSC Joint Committee.

5. Managing **Director's Report**

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

- Progress on South Wales Neonatal ODN - Funding for the South Wales Neonatal Transport Operational Delivery Network (ODN) was agreed at the 14 March 2023 Joint Committee meeting and funding has been released. However, the recruitment process has not yet taken place and therefore in line with our approach for other, as yet uncommitted investments, we have suspended implementation for this financial year. We will review the need and/or different options for delivering the scheme in 2024-2025. This scheme will now be considered within our process for prioritisation of all uncommitted expenditure and we have requested further information from Swansea Bay UHB (SBUHB), the provider Health Board (HB) to inform this evaluation,
- Fertility Update - WHSSC Policy development: - CP37 Pre-implantation Genetic Testing-Monogenic Disorders, Commissioning Policy - CP38, Specialist Fertility Services: Assisted Reproductive Medicine, Commissioning Policy - The WHSSC team met with Llais on 31 August 2023 to discuss the next steps regarding the policy development. WHSSC informed Llais that because of the uncertainty surrounding the budget impact of any policy changes, the current financial challenges for the NHS in Wales meant that policy development has been halted. Colleagues in Llais understood the financial challenge and the difficult choices faced by WHSSC and HBs. A further update meeting is planned for late September 2023; and
- South Wales Spinal Network (SWSN) - Following discussion at the NHS Wales Health Collaborative Executive Group (CEG), the

Cardiff and Vale UHB (CVUHB) and SBUHB Regional and Specialised Services Provider Planning Partnership (RSSPPP) set up a project to develop a new service model, to clarify the regional model for South East and South West Wales respectively, as well as the supra-regional model for South Wales, West Wales and South Powys. The project was launched in October 2020, with the aim of developing recommendations for delivering a safe, effective and sustainable model for spinal surgery in South and West Wales.

The final report was presented to the NHS Wales Health CEG on the 6 April 2021. The recommendation was accepted by the CEG, and the responsibility for commissioning the ODN was delegated to the Welsh Health Specialised Services Committee (WHSSC).

Members (1) Noted the report; and (2) Noted that the South Wales Spinal Network (SWSN) will go live on 25 September 2023.

6. Development of the Integrated Commissioning Plan (ICP) 2024/25

Members received a report offering assurance regarding the development of the 2024/2025 Integrated Commissioning Plan (ICP) and the approach to its development within wider NHS Wales situational context.

Members (1) Noted the report (2) Received assurance on the planning process to date which is in line with timeline received by the Joint Committee in May 2023; and (3) Noted the approach being taken to respond to the NHS Wales situational context, including an enhanced risk assessment.

7. South Wales Sexual Assault Referral Centres (SARC) Regional Model Implementation Briefing Paper

Members received a report providing an update on the implementation of the South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme following the Business Case approval in 2019, which proposed that the WHSSC Joint Committee fulfil the CEO reporting function at the request of the NHS Wales Chief Executives; and which requested that the Joint Committee give final approval for Phase 1 implementation of the Programme.

Members (1) Noted the report, (2) Approved the updated South Wales Sexual Assault Referral Centres (SARC) Regionalisation Programme model, prior to a report being issued to the seven HBs for final approval, (3) Considered and approved that the WHSSC Joint Committee will fulfil the CEO reporting function for the programme with immediate effect, prior to a report being issued to the seven HBs for final approval, (4) Recommended to HBs for approval of an in year funding uplift of £347k and a recurrent full year funding of up to £506k by 2025/26 for phase 1 of the implementation of the SARC Regionalisation Programme, prior to a report being issued to the seven HB's for final approval; and (5)

Recommended to HBs for approval of a continuation of funding for Phase 2 at the current level prior to a report being issued to the seven HBs for final approval.

A separate note will follow to HBs clarifying the financial arrangements for Phase 1.

8. Welsh Government National Commissioning Review Update
Members received a verbal update on progress with the Welsh Government national commissioning programme commissioned by the Minister for Health & Social Services.

Members noted that the National Commissioning Review Implementation Board meeting was taking place immediately after the WHSSC Joint Committee meeting.

Members noted the verbal update.

9. Single Commissioner for Secure Mental Health Service Project Initiation Document (PID)
Members received a report presenting the Project Initiation Document (PID) for the Single Commissioner Model for Secure Mental Health Services.

Members (1) Noted the report; and (2) Supported the recommendation to initiate the project to develop a Single Commissioner Model for Secure Mental Health Services.

10. Revision to Financial Delegated Limits
Members received a report requesting changes to the financial limits for Individual Patient Funding Request (IPFR) approvals.

Members (1) Noted the report, and (2) Approved the requested changes to the financial limits for Individual Patient Funding Request (IPFR) approvals.

11. WHSSC Model Standing Orders – Governance and Accountability Framework
Members received a report providing an update on the WHSSC Model Standing Orders and Governance and Accountability Framework.

Members (1) Noted the report, (2) Approved the proposed changes to the WHSSC Standing Orders (SOs), prior to being issued to the seven HB's for approval and inclusion as schedule 4.1 within their respective HB SOs, (3) Approved the proposed changes to the WHSSC Standing Financial Instructions (SFIs) prior to being issued to the seven HBs for approval and inclusion as schedule 4.1 Annex 2.1 within their respective HB SOs; and (4) Noted that there are no changes to the Memorandum of Agreement (MoA).

12. WHSSC Performance Report Month

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

Members noted the report.

13. Financial Performance Report – Month 4 2023-2024

Members received the financial performance report setting out the financial position for WHSSC for month 4 2023-2024. The financial position was reported against the 2023-2024 baselines following approval of the 2023-2026 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2023.

The year to date financial position reported at Month 4 for WHSSC was a forecast overspend of £2.164m against the ICP financial plan and a forecast year-end underspend of £4.202m.

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

14. South Wales Neonatal Transport Delivery Assurance Group Report (April 2023 - June 2023)

Members received a report providing a summary of the South Wales Neonatal Transport Delivery Assurance Group (DAG) quarterly report for 1 April 2023 – 30 June 2023.

Members (1) Noted the highlights of the Q1 Neonatal Transport DAG report, (2) Noted that the full report was being shared In-Committee due to potential patient identifiable data; and (3) Received assurance that the Neonatal Transport service delivery and outcomes were being scrutinised by the Delivery Assurance Group (DAG).

15. South Wales Trauma Network Delivery Assurance Group Report (Q1)

Members received a report providing a summary of the Quarter 1 2023/24 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members noted the full South Wales Major Trauma Network (SWTN) DAG Report and highlights contained in the cover report.

16. Specialised Paediatric Services Strategy – Implementation Board Highlight Report

Members received a report providing a progress update on the implementation of the Specialised Paediatric Services Strategy.

Members noted the report and the progress made.

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

Members noted the progress made by the All Wales Positron Emission Tomography (PET) Programme and its associate projects and workstreams.

18. 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.

19. 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); and
- Quality & Patient Safety Committee (QPSC);

20. Any Other Business

- Cheshire & Wirral Mother and Baby Unit (MBU) – Members noted that a contractor had been identified and a start on site was expected before Christmas. Recruitment to the posts was expected to start in April 2024 with view to new unit being operational by 1 October 2024; and
- WHSSC Annual Report – members noted that the WHSSC Annual Report would be circulated via email for approval and brought back to the November meeting for ratification.

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	Emergency Ambulance Services Committee
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	19 September 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link:
https://easc.nhs.wales/the-committee/meetings-and-papers/september-2023/
The minutes of the EASC meeting held on 18 July 2023 were approved.

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

Members noted that:

- 999 call volumes were approximately 12% lower than the same period last year although more patients were attending Emergency Departments
- 10.3% reduction in incidents in July 2023 compared to July 2022
- Hear and Treat rates were 2.3% (460 incidents) higher in July 2023 compared to July 2022
- Despite the issues above the volume of incidents (patients) transported to a Tier 1 site (Major ED) had increased, 20% higher in July 2023 compared to July 2022 and the delivery of red performance remained challenging and not where it needed to be
- In specific health board areas:
  - Swansea Bay (SBUHB), impacts included increasing pressures of handover delays for 4hour and 10hour delays now implementing the Continuous Flow Model to improve patient care
  - Hywel Dda (HDUHB), issue of the reinforced autoclaved aerated concrete (RAAC) on capacity and the impact on services for the population of West Wales.
  - Cwm Taf Morgannwg (CTMUHB), variation remained from site to site and day to day but overall improvements seen
  - Cardiff and Vale (CVUHB), continued to deliver excellent performance and were meeting their predicted trends as per the Integrated Commissioning Action Plan (ICAP)
  - Aneurin Bevan (ABUHB), remained to have variable performance but some signs of improvement seen
  - Betsi Cadwaladr (BCUHB), stabilisation underway although variation between hospital sites and ongoing learning.

The ICAP plans for SBUHB and HDUHB appeared to be focusing on the right areas but these remained challenging areas

Members noted:

- The mixed view in terms of the impact of handover delays which was leading to improvements to Amber patients. However, this would need to translate into impacting on improving red performance.
- Ongoing work with WAST (by the EASC Team) to plan the trajectory of improvements required which would be shared with Members (Action Log) and Welsh Government officials; the ICAP process would monitor the impact
- Need to better understand utilisation and what a good level would be for all resources to be at the right level
- Amber, median, 65th, 95th and the longest Amber waits remained lower than 2022
- Ambulance handover times were stabilizing on a number of metrics, including total lost hours, % handed over in 15 min and handovers over 4 hours.

Members raised and noted:

- Their support for the approach in relation to the current position and the level of red response performance which was very concerning and remained at a deteriorating position despite local efforts
- That the unseasonal weather had also impacted adversely on the performance
- That actions had been agreed in the ICAPs but the resulting improvement was not always being seen in terms of impacting positively on handover delays
- In some areas, the tolerance remained that 4hour waits were acceptable as a large number of patients were breaching the 4hour target on a daily basis.
- The variability of the WAST ambulance unit hour production (UHP)
- The impact of 'overtime bans' (which were outside of the those identified within the Integrated Medium-Term Plan)
- The importance of getting back to the basics of delivering a responsive ambulance service and the ultimate aim to return to no handovers over 15 mins in line with the statutory targets.

In response, Jason Killens explained that an overtime ban was not in place, although the WAST financial plan had aimed to target areas to control spend. Additional resources had been provided to aid WAST management in a difficult and unanticipated period of demand.

Members noted:

- A deliberate choice had been made to develop the Cymru High Acuity Response Units (CHARU) and this had led to a marginally better performance. The quality of services received by patients had improved including an improvement in the rates of return of spontaneous circulation (ROSC) used as one indicator of patient outcomes
- The current WAST planning model for resources and geographical location was based on up to 6,000 lost hours; the current rate at 18,000+ was impacting adversely on ambulance performance
- Returning to a more traditional (dual crewed ambulance) would not improve performance and it would be more costly and would not be efficient or effective for patients
- WAST answering around 100 calls every day of red calls (which was a small number) and reiterated the need to focus attention on a relatively small number of calls.

- That the impact of the CHARU service had not led to improving performance and it was asked whether this had been the right action for the service. However, although the performance percentages had not increased the quality of the service had improved for patients.

Members welcomed the additional work to target frequent callers and asked how the additional 100WTE staff funding had translated into improvements in health board areas and its impact. Further information was requested about capacity and constraints for the next provider report (Action Log).

Members noted:

- The difficulties in recruiting staff in areas across Wales
- Potential issue looming if no improvements in handover delays and the likelihood of difficult conversations where change was not seen
- Improvements expected in performance in line with reducing handover delays
- Increased sickness levels at WAST in August and not yet clear if this was a blip or recurring trend
- Ongoing work in providing different crews to attend incidents where different needs identified (not one size fits all)
- Improvement event planned with WAST in October and further work to do in supporting non-conveyance and alternatives to conveyance to EDs
- The need to have the alternate blended approaches and help to manage variation and note the risk management approach by WAST
- The importance of maintaining the ICAP process and holding each other to account; and the cross-reference to the national work such as the Six Goals for Urgent and Emergency Care Programme.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received.

In presenting the report, Stephen Harrhy highlighted the presentation of the revised quality report in light of the requirements of the Duty of Candour and Duty of Quality.

Noted:

- The importance of the quality of services being paramount
- National Reportable Incidents (NRIs) key themes continued to be community response and calls categorisation
- Coroner requests have remained higher than pre pandemic levels; was 244 then and 450 in the last year; growing concerns for patient care
- High numbers of patients receiving ‘no send’ although not as high as previously but had remained at around 900
- 195 people presented at Emergency Departments who were categorised at Category 1 – immediately life threatening which was concerning; could have benefited from earlier treatment interventions by skilled well trained WAST staff
- Actions to be taken in relation to the Ambulance Service Indicators (ASIs) and work underway to review in line with the Duty of Quality and therefore provide evidence how compliance is assured through the commissioning lens
- Importance of patient story for the next meeting.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received.

- EASC Commissioning Frameworks - in line with the Commissioning Cycle and the discussion at the previous meeting work had commenced to review the Non-Emergency Patient Transport Service (NEPTS) Commissioning Framework, this included the development of a long-term strategy for the service. Further updates would be provided at future meetings.
- An update on Integrated Commissioning Action Plans (ICAP)
  - the on-going commitment from health boards and WAST to the process
  - an outline of the work undertaken by health boards was provided in an appendix which included the impact of the ongoing work
  - further work plans included the validation of data relating to immediate release requests and the further development of remote clinical triage and signposting opportunities.
- EASC Integrated Medium Term Plan (IMTP) – Formal approval by Welsh Government was awaited. Members noted the IMTP Tracker which reflected the progress made against the agreed performance ambitions. The IMTP Tracker would be updated monthly and updates would be provided at future meetings.
- EASC Commissioning Intentions 2023-24 – Members noted that the Quarter 2 update would be presented the EASC Management Group in October.

Members noted that WAST had not committed to achieving the ambition set within the EASC IMTP that sickness levels should be maintained below 5.5% (WASTs internal target was noted at 6% at the end of the year). It was also noted that the trajectories within the IMTP were multi-factorial, some actions for WAST, some for health boards and some joint actions across WAST and health boards.

The CASC also suggested that the approach towards developing the legacy statement for the IMTP would continue as in previous years despite the work to create a new Joint Committee for national commissioning. The plan going forward would be clear for WAST and would dovetail into the new arrangements.

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

The update report on the EMRTS Service Review was received. Lee Leyshon presented the report and gave an overview of work to date in the phased approach.

Noted:

- Previous information shared at the 'Focus on' session
- In 2nd Phase and seeking public and stakeholder comments on the work started afresh following the EASC decision on 8 November 2022
- The approach adopted was previously outlined at EASC
- Emerging themes identified in Phase 1
- External supplier stakeholder and representative sample feedback
- Remit of the external supplier and highlighted key areas received
- Note that the work of the CASC and External Supplier (Picker Institute) was independent of each other to capture as much public feedback as possible

- Themes identified to date to be part of the core engagement materials for Phase 2
- Data modelling planned in addition to the issues raised in Phase 1 and detail for the approach taken.
- Phase 1 listened to comments and Phase 2 would present the independent review but would also continue to listen to stakeholders and the public in order to arrive at a recommendation for presentation to EASC
- Phase 2 in person / face to face meetings taking place between 12 Oct to 20 Oct and the timetable developed
- Window to respond for the public allowing 4 weeks until 5 November 2023
- Focused listening opportunity for the Commissioner – based on the learning from Phase 1
- Plan to arrive at a recommendation and potentially a preferred option by the Chief Ambulance Services Commissioner to present to EASC
- Concerns remain highest for the members of the public who live closest to the affected bases.

Members thanked the CASC and the EASC Team for the work undertaken to date and noted:

- the 4week public engagement window – 9 October to 5 November 2023 (subsequently increased to 12 November)
- Llais and the interface to check that they are content with the continuing approach
- The rapid opportunity to work through the modelling work and early heads up for HBs to be alongside for any events and be fully apprised of the work to date.

Members also noted

- A meeting took place with Llais in July which generally accepted the extent and the nature of Phase 1. The initial advice from the then Community Health Councils had been to undertake formal engagement for 6-8 weeks followed by a break and then a further 2 weeks and this timescale had been extended based on the public response and the need for sufficient time to consider the complex work involved.
- Ongoing dialogue across NHS Wales and with key stakeholders
- Information would be shared with Members before it was made public
- At the time, some areas of modelling were still outstanding.

The CASC thanked Members and welcomed that all HBs were supportive of the approach taken to date but particularly of Powys and BCU health boards.

The Chair explained that he had deliberately not engaged in the process to maintain an impartial approach for the Joint Committee. The important matter for the work was to provide an improved EMRTS service across Wales utilising the highly specialist critical care service.

WELSH AMBULANCE SERVICES NHS TRUST REPORTS

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received. In presenting the report, Jason Killens highlighted:

- the work undertaken by WAST to maximise opportunities to improve response to red calls

- Sickness trajectory had been on a downward trend except for August which was being analysed further to identify key reasons
- As part of the Demand and Capacity work and the Roster Review utilising the Cymru High Acuity Resource Units (CHARUs) to improve outcomes, Members noted that WAST was starting to see a month on month improvement particularly in the return of spontaneous circulation (ROSC) as an important outcome measure for patients and last month was the highest ever recorded. Initially only half of the CHARU was 'funded' but WAST had assessed the available resources to get the best response, mindful of the quality and performance issues. Members noted that this was an overall improvement in quality outcomes for patients
- The revised overtime profile and the capacity for the coming winter
- Although not contained within the report, as provider of the 111 service Members noted the ongoing work with the 'new' software provider SALUS and that the contract would soon be terminated by the Programme. Jason Killens raised the question of who would own the re-procurement required for the new call handling system and this would be raised at a future meeting as this was time sensitive (Action Log).

Members noted (in relation to 111)
- the impact on 999 call handling (or call taking) and the need for EASC to be aware
- Resilience would be an issue, although WAST did not feel this would be a significant matter in the first instance
- The opportunity emerging to bring 111 and 999 together particularly in the clinical advice area
- The importance of agreeing the approach and where the 111 work would be best dealt with until the new Joint Committee was in operation
- The importance of the provider procuring the right software to support service delivery
- WAST would want to procure the right software/system as part of the provision of the service but this had not yet been finalised by the programme.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received. In presenting the report, Stephen Harrhy highlighted key areas which included:
- Meetings with Welsh Ambulance Services NHS Trust (WAST)
- Meeting with Health Boards
- Review of remote clinical support
- Six Goals for Urgent and Emergency Care Programme
- Connected Support Cymru (previously known as Night Sitting Service)
- Transfer, Discharge and Repatriations
- Review of National Commissioning
- Data linking.

Members noted:
- The report by Healthcare Inspectorate Wales (HIW) on system flow and the impact on WAST and on the EASC Team who would be leading the work to respond
- The continuous flow model and the ongoing work with three health boards to implement; Aneurin Bevan, Betsi Cadwaladr and Swansea Bay University Health Boards

- That the Escalation Policy had been approved by the NHS Leadership Board a while ago and it would need to be updated to get the right balance for the ask between urgent and emergency care, cancer and scheduled care
- New normal to be described to update to the current position
- The link to Goal 5 in the Six Goals for Urgent and Emergency Care Programme and bring together
- Visits to health boards undertaken with a focus on local matters and performance within a more bespoke session
- Regular meetings with WAST; the Review of the Clinical Support Desk which would be presented at a future meeting (Action Log)
- The Six Goals for Urgent and Emergency Care Programme in particular Goal 4 – work with ED colleagues and out of ED; 'what does a good ED look like?' and frailty at the front door
- In relation to Connected Support Cymru, how to better use IT and remote IT; noted that some patients presented when the service they needed was not available and the work on how to support the patient until the service they needed was available; an evaluation report had just been finalised and would be circulated to Members (Action Log)
- Transfer, discharge and repatriation – a holding response had been sent to the Deputy Chief Medical Officer (DCMO) and work was continuing by the EASC Team to plan how to progress and identify the potential resource implementation
- Data linking; consultant paramedic would be identifying better links to the data within the Emergency Communication Nurse System (ECNS) and an update would be provided
- Fire Service – potential for fire services to respond to some red calls and act as the first responder, analysis undertaken (to be shared – Action Log) utilisation of fire services at 15% could link to work with volunteers. Fire Service staff are already trained and have access to defibrillators which could improve red response by 5% (approx.) this could have a big impact in rural areas and could also support non-injury falls.

Members highlighted

- Opportunities within the report;
- Additional information and create an eco-structure of out of hospital services and build a system from the start to cross cover and increase system resilience
- Describing inverting the triangle and what could be done within commissioning intentions
- Opportunity to discuss further what the WAST offer could be in terms of rapid response, remote clinical assessment and 24/7 urgent response to help keep patients at home – consider for a 'focus on' session (Action Log).

EASC FINANCIAL PERFORMANCE REPORT MONTH 4 2023/24

The EASC Financial Performance Report at month 4 in 2023/24 was received. James Leaves presented the report and Members noted no variances within the plan. Discussion had taken place earlier in the meeting in relation to the 100wte staff. All additional funding was being utilised to support the additional overtime costs.

SUMMARY OF THE EASC MANAGEMENT GROUP MEETING HELD IN AUGUST 2023

The meeting had been cancelled due to the number of apologies and the meeting would not have been quorate.

EASC SUB-GROUPS CONFIRMED MINUTES

Approved:

- Non-Emergency Patient Transport Services Delivery Assurance Group notes 1 June 2023

EASC GOVERNANCE

The report on EASC Governance was received which included the:

- EASC Risk Register
- EASC Assurance Framework
- EASC Key Organisational Contacts
- Welsh Language Commissioner – Final Report and Decision Notice
- Letter to host in relation to the statutory Duty of Quality and Candour.

Noted that:

- The Risk Register had five red risks in total, three scoring the highest level at 25.
- The EASC Assurance Framework had been updated in line with the changes above to the risk register, the framework utilised the host body's risk management approach and assurance framework.
- The updated Model Standing Orders were received, Members noted the changes in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020 which included working with 'Llais Cymru', previously known as Community Health Councils. Once approved the Standing Orders would form part of the schedule for Health Boards.
- Work remained ongoing in relation to the investigation by the Welsh Language Commissioner, supported by the host Cwm Taf University Health Board. The work involved changes to the website software and involved Digital Health and Care Wales. Further updates would be provided at future meetings
- The latest EASC Key Organisational Contacts report was presented and Members asked to review their organisational representatives at EASC and its sub groups
- There were no governance concerns to raise in relation to the Annual Reports prepared by the Emergency Medical Retrieval and Transfer Service (EMRTS) Delivery Assurance Group or the Non-Emergency Patient Transport Services (NEPTS) Delivery Assurance Group.
- The short summary (for assurance) of the latest Audit and Risk Committee meeting which took place on 16 August 2023

FORWARD LOOK AND ANNUAL BUSINESS PLAN

The Forward Look and Annual Business Plan was received and approved.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance

• Handover delays (and the development of handover improvement plans in HBs with trajectories) and the impact on services provided to HB local communities and to WAST • The ongoing formal engagement process for the EMRTS Service Review, the closure of Phase 2 and the potential recommendation to the December meeting of EASC.
Matters requiring Board level consideration
• To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours – especially in relation to the quality of services patients receive
Forward Work Programme and Annual Business Plan
Considered and agreed by the Committee.

Committee minutes submitted	Yes		No	✓
Date of next meeting	21 November 2023			

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Service Partnership Committee
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	21 September 2023

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Matters Arising

- *Duty of Quality Update* – The Medical Director gave a verbal update on progress with the implementation of the Duty of Quality. Good progress has been made but challenges remain in making the Duty fit to non-patient facing services and we are meeting shortly with both DHCW and HEIW to share thoughts on how best to approach this. Reference was also made to two major projects (Laundry and TrAMS) that have quality improvements at their core but being unable to make significant progress due to lack of capital.
- *Recruitment Modernisation Update* – A presentation was given by the Deputy Director of Employment Services and the Head of Recruitment on progress in addressing recruitment challenges across NHS Wales. Measures have been implemented that have significantly streamlined the process and members commented favourably on the reduction in the time taken to successfully recruit new members of staff.

Chair's Report

The Chair noted attendance at recent meetings with the Minister largely focused on the financial situation across NHS Wales.

The Committee NOTED the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The establishment of a Value and Sustainability Group within NWSSP to drive an organisation wide approach to strengthen cross divisional working, to co-ordinate and deliver actions to demonstrate value for money as well

as continue to innovate and improve quality and consistency for NHS Wales. The Value and Sustainability Group mirrors the national approach and will closely monitor progress in achieving planned savings.

- The negotiations with the landlord on the Mamhilad site for provision of alternative accommodation for the Patient Medical Record service are nearing completion following the discovery of significant Reinforced Autoclaved Aerated Concrete issues in Brecon House. The costs of moving are however substantial with the need to shift 140,000 boxes of records and we are working on how to undertake this in the most cost-effective way.
- The move from the Regional Office in Companies House to Cathays Park has paused as a number of issues have recently arisen in respect of Cathays Park which have caused us to investigate what other options may be available.

The Committee NOTED the update.

Items for Approval

Energy April 26 V30 Basket Strategy - The Welsh Energy Group have considered NHS Wales' participation in a longer-term basket strategy for an initial 12-month supply period commencing 1st April 2026. The paper outlined the recommended approach for NHS Wales to confirm participation in the Long-Term Variable (V30) basket strategy for supply of energy for the period. The Committee APPROVED participation in the April26 V30 basket strategy.

Laundry Reconfiguration - The paper presented the option of reducing the Laundry Production Units currently utilised in the All-Wales Laundry service from five to four units through the decommissioning of the West Wales unit in Carmarthen and the formation of a storage and distribution hub. The Committee APPROVED the proposed decommissioning of the Carmarthen Laundry Production Unit, the creation of a Southwest distribution hub and the subsequent redistribution of volumes across South West and South East Wales.

Changes to the Welsh Risk Pool Risk Sharing Agreement – these had been discussed and agreed at the Welsh Risk Pool Committee on the previous day. The paper set out the Risk Share charges for 2023/24 arising from excess expenditure above the Welsh Government annual allocation for Clinical Negligence and Personal Injury claims. Following the receipt of the 2022/23 annual accounts, the proportions have been reassessed for 2023/24 based on agreed criteria and this has led to some organisations being asked to contribute more, while others will see a reduction in their contributions. The Committee APPROVED the updated Risk Share charges to NHS Wales for 2023/24.

Items for Noting

Transforming Access to Medicine (TrAMS)

The original plans for TrAMS have been significantly curtailed by the restrictions on available capital. Accommodation for the service within Southeast Wales is being urgently sought and there are a number of possible options. The existing

Pharmacy Service Technical Units are reaching end-of-life and the need to source alternative accommodation as soon as possible was stressed by a number of members.

The Committee NOTED the verbal update.

Finance, Performance, People, Programme and Governance Updates

Finance – The Month 5 financial position is a year-to-date overachievement of non-recurring savings of £0.999m. We continue to forecast a break-even financial position for 2023/24 dependent upon a number of income assumptions relating to pay award funding, energy costs for laundries, continued demand and the costs to support increased transactional activity, IP5 running costs and transitional funding for TRAMS. We are anticipating an element of savings achieved to date will be required to support the transitional and removal costs relating to the transfer of significant volumes of medical records to new premises. Our additional savings submission to Welsh Government on 11th August identified we can make a £1.6m distribution this financial year, in addition to identifying NWSSP supported initiatives that will result in cash releasing savings direct to NHS Wales Organisations and Welsh Government. Following the decision to transfer our utility supplies to the CCS Framework, this gave rise to the opportunity to sell back some small quantities of energy that we had secured the right to forward purchase at lower than current market rates for 2024/25 and 2025/26. The Wales Energy Group (which comprises each Director of Finance or their designated representative) agreed that these tranches of energy will be sold back to British Gas with a net £2.520m one-off windfall gain to NHS Wales to be accounted for in the 2023/24 financial year.

People & OD Update – Sickness absence remains low and statutory and mandatory performance is good. PADR rates are below target and the position has slightly worsened over recent months.

Performance – The in-month July performance was generally good with 37 KPIs achieving the target against the total of 41 KPIs. However, 4 KPIs did not achieve target and are considered Red/Amber. Two of these relate to Recruitment, one to customer satisfaction with the Digital Workforce Team, and one relating to Procurement Savings.

Project Management Office Update – Three projects are currently rated as red, these are the Brecon House relocation where there are issues with the current building being unsafe and the cost of relocation of records, Primary Care Contract reform, and the TrAMS project and particularly the affordability of the proposed solution as part of the wider capital programme.

Corporate Risk Register – There are currently eight red risks on the Corporate Risk Register. These cover energy costs, staffing shortages, the Legal & Risk Case Management System, Brecon House, TrAMs, the impact on the Single Lead Employer Team of proposed Junior Doctors Industrial action, the limitations

imposed by the overall financial climate and the reputational issues for NWSSP relating to the situation at BCUHB. The Committee NOTED the above Reports.	
Papers for Information	
The following items were provided for information only: • Welsh Infected Blood Support Service Annual Report 2022/23; • PPE Stock Report; • Audit Committee Assurance Report; and • Finance Monitoring Returns (Months 4 and 5).	
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	Thursday 23rd November 2023 10am – 12pm

TRUST BOARD

TRUST SEAL REPORT: 4TH OCTOBER – 22ND NOVEMBER 2023

DATE OF MEETING	30/11/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal request (**period 4th October to 22nd November 2023**).

1.2 Board members are asked to view the contents of the report. Further information or queries should be directed to the Director of Corporate Governance and Chief of Staff.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis: Please refer to the Seal Register at **Appendix 1**.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the contents of the Trust Board Seal Register included in Appendix 1.

Appendix 1 – Seal Register

Date	Document Details	Signed
4th October 2023	Lease relating to Part 3rd Floor of the property known as Matrix Business Park, between (1) Velindre University NHS Trust and (2) Toast (Mail Order Ltd).	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
4th October 2023	Deed of Collateral Warranty of Architect and Lead Designer in respect of the nVCC, between (1) White Arkitekter AB and (2) Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
24th October 2023	Deed of Variation between (1) Cardiff and Vale University Health Board and (2) Velindre University NHS Trust re Land at Whitchurch Hospital, Whitchurch, Cardiff.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
7th November 2023	Counterpart Lease relating to Unit 2, Charnwood Court, Heol Billingsley, Parc Nantgarw, Cardiff, CF15 7QZ, between (1) Treforest Trustee (Jersey) Ltd and Treforest Nominee (Jersey) Ltd as Trustees of the Treforest Unit Trust and (2) Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO