Public Trust Board

Tue 31 January 2023, 10:00 - 13:15

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Agenda

10:00 - 10:10
10 min

1. STANDARD BUSINESS

Led by Prof Donna Mead OBE, Chair

1.1. Apologies

Led by Prof Donna Mead OBE, Chair

1.2. In Attendance

Led by Prof Donna Mead OBE, Chair

1.3. Declarations of Interest

Led by Prof Donna Mead OBE, Chair

1.4. Action Log

Led by Prof Donna Mead OBE, Chair

1.4 ACTION LOG V3.pdf (2 pages)

1.4.1. Matters Arising

Led by Prof Donna Mead OBE, Chair

10:10 - 10:20
10 min

2. CONSENT ITEMS

2.1. FOR APPROVAL

2.1.1. Minutes of the Public Trust Board meeting held on 24.11.2022

Led by Prof Donna Mead OBE, Chair

2.1.1 Draft Minutes Public TB 24.11.2022ES-LF-DM final without track changes.pdf (10 pages)

2.1.2. Chair's Urgent Actions Report

Led by Prof Donna Mead OBE, Chair

2.1.2 Chairs Urgent Action Report_January 2023.pdf (3 pages)

2.1.3. Commitment of Expenditure Exceeding Chief Executive's Limit

Led by Matthew Bunce, Executive Director of Finance

2.1.3 January 2023 Trust Board_Commitment of Expenditure Cover Paper.pdf (4 pages)
2.1.3a Appendix 1- Value Based Healthcare Clinical - Commitment of Expenditure.pdf (7 pages)
2.1.3b Appendix 2 - Value Based Healthcare Analytics - Commitment of Expenditure .pdf (8 pages)
2.1.3c Appendix 3 - Investment Strategy to support Research Hub final v1.pdf (8 pages)
2.1.3d Appendix 4 - Fire Compartmentation Commitment of Expenditure - Trust Board 31.01.23(2).pdf (27 pages)

2.1.4. Amendment to Standing Orders – Schedule 3

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

- 2.1.4a Amendment to Standing Orders_Schedule 3.pdf (4 pages)
- 2.1.4b Amendment to Standing Orders Appendix 1_without track changes.pdf (12 pages)
- 2.1.4c Amendment to Standing Orders Appendix 2 - with track changes.pdf (13 pages)

2.1.5. Trust Wide Policies

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

- 2.1.5 TRUST WIDE POLICIES UPDATE v2.pdf (3 pages)
- 2.1.5a Management of Safety Alerts and Important Notifications Policy.pdf (7 pages)

2.2. FOR NOTING

2.2.1. Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report dated 17.11.2022

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

- 2.2.1 Highlight Report - PUBLIC TCS 17.11.2022.pdf (4 pages)

2.2.2. Strategic Development Committee Highlight Report dated 08.12.2022

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

- 2.2.2 Highlight Report - PUBLIC SDC 08.12.22-LF-SH.pdf (4 pages)

2.2.3. Quality, Safety & Performance Committee Highlight Report dated 17.01.2023

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

- 2.2.3 Public Quality Safety Performance Committee Highlight Report 17.01.23 (v4 approved).pdf (7 pages)

2.2.4. Audit Committee Highlight Report dated 12.01.2023

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

TO FOLLOW

2.2.5. Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing (10.01.2022 and 17.01.2022)

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

- 2.2.5 WHSCC Joint Committee Briefing (Public) 10 January 2023.pdf (3 pages)
- 2.2.5 WHSCC Joint Committee Briefing (Public) 17 January 2023.pdf (5 pages)

2.2.6. Emergency Ambulance Services Joint Committee (EASC) Briefing (08.11.2022 and 06.12.2022)

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

- 2.2.6 Confirmed minutes EASC 8 Nov 2022 final_EASC_6Dec2022.pdf (16 pages)
- 2.2.6 Chair's EASC Summary from 6 December 2022 final.pdf (6 pages)

10:20 - 10:40
20 min

3. KEY REPORTS

3.1. Chair's Update

Led by Prof Donna Mead OBE, Chair

- 3.1 Chair Update Jan 2023 - Final.pdf (6 pages)

3.2. Chief Executive's Update

Led by Steve Ham, Chief Executive

- 3.2 Chief Exec Jan 2023 -Final.pdf (5 pages)

10:40 - 11:40
60 min

4. QUALITY, SAFETY AND PERFORMANCE

4.1. Delivering Excellence Performance Report

Led by Cath O'Brien, Chief Operating Officer

- 4.1.0 VUNHST NOVEMBER PERFORMANCE COVER PAPER FOR JANUARY Board v1.pdf (9 pages)
- 4.1.0a VCC Performance Report - Nov 2022.pdf (20 pages)
- 4.1.0b Nov2022 WBS PMF ReportFINAL (003).pdf (10 pages)
- 4.1.0c Trust-wide WOD Performance Report - Nov 2022.pdf (13 pages)

4.2. Financial Report Period (November 2022)

Led by Matthew Bunce, Executive Director of Finance

- 4.2.0 Month 8 Finance Report Cover Paper - TRUST BOARD 31.01.2023.pdf (6 pages)
- 4.2.0a M8 VELINDRE NHS TRUST FINANCIAL POSITION TO NOVEMBER 2022 - TRUST BOARD 31.01.2023.pdf (22 pages)
- 4.2.0b Appendix 1 - TCS Programme Board Finance Report (November 2022) - Main Report.pdf (14 pages)

4.3. VUNHST Risk Register and Risk Appetite for Approval

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

- 4.3 TRUST BOARD - Trust Risk Register Paper -31.01.20223 - vfinal.pdf (18 pages)
- 4.3a Copy of Appendix 1 - RISK-TB- 31.01.2023 - REPORT DATA - Final.pdf (6 pages)

4.4. TRUST ASSURANCE FRAMEWORK

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

- 4.4 TAF Review Paper - JAN 23 - Trust Board-Final.pdf (7 pages)
- 4.4.a V27 - TAF DASHBOARD - 31.01.2023 (2).pdf (35 pages)

11:40 - 11:50
10 min

5. BREAK

11:50 - 12:00
10 min

6. LEGAL MATTERS

6.1. Infected Blood Inquiry

Led by Cath O'Brien MBE, Chief Operating Officer

- 6.1.0 IBI _Trust Board Update_Jan 2023.pdf (4 pages)
- 6.1.0a 2022 12 16 WBS Submission Final.pdf (2 pages)

12:00 - 12:45
45 min

7. ANNUAL REPORTS

Led by Prof Donna Mead OBE, Chair

7.1. Annual Equality, Diversity & Inclusion Report 2021-22

Led by Sarah Morley, Executive Director of Organisational Development & Workforce

7.1.0 Trust Board Annual Equality Report 2022 31.1.23.pdf (16 pages)

7.2. Gender Pay Gap Report 2022

Led by Sarah Morley, Executive Director of Organisational Development & Workforce

7.2.0 Trust Board Gender Pay Gap 2022 31.1.23.pdf (6 pages)
7.2.0a Gender Pay Gap Report 2022.pdf (11 pages)

7.3. Executive Equality Ambassador Presentation - Gender (Sex)

Led by Cath O'Brien MBE, Chief Operating Officer

7.3.0 Executive Equality Ambassador Presentation - Gender (Sex).pdf (15 pages)

7.4. Sustainability Report 2021-22 (including Decarbonisation)

Led by Carl James, Director of Strategic Transformation, Planning and Digital

7.4.0 ANNUAL SUSTAINABILITY REPORT COVER PAPER_.pdf (3 pages)
7.4.0a SUSTAINABILITY ANNUAL REPORT 2021-2022.pdf (23 pages)

12:45 - 12:45
0 min

8. ANY OTHER BUSINESS

Led by Prof Donna Mead OBE, Chair

12:45 - 12:45
0 min

9. DATE OF NEXT MEETING

Led by Prof Donna Mead OBE, Chair

30th March 2022

12:45 - 13:15
30 min

10. LUNCH

VELINDRE UNIVERSITY NHS TRUST

PUBLIC TRUST BOARD MEETING 24 NOVEMBER 2022
ACTION LOG

ACTIONS ARISING FROM 27/01/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
7.2.0	**Cardiff Cancer Research Hub, Proposal for a Tripartite partnership between Cardiff and Vale UHB, Cardiff University and Velindre University NHS Trust** The next phase of development to include agreement to key principles that will go on to establish a formal Heads of Terms for the model going forwards.	Executive Medical Director	**January 2023**	The Heads of Terms (HoT) document is nearing completion and an update is scheduled to be presented at Executive Management Board on 6 February together with progress in relation to the Hub branding. Legal review of the HoT is planned. HoT are not legally binding but are a precursor to an appropriate future legally binding agreement.	**OPEN**
ACTIONS ARISING FROM 26/05/2022					
5.1.0	**Trust Enabling Strategies for Approval** The case studies that are to be included in the Trust Enabling Strategies will be circulated to the Board when finalised.	Director of Strategic Transformation, Planning and Digital	**End December 2022**	Documents will be presented to the Board on 30th March 2023.	**CLOSED**

ACTIONS ARISING FROM 24/11/2022					
No.	**Action**	**Owner**	**Target Date**	**Progress to date**	**Status (Open / Closed)**
5.1.0	An update on Brachytherapy to be presented to the Board at the January 2023 Board	Chief Operating Officer	**31/01/2023**	The Brachytherapy update is included in the cover paper of the Performance Report included in the January 2023 Trust Board meeting papers.	**CLOSED**
5.6.0	The wording in the paragraph at the end of page 3 to be amended to correctly reflect status of training during the time period.	Executive Director of Nursing, AHPs and Health Science	**31/01/2023**	The paragraph was amended to reflect the following: There have been no incidents or complaints affecting care linked to staffing levels for the reporting period. PADR compliance overall was good achieving 100% in some areas. There was a plan to undertake all outstanding PADR's where 100% was not achieved. Training compliance good overall. Discussions were held around achieving top of license working and the implementation of Band 4 Associate Practitioners based on NHS Wales agreed standards.	**CLOSED**
7.1.0	The risk in relation to Brachytherapy is currently green however, due to new issues a review and update of the risk to be done.	Chief Operating Officer	**31/01/2023**	The review of this risk is being undertaken as part of the regular risk review cycle and, as such, is currently working through the approval process.	**OPEN**

MINUTES PUBLIC TRUST BOARD MEETING – PART A
VELINDRE UNIVERSITY NHS TRUST LIVE STREAMED
24 NOVEMBER 2022 at 10:00AM

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

1.0.0	STANDARD BUSINESS	ACTION LEAD
	The Chair opened the meeting and welcomed everyone in attendance.	
1.1.0	**Apologies noted:** • Steve Ham, Chief Executive • Martin Veale, Independent Member It was noted that Nicola Williams, Executive Director of Nursing, AHPs and Health Science would need to leave the meeting at 13:00.	
1.2.0	**In Attendance** Regular Attendees: • Katrina Febry, Audit Wales Lead • Stephen Allen, Chief Officer, Community Health Council (CHC) • Krisztina Kozlovszky standing in for Emma Rees, Head of Internal Audit, • David Cogan, Patient Liaison Representative Guest attendees joining the meeting for item 8.1.0: • David Mason-Hawes, Head of Digital Delivery, Delivery Services • Jon Norman, Portfolio Project Manager • Felicity May, Clinical Specialist Histocompatibility & Immunogenetics	

1.3.0	**Declarations of Interest** There were no declarations of interest to **NOTE**.	
1.4.0	**ACTION LOG** Board members confirmed there was sufficient information contained in the log to provide assurance that the action identified as completed could be **CLOSED** and **NOTED** the update provided. The Action Log was **APPROVED**.	
1.4.1	**Matters Arising** There were no matters arising.	
2.0.0	**CONSENT ITEMS**	
2.1.0	**For Approval**	
2.1.1	**Minutes from the Public Trust Board meeting held on 29.09.2022** The Trust Board **APPROVED** the Minutes of the meeting held on **29.09.2022** as an accurate and true record.	
2.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chairs urgent action taken between the 29/09/2022 – 15/11/2022 as outlined in Appendix 1 of the report.	
2.1.3	**Commitment of Expenditure Exceeding Chief Executive's Limit** The Trust Board **AUTHORISED** the Chief Executive to **APPROVE** the award of contracts summarised within the paper and supporting appendices and **AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.	
2.1.4	**Trust Wide Policies** The Trust Board **NOTED** the policies that have been approved since the September 2022 Trust Board.	
2.2.0	**For Noting**	
2.2.1	**Transforming Cancer Services Communication and Engagement Update** The Trust Board **NOTED** the contents of the Transforming Cancer Services (TCS) Communication and Engagement update report.	
2.2.2	**Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report – 22.09.2022 and 18.10.2022** The Trust Board **NOTED** the contents of the TCS Programme Scrutiny Sub Committee Highlight Reports dated 22 September 2022 and 18 October 2022.	
2.2.3	**Strategic Development Committee Highlight Report 13.10.2022** The Trust Board **NOTED** the contents of the Strategic Development Committee Highlight Report held on 13 October 2022.	

2.2.4	**Quality, Safety & Performance Committee Highlight Report 10.11.2022** The Trust Board **NOTED** the key deliberations and highlights from the meeting of the Quality, Safety and Performance Committee held on the 10th November 2022.	
2.2.5	**Audit Committee Highlight Report 04.10.2022** The Trust Board **NOTED** the contents of the Audit Committee Highlight Report held on 4 October 2022.	
2.2.6	**Remuneration Committee Highlight Reports 22.09.2022 & 25.10.2022** The Trust Board **NOTED** the contents of the Remuneration Committee Highlight Reports dated 22 September 2022 and 25 October 2022 and actions being undertaken.	
2.2.7	**Welsh Health Specialised Services Committee (WHSSC) Joint Committee Briefing 08.11.2022** The Trust Board **NOTED** the contents of the WHSSC Joint Committee Public Briefing.	
2.2.8	**NHS Wales Shared Services Partnership Assurance Report 22.09.2022** The Trust Board **NOTED** the work of the NHS Wales Shared Services Partnership Committee Assurance Report.	
2.2.9	**COVID 19 Inquiry Preparation Group Highlight Report** The Trust Board **NOTED** the key deliberations and highlights from the meeting of the COVID 19 Prep Inquiry Group meeting held on 21 October 2022.	
3.0.0	**KEY REPORTS**	
3.1.0	**Chair's Update** The Trust Board **NOTED** the content of the update Report.	
3.2.0	**Chief Executive's Update** The Trust Board **NOTED** the content of the update Report.	
4.0.0	**ANNUAL REPORT**	
4.1.0	**Wales Infected Blood Support Scheme (WIBSS)** Lauren Fear presented the Wales Infected Blood Support Scheme (WIBSS) Annual Report highlighting the following: • The cover paper sets out the background to the WIBBS. • The governance group monitors the operational management of WIBSS and provides governance for WIBBS with representation from the Trust, NHS Wales Shared Services Partnership (NWSSP) and Government colleagues. • A point of significance noted to the Board relates to compensation which is an agreement from UK Government. The agreement indicates that while the inquiry is concluding, each of the four nations would ensure distribution of payments via the existing support schemes. A collaborative effort between NWSSP and the Trust ensured that payments were made promptly. Additional comments: • In terms of communication, it was noted that a quarterly newsletter is circulated to beneficiaries and the Annual Report published on the Trust Website.	

	• In addition to distribution of funding, support is also provided to beneficiaries in Wales. Trust Board **APPROVED** the Annual Report.	
5.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
5.1.0	**Delivering Excellence Performance Report** Cath O'Brien highlighted key points for the Velindre Cancer Service (VCS) and the Welsh Blood Services (WBS) September 2022 Performance Report. **Velindre Cancer Service** • Continual improvement of services pertaining to timescales have been maintained. • As a result of configuration changes to the Linear Accelerator (LINAC), treatment for breast referrals can be provided. • Systemic Anti-Cancer Therapy (SACT) provision is now available at Prince Charles Hospital. • A new process for harm review is in the process of being implemented to enable an improved systematised way of capturing information, to support continuous improvement. • The current manual method of data collection for outpatients is not as robust as it could be. To address this, a piece of work around service improvement is underway and the metric is currently being reviewed. Discussion, comments and contributions are summarised below: • A re-review and further scrutiny has been requested by the Executive Director of Nursing, AHPs and Health Science for pressure ulcers recorded as unavoidable. • An improvement plan including a workforce plan has been drafted and submitted to SLT for review and approval. These will be presented to the Board in coming months. **Welsh Blood Service** • Good stock and donor satisfaction levels have been maintained. • Support was provided to Northern Ireland Blood Service. • Workshops have been run with Health Boards to effectively manage stock levels during the winter months in the event of blood shortage levels, reflecting good collaborative working. • Additional pieces of work to increase bone marrow donor registry, determine reasons for not registering and ways to attract and recruit young donors have initiated. • A project with a look back exercise on historic data to inform projections for stock levels is currently being undertaken. Discussion, comments and contributions is summarised below: • Discussions have been held to review social platforms and how these can be used to communicate with the younger generation for example TikTok. Beyond the platform, how people access information is also key, for example the inclusion of influencers. • A story has been shared about the WBS returning to schools with good feedback from young people (link to story is provided in the Quality, Safety and Performance Committee Highlight Report).	

	• A Standard Operating Procedure is in place for the management of children at the clinic. Any decisions taken in this regard will consider hazards and suitability. To avoid challenges, advance notices are sent out to donors. • Failed venepuncture rates are below set tolerance threshold levels for newly trained staff in North Wales, these are reviewed regularly and no clinical concerns have been raised. ****ACTION:** An update on Brachytherapy to be included in the update to the January 2023 Board. **Workforce and Organisational Development** • The data shared is up to September 2022 which reflects Performance Achievement and Development Review (PADR) levels are increasing. • Corporate PADR rates have increased to 62%. • Sickness levels are currently 6.19% year to date up to November 2022 and is slightly higher than historical figures. 38% of all absence relate to stress and anxiety. The staff psychologist is working closely with Workforce and Organisational Development (WOD) on a case by case basis. • Various interventions are in place in support of staff wellness. • Planning is currently ongoing regarding potential Industrial Action. Discussion, comments and contributions are summarised below: • The target for absence management was implemented by Welsh Government. There are no discussions currently to review the target however this has been raised with Welsh Government. • Management of sickness and wellbeing is complex and extends to societal factors. • Significant improvement in compliance for statutory and mandatory training was noted by the Board. • The Trust will revise and refresh its performance targets. Any revised performance targets will be evidence based. • It was noted that absence will have an impact on performance especially for services such as SACT. Triangulation of data is key to identify hotspots to better understand how different factors are impacting performance. • It was noted that unions are required to provide two weeks' notice for any planned Industrial Action.. Trust Industrial Action Cell meetings have been ongoing. The Trust Board **NOTED** the contents of the Performance Reports.	**COB**
5.2.0	**Financial Report Period September 2022** In presenting the report, Matthew Bunce highlighted the following: • NHS Wales reflected a deficit of £200million in August 2022 which has since increased to £240million. • In recent weeks there have been discussions with budget holders and ministers to determine ways to cover the gap. • Funding for pay inflation has been approved by Welsh Government based on actual staff in posts. It was noted that this excludes vacant positions. The key message from Welsh Government is to manage costs down with the expectation of exceptional cost pressures in the coming year. Discussion, comments and contributions are summarised below:	

	• The Integrated Medium Term Plan (IMTP) makes provision to cover off any additional issues that may arise relating to cost pressures. • The service is changing with the expectation of additional demands placed on the organisation. This additional pressure needs to be reflected in the financial planning and will be discussed further at the next Board Development session. Trust Board **NOTED** the following: • The contents of the September 2022 Financial Report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs. • The Transforming Cancer Services Programme Financial Report for September 2022 attached as Appendix 1. • The Transforming Cancer Services Finance Report was discussed at the Transforming Cancer Services Scrutiny Sub-Committee on 17th November 2022. Members of the Sub-Committee requested the report be displayed in a clearer way, particularly in relation to the relationship between the programme spend and Trust reserves. This action was agreed to be completed for the next reporting period.	
5.3.0	**VUNHST Risk Register** In presenting the risk register, Lauren Fear highlighted the following: • Velindre Cancer Centre (VCC) risks have undergone extensive review and updates. • It was discussed at Board Development session held on 8th November 2022 that the Risk Appetite levels set by the Board will impact the reporting of risks. The revised Risk Appetite levels will be brought to Audit Committee and Trust Board in January 2023. Additional comments and discussions • Digital Health Care Record system has been launched. The risk will be updated to reflect any new issues experienced with the introduction of the new system. • Some review dates have passed which will be updated. The Trust Board: • **NOTED** the risks reported in the Trust Risk register and the actions underway to mitigate those risks. • **NOTED** the on-going developments of the Trust's Risk Framework.	
5.4.0	**Trust Assurance Framework (TAF)** Lauren Fear highlighted the following: • The cover paper references linking strategic risks into our ways of working as an organisation. There was good discussion around this at the Board Development session on 8th November 2022. • An alignment of strategic risks with the IMTP is being undertaken. As part of the alignment of strategic risks, the process will be more embedded within structures through templates, culture and decision making. Additional comments and discussion: • It was noted that actions have been updated with the majority of actions on track. • Controls should reflect those in place and not future.	

	• Examples were discussed where there are gaps in controls without clear corresponding actions which will be addressed in next reporting period. • The Chair noted progress to date and the maturing of the framework since its implementation. The Trust Board: • **DISCUSSED AND REVIEWED** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 2. • **DISCUSSED AND REVIEWED** the update to the Trust Assurance Framework Dashboard, included at Appendix 1	
5.5.0	**Nurse Staffing Levels (Wales) Act 2016** In presenting the paper, Nicola Williams highlighted the following: • The paper provides the mid-year position in respect of compliance with the Nurse Staffing Act (Wales). • No negative impact to patient or donor care as a result of staffing levels during the reporting period. • There are no incidents or complaints linked to staffing concerns. • Training and outcomes have been very good. • Discussions around consideration for Band 4 Practitioners are currently taking place which is based on the NHS Wales agreed standards. It was noted that the paper was received and discussed at the Quality, Safety and Performance Committee. The Trust Board **NOTED** the mid-year position in relation to compliance with the Nurse Staffing Act (Wales) requirements. **ACTION**: The wording in the paragraph at the end of page 3 to be amended to correctly reflect status of training during the time period.	**NW**
6.0.0	**LEGAL MATTERS**	
6.1.0	**Infected Blood Inquiry Update** Cath O'Brien presented the report and highlighted the following: • It was noted that final submissions will be sent to meet the December 2022 deadline. • The Trust is a core participant in this Inquiry. Summary of additional comments and discussion • It was acknowledged that the work around the Inquiry has been a huge undertaking and the team are commended for their efforts. • It was noted that the Trust will produce its own submission with a focus on the Welsh context. The Trust Board **NOTED** the update for the final written Statement to Infected Blood Inquiry by the December 16th deadline.	
7.0.0	**STRATEGIC**	
7.1.0	**Integrated Medium Term Plan (IMTP) Q1 and Q2 Progress and Accountability Conditions** Carl James presented the progress report highlighting the following:	

	• There are two parts for reporting to Board and Welsh Government, accountability covered in paragraph 2.2 and accountability conditions outlined in Appendix A. • A composite view is given in the paper based on the requirements outlined by Welsh Government. Discussions and comments are summarised below: • Two quarters of activity are reported in the paper, quarter 1 and quarter 2. It was noted that an update on the IMTP was not provided at the end of quarter 1 due to the sequence of reporting, however an audit trail of papers regarding the IMTP has provided assurance on progress. • Discussion on the red rated deliverables with particular focus is capacity around SACT and Radiotherapy as well as the ability of the service to achieve decarbonisation by the target date. The Trust Board **NOTED** the paper which sets out the progress made in delivering the requirements set out in the Accountability Conditions and the IMTP 2022 – 2025. **ACTION**: The reporting on Brachytherapy is currently green however, due to new issues a review and update to be undertaken.	**COB**
7.2.0	**Prioritisation Framework and Transformation Roadmap** In presenting the paper Carl James and Lauren Fear highlighted the following: • To achieve our Trust strategy within the capacity available, a set of priorities have been identified. • Comments from Strategic Development Committee are reflected. • The work carried out through the summer undertook to prioritise activities based on our strategy which has service excellence embedded through the strategic aims and quality and safety as the golden thread. The Trust Board **NOTED** the contents of the presentation and the programmes of work that will feed into the Integrated Medium Term Planning guidance.	
7.3.0	**Anti-Racist Wales Trust Action Plan** Sarah Morley highlighted the following: • In June 2022 Welsh Government published its Anti Racist Wales action plan with organisations tasked with responding to the plan. • The plan presented to the Board is the first of the organisation's plans aligned with actions set out by Welsh Government. • A focus group report published by Public Health Wales provides information on experiences of minority groups. • It was noted that culture change is required to achieve an anti-racist organisation. To do this, discussions need to be held with staff, donors, patients and stakeholders to understand experiences (lived and personal). This will inform how we improve their interactions with the organisation. • It was noted that objectives will be outlined for Board members and monitored for achievement and progress. Discussions and comments are summarised below: • It was noted that there are specific expectations for Independent members and the Trust Chair.	

	• Lived experiences will inform expected outcomes and what needs to be achieved by Board members and the organisation. • This work will inform the work on the patient engagement strategy. • Having the item on the agenda was welcomed. • The list of actions is likely to evolve. The Board **APPROVED** the Anti-Racist Wales Trust Action Plan.	
8.0.0	**BUSINESS CASE**	
8.1.0	**Business Case for the Replacement Laboratory Information Management System (LIMS) for the Welsh Histocompatibility & Immunogenetics Service (WHAIS)** The business case was presented by Carl James, supported by the Digital Services Team: • David Mason-Hawes, Head of Digital • Jon Norman, Portfolio Project Manager • Felicity May, Clinical Specialist Histocompatibility & Immunogenetics Digital Lead A summary is provided below: • Welsh Histocompatibility & Immunogenetics Service (WHAIS) is a department at the Welsh Blood Service providing a suite of services including scientific advice, diagnostics and investigations for transplantation and selective transfusion. • This is the only laboratory in Wales able to provide the above mentioned services. • The current IT system is limited in terms of its capability for what we do. As a result, there has been some inefficient resourcing with work being done manually. • Following the procurement process during 2021, Digital went to market in 2022 to establish options to fit our requirements. Some viable commercial product options are available that meet our requirements. This information is contained in the business case as well as indicative costs. • In terms of funding the intention is to obtain cost cover from Welsh Government. The procurement of the product falls within the national context of Laboratory Information Management System (LIMS). Discussions, comments and contributions are summarised below: • Previously, there were no service providers to provide a system to enable the work done by WHAIS, therefore the current system was developed in-house. • The Board has been made aware of the challenges with the current system provision and the need for a new product. • There has been engagement with laboratories within the United Kingdom and abroad with useful information obtained. • A new system will expand opportunities and access to data. • The scale of this piece of work is recognised by the Board. • At this point, the intention is to procure a system with national integration. • Data protection for the new system once procured will be managed. A data protection impact assessment process has resumed. The team were congratulated on the work undertaken.	

	The Trust Board **APPROVED** the Strategic Case, attached as Appendix 1, for the procurement and implementation of a commercial “off-the-shelf” H&I-specific LIMS solution for the WTAIL WHAIS laboratory in the Welsh Blood Service.	
9.0.0	**ANY OTHER BUSINESS** There were no other items.	
10.0.0	**DATE and TIME OF THE NEXT MEETING** Tuesday 31st January 2023	
11.0.0	**CLOSE**	

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance and Chief of Staff

REPORT PURPOSE	**CONSIDER** and **ENDORSE**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board Members – Via Email	13/01/2023	Approved

ACRONYMS	
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 In accordance with Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Director of Corporate Governance & Chief of Staff, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Director

of Corporate Governance & Chief of Staff must ensure that any such action is formally recorded, and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.

1.2 Chair's action may not be taken where either the Chair or the Chief Executive has a personal or business interest in an urgent matter requiring decision. In this circumstance, the Vice-Chair or the Executive Director acting on behalf of the Chief Executive will take a decision on the urgent matter, as appropriate.

1.3 This report details Chair's Urgent Action taken between the **16/11/2022 – 23/01/2023**.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

The items outlined in **Appendix 1** have been dealt with by Chairs Urgent Action.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

4.1 The Board is asked to **CONSIDER** and **ENDORSE** the Chairs urgent action taken between the **16/11/2022 – 23/01/2023** as outlined in **Appendix 1**.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. WBS Feasibility Study Laboratory Modernisation

The Trust Board were sent an email on the **13/01/2023** regarding a Commitment of Expenditure request to take forward a Feasibility Study to support Laboratory Modernisation within the Welsh Blood Service.

The Trust Board were requested to **APPROVE** the following:

- To **AUTHORISE** the Chief Executive to **APPROVE** the financial commitment to be awarded as summarised within the supporting paper provided to the Board, and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements where appropriate.

A number of points and queries were raised that were subsequently addressed via a revised supporting paper re-issued to the Board.

There were no objections to approval.

Recommendation Approved by:

- Donna Mead, Chair
- Steve Ham, Chief Executive
- Stephen Harries, Vice Chair
- Vicky Morris, Independent Member
- Professor Andrew Westwell, Independent Member
- Sarah Morley, Executive Director of Organisational Development & Workforce

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 31 January 2023 to 30 March 2023

DATE OF MEETING	31 January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, (***Appendix 1 & 2***) Executive Director of Finance Matthew Bunce / Jaz Abraham, (***Appendix 3***) Executive Director of Finance / Executive Medical Director Carl James, (***Appendix 4***) Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	**APPROVAL**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	03/01/2023 (***Appendix 1 & 2***)	Endorsed
Executive Management Board	27/01/2023 (***Appendix 3***)	Endorsed
Executive Management Board	24/01/2023 (***Appendix 4***)	Endorsed

ACRONYMS	
BI	Business Intelligence
CANISC	Clinical and Patient Administration System
CCRH	Cardiff Cancer Research Hub
DH&CR	Digital Health & Care Record
MCF	Management Consultancy Framework
MoSCoW	Must, Should, Could, Will not do at this point
NWSSP	NHS Wales Shared Services Partnership
OJEU	Official Journal of the European Union
PROMs	Patient Reported Outcome Measures
SMART	Specific Measurable Realistic Time bound
VAT	Value Added Tax
VBHC	Value Based Healthcare
WCP	Clinical Portal
WPAS	Wales Patient Administration System

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust (VUNHST) has a Scheme of Delegation, as set out in its Standing Orders, together with its Standing Financial Instructions (SFIs), which ensures that there are effective governance arrangements in place for the delegation of financial authority.

1.2 Financial limits apply to the commitment of expenditure. If expenditure is greater than an individual's financial limit, and is more than the limit delegated to the VUNHST Chief Executive, the planned expenditure will require VUNHST Board approval. For extensions of existing contracts in place, this only applies if the provision for extension was not included in the original approval granted by the Trust Board.

1.3 The decisions expected during the period **31 January 2023 to 30 March 2023** are highlighted in this report and are seeking approval for the Chief Executive to authorise approval outside of the Trust Board.

1.4 In line with the review of the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are now received by the Executive Management Board to ensure Executive oversight and scrutiny, to provide the Board with supporting recommendations and additional assurance as required.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendices 1-4** for the detailed appraisals undertaken for each of the expenditure proposals that the Trust Board is asked to **APPROVE**. The table below provides a summary of the decisions being sought from the Trust Board:

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (Inc. VAT)
Appendix 1	Corporate Finance	Value Based Healthcare Programme - ***Clinical***	Start: 01/02/2023 End: 01/08/2023 Option to extend: This application is for a 6-12 month contract on a time and materials basis. The contract may be extended up to a maximum of 50% of the contract value in line with procurement contract regulations.	£180,000
Appendix 2	Corporate Finance	Value Based Healthcare Programme - ***Analytics***	Start: 01/02/2023 End: 01/08/2023 Option to extend: This application is for a 6-12 month contract on a time and materials basis. The contract may be extended up to a maximum of 50% of the contract value in line with procurement contract regulations.	£540,000
Appendix 3	Research, Development & Innovation	Investment Strategy to support Research Hub	Start: 01/03/2023 End: 01/07/2023 Option to extend: This application is for a 4-month contract on a time and materials basis. The contract may be extended up to a maximum of 50% of the contract value in line with procurement contract regulations, however, additional funding would need to be approved if any contract extension is required.	£150,000

Appendix No.	Division	Scheme / Contract Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (Inc. VAT)
Appendix 4	Estates, Environment & Capital	Fire Compartmentation Compliance	***Please refer to separate report: 'Fire Compartmentation Compliance' together with supporting annexes.***	

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Undertaken on a case by case basis, as part of the procurement process.
LEGAL IMPLICATIONS / IMPACT	If applicable, as identified in each case as part of the service design/procurement process.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Further details are provided in Appendix 1-4 of this report.

4. RECOMMENDATION

4.1 The Board is requested to **AUTHORISE** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices **and AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	VALUE-BASED HEALTHCARE PROGRAMME
DIVISION / HOST ORGANISATION	Corporate, Finance
DATE PREPARED	21/12/2022
PREPARED BY	Chris Moreton, Deputy Director of Finance
SCHEME SPONSOR	Matthew Bunce, Executive Director of Finance

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Clinical and Scientific Strategy and Prioritisation

The Value Based Healthcare programme is also committed to support a strengthened clinical leadership infrastructure. The purpose of this is to provide the required level of clinical leadership to lead on optimising the non-surgical oncology pathways across South East Wales, and to also lead on the clinical workforce modernisation / transformation in order to ensure that the regional non-surgical oncology workforce is 'fit for the future'.

In support of this work, there is a need to develop a Trust Clinical Scientific Strategy and external support and expertise is being sought to help deliver this given the capacity constraints on current staff.

Requirement

In order to accelerate the progress of the Value-Based Healthcare programme we are also seeking external support and expertise to deliver the Trust's Clinical Scientific Strategy.

Summary of Estimated Contract Charges (Excl. VAT)

The estimated cost of the contract for 6-12 months is £150k (inc. the value of up to 50% maximum extension).

1.1 Nature of contract:	First time	☒	Contract Extension	☐	Contract Renewal	☐

Please indicate with a (x) in the relevant box						

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/02/2023
Expected End Date of Contract	01/08/2023
Contract Extension Options **(E.g. maximum term in months)**	This application is for a 6-12 month contract on a time and materials basis. The contract may be extended up to a maximum of 50% of the contract value in line with procurement contract regulations.

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES		

This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☒	Integration	☒	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Clinical Scientific Strategy Option 1 - Do Nothing – If the contract is not put in place, the progress of the Value-Based Healthcare programme and the development of the Trust Clinical Scientific Strategy will be severely restricted. Option 2 – Award contract – Awarding the contract with a provider for 6-12 months will enable the development of the Trust's Clinical Scientific Strategy at Velindre and support the development of the Value-Based Healthcare programme through clear direction and set of clinical / scientific priorities.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The benefits of the Clinical Scientific Strategy include: • Person centred care / services • Improved experience • Best Care, Best Place by Right Staff @ Right Time • Clarity of priorities • Ensuring equitable access to new science and technologies • Enhanced opportunities for joint & collaborative working • Preparing for clinical transformation/direction of travel • Clarity about areas of clinical risk • Identifying where we are unable to meet our objectives and why.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Not proceeding will severely restrict the progress of the Value-Based Healthcare programme, the Value Intelligence Centre and the Clinical Scientific Strategy. There is a reputational risk to Velindre that we will not deliver on the commitments made within the business case submitted to Welsh Government and will lose access to funding as a result.	There is no mitigation. If the contract is not in place, we will not be able to proceed with the scope of work that was provided to Welsh Government in the Value Intelligence Centre business case.

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

The Framework MCF3 has been identified as the appropriate procurement route.

6.3 What is the approximate time line for procurement?

NWSSP Procurement services will have negotiated the 6 month contract with a supplier by the 30th January 2023. Extending the contract by a further 6 months is permitted as long as it is within the maximum 50% additional value stipulated in Regs 72 of the Public Contracts Regulations (2015).

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route

Head of Procurement Name:	Helen James
Signature:	
Date:	21st December 2022

Maximum expected whole life cost relating to the award of contract	Excluding VAT (£k) £150k	Including VAT (£k) £180k
The nature of spend	Capital ☐	Revenue ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below: For clarity, funding for the Value-Based Healthcare programme is being provided by Welsh Government who have authorized this spend as part of an approved business case.		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 31st Jan 2023 – 30th Jan 2024 (exc. VAT) £	Total (exc. VAT) £	Total (inc. VAT) £
Clinical Scientific Strategy	£100,000	£100,000	£120,000
Clinical Scientific Strategy extension (up to 50% max value of contract)	£50,000	£50,000	£60,000
Total	**£150,000**	**£150,000**	**£180,000**

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	N/A This contract will be managed by Finance as the host function for the Value-Based Healthcare programme.

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:	
Service Area:	Finance
Date:	21/12/2022

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
EMB RUN	03/01/2023

This is a Trust-wide initiative procured at corporate level.

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	VALUE-BASED HEALTHCARE
DIVISION / HOST ORGANISATION	Corporate, Finance
DATE PREPARED	21/12/2022
PREPARED BY	Chris Moreton, Deputy Director of Finance
SCHEME SPONSOR	Matthew Bunce, Executive Director of Finance

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Analytics Capability Development for the Value Intelligence Centre

Velindre University NHS Trust are establishing a Value Intelligence Centre to develop a common approach to the delivery of Value-Based Healthcare management practices across the Trust. As a Centre-of-Excellence for Value-Based Healthcare across the Trust, it will support the embedding of value principles by building capacity and capability to enable behavioural change. This will include:

- Dedicated VBH expertise and capability
- Additional Digital and Business Intelligence / Analytics capacity and capability
- Consistent approach to agile project management methods
- Identification and delivery of some quick wins where the application of value principles can improve services for patients and donors with better outcomes and / or experience.

Velindre's approach will align with the National Value in Health strategy, which can be found here.

The Cancer Centre BI team are currently involved in the implementation of the replacement of CANISC (Clinical and Patient Administration System) with the Digital Health & Care Record (DH&CR). This includes implementing WPAS (Wales Patient Administration System) and WCP (Welsh Clinical Portal) clinical forms in addition to the change of integration into the Data Warehouse. These two programmes of work are utilising much of the capacity of the BI team

and therefore the Trust is seeking some temporary external support to progress the VBHC program in the short term.

The initial focus of the work will be on cancer services tertiary pathway and making the most out of the data currently available within the Trust. A roadmap of developments may consider the incorporation of wider pathway / sources of data in the longer term.

The Trust has 12 Site Specific Teams – Breast; Colorectal; Gynaecology; Head & Neck; Lung; Lymphoma; Melanoma & Skin; Neuro; Palliative Care; Sarcoma; Upper GI; Urology.

Requirement

In order to accelerate the progress of the Value Intelligence Centre with regards to our BI and Analytics capability we are seeking options of support to deliver the following outputs:

- A baseline assessment to understand where PROMS data is being collected across the Trust
- A set of Clinical Personas for each Site-Specific Team, which will provide a better understanding of end-user reporting requirements to support Person-centred care
- A Proof-of-Concept Value Based Healthcare dashboard pilot for one Site-Specific Team and a prioritised pathway, building on the baseline assessment and Clinical Personas.
- Development of a Use Case for a Value-Based Healthcare dashboard.
- Development of an agile process for Value Based Healthcare dashboard development that is consistent, repeatable and clarifies roles and responsibilities across the end-to-end process.
- Vision for VBH analytics and development of a roadmap to handover to / help upskill inhouse capability.

Summary of Estimated Contract Charges (Excl. VAT)

The estimated cost of the contract for 6-12 months is £450k (inc. the value of up to 50% maximum extension).

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	01/02/2023					

Expected End Date of Contract	01/08/2023
Contract Extension Options **(E.g. maximum term in months)**	This application is for a 6-12 month contract on a time and materials basis. The contract may be extended up to a maximum of 50% of the contract value in line with procurement contract regulations.

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐

Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☒	Integration	☒	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Analytics Capability Development Option 1 - Do Nothing – If the contract is not put in place, the progress of the Value-Based Healthcare programme will be severely restricted. Option 2 – Award contract – Awarding the contract with a provider for 6-12 months will enable the development of analytics capability at Velindre to support the development of the Value-Based Healthcare programme.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The benefits of the work with regards to our BI and Analytics capability will include the following: • A baseline assessment to understand where PROMS data is being collected across the Trust • A set of Clinical Personas for each Site-Specific Team, which will provide a better understanding of end-user reporting requirements to support Person-centred care

- A Proof-of-Concept Value Based Healthcare dashboard pilot for one Site-Specific Team and a prioritised pathway, building on the baseline assessment and Clinical Personas.
- Development of a Use Case for a Value-Based Healthcare dashboard.
- Development of an agile process for Value Based Healthcare dashboard development that is consistent, repeatable and clarifies roles and responsibilities across the end-to-end process.
- Vision for VBH analytics and development of a roadmap to handover to / help upskill inhouse capability.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
Not proceeding will severely restrict the progress of the Value-Based Healthcare programme, the Value Intelligence Centre and the Clinical Scientific Strategy. There is a reputational risk to Velindre that we will not deliver on the commitments made within the business case submitted to Welsh Government and will lose access to funding as a result.	There is no mitigation. If the contract is not in place, we will not be able to proceed with the scope of work that was provided to Welsh Government in the Value Intelligence Centre business case.

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
The Framework MCF3 has been identified as the appropriate procurement route.
6.3 What is the approximate time line for procurement?
NWSSP Procurement services will have negotiated the 6 month contract with a supplier by the 30th January 2023. Extending the contract by a further 6 months is permitted as long as it is within the maximum 50% additional value stipulated in Regs 72 of the Public Contracts Regulations (2015).

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Helen James
Signature:	
Date:	21st December 2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£450k**	**Including VAT (£k)** **£540k**
The nature of spend	**Capital** ☐	**Revenue** ☒

How is the scheme to be funded? Please mark with a (x) as relevant.

Existing budgets	☒
Additional Welsh Government funding	☒
Other	☐

If you have selected 'Other' – please provide further details below: For clarity, funding for the Value-Based Healthcare programme is being provided by Welsh Government who have authorized this spend as part of an approved business case.

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 31st Jan 2023 – 30th Jan 2024 (exc. VAT) £	Total (exc. VAT) £	Total (inc. VAT) £
Value-Based Healthcare Analytics Capability Development	£300,000	£300,000	£360,000
Value-Based Healthcare Analytics Capability Development extension (up to 50% max)	£150,000	£150,000	£180,000
Total	**£450,000**	**£450,000**	**£540,000**

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	N/A This contract will be managed by Finance as the host function for the Value-Based Healthcare programme.

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:	
Service Area:	Finance
Date:	21/12/2022

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
EMB RUN	03/01/2023

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	INVESTMENT STRATEGY TO SUPPORT OUR CANCER RESEARCH AMBITIONS
DIVISION / HOST ORGANISATION	Research, Development and Innovation
DATE PREPARED	20/01/2023
PREPARED BY	Chris Moreton, Deputy Director of Finance
SCHEME SPONSOR	Dr. Jacinta Abraham, Executive Medical Director

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Cancer Research Hub Strategic Investment Case

The scope of the Cancer Research Hub Partnership Strategic Investment Case includes:

1. **Investment objectives, existing arrangements and needs**
   - Development of SMART Investment Objectives aligned to the strategic priorities of the Cancer Research Hub including:
     - Delivery of novel and advanced therapies to patients
     - Building workforce capability and translational research expertise from lab to clinic
     - Developing digital capability and integrated healthcare data
     - Investment in physical infrastructure for the Hub
   - Identification of investment funding sources that could help to achieve the investment objectives
   - Identification of partner best placed to lead on each source of investment funding
   - An assessment of existing arrangements and current Hub service provision from all partners in respect of the Hub
   - A rough order of magnitude investment assessment and high-level phasing to meet the Hub needs

2. **Scope and Requirements**
   - Determine the scope of the Hub and key service requirements including MoSCoW assessment (i.e. prioritisation of requirements by Must, Should, Could, Will not do at this point)

3. **Benefits, Risks, Constraints and Dependencies**
    - Assessment of the anticipated quantitative and qualitative benefits:
        - For each partner in the partnership and the partnership as a whole
        - Indirect public sector benefits
        - Wider benefits to Wales
    - Identification of risks, constraints and dependencies

Approach

- The work will be delivered through Velindre University NHS Trust on behalf of the Partnership
- The provider will work with stakeholders from Velindre University NHS Trust, Cardiff University and Cardiff and Vale Local Health Board.
- It is expected that the work will require a combination of key stakeholder interviews, document review and facilitated workshop(s).

Timeline

- It is expected that the project will take a maximum of 4 months to complete.

Deliverables

The expected outputs from the specification of work are:

- Cancer Research Hub Partnership Strategic Investment Case which delivers on the scope, approach and timeline

Summary of Estimated Contract Charges (Excl. VAT)

The estimated cost of the contract for 4 months is £125k (exc. VAT).

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	01/03/2023					

Expected End Date of Contract	01/07/2023
Contract Extension Options **(E.g. maximum term in months)**	This application is for a 4-month contract on a time and materials basis. The contract may be extended up to a maximum of 50% of the contract value in line with procurement contract regulations, however, additional funding would need to be approved if any contract extension is required.

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☒
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒

Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☒	Integration	☒	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Option 1 - Do Nothing – If the contract is not put in place, the progress of the Cancer Research Hub programme will be restricted. Option 2 – Award contract – Awarding the contract with a provider for 4-months will enable the development of a strategic investment case to support the development of the development of the Cancer Research Hub.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The benefits of the work will include the following: • Development of a Cancer Research Hub Partnership Strategic Investment Case which delivers on the scope, approach and timeline outlined in the specifications. • Clarify the strategic funding options for the Cancer Research Hub.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Not proceeding will restrict the progress of the Cancer Research Hub programme. There is a risk that Velindre will not deliver on the recommendations made by the Nuffield Trust report.	There is no mitigation. If the contract is not in place, we will not be able to proceed with the scope of work.

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

The Framework MCF3 and NHS SBS Consult 18: Multidisciplinary Consultancy Services have been identified as the appropriate procurement routes.

There is an option to direct award contracts under both of these frameworks which will enable work to progress at pace.

6.3 What is the approximate timeline for procurement?

NWSSP Procurement services will have negotiated the 4-month contract with a supplier by the 24th February 2023. Extending the contract is permitted as long as it is within the

maximum 50% additional value stipulated in Regs 72 of the Public Contracts Regulations (2015).

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Helen James
Signature:	
Date:	25/01/2023

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£125k**	**Including VAT (£k)** **£150k**
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: This work will be funded through budget secured through an application to the Velindre Charity (£75k inc. VAT) and use of non-recurrent Trust reserves for 2022/23 (£75k inc. VAT).		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 31st Jan 2023 – 30th Jan 2024 (exc. VAT) £	Total (exc. VAT) £	Total (inc. VAT) £
Cancer Research Hub Strategic Investment Case	£125,000	£125,000	£150,000
Total	**£125,000**	**£125,000**	**£150,000**

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:	Dr. Jacinta Abraham, Executive Medical Director

Signature:	
Service Area:	Research, Development and Innovation
Date:	25/01/2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
VCC SLT (Chairs Urgent Action)	n/a
EMB RUN (Chairs Urgent Action)	tbc

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST – FIRE COMPARTMENTATION COMPLIANCE

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	JASON HOSKINS ASSISTANT DIRECTOR ESTATES, ENVIRONMENT AND CAPITAL
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning, Performance & Estates
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Capital Group EMB	17/01/2023 24/01/2023	IN SUPPORT

ACRONYMS	
VCC WBS EMB	Velindre Cancer Centre Welsh Blood Service Executive Management Board

1. SITUATION/BACKGROUND

1.1 A specification for works to address fire compartmentation issues that have been identified within Trust Buildings was tendered late 2021/22 with a view to complete works in the 2022/23 financial year. The initial Board paper set out cost of works as follows;

- Contract Sum £186,666,66 exc VAT
- Contingency £100,000 exc VAT

1.2 The Board requested that the contingency figure be reduced to c. £34,624, as they were not in agreement with the recommendation. Approval was granted for a total project cost of £221,290 exc VAT as detailed in the signed Commitment of Expenditure Paper Exceeding Chief Executives Limit (Annex 1). The contract was awarded to Intrinsic Fire Protection ltd.

1.3 Works commenced on the VCC site and it became apparent early on in the project that further works were required over and above those identified within the initial tender. This was anticipated and is usual with compartmentation works, which was reflected in the initial request to include a large contingency sum. The tender identified circa 2500 apertures that required repair at the VCC site, furthermore to date there has been over 5000 apertures completed in VCC through intrusive investigation and repair demonstrating over double the initial figure quoted.

1.4 Quality checks are in place to manage the scheme and each individual repair is documented, numbered and costed in line with the agreed scheduled of rates. All works are verified by The Trust Fire Safety Manager and independent Project Manager.

1.5 Due to the number of repairs identified over and above those listed in the tender, the Trust requested the contract firm undertake detailed investigation of areas ahead of any further instruction to ascertain a final project cost. This exercise was conducted with The Trust Fire Safety Manager and independent Project Manager to verify requirements and cost.

1.6 The contract firm have been stood down while further financial approval is sought. Current project expenditure remains within financial approval limits set out within Commitment of Expenditure Paper Exceeding Chief Executives Limit issued in accordance with the scheme.

1.7 The current situation in term of expenditure and further investment is set out below;

- Board Approval £221,290 exc VAT
- Total Cost of Works following Survey and verification exercise Total Cost of
    - VCC £279,109.48 exc VAT (require uplift of £58K)
    - WBS £150,000.00 exc VAT (requires uplift of the full amount)

- The Project has been discussed at the Trust Capital Group and the funding has been approved to complete both work packages, subject to Board approval

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Progression of the scheme has remained confined to works at VCC to date. It was felt that due to identified extra works, it was beneficial from a Programme and cost management perspective to complete one site at time. The final costs exceed those currently approved which presents a number of options outlined below in Table 1.

2.2 Table 1 - Options for Consideration and Approval

Options	Benefit	Dis Benefit
1. Do nothing – Stop works without incurring further costs to those approved by the Board previously	Finances remain in keeping with the initial approvals	The risks associated with surveys undertaken at VCC and WBS are substantial and will be listed under Datix as 20 or above
2. Complete works to VCC Only	All Risks relating to compartmentation at VCC will be removed. Contractor onsite and mobilised.	The risks associated with surveys undertaken at WBS are substantial and will be listed under Datix as 20 or above. Project cost uplift c.£58K exc VAT compared with initial Board sign off.
3. Complete works to VCC and WBS **(Preferred Option)**	All Risks relating to compartmentation at VCC and WBS will be removed. Contractor onsite and mobilised.	Project cost uplift c.£58K exc VAT compared with initial Board sign off to complete VCC, and a further uplift of £150K exc VAT to complete identified works at WBS.

2.2 Procurement advice has been sought and endorsed regarding the preferred option 3 which is to complete works as identified below;

- **Velindre Cancer Centre**
  To complete works at VCC the initial Purchase Order will require uplifting to reflect the contract value of £279,109.48 exc VAT. This is acceptable as defined in the Standing Financial instructions considering initial PO value £186,666.66, exc VAT. Standing Financial Instruction state;

Modification of contracts during their term

72.—(1) Contracts and framework agreements may be modified without a new procurement procedure in accordance with this Part in any of the following cases:—

(c)where all of the following conditions are fulfilled:—

(i) the need for modification has been brought about by circumstances which a diligent contracting authority could not have foreseen;

(ii) the modification does not alter the overall nature of the contract;

(iii) any increase in price does not exceed 50% of the value of the original contract or framework agreement.

- **Welsh Blood Service**
  To complete works at WBS it is advised that the services of Intrinsic Fire Protection ltd be maintained through issue of a Single Tender Action. Procurement colleagues will endorse due to the recent tender exercise undertaken which highlighted the competitive costs presented by the incumbent contractor. Taking this approach will allow completion of works this financial year, fully mitigating all risks to the Trust from a fire compartmentation perspective

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Failure to complete this works presents a risk to Life and limb and business continuity
RELATED HEALTHCARE STANDARD	Safe Care
	The Estates will remain non compliant with Fire safety Legislation which presents risk to all users of the Trust Estate
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Non Compliant with; WHTM H&S Legislation

	The Fire Safety Reform Order
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Funding Requirement VCC £ 58K exc VAT WBS £150K exc VAT

4. RECOMMENDATION

4.1 It is the recommendation of this paper that the Board approve further expenditure against this scheme in doing so support Option 3 which is to;

I. Approve a 50% uplift against the original purchase order to allow completion of all identified compartmentation works at VCC.

II. Proceed with a Single Tender Action Annex 3, as endorsed by Procurement and Finance colleagues approving a spend of £150K exc VAT to complete all identified works at WBS. Endorse and approve the Commitment of Expenditure Paper Exceeding Chief Executives Limit Annex 2.

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	VELINDRE UNHS TRUST - COMPARTMENTATION
DIVISION / HOST ORGANISATION	Corporate Estates, Environment and Capital
DATE PREPARED	25/04/2022
PREPARED BY	Jason Hoskins Assistant Director Estates, Environment and Capital
SCHEME SPONSOR	Carl James Director of Strategic Transformation, Planning, and Digital

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Fire Stopping Works (Compartmentation):

- To address all know compartmentation issues at VCC and WBS HQ as listed in the detailed survey as completed by independent consultant commissioned by the Trust.

Background

- Assessment of the Trust Estate has highlighted a number of issues that present a risk from a fire safety perspective
- A business case has been presented to Welsh Government outlining funding requirements to address concerns raised
- Welsh Government have endorsed the proposal providing £1.1M of funding staged over a number of years in support rectification of the identified issues with £500K allocated for 2022/23
- An external consultancy firm was commissioned to carry out an assessment of the condition of compartmentation across which has informed the approach adopted by the Trust
- A work package to address issues that exist across the Trust relating to compartmentation has been compiled in preparation to go to tender.
- The works outlined in the documentation details areas of concern which require address through this work package
- All works have been reviewed and signed off internally by the Trust Fire Safety Manager, and an external independent consultant.

• Tendered costs have been returned at £265,548 inc of VAT and contingency • A detailed review of the tender documentation has been concluded.						
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	01/05/2022
Expected End Date of Contract	31/08/2022
Contract Extension Options **(E.g. maximum term in months)**	Two months

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☒
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**

	☒	☐
This scheme has been identified as part of the Estates Compliance Capital works 2021 – 2023. Funding has been secured through Welsh Government.		
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
There are limited options available with the exception of *Option 1 - Do Nothing – presents ongoing H&S risks associated with the non-compliance – Fire Safety legislation and H&S legislation breach* *Option 2 – Carry out works to improve compartmentation to meet the requirements of the external survey, In doing so making the Trust compliant with WHTM and H&S Legislation* *Preferred Option – This option provides a compliant solution reducing risk of fire to life, limb, and property. Underpinned by a full assessment of each element of work which will be logged on the electronic estates management system (Bolster) for record.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Provides a fully auditable compliant solution to asset level including update of the Trust Fire Safety Management documentation, and Bolster system allowing ongoing management of each repair. • Removes all identified risk presented by insufficient compartmentation as detailed within the commissioned survey and provides a benchmark for future management.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
• Non compliance with WHTM firecode • Non compliance with H&S Legislation • Non compliance with building documentation - The Fire Strategy for buildings	• Risks cannot be fully mitigated

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
Formal procurement exercise to be undertaken via issue through external consultant (Gleeds)
6.3 What is the approximate time line for procurement?
4 weeks (completed)

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Helen James
Signature:	
Date:	25th April 2022

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)**	**Including VAT (£k)**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		

If you have selected 'Other' – please provide further details below:

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Compartmentation	£221,290				£221,290	£265,548
Overall Total	£221,290				£221,290	£265,548

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*This project will be managed against organisational SFI's and the estates project management process.*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Carl James
Signature:	
Service Area:	Planning and Digital

Date:	30/05/2022

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	15/03/2022
Divisional Senior Management Team	N/A
Executive Management Board	12/05/2022

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	
HTW – Senior Management Team	

SINGLE QUOTATION/TENDER REQUEST FORM

Important Notes:
Single quote/tender action shall only be undertaken following the approval of this request in **advance** of procurement activity commencing and only in **exceptional circumstances**.

Important Notes to Aid Completion:

- Advice must be sought from the local Finance Department and Procurement Services in advance of completion, to ensure appropriate financial and procurement procedures are applied and prevent delays in the procurement process.
- Consideration must be given to the Welsh Audit Office Guidance available from the Procurement Team prior to submission.
- Competition requirements are currently set at the following thresholds:
  - quotations (purchases between £5,000 - £24,999)
  - tenders above £25,000.
  - Waiver requests over the prevailing OJEU threshold will require a VEAT notice to be published via Sell2Wales.

It is important that the form is completed **IN FULL** in order to satisfy the Health Organisation Standing Orders, which incorporate the Standing Financial Instructions, requiring competitive quotations/tenders to be obtained to demonstrate value for money is still delivered.

NB1: All requests to waive competition requirements are formally reported to Audit Committee for noting.
NB2: The form will be returned to the originator if not completed in full.
NB3: Approval cannot be granted retrospectively. Should this be the case, please seek advice from the Procurement department. Expenditure committed without appropriate advance authority/due regard to the Standing Financial Instructions, is also reported to Audit Committee

Section 1 - To be completed by the Requesting Officer

Name of Health Organisation: ***Hosted Body and Hosted Unit Title to be provided***	**Velindre University NHS Trust**			
Please tick as appropriate	**Single Quotation Request**		**Single Tender Request**	✓
***Supplier:**	Intrinsic Fire Protection ltd			
The granting of this request for a single firm or contractor of a special character is required or a proprietary item or service may be assessed as appropriate: • **the service/good/works is 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);** • **there is a compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;** • **there is genuinely only one provider;** • **there is a need to retain a particular contractor for real business continuity issues (not just preferences).** *NB: Evidence of all contact with potential alternative suppliers should be retained. Where no other supplier has been approached justification must also be included to ensure the request is not delayed*				
***Please provide detail of Goods/Services/Works required:**	Works to complete identified compartmentation defects at Welsh Blood Service Head Quarters			

If Services, is this for Consultancy/Individual? *Please delete as appropriate*	**No**	**If 'yes', has an IR35 assessment been completed**	**Yes / No**
Does this requirement have an implication under GDPR? *Please delete as appropriate*	**No**	**If 'yes', has the IG Department been consulted**	**Yes / No**
Proposed agreement period including start and end dates and any extension provision required.	01/2/23 start 31/3/23 completion		
***Unit Cost/Annual Cost:**	As set out in the agreed schedule of rates		
***Total Cost** *(inc delivery & VAT):*	£150,000 exc VAT		
***Whole Life Costs:** (*Please state all additional goods/services/works that may be required during the life of the goods/service/works being requested here. E.g. Maintenance, Consumables etc.)*	none		
***New or Replacement Equipment/Service:** *(Please state)*	Various repairs to the integrity of fire walls throughout the building		
***Life Expectancy of equipment**	25 years		
***Is this a Recurring Procurement?** *(Please tick as appropriate)*	**Yes**	No ✓	
*__Source of Funding:__ *(Revenue/Capital/Charity etc.)*	Discretionary Capital	***Please provide Financial Code:**	A513
Breakdown of estimated capital and on-going revenue charges per annum. *(Please ensure your Finance Team are consulted before completion)*	Initially funded by discretionary Capital. Once completed there is no ongoing costs		

Have any revenue consequences (particularly staffing or maintenance implications), been agreed? (*Please tick as appropriate)*	**Yes**	~~**No**~~	**If yes give details** Resourced by estates team	
	Yes			
Any other financial consideration to be declared e.g. risks to ongoing funding, savings: cash releasing, cost avoidance, cost pressure, VFM impact.	None			
***Background: Reason for single supplier & details of any alternatives considered & reasons for their rejection (supplier(s) details required)**	• Assessment of the Trust Estate has highlighted a number of issues that present a risk from a fire safety perspective • A business case has been presented to Welsh Government outlining funding requirements to address concerns raised • Welsh Government have endorsed the proposal providing £1.1M of funding staged over a number of years in support rectification of the identified issues with £500K allocated for 2022/23 • An external consultancy firm was commissioned to carry out an assessment of the condition of compartmentation across which has informed the approach adopted by the Trust • A work package to address issues that exist across the Trust relating to compartmentation has been tendered and the contract awarded. • Works to the VCC Site have been concluded, which involved extra works. The extra works identified required expenditure of the full contract sum detailed under the tender return along with all contingencies • Further works have been identified through progression of delivery of works to WBS. • All works have been reviewed and signed off internally by the Trust Fire Safety Manager, and an external independent consultant. • Costs have been returned as extra works identified under the existing contract. Costs are outlined as stated in the agreed schedule of rates. Total cost £150,000 exc of VAT and a detailed review of the tender documentation has been concluded.			
***Explicit Reasons as to how Value for Money will be achieved when a single supplier provides the requirement.** *Sufficient detail should be provided in this section or the request will be returned.*	A tender took place against a specification for compartmentation works for which Intrinsic were successful by some margin. As part of the tender assessment they provided a schedule of rates which was used to cost this works. This has already been verified under the original tender with no cost increase despite cost of living pressures. The incumbent provider were substantially more cost effective than the competition ie. Over 100% cheaper. Every repair is documented and QS'd as part of the Trust quality check, this exercised will be independently reviewed.			
***Have any Trials / Evaluations been undertaken within the Health Organisation?**	~~**Yes**~~	**No**	If Yes, please state the evaluation reference	

NB: Appropriate advice should be sought from Procurement in advance of trials being undertaken (*Please tick as appropriate)*		**no**	number if available e.g. SMTL trials	
If Yes, please give full details of evaluation. Including whether or not any relevant Groups have been made aware of this evaluation.				
***Consequence & Impact if not approved:**	Currently risk to Trust rated at risk factor 20 and is in breach of legislation. The contract firm have already undergone and been successful in an open tender exercise and are already mobilised and on site completing the works detailed during the initial tender.			
E*Is this an Essential or Non-Essential requirement?	**Essential**			
***Name:**	Jason Hoskins			
***Title:**	Assistabt Director of Estates Capital and Environment			
***Ward/Department:**	Estates			
***Contact No:**	07432126899			
***Budget Holder:**	Jason Hoskins			
I have delegated responsibility for the non-pay expenditure budget specified above. I confirm that sufficient funding is available within the budget code specified, and authorise the expenditure to be coded accordingly.				
***Signature of requestor (please also print name & position):**	Jonathan fear Estates Manager		***Signature of budgetary approver (please also print name & position):**	
Date of Request:	22/01/2023		**Date of Approval :**	
Statement of Support by Approver:				

**** Requestor to Complete****

Section 2

Declaration of Interest

The Health Organisation is obliged to ensure that all procurement processes are carried out in accordance with the public procurement rules and NHS Wales's guidance. Where an employee is engaged in a procurement exercise a formal declaration is required to confirm that there is no potential interest, which may give rise to a conflict.

Please confirm the following statements are correct:

		✓ ✗
1.	Neither I, my family, friends, acquaintances or work colleagues involved in this process, will receive any benefit or gain (financial or otherwise, directly or indirectly) if the contract is awarded to any of the bidders involved in the process as they become known.	✓
2a.	I have no material interest in whether the contract is awarded or not.	✓
2b.	I am not in possession of any Additional Information in respect of the procurement process. (Save for the information in the 'Additional Information box below)	✓

3.	I currently do not benefit in any way, financially or otherwise, including (but not limited to) the receipt of a grant or outside funding, that could influence my decision in respect of the procurement or any of the bidders involved in this process .	✓
4.	I have not received hospitality (other than of a nominal value or that declared in the register of gifts and hospitality maintained by Corporate Management) or any material gifts, as outlined in the Trusts Standards of Behaviour Framework Policy http://howis.wales.nhs.uk/sitesplus/972/page/51681 from any of the bidders involved in the process.	✓
5.	I have read, understood and will abide by the NHS Guidance entitled "Standards of Business Conduct for NHS Staff" (DGM (93)84) and the Trust Standards of Behaviour Framework Policy. http://howis.wales.nhs.uk/sitesplus/972/page/51681	✓
6.	By signing this declaration, I understand that it is my responsibility that should my circumstance change or a new relationship be established in relation to any bidding organisation, I will consult with the Lead Procurement contact and am aware that I may be required to complete a new Declaration of Interest or be required to withdraw my participation.	✓
7.	I will keep the identities of the bidders, the content of the bids and procurement documents confidential.	✓

I hereby certify that, to the best of my knowledge and belief, the statements set out above are correct. I understand that any failure on my part to declare an interest in a contract or otherwise, to breach the rules and instructions mentioned above is a serious matter and could result in further legal or professional action being taken against me, including (but not limited to):

- Exclusion from the current procurement exercise and future procurement activities
- For Trust employees, it could result in disciplinary proceedings being initiated.
- For non-employees of the Trust we reserve the right to report the matter to their relevant employing organisation and professional body as potential professional misconduct
- Should the matter involve issues that are of a criminal nature e.g. fraud, bribery or corruption then the Trust will notify the appropriate authority to take any necessary action, which may include prosecution.

Signature:

Signature: Jonathan Fear
Print Name: Jonathan Fear
Position: Estates Manager
Date:24/01/2022

Section 3 – Authorisation – In accordance with Health Organisation Scheme of Delegation

Designation	**Signature/approval**	**Date**
Directorate Manager/Head of Service		
Comments:	**Due to the nature and the criticality of concerns raised, I feel urgent deployment of this solution is imperative.**	

Executive Director/Director/ Divisional Director *(In accordance with Health Organisation procedures)*	**Carl James** **24/01/2023**	
Comments:		

Please note Single Tender/Quotation Action requests cannot be processed unless supported by the above signatures, electronic signatures will NOT be accepted, unless accompanied by an e-mail trail to prove that the authorisation has been completed correctly.

Please now forward to Procurement Services as per the relevant Health Organisation contact email address ****Please forward in Microsoft Word format only, if electronic signature is not an option please attach an email approval from the approver noted above****	
Velindre NHS Trust – Divisions and Hosted Units **NWSSP** **NWIS**	**NWSSP.HEIW.PHW.VEL.Procurement@wales.nhs.uk**
Public Health Wales NHS Trust	**NWSSP.HEIW.PHW.VEL.Procurement@wales.nhs.uk**
Health Education Improvement Wales	**NWSSP.HEIW.PHW.VEL.Procurement@wales.nhs.uk**

Section 4 - For Procurement Department Completion Only

Procurement Advice or Rejection Comments: *(e.g.* • *Yes, the SQA or STA is an appropriate course* • *No, an alternative option can be pursued* • *No option* • *Includ any conditions/future actions):*	Endorsed – essential to use same supplier.		
Endorsed *(Please tick as appropriate)*	**Yes**	**No**	
	X		
If Endorsed, procurement reference assigned:			
Head of Procurement Signature:			23rd January 2023

NB: in the event the Head of Procurement does not endorse this request, the relevant Procurement Business Partner will inform the requestor immediately.

Section 5 – Finance Approval in accordance with any Health Organisation specific procedures and Scheme of Delegation

Director of Finance			
Director of Finance/person with delegated Authority			
Approved		**NOT APPROVED**	
Comment:			
Name	**Position**	**Signature**	**Date**

Counter Signature for hosted organisations only *Only if required in line with the Scheme of Delegation and exceeding the Primary Signatory limit)*			
Director of Finance/person with delegated Authority			
Approved		**NOT APPROVED**	
Comment:			
Name	**Position**	**Signature**	**Date**

NB 1: In the event the Health Organisation does not authorise the request, the Procurement Business Partner will advise the requestor immediately of the decision.
NB 2: Requisitions must NOT be created before the SQA/STA request is approved and the associated procurement procedures followed.
NB 3: If approved, this form must be attached to the requisition.

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	VELINDRE UNHS TRUST - WBS COMPARTMENTATION FURTHER WORKS
DIVISION / HOST ORGANISATION	Corporate Estates, Environment and Capital
DATE PREPARED	22/01/2023
PREPARED BY	Jason Hoskins Assistant Director Estates, Environment and Capital
SCHEME SPONSOR	Carl James Director of Strategic Transformation, Planning, and Digital

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Fire Stopping Works (Compartmentation):

- To address all know compartmentation issues at WBS HQ as listed in the detailed survey and extra works identified following further intrusive inspection as completed by independent consultant commissioned by the Trust.

Background

- Assessment of the Trust Estate has highlighted a number of issues that present a risk from a fire safety perspective
- A business case has been presented to Welsh Government outlining funding requirements to address concerns raised
- Welsh Government have endorsed the proposal providing £1.1M of funding staged over a number of years in support rectification of the identified issues with £500K allocated for 2022/23
- An external consultancy firm was commissioned to carry out an assessment of the condition of compartmentation across which has informed the approach adopted by the Trust
- A work package to address issues that exist across the Trust relating to compartmentation has been tendered and the contract awarded.
- Works to the VCC Site have been concluded, which involved extra works. The extra works identified required expenditure of the full contract sum detailed under the tender return along with all contingencies

• Further works have been identified through progression of delivery of works with further funding requirements requested for the WBS HQ Building • All works have been reviewed and signed off internally by the Trust Fire Safety Manager, and an external independent consultant. • Costs have been returned as extra works identified under the existing contract. Costs are outlined as stated in the agreed schedule of rates. Total cost £150,000 exc of VAT and a detailed review of the tender documentation has been concluded.						
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	01/02/2023
Expected End Date of Contract	31/03/2023
Contract Extension Options **(E.g. maximum term in months)**	Two months

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☒
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
This scheme has been identified as part of the Estates Compliance Capital works 2021 – 2023. Funding has been secured through Welsh Government.		

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
There are limited options available with the exception of

Option 1 - Do Nothing – presents ongoing H&S risks associated with the non-compliance – Fire Safety legislation and H&S legislation breach *Option 2 – Carry out works to improve compartmentation to meet the requirements of the external survey, In doing so making the Trust compliant with WHTM and H&S Legislation* *Preferred Option – This option provides a compliant solution reducing risk of fire to life, limb, and property. Underpinned by a full assessment of each element of work which will be logged on the electronic estates management system (Bolster) for record.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Provides a fully auditable compliant solution to asset level including update of the Trust Fire Safety Management documentation, and Bolster system allowing ongoing management of each repair. • Removes all identified risk presented by insufficient compartmentation as detailed within the commissioned survey and provides a benchmark for future management. • Having very recently tendered this scheme the incumbent service provider were seen to be over 100% more cost effective than the competition. The tendered rates are being honored with no cost of living increase added.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
• Non compliance with WHTM firecode • Non compliance with H&S Legislation • Non compliance with building documentation - The Fire Strategy for buildings	• Risks cannot be fully mitigated

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

Formal procurement exercise has already been undertaken against the initial specification issued via issue through external consultant (Gleeds). This is an extension of works to address identified variations not included within the original tender. The contractor identified within the STA was the successful partner for the initial contract and were more cost effective by some margin. They are currently mobilised onsite and there is an agreed schedule of rates in place from the original contract.

6.3 What is the approximate time line for procurement?

N/A

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route

Head of Procurement Name:	Helen James
Signature:	

Date:	23rd January 2023

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)**	**Including VAT (£k)**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Compartmentation	£150,000				£150,000	£180,000
Overall Total	£150,000				£150,000	£180,000

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*This project will be managed against organisational SFI's and the estates project management process.*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Carl James
Signature:	
Service Area:	Director of Transformation, Planning and Digital
Date:	24/01/2023

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	
Divisional Senior Management Team	N/A
Executive Management Board	

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	
HTW – Senior Management Team	

Trust Board

AMENDMENT TO STANDING ORDERS – SCHEDULE 3

DATE OF MEETING	31st January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Lauren Fear Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs & Health Science
REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	26/10/2022	ENDORSED
Quality, Safety & Performance Committee	10/11/2022	ENDORSED
Audit Committee	12/01/2023	ENDORSED

ACRONYMS	
SO	Standing Orders
ToR	Terms of Reference

1. SITUATION

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

The purpose of this report is to outline the required changed to the Trust Standing Orders – **Schedule 3,** resulting from the Annual Review of the **Terms of Reference and Operating Arrangements** in respect of the **Quality, Safety & Performance Committee**, (ref. ***Appendix 1 [no track changes] & Appendix 2 [with track changes],*** and is seeking formal **APPROVAL** by the Trust Board.

2. BACKGROUND

The amendments detailed in this report have been agreed via collaborative engagement with the wider Executive Management Team in conjunction with effective oversight and review by the Chair of the Quality, Safety & Performance Committee. The proposed changes have been formally ENDORSED by the Quality, Safety & Performance Committee in November 2022 and the Trust Audit Committee in January 2023.

3. ASSESSMENT /SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Summary of Amendments

The revised Terms of Reference and Operating Arrangements for the Quality, Safety & Performance Committee are set out in ***Appendix 1 & 2,*** with the latter inclusive of track changes for ease of reference and transparency. The proposed amendments include the following key changes summarised below:

Terms of Reference & Operating Arrangements	Summary of Amendments
Quality, Safety & Performance Committee	**Section 3:** - Addition of **Duties of Quality and Candour** to the Quality Management System the Trust already has in place. - Addition of **Integrated Quality & Safety Group** to **Sub Committees,** to provide triangulation and analysis of outcomes of the Quality Management System and Divisional Quality Hubs to the Quality, Safety & Performance Committee. **Section 3 *additional*:** - Highlighted items within the **Delegated Powers and Authority** section are due to be addressed / agreed via further discussion at the November 2022 Quality, Safety and Performance Committee, namely: o 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; o 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; o 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. **Section 4:** - Addition of **Deputy Director of Organisational Development and Workforce** to attendees of the Quality, Safety & Performance Committee. - Amendment of job title of **Quality & Safety Manager** to **Head of Quality, Safety & Assurance**. **Section 6:** - Highlighted items within the **Relationships & Accountability** section are due to be addressed / agreed via further discussion at the November 2022 Quality, Safety and Performance Committee, namely: o **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

Terms of Reference & Operating Arrangements	Summary of Amendments
	Board on the adequacy of the Trust's overall framework of assurance. ○ The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) Evidence suggests there is a correlation between governance behaviours in an organisation and the level of performance achieved at the same organisation. Therefore, ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Trust Board is asked to **APPROVE** the amendments to the Trust Board Standing Orders – **Schedule 3** as outlined in section **3** of this report, and included in ***Appendix 1 & 2.***

Quality, Safety and Performance Committee

Terms of Reference &

Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 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.

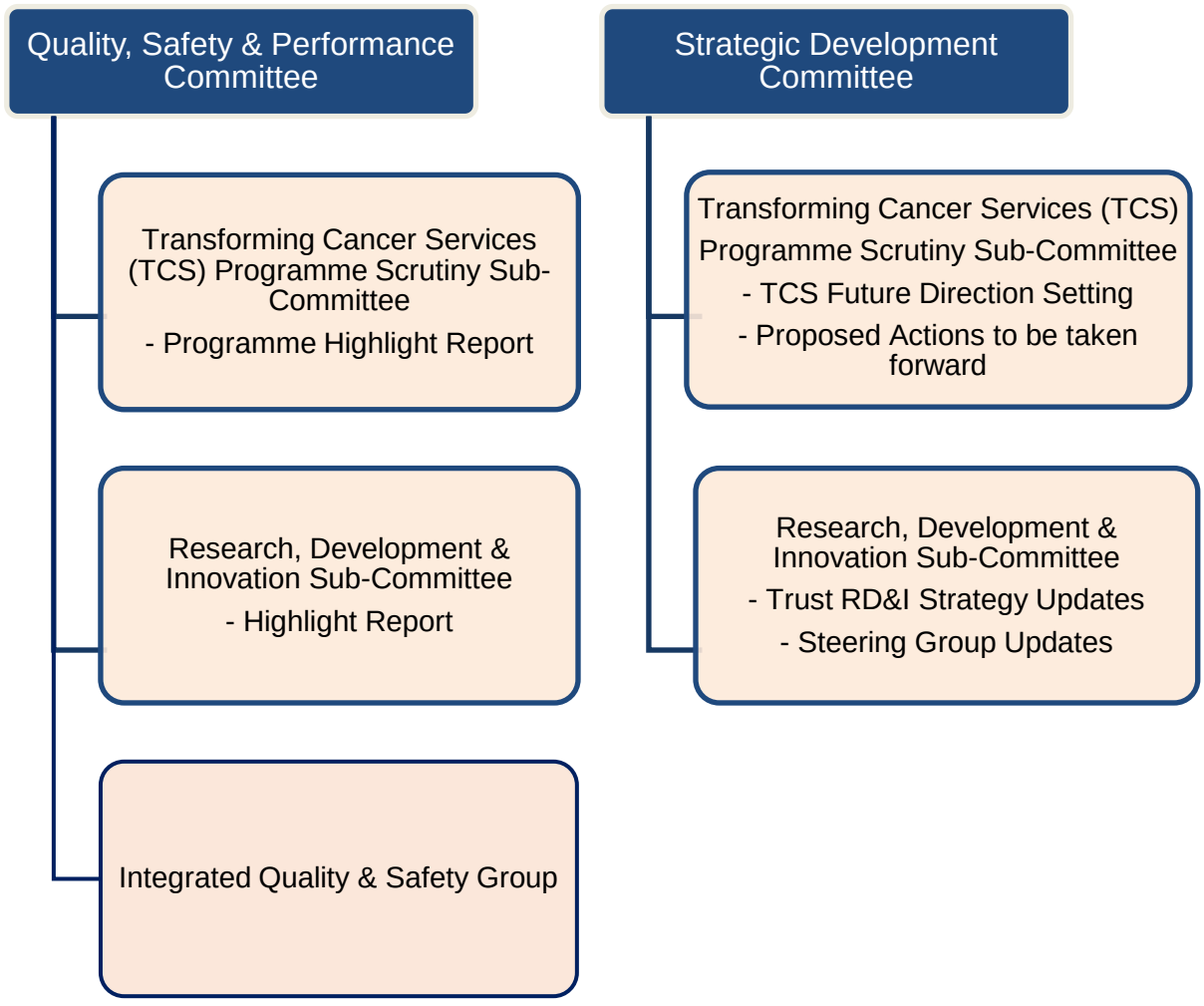
Sub Committees

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

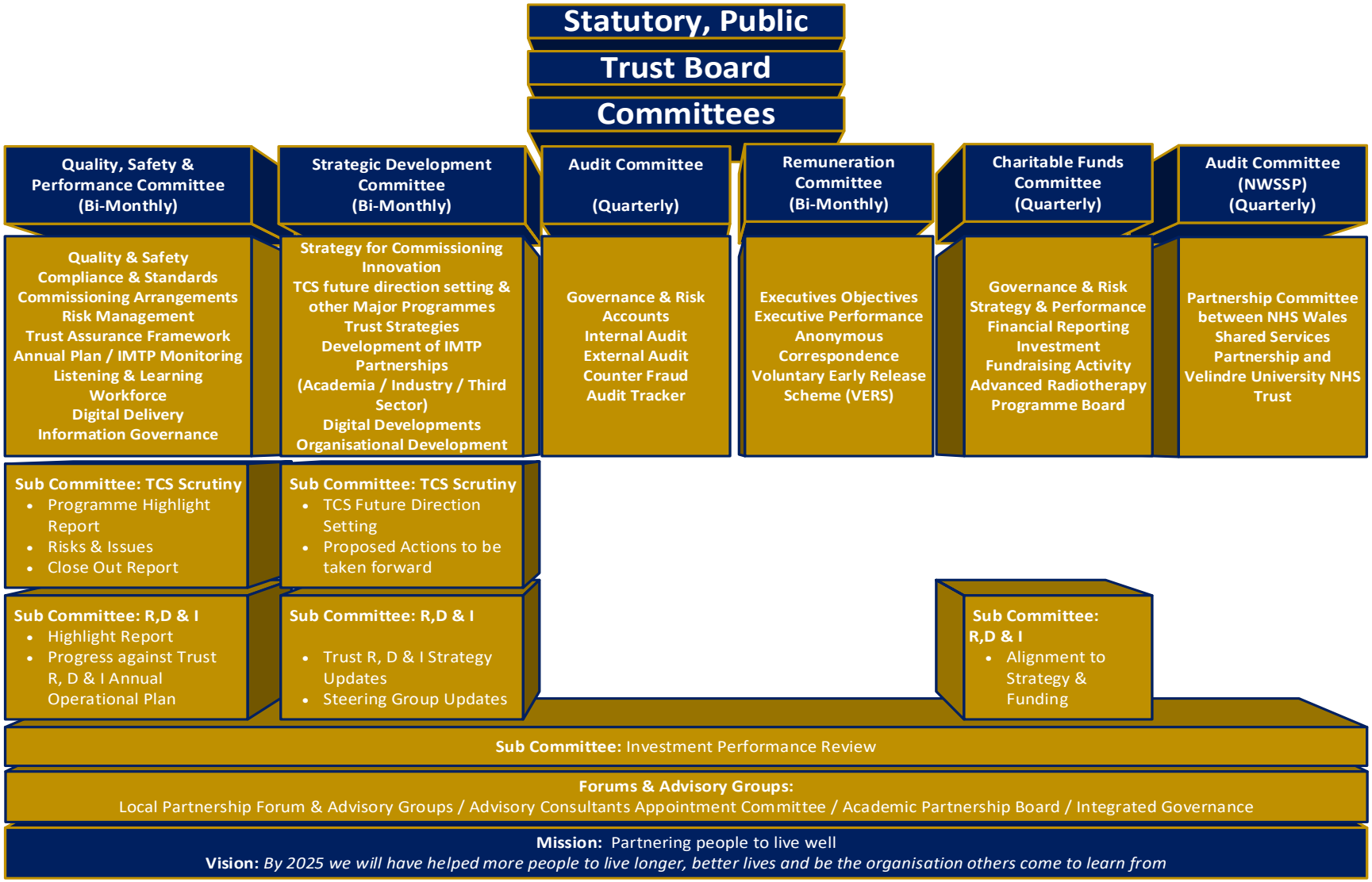
9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

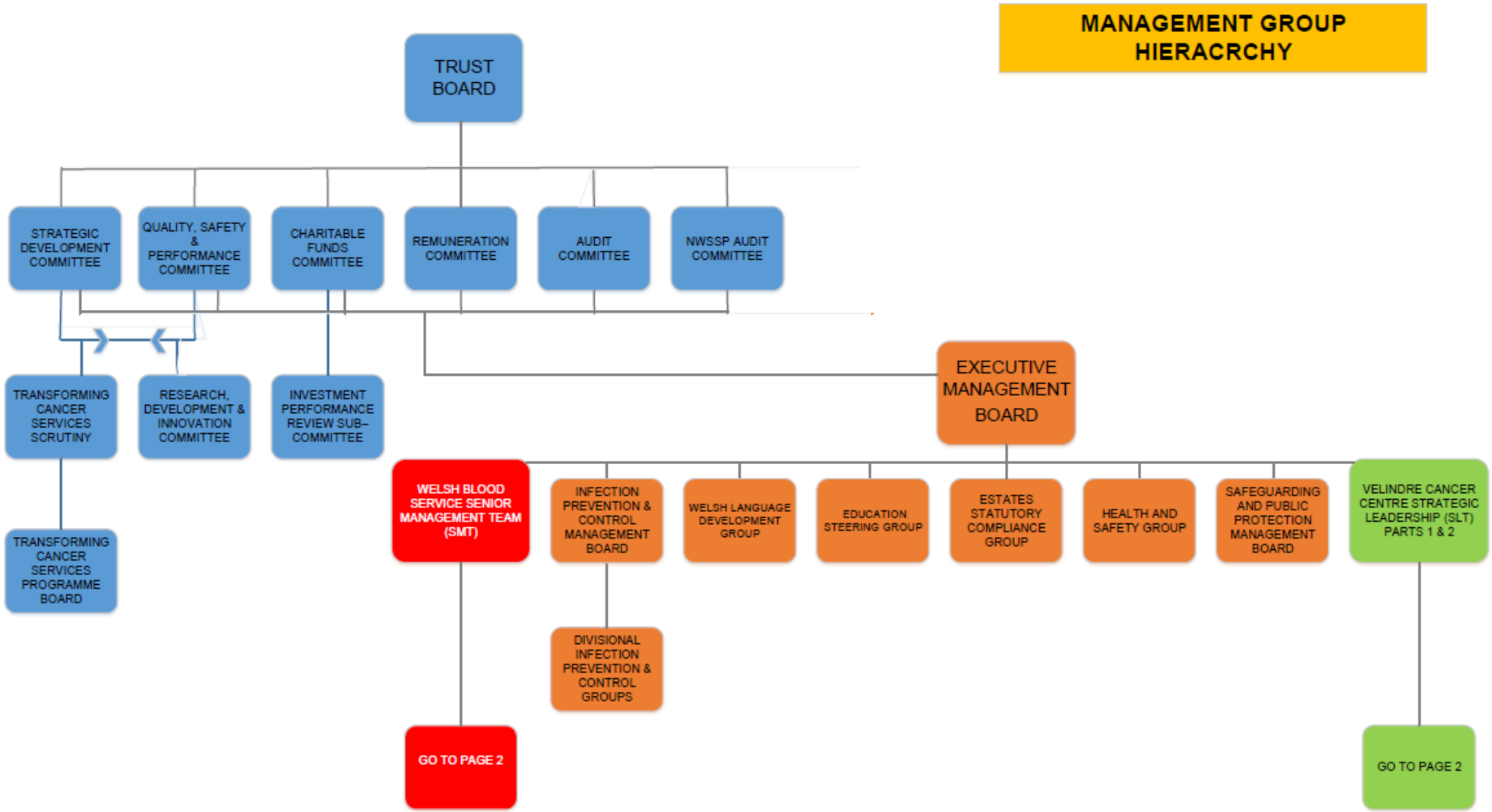
10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf 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.

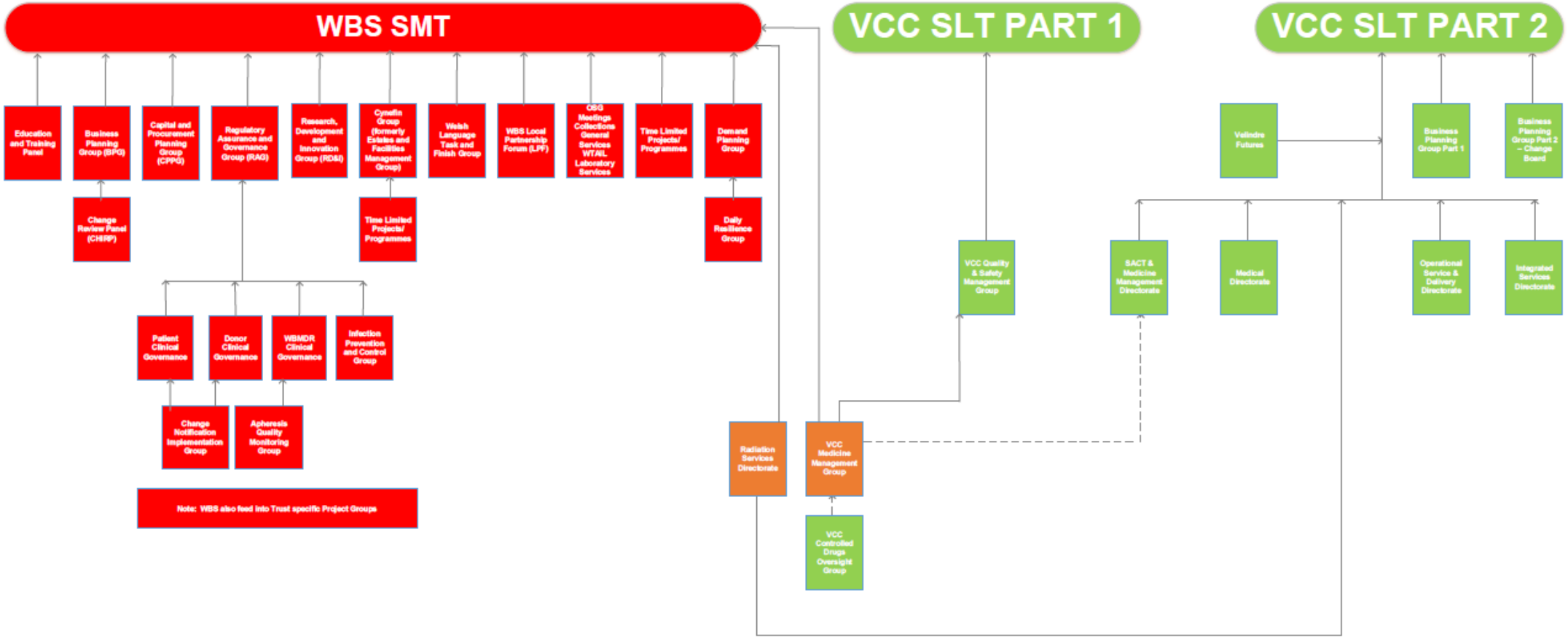
10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK




WBS SMT
VCC SLT PART 1
VCC SLT PART 2
Education and Training Panel
Business Planning Group (BPG)
Capital and Procurement Planning Group (CPPG)
Regulatory Assurance and Governance Group (RAG)
Research, Development and Innovation Group (RD&I)
Cynefin Group (formerly Estates and Facilities Management Group)
Welsh Language Task and Finish Group
WBS Local Partnership Forum (LPF)
QEG Meetings Collections General Services WT/AL 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 Quality & Safety Management Group
Radiation Services Directorate
VCC Medicine Management Group
VCC Controlled Drugs Oversight Group
Velindre Futures
Business Planning Group Part 1
Business Planning Group Part 2 – Change Board
SACT & Medicine Management Directorate
Medical Directorate
Operational Service & Delivery Directorate
Integrated Services Directorate

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 2023

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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.

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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

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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;

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- 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:

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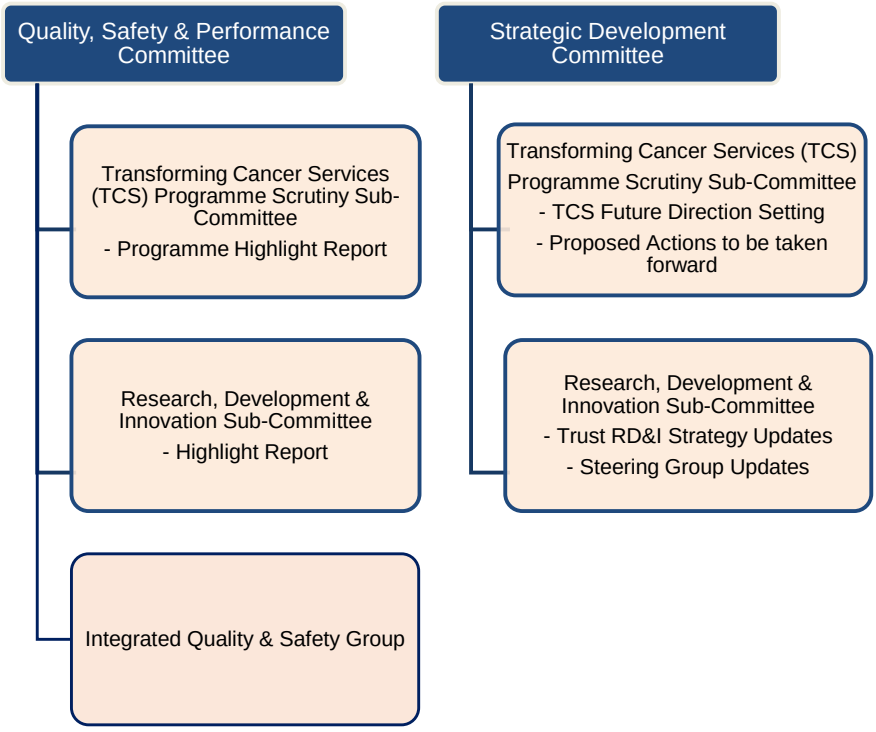

Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted by the Trust Board. Further details regarding 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.

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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

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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.

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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.

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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.

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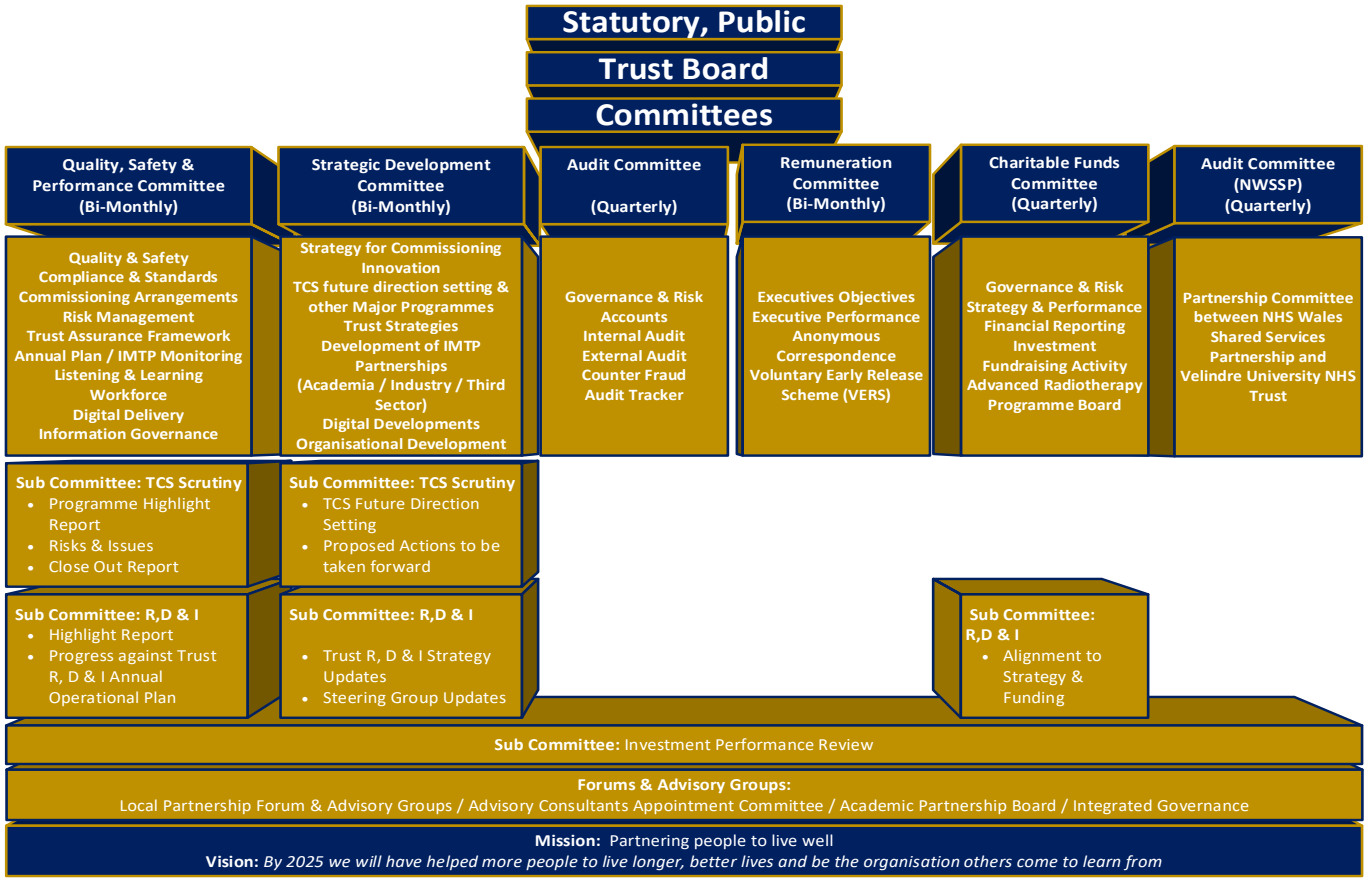

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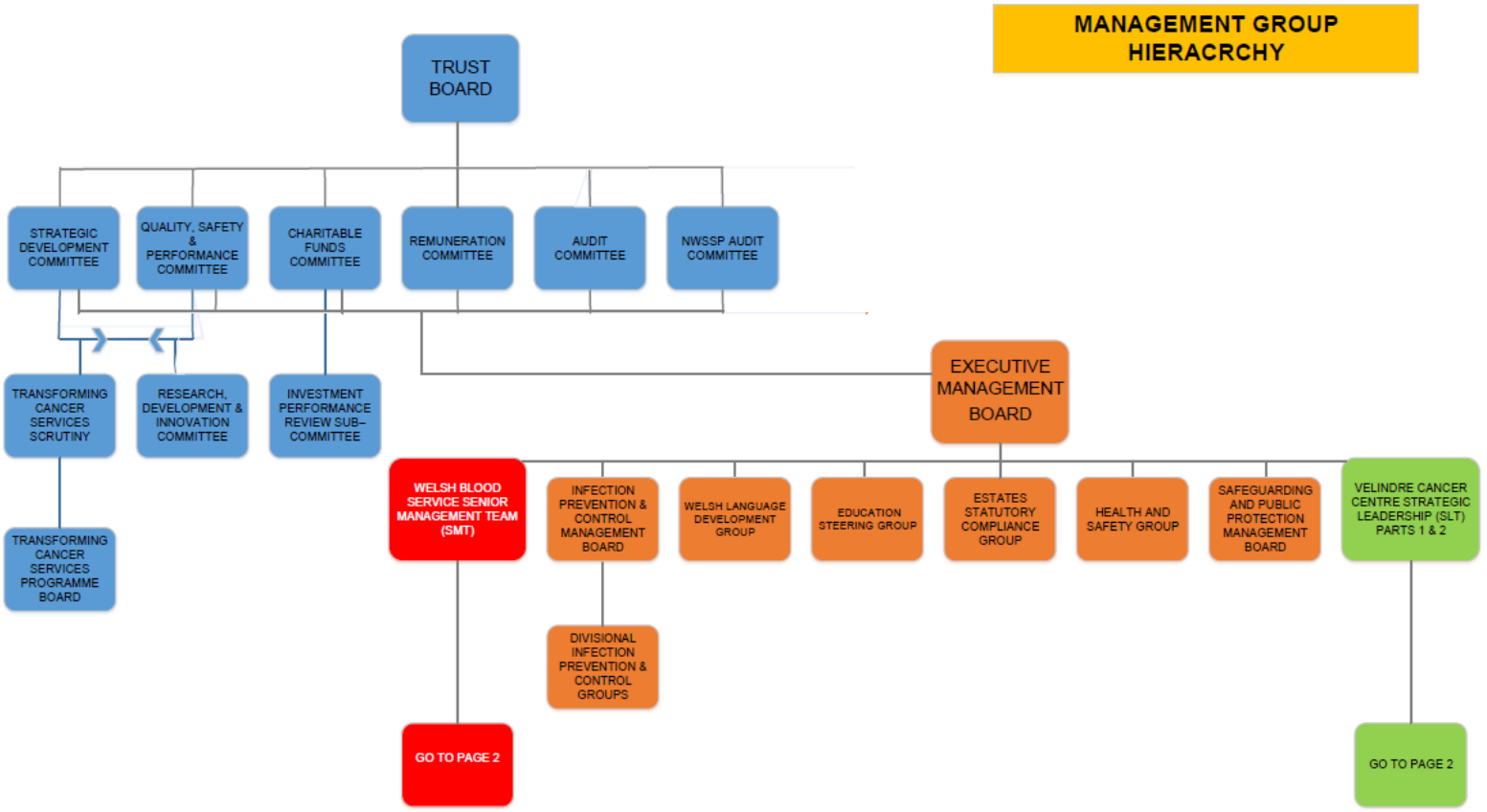

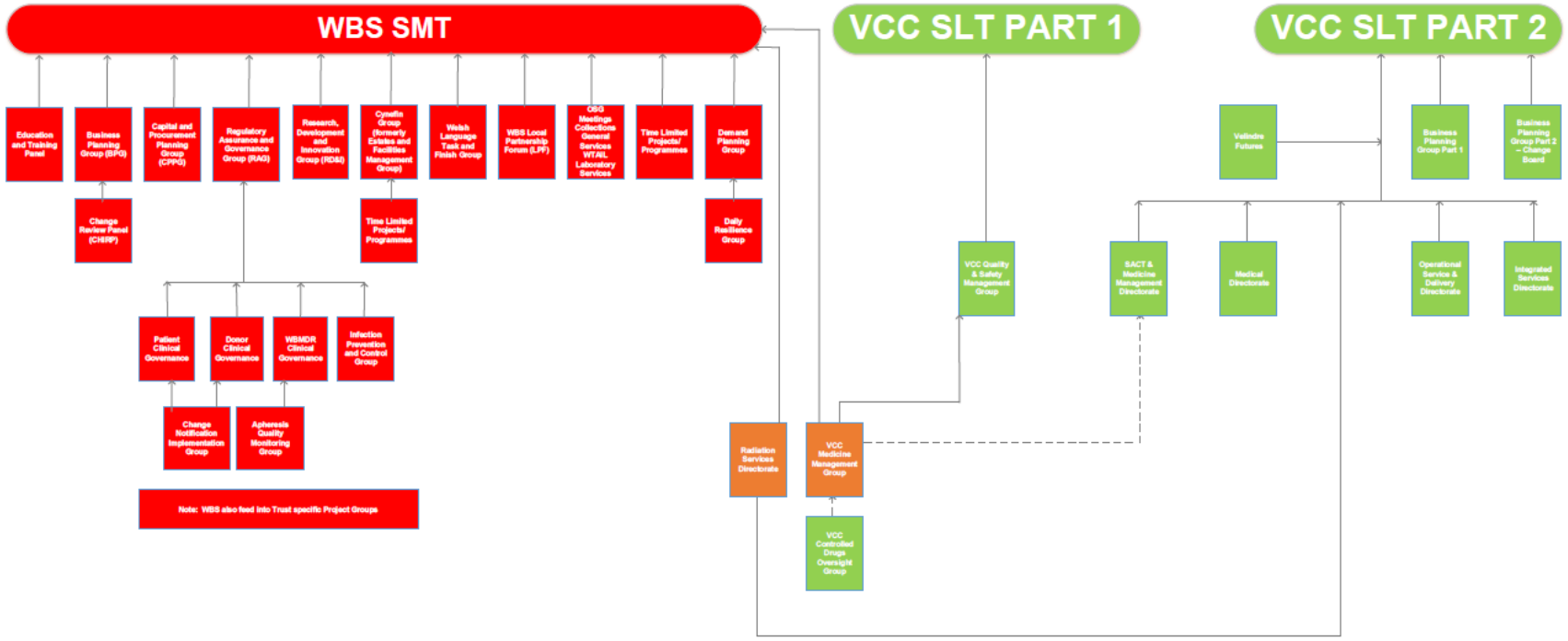
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Business Planning Group Part 2 – Change Board
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TRUST BOARD

TRUST WIDE UPDATE

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	03/01/2023	ENDORSED FOR APPROVAL OR ADOPTION
Quality, Safety & Performance Committee	17/01/2023	ENDORSED FOR APPROVAL OR ADOPTION

ACRONYMS	
EMB	Executive Management Board
QSP	Quality, Safety & Performance Committee

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy for the Management of Policies, Procedures and other Written Control Documents", the Trust Board is required to approve some policies.

1.2 The purpose of this report is to present to the Trust Board the amendments and updates made to a Trust wide Policy.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Executive Management Board and Quality, Safety and Performance Committee have endorsed the Management of Safety Alerts and Important Notification Policy (Reference QS02) for approval by the Trust Board.

2.2 The Management of Safety Alerts and Important Notification Policy (Reference QS02) has been updated to reflect:

- Enhanced arrangements in line with Welsh Government's authorisation for the NHS Wales Delivery Unit to lead on adapting existing Patient Safety Solutions so they are applicable in Wales and,
- Revised oversight arrangements – the closure of the Safety Alerts Group with transfer of the oversight of delivery against requirements of national safety alerts to the newly established Integrated Quality & Safety Group

2.3 The Policy will require a further review in April 2023 to ensure additional updates are captured in line with the introduction of the Once for Wales Safety Alerts module reporting system and the additional functionality provided.

2.4 Following Trust Board approval of the above Quality and Safety policy, it will be uploaded to the Trust Intranet, published on the Trust's Website and circulated via the policy distribution list for immediate implementation.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) The Trust has a defined process for the management of policies and written control documents. The purpose of which is to ensure staff are aware of their responsibilities with regards to Trust policy documents and to provide a 'model' guide and consistent approach for the development, management and dissemination of the Trusts documents

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes Each policy has been individually assessed to ensure compliance with EQIA's
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal. Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.

4. RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the following Quality and Safety Policy endorsed for approval by the Executive Management Board and Quality, Safety and Performance Committee:

- Management of Safety Alerts and Important Notification Policy (Reference QS02)

QS02
Management of Safety Alerts and Important Notifications Policy

Executive Sponsor &Function:	Executive Director Nursing, Allied Health Professionals and Health Science
Document Author:	Quality, Safety and Assurance Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	*17.1.2023 (TBA)*
Date of Equality Impact Assessment:	NA
Equality Impact Assessment Outcome:	NA
Review Date:	*January 2024*
Version:	1

TABLE OF CONTENTS **PAGE NUMBER**

APPENDICES

1. Policy Statement

Safety Alerts and Important Notifications are developed and distributed to Velindre University NHS Trust, to support and direct solutions required to improve patient safety. The NHS Wales Delivery Unit has been given the authority by Welsh Government to lead on the vital role of adapting existing Patient Safety Solutions, so that they are applicable for Wales. Key safety risks, concerns and solutions are identified and developed at a national level, and where appropriate are adopted in Wales through a collaborative approach. The Delivery Unit is responsible for distributing Patient Safety Solutions at an all-Wales level to help manage risks identified and monitor compliance with NHS Wales's organisations.

The purpose of this procedure is to set out and ensure an effective internal management system within Velindre University NHS Trust for the distribution, monitoring and compliance of all Safety Alerts and Important Notifications received throughout the Trust. The Trust must be able to demonstrate that it has responded appropriately to alert information that is received, and evidence that robust audit trails are in place which confirm that appropriate actions have been taken within a reasonable time period.

It does not replace the duty and professional accountability of staff to report any adverse incidents with a medical device, hazardous product or unsafe procedure.

Working to a defined standard will reduce variations, so that solutions are relevant and useful to Velindre University NHS Trust and should avoid unnecessary overload of solutions work.

2. Responsibilities

The Chief Executive has overall responsibility for the management and oversight of all alerts and notifications management process, alert compliance, implementation and sign off within the Trust. For the practical operation of the system the Chief Executive has delegated this responsibility to the Corporate Quality and Safety Department (Quality, Safety and Assurance Manager's) who have a central role in ensuring that key personnel receive the solutions for actions, as considered appropriate by Velindre University NHS Trust. The role requires responsibility for acknowledging, disseminating, closing off safety alerts and providing feedback to relevant service divisions within designated timescales

The Divisional Directors have responsibilities to ensure arrangements are in place locally for the dissemination, action, and review of alerts within their area(s) of activity and responsibilities. This includes the nomination of an assigned nominated lead for the alerts and notification process and is set out in **APPENDIX 1** within this policy.

If, following the implementation of alert, information needs to be shared to identified staff, this will be done so via the most appropriate method of communication. All staff who receive information are responsible for ensuring they understand and apply to their practice.

2.1 The nominated Trust lead/deputy is responsible for:

- The onward distribution within the Trust to the Velindre Cancer Service and Welsh Blood Service Divisional leads.
- Consulting with the Divisional leads nominated to review the alert.
- Monitoring progression of solutions against set deadlines.
- Liaising with the Delivery Unit, updating the Datix Alerts Module, to ensure up to date and robust compliance recording.
- Confirming to the Delivery Unit the Trust compliance status by the deadline set out within the alert.
- Attending the All-Wales Patient Safety Solutions Reference Group contributing to the development and oversight of solutions compliance.

2.2 The service leads are responsible for:

- Receiving alerts via the Corporate Quality & Safety Department on behalf of their Division and speciality area.
- Acknowledging all alerts and to confirm if the alert is applicable within 48 hours of receipt.
- Ensuring the review of alerts and identifying appropriateness for the service.
- Undertaking a baseline assessment against Divisional compliance, risk assessing the issues involved and adding to the Risk Register if appropriate.
- Ensuring actions are identified and implemented within the area of responsibility to enable compliance with the alert.
- Leading on completing the actions held within the action plans and return compliance status to the Corporate Quality and Safety Department.

3. The various types of Safety Alerts and Important Notifications include:

- Patient Safety Alerts
- Patient Safety Notices
- Ministerial Letters
- Pharmaceutical Alerts
- Product Recalls and Manufacturer/Field Safety Notices
- Estates and Facilities Alerts
- Medical Device Alerts
- Security Alerts
- Healthcare Inspectorate Wales Reports
- Regulatory agency reports e.g., Health and Safety Executive, Fire authority, Human Tissue authority
- Accreditation visit reports
- Internal Safety Notices (Health and Safety)
- Internal Safety Notices (Patient Safety)
- Professional Regulatory Alerts

This list is not exhaustive and from time-to-time other important notifications may be received which require an equivalent response by the Trust. NHS organisations are required to submit responses on the action they have taken and are monitored on their compliance with completing such alerts within agreed deadlines when required.

4. Safety Alerts Oversight Arrangements

The Trust Integrated Quality & Safety Group is responsible for monitoring and overseeing the implementation of national safety alerts through receipt of at least a quarterly position report. The Group is also responsible for commissioning implementation and assurance audits. The outcomes and outputs will be reported quarterly to the Quality, Safety & Performance Committee.

5. Record Keeping

The Corporate Quality and Safety department is responsible for maintaining a register of all publications received and monitoring follow-up action status for reporting to the Trust Quality, Safety and Performance Committee.

To ensure the Trust is operating a robust system for managing alerts regular monitoring will be carried out. Quarterly reports outlining performance will be reported to the Trust Quality, Safety and Performance Committee.

6. Audit and Review

An annual audit will be undertaken by the Trust Corporate Quality and Safety Department to assess ongoing compliance with actions and timeframes and will include a review against compliance of twenty percent of Safety Alerts and Important Notifications received within each financial year.

The audit outcome will be reported to the March Trust Quality, Safety and Performance Committee.

Appendix 1

Nominated assigned leads

Type of safety alert / notification	Divisional nominated leads	Department	Responsible group
Patient safety alerts	**VCC:** Head of Nursing Quality and Safety Manager **WBS:** Head of Quality Assurance	VCC & WBS Quality and Safety Department	VCC SLT/WBS SMT/ Integrated Quality & Safety Group
Patient safety notices	**VCC:** Head of Nursing Quality and Safety Manager **WBS:** Head of Quality Assurance	VCC & WBS Quality and Safety Department	VCC SLT/WBS SMT/ Integrated Quality & Safety Group
Ministerial Letters	Board Secretary	Corporate Governance Department	Executive Management Board
Pharmaceutical Alerts	**VCC:** Head of Pharmacy /deputy	VCC Pharmacy Department	Medicine Management Group
Product Recalls and Manufacturer /Field Safety Notices	Head of Estates Health, Safety & Environment Officer (WBS)	Estates Department / Health and Safety	Health & Safety Management Group
Estates and Facilities Alerts	Head of Estates (VCS) Health, Safety & Environment Officer (WBS)	Estates Department /Health and Safety	Trust Health &Safety Management Group
Medical Device Alerts	VCC Medical Physics lead	VCC Medical physics	Trust Health and Safety Management Group
Security Alerts	Head of Estates	Estates Department	Trust Health & Safety Management Group
Healthcare Inspectorate Wales Reports	**Corporate:** Head of Quality and Safety **VCC:** Head of Nursing Quality and Safety Manager **WBS:** Head of Quality Assurance	Corporate Quality and Safety Department Divisional Q&S Teams	VCC SLT/WBS SMT/ Integrated Quality & Safety Group
Regulatory agency reports e.g., Health and Safety Executive,	**VCC:** Head of Nursing Quality and Safety Manager **WBS:** Head of Quality	Corporate Quality and Safety Department	VCC SLT/WBS SMT/ Integrated Quality & Safety Group

Fire authority, Human Tissue authority	Assurance **Corporate:** Head of Quality and Safety Department	Divisional Q&S Teams	
Accreditation visit reports	Head of Corporate Governance	Corporate Governance Department	Executive Management Board
Internal Safety Notices (Health and Safety)	Health and Safety Manager	Health and Safety Department	Trust Health & Safety Management Group/Local Groups
Internal Safety Notices (Patient Safety)	**VCC:** Head of Nursing / Quality and Safety Manager **WBS:** Head of Quality Assurance	Divisional Quality and Safety Departments	VCC SLT/WBS SMT/ Integrated Quality & Safety Group
Professional Regulatory Alerts	HR Officers Medical/Clinical Directors Professional Heads of Department	VCS/WBS Divisions/Hosted Organisations	Professional Groups: PNF, AHP & Health Science Meeting Executive Management Board

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	31st January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
WG	Welsh Government
LHB	Local Health Board
nVCC	New Velindre Cancer Centre
IRS	Integrated Radiotherapy Solution

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 17th November 2022.

1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert/Escalation to the Trust Board.
ADVISE	There were no items identified to Advise the Trust Board.
ASSURE	**TCS Programme Finance Report** The Sub-Committee received the TCS Programme Finance Report and the following queries were raised: • It was noted that the Sub-Committee are keen to gain a clear understanding of the potential impact on the Trust's finances. This was to be fed back to the author in order to further develop this detail in the report. • The Sub-Committee noted that the £0.434m sum to support the IRS programme has now been returned to the Trust Discretionary fund upon approval of the FBC. • Clarity was sought with regards to potential further underspend this year over and above the current underspend and whether this would mean a shortfall in the enabling works project next year due to delays in utilising the funds. It was explained that due diligence had been conducted in terms of reviewing and assessing the contracts in order to produce an accurate forecast and that there are processes by which this can be managed with Welsh Government, although it is understood that revising the planned spending generally becomes more difficult. • The potential impact of the annual NHS pay award referenced at para 7.28 was queried and it was confirmed that this had been factored into the revenue position. The Sub-Committee **noted** the TCS Programme Finance Report.

	Programme Director's Report The Sub-Committee received the Programme Director's Report, noting that the Programme Tranche Review has now received an initial review by the Independent Members. Noted also that the IRS is now ready to be signed and is awaiting ministerial approval. The "new" status of Risk R394 was queried. It was clarified that this is not a new risk but is a long-standing risk being presented in a different way. It was agreed that this was misleading and the words "new risk" would be removed. It was noted that a number of the risks had review dates which had passed. It was explained that these risks related to the outreach project which is currently still on hold. The accuracy of the description of Risk R2418 was queried. It was agreed that this risk in indeed due for review and that this would be carried out shortly with an update to follow. Concerns were raised over the current hard campaign against the TCS clinical model and the potential effect, if any, this was having on Welsh Government decisions. It was noted that on the balance of evidence, there was sufficient confidence that the objectives can and will be achieved. The Sub-Committee noted the Programme Director's Report. **Nuffield Recommendations Update** The Sub-Committee received the Nuffield Recommendations update and noted that good progress continues to be made. It was noted that the Heads of Terms had been agreed and that branding work is underway but clarity was sought as to what extent Velindre has been incorporated in either the nomenclature or the branding. The Sub-Committee were advised that the Heads of Terms, which have been written by a member of Velindre staff, are currently in draft and will be taken through EMB for sign-off, and that Velindre are very much in control of both pieces of work. It was queried whether legal input had been given and this was confirmed. The Sub-Committee **noted** the Nuffield Recommendations Update.

	The Sub-Committee received a brief update of the **FBC and Planning** progress, and **noted** that the FBC has been approved by Health Boards and is complete and that planning is imminent.
INFORM	**Communications & Engagement** The Sub-Committee received and **noted** the Communications and Engagement update.
APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	31st January 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Stephen Harries, Vice-Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
EqIA	Equality Impact Assessment
IRS	Integrated Radiotherapy Solution

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee held on 8th December 2022.

1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Trust Board.
ADVISE	**Workforce Planning (Workforce Risks and Issues)** The Committee received a presentation on Workforce Planning which was discussed as follows: • The Trust's level of freedom in terms of recruitment (e.g. recruiting internationally) was queried. It was clarified that from an advertising perspective the Trust has autonomy to advertise as it sees fit and does indeed have the remit to recruit internationally. • Although the Committee was supportive of the presentation content and its future planning, concern was raised regarding the current workforce challenges and assurance sought around what action is being taken to address the immediate issues in areas such as Medical Physics, Planning, etc. It was noted that whilst this is indeed an important point, the presentation was made for this committee which addresses future plans as opposed to the "here and now", which are matters that would be addressed at the Trust's Quality, Safety and Performance (QSP) Committee. • The Committee noted a recent successful recruitment round within the IRS programme, including a number of people from outside the organisation being appointed into senior roles, attracted by the organisation's future direction. The Committee **noted** the Workforce Planning (Workforce Risks and Issues) presentation. **Integrated Medium Term Plan** **Welsh Government Planning Framework 2023-2026** **IMTP 2023-2026 Progress to Date** The Committee received an update on current IMTP progress, noting that well-developed, detailed plans will be brought to the February meeting of the Committee.

	It was noted that following recent Welsh Government guidance, the submission date has been revised to 31st March 2023. The Committee **noted** the Integrated Medium Term Plan update.
ASSURE	There were no items identified to assure the Trust Board.
INFORM	The Committee received the **Destination 2032 Launch Plan** and noted that care should be taken when introducing to the wider audience to ensure it is delivered in an uncomplicated, easily digestible manner. The apparent non-requirement for an Equality Impact Assessment, as stated on the Covering Paper template, was queried, and assurance sought that all potential equality and diversity issues had been considered. It was clarified that all strategies which received Board approval in May were EqIA assessed but it was agreed that this would be reviewed in terms of the Launch Plan. The Committee **noted** the Destination 2032 Launch. The Committee received the **Welsh Blood Service Five-Year Plan – Update** It was queried whether the five-year strategy had been developed as an all-Wales document. Engagement with key partners and stakeholders, the CHC and WBS staff was confirmed. Attention was brought to the lack of detail surrounding some of the key areas (building renovations, Plasma for Fractionation, etc.), although it was noted that the current intention is primarily to build the broad framework for the strategy, and that further details of each area will be brought back to the Committee by way of regular updates as each programme is developed. Concern was raised regarding the stated commitment to achieving carbon neutrality by 2030, due to the likely challenges in meeting this. It was agreed that this was an ambitious target and this statement would be reviewed. The Committee **noted** the Welsh Blood Service Five-Year Plan update. The Committee received a brief outline of the **Building Our Future Together Programme**.

	It was noted that engagement of staff is addressed in the paper but the level of continuous engagement with the wider community and stakeholders was queried. It was explained that the focus is on developing the narrative of becoming an organisation that engages the community to support and provide input, although concern was raised at setting the framework without engagement of the community which could leave to decisions being made and later opposed. The Committee **noted** the Building Our Future Together Programme update. The Committee **noted** the **Performance Accountability Framework and Delegation Framework update** The Committee **noted** the **Talbot Green Infrastructure Programme Progress Update** The Committee **noted** the **Value Based Healthcare Programme of Work**. The Committee **noted** the **Trust Assurance Framework update**. The Committee **noted** the **RD&I Sub-Committee Highlight Report**.
APPENDICES	None.

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	31st January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

ACRONYMS	
HIW	Healthcare Inspectorate Wales
NRI	National Reportable Incident

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 17th January 2023.

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. Following its annual review in October

2022, the Committee continues to mature, actively seeking opportunities for continuous improvement, together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHT REPORT: 17th January 2023

3.1 Committee Governance

Committee Governance was a core theme of the meeting. Committee members identified that although there have been improvements in the quality of papers in the last year, further work is required to ensure robust, clear and focussed reporting, with effective tracking of improvement actions to provide the necessary assurance. The establishment of the new operational Integrated Quality & Safety Group and the work due to commence on the implementation of the 7 levels of assurance framework will enable improved reporting and Committee effectiveness. It was recognised that the Integrated Quality & Safety Group will require time to mature and that a robust business intelligence system is required to facilitate effective triangulation.

A review of the highlight report was undertaken following the November 2022 meeting to facilitate targeted, high-level reporting of items for escalation, key risks and actions undertaken / required to the Board. For Board members, who are not members of the Committee who require further detail, the agenda and papers for the January Quality, Safety & Performance Committee can be accessed at: https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-committee-2023/quality-safety-performance-committee-papers-17012022/

3.2 Summary of Committee Highlights

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

ALERT / ESCALATE	There are no items to alert or escalate to the Board.
ADVISE	• **Finance Report** The Committee received the Financial Report, outlining the financial position for the period to end of November 2022, **NOTING** the year end

	forecast to achieve breakeven and ongoing risk relating to income to cover the COVID backlog and additional capacity costs. • **Welsh Blood Service Divisional Report** The Welsh Blood Service performance report, for November 2022 reporting period was received and the Committee **NOTED** the current positive stock level position across all priority groups. The provision of mutual aid to Northern Ireland, the maintenance of stock levels throughout the Christmas period and during industrial action and, an increase in Bone Marrow volunteers resulting from targeted education campaigns was commended. • **Duty of Quality Gap Analysis** The gap analysis report against the Duty of Quality consultation Statutory Guidance and draft implementation plan were received and discussed, recognising that a number of timescales will be challenging in terms of delivery. Work has been undertaken in conjunction with the national Duty of Quality & Duty of Candour Implementation Board to identify minimum requirements to be in place by the 1st April 2023. Resource requirements for delivery were flagged and these will be included within the IMTP. The Committee noted that the final Statutory Guidance document was unlikely to be published until just a few weeks prior to the 1st April 2023. The Committee will receive an implementation update at the next meeting.
ASSURE	• **Velindre Cancer Service – Patient Story** The Committee received a heart-warming patient story by means of a PowerPoint presentation, relating to the arrangement of a wedding blessing at Velindre Cancer Centre for a patient who had received a terminal prognosis. The story demonstrated how staff, teams and departments at Velindre Cancer Centre worked together to deliver what mattered most to the patient, which was a wedding blessing and to be able to die at home. The importance of ascertaining what mattered most to the patient and working as a team to go above and beyond to achieve this for the patient was recognised and commended. • **Trust Integrated Quality & Safety Group** A report was received covering the Integrated Quality & Safety Group outcomes from October 2022 (inaugural meeting) to December 2022. The Integrated Quality & Safety Group was established to provide Executive operational oversight to support the Trust in meeting its

	Quality and Safety responsibilities, including the legislative and national requirements in relation to the 'Duty of Quality' responsibilities to help to ensure quality is at the centre of all decision making across the Trust. The Integrated Quality & Safety Group identified the need to develop a robust automated business intelligence system and to identify the Trust's comprehensive suite of quality, harm and safety measures. The Committee **APPROVED** the Integrated Quality & Safety Group Terms of Reference, with an initial six-month review period. • **Workforce & Organisational Development Performance Report / Finance Report** The report was received and discussed, highlighting current key workforce and associated financial risks. The Committee was assured that targeted recruitment interventions in hotspot areas had resulted in improvement, leading to an anticipated 16% year on year reduction in Agency spend for 2022-23. The committee sought assurance that the progress made in these hot spot areas could be replicated in other recruitment hotspots. QSP will continue to closely monitor this. • **Workforce Report** The Workforce Report was received and the Committee was again assured that 85% compliance with PADR would be achieved within Corporate areas by the end of March 2023 (currently at 63.64%). This will be monitored by the Committee. • **Velindre Cancer Service Quality Safety & Performance Divisional Report** The Velindre Cancer Service integrated Quality, Safety and Performance report was received. The Committee highlighted that the performance data in the cover paper was for November 2022 and Quality and Safety information in the VCC paper was to the end of October 2022. The Committee **NOTED** current improvements:- • 100% compliance relating to management of concerns. • Positive feedback following two unannounced Healthcare Inspectorate Wales (HIW) visits to Nuclear Medicine and First Floor Ward.

- Work undertaken to implement improvements to the Brachytherapy Service.

It was also noted that following two National Reportable Incidents (NRIs) resulting from missed opportunities to refer patients via the treatment helpline for an earlier medical review, immediate learning and improvements had been identified and a full review is underway.

The Committee was assured that the recurring issue of misalignment of the timings of the Velindre Cancer Service Divisional Report (October 2022) and Summary Performance Report (November 2022) would be addressed via the Executive Director of Nursing, Allied Health Professionals and Health Science.

- **Sustainability Report (including Decarbonisation)**

The Annual Sustainability Report April 2021-March 2022 was positively received and commended for its clear format, presentation and layout, demonstrating the achievements the Trust has made to actively take forward its commitment to sustainability over the course of the year. The Committee **ENDORSED** the report for Trust Board approval.

- **Trust Risk Register**

The current extract of Risk Registers was received, providing oversight and assurance of the management of risks across the Trust.

Ongoing work has continued regarding Velindre Cancer Service risk register management, in addition to a review of Welsh Blood Service risk register, to identify potential duplications and assess risk scores, amending as appropriate prior to Trust Board. The chair and IM members identified that the summary table still made it difficult to be able to track changes since the last report and actions being taken to achieve the target scores and demonstrate mitigation of risk. The Committee referenced the Quality Governance Review (Audit Wales) regarding the same issues and recommendations and triangulating this with the discussion in a recent Audit Committee. A proposed enhanced template format will be developed via active engagement with Audit Committee members and the Chair of the Quality, Safety & Performance Committee.

The Committee **NOTED** the revised risk appetite levels.

	• **Trust Assurance Framework** The Trust Assurance Framework was received, providing the current position in relation to principal risks falling within the remit of the Committee. Subsequent to discussions at Audit Committee and Executive Management Board, it was noted that following cross-reference with the Audit Tracker and Legislative Compliance Register, the Trust Assurance Framework template will be redeveloped to include: • The capture of explicit actions / reasons in relation to how identified gaps will be managed / accepted; • Clear corresponding actions in response to partial assurance ratings and / or gaps in controls; • Clear impact of 'closed' actions on the assurance rating. The Committee was also advised that a refresh of the Trust Strategic Risks is underway and will be aligned with the development of the Trust Integrated Medium Term Plan for presentation to Trust Board. • **January Analysis of Quality, Safety & Performance Committee Effectiveness** Feedback regarding analysis of triangulation was received from Committee members. Following agreement at the November 2022 meeting, a series of targeted questions will be circulated following each Committee to enable regular feedback and ongoing assessment of Committee effectiveness, facilitating continuous improvement.
INFORM	• **Policies for approval (QS02 – Management of Safety Alerts and Important Notifications Policy)** The Committee **APPROVED** the revised policy, subject to further amendments following discussions at the January 2023 Committee. These will be completed and the policy re-circulated to Committee members and attendees prior to Trust Board. • **Annual Equality, Diversity & Inclusion Report 2021-22** The Committee received and **ENDORSED** the 2021-2022 Annual Equality, Diversity & Inclusion report for onward submission for Trust Board approval.

	• **Business Continuity** The Committee received the Business Continuity report and **NOTED** that an update would follow in 6 months' time (the 2022/23 annual report) to support a level of assurance in terms of progress being made. • **Medical Devices Report** The Medical Devices Report was removed from consent to allow for further discussion and it was agreed that a further update would be provided prior to the next annual report, as new regulations are coming into effect and the Trust needs to monitor compliance against these. • **Additional items discussed at the November Committee:** Gender Pay Gap Report The agenda and papers for the Quality, Safety & Performance Committee (all meetings) can be accessed at: https://velindre.nhs.wales/about-us/quality-safety-performance/
APPENDICES	N/A

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 17th January 2023.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
EXTRAORDINARY JOINT COMMITTEE MEETING BRIEFING
– 10 JANUARY 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 10 January 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Single Commissioner for Secure Mental Health Proposal
Members received a report presenting the feedback received from Health Boards (HBs) on the options assessment for a single national organisation to commission integrated secure mental health services for Wales and to request support for the recommended course of action to be given to Welsh Government (WG) to achieve a single commissioner for secure mental health services in Wales.

Members (1) **Noted** the report, (2) **Noted** the feedback received from the seven Health Boards (HBs) on the options assessment circulated by the WHSSC team, (3) **Noted** that six of the seven Health Boards (HBs) supported WHSSC as the single commissioner with one HB raising concerns regarding the need for a single commissioner, (4) **Noted** that feedback emphasised a number of issues which would need to be addressed to ensure successful implementation of the change; and (5) **Supported** the following recommendations going forward to Welsh Government:

- That secure mental health services in Wales should be commissioned by WHSSC,
- That a national programme of work, including representatives from Welsh Government, WHSSC and all the seven Health Boards (HBs) should be set up to manage the transfer of the commissioning of low secure services; and
- That more detailed work needs be done to define the appropriate timescales but that the programme of work is unlikely to be completed before April 2024 at the earliest.

2. Audit Wales WHSSC Committee Governance Arrangements – Update

Members received a report providing an update on progress against the recommendations outlined in the Audit Wales WHSSC Committee Governance Arrangements report.

Members (1) **Noted** the report, (2) **Noted** the progress made against WHSSC management responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report, (3) **Noted** the progress made against the Welsh Government responses to the Audit Wales recommendations outlined in the WHSSC Committee Governance Arrangements report; and (5) **Noted** that a further update on progress will be brought to the May 2023 Joint Committee meeting; thereafter an update will be submitted to Audit Wales and to HB Audit Committees for assurance in June/July 2023.

3. Preparedness for the COVID-19 Public Inquiry

Members received a report providing an update on WHSSC's preparedness for the COVID-19 Public Inquiry.

Members **noted** the report.

4. Review of Financial Limits and Reporting

Members received a report requesting that the increased financial delegation limits introduced in March 2020 to enable effective financial governance as a consequence of the COVID-19 pandemic were approved as new permanent limits.

Members discussed the report and noted that discussion had been held with HB finance colleagues on the proposed approach. Members advised they were in agreement to approve the recommendations, subject to further discussion with the HB Board Secretaries.

Members (1) **Noted** the report, (2) **Noted** the rationale for the increase in financial delegation limits as a consequence of the COVID-19 pandemic, (3) **Approved** the updated financial authorisation matrix, which includes the increased financial delegation limits introduced in March 2020 to enable effective financial governance as a consequence of the COVID-19, (4) **Approved** the updated process for the current SFI requirement for Joint Committee "approval" of non-contract cases above defined limits for annual and anticipated lifetime cost, to be replaced by an assurance report to Joint Committee and the CTMUHB Audit & Risk Committee (ARC) notifying of all approvals above the defined limit and Chairs action to reflect the need for timely approval action, subject to further discussion with the HB Board Secretaries. (5) **Noted** that the Standing Financial Instructions (SFI's), and the scheme of delegation will be updated to reflect the changes; and (6) **Noted** that the updated scheme of delegation and the financial matrix will be appended to the SFI's for completeness.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 17 JANUARY 2023

The Welsh Health Specialised Services Committee held its latest public meeting on 17 January 2023. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within the Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings
The minutes of the meeting held on the 8 November 2022 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. Draft Integrated Commissioning Plan (ICP) 2023-2024
Members received a presentation on the draft Integrated Commissioning Plan (ICP) 2023-2024 and a report presenting the plan for approval.

Members noted that the ICP had been updated following the Joint Committee ICP workshop on 10 January 2023 during which a range of scenarios were considered and it was recognised that the financial situation of NHS Wales had become clearer and the context for consideration of the plan had become more difficult.

Members discussed the financial elements of the plan and noted the constrained economic environment, recovery challenges and the volatile inflationary pressures. Members agreed to support the plan in principle but requested that additional work was required to focus on risks, efficiencies, monitoring and reporting, to be undertaken before being brought back to an extraordinary Joint Committee meeting in February 2023, in order to approve the ICP in readiness for inclusion in Health Board (JB) Integrated Medium Term Plans (IMTP's).

Members (1) **Noted** that the Plan has been finalised following the Joint Committee Workshop held on 10 January 2023, (2) **Agreed** to support the plan in principle but requested additional work be undertaken to focus on risks, efficiencies, monitoring and reporting before they could provide final approval,

(3) **Agreed** to convene an extraordinary Joint Committee meeting in February 2023 to:

- **Approve** the requirements of the Integrated Commissioning Plan (ICP) for inclusion in Health Board Integrated Medium Term Plans (IMTPs); and
- **Approve** the Integrated Commissioning Plan (ICP) 2023-2024 for submission to Welsh Government.

4. Chair's Report

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

- Key meetings attended.

Members **noted** the report

5. Managing Director's Report

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

- **National Skin Camouflage Pilot Service** - WHSSC had received a formal request from Welsh Government (WG) following agreement at the NHS Wales Leadership Board (NWLB) for WHSSC to commission the national skin camouflage pilot service,
- **Individual Patient Funding Request (IPFR) Engagement Update** – The formal engagement process to review the WHSSC Individual Patient Funding Request (IPFR) panel Terms of Reference (ToR) and the specific and limited review of the all Wales IPFR policy, commenced on 10 November 2022 for a 6- week period following the Joint Committee supporting the proposed engagement process at its meeting on 8 November 2022. The feedback is being reviewed and an update will be provided to the Joint Committee in March 2023,
- **Board Development - Compassionate and Collective Leadership in Health and Social Care -** On 29 November 2022, the CDGB received a briefing from Professor Michael West CBE on Compassionate and Collective Leadership in Health and Social Care as part of his mandate to visit all NHS bodies to discuss the importance of compassionate and collective leadership, which is being led by Health Education & Improvement Wales (HEIW). Professor West will facilitate a session with the Joint Committee in 2023 to support discussions on working in partnership, developing cross-boundary team-based working and system leadership.

Members **noted** the report.

6. Plastic Surgery: realignment of future commissioning responsibilities between WHSSC and Health Boards

Members received a report outlining the outcome of the plastic surgery commissioning workshop held with the Management Group in September 2022 and to request support for WHSSC to establish a project to realign

commissioning responsibilities for plastic surgery between WHSSC and Health Boards (HBs).

Members (1) **Noted** the report, (2) **Noted** the outcome of the Management Group plastic surgery workshop held in September 2022, (3) **Considered** and **approved** the proposed realignment of commissioning arrangements for plastic surgery so that non-specialised surgery will be commissioned by Health Boards (HBs) and specialised surgery will be commissioned by WHSSC; (4) **Supported** a project led by WHSSC to undertake the work to transfer commissioning responsibility for non-specialised plastic surgery to Health Boards (HBs) and retain specialised surgery as commissioned by WHSSC.

7. WHSSC Cardiac Review

Members received a report addressing a number of recent events and trends that had impacted the WHSSC-commissioned cardiac surgery and TAVI services, and which sought to identify how they might be coherently and collectively addressed. The subjects of this analysis comprise:

- The 2021 GIRFT review of cardiac surgery,
- Changes to the volume of TAVI and cardiac surgery, together with cardiac surgery performance and escalation issues; and
- The clinical rationale for the selection of TAVI valves, in view of their differential costs.

Members (1) **Noted** the report, (2) **Noted** the impact of the recent events and trends as drivers change in the commissioning of cardiac surgery and TAVI services, (3) **Noted** the important link between the cardiac review and the Integrated Commissioning Plan (ICP) in that the work will conclude what level of cardiac surgery is required and inform the scale of any resultant de-commissioning, (4) **Approved** the development of new contract baselines for cardiac surgery and TAVI, (Stage 1), to be completed by June 2023, (5) **Approved** the proposal that the current TAVI commissioning policy be reviewed (Stage 1), to be completed by June 2023; and (6) **Approved** the recommendation that further demand and capacity planning be undertaken, concluding with an options appraisal to identify the preferred future service configuration of WHSSC-commissioned cardiac surgery and TAVI activity (Stage 2), to be undertaken during 2023-24 and 2024-25.

8. Governance Review of Welsh Kidney Network (WKN)

Members received a report which outlined the recommendations from the recent independent Governance Review for the Welsh Kidney Network (WKN) and which provided an assurance that the recommendations were being enacted through an action plan that had been developed, agreed and monitored through the WKN Board.

Members (1) **Noted** the report; and (2) **Received assurance** that there are robust processes in place to ensure delivery of the recommendations

detailed within the recent Governance Review of the Welsh Kidney Network (WKN).

9. South Wales Trauma Network Delivery Assurance Group (DAG) Report (Quarter 2 2022-23)

Members received a report providing a summary of the Quarter 2 2022-23 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members noted the South Wales Major Trauma Network (SWTN) Delivery Assurance Group (DAG) Report for Quarter 2 2022-2023.

10. Corporate Risk Assurance Framework (CRAF)

Members received a report presenting the updated Corporate Risk Assurance Framework (CRAF) which outlined the risks scoring 15 or above on the commissioning teams and directorate risk registers, which provided an update on the progress made to develop the CRAF following the risk management workshop held in September 2022 and which presented a revised risk appetite statement for approval.

Members (1) **Noted** the report; (2) **Approved** the updated Corporate Risk Assurance Framework (CRAF) and **noted** the changes to the risks outlined in the report as at 31 December 2022, (3) **Noted** that a risk workshop was held in September 2022 to review the CRAF and WHSSC's risk appetite; and (4) **Approved** the updated risk appetite statement.

11. All Wales Positron Emission Tomography (PET) Programme Board Update

Members received a report providing an update on the All Wales Positron Emission Tomography (PET) Programme, including an assessment of clinical demand and growth for PET scanning in Wales and requests support for the recommendation to Welsh Government (WG) that a fourth scanner will be needed to meet predicted scanning demand.

Members (1) **Noted** the report, (2) **Considered** and **approved** a recommendation to Welsh Government (WG) (Programme Sponsor) for a fourth fixed PET scanning site within Wales, based upon up-to-date assessment of clinical demand, which confirms growth is in line with that described in the original Programme Business Case (PBC); and (3) **Received assurance** that there are robust processes in place to ensure delivery of the All Wales Positron Emission Tomography (PET) Programme.

12. COVID-19 Period Activity Report for Month 7 2022-2023 COVID-19 Period

Members received a report that highlighted the scale of the decrease in activity levels during the peak COVID-19 period and whether there were any signs of recovery in specialised services activity.

Members **noted** the report.

13. Financial Performance Report – Month 8 2022-2023
Members received the financial performance report setting out the financial position for WHSSC for month 8 2022-2023. The financial position was reported against the 2022-2023 baselines following approval of the 2022-2023 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2022.

The financial position reported at Month 8 for WHSSC is a year-end outturn forecast under spend of £14,195k.

Members **noted** the current financial position and forecast year-end position.

14. 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.

15. Other reports
Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit and Risk Committee (ARC)
- Management Group (MG),
- All Wales Individual Patient Funding Request (IPFR) Panel
- Welsh Kidney Network (WKN)

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

EMERGENCY AMBULANCE SERVICES JOINT COMMITTEE MEETING

'CONFIRMED' MINUTES OF THE MEETING HELD ON 8 NOVEMBER 2022 AT 09:30HOURS VIRTUALLY BY MICROSOFT TEAMS LIVE

PRESENT

Members:	
Chris Turner	Independent Chair
Stephen Harrhy	Chief Ambulance Services Commissioner (CASC)
Nicola Prygodzicz	Chief Executive, Aneurin Bevan ABUHB
Gill Harris	Interim Chief Executive Betsi Cadwaladr, BCUHB
Suzanne Rankin	Chief Executive, Cardiff and Vale CVUHB
Paul Mears	Chief Executive, Cwm Taf Morgannwg CTMUHB (in part)
Andrew Carruthers	Chief Operating Officer, Hywel Dda HDUHB
Carol Shillabeer	Chief Executive, Powys PTHB
Sian Harrop-Griffiths	Director of Strategy, Swansea Bay SBUHB
Associate Members:	
Jason Killens	Chief Executive, Welsh Ambulance Services NHS Trust (WAST)

In Attendance:	
Nick Wood	Deputy Chief Executive, NHS Wales
Rachel Marsh	Director of Planning, Strategy and Performance, Welsh Ambulance Services NHS Trust (WAST)
Matthew Edwards	Head of Commissioning & Performance EASC Team, National Collaborative Commissioning Unit (NCCU)
Phill Taylor	Head of Commissioning & Performance EASC Team, National Collaborative Commissioning Unit (NCCU)
Sian Ashford	Senior Lead Nurse, Quality and Delivery Frameworks, National Collaborative Commissioning Unit (NCCU)
Gwenan Roberts	Committee Secretary

In Attendance:	
In Attendance for agenda item 2.3 Emergency Medical Retrieval and Transfer Service (EMRTS) Cymru Service Development Proposal	
David Lockey	National Director, Emergency Medical Retrieval and Transfer Service (EMRTS Cymru)
Sue Barnes	Chief Executive, Wales Air Ambulance Charity
Mark Winter	Operations Director, Emergency Medical Retrieval and Transfer Service (EMRTS Cymru)
Matt Cann	Programme Manager, Emergency Medical Retrieval and Transfer Service (EMRTS Cymru)
Steven Stokes	Director of Communications and Strategic Engagement, Wales Air Ambulance Charity

Part 1. PRELIMINARY MATTERS		**ACTION**
EASC 22/111	**WELCOME AND INTRODUCTIONS** Chris Turner (Chair), welcomed Members to the virtual 'Teams Live' meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee and gave an overview of the arrangements for the meeting. This was the first EASC meeting to be live streamed.	Chair
EASC 22/112	**APOLOGIES FOR ABSENCE** Apologies for absence were received from Steve Moore, Mark Hackett and Steve Ham.	Chair
EASC 22/113	**DECLARATIONS OF INTERESTS** There were none.	Chair
EASC 22/114	**MINUTES OF THE MEETING HELD ON 6 SEPTEMBER 2022** The minutes were **confirmed** as an accurate record of the Joint Committee meeting held on 6 September 2022 with the exception of: • clarification between the 'Internal Service Analysis' undertaken by the Emergency Medical Retrieval and Transfer Service and the 'Strategic Review' undertaken by the Wales Air Ambulance Charity • the addition of the word 'need' at the top of minute 22/100 (page 9), so that the sentence now reads 'Key headlines from the Strategic Review included under-utilisation and unmet need (geographic, overnight and hours of darkness)' • Amend the resolution to reflect that a service development proposal would be received.	Chair

	Members **RESOLVED** to: • **APPROVE** the minutes of the meeting held 6 September 2022, subject to the amendments noted above.	
EASC 22/115	**NOTES OF THE BRIEFING MEETING HELD ON 27 OCTOBER 2022** The notes were **confirmed** as an accurate record of the Joint Committee meeting held on 27 October 2022, with the exception of amending to include accurate titles for Hayley Thomas, Stephen Powell and Joanne Abbott-Davies. Members **RESOLVED** to: • **APPROVE** the notes of the meeting held 27 October 2022, subject to the amendments noted above.	Chair
EASC 22/116	**ACTION LOG** Members **RECEIVED** the action log and **NOTED**: **EASC 22/101** • **WAST Provider Report – Red variation** Ross Whitehead updated that 'a deep dive' into red performance had been undertaken by WAST. Members were also reminded that changes had been made following the discussion relating to the categorisation of Medical Priority Dispatch System (MPDS) codes within the Dispatch Cross Reference (DCR) Table, held at the September meeting of the EASC Committee. It was agreed that these will be considered at a future EASC Management Group meeting. • **Clinical Response Model and the Categorisation of the Medical Priority Dispatch System codes within the Dispatch Cross Reference Table** Jason Killens confirmed that this had been received at the WAST Board meeting held at the end of September and the changes went live in October. No difficulties had been reported. **EASC 22/79** • **Different staff input to WAST Control / call options** Jason Killens provided an update on the composition of WAST Control and the clinical support desk with representatives of the paramedic, nursing, midwifery, social work professions now ensuring multi-disciplinary advice was provided to 999 callers. It was agreed it would be important to evaluate the impact of this in due course (item to remain on Action Log).	WAST WAST

	EASC 22/81 • **Roster Reviews** Jason Killens reported that this programme of work commenced in October and was on track for completion at the end of November. It was agreed that WAST would provide the numbers of staff available on a health board by health board basis. • **WAST Working Practices** Jason Killens confirmed that progress had been made on a range of working practices with the Trade Unions, including a potential pathway for emergency medical technicians. It was further noted that industrial action could take place in coming months. • **Immediate Red Release** The Chair asked Members to ensure that, whilst some progress was being made, a request for red release should continue to be seen as an absolute priority. **EASC22/20** • **Performance Report** This was on the action log awaiting further update re Digital Health and Care Wales looking at linked data sets related to patient outcomes. In future this would be added as a standing item in the Chief Ambulance Services Commissioner's Report. **EASC 22/10** • **Key Reports and Updates** It was reported that the new WAST Director of Quality and Nursing was currently in the process of reviewing the reporting process on a range of metrics. An update would be provided at a future meeting. **EASC 21/26** • **Committee effectiveness** The Chair reported that attempts had been made to contact the Citizen's Voice Body and would report progress at the next meeting. Members **RESOLVED** to: **NOTE** the Action Log.	WAST ALL EASCT WAST
EASC 22/117	**MATTERS ARISING** There were no matters arising from the minutes.	Chair
EASC 22/118	**CHAIR'S REPORT** The Chair's report was received. Members **RESOLVED** to: • **NOTE** the Chair's report and the Chair's finalised objectives as set by the Minister.	Chair

Part 2. ITEMS FOR DISCUSSION AND APPROVAL		ACTION
EASC 22/119	**PERFORMANCE REPORT** The Performance Report was received. In presenting the report Ross Whitehead highlighted the following areas: • **Ambulance Service Indicators -** September's data were now available on the EASC website • **Handover delays** including the handover improvement trajectories • **EASC Action Plan** – most recent version included in the meeting papers and the EASC Team was due to submit the latest version to Welsh Government (WG) and stakeholders following the meeting. Members noted that this was an integrated plan that draws various elements of work together, was developed with health boards and was aligned to actions from the Six Goals for Urgent and Emergency Care Programme. The winter resilience letter issued by Welsh Government and its expectation for progress was also noted in this context. Members noted the need to use the plan to track progress, to identify and share areas of best practice, to learn from the bad weeks and to ensure mitigating action where required. Two key areas were noted, these were addressing 4 hour waits and generally reducing the variation within the system. Nick Wood noted the actions being undertaken across NHS Wales, summarised in the consolidated EASC Action Plan and sought assurance from health boards and WAST regarding their organisational commitment to being a part of the conversations being held and to delivering the actions in the plan. Jason Killens confirmed the commitment of WAST to its agreed actions and, while noting that further work was required in other areas, reported the progress already made against the roster review programme, working towards stretch targets for 'Consult and Close' and on track in terms of recruitment for the additional 100 full time equivalents by 23 January. The good progress made by WAST was noted. There was discussion regarding the progress in relation to the shared actions between WAST and health boards with the example of active discussion to expand the provision of advanced paramedic practitioners to direct activity away from Emergency Departments provided.	

	Members noted that severe pressures exist throughout the system from the 'front door' to community care, and, in addition to the requirement for increased community care capacity, there was a need maximise the opportunities with regard admission avoidance schemes and same day emergency care services. The focus on the winter plan and the actions within the Six Goals for Urgent and Emergency Care Programme with a particular focus on improving handover delays, 4 hour waits, red release and reducing community risk. It was recognised that the role of local authorities was critical in addressing delayed transfers, also the impact of ambulance services on other emergency services (primarily police services) and there was therefore a requirement for a joint approach and a wider public service message than was currently being conveyed. Members noted that there was an increasing trend in terms of units of hours produced and this position would further improve once the additional 100 full time equivalents become operational; while red performance was challenging, more patients were receiving a service. Further work was also required in relation to outcomes for patients that do receive a response and outcomes for those that do not. Highlighting the citizen's perspective, the Chair welcomed the weekly dashboard being widely circulated to the NHS by the EASC Team. This was felt to be helpful in identifying where performance had improved and deteriorated and broadly indicated where actions at the front door might have made an impact. Members noted the use of the dashboard and requested further work to better understand the wider context, the correlation between different elements and to understand the key drivers behind the data. It was agreed that further work would now be undertaken with the required teams to ensure access to key data and further development of the dashboard. Members **RESOLVED** to: • **NOTE** the content of the report. • **NOTE** the Ambulance Services Indicators • **NOTE** additional actions that the committee could take to improve performance delivery of commissioned services • **NOTE** the handover improvement trajectories • **NOTE** the EASC Action Plan • **NOTE** the request to progress the dashboard.	WAST EASCT

EASC 22/120	**QUALITY AND SAFETY REPORT** The Quality and Safety Report on commissioned services was received. In presenting the report, Ross Whitehead reminded Members that an increased focus on quality and safety matters was a priority within the EASC Integrated Medium Term Plan (IMTP). The following areas were highlighted: • The work of the **Healthcare Inspectorate Wales (HIW) Task & Finish Group** (convened by the EASC Team) established to lead and coordinate the work in response to the recommendations made as part of the HIW 'Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover'. A formal update was provided to HIW on 30 September, outlining the positions of all health boards and WAST relating to each of the recommendations. A formal response from HIW had been received requesting further detail on a number of the recommendations. Health Boards and WAST had also been asked for a response. A further 'Fundamentals of Care' workshop was planned to take place at the end of November to further address recommendations relating to patient care whilst waiting for delayed periods of time, on ambulances, outside hospitals. • Fortnightly meetings had been held in response to the **NHS Wales Delivery Unit Report on Appendix B** submissions. As a result of these meetings, a section of the policy had been developed to improve the process for the joint investigation between WAST and other NHS Wales organisations. Members noted this process would be tested over the forthcoming weeks. The Deputy Chief Ambulance Service Commissioner had written to each health board asking for written confirmation that they accepted the recommended new process. In order to provide support in the testing of the process a new form had been developed to replace the Appendix B form. A draft all Wales agenda template for joint meetings had also been produced to support this new process.	

	Rachel Marsh noted the potential additional workload and capacity issues for WAST and the need to review the impact of this as soon as feasible. It was confirmed that the group would continue to meet to review the new process and to intervene and adapt as required. • **Regulation 28 – Prevention of Future Deaths** – Members were asked to note the Regulation 28 – Prevention of future death notice that had been issued to the Welsh Ambulance Service NHS Trust and Betsi Cadwaladr University Local Health Board. Whilst the report related to a specific case within the health board, Members recognised similar challenges across Wales in the delivery of effective ambulance services both for community response and inter-hospital transfers. Members **RESOLVED** to: • **NOTE** the content of the report and the progress made by both Task and Finish Groups • **NOTE** the impact of deteriorating performance and the resulting challenges in commissioning the provision of safe, effective and timely emergency ambulance services, including the recent issuing of a regulation 28. • **NOTE** that Quality and Safety Reports relating to commissioned services would be received at all future meetings.	EASCT
EASC 22/121	**EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) AND WALES AIR AMBULANCE CHARITY SERVICE DEVELOPMENT PROPOSAL** The Service Development Proposal report was received. In introducing the report, Ross Whitehead, provided Members with background information and an introduction to the proposal developed by the Emergency Medical Retrieval and Transfer Service (EMRTS Cymru) and the Wales Air Ambulance Charity Trust. Members noted that the proposal had been received and discussed at the EMRTS Delivery Assurance Group held on 1 November 2022 and further work and scrutiny had been requested, including in relation to weather, modelling and resource requirements. Members noted that the proposal had been developed following internal service analysis undertaken by the EMRT service (the Charity had carried out a Strategic Review), with key findings indicating under-utilisation of assets and confirming unmet need (geographic, overnight and hours of darkness).	

	The analysis and modelling indicated the opportunity for extended hours of operation and also included changes to base locations. The proposal suggested that by optimizing the operational configuration the service could: • potentially attend an additional 583 patients and • achieve 88% of the total demand compared with the existing model that meets 72% (within the same resource envelope). Members were aware there had been significant public and political concerns raised around the development of the proposal, particularly in relation to the potential closure of air bases. This has resulted in challenges for both the Charity and EMRTS and there had also been an impact on individual health boards. Additional challenges were recognised in relation to the Charity including its need to renew aviation contracts and the associated commercial negotiations, both of which could be impacted by the timeliness of the work required to assess the proposal. The proposal outlined the level of unmet need that exists for the all Wales Service and the Committee would need to understand, and evaluate this, either through the adoption of this proposal or through further work. Professor David Lockey, EMRTS National Director thanked members for considering the proposal. He noted that it built upon service developments already undertaken by the service since its establishment in 2015, including an increase in the number of air bases, commencement of night operations, the introduction of the Adult Critical Care Service (ACCTS) in both North and South Wales and the work linked to the Major Trauma network. Prof Lockey also referred to the Strategic Review undertaken by the Charity. Sue Barnes, Chief Executive of the Charity, outlined the process undertaken by the Charity working with EMRTS to understand what further opportunities could be realized. This included alignment with the opportunity afforded by the Charity's required long-term aircraft procurement process with renewal due at the end of 2023. Members recognised that the EASC Team had not had the opportunity to undertake appropriate due diligence and scrutiny of the proposal ahead of presenting it and making recommendations to Members. However, in view of the public interest it was felt that it was appropriate to receive the proposal at the meeting.	

	Ross Whitehead explained that there could be an impact on the capacity of the EASC team to support the process of scrutiny and engagement on this proposal, whilst also maintaining business as usual in terms of the commissioning arrangements for all EASC commissioned services. It was agreed that the Committee might need to consider providing temporary additional support once the likely impact has been fully considered. Stephen Harrhy, the Chief Ambulance Services Commissioner summarised some of the key issues that had been raised and noted by the EASC Team during the activities already undertaken with stakeholders and the comments and questions received to date. These included: • clarifying the position regarding resource implications • responding to the significant comments raised and views regarding the importance of response times • understanding how the air and road response model works, recognizing that for urban and rural areas it would be different • further work required regarding the impact of weather • consideration of the data reference period to ensure that this is appropriate and not unintentionally biased • understanding any seasonal variation • improving the understanding of the options available, including to consider whether changing bases is necessary, identifying further options and understanding why options have been discounted • working with health board colleagues to consider the modelling undertaken. Members agreed with the proposed approach for additional scrutiny, including the need to develop a streamlined and simplified proposal and to better understand the options identified. Members felt it would benefit health boards to better understand the data and modelling already undertaken and supported utilising the data analysis tool that was being developed to identify the impact on local communities. It was felt that this approach would ensure that the benefits and risks of each option could be fully understood and appraised including the implications relating to key elements such as air and road response, equity of access for the population and resource effectiveness. Members stressed the need for an open and robust engagement process, in line with the direction provided by the Community Health Councils in Wales and questioned whether the January decision timeline was feasible, considering the need for the development and agreement of suitable engagement material, agreeing the equality impact assessment and the requirements for a mid-process review.	

	The CASC agreed that there were a number of phases to be undertaken and that there was a need to be transparent and realistic, to ensure the correct process was undertaken and that timelines would need to be revisited. In addition to the initial phase of due diligence and scrutiny already discussed, it was also noted that Community Health Councils had recommended that a meaningful and comprehensive public engagement process should be undertaken for at least 8 weeks, this engagement phase would need to be incorporated in to the timeline. The CASC assured Members that the EASC Team would now work closely with the EMRTS and the Charity to scrutinise the detail in the proposal. Discussions would also need to take place with health board communication, engagement and service change leads to ensure a robust process. It was recognised that there were many elements to focus on before an update could be provided and next steps agreed at the scheduled EASC session on 6 December. After discussion Members **RESOLVED** to: • **NOTE** the content of the EMRTS Cymru and Wales Air Ambulance Charity Service Development Proposal and appendices • **AGREE** the next steps for additional scrutiny by the EASC Team and the development of a simplified proposal, including suitable engagement materials to meet the requirements of the Community Health Councils in respect of the proposal • **NOTE** the key risks and any mitigations the Committee need to be put in place.	EASCT EASCT
EASC 22/122	**PROGRESS REPORT ON THE PLAN IN RELATION TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE EMRTS CYMRU AND WALES AIR AMBULANCE CHARITY SERVICE DEVELOPMENT PROPOSAL** The progress report on the plan in relation to the EMRTS Cymru and Wales Air Ambulance Charity Service Development Proposal was received. Ross Whitehead presented an update on the activity that had taken place following the request made by Members at the EASC meeting in September and included the: • Activities already undertaken with stakeholders • Comments and questions received to date • Draft Communications and Engagement Plan • Draft Project Plan • Initial Equality Impact Assessment.	

	Members noted that the CASC was continuing to work with Community Health Councils in Wales and was receiving advice and recommendations for the engagement process required. It was confirmed that discussions with health board and CHC colleagues would continue to take place to agree what would be engaged upon, including the required engagement materials and to further develop the communications and engagement plan. Following the briefing note issued on 14 October, a second briefing note would be prepared to update stakeholders with regards discussions held at today's meeting and the next steps would be clarified. In addition, the comments and questions received to date would continue to be collated via the online facility on the dedicated page on the EASC website; an important part of the scrutiny process to lead to the engagement phase. In line with discussions held, the timeline would be reassessed and reconsidered in readiness for an update to be provided at the EASC meeting on 6 December. Members noted the importance of mitigating any impact on the Wales Air Ambulance Charity in the next phase of the work. In light of the previous agenda item and discussions held relating to the detailed proposal received and the need to undertake appropriate due diligence and scrutiny ahead of a process of engagement, the final recommendation relating to commencement of the formal engagement process was withdrawn. Members **RESOLVED** to: • **NOTE** the structured approach adopted since the Committee meeting held 6 September • **NOTE** the activities already undertaken with stakeholders both face-to-face and online • **NOTE** the discussions held with CHCs, attendance at CHC meetings as requested by them and completion of the CHC 'Joint Services, Planning & Change Committee Service Change Pro forma' • **NOTE** the record of activities undertaken to date • **NOTE** the key themes arising from the questions, comments and letters received by stakeholders • **NOTE** the Briefing Note sent to stakeholders on 14 October • **NOTE** the development of a dedicated page on the EASC website • **NOTE** the draft Communications and Engagement Plan developed to date and a further document would be developed for engagement with the public based on a simplified proposal to be developed • **NOTE** the draft project plan included for comment • **NOTE** the Initial Equality Impact Assessment.	EASCT EASCT

EASC 22/123	**WELSH AMBULANCE SERVICES NHS TRUST (WAST) UPDATE** The Welsh Ambulance Services NHS Trust update report was received. In presenting the report, Jason Killens highlighted the following areas: • Point 2.5 - challenging red performance in September 2022 • Point 2.8 - almost 900 patients waiting more than 12 hours • Points 2.16 & 2.17 following temporary cessation of clinical indicator reporting relating to transition to the electronic patient clinical record (ePCR) new data was now available for stroke, fractured neck of femur, hypoglycaemia and ST elevation myocardial infarction (STEMI). Deep dive audits had been completed for these clinical indicators and the return of spontaneous circulation (ROSC) (at hospital door) deep dive audit was ongoing with this clinical indicator scheduled to be published over the coming months • Point 2.21 – increase in red demand • Point 2.21 – ambulance production was encouraging with unit hour production at 96% in September against the benchmark of 95% • Point 2.21 – improvements in sickness aligned to IMTP trend • Point 2.21 – highest ever handover lost hours at 28,500 hours, equating to over 30% of WAST conveying capacity • A verbal update was provided regarding NEPTS and the letting of new contracts as a result of the all-Wales business case with the new providers recently notified of the outcome of the tendering process. It was agreed that the additionality diagram at the bottom of page 12 was useful, that it is a complicated picture and that it would now be sensible to build an improvement trajectory and to understand the likely impact of all interventions. The Chair summarised including to: • Note the positive impact in relation to additional capacity and unit hour production, however it was noted that this was not sufficient to counter the losses across the system as noted above • Welcome the progress made re the electronic patient clinical record and the next steps in terms of data linkages • Note the update in terms of NEPTS procurement, resulting efficiencies and the focus on service quality. Members **RESOLVED** to: • **DISCUSS** and **NOTE** the WAST Provider Report	WAST WAST

EASC 22/124	**CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT** The Chief Ambulance Services Commissioner's report was received. Stephen Harrhy presented the report and highlighted the following: • Progress on the recruitment of the additional 100 front line staff at WAST • Ongoing work with Heads of Midwifery in health boards and the particular impact of delayed ambulance response on obstetric emergencies. Work was underway to find out what could be achieved and an urgent temporary position was being sought. Members **RESOLVED** to: **NOTE** the report.	
EASC 22/125	**EASC COMMISSIONING UPDATE** The EASC Commissioning Update was received. Matthew Edwards presented the report and Members noted that it provided an overview of the progress being made against the key elements of the collaborative commissioning approach**.** Members noted the many discussions in relation to the commissioning framework for emergency ambulance services over recent months at EASC Committee, EASC Management Group and other related fora. These discussions have resulted in a collaborative approach to transition and transformation through the development of local integrated commissioning action plans (ICAPs). The commissioning framework was included as a 'focus on' item at a previous meeting of the EASC Management Group and discussions have more recently taken place with all health boards. Work is being undertaken throughout November to use handover improvement plans to populate ICAPs. Health boards are asked to commit to sending appropriate representation to these meetings. The update also stated that there would be a focus on aligning actions within the ICAPs to the Six Goals for Urgent and Emergency Care Programme. In addition to the update on the commissioning framework, the update also included a Quarter 2 update against the EASC integrated Medium Term Plan and the agreed EASC Commissioning Intentions for 2022-23, with detailed updates appended.	

	Members **RESOLVED** to: • **NOTE** the collaborative commissioning approach • **NOTE** the progress made in terms of developing the EMS Commissioning Framework, including the development of the local Integrated Commissioning Action Plans • **NOTE** the progress made against the EASC IMTP in Quarter 2 as set out in the update provided • **NOTE** the Quarter 2 update against the commissioning intentions for each of the commissioned services.	
EASC 22/126	**FINANCE REPORT MONTH 6** The Month 6 Finance Report was received. The purpose of the report was to set out the estimated financial position for EASC for the 6th month of 2022/23 together with any corrective action required. A forecasted break-even position was reported. In light of the significant financial pressure within the system, it was agreed that there is a need for robust financial planning. It was reported that the financial assumptions are in line with the assumptions made by health boards and that there is a need to demonstrate the best use of existing commissioning allocations. Further discussions would be held to ensure alignment with the IMTP process. Members **RESOLVED** to: **NOTE** the report.	
EASC 22/127	**EASC SUB-GROUPS CONFIRMED MINUTES** The confirmed minutes from the following EASC sub-groups were received: • Chair's Summary EASC Management Group – 20 October 2022 – Members noted that the meeting was not quorate and agreed to consider how their organisation would be represented at future meetings. • EASC Management Group – 18 August 2022 • NEPTS Delivery Assurance Group – 4 August 2022 • EMRTS Delivery Assurance Group – 7 June 2022 Members **RESOLVED** to: **APPROVE** the confirmed minutes.	
EASC 22/128	**EASC GOVERNANCE** The report on EASC Governance was received. Gwenan Roberts, Committee Secretary presented the report and highlighted a number of items for approval, including:	

	• The EASC Risk Register presented to each meeting of the EASC Committee, EASC Management Group and received for assurance at the CTM UHB Audit and Risk Committee (as the host organisation) • The 3 red risks within the EASC Risk Register relating to key items already discussed at the meeting • EASC Assurance Framework report, it was noted that this was in same style as the host body's assurance framework (CTMUHB) • The EASC Standing Orders would be reviewed prior to the next meeting in line with arrangements by the Welsh Health Specialised Services Committee and would tie into the review of the WHSSC / EASC Standing Financial Instructions • The list of key organisational contacts was noted. Members **RESOLVED** to: • **APPROVE** the risk register • **APPROVE** the EASC Assurance Framework • **NOTE** the EASC Standing Orders would be reviewed prior to the next meeting • **NOTE** the information within the EASC Key Organisational Contacts.	
EASC 22/129	**FORWARD LOOK AND ANNUAL BUSINESS PLAN** The Forward Look and Annual Business Plan was received. The Chair asked Members to forward any suggestions for future 'Focus on' sessions. Members **RESOLVED** to: **NOTE** the report.	
Part 3. OTHER MATTERS		**ACTION**
EASC 22/130	**ANY OTHER BUSINESS** The Chair closed the meeting by thanking Members for their contribution to the discussions.	
DATE AND TIME OF NEXT MEETING		
EASC 22/131	The next scheduled meeting of the Joint Committee would be held at 13:30 hrs, on Tuesday 6 December 2022 at the Welsh Health Specialised Services Committee (WHSSC), Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL but likely to be held virtually on the Microsoft Teams platform.	Committee Secretary

Signed ……

Christopher Turner (Chair)

Date ……

GIG CYMRU NHS WALES

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	6 December 2022

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/december-2022/
The minutes of the EASC meeting held on 8 November were approved.

PERFORMANCE REPORT

In presenting the report, Stephen Harrhy gave an update on the current emergency ambulance performance and an overview of the range of actions and processes that had or would be implemented to support performance improvement. The report also presented information in line with the most recent publication(s) of the Ambulance Service Indicators.

NOTED that:

- the report presented a picture of a system that was under severe and sustained pressure. It was reported that ambulance performance was well below levels that the Committee would want delivered and the actions being taken to improve performance were included within the report. Members were reminded that a proposal had previously been approved by Committee to alter a number of dispatch codes and that the likely consequence was that an increase the number of red calls would be received. It was noted that the service had started to see this impact
- the current position with record numbers of handover delays at hospital sites across Wales. Most members had been present at the recent **Ministerial Summit that took place on 28 November**, with the aim of discussing ongoing concerns around ambulance handover delays that were causing harm to patients. It was noted that the Minister for Health and Social Services opened the Summit by outlining her concerns around handover delays and reminded those in attendance of their organisational commitments to reducing delays.
    - Examples of improvements were shared by Walsall Healthcare NHS Trust, with key messages in relation to the organisational ownership of patients from the time they call 999 and take leadership for their care within the organisation. In addition, Cardiff and Vale University Health Board shared their experience of improving handover delays, following a focus on the 4-hour red line and further work was planned to further reduce delays.

Each health board provided an update on their handover improvement plans and commitments at the Summit

AGREED that:

the presentation by Walsall NHS Trust provided a helpful focus on areas of learning. It was proposed that further contact would be facilitated via the Chief Ambulance Services Commissioner rather than through a number of separate discussions and that this would be in line with the work in Goal 4 of the Six Goals for Urgent and Emergency Care Programme

NOTED that:

- **Fortnightly handover improvement plan meetings** continued to be helpful and constructive and ensured specific consideration of the agreed trajectories
- **Conveyance rates were reducing**, this impact must be considered in light of a reduction in attendance in response to escalation decisions; also that this reflected the increasing role of 'hear and treat' and the impact of recent investment in both staff and technology within the clinical support desk. Close relationships with NHS Wales 111 were also felt to be an important factor in reducing conveyance
- The **'hear and treat'** efficiency target of 10.2% of daily volume and that the Welsh Ambulance Services NHS Trust (WAST) had set an internal target of 15% by the end of the calendar year, it was reported that 16% had been reported on some days. The impact of new video technology and staff use of the ECNS (Emergency Nurse Communication System) to support decision-making
- **The level of risk and harm to patients across the system was widely recognised and the additional need to protect ambulance resources out of area, particularly for rural areas at a distance from emergency departments**
- Actions making a significant impact across the system included use of alternative pathways and services other than conveyance to emergency departments where appropriate to do so, a focus on the effective use of falls services and strengthened liaison between health boards and WAST to ensure effective communication, handover and release, particularly against the four-hour trajectory
- Work continued in partnership with local authorities to increase community care capacity with in excess of 450 bed/bed equivalents extra reported to date. Members were in agreement that this was significant, however, this would not solve the problems across the system with further work required on longer term provision, including additional care packages and support for people leaving hospital.

The Chair summarised and noted the key messages of the Minister for Health and Social Services in her closing remarks including the need for organisational commitment to the agreed actions, a focus on fewer key actions and the sharing of the key actions already having an effect.

Members **RESOLVED** to:

- **NOTE** the Ambulance Services Indicators
- **NOTE** additional actions that the Committee could take to improve performance delivery of commissioned services
- **NOTE** the handover improvement Ministerial summit discussion and the specific requirements of organisations.

UPDATE ON PROGRESS RELATED TO THE SERVICE DEVELOPMENT PROPOSAL EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) AND WALES AIR AMBULANCE CHARITY

The report provided Members with an overview of the progress made since the Committee meeting on 8 November 2022. At that meeting, the EASC Team was asked to progress on:

- clarifying the position regarding resource implications
- responding to the significant comments raised and views regarding the importance of response times
- understanding how the air and road response model works, recognizing that for urban and rural areas it would be different
- further work required regarding the impact of weather
- consideration of the data reference period to ensure that this is appropriate and not unintentionally biased
- understanding any seasonal variation
- improving the understanding of the options available, including to consider whether changing bases is necessary, identifying further options and understanding why options have been discounted
- working with health board colleagues to consider the modelling undertaken.

NOTED that:

- Given the above requirements and the challenges raised by Committee members and stakeholders and in order to avoid protracted discussions over the process, content and transparency of the original proposal, the EASC Team had undertaken to start the process of undertaking this analysis afresh.
- the scrutiny in key areas would continue. The report focused on a description of the current service provision and the historical activity that had been delivered, including an overview of four specific areas related to base activity, these were:
    - Geographical coverage
    - Rapid Response Vehicle Usage (RRV)
    - Utilisation
    - Unmet need.
- there were potential opportunities for service improvement to be explored. The utilisation of all resources was included and, as an example to amplify this issue, both Caernarfon and Welshpool bases were reported as having lower levels of utilisation than the bases in Dafen and Cardiff. It was understood that an element of this would be related to the rural position and lower population density in these areas but options to provide equitable services should be explored
- when combined with unmet need, this would demonstrate that the EMRT service could potentially do more within its existing resource if changes were implemented to increase utilisation and reduce unmet need.

AGREED that:

- there was a need to explore and maximise the additional activity that could be achieved from existing bases and also to explore how any options to reconfigure the service could reduce the number of patients who require a critical care response from EMRTS but currently do not receive one (unmet need).

NOTED that

- modelling and modelling outputs would be part of a robust evaluation process, not used as a sole determinant
- as per the request at the last meeting, activity data from 2022 and weather probability information had been integrated into the preparation for the modelling, and this in turn would support further scenario modelling
- outputs of modelling would be determined by the assumptions that would be placed upon the modelling scenarios and, in order to do this, an understanding of the constraints that should be applied to any development process would be required
- noted that the report EMRTS 24/7 Service Expansion Review (received at the EASC meeting on 13 November 2018) provided the constraints that were adopted as part of the work and it was suggested that a similar a set of constraints would be appropriate and helpful for this current review
- the investment objectives that were used as part of the original case for the establishment of the 24-hour EMRTS service and the weighting that was applied to these objectives to inform the decision-making process for the 24/7 expansion review. The investment objectives were:
    - Health Gain
    - Affordability
    - Clinical Skills and Sustainability
    - Equity
    - Value for Money.

The Committee was asked to consider that the initial engagement process with the public, individual health boards and the Wales Air Ambulance Charity Trust should explore the appropriateness of the constraints, investment objectives and weighting presented, as part of a robust option appraisal process to inform discussion once further modelling and analysis was complete.

Stephen Harrhy gave an overview of the engagement activity that had been undertaken by the EASC Team since the last EASC meeting which included:

- Activities undertaken with many stakeholders both face to face and virtually
- Ongoing collation of, and responses to, over 60 stakeholder comments and questions
- Circulation of the latest stakeholder Briefing Note 2
- Updates to Community Health Councils (CHCs) and confirmation of the agreed key principles of engagement
- Fortnightly meetings with health board engagement, communication and service change leads.

The report proposed that the EASC Team would need to work closely with health board engagement, communication and service change leads and with Community Health Council (CHCs) colleagues in the development and agreement of appropriate engagement materials including the engagement document and the stakeholder engagement timetable.

It was proposed that the formal public engagement process could commence in early January, subject to agreement of engagement materials by health boards and CHCs.

The proposed engagement would include two phases, these were:

Phase 1:

- Explain how the current service works
- Test the constraints, investment objectives and weightings

Six-Week Review

- Agree options to be modelled

Phase 2:

- Undertake the modelling and use to inform a robust option appraisal process
- Make a recommendation to EASC Members.

Members discussed:

- The importance of utilisation of resources and the need for a balance in terms of availability of resources against the efficiency and effectiveness of service delivery (not over or underutilised)
- The need to explore reasonable utilisation levels considering population densities, urban vs rural locations etc
- EMRTS as a national service, not covering a geographical area like road-based ambulances
- The need to understand the current co-ordination and deployment process
- The need to review operating hours when looking at options to maximise additional activity that could be achieved from existing bases and the options to reconfigure
- The impact of the announcement of the preferred bidder for the new aircraft contract; it was confirmed that this process had been ongoing for sixteen months and that the only agreement in place was for four aircraft plus the back-up capability. Members noted that there had been no pre-determination on the number of or location of bases, this was pending the outcome of the EASC processes (engagement)
- The need for a range of engagement material, including the need for them to be bilingual and easy to understand
- the need to develop an effective engagement approach that asked the right questions and reached as many people as possible. It was agreed that this would need to be a collaborative effort with health boards and CHC colleagues and that local leads would be able to inform this, e.g. the positive Powys experience utilising drop-in sessions was noted
- The two phases of engagement proposed, including the review at six-weeks; Members supported this approach
- Questions had been raised by Swansea Bay University Health Board ahead of the meeting asking for additional clarification on the engagement process, the work with health boards and the community health councils and the need for Equality Impact Assessments
- The need for a pragmatic approach in terms of signing off the engagement materials, involving Engagement or Service Change Leads working with Board Secretaries. Members noted Gwenan Roberts would be the point of contact from the EASC Team
- Formal public engagement could commence 9 January if the required agreed documents were in place
- Consideration be given regarding short term support for the EASC Team.

The Chair confirmed that he would ensure the required assurance was in place ahead of undertaking Chair's Action (on behalf of the Committee) to commence the formal engagement process.

Members resolved to:

- **NOTE** the high-level overview provided and the variation in service delivery from the existing bases
- **AGREE** that the issues highlighted by this paper require further exploration and options appraisal process to deliver improvements
- **APPROVE** the service development constraints to be engaged upon
- **APPROVE** the EMRTS key investment objectives and weightings to be engaged upon
- **APPROVE** the commencement of a formal public engagement process as agreed
- **APPROVE** the use of the agreed constraints to inform subsequent modelling and development of options
- **APPROVE** the use of agreed EMRTS key investment objectives and weightings in the options appraisal process
- **APPROVE** Chair's action to commence the formal engagement process when documentation agreed.

Key risks and issues/matters of concern and any mitigating actions

- Red and amber performance
- Handover delays (and the development of handover improvement plans in HBs with trajectories) and the impact on WAST
- Structured approach relating to the engagement process for the EMRTS Service Review.

Matters requiring Board level consideration

- To acknowledge the significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours
- Opportunity for health boards to take part in the public engagement process related to the potential changes to EMRTS Cymru working in partnership with the Wales Air Ambulance Charity.

Forward Work Programme

Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	**17 January 2023**			

Trust Board

CHAIR REPORT

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

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

ACRONYMS	

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chair on a number of matters. A summary of activities and engagements is included to advise of areas of focus since the last Trust Board meeting held in November 2022.

Matters addressed in this report cover the following areas:

- Board Development Session
- Minister for Health and Social Services Visit to the Trust
- Young Ambassadors Event
- Future Generations Commissioner for Wales
- Hefyd Programme - Roundhouse opening
- MBE Ceremony

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

A summary of priorities, activities, engagements and matters of interest is provided by the Chair below.

2.1. Board Development Session

A Board Development Session was held on 12th December 2022. The topics discussed were:

- The Business Case for the new Velindre Cancer Centre
- Value Based Healthcare
- Finance Contracting
- Duty of Candour and Quality
- Recruitment
- Building our Future Together

2.2. Minister for Health and Social Services Visit to the Trust

Minister Eluned Morgan visited the Velindre Cancer Centre on 26th January. It was an opportunity for her to visit Velindre and to publicise Welsh Government investment in the Integrated Radiotherapy Solution and the Radiotherapy Satellite Centre in Nevil Hall, Abergavenny. There were representatives from the Trust, Aneurin Bevan University Health Board, Varian, the Integrated Radiotherapy Solution provider and the Wales Cancer Network. The visit was covered across various media channels.

2.3. Young Ambassadors Event

On 12th January, Velindre Cancer Charity hosted a Young Ambassador Presentation Evening which welcomed Velindre's youngest supporters to The Miskin Manor Hotel where they were celebrated for their commitment, passion and unwavering support for Velindre Cancer Centre.

The children were presented with their prizes by the Chair and received a personal thank you and photo with our celebrity guest, former Welsh rugby player, Lee Byrne.

During the previous 12 months, the Velindre Young Ambassadors have been using their voice, boosting support and raising funds through a variety of activities including raffles, bake sales, fitness challenges, school events, talks within their communities and a special planting project that took place at the staff well-being hub at the cancer centre.

2.4. Future Generations Commissioner for Wales

The Chair would like to share with the Board her attendance to and event on 24th January to mark the end of the term for Sophie Howe, the first Future Generations Commissioner for Wales. At the event, a presentation was made by Sophie on her final reflections and hopes for the Future Generations Commissioner. A presentation was also made by First Minister, Mark Drakeford.

2.5 Hefyd Programme - Roundhouse opening

As part of the Hefyd programme, the team have worked with Down to Earth, one of our social enterprise partners to build a roundhouse.

Volunteers comprising of Velindre patients, family, staff and local community members worked together to build the roundhouse, in addition to groups from a wide variety of organisations across south Wales, with the support of the Down to Earth Project team.

Groups involved in the build included:

- Llamau Cardiff who work with homeless young people and women
- Neath Port Talbot Youth Service who works with vulnerable young people aged 11 – 25 to give them interesting and challenging experiences to gain new skills and become active members of their community
- Oasis who helps refugees and asylum seekers in Cardiff to integrate and settle in their local communities

The roundhouse will later move to its permanent home at the new Velindre Cancer Centre. It will become a key landmark on the new site and provide a space for patients, families and the wider community.

Several staff members attended the opening event in December alongside other community representatives including Julie Morgan MS.

2.6 MBE Ceremony

The Chair is pleased to share with the Board that Seema Arif received her MBE at a ceremony held at Bucking Palace on 13/01/2023. The medal was presented by Her Royal Highness Princess Ann.

3 IMPACT ASSESSMENT

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

4 RECOMMENDATION

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

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

Date of meeting	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

1. SITUATION/BACKGROUND

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

Matters addressed in this report cover the following:

- Industrial Action
- COVID-19 Update
- Welsh Language Commissioner Investigation
- Lifetime Achievement Award
- Chief Executive NHS Wales Visit to the Velindre Cancer Centre

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Industrial Action

December 2022 saw strike action by the Royal College of Nursing (RCN) across Wales. The Trust worked in partnership with the RCN Dispute Committee ensured that on the first dates of action (15th and 20th December 2022), RCN members were given the opportunity to participate in the action, in varying ways, while we continued to maintain essential life-preserving services. The RCN have announced they will strike again on 6th and 7th February 2023. We have also been informed of future action by other unions, as per table below for the Board's information. The Chief Executive would like to thank all staff for their continued hard work and commitment to the care of our patients and donors.

Union	Current Position (25 January 2023)
British Medical Association	Not currently balloting members in the Trust
Chartered Society of Physiotherapists	Balloting closed - Industrial action confirmed for Tuesday 7th February
GMB	Industrial action confirmed with WAST employees only on four future dates: Monday 6th and Monday 20th February Monday 6th and Monday 13th March
Royal College of Nursing	Balloting closed - Industrial action confirmed

	First action undertaken 15th and 20th December 2022. Next action planned for Monday 6th February and Tuesday 7th February.

2.2 Welsh Language Commissioner Investigation

The Chief Executive would like to update the Board about developments for the Welsh Language Commission Investigation. Further communication has been received from the Welsh Language Commissioner requesting telephone numbers relevant to the investigation. These numbers are the main line numbers to the Trust Headquarters, Velindre Cancer Centre and Welsh Blood Service. One other number for NHS Wales Shared Services Partnership (NWSSP) was also included. Work is underway to ascertain what training and awareness is needed by the staff charged with answering these telephone lines. Once more information and clarification is received, a plan will be drawn up to ensure staff are aware of their statutory duties relating to communication and bilingual messaging. A joint formal response is also being prepared by the Trust and NWSSP for submission to the Commissioner's office by the end of January 2023 as requested.

2.3 UK Covid-19 Public Inquiry

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

The Trust received a letter from the Chair of the Inquiry to say that the Inquiry has identified about 450 organisations across the four nations that are likely to have important healthcare information to share in relation to Module 3 specifically, whether or not they had applied for Core Participant status. This included the Trust. The Trust replied to a short

questionnaire regarding the role of the Trust and a high level summary across the aspects of the scope of Module 3.

The preliminary hearing for Module 3 has been set for 28th February and it is expected the decision of the Inquiry regarding Core Participant status will be made public shortly before this time.

2.4 Lifetime Achievement Award

The Chief Executive on behalf of the Board would like to congratulate Sarah Morley for receiving the Life Time Achievement Award at the Healthcare People Management Association (HPMA) Excellence in People Awards. The award was presented at a ceremony held at the International Convention Centre (ICC) in Birmingham.

2.5 Chief Executive NHS Wales Visit to the Velindre Cancer Centre

The Chief Exec would like to inform the Board that the Chief Executive for NHS Wales, Judith Paget visited the Velindre Cancer Centre on 6th January 2023. The visit included a walk through and information sharing for Outpatients, Chemotherapy Day Unit, Radiotherapy and the Assessment Unit. This was her first visit to the VCC in her capacity as Chief Executive for NHS Wales. Judith praised the work and effort of all at the Cancer Centre.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT	Not required

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

4. RECOMMENDATION

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

TRUST BOARD MEETING

NOVEMBER 2022 Performance Management Framework COVER PAPER

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Wayne Jenkins, Head of Planning and Performance Velindre Cancer Centre Alan Prosser, Director WBS Amanda Jenkins, Head of WOD
PRESENTED BY	Cath O'Brien, Chief Operating Officer Sarah Morley, Director WOD
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT MEETING	13.12.2022	Reviewed and Noted
VCC SLT	19.12.2022	Reviewed and Noted
WBS PERFORMANCE REVIEW	21.12.2022	Reviewed and Noted
VCC PERFORMANCE REVIEW	21.12.2022	Reviewed and Noted

EXECUTIVE MANAGEMENT BOARD	06.01.2023	Reviewed and Noted
QUALITY, SAFETY & PERFORMANCE MEETING	17.01.2023	Reviewed and Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
UHB	University Health Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
QSP	Quality, Safety & Performance Committee
RCR	Royal College of Radiologists
JCCO	Joint Council for Clinical Oncology
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee
IPC	Infection Prevention Control
RCC	Rutherford Cancer Centre

1. SITUATION/BACKGROUND

The attached Trust performance reports provide an update to the Quality, Safety and Performance Committee with respect to Trust-wide performance against key performance metrics through to the end of November 2022 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The reports set-out performance at Velindre Cancer Centre **(*appendix 1*),** the Welsh Blood Service **(*appendix 2*)** and the Workforce **(*appendix 3).*** Each report is prefaced by an '*at a glance*' section which is intended to draw attention to key areas of performance. A number of areas from the reports are highlighted below.

2.1 Velindre Cancer Centre:

Due to the implementation of the new digital patient system DHCR, there is a requirement to fully remap and rebuild the extraction of data from this system into our data warehouse and rebuild all of the reports. This is a known and planned stage of the replacements of such systems and has previously been highlighted in relation to the DHCR programme. This extensive work programme is still ongoing and being delivered according to the delivery plan. The impact of this is mainly for the radiotherapy treatment times and outpatient attendances that this system provides. The data system work is due to be completed in late January/early February and will then be operationally validated. This will then enable the retrospective data for November, December and January to be compiled for review. Data will be shared as it becomes available.

VCC continues to experience challenge in providing capacity to meet the overall demand for services within SACT and Radiotherapy, with referrals increasing as health boards undertake additional activity to address their longest waiting patients. There continues to be variation in demand and tumour sites.

Regular operational meetings continue to take place between VCC and the local Health Boards, which help to provide a more detailed picture of the expected number of referrals to VCC from Health Boards and changes to specialist teams and practice that are likely to impact on demand for services from VCC. There are planned activities in Health Boards to significantly reduce their waiting lists which will have a likely impact upon VCC services through quarter 4 of 2022-23. There is detailed analysis of the Health Board data to ensure this is fed into the VCC demand data to allow services to plan for the likely surge.

Alongside better intelligence on demand to support planning, there is a comprehensive programme of work supported by activity plans to maximise efficiency and productivity to

demonstrate the most effective use of resources. However, it should be noted that variation in referral patterns occurring continues to be a challenge as health boards undertake focused activity within specific specialist areas.

Whilst the forecast increase in referrals to SACT and RT of 12% and 8% respectively has yet to be seen, information from within individual health board cancer trackers suggests that this level of increase in referrals is still potentially to be realised by 31st March 2023.

A number of immediate actions have been implemented as part of the ongoing capacity task force groups established in radiotherapy and SACT. The improvement programmes have led to an ongoing improvement in waiting times in both radiotherapy and SACT.

2.1.2 Radiotherapy Waiting Times

As explained above, due to the implementation of DH & CR in the cancer centre, we are unable to report the November waiting times position yet as the reports are still being written which could not be done in advance of the implementation. We are expecting to report at the end of February when we will report November's position alongside December.

A gradual increase in LINAC capacity has been underway to increase the number of planned hours, which is being supported through a temporary increase in staffing hours and reallocation of roles. This has helped support the improving position.

In addition, a change in software has increased the number of Linacs on which breast patients may be receive treatment, which has resulted in increased flexibility to manage these patients.

Work is also being undertaken through a taskforce to understand principal reported causes for delays and breaches. Three main areas have been identified: delays in planning for those patients waiting for radial RT, requirement for 3D conformal Plans for palliative radiotherapy patients, change of intent and transport times.

There will now be some focused work to address these issues, which include:

- Implementation of holistic pathway improvement project, which will require a more granular analysis of the breaches to determine a way forward.
- Complex palliative treatments will be re-categorised as 'scheduled' (January 2023) in conjunction with new COSC guidelines and clinical leads.
- Work with WAST on revised transport arrangements and a clear action in relation to transport times for radiotherapy patients.

Attendances show significantly less than 2019/20 baseline. However, this is as a result of change in the management of patients i.e. introduction of hyperfractionation.

Challenges in radiotherapy remain aligned to the fragility of the equipment associated with its age, resulting in a greater risk of breakdown, as we increase usage and capacity issues in brachytherapy and medical physics as a result of staffing issues

2.1.3 SACT Waiting Times

Performance against the non-emergency time-to-treatment target has continued to improve and has resulted in full compliance with waiting times targets in November. Breach numbers have also reduced from 14 in October to 6 in November. The 6 patients who breached were all treated within 28 days, which is also a considerable improvement from recent months. We are continuing to monitor delivery against demand.

Other areas

2.1.4 Falls

During November 2022, there were 4 Velindre falls on first floor ward. All falls were discussed at the Scrutiny Panel and two were deemed avoidable. Appropriate actions have been identified.

2.1.5 Pressure Ulcers

During November 2022, there was 1 Velindre acquired pressure ulcer on first floor ward. This was deemed as unavoidable by the Scrutiny Panel and all learning and actions to reduce the risk of pressure ulcers occurring was undertaken.

2.1.6 Healthcare Acquired Infections

No Healthcare Acquired Infections (HAIs) were reported in November 2022.

2.1.7 SEPSIS bundle NEWS score

6 patients met the criteria for response to sepsis and all 6 received antibiotics within 1 hour where appropriate = 100% compliance.
5 of the 6 patients went on to receive a diagnosis of sepsis and all 5 patients received all 6 elements of the SEPSIS bundle within 1 hour = 100% compliance.

2.1.8 Delayed Transfers of Care (DTOC's)

There was 1 delayed transfers of care reported in November 2022. The delay was due to lack of bed availability at the District General Hospital.

Further detailed performance data is provided in Appendix 1

2.2 Welsh Blood Service

Demand for red blood cells averaged at 1371 units per week, and all clinical demand was met in November placing the service in good and stable position. During November the red cell stock holding did not drop below 3 days for priority blood groups, and stock levels were satisfactory across all groups. Due to this, the service was in a position to export 120 units to Northern Ireland. The role of the daily Demand Planning Group meeting, which includes representatives from all departments supporting the supply chain, has been critical to steering the service through extremely challenging times.

2.2.1 Quality

At 96% quality incident investigations completed continues to exceed the target of 90% closed within 30 days. There were no critical or major non-conformances recorded from audits in November, no adverse event reports submitted to the MHRA and no adverse event reports were submitted to the HTA. In addition, no Serious Hazards of Transfusion (SHOT) incidents were reported during the month.

At 96% donor satisfaction continues to remain above target.

In November 2022, 7,904 donors were registered at donation clinics with 8 concerns (0.1%) reported within this period. The one formal concern recorded in November is expected to be completed before the 30 day target of 05/01/23, whilst the remaining concerns were managed as 'early resolution' within the required timescales.

2.2.2 Recruitment of new Bone Marrow Volunteers

In November, 315 new donors were recruited to the Welsh Bone Marrow Donor Registry (WBMDR) against a target of 333, the highest number recruited this year. The Recovery Plan continues to focus on recruitment of donors at schools, colleges and universities, and in November ensured that a 'Bone Marrow Champion' was present at every school, college and university blood collection session. The service continues to work proactively to understand the optimum programme for recruitment of donors via buccal swab, including utilising digital solutions to improve ways of generating an increase in numbers.

The total stem cells collected in November was 1 (1 collection was cancelled during November for patient reasons). The total stem cell provision for the service was 6 (1 collected and 5 imported for Welsh patients). The WBMDR five year strategy, re-

appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment.

2.2.3 Part Bags & Failed Venepuncture

Performance for both % part bags and failed venepuncture are within tolerance, however, there is an upward trend in monthly figures that is currently being explored.

2.2.4 Collection Efficiency

Collection efficiency performance failed to meet target in November. This drop in performance is a short-term consequence of managing low hospital demand. The number of donor slots was reduced to avoid over collection, however the time was utilised to support staff to complete mandatory training and PADRs.

2.2.5 Reference Serology

Reference Serology turnaround performance failed to meet the 80% target in November at 65%. Recent performance is due to continued staff absences, high levels of testing requests and planned annual leave. An additional Band 6 Specialist Biomedical Scientist resource to increase complex testing is being recruited. Validation the new automated analyser has been completed and this will start to support an improvement in performance. Further validation of red cell phenotyping is expected to be completed by the end of January 2023 further improving efficiency.

2.2.6 Time Expired Platelets

All clinical demand for platelets was met averaging 161 units per week, representing a strong performance against this metric in November. However, platelet wastage is still above target at 15%. Creation of a forecasting tool to inform decisions around pooled platelet manufacture will support a reduction in this figure. This is due to be completed in quarter 4.

3 WORKFORCE

3.1 PADR (Target 85%)

Trust Wide 75.40%, increase on previous month
WBS 84.67%, increased compared to last month
VCC 74.90%, increased compared to last month

3.2 Sickness Absence (Target 3.54%)

Trust wide 6.23%, very slight increase on previous month
WBS 7.17%, sickness rates decreased compared to last month
VCC 6.20%, sickness decreased compared to last month.

3.3 Statutory & Mandatory Compliance (Target 85%)

Trust Wide 85.69%, above target increase on previous month.
WBS 90.96%, above target but decrease on previous month
VCC 84.92% decrease on previous month.

4.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

5.0 RECOMMENDATION

5.1 Trust Board is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC October PMF Report
2. WBS October PMF Report
3. Workforce Monthly October PMF Report

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (November 2022)

			Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page xx)	Actual	92%	78%	92%	92%	92%	87%	92%	83%	72%	77%	82%	91%	Not Available
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page xx)	Actual	74%	84%	90%	90%	81%	79%	81%	83%	83%	85%	84%	84%	Not Available
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page xx)	Actual	85%	89%	100%	93%	88%	84%	88%	100%	100%	94%	93%	95%	Not Available
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page xx)	Actual	99%	99%	94%	91%	71%	69%	61%	58%	66%	77%	89%	96%	98%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page xx)	Actual	86%	100%	100%	100%	83%	100%	100%	86%	100%	100%	100%	100%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within	Actual	65%	Data Collection (Paused)	Data Collection (Paused)	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)-	Data Collection (Paused)	70%	47%	57%	Data Collection (Paused)	Data Collection (Paused)

			Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
	30 minutes of the Scheduled Appointment Times (National Target) (page xx)	Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Did Not Attend (DNA) Rates	Actual	5%	3%	3%	3%	3%	3%	3%	3%	5%	5%	5%	4%	Not Available
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	95%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page xx)	Actual (Dietetics)	100%	95%	98%	100%	98%	100%	100%	100%	100%	100%	100%	100%	98%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%

			Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Routine Therapies Outpatients Seen Within 6 Weeks (page xx)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page xx)	Actual	0	1	0	1	1	0	0	1	0	0	0	1	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page xx)	Actual (Total)	1	4	3	2	9	4	1	1	2	1	3	4	4
		Unavoidable	1	4	2	2	9	3	0	1	2	1	2	0	2

			Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
		Avoidable	0	0	1	0	0	1	1	0	0	0	1	0	2
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	1	4	1	1	0	0	0	0	1	2	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0	Not Available
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater than or Equal to Three Who Receive all 6 Elements in Required Timeframe	Actual	100%	100%	100%	100%	100%	88%	100%	100%	100%	100%	100%	100%	90%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	0
	Healthcare Acquired Infections	Actual	0	0	1 (*C.diff*)	0	0	0	0	0	1 (E.Coli bacteremia)	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date		Actual	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
		Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above. Red - Target not achieved.

KEY NOTE:

Due to the implementation of the new digital patient system DH & CR, there is a requirement to fully remap and rebuild the extraction of data from this system into our data warehouse and rebuild all of the reports. This is a known and planned stage of the replacements of such systems and has previously been highlighted in relation to the DHCR programme. This extensive work programme is still ongoing and being delivered according to the delivery plan. The impact of this is mainly for the radiotherapy treatment times and outpatient attendances that this system provides. The data system work is due to be completed in late January/early February and will then be operationally validated. This will then enable the retrospective data for November, December and January to be compiled for review. Data will be shared as it becomes available.

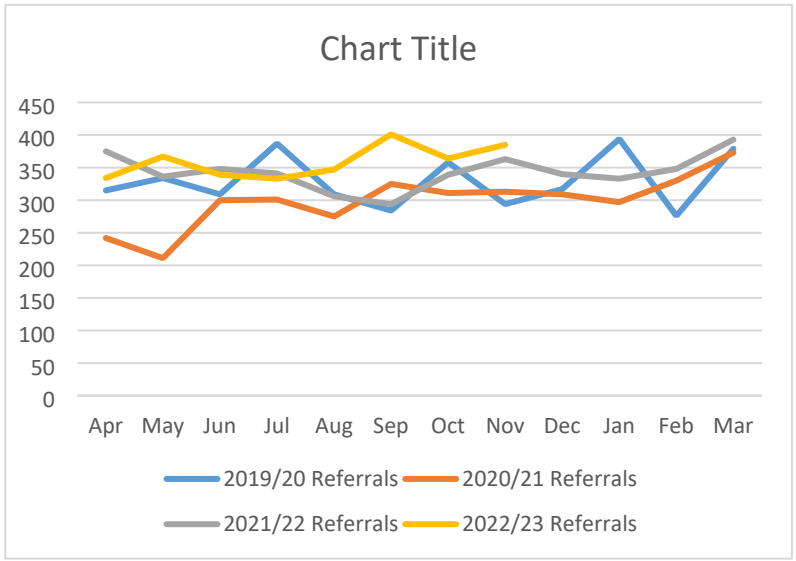
Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance
	Medium Term Actions
	Actions: what we are doing to improve • Gradual increase in LINAC capacity by 8% has occurred from Mid-July onwards. Work being undertaken within the Directorate extended working days and increased utilisation of LINAC capacity from 73.5planned hours in June to 76.5 hours delivered in October. • Risks remain however to provide specific Brachytherapy capacity and Radiotherapy Physics capacity and there are significant risks associated with the age of the equipment and potential breakdown. • Fleet configuration changes to support Breast patient treatment options have been implemented. • Treatment planning taskforce established to identify opportunities to release non-medical treatment planning. • Escalation processes continue to monitor predicted failures to meet time to treatment metrics and prioritise patients to

	commence treatment and minimise delay where possible, undertaken through weekly capacity meetings. Delays and cancellations are monitored weekly and reported back to Radiotherapy Management Group and the pathway sub-group.

Patients Receiving Palliative Radiotherapy Within 14-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance
	Medium Term Actions
	Refer to 28 day medium term actions.

Patients Receiving Emergency Radiotherapy Within 2-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance
	Actions: Refer to short and medium term actions above:

SACT Referral Trends - Overall



All SACT Referrals

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 Actual	315	334	309	387	309	284	359	294	317	394	276	379
2020/21 Actual	242	211	300	301	275	326	311	313	309	298	330	374
2021/22 Actual	375	336	348	342	306	294	339	364	341	333	349	395
2022/23 Actual	332	366	338	330	344	392	374	385				

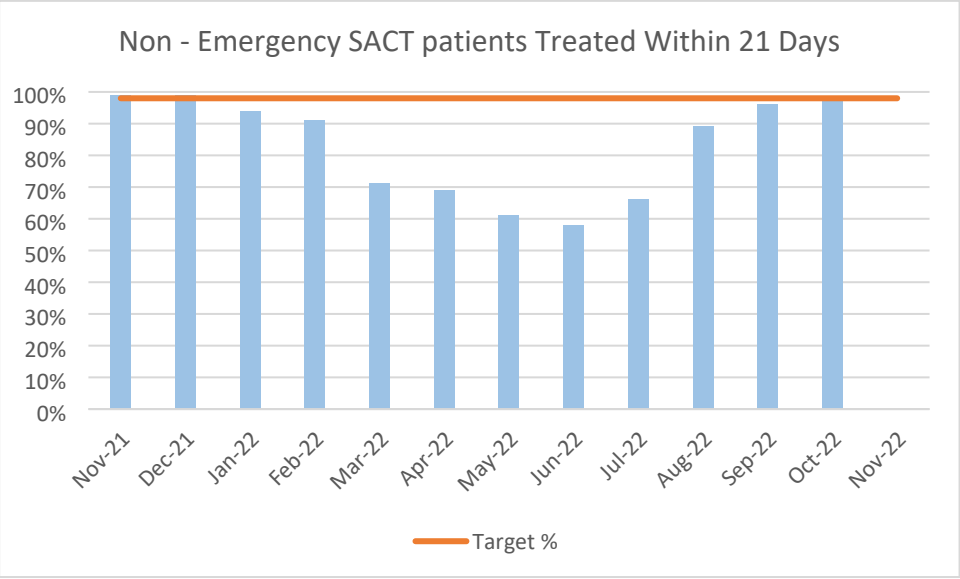
Another month of high referrals into the SACT service with November 2022 being the 3rd highest ever recorded.

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Chief Pharmacist

Current Performance



Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (Nov 2022)
Non - emergency	Patients Scheduled to Begin Treatment (Nov 2020)	321 Patients Scheduled to Begin Treatment (Nov 2021)	354
		325	

Trend

Of 354 patients treated, 6 patients waited over 21 days = performance of 98%. This is the first time the performance target has been achieved since December 2021.

Intent /Days -	22-28
Non-emergency (21-day target)	6

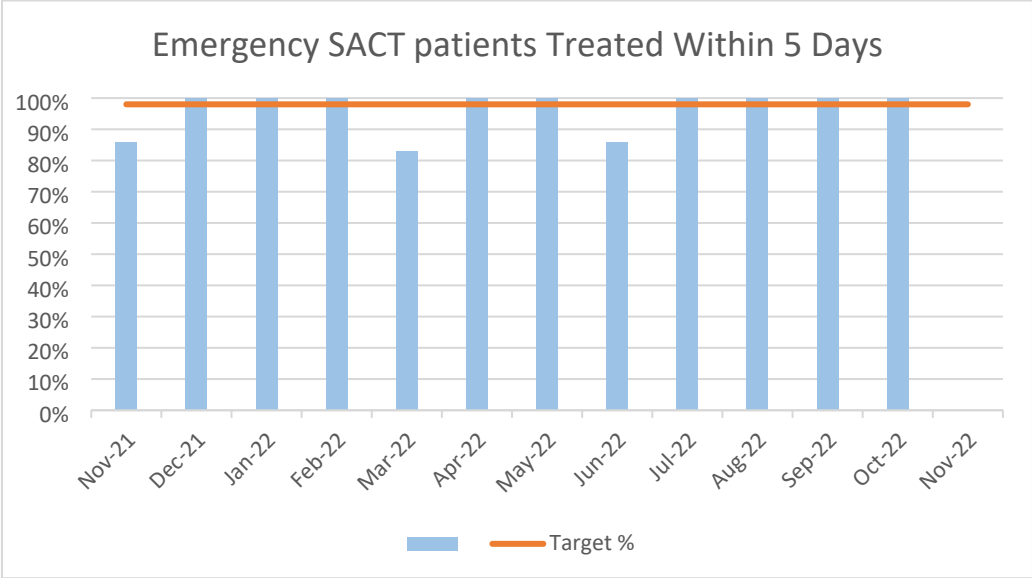
This is the 6th month where performance has improved from the previous month, arresting a 7-month decline. Breach numbers have also reduced to 6 in November from 14 in October.

No patient waited longer than 28 days for treatment, which is also a significant improvement as we have been regularly treating patients waiting 50 days in recent months.

Short Term Actions

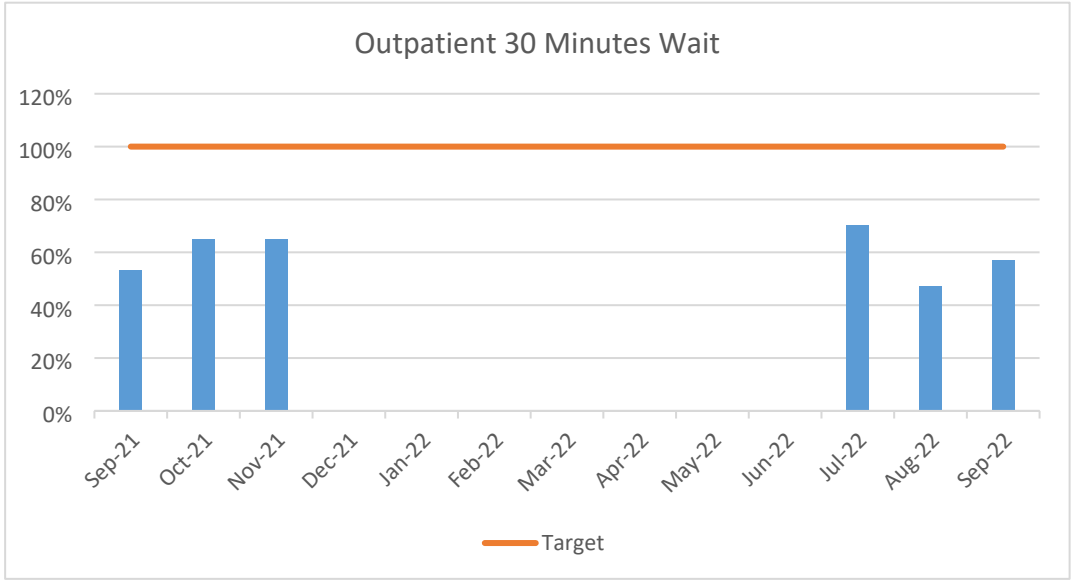
Incremental gains in pharmacy capacity are being delivered through reviews of working practices and the focus on maximising SACT provision.

Discussions with Aneurin Bevan UHB regarding the reintroduction of services at Nevill Hall Hospital (NHH) as an interim solution taking place.

Emergency SACT Patients Treated Within 5-Days	
Target: 98%	**SLT Lead: Chief Pharmacist**
Current Performance	Trend
	6 patients referred for emergency SACT treatment were scheduled to begin treatment in November 2022. All were treated in target with 100% performance.
	Actions
	• Continue to balance demand and ring fencing with capacity.

The number of patients scheduled to begin emergency SACT treatment in October 2022 (5) was lower than in September (9).

Intent	Monthly Average (2020-21)	Monthly Average (2021-22)	Patients Scheduled to Begin Treatment (Nov 2022)
Emergency		6	6
	Patients Scheduled to Begin Treatment (Nov 2020)	Patients Scheduled to Begin Treatment (Nov 2021)	
		6	

Outpatient 30 minute wait	
Target: 100%	**SLT Lead: Outpatient Manager**
Current Performance	Trend
	Monitoring of indicator reinstated between July and September, but remained limited as only a snapshot of clinics at particular times. Currently paused due to DHCR implementation.
	Actions
	Focus Groups to be established with patient involvement to define performance measures reflecting the entire patient experience at outpatients as part of the Trust wide PMF review.

Equitable and Timely Access to Services - Therapies	
Target: 100%	**SLT Lead: Head of Nursing**

Current Performance

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	95%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%	100%	100%

Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks

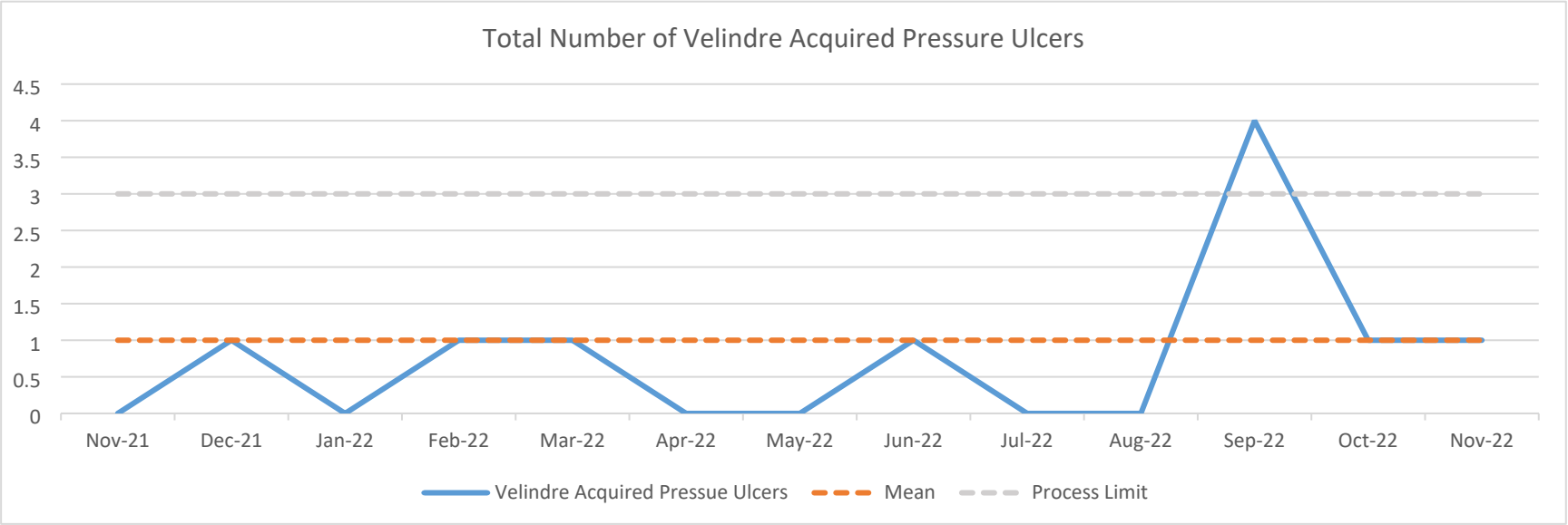
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Dietetics	100%	95%	98%	100%	98%	100%	100%	100%	100%	100%	100%	100%	98%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	86%	100%	100%	100%	100%	100%	100%	100%	78%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%

OP's (urgent) **DT = 98 %** (x 1 breach. The referral was received on 3/11. The patient had an appointment in clinic on 15/11 but Dietitian covering the clinic was on annual leave. Dietitians made contact with him 18/11 - hence the breach.	**Actions:** Review cross cover arrangements. Small team makes cross cover a challenge. The breach was due to annual leave. There are x2 part time locums. Recruitment has proved difficult to date and a current risk is still open regarding this. Cover is prioritised cover on a daily basis and recruitment for the vacancies are still underway. Posts are being redesigned where appropriate.

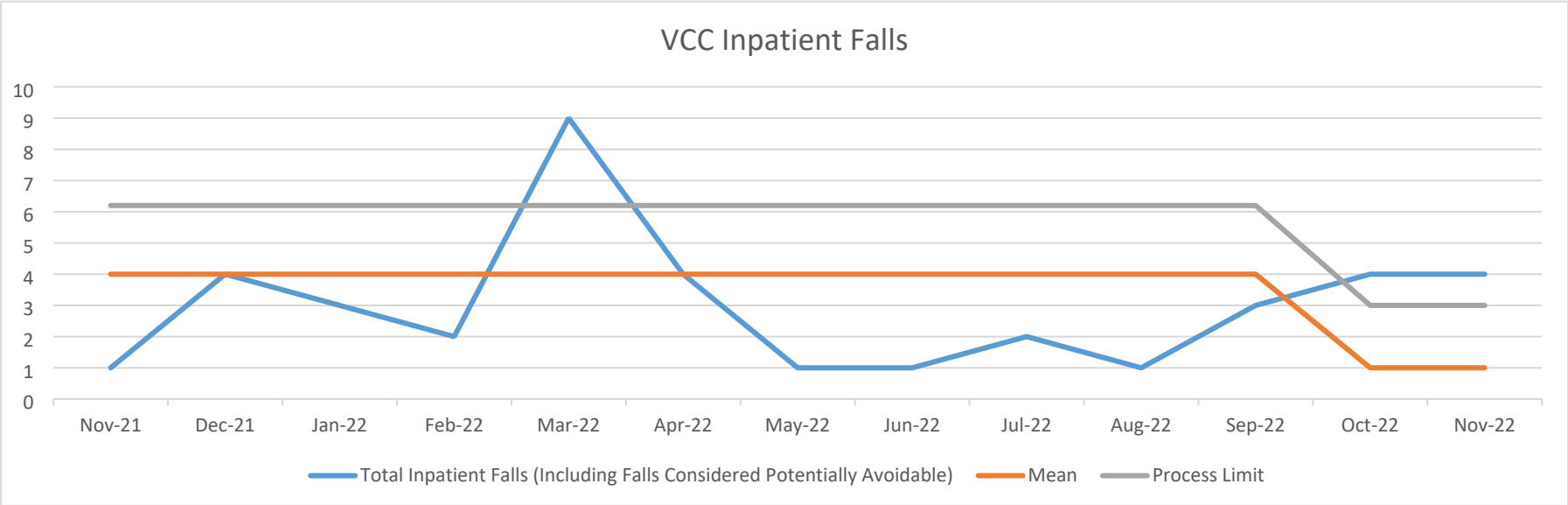
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Velindre Acquired Pressure Ulcers (Total)	1	0	1	0	1	1	0	1	0	0	4	1	1
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	0	0	1	0	0	1	0	0	0	0	0

Trend	Action
During November 2022 1 VCC acquired pressure ulcer was reported. The patient's family attempted to move the patient with the bed sheet, a grade 2 pressure ulcer was subsequently identified on the patients back. The scrutiny panel deemed this unavoidable.	**Actions: what we are doing to improve** Information was provided to the patient's family members regarding repositioning and advised to call for staff if patient requires repositioning.

Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Nov -21	Dec -21	Jan -22	Feb -22	Mar -22	Apr -22	May -22	Jun -22	Jul -22	Aug-22	Sep-22	Oct-22	Nov-22
Total Inpatient Falls	1	4	3	2	9	4	1	1	2	1	3	4	4
Potentially Avoidable Inpatient Falls	0	0	1	0	0	1	1	0	2	0	1	0	2

Trend	Action
There were 4 falls during November 2022, 2 of which were deemed avoidable after a multi-disciplinary review. Fall 1 –The patient was deemed at risk of falls. All relevant care plans and equipment were in place. Patient had full capacity and did not use the call bell before mobilising and fell. All post fall care completed, and **no harm** identified. Fall 2 – The patient was deemed at risk of falls. All relevant care plans and equipment were in place. Patients second fall during admission. Patient had full capacity and did not use the call bell before mobilising and fell. All post fall care completed, and **no harm** identified. Fall 3 - The patient was deemed at risk of falls due to previous falls at home. All relevant care plans and equipment were in place. The patient was admitted out of hours on the weekend. There was a missed opportunity for referral to out of hours physiotherapy which may have resulted in supply of a walking aid. This fall is therefore deemed avoidable. All post fall care completed, and **no harm** identified. Fall 4 - The patient was deemed at risk of falls due to confusion and agitation and required 1:1 nursing. During a busy night shift, another patient required urgent support from a number of staff. During this period the nurse undertaking the 1:1 supervision was asked to assist. The patient was asleep at the time of the decision, however the patient subsequently woke up and attempted to mobilise and fell. All post fall care completed, and **no harm** identified. Due to the unexpected increase in acuity on the night shift this fall was deemed avoidable.	**Actions: what we are doing to improve** Revise investigation tool. Feedback the outcomes of scrutiny panel back to ward staff. To remind staff about the services provided by physiotherapy on the weekend – this will be discussed with the staff daily during w/c 12/12/22 at the staff huddle. Implement a checking system to check sensor mat equipment. Physiotherapy to develop a referral criteria and attend ward huddles and staff meetings to discuss. This is not currently done at weekends.

Delayed Transfer of Care	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	

There was 1 DTOC in November 2022.

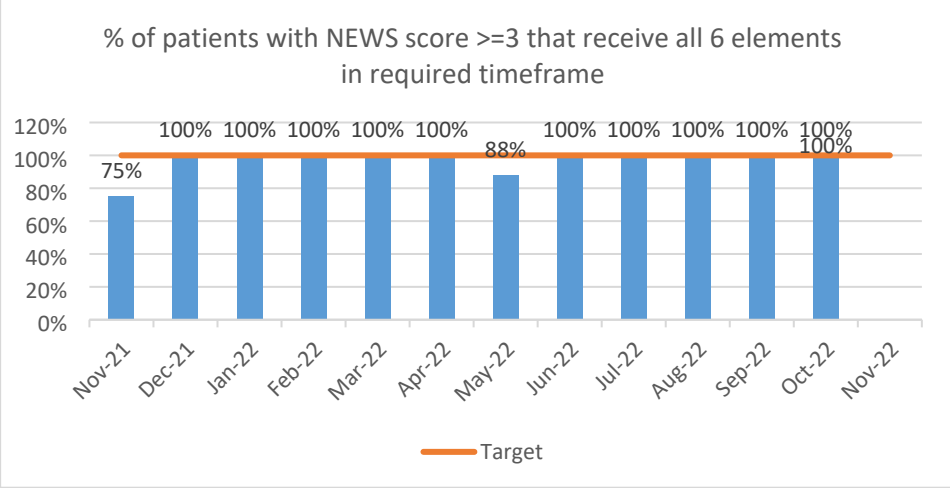
Patient admitted 7/10/22 to FF ward and had a prolonged admission requiring physiotherapy and occupational therapy input to support discharge home and ongoing rehabilitation. Patient was referred for repatriation to local DGH 15/11/2022 for rehabilitation. There was a delay in repatriation due to lack of bed capacity at accepting DGH. A social work referral and therapies input to support discharge were ongoing during admission and the patient was safely discharged home from VCC 06/12/2022, resulting in a delay of 21 days.

Actions:

Monthly operational meetings are now in place between VCC senior team and Health Board teams. We will add DTOC to that agenda to ensure that these cases are understood by the HBs and to consider joint improvements to manage these issues.

In addition, we will join the daily patient flow meetings with HBs, WAST and Welsh Government to ensure that issues impacting on us are shared with the health community for awareness and resolution.

Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe	
Target: 100%	**SMT Lead: Clinical Director**
Current Performance	Trend



Assessment of current performance, set out key points:

- 7 patient episodes met criteria for response to sepsis - 7 received antibiotics within 1 hour where appropriate = 100%
- In total 5 patient episodes received diagnosis of sepsis - 5 received all 6 elements within 1 hour = 100%

Actions

No improvement actions required.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
C.diff	0	0	1	0	1	0	0	0	0	0	0	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0
E.coli bacteremia	0	0	0	0	0	0	0	0	1	0	0	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
There were no reported infections in November 2022.	No specific action required.

Welsh Blood Service Monthly Report
November 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Demand for red blood cells (full weeks) averaged at 1371 units per week, and all clinical demand was met in November placing the service in good and stable position. During November the red cell stock holding did not drop below 3 days for priority blood groups (O, A and B+), and stock levels were satisfactory across all groups. Due to this, the service was in a position to export 120 units to Northern Ireland. The role of the daily Demand Planning Group meeting, which includes representatives from all departments supporting the supply chain, has been critical to steering the service through extremely challenging times.

At 96% quality incident investigations completed continues to exceed the target of 90% closed within 30 days. There were no critical or major non-conformances recorded from audits in November, no adverse event reports submitted to the MHRA and no adverse event reports were submitted to the HTA. In addition, no Serious Hazards of Transfusion (SHOT) incidents were reported during the month.

At 96% donor satisfaction continues to remain above target.

In November 2022, 7,904 donors were registered at donation clinics with 8 concerns (0.1%) reported within this period. The one formal concern recorded in November is expected to be completed before the 30 day target of 05/01/23, whilst the remaining concerns were managed as 'early resolution' within the required timescales.

Performance for both % part bags and failed venepuncture are within tolerance, however there is an upward trend in monthly figures that is currently being explored.

Collection efficiency performance failed to meet target in November. This drop in performance is a short term consequence of managing low hospital demand. The number of donor slots was reduced to avoid over collection, however the time was utilised to support staff to complete mandatory training and PADRs.

At 96% the turnaround time for routine Antenatal tests in November remains above the target of 90%, however, Reference Serology turnaround performance failed to meet the 80% target in November at 65%. Recent performance is due to continued staff absences, high levels of testing requests and planned annual leave. An additional Band 6 Specialist Biomedical Scientist resource to increase complex testing is being recruited. Validation of the new automated analyser has been completed and this will start to support an improvement in performance. Further validation of red cell phenotyping equipment is expected to be completed by the end of January 2023 further improving efficiency.

All clinical demand for platelets was met averaging 161 units per week, representing a strong performance against this metric in November. However, platelet wastage is still above target at 15%. Creation of a forecasting tool to inform decisions around pooled platelet manufacture will support a reduction in this figure. This is due to be completed in quarter 4.

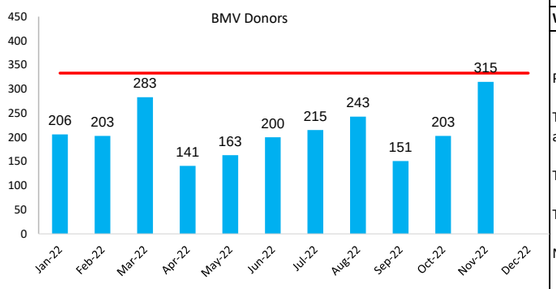
In November, 315 new donors were recruited to the Welsh Bone Marrow Donor Registry (WBMDR) against a target of 333, the highest number recruited this year. The Recovery Plan continues to focus on recruitment of donors at schools, colleges and universities, and in November ensured that a 'Bone Marrow Champion' was present at every school, college and university blood collection session. The service continues to work proactively to understand the optimum programme for recruitment of donors via buccal swab, including utilising digital solutions to improve ways of generating an increase in numbers.

The total stem cells collected in November was 1 (1 collection was cancelled during November for patient reasons). The total stem cell provision for the service was 6 (1 collected and 5 imported for Welsh patients).The WBMDR five year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment.

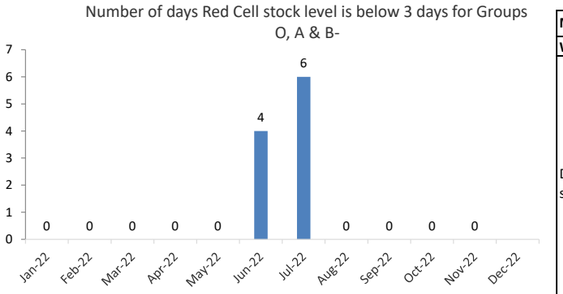
Reference Table

Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs manufactured as a % of the number of issues to hospitals **(% Red Cell Demand Met)**	100%	Monthly	Local
Number of bags of platelets manufactured as a % of the number of issues to hospitals **(% Platelet Demand Met)**	100%	Monthly	Local
Number of Confirmatory Tests (CTs) requested and bled as a % of the total CTs requested **(Confirmatory Tests Bled)**	65%	Monthly	Local
Number of Stem Cell Collections	80	Annual	Local
Number of antenatal patient results provided to customer hospitals within 3 working days from receipt of sample **(Antenatal Turnaround Times)**	90%	Monthly	Local
Number of samples referred for red cell reference serology work ups provided to customer hospitals within 2 working days. **(Reference Serology Turnaround Times)**	80%	Monthly	Local
% of Quality Incident Records (recorded in DATIX), closed within 30 days over a rolling 3 month period	90%	Rolling	Local
Number of critical non-conformances through external audits or inspections	0	Annual	Local
Number of Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines and Healthcare products Regulatory Agency (MHRA)	0	Annual	Local
Number of whole blood donations that are collected on session which are below the minimum viable volume, as a % of the total number of whole blood donations collected **(% Part Bags)**	3%	Monthly	Local
Number of donors where venepuncture is attempted to be performed on but no blood enters the bag, as a % of the number of donors who have reached the donation chair **(% Unsuccessful Venepuncture)**	2%	Monthly	Local
The number of blood components (weighted) collected per Standardised FTE (**Blood Collection Efficiency)**	1.25 WTE	Monthly	Local
Number of components manufactured per Standardised FTE. **(Manufacturing Efficiency)**	392	Monthly	Local
Number of platelets which have time expired as a % of the total number of platelets manufactured **(Time Expired Platelets)**	10%	Monthly	Local
Number of RBC units which become non-viable during the manufacturing process which could have been avoided, as a % of the number of complete whole blood donations **(Controllable Manufacturing Losses)**	0.5%	Monthly	Local
Number of bags of RBC, including Paediatric bags, which have time expired as a % of the total number of RBC bags manufactured **(Time Expired Red Cells)**	1%	Monthly	Local
Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied with their overall donation experience after they have been registered on clinic to donate **(Donor Satisfaction)**	71%	Monthly	Local
Number of 'formal' and 'informal' concerns received from blood donors	~	~	~
% of 'formal' concerns received and treated under 'Putting things Right Regulations within 30 working days	100%	Monthly	National
% of all concerns (formal and informal) acknowledged within 2 working days as required by the 'Putting things Right' Regulations	100%	Monthly	National
Number of new Whole Blood Donors recruited to the donor panel	2,750	Quarterly	Local
Number of new Apheresis Donors recruited to the donor panel	14	Quarterly	Local
Number of Deceased Donor Typing / Cross Matching reported within given period	80%	Quarterly	Local
Number of Anti D & -c Quantitation patient results provided to customer hospitals within 5 working days	90%	Quarterly	Local

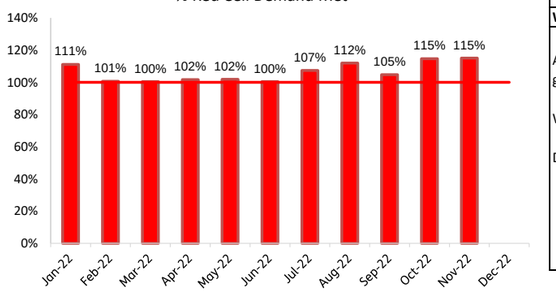
Monthly Reporting



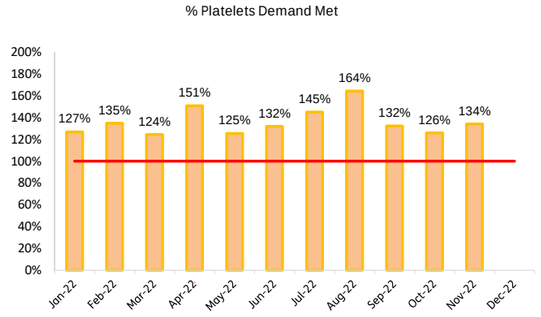
Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance has started to improve as the Recovery Plan is implemented but has still not met target in November. The service continues to focus on recruitment of donors at schools, colleges and universities, with a bone marrow champion present at every school, college and University blood session. The number of eligible donors increased in November to 951 versus 700 in October. The service continues to work proactively to understand the optimum programme for recruitment of donors via buccal swabs. NB: there is a delay between timelines of registration and receiving the swabs back from donors of up to six weeks.	A Recovery Plan has been developed to explore new ways to increase recruitment of bone marrow volunteers. A project group has been established to drive implementation and is meeting weekly. A review is being carried out in December and the plan will be adapted accordingly to focus on areas where results are being seen. As part of that plan, targeted bone marrow donor recruitment on social media commenced in November. A 'Roadshow' marketing campaign, which aims to actively recruit donors aged between 17-30 across Wales, is being piloted between December 2022 and May 2023. Digital solutions are being explored to support recruitment. 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.	Ongoing May 2023 Qtr 4



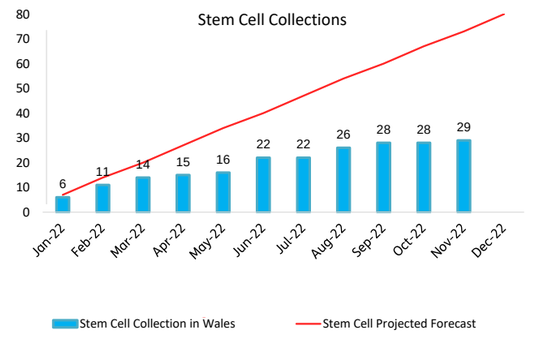
Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
During November, the red cell stock holding did not drop below 3 days for priority blood groups (O, A and B+). Stock levels are satisfactory across all groups.	The service constantly monitors the availability of blood for transfusion through its daily Demand Planning 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. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.	Reviewed daily to support responses to changes in demand.



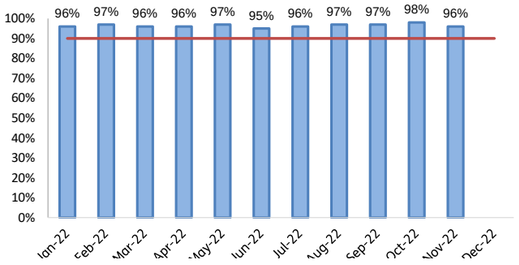
Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand was met in November with the service in good and stable position, with healthy stock levels across all priority groups. Due to this, 120 O+ units were able to be exported to Northern Ireland in November. Washed red cells received due to specialist requirements. Demand in November (full weeks) averaged at 1371 units per week.	The service constantly monitors the availability of blood for transfusion through its daily Demand Planning 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. Appropriate operational adjustments are made to maintain adequate stock levels and minimise blood shortages.	Reviewed daily to support responses to changes in demand.



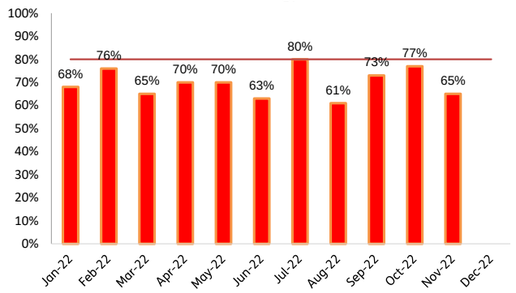
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand for platelets was met representing a strong performance against this metric in November. Platelet demand was 161 units per week on average. Note: 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.	Due to their short shelf life (7 days), platelet stocks are monitored on a daily basis to ensure adequate response time to any 'spikes' in demand. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. The service carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish Groups were established in Q3 to implement the recommendations. They cover optimising the clinic collection plan for Apheresis and creation of a forecasting tool to inform decisions around pooled platelet manufacture.	Reviewed daily 12 months Qtr 4



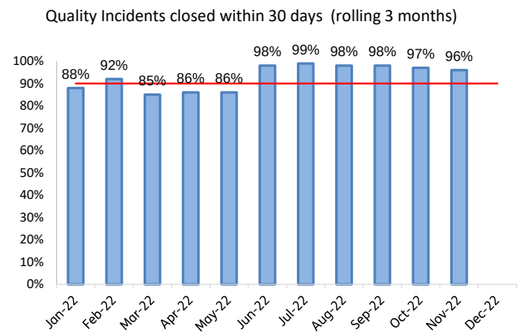
Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The total stem cells collected was 1 (1 collection was cancelled during November for patient reasons). The total stem cell provision for the service was 6 (1 collected and 5 imported for Welsh patients). In addition, 2 Peripheral Blood Lymphocytes were collected. The Service continues to experience a cancellation rate of approx. 30% compared to 15% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment. Currently, 4 stem cell products are due for collection in December.	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.	Quarter 4



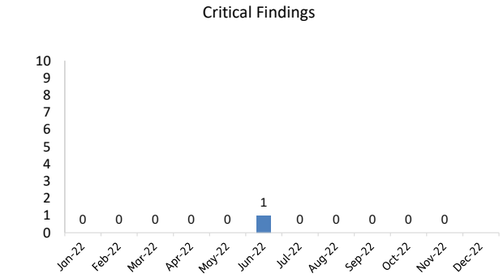
Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96% the turnaround time for routine Antenatal tests in November remains above the target of 90%.	Efficient and embedded testing systems are in place. Continued monitoring and active management remains in place, maintaining high performance against current target.	Business as Usual, reviewed daily



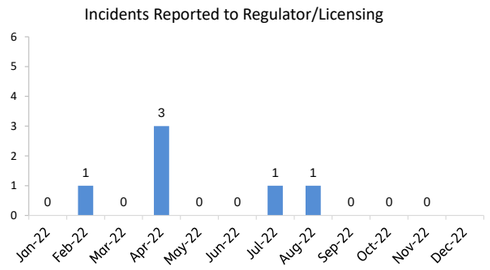
Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Reference Serology 'turnaround' performance failed to meet the 80% target in November 2022. Recent performance is due to continued staff absences, continued high levels of testing requests and planned annual leave. Compatibility testing (43% of referrals) continues to meet clinical target and all time-critical tests are being completed on time, whilst the volume of testing requests has increased slightly to 228 per month compared to Average 226/month for 2021.	The service conducts specialist tests to confirm hospital results that are difficult to interpret or will undertake additional testing which is not performed in the hospital blood banks. These tests must be performed within 7 days of the sample being taken and are prioritised appropriately to ensure the fastest turnaround possible. The service continues to prioritise compatibility referrals and safe provision of red cells for transfusion. All referrals are prioritised based on clinical need. An additional Band 6 Specialist Biomedical Scientist resource to increase complex testing is being recruited. Validation the new automated analyser has been completed and this will start to support an improvement in performance through efficiency. Further validation of red cell phenotyping equipment is expected to be completed by the end of January 2023 further improving analytical efficiency.	Quarter 4 January 2023



Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96% Quality incident investigations closed within 30 days continues to exceed the target of 90% . A 1% reduction in month is within expected variation for this measure.	Continue to closely monitor performance. Each incident report is reviewed within a working day of being reported to ensure all information needed for effective risk assessment and investigation is captured. The review identifies complex investigations that may need multi-disciplinary support to establish a root cause. We expect the multidisciplinary approach to investigating complex incidents to enable faster identification of root cause and more effective preventative action to be put in place. The progress of actions to address incidents is closely monitored. The QA team continue to send weekly updates alerting owners/managers of actions recorded within QPulse that are likely to breach close-out deadlines.	Every incident report is reviewed within a working day of being reported

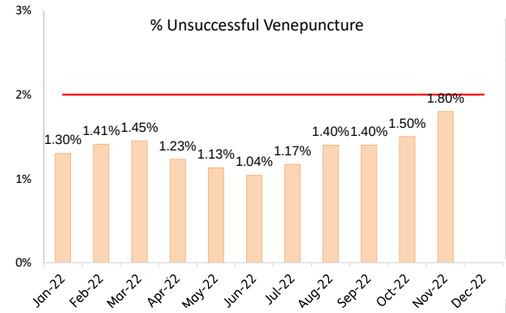


Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no critical or major non-conformances in November.	Where they occur, the work to assign root causes of non conformances will be completed.	

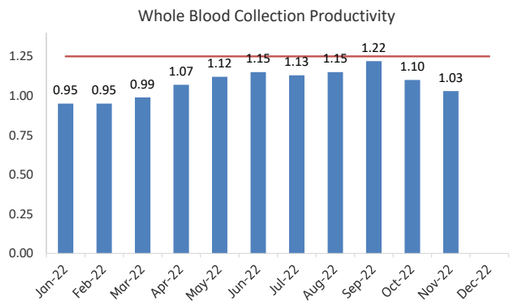


Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were no Serious Averse Blood-Related Event (SABRE) reports submitted to the Medicines and Healthcare Product Regulatory Agency (MHRA) in November. No adverse event reports were submitted to the Human Tissue Authority (HTA), and no Serious Hazards of Transfusion (SHOT) incidents were reported during the month.	Completion of Corrective Actions and Preventative Actions (CAPA), in respect of SABRE reports, is monitored via existing processes and reported to the Regulatory Assurance and Governance Group (RAGG).	Progress of completion of investigations is monitored via monthly QA metrics reporting into RAGG.

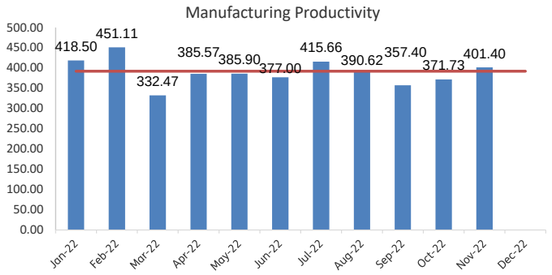
Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains within the required tolerance level of 3% at 2.92% for November, however there is an upward trend in monthly figures that is being explored. NB: Causes of Part Bags are various (needle placement, clinical risk, donor is unwell, donor request to stop donation, late donor information and equipment failure) and at times cessation of donation resulting in a part bag is clinically appropriate. This is a separate factor to Failed Venepuncture (FVPs).	Work is underway with Clinical Services and the Training Team to understand rationale for upward trend. Findings shared with operational managers and further training/support provided where required. Continue with close monitoring and intervention where required.	Ongoing



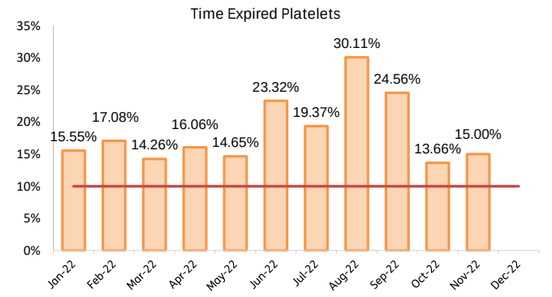
Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 1.8%, overall performance is within the required tolerance (2%), however there is an upward trend in monthly figures that is being explored.	Work is underway with Clinical Services and the Training Team to understand rationale for upward trend. Findings shared with operational managers and further training/support provided where required. Continue with close monitoring and intervention where required.	Ongoing



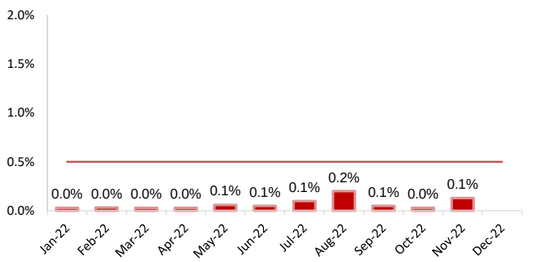
Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Collection efficiency performance failed to meet target in November. This drop in performance is a short term consequence of managing low hospital demand. The number of donor slots was reduced to avoid over collection, however the time was utilised to support staff to complete mandatory training and PADRs. NB. Current resource reporting does not allow for recording of non-donor facing hours which also has had a direct impact on performance reporting.	Daily review of stock levels in conjunction with the wider service to support correct available 'days of blood' by blood group stock levels. Supporting staff to complete mandatory training and PADRs when capacity allows. Daily monitoring of hospital demand to support flexible increases in capacity if required. Update the current efficiency reporting tool to incorporate the capture of non-donor facing hours, this will lead to a more accurate reporting efficiency.	December 2022



Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
At 401 manufacturing efficiency performance exceeds the target of 392. NB. This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured.	Continue to monitor and review as part of development of new suite of KPIs.	

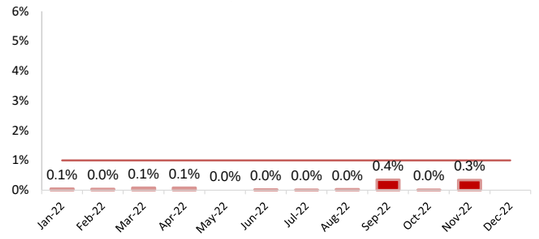


Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Platelet wastage is still above target at 15% due to difficulty in understanding production/distribution efficiency performance. Demand continues to be met without the need for Mutual Aid support.	Given the variability of expired platelets over the past 12 months, the service has carried out a review to better understand current demand trends in order to improve production/distribution efficiency performance. Task & Finish groups have been established in November to implement the recommendations. They cover optimising the clinic collection plan for Apheresis and creation of a forecasting tool to inform decisions around pooled platelet manufacture. Regular highlight reports are being submitted to the SMT. More sustained resolution will arise through the work exploring cold platelet storage which the Component Development Laboratory are facilitating.	12 months Qtr 4



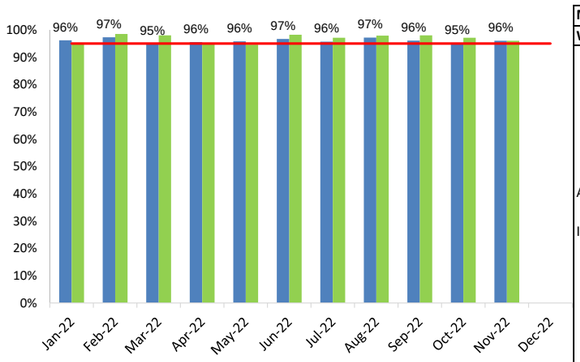
Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Controllable losses were low at 0.13% and remain within tolerance of below 0.5%. These levels are well within tolerance and represent good performance.	Active management of the controllable losses in place, including vigilance and reporting of all units lost. Ongoing monitoring of losses when occurring in order to understand the reasons and consider appropriate preventative measures thus continuously improving practice through lessons learned and analysis.	Business as Usual, reviewed monthly

Time Expired Red Cell



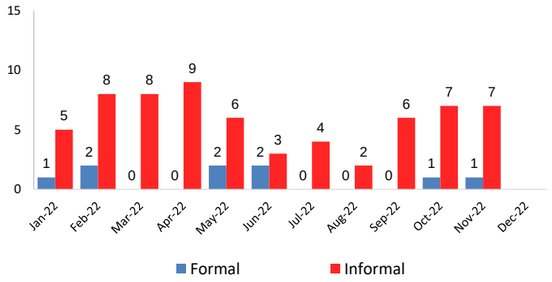
Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
This metric remains well within the target and there are no concerns around expiry of red cells.	Daily monitoring of age of stock as part of the resilience meetings. Red Cell shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly. Continued effective management of blood stocks to minimise the number of wasted units.	Business as usual, reviewed daily

Donor Satisfaction



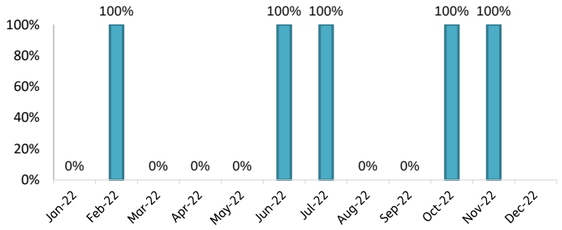
Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
At 96.1% donor satisfaction continues to be above target for November. In total there were 1,100 respondents to the donor survey.	Findings are reported to the Senior Management Team (SMT) at the Collections meeting to address any actions for individual teams. WBS has now fully implemented the Civica tool at post donation care on donor sessions. Feedback will be incorporated into future quarterly divisional highlight reports.	Business as usual, reviewed monthly

Number of Concerns Received



Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In November 2022, 7,904 donors were registered at donation clinics with 8 concerns (0.1%) reported within this period. The one formal concern recorded in November is being managed under 'Putting Things Right' (PTR) regulations and is expected to be completed before the 30 day target of 05/01/23. The formal concern recorded in October was completed on 21/10/22, ahead of the 30 day target. The remaining concerns were managed as 'early resolution' within the required timescales. Formal Concern: A Donor raised a number of concerns around donation experience. Early Resolutions: 1. A donor felt rushed, was disappointed with RN's behaviour. 2. 2 Donors were unhappy to be turned away from session when attending with children. 3. 2 Donors were unhappy to be turned away from session for being late. 4. A donor was unhappy with the lack of available venues in postcode area. 5. A donor was unhappy that a staff member made comment about existing bruise on arm.	Formal Concern: A full Investigation underway to establish if there was a breach of duty. Early Resolution: 1. An apology was made to the donor regarding their donation experience, caused by the failure of the RN to explain the need to wash hands following a blood spillage. The RN has been reminded of the importance of effective communication. 2. The Clinical Lead RN in question has been reminded to discuss attendance at collections session with donors who bring children, emphasising that accepting children at donation centres will be at their discretion and based on clinical safety and venue capacity. 3. Reception staff have been reminded to inform the Clinical Lead RN of donors who arrive late for their appointment, in order to be able to assess clinic capacity and safety and the potential to accept late donors. 4. Following appropriate risk assessments as part of the aim to restore collections to pre COVID levels, plans to re-introduce Mobile Donation Units (MDU) to support the availability of collections made in the community are now in place. 5. Collections team staff have been reminded of the importance of effective and sensitive use of their communication skills with donors.	

% Responses to Concerns within 30 Working Days



Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All concerns due to be completed in November were dealt with in October ahead of timeline. The Service is on target to conclude the formal concern received in November within the 30-working day timeframe. All concerns continue to be monitored and actioned as appropriate. * Under PTR guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.	Continue to monitor this measure against the '30 working day' target compliance. Continued emphasis of the 'Concern' timescale needs to all involved in concerns management reporting. Review Standard Operating Procedure (SOP) relating to children attending session with donors. - Training Awareness of Effective Documentation Skills is taking place. - Ongoing individualised staff assessments.	December 2022

% Concerns Acknowledged within 2 Working Days

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance met target in November 2022, with all concerns managed within required timelines.	Continued daily monitoring of this measure against the 'two working day' compliance target. Remind all staff involved in concerns management of the importance of the 2-day response timescale Review the Standard Operating Procedure (SOP) relating to children attending donation sessions Training Awareness of Effective Documentation Skills is taking place. Ongoing individualised staff assessments	

Canolfan Ganser Felindre
Velindre Cancer Centre

Workforce Monthly Report

November 2022

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness, PADR, Statutory and Mandatory training;
- Hotspots identified, with in month actions to explain improvement trajectory work. Hotspots defined as areas where KPIs are not met and there has been a downward trend over the last three months;
- In month Job Planning figures with narrative to notify areas of improvement;
- Usage of Work in Confidence platform.

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Nov-22	Oct-22	
PADR	75.40	71.24	85%
Sickness	6.19	6.30	3.54%
S&M Compliance	86.79	85.69	85%

Workforce Dashboard

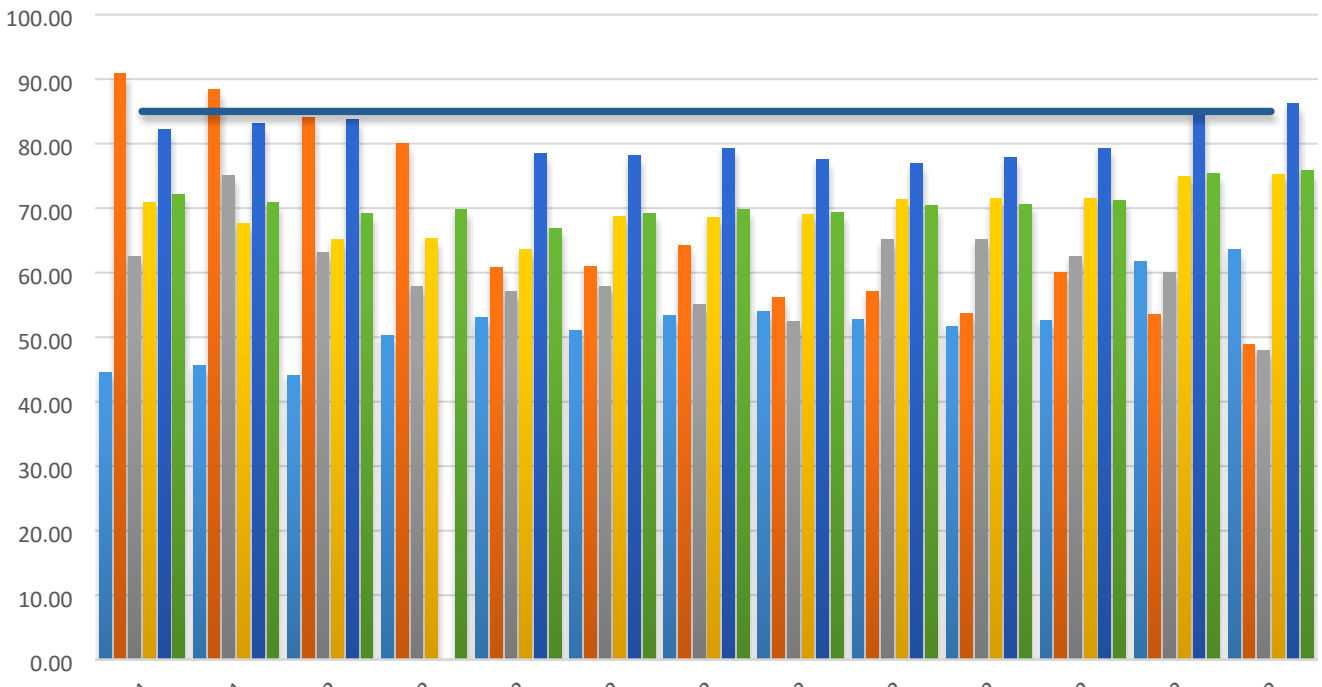
Data below highlights rolling figures for workforce KPI's. This provides a running total of the values of the last 12 months of an indicator providing trend data for the indicators. Granular monthly data is generated for divisions as separate reports. Data RAG rated for ease of reading.

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.													
PADR	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	44.59	45.64	44.08	50.33	53.02	51.01	53.38	54.05	52.74	51.72	52.63	61.69	63.64
Research, Development & Innovation	90.91	88.37	84.09	80.00	60.87	60.98	64.29	56.10	57.14	53.66	60.00	53.49	48.89
Transforming Cancer Services	62.50	75.00	63.16	57.89	57.14	57.89	55.00	52.38	65.22	65.22	62.50	60.00	48.00
Velindre Cancer Centre	70.90	67.61	65.16	65.25	63.56	68.69	68.62	69.04	71.30	71.47	71.50	74.90	75.23
Welsh Blood Service	82.19	83.06	83.73	81..75	78.44	78.16	79.26	77.53	76.90	77.86	79.27	84.67	86.17
Velindre Organisations	72.11	70.83	69.21	69.75	66.86	69.24	69.81	69.29	70.45	70.61	71.24	75.40	75.80
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude those on Maternity and those currently off with sickness absence													
Stat and Mand Compliance (10x CSTF)	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	72.32	74.40	72.17	73.64	74.51	73.48	74.31	74.41	73.06	71.95	73.84	76.12	77.14
Research, Development & Innovation	84.58	85.83	84.26	80.42	80.21	80.23	79.56	82.95	81.09	80.22	84.77	87.45	87.23
Transforming Cancer Services	83.33	81.43	77.86	77.39	77.39	78.64	80.91	76.96	75.65	75.42	77.20	79.23	80.38
Velindre Cancer Centre	84.91	84.93	84.73	84.18	84.88	85.17	85.46	85.22	84.68	84.39	85.01	84.92	85.31
Welsh Blood Service	93.36	93.56	93.78	92.02	92.30	92.19	92.44	93.17	91.72	92.19	91.33	90.96	93.75
Velindre Organisations	86.06	86.40	85.97	85.26	85.77	85.76	85.08	86.20	85.27	85.10	85.49	85.69	86.79

Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	5.01	5.34	5.48	5.53	5.57	5.63	5.59	5.37	5.19	4.99	4.72	4.49	4.21
Research, Development & Innovation	4.41	4.31	4.51	4.81	5.41	6.21	6.84	7.29	7.32	7.42	7.36	7.38	7.53
Transforming Cancer Services	1.29	1.01	0.98	1.05	1.10	1.24	1.27	1.24	1.21	1.15	1.07	1.10	0.90
Velindre Cancer Centre	5.63	5.51	5.56	5.63	5.92	6.15	6.24	6.32	6.44	6.47	6.35	6.32	6.24
Welsh Blood Service	5.99	6.27	6.45	6.53	6.80	7.04	7.04	7.18	7.40	7.32	7.20	7.19	7.06
Velindre Organisations	5.58	5.63	5.73	5.81	6.07	6.30	6.36	6.42	6.53	6.50	6.36	6.30	6.19
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

PADR – The Figures



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	44.59	45.64	44.08	50.33	53.02	51.01	53.38	54.05	52.74	51.72	52.63	61.69	63.64
Research, Development & Innovation	90.91	88.37	84.09	80.00	60.87	60.98	64.29	56.10	57.14	53.66	60.00	53.49	48.89
Transforming Cancer Services	62.50	75.00	63.16	57.89	57.14	57.89	55.00	52.38	65.22	65.22	62.50	60.00	48.00
Velindre Cancer Centre	70.90	67.61	65.16	65.25	63.56	68.69	68.62	69.04	71.30	71.47	71.50	74.90	75.23
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Velindre Organisations	72.11	70.83	69.21	69.75	66.86	69.24	69.81	69.29	70.45	70.61	71.24	75.40	75.80
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

PADR – The Narrative

Performance Indicator	RAG / change from previous month	Oct Figure	Hotspot Areas	%	Comment
PADR Compliance (85%)	**76%** ↑	75%	**Welsh Blood Service (86%)**		
			Directors	50%	*Same as previous month* Identified issue with manager accuracy imputing PADRS dates into the system. This issue has now been rectified and data should be updated from December onwards.
			Velindre Cancer Centre (%)		
			CSMO	54%	Increase from previous month (44%) Targeted interventions being undertaken with SBP and monitored in monthly performance meetings with SLT.
			Clinical Audit	33%	*Decrease on previous month (50%)* Due to the low headcount in this department (3 total) the outstanding PADR is due to absence.
			Outpatients	48%	*Decrease on previous month (52%)*
			Corporate Areas (53%)		
			RD&I	49%	*Decrease on previous month (53%)* TCS compliance has declined month on month for the past 3 months and is therefore now considered a hotspot area. WOD continue to support managers in completing PADR's in an accurate and timely manner.
			TCS	48%	*Decrease on previous month (60%)* TCS compliance has declined month on month for the past 3 months and is therefore now considered a hotspot area. Senior Managers have noted the compliance dip and a targeted

					review is taking place during January to improve compliance with support from SBP.

Action/reasons/initiatives:

Velindre University NHS Trust

PADRs across the Trust continue to steadily increase (4% increase in comparison to November 2021 compliance) and the new Pay Progression Policy is now fully live and operational across the organisation.

WBS

PADR Compliance has increased again this month, after a sustained effort from the teams to increase compliance following pay progression discussions. Compliance is reporting above the target of 85%.

VCC

PADR rates continue to increase month on month (4% since Nov 21) however they remain below Trust target level of 85%

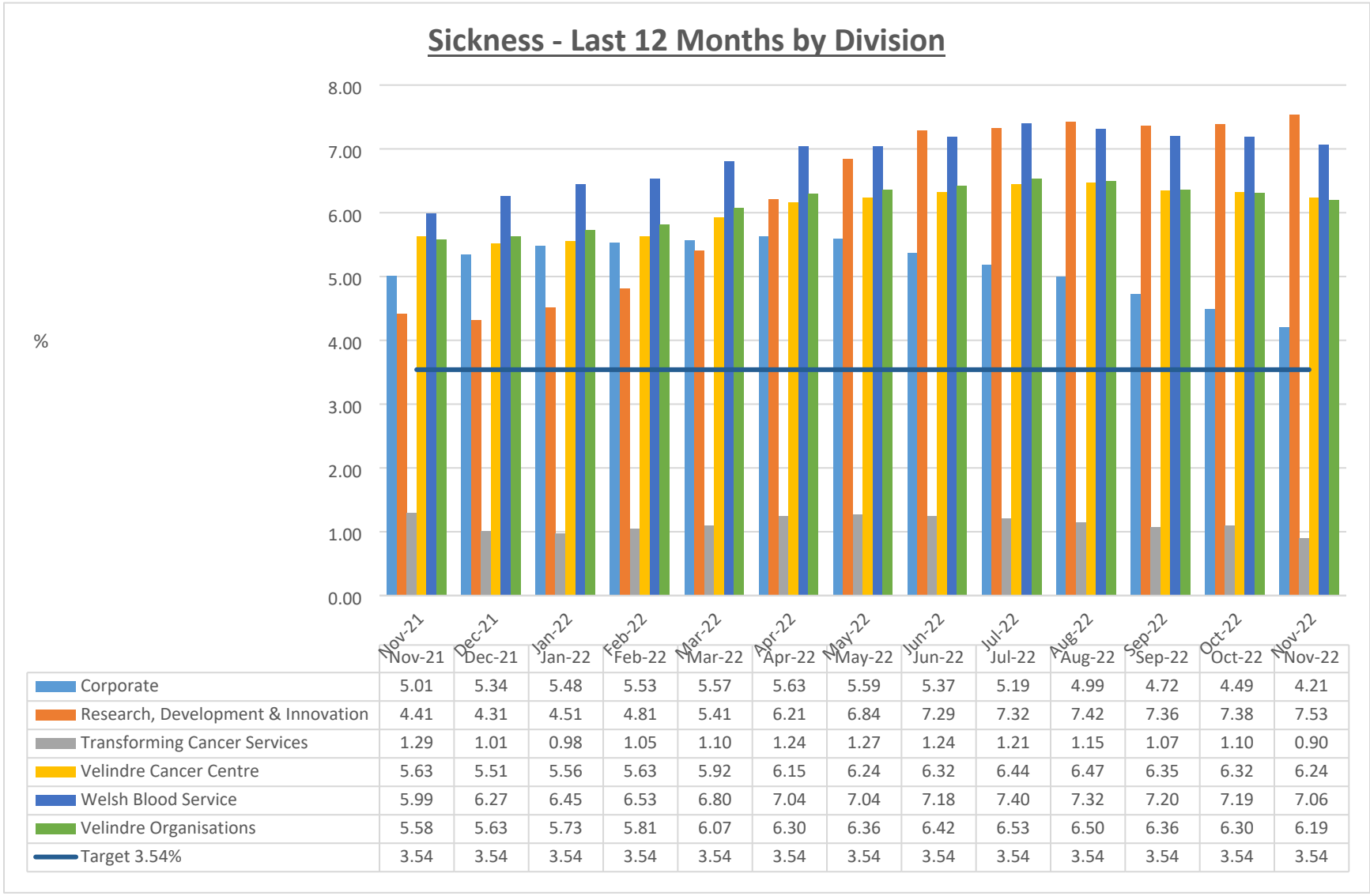
Targeted intervention has taken place in CMSO with the significant improvement of 10% on last month's figures as demonstrated in the hotspot table above.

Corporate Services

Two areas identified as new hotspots, TCS and RD&I after 3 consecutive months of PADR decline. Senior Managers will work with WOD colleagues to improve compliance and identify issues of concern in January 2023.

Corporate PADR compliance continues to rise month on month with a significant growth of 19% since November 2021. WOD Senior BP will continue to support managers in ensuring PADRs are completely in a timely and accurate manner.

Sickness Data – The Figures



	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22
Corporate	5.01	5.34	5.48	5.53	5.57	5.63	5.59	5.37	5.19	4.99	4.72	4.49	4.21
Research, Development & Innovation	4.41	4.31	4.51	4.81	5.41	6.21	6.84	7.29	7.32	7.42	7.36	7.38	7.53
Transforming Cancer Services	1.29	1.01	0.98	1.05	1.10	1.24	1.27	1.24	1.21	1.15	1.07	1.10	0.90
Velindre Cancer Centre	5.63	5.51	5.56	5.63	5.92	6.15	6.24	6.32	6.44	6.47	6.35	6.32	6.24
Welsh Blood Service	5.99	6.27	6.45	6.53	6.80	7.04	7.04	7.18	7.40	7.32	7.20	7.19	7.06
Velindre Organisations	5.58	5.63	5.73	5.81	6.07	6.30	6.36	6.42	6.53	6.50	6.36	6.30	6.19
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

Sickness – The Narrative

Performance Indicator	RAG/ Change from previous month	Oct Figure	Hotspot	%	Comment
Sickness absence (3.42%)	**6%** →	6%	**Welsh Blood Service (7%)**		
			Collections	10%	*Same as previous month (10%)* The People and Relationships team continue to support managers in the application of MAWW policy. Sickness audits underway with expected outcomes in late January 2022.
			Laboratory	8%	*Increase on previous month (7%)* Outcome of targeted Respect and Resolution interventions to be collated for SMT and further action will be required.
			Velindre Cancer Centre (6%)		
			Clinical Audit	12%	*Decrease on previous month (14%)* Due to the smaller nature of the department one absence has had significant impact on the overall sickness compliance of the team.
			Outpatients	14%	*Decrease on previous month (15%)* The People and Relationships team continue to support managers in the application of MAWW policy.
			Private Patients	9%	*Same as previous month (9%)* In month absence has declined and it is expected the rolling absence compliance will decline as the year progresses.
			Information Section	9%	*Increase on previous month (7%)* New hotspot areas due to increasing compliance month on month. Detailed analysis required by services leads and WOD Business Partner.

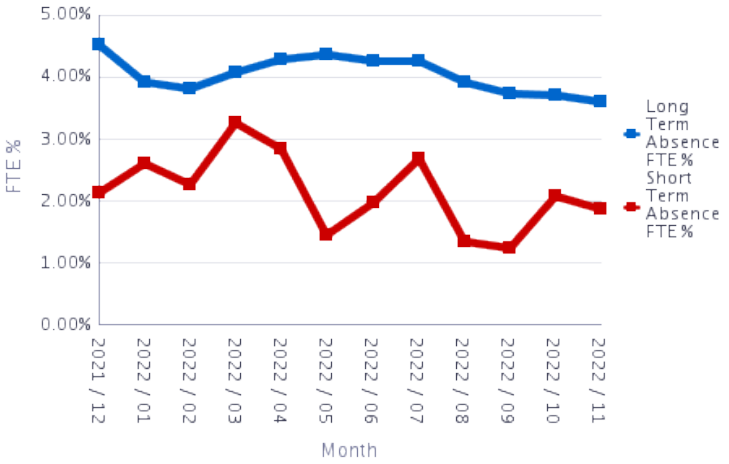
	Operational Services	9%	*Increase on previous month (8%)* New hotspot areas. Operational services were removed from the hotspot category after significant improvement in absence earlier in the year however they now have 3 consecutive months of absence growth which is a cause for concerns to be further analysed by Senior BP and service leads.
	Corporate Areas (4%)		
	Clinical Corporate Governance	12%	*Same as previous month (12%)* Highly complex long-term sickness cases remain the primary concern for the department and these cases are being managed in line with the MAWW policy.
	RD&I	7%	*Same as previous month (7%)* Long-term absence cases remains to be the primary concern in RD&I and cases are being managed in line with the MAWW policy.
	TCS	0%	The spike in short-term absence in the month of October has ended and TCS absence has returned to its normal position. This will be removed as a hotspot.

Velindre University NHS Trust

Long Term Sickness (in month) **1.87%**
Short Term Sickness (in month) **3.59%**

The graph opposite shows the changing position of long and short term sickens (rolling 12 months) absence. There is an overall decline in long-term and short-term sickness as the People and Relationship Team continue to support managers in the application of the MAWW policy.

Anxiety/stress/depression/other psychiatric illnesses remains the highest reason for absence across the Trust at 31% and wellbeing drop in



session have been scheduled to support staff and glean useful qualitative data for improving this figure.

WBS

Long Term Sickness (in month) **2.18%**
Short Term Sickness (in month) **4.72%**

Stress/Anxiety related absence continues to be the highest reason of all absences over the last 12 months, at a slightly increased rate this month, of 36.8% coupled with a turnover rate (12 month) is reported at 17.26% there has been a need for targeted intervention within WBS to understand any correlation and provide analysis to this quantitative day.

Ongoing interventions and collation of qualitative data from within hotspot areas and this information is being prepared for SMT in January 2022 which will also become part of ongoing OD interventions regarding culture and values within the organisation.

VCC

Long Term Sickness (in month) **3.14%**
Short Term Sickness (in month) **2.04%**

In month sickness has increased slightly once more in November 5.18% and managers continue to manage cases in line with the MAWW policy. Sickness Audits undertaken in departments across VCC have shown no cause for concern in relation to the application of the MAWW policy.

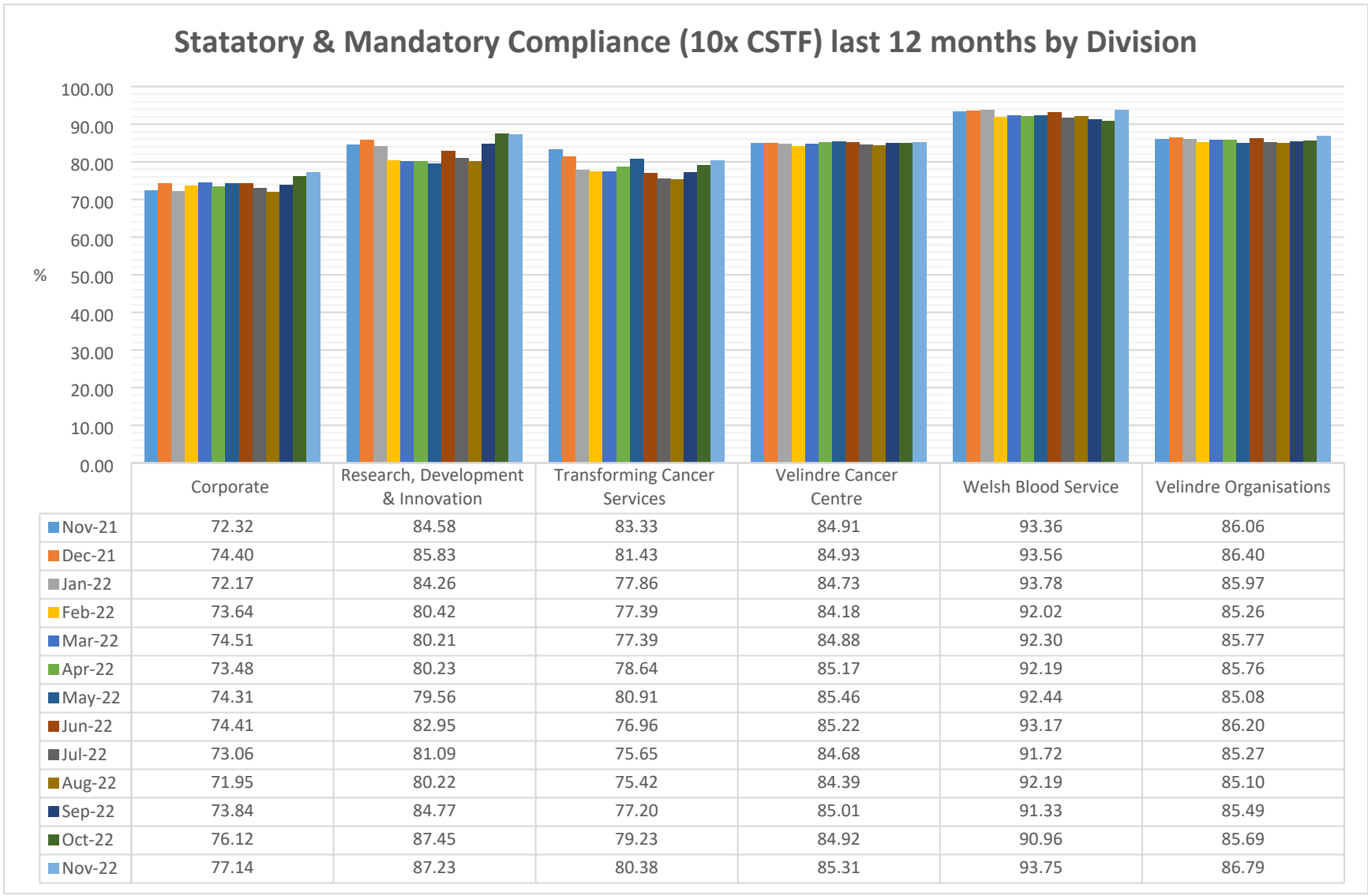
Corporate Areas (including RD&T, HTW & TCS)

Long Term Sickness (in month) **3.43%**
Short Term Sickness (in month) **0.71%**

The significant increase in short–term absence seen in October 2022 has returned to normal in the month of November.

There are several ongoing complex long-term absence cases in Corporate and RD&I that are being managed sensitively and in line with the MAWW policy.

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Nov-21	72.32	84.58	83.33	84.91	93.36	86.06
Dec-21	74.40	85.83	81.43	84.93	93.56	86.40
Jan-22	72.17	84.26	77.86	84.73	93.78	85.97
Feb-22	73.64	80.42	77.39	84.18	92.02	85.26
Mar-22	74.51	80.21	77.39	84.88	92.30	85.77
Apr-22	73.48	80.23	78.64	85.17	92.19	85.76
May-22	74.31	79.56	80.91	85.46	92.44	85.08
Jun-22	74.41	82.95	76.96	85.22	93.17	86.20
Jul-22	73.06	81.09	75.65	84.68	91.72	85.27
Aug-22	71.95	80.22	75.42	84.39	92.19	85.10
Sep-22	73.84	84.77	77.20	85.01	91.33	85.49
Oct-22	76.12	87.45	79.23	84.92	90.96	85.69
Nov-22	77.14	87.23	80.38	85.31	93.75	86.79

Statutory and Mandatory Figures – The Narrative

<table>
<tr><th>Performance Indicator</th><th>RAG/ Change from previous month</th><th>Oct Figure</th><th>Hotspot</th><th>%</th><th>Comment to include reasons for change / rates high or low</th></tr>
<tr><td rowspan="6">Stat & Mand Training (85%)</td><td rowspan="6">87%
↑</td><td rowspan="6">85%</td><td colspan="3">Welsh Blood Service (94%)</td></tr>
<tr><td colspan="3">Continuously above target for over 12 months</td></tr>
<tr><td colspan="3">Velindre Cancer Centre (85%)</td></tr>
<tr><td colspan="3">Continuously at or above target for 8 months</td></tr>
<tr><td colspan="3">Corporate Areas (81%)</td></tr>
<tr><td>Corporate Management Section</td><td>64%</td><td>Same as previous month 64%</td></tr>
<tr><td></td><td></td><td></td><td>Fundraising</td><td>57%</td><td>Same as previous month 57%</td></tr>
<tr><td colspan="6">Action/ initiatives:

<u>Velindre University NHS Trust</u>

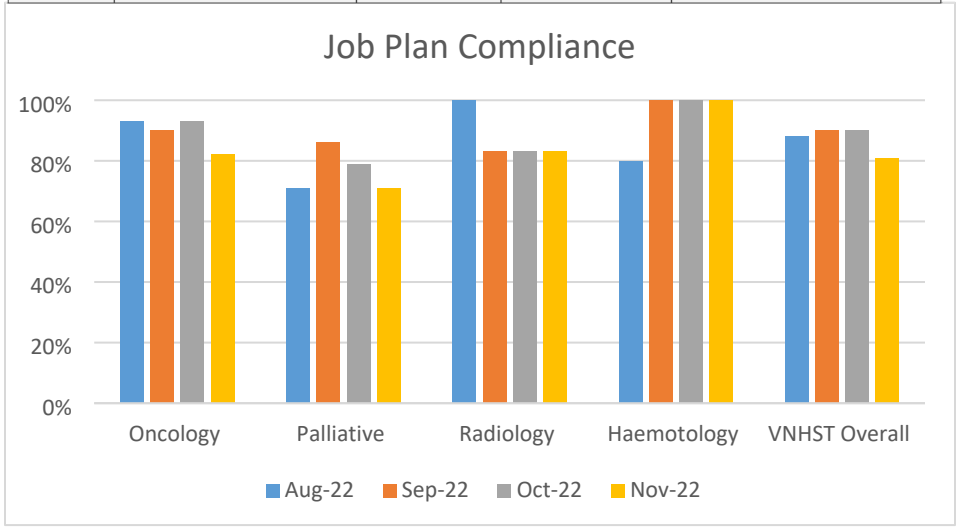
Statutory and Mandatory compliance remains within target across the Trust for the year (December 21 – November 22) and in comparison to this time last year (Nov 21) compliance is up by 1% overall.

The Education and Development team are currently working on developing a new virtual reality training programme for fire safety that will immerse the learner into an exact replica of their work environment providing different fire scenarios they may face and allowing them to virtually decide on the appropriate action to be taken.</td></tr>
</table>

Job Planning

Job planning data as of 24th November 2022, not including new starters, maternity leave or long-term sickness

Directorate	Role	Assignment Count	Job Plans Completed	Percentage of Job Plans completed
Oncology	Overall	45	37	82.22%
	Clinical Oncologists Consultan	36	28	77.78%
	Medical Oncologist Consultant	8	8	100.00%
	Specialty Doctors	1	1	100.00%
Palliative	Overall	14	10	71.43%
	Palliative Care Consultants	13	9	69.23%
	Specialty Doctors	1	1	100.00%
Radiology	Overall	6	5	83.33%
	Radiology Consultants	6	5	83.33%
	Specialty Doctors	1	1	100.00%
Haemotology	Overall	5	5	100.00%
	WBS Consultants	4	4	100.00%
	Specialty Doctors	1	1	100.00%
NWSSP	Overall	0	0	#DIV/0!
	Medical Examiners	0	0	#DIV/0!
VNHST	Overall	70	57	81.43%



Work In Confidence (WIC)

No new concerns have been raised via the Work in Confidence platform in relation to behaviour of colleagues.

In all contacts with staff, staff are encouraged, where appropriate, to share their concerns with their Line Manager (or next appropriate Manager), in order to achieve an early, informal resolution.

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 30 NOVEMBER 2022 (M8)

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB QSP	03/01/2023 17/01/2023	NOTED

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

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of November 2022.

1.2 This financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as they are directly accountable to WG for their financial performance. Only the balance sheet (SoFP) and cash flow provides the full Trust position as this is reported in line with the WG monthly monitoring returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.002)	0.003	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.149	10.010	28.312
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.0%	95.7%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget (excl. Covid and the exceptional cost pressures) remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of November 22 is an underspend of **£0.003m**, with an outturn forecast position of **Breakeven**.

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

The pay award funding received for 2022-23 was £3.065 leaving a funding risk of circa £0.450m. This year the gap will be mitigated through non recurrent measures with divisions calculating the recurrent impact into future years as part of the IMTP budget setting process.

The Trust is yet to receive full funding from WG for both Covid response and the incremental increase in Energy costs, however confirmation has been received that funding will be provided based on a maximum of the outturn forecast as at September leaving minimal risk to the Trust.

It is expected that any potential cost pressures are managed by budget holders to ensure the delegated expenditure control limits are not exceeded in line with budgetary control procedures.

Two saving schemes relating to service redesign and supportive structures have turned red with contingency plans have been put in place to ensure that the saving target is met for this financial year.

The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be funded based on the month 6 forecast position. Covid funding towards recovery from commissioners remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

2.3 PSPP Performance

During November ’22 the Trust (core) achieved a compliance level of **96%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.72%** as at the end of month 8.

2.4 Covid Expenditure

Covid-19 Revenue Spend / Funding 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.225		0.225	0.375	0.150
PPE	0.070		0.070	0.335	0.265
Cleaning	0.293		0.293	0.427	0.134
Other Covid Response	0.304		0.304	0.967	0.663
Covid Recovery - Internal Capacity		3.645	3.645	6.056	2.411
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.893	**3.906**	**4.799**	**12.310**	**7.511**

The overall gross funding requirement related to Covid has reduced further and currently stands at £4.799m, with £0.893m being recognised for funding from WG, and the balance of £3.906m being sought from our Commissioners.

The £4.799m represents a significant reduction in outsourcing costs from the Trust IMTP plan as of 31st March, largely due to the liquidation of the Rutherford Cancer Centre (RCC).

Other funding / cost reduction reflects control measures and review of service delivery models to reflect latest WG Covid de-escalation guidance.

2.5 Reserves

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

A review of the reserves position is currently underway which is following confirmation from WG that both Covid and the Exceptional National Costs will be funded.

2.6 Financial Risks

Covid

The Trust continues to be in dialogue with Commissioners with regards to the costs of additional capacity required to meet the demands placed on our Planned Care services. To date, the full requirement of £3.906m, which has been invested in securing additional capacity, has not been agreed by Commissioners.

The Trust has received signed Long Term Agreements (LTA's) from our Commissioners. However, the funding for Planned care & Covid backlog capacity remains a risk as the marginal income that the Trust is forecast to receive will not cover the additional costs being incurred.

2.7 Capital

a) All Wales Programme

Performance against the current agreed All Wales Programme budget allocations are at this stage expected to deliver to budget. Slippage on the nVCC Enabling works has resulted in the Trust returning £6.393m of funding to WG during 2022/23 which will be re-provided next financial year.

The Trust (during November) received the funding award letter from WG in relation to IRS. The total funding allocated is £41.602m for the period April 22 to March 2026 with £7.9m of the total to be provided during 2022/23.

Also, in November the Trust received an additional £0.370m of funding from WG yearend slippage money which will go towards priority schemes approved by EMB on the 26th October.

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

Due to the timing of meetings the CEL reported in the TCS finance report does not include the requested changes to the nVCC enabling and project costs. This will be updated to align with the main finance report from next month.

b) Discretionary Programme

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

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

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of November 2022 is an underspend of £0.003m with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

Trust Board is asked to **NOTE**

4.1 the contents of the November 2022 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even and key risk in relation to income to cover Covid backlog additional capacity costs.

4.2 the TCS Programme financial report for November 2022 attached as **Appendix 1**.

Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED NOVEMBER 2022/23

TRUST BOARD
31/01/2023

1. Introduction

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

2. Background / Context

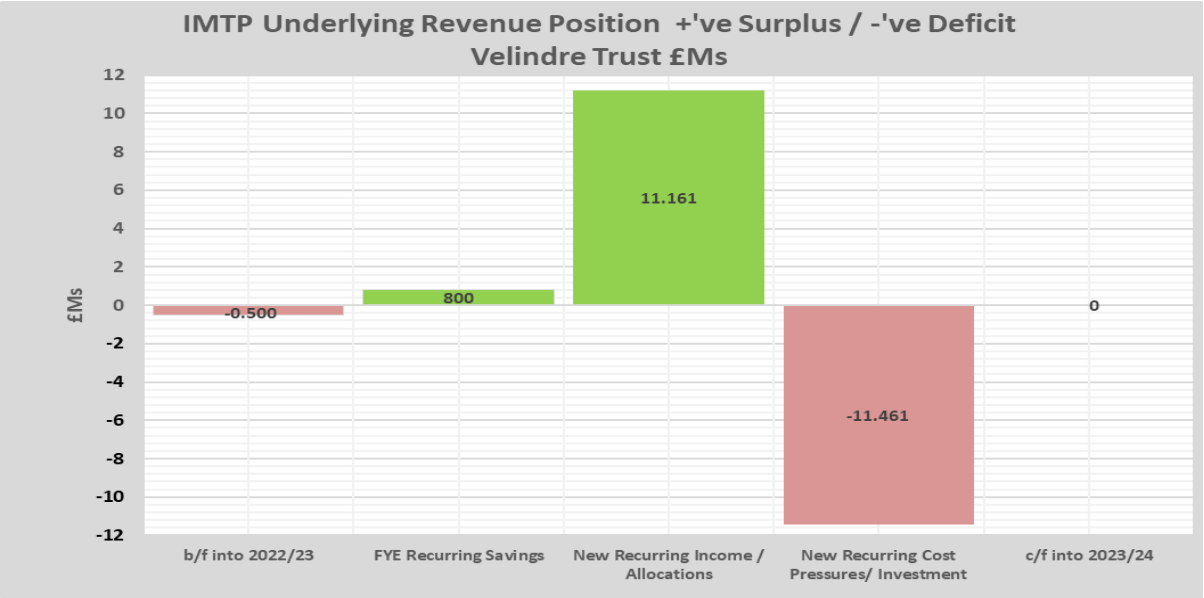
The Trust IMTP Financial Plan for the period 2022-2025 was set within the following context.

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

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

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

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



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

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	(0.002)	0.003	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2.149	10.010	28.312
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	96.0%	95.7%	95.0%

Performance against Planned Savings Target

Efficiency / Savings	Variance	0	0	0

Revenue

The Trust has reported a £(0.002)m overspend for November '22, with a cumulative position of £0.003m underspent, and an outturn forecast position of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at November '22 is **£28.312m**. This represents all Wales Capital funding of **£26.858m**, and Discretionary funding of **£1.454m.** The Trust reported Capital spend to November'22 of £10.010m and is forecasting to remain within its CEL of £28.312m for 2022-23.

The Trust's CEL is broken down as follows:

	£m Opening	£m Movement	£m November 2022
Discretionary Capital	**1.454**	**0.000**	**1.454**
All Wales Capital:			
Fire Safety	0.500	0.000	0.500
CANISC Cancer Project	0.000	0.579	0.579
TCS Programme	23.902	-6.393	17.509
IRS		7.900	7.900
Priority Year end Spend		0.370	0.370
Total CEL	**25.856**	**2.456**	**28.312**

With WG agreement, slippage on the TCS Programme has led to £6.393m Capital funding being pushed back into 2023/24.

The Trust has now received approval from WG for the Integrated Radiotherapy Solution (IRS) capital expenditure with £7.900m being provided during 2022-23 and has also been awarded £0.370m as part of the request for year-end priority schemes which gives a revised Trust CEL of £28.312m for 2022-23.

PSPP

During November '22 the Trust (core) achieved a compliance level of **96%** (October 22: 97.29%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **95.72%** as at the end of month 8, and a Trust position (including hosted) of **95.73%** compared to the target of 95%.

Efficiency / Savings

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

Revenue Position

Cumulative				Forecast		
£0.003m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(118.305)	(118.110)	(0.196)	(182.187)	(182.023)	(0.165)
Pay	51.012	50.652	0.359	76.493	76.365	0.128
Non Pay	67.294	67.454	(0.160)	105.694	105.658	0.036
Total	**(0.000)**	**(0.003)**	**0.003**	**(0.000)**	**(0.000)**	**0.000**

The overall position against the profiled revenue budget to the end of November 2022 is an underspend of **£0.003m**, along with an overall outturn forecast position of **Breakeven**.

The Trust continues to report a year end forecast breakeven position which is following confirmation from WG that the Exceptional National cost pressures and Covid response costs will be funded based on the month 6 forecast position. Covid funding towards recovery from commissioners remains a risk, however, will be mitigated on a non-recurrent basis during 2022-23.

4.1 Revenue Position Key Issues

Income Key Issues

Income underachievement to November is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS, with plans having already been put in place to support recovery in the latter part of the year particularly around plasma sales which has seen a significant overachievement during November.

The WBS underachievement (£0.595k) to date is being partly offset by VCC income generated through increase in activity from providing SACT homecare and the additional VAT savings, along with the over achievement on private patient income due to drug performance.

Pay Key Issues

The total Trust vacancies as at November 2022 is 101wte, VCC (49wte), WBS (31wte), Corporate (5wte), R&D (9wte), TCS (0wte) and HTW (7wte).

The Trust has now received the pay award funding of £3.065m from WG relating to 2022/23. The funding provided leaves a funding risk of circa £0.450m, with £3.510m being the total funding required to cover the core Trust full establishment including vacancies and increments. The divisions are currently reviewing the impact on the position however any funding gap for this year will be met through the high level of vacancies that has been carried through the Trust across the period, along with the release of the additional annual leave provision carried forward from last year. The recurrent financial impact into future years will need to be considered as part of the IMTP process which is currently underway.

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

Vacancies throughout the Trust although reducing remain high, however several posts in both VCC and WBS have been appointed at risk in response to Covid activity backlog and additional capacity required for forward recruitment on service developments without agreed funding pending activity undertaken or FBC approval by WG and Commissioners. In addition, work continues to be underway in both divisions to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

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

Non Pay Key Issues

The expected increase in energy prices has reduced further during November to £0.671m (October £0.845m) following the introduction of the price cap and review of volume consumption. The stepped increase of £0.671m has been recognised as an Exceptional National cost pressures by WG with confirmation that funding will be provided based on the month 6 forecast (£0.898m) as a maximum.

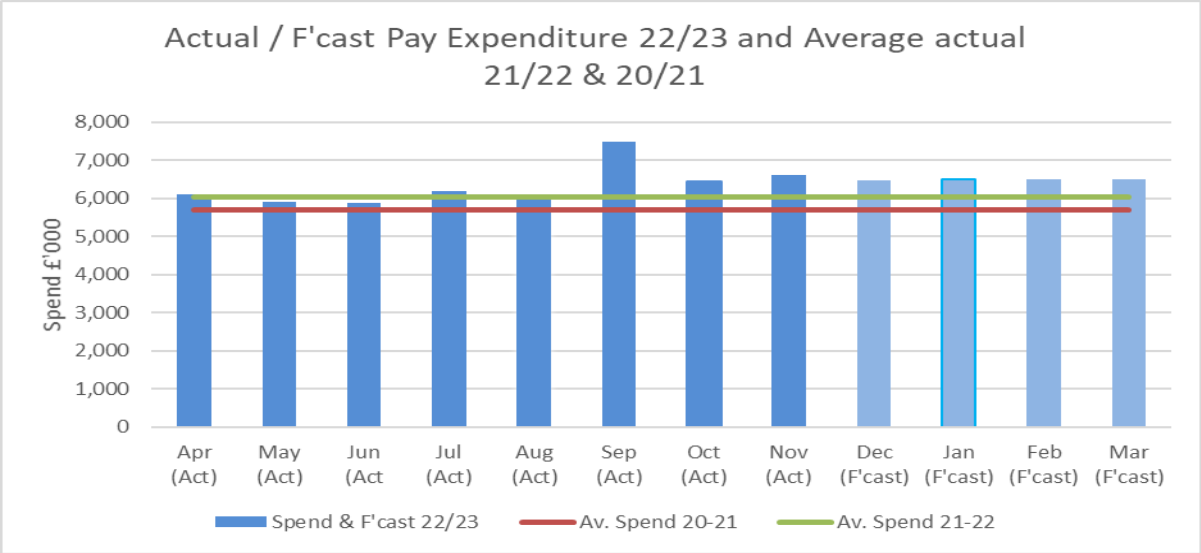
Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The savings target for each division was set as VCC £0.700m, WBS £0.500m and Corporate £0.100m as part of the IMTP for 2022/23.

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

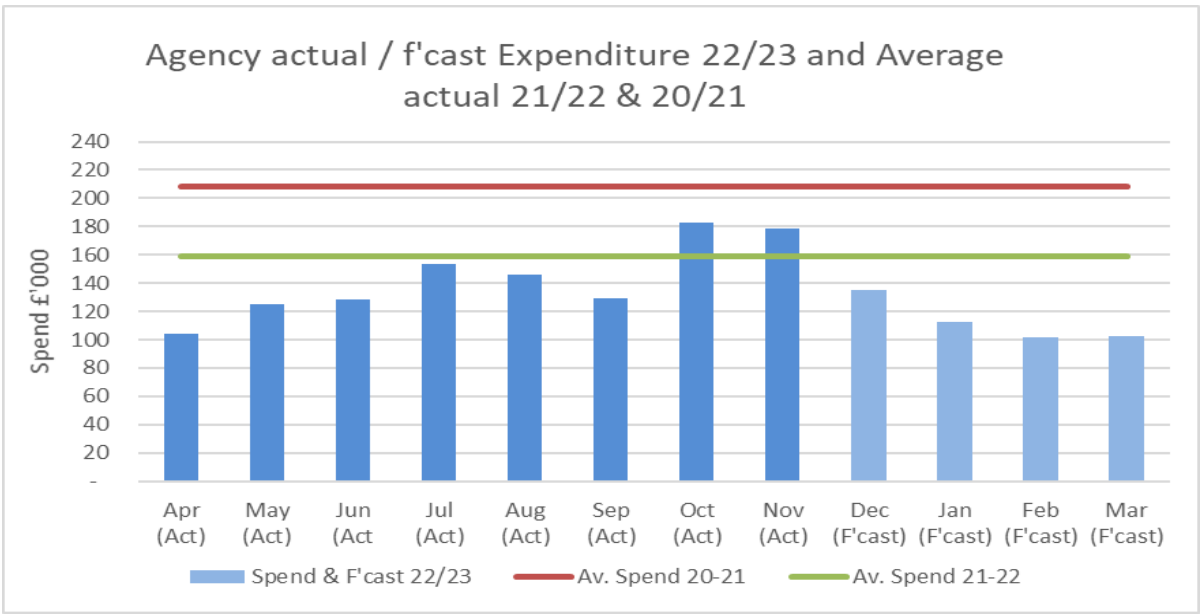
4.2 Pay Spend Trends (Run Rate)

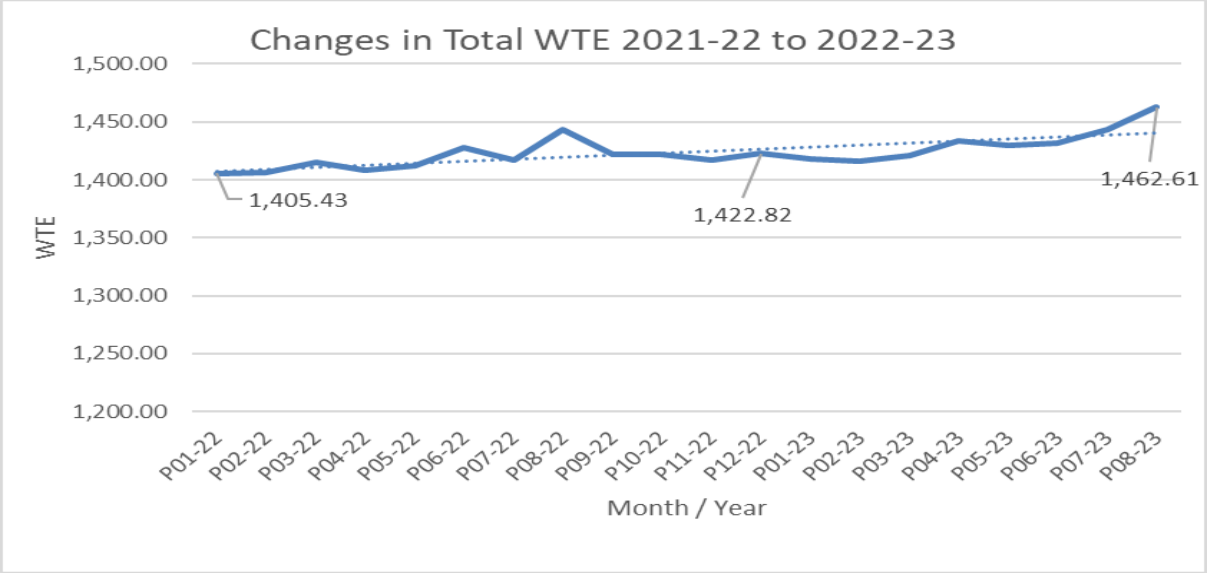
The pay award for 2022/23 was paid in September (back dated to April) as demonstrated in the spike in pay spend shown in the graph below. Agency costs have decreased this year from the 2021/22 levels largely due to the reduction of agency staff previously recruited to support Covid response. Further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

particular to support the running of estates in VCC in order to deliver ongoing maintenance and statutory compliance duties. The service are actively trying to recruit into current vacancies in order to reduce the need of agency support.

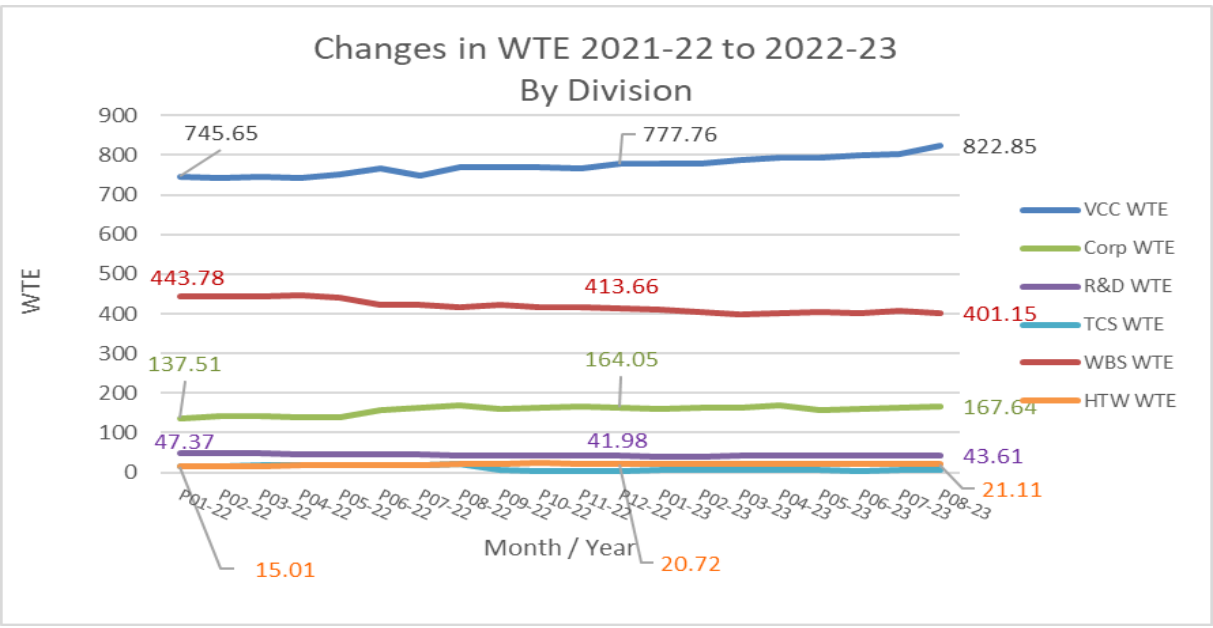


The spend on agency for November 22 was £0.179m (October £0.183m), which gives a cumulative year to date spend of **£1.149m** and a current forecast outturn spend of circa **£1.600m** (£1.906m 2021/22). Of these totals the year to date spend on agency directly relating to Covid as at the end of November is £0.221m and forecast spend is circa £0.315m (£0.826m 2021/22).



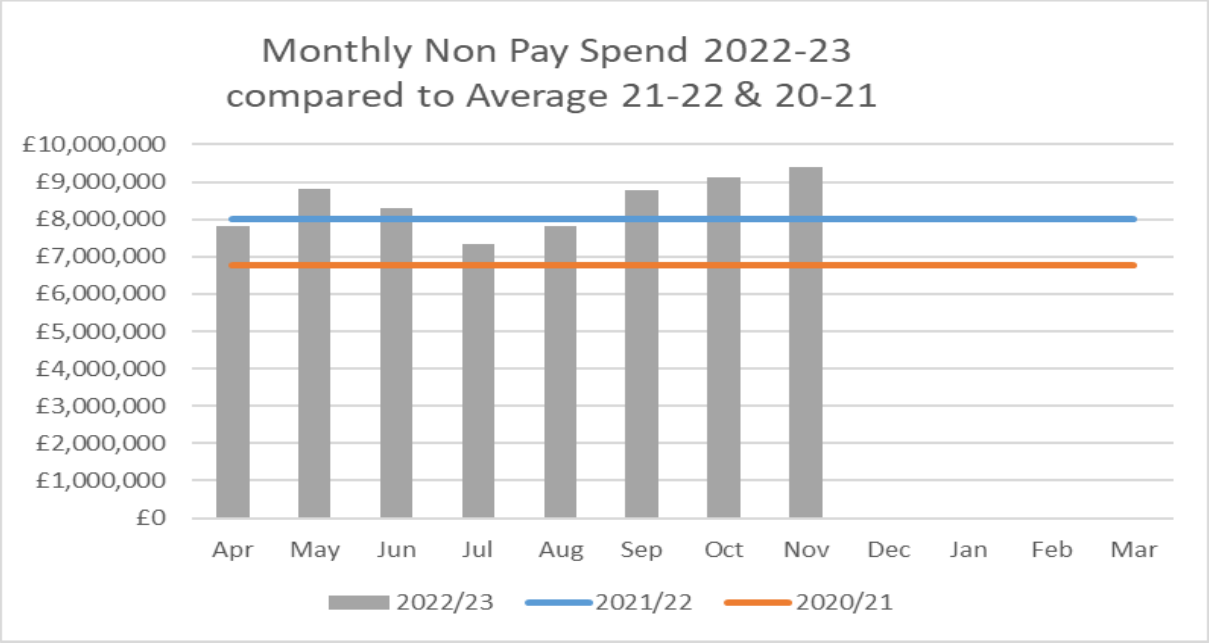


The increase in WTE (20) during November is largelywithin VCC and relates to the recruitment of Nurses and HCSW into service area's such as inpatients, Chemotherapy and Prince Charles.



4.3 Non Pay

Non-pay 21/22 (c£96m) average monthly spend of £8m was £1.2m higher than the reported monthly average spend for 20/21 (£6.8m). Most of the monthly average increase (circa £0.9m) related to the growth in NICE / High Cost drug usage following the recovery and associated surge related to Covid and an increase in WBS wholesaling (circa £0.3m). The average monthly spend for 22-23 is currently £8.4m which is an average increase of circa £0.4m against 21/22 expenditure and is mainly due to the increase in NICE / High Cost drugs.



4.4 Covid-19

The latest forecast funding requirement as at 30th November in relation to Covid for 2022-23 has been further revised down to £4.799m (October £4.856m) which is a significant reduction from the £12.310m that was submitted as part of the Trust IMTP. Of the £4.799m total Covid requirement £0.893m (IMTP plans £2.104m) is being requested directly from WG, and the balance of £3.906m (IMTP plans £10.206m) being sought from our commissioners.

Covid-19 Revenue Spend / Funding 2022/23					
	WG £m	Commissioners £m	Total £m	IMTP Plans £m	Cost Reduction £m
Mass Vaccination	0.225		0.225	0.375	0.150
PPE	0.070		0.070	0.335	0.265
Cleaning	0.293		0.293	0.427	0.134
Other Covid Response	0.304		0.304	0.967	0.663
Covid Recovery - Internal Capacity		3.645	3.645	6.056	2.411
Covid Recovery - Outreach		0.261	0.261	4.150	3.889
	0.893	**3.906**	**4.799**	**12.310**	**7.511**

The latest forecast spend and funding requirement from WG has decreased by a further £0.057m from £0.950m reported in October to £0.893m. A further de-escalation of required cleaning is reducing both cost and funding requirements.

Following DoF's meeting on the 2nd November the Trust is now assuming that full funding for Covid response costs will be provided by WG. The Trust has already invoiced and received funding for costs in relation to Mass Vaccination and PPE, for the first quarter of the year from April to June 2022.

The Trust Covid expenditure is based on activity demand forecast modelling which commenced in 2021/22 and has been updated regularly working with Health Board operational teams. The Trust

has already invested £2.943m in additional capacity. The anticipated funding requirement of £4.150m for outsourcing has been removed as the Rutherford went into liquidation earlier this year. The Trust had also been working up plans to expand internal capacity which it has now established in its outreach Centre at Prince Charles Hospital (from October) for SACT, with forecast additional cost above that already invested in Covid capacity of circa £0.261m. In addition, the Trust has developed plans for expanding Radiotherapy capacity internally through use of weekend working which will require existing staff to work additional hours as WLIs with enhanced pay rates. The full cost and operational deliverability of this additional capacity is still being worked up. These additional investments in capacity to meet the activity demand from Health Boards will not be fully covered through LTA marginal income leading to an additional financial pressure to the Trust which it is managing through use of non-recurrent measures in 2022-23. However, with the anticipated removal of the LTA income protection in 2023-24 there will be a significant financial risk of £1.5m – £2m which the Trust may not be able to cover depending on demand and its ability to deliver activity within the current capacity.

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

4. Savings

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

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

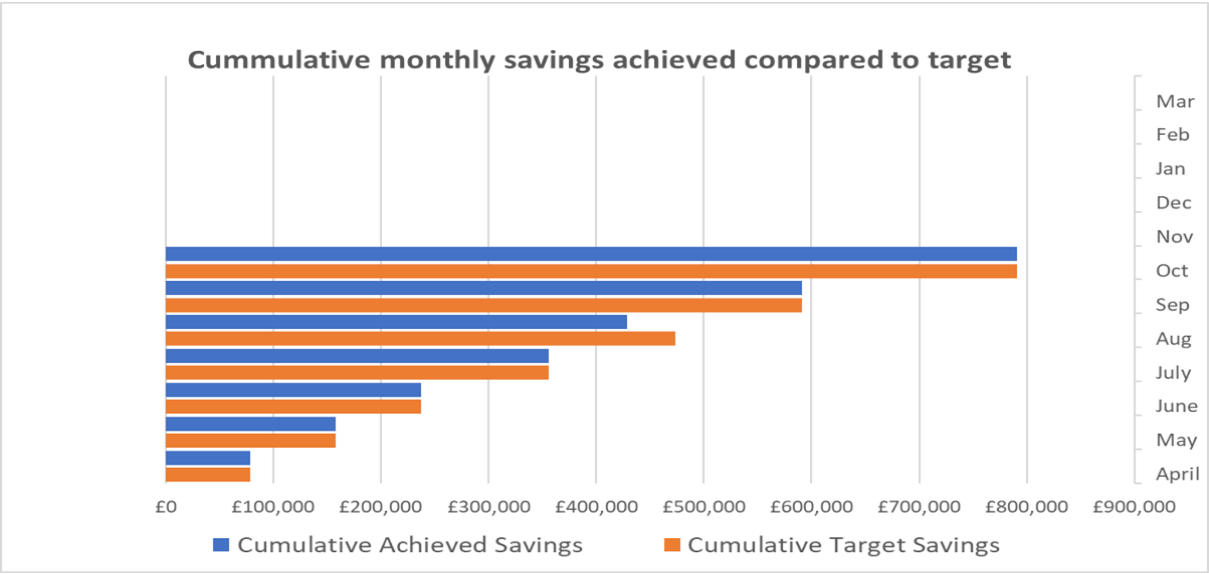
Two schemes continue to be impacted by Covid during 2022-23 have now turned red which relate to service redesign and supportive structures.

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

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

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	**700**	**360**	**272**	**(88)**	**500**	**(200)**
			76%		**71%**	
WBS TOTAL SAVINGS	**500**	**292**	**292**	**0**	**500**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**100**	**58**	**58**	**0**	**100**	**0**
			100%		**100%**	
TRUST LEVEL TOTAL SAVINGS			**88**	**88**	**200**	**200**
TRUST TOTAL SAVINGS IDENTIFIED	**1,300**	**710**	**710**	**0**	**1,300**	**0**
			100%		**100%**	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Establishment Control (Corporate)	Green	100	58	58	0	100	0
Laboratory & Collection Model (WBS)	Green	50	29	29	0	50	0
Laboratory & Collection Model (WBS)	Green	50	29	29	0	50	0
Stock Management (WBS)	Green	100	58	58	0	100	0
Stock Management (WBS)	Green	150	88	88	0	150	0
Procurement - Supply Chain (WBS)	Green	50	29	29	0	50	0
Service Redesign (VCC)	Red	100	44	0	(44)	0	(100)
Supportive Stuctures (VCC)	Red	100	44	0	(44)	0	(100)
Procurement - Supply Chain (VCC)	Green	50	29	29	0	50	0
Bank Interest (Trust - In Year)	Green		0	55	55	167	167
Vacancy Factor (Trust - In Year)	Green		0	33	33	33	33
Total Saving Schemes		**750**	409	409	0	750	0
Income Generation							
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	29	29	0	50	0
Maximinsing Income Opportunities - Income Attraction (WBS)	Green	50	29	29	0	50	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	150	67	67	0	150	0
Maximinsing Income Opportunities - Private Patients (VCC)	Green	100	58	58	0	100	0
Maximinsing Income Opportunities - Income Attraction (VCC)	Green	200	117	117	0	200	0
Total Income Generation		**550**	300	300	0	550	0
TRUST TOTAL SAVINGS		**1,300**	**709**	**709**	**0**	**1,300**	**0**
				100%		**100%**	



5. Reserves

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

Summary of Total Recurrent Reserves Remaining Available in 2022/23	£m
Recurrent Reserves Available for investment	1.241
Previously Committed Reserves Bfwd 2021-22	(0.137)
Previously agreed Exec Investment	(0.973)
New Commitments	(0.131)
Emergence of Slippage against Recurrent Reserves Commitments	
Remaining Balance	**0**

Summary of Total Non-Recurrent Reserves Remaining Available in 2022/23	£m
Non-Recurrent Reserves Available for investment	1.471
Previously Committed Reserves Bfwd 2021-22	(0.102)
Previously Agreed Exec Investment	(1.302)
New Commitments	(0.067)
Emergence of Slippage against Non-Recurrent Commitments	
Remaining Balance	**0**

A review of the reserves position is currently being undertaken which is following confirmation from WG that both Covid and the Exceptional National Costs will be funded.

6. End of Year Forecast / Risk Assessment

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

Covid Funding via Commissioners – *Risk £500k, Likelihood - Medium*

Commissioners have not committed to providing the full funding ask of £3.906m as a block funding arrangement but have all stated that any funding required to cover additional Covid recovery costs will flow through the LTA under the national funds flow mechanism. This mechanism, whilst providing enhanced income protection over the normal LTA arrangements, does not cover the additional costs of enhanced pay rates for WLI's or additional costs above marginal when establishing new capacity. The Trust has received signed LTA's back from our commissioners, however the funding for planned care & Covid backlog capacity remains a risk for the Trust.

Other C-19 Response Costs – *Risk £0.755m (total £0.893m less income received £0.138m), Likelihood - Low*

Following further Covid de-escalation related activity and a review of operational costs in line with the updated WG guidance, the latest forecast spend and funding requirement from WG has reduced further by £0.057m from £0.950m reported in October to £0.893m. The risk level has been reduced to low given the message delivered by Steve Elliot Interim Director of Finance for Health and Social Care, Welsh Government at DoFs on the 2nd November that Covid response funding will be provided based on the year-end forecast provided in month 6.

Exceptional National Cost Pressures – *Risk £0.671m - Low*

Following DoF's meeting on the 2nd November the Trust is now assuming to receive full funding for Energy prices based on the month 6 year end forecast and so this risk has been reduced to low but will remain flagged as a risk until the funding flows through to the Trust. The incremental increase in Energy prices has reduced slightly from £0.845m in October to £0.671m which reflects the latest forecast provided by NWSSP Colleagues during November.

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 @ M8 £m	Full Year Actual Spend £m	Year End Variance £m
All Wales Capital Programme						
nVCC - project costs	2.394	2.073	0.000	0.321	2.894	-0.500
nVCC - Enabling Works	15.115	6.048	0.000	9.067	14.615	0.500
Canisc Cancer Project	0.579	0.579	0.000	0.000	0.579	0.000
Fire Safety	0.500	0.172	0.000	0.328	0.500	0.000
Integrated Radiotherapy Solutions (IRS)	7.900	0.809	0.000	6.831	7.640	0.260
WG Priority Year end Spend	0.370	0.000	0.000	0.370	0.370	0.000
Total All Wales Capital Programme	26.858	9.681	0.000	16.917	26.598	0.260
Discretionary Capital	1.454	0.329	0.000	1.125	1.714	-0.260
Total	28.312	10.010	0.000	18.042	27.942	0.000

The approved 2022/23 Capital Expenditure Limit (CEL) as at November 2022 was £28.312m. This includes All Wales Capital funding of £26.858m, and discretionary funding of £1.454m. The approved CEL has increased in year by £2.456m which reflects approval of the Canisc Cancer Project (0.579m), IRS (7.900m), and Velindre's share of the WG yearend spend request (0.370m). This is offset by a reduction of 6.393m on the nVCC Enabling works project to reflect the latest forecast requirement for 2022/23. Following agreement with WG the £6.393m will be re-provided to the programme during 2023/24.

WG colleagues have agreed a further movement of £0.500m between the nVCC enabling and project costs which is reflected in the table above but represented as a variance rather than a CEL adjustment.

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

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

Following a request from WG a list of prioritised bids was approved by EMB on 26th October for submission to WG should any Capital funding become available. The Trust has received confirmation during November that £0.370m of additional funding will be provided to support delivery of the priority one schemes which includes replacement Hemoflows in WBS £0.238m, Patient Monitors in VCC £0.062m and £0.070m towards Digital priorities.

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

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

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

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

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

Performance to date

The actual cumulative expenditure to November 2022 on the All-Wales Capital Programme schemes was £9.681m, this is broken down between spend on the nVCC enabling works £6.048m, nVCC project costs of £2.073m, Canisc Cancer Project £0.579m, fire safety £0.172m, and IRS £7.900m.

Spend to date on Discretionary Capital is currently £0.329m leaving a remaining balance of £1.125m as at the 30th November.

Year-end Forecast Spend

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

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

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

	Scheme	Scheme Total	Stage (i.e. OBC development, FBC development, scoping etc.)	22/23 £m	23/24 £m	24/25 £m	25/26 £m	26/27 £m	27/28 £m	28/29 £M
1	WBS HQ	34.125*	FBC under development	0.150	13.674	9.996	4.434	5.215	0.608	0.048

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

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

8. BALANCE SHEET (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 22	Closing Balance End of Nov-22	Movement from 1st April Nov-22	Forecast Closing Balance End of Mar 23
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	143.136	155.186	12.050	149.550
Intangible assets	8.667	7.803	(0.864)	8.200
Trade and other receivables	1,092.008	1,403.114	311.106	1,403.114
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,243.811	1,566.103	322.292	1,560.864
Current Assets				
Inventories	65.207	50.298	(14.909)	50.298
Trade and other receivables	540.227	178.530	(361.697)	212.888
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	30.404	52.858	22.454	18.500
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	635.838	281.686	(354.152)	281.686
TOTAL ASSETS	1,879.649	1,847.789	(31.860)	1,842.550
Current Liabilities				
Trade and other payables	(277.601)	(240.708)	36.893	(235.469)
Borrowings	0.00	0.00	0.000	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(341.123)	(342.831)	(1.708)	(342.831)
Current Liabilities sub total	(618.724)	(583.539)	35.185	(578.300)
NET ASSETS LESS CURRENT LIABILITIES	1,260.925	1,264.250	3.325	1,264.250
Non-Current Liabilities				
Trade and other payables	(7.336)	(7.336)	0.000	(7.336)
Borrowings	0.00	0.00	0.000	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,094.206)	(1,091.599)	2.607	(1,091.599)
Non-Current Liabilities sub total	(1,101.542)	(1,098.935)	2.61	(1,098.935)
TOTAL ASSETS EMPLOYED	159.383	165.315	5.932	165.315
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	30.935	30.934	(0.001)	30.934
PDC	112.982	118.911	5.929	118.911
Retained earnings	15.466	15.470	0.004	15.470
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	159.383	165.315	5.932	165.315

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 £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

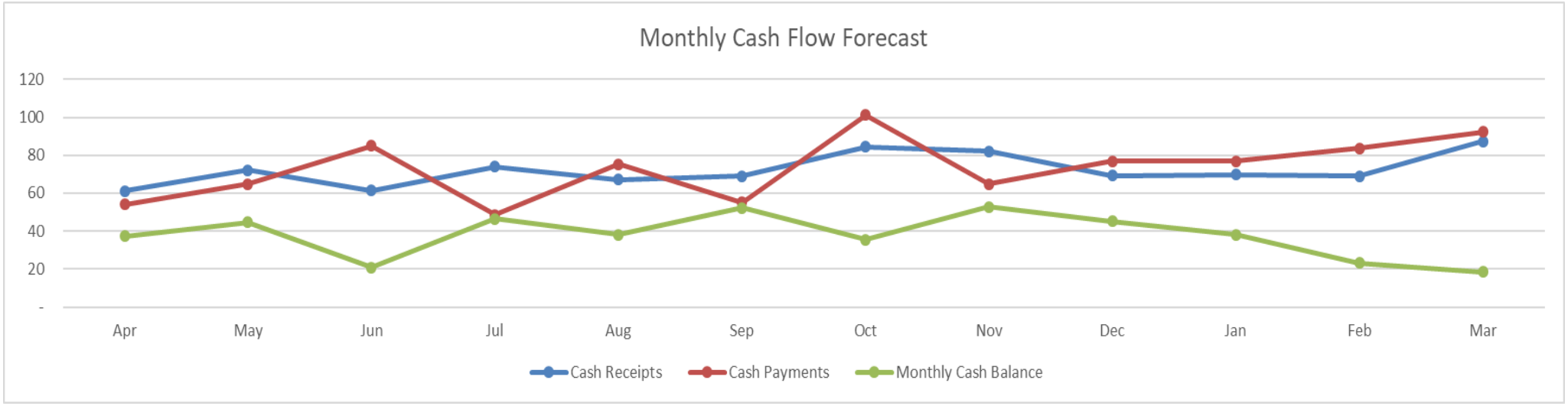
To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP are continuing to liaise with WG regarding the level of Brexit stock to maintain but it is anticipated that the repayment of the additional cash will take place later this year but will be dependent on the stock being released.

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

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

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	LHB / WHSSC income	33.135	40.208	40.042	37.491	47.836	36.522	43.649	41.695	40.900	41.380	41.870	40.718	485.446
2	WG Income	20.937	24.551	17.010	24.552	15.002	26.148	32.585	33.410	23.568	24.458	23.687	24.982	290.889
3	Short Term Loans													0.000
4	PDC				5.928								17.124	23.052
5	Interest Receivable	0.019	0.027	0.030	0.025	0.037	0.062	0.075	0.105	0.050	0.050	0.050	0.050	0.580
6	Sale of Assets													0.000
7	Other	7.106	7.289	4.321	6.094	4.246	6.395	8.220	6.982	4.771	3.820	3.283	4.547	67.075
8	TOTAL RECEIPTS	**61.197**	**72.074**	**61.403**	**74.090**	**67.121**	**69.127**	**84.529**	**82.192**	**69.289**	**69.708**	**68.890**	**87.421**	**867.042**
	PAYMENTS													
9	Salaries and Wages	21.735	29.243	29.483	29.705	29.549	34.417	36.535	33.118	33.026	33.014	33.056	33.531	376.412
10	Non pay items	30.543	33.079	54.139	17.703	44.384	20.200	63.158	29.085	40.438	38.260	44.654	44.006	459.649
11	Short Term Loan Repayment												7.000	7.000
12	PDC Repayment													0.000
14	Capital Payment	1.926	2.567	1.420	1.215	1.428	0.446	1.469	2.732	3.454	5.630	5.927	7.671	35.885
15	Other items													0.000
16	TOTAL PAYMENTS	**54.205**	**64.889**	**85.042**	**48.623**	**75.361**	**55.063**	**101.162**	**64.935**	**76.918**	**76.904**	**83.637**	**92.208**	**878.946**
		1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	
17	Net cash inflow/outflow	6.993	7.185	(23.639)	25.467	(8.240)	14.064	(16.633)	17.257	(7.629)	(7.196)	(14.747)	(4.786)	
18	Balance b/f	30.404	37.397	44.582	20.943	46.410	38.170	52.234	35.601	52.858	45.229	38.033	23.287	
19	Balance c/f	37.397	44.582	20.943	46.410	38.170	52.234	35.601	52.858	45.229	38.033	23.287	18.500	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	(24,706)	(24,706)	0	(38,364)	(38,364)	0
RD&I	(383)	(383)	(0)	240	240	0
WBS	(13,826)	(13,826)	(0)	(20,797)	(20,797)	0
Sub-Total Divisions	**(38,915)**	**(38,915)**	**(0)**	**(58,922)**	**(58,922)**	**0**
Corporate Services Directorates	(7,303)	(7,300)	(3)	(11,279)	(11,279)	0
Delegated Budget Position	**(46,218)**	**(46,215)**	**(3)**	**(70,201)**	**(70,201)**	**0**
TCS	(433)	(433)	0	(797)	(797)	0
Health Technology Wales	(39)	(38)	0	(48)	(48)	0
Trust Income / Reserves	46,689	46,689	0	71,046	71,046	0
Trust Position	**0**	**3**	(3)	**0**	**0**	**0**

VCC

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**46.178**	**46.589**	**0.410**	**71.698**	**72.139**	**0.441**
Expenditure						
Staff	**30.207**	**30.188**	**0.019**	**45.366**	**45.195**	**0.171**
Non Staff	**40.677**	**41.107**	**(0.430)**	**64.697**	**65.309**	**(0.612)**
Sub Total	**70.884**	**71.295**	**(0.410)**	**110.063**	**110.504**	**(0.441)**
Total	**(24.706)**	**(24.706)**	0.000	**(38.364)**	**(38.364)**	**0.000**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of November 2022 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 8 represents a surplus of **£0.410m** and a forecast outturn overachievement of **£0.441m**. This is largely from an increase in activity from providing SACT homecare and the additional VAT savings, and over achievement on private patient income due to drug performance, which is above general private patient performance, along with a one-off drug rebate. This is offsetting the divisional income savings target of £0.541m as at the end of November.

VCC have reported a year-to-date underspend of **£0.019m** against staff, and a forecast of **£0.171m** underspent. The level of vacancies within VCC reduced by circa 20wte during November following recruitment of Nurses and HCSW into service areas such as inpatients, Chemotherapy and Prince Charles. As at month 8 the Division is still carrying 49wte vacancies with the savings being above the divisional vacancy factor target and offsetting the cost of agency (£0.807)m to end of November, £0.193m being directly related to Covid). In additions the savings from vacancies are also supporting the costs of advanced recruitment into IRS.

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

Early recruitment to the delayed Integrated Radiotherapy Solution (IRS) has led to year to date committed cost of £0.353m.

Non-Staff Expenditure at Month 8 was **£(0.430)m** overspent, forecast **£(0.612)m** overspend. The overspend largely relates to the facilities management office pressures which were previously supported by Covid, maintenance and repair of the Linacs, transport SLA overspend, consumable spend from increased activity, and unexpected prior year invoices being received from Virgin Media, which are being partly offset by an underspend on general drugs.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**17,519**	**16,924**	**(595)**	**24,718**	**23,930**	**(788)**
Expenditure						
Staff	11,438	11,443	(4)	16,878	17,302	**(424)**
Non Staff	19,906	19,308	599	28,637	27,425	**1,212**
Sub Total	**31,345**	**30,750**	**595**	**45,515**	**44,727**	**788**
Total	**(13,826)**	**(13,826)**	**0**	**(20,797)**	**(20,797)**	**0**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of November 2022 was **breakeven** with an outturn forecast position of **breakeven** currently expected.

Income underachievement to date is **£(0.595)m** forecast **£(0.788)m**, where activity is lower than planned on Bone Marrow and Plasma Sales. Targeted income generation YTD from plasma sales to research is not achieving desired levels, however contract one of two awarded for new supplier in October which includes increased selling price. Benefits of new contract reflected with significant overachievement during November and expectation that the underachievement will be recovered by the year end for plasma sales to breakeven. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in activity being considerably lower than target.

Assumed WHSSC income for supressed income is reflected as an underspend within the non-pay position, however WHSSC income support for the underachievement has now been fully utilised.

Staff reported a small year-to-date overspend of **£(0.004)m** to November, forecast **£(0.434)m**. Outturn overspend expected from posts supported without identified funding source which includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured. WG bid has been submitted to support Plasma Fractionation staffing costs.

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

Non-Staff underspend of **£0.599m,** forecast **£1.212m** is largely due to reduced costs from suppressed activity underspends within Laboratory Services and WTAIL. WTAIL underspend is inclusive of £0.217m relating to Bone Marrow reflected to contra income underachievement as described above.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**697**	**969**	**272**	**1,226**	**1,619**	**393**
Expenditure						
Staff	6,219	6,106	112	9,659	9,546	**113**
Non Staff	1,782	2,163	(381)	2,845	3,352	**(507)**
Sub Total	**8,000**	**8,269**	**(268)**	**12,505**	**12,898**	**(393)**
Total	**(7,303)**	**(7,300)**	**3**	**(11,279)**	**(11,279)**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of November 2022 was an underspend of **£0.003m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust is currently benefiting from receiving greater returns on cash being held in the bank due to the rise in interest rates which will be partly utilised to support the WRP contribution on the expectation this cost will become recurrent in nature.

Staff expectation is that vacancies within the division, will help offset use of agency and achieve the £0.100m divisional savings target.

Non pay overspend is **£(0.381)m,** forecast **£(0.507m)** as at month 8 largely relates to the divisional savings target £(0.0104)m as at end of November which is expected to be met in year via staff vacancies and the additional income being received in response to the increase in interest rates. Other large pressures include the increased running costs for the hospital Estate.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,542**	**1,420**	**(123)**	**3,238**	**3,027**	**(211)**
Expenditure						
Staff	1,785	1,656	129	2,766	2,498	**268**
Non Staff	140	146	(6)	232	289	**(57)**
Sub Total	**1,925**	**1,803**	**123**	**2,998**	**2,787**	**211**
Total	**(383)**	**(383)**	**0**	**240**	**240**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of November 2022 was **breakeven** with a current forecast outturn position of **breakeven**.

Staff vacancies which are relatively high at the moment within R&D are offsetting the innovation income target with the stretched target for this year and not expected to be met.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**0**	**0**	**0**	**0**	**0**	**0**
Expenditure						
Staff	372	372	0	598	598	**0**
Non Staff	61	61	0	76	76	**0**
Sub Total	**433**	**433**	**0**	**674**	**674**	**0**
Total	**(433)**	**(433)**	**0**	**(674)**	**(674)**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of November 2022 is **Breakeven** with a forecasted outturn position of **Breakeven.**

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

HTW (Hosted Other)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,109**	**949**	**(161)**	**1,664**	**1,664**	**0**
Expenditure						
Staff	991	887	104	1,476	1,476	**0**
Non Staff	157	99	57	235	235	**0**
Sub Total	**1,148**	**987**	**161**	**1,712**	**1,712**	**0**
Total	**(39)**	**(38)**	**0**	**(48)**	**(48)**	**0**

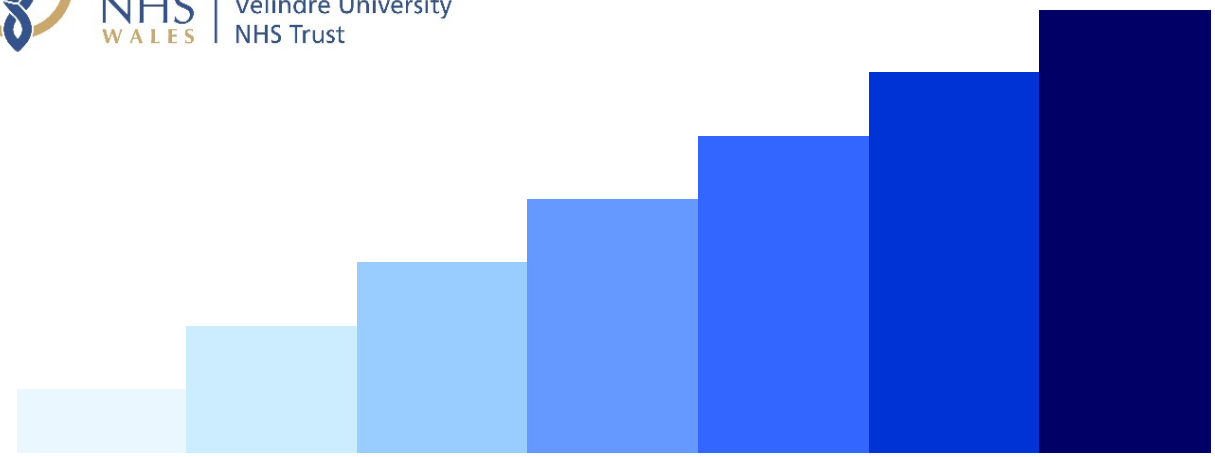
HTW Key Issues

The reported financial position for Health Technology Wales at the end of November 2022 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage will be handed back to WG**.**

Appendix 1 – TCS Programme Board Finance Report

TCS Programme Board Finance Repo

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



TCS PROGRAMME FINANCE REPORT 2022/23

Period Ending November 2022

Presented to the
TCS Programme Delivery Board on
14th December 2022

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 2022/23, outlining spend to date against budget as at November 2022 and the current year-end forecast.

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

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2022/23 as at 30th November 2022 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Capital	£8.297m	£17.687m	£17.677m	£0.010m
Revenue	£0.433m	£0.674m	£0.674m	£0
Total	**£8.730m**	**£18.361m**	**£18.351m**	**£0.010m**

2.2 The Programme is currently forecasting an overall underspend of £0.010m against a budget of £18.361m for the financial year 2022/23.

2.3 The Enabling Works forecast position reflects an under-spend of £0.805m, which will support the nVCC Project. This will be provided from the Enabling Works QRA and poses a low financial risk for the Enabling Works Project. The approach has been agreed with WG and we are awaiting formal approval.

2.4 A review of the Enabling Works Project in October 2022 has resulted in a further virement of £3.021m from 2022/23 into 2023/24, as agreed with WG. This reduces the overall **capital** funding for 2022/23 to **£17.687m**. To date the EW Project has undertaken the following adjustments into 2023/24:

- Adjustment of £1.9m in May 22 – delay in Enabling Works Project
- Adjustment of £1.472m in August 22 – delay in the Asda works
- Adjustment of £3.021m in October 22 – delay in the Asda works; utilities and Added Value works

2.5 The Welsh Government position is that the funding allocations shown on CRL / CEL schedules at the end of October 2022 will be considered fixed. Therefore, following the above reviews, the EW Project has confirmed its funding requirements to deliver the EW FBC in 2022-23. The project will need to manage its financial position, and any further 'slippage' will need to be managed by the Trust's Capital Programme or returned to WG without reprovision.

2.6 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project will now close. The final costs for this Project are

£0.178m. Therefore, of the £0.434m funding ring fenced from the core Trust discretionary programme for the project in lieu of FBC approval, only the final requirement of £0.178m will be drawn down by the Project. However, as there is provision to fund these costs in the FBC, this amount will reimbursed back to the discretionary programme for utilisation elsewhere within the Trust.

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

2.8 The Trust has approved a budget of £0.033m for the Judicial Review matter, a decrease of £0.010m from the original budget ring fenced for this matter (further details in paragraph 7.16 below). The **revenue** budget has now reverted to **£0.674m** for 2022/23.

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

- A further underspend within the Enabling Works Project as a result of the delay in key project activities;
- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage; and
- Further legal fees relating to the Judicial Review matter.

2.10 These risks have mitigation plans in place or being developed by the relevant Project Teams.

3. BACKGROUND

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

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

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

3.4 The current funding provided to support the TCS Programme in 2022/23 is £17.943m capital and £0.704m revenue, as outlined in Appendix 2.

4. CAPITAL POSITION

4.1 The current capital funding is outlined below:

• EW Project	£15.420m	Capital Expenditure Limit (CEL)
• nVCC Project	£2.089m	Capital Expenditure Limit (CEL)
• IRS Project	£0.178m	Trust's discretionary capital allocation
Total	**£17.687m**	

4.2 The capital position as at 30th November 2022 is outlined below, with a forecast underspend for 2022/23 of £0.010m.

Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£6.046m	£15.420m	£14.615m	£0.805m
nVCC Project	£2.073m	£2.089m	£2.885m	-£0.796m
IRS Procurement Project	£0.178m	£0.178m	£0.178m	£0
Total	**£8.297m**	**£17.687m**	**£17.677m**	**£0.010m**

4.3 The forecast overspend of £0.796m for the nVCC Project will be supported by the Enabling Works Project underspend of £0.805. This will be provided from the Enabling Works QRA and poses a low financial risk for the Enabling Works Project. The approach has been agreed with WG and we are awaiting formal approval.

4.4 Following Ministerial approval of the IRS Final Business Case during November 2022, the IRS Procurement Project will now close. The final costs for this Project are £0.178m. Therefore, of the £0.434m funding ring fenced from the core Trust discretionary programme for the project in lieu of FBC approval, only the final requirement of £0.178m will be drawn down by the Project. However, as there is provision to fund these costs in the FBC, this amount will reimbursed back to the discretionary programme for utilisation elsewhere within the Trust. Further details are provided in Section 7.

5. REVENUE POSITION

5.1 The current revenue funding is outlined below:

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

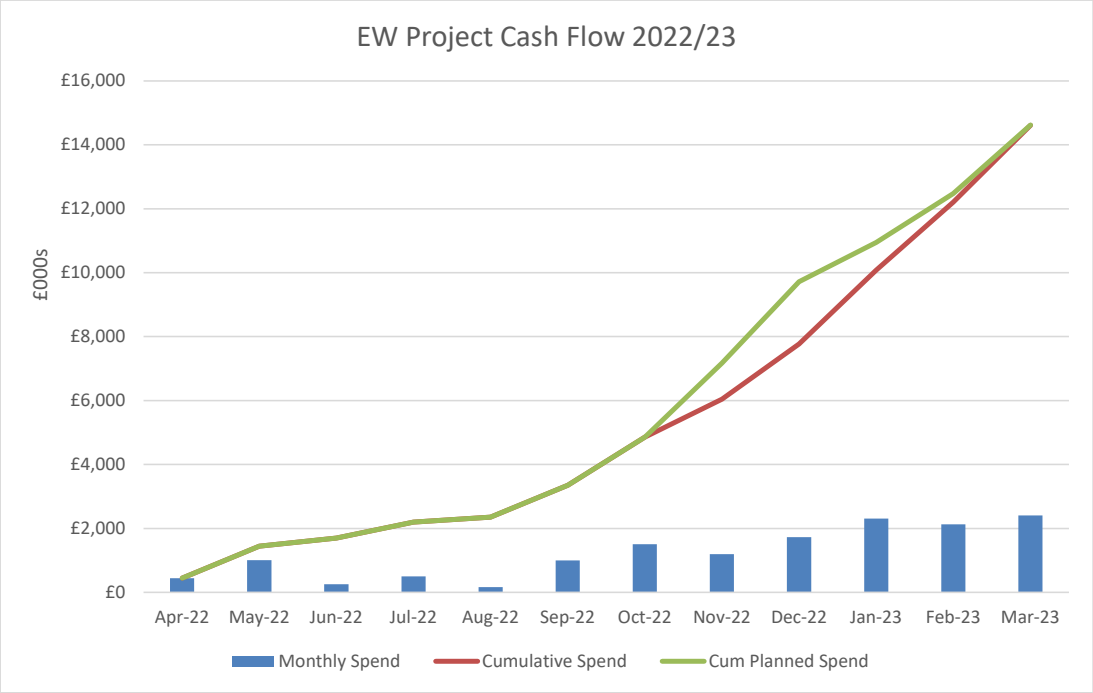
5.2 Following the implementation of the annual NHS pay award in September 2022, a review of the forecast revenue pay for 2022/23 has taken place in November 2022. Adjustments has been made in to the relevant pay and non-pay budgets, allowing increased revenue pay costs in 2022/23 to the covered from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

5.3 The revenue position as at 30th November 2022 is outlined below, with a forecast breakeven outturn for 2022/23 against a revised budget **of £0.674m**.

Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
PMO	£0.171m	£0.300m	£0.300m	£0
nVCC Project	£0.054m	£0.063m	£0.063m	£0
SDT Project	£0.207m	£0.311m	£0.311m	£0
Total	**£0.433m**	**£0.674m**	**£0.674m**	**£0**

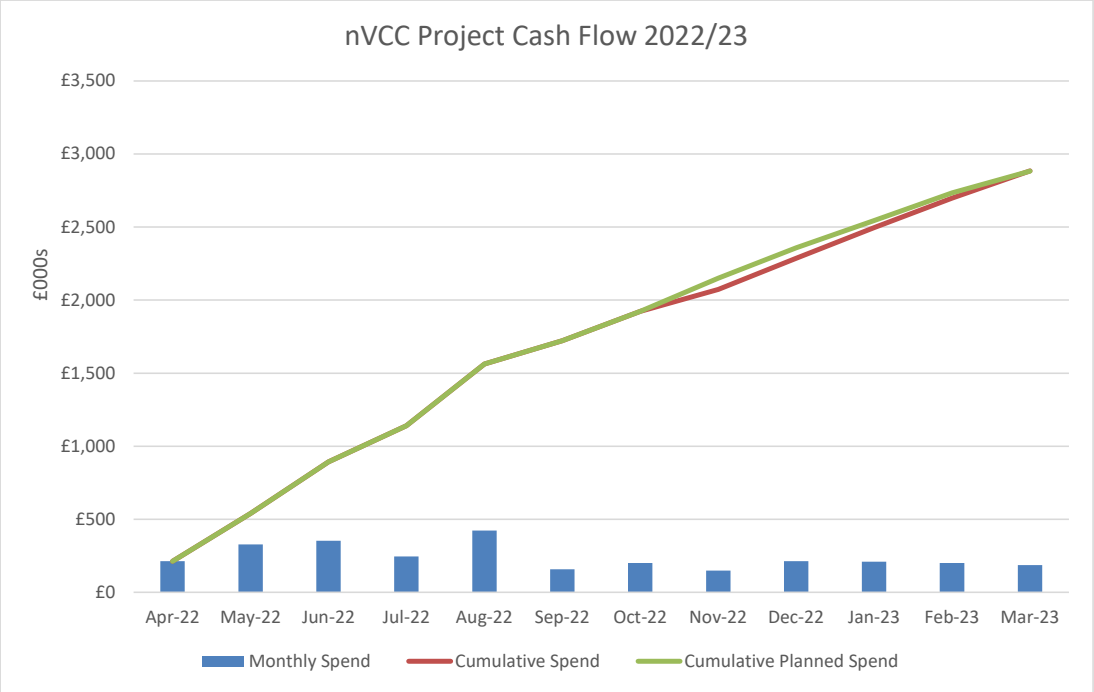
6. CASH FLOW

6.1 The projected capital cash flow for the **EW Project** is outlined below:



6.2 The run rate indicates that around 80% of the costs will be incurred in the second half of the financial year. This is due to the delay in the start of the works.

6.3 The projected capital cash flow for the **nVCC Project** is outlined below:



6.4 The run rate for the nVCC Project is relatively 'flat' and reflects planned activities in respect of the successful participant stage.

6.5 The capital cash flow for the **IRS Project** and the **Revenue** cash flow are not reported as these are not of a material nature.

7. PROJECT FINANCE UPDATES

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

Programme Management Office

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

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

7.4 The revenue position for the PMO as at 30th November 2022 is shown below.

PMO Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.165m	£0.287m	£0.287m	£0
Non Pay	£0.006m	£0.013m	£0.013m	£0
Total	**£0.171m**	**£0.300m**	**£0.300m**	**£0**

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

7.6 There is a low financial risk of an underspend due to a delay in project and support work carried out by the PMO. However, plans will be developed during December to mitigate this risk.

Enabling Works Project

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

7.8 For 2022/23 the EW Project initially received a CEL for £21.813m but after several reviews the final CEL is **£15.420m.** It should be noted that the Welsh Government position, is that the funding allocations shown on CRL / CEL schedules at the end of October 2022 will be considered fixed. Therefore, following the above reviews, the EW Project has confirmed its funding requirements to deliver the EW FBC in 2022-23. The project will need to financially manage its position, and any further 'slippage' will need to be managed by the Trust's Capital Programme or returned to WG without reprovision.

7.9 The Project's financial position for 30th November 2022 is shown below. The forecast position reflects an underspend of £0.805m due to a delay in key activities, which will be used to support the nVCC Project as agreed by WG.

Enabling Works Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.224m	£0.220m	£0.335m	-£0.115m
Non Pay	£5.822m	£15.200m	£14.280m	£0.920m
Total	**£6.046m**	**£15.420m**	**£14.615m**	**£0.805m**

7.10 The spend relates to the following activities:

Enabling Works Project Capital Budget & Spend Summary 2022-23

Description		Year to Date Budget Nov-22 £	Year to Date Spend Nov-22 £	Year to Date Variance Nov-22 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY							
Project 1b - Enabling Works FBC		146,496	224,227	-77,731	219,744	334,878	-115,134
Pay Capital Total		**146,496**	**224,227**	**-77,731**	**219,744**	**334,878**	**-115,134**
NON-PAY - PROJECTS							
EF01	Construction Costs	0	40,981	-40,981	0	40,981	-40,981
EF02	Utility Costs	62,576	62,576	0	979,771	979,771	0
EF03	Supply Chain Fees	373,231	371,731	1,500	527,481	527,481	0
EF04	Non Works Costs	175,914	273,001	-97,087	225,603	343,690	-118,087
EF05	ASDA Works	485,706	446,652	39,054	3,022,743	2,961,798	60,945
EF06	Walters D&B	4,150,714	4,150,714	0	8,735,418	8,735,418	0
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0	174,000	0	174,000
EFQR	Quantified Risk	826,863	195,878	630,986	1,227,798	410,078	817,720
EFQS	QRA - SCP	307,200	316,895	-9,695	307,200	316,895	-9,695
EFRS	Enabling Works FBC Reserves	0	-36,375	36,375	0	-36,375	36,375
Enabling Works Project Capital Total		**6,382,205**	**5,822,053**	**560,152**	**15,200,014**	**14,279,737**	**920,278**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**6,528,701**	**6,046,280**	**482,421**	**15,419,758**	**14,614,615**	**805,143**

7.11 There is a risk of a further underspend within the Enabling Works Project as a result of the delay in key project activities.

New Velindre Cancer Centre Project

Capital

7.12 In March 2021, the Minister for Health and Social Services approved the nVCC OBC. This has provided capital funding of £5.550m in total, with a CEL for 2022/23 is **£2.089m**.

7.13 The capital financial position for the nVCC Project for 30th November 2022 is shown below, with a further breakdown provided in Appendix 4. The forecast position reflects an overspend of £0.796m, which will be supported from the Enabling Works Project as agreed by WG.

nVCC Capital Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.770m	£1.274m	£1.175m	£0.099m
Non Pay	£1.303m	£0.815m	£1.709m	-£0.894m
Total	**£2.073m**	**£2.089m**	**£2.885m**	**-£0.796m**

7.14 The spend relates to the following activities:

nVCC Project Capital Budget & Spend Summary 2022-23

Description	Year to Date Budget Nov-22 £	Year to Date Spend Nov-22 £	Year to Date Variance Nov-22 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership	139,184	138,922	262	208,776	207,909	867
Project 2a - New Velindre Cancer Centre OBC	723,023	630,971	92,052	1,065,097	967,269	97,828
Pay Capital Total	**862,207**	**769,893**	**92,313**	**1,273,873**	**1,175,177**	**98,695**
NON-PAY						
nVCC Project Delivery	**44,790**	**41,078**	**3,712**	**84,000**	**81,518**	**2,482**
Work Packages						
VC08 Competitive Dialogue - Dialogue & SP to FC	627,015	1,184,634	-557,619	731,127	1,500,634	-769,507
VC10 Legal Advice	0	10,630	-10,630	0	10,630	-10,630
VC11 S73 Planning	0	88,681	-88,681	0	88,681	-88,681
VC12 nVCC FBC	0	43,500	-43,500	0	82,000	-82,000
VCRS nVCC Reserves	0	-65,460	65,460	0	-54,050	54,050
nVCC Project Capital Total	**627,015**	**1,261,984**	**-634,969**	**731,127**	**1,627,894**	**-896,767**
TOTAL nVCC fbc CAPITAL EXPENDITURE	**1,534,012**	**2,072,955**	**-538,944**	**2,089,000**	**2,884,589**	**-795,589**

7.15 There is a financial risk relating to increased advisory fees in the range of £0.100m to £0.200m required to conclude the tender evaluation stage and Successful Participant to Financial Close stage. The Project's financial position will be monitored closely over the remaining months of the financial year.

Revenue

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

7.17 The revenue financial position for the nVCC Project for 30th November 2022 is shown below, reflecting a forecast breakeven spend against a budget of **£0.063m**.

nVCC Revenue Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Project Delivery	£0.021m	£0.030m	£0.030m	£0
Judicial Review	£0.033m	£0.033m	£0.033m	£0
Total	**£0.054m**	**£0.063m**	**£0.063m**	**£0**

7.18 The legal team has provided an estimated final cost for this matter of £0.134m. £0.084m of this was expended in 2021/2022, and the remaining £0.050m is expected during 2022/23. Therefore there is a risk of an overspend of £0.017m in this financial year. The action to mitigate this risk is to request additional funding from the Trust Reserves during December 2022.

Integrated Radiotherapy Solution Procurement Project

7.19 Ministerial approval of the IRS Final Business Case during November 2022, and subsequent signing of the contract with the preferred bidder, has instigated the closure of the IRS Procurement Project by 30th November 2022. Continuation of the overall project will continue with the IRS Implementation Project, managed by Velindre Cancer Centre.

7.20 The final costs for the IRS Procurement Project are £0.178m, as outlined below:

Pay	£0.083m
Legal Advisors	£0.092m
Other Costs	£0.003m
Total costs	**£0.178m**

7.21 Estimated costs of £0.127m in 2022/23 for bunker refurbishment LA5 previously reported by the Project will now be covered directly by funding provided directly from the FBC and have been removed from the final Project costs.

7.22 Of the £0.434m funding ring fenced from the core Trust discretionary programme for the project in lieu of FBC approval, only the final requirement of £0.178m will be drawn down. However, as there is provision to fund these costs from the FBC funding letter provided by WG, this will reimbursed back to the discretionary programme for utilisation elsewhere within the Trust.

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

7.24 The capital position for the IRS Project for 30th November 2022 is outlined below, with a breakeven position forecast for the year.

IRS Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.083m	£0.083m	£0.083m	£0
Non Pay	£0.095m	£0.095m	£0.095m	£0
Total	**£0.178m**	**£0.178m**	**£0.178m**	**£0**

7.25 There is a risk of the final legal fee being higher than expected. However, it is not anticipated that this will be a significant amount. There are no financial risks relating to the IRS Procurement Project.

Service Delivery and Transformation Project

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

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

7.28 The SDT Project revenue position as at 30th November 2022 is shown below.

SDT Expenditure	Year to Date Spend	2022-23 Full Year		
		Budget	Forecast	Variance
Pay	£0.207m	£0.288m	£0.288m	£0
Non Pay	£0.000m	£0.023m	£0.023m	£0
Total	**£0.207m**	**£0.311m**	**£0.311m**	**£0**

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

7.30 There is a low financial risk of an underspend due to a delay in project and support work carried out by the SDT Project. However, plans are being developed to mitigate this risk.

8. KEY RISKS AND MITIGATING ACTIONS

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

- A further underspend within the Enabling Works Project as a result of the delay in key project activities;
- Increased advisory fees to conclude the tender evaluation stage and Successful Participant to Financial Close stage; and
- Further legal fees relating to the Judicial Review matter.

8.2 These risks have mitigation plans in place or being developed by the relevant Project Teams.

9. TCS SPEND REPORT SUMMARY

9.1 This update is currently being developed.

APPENDIX 1: TCS Programme Budget and Spend 2022/23 as at 30th November 2022

CAPITAL	Year to Date			Financial Year		
	Budget Nov-22	Spend Nov-22	Variance Nov-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	139,184	138,922	262	208,776	207,909	867
Project 1b - Enabling Works FBC	146,496	224,227	-77,731	219,744	334,878	-115,134
Project 2a - New Velindre Cancer Centre OBC	723,023	630,971	92,052	1,065,097	967,269	97,828
Project 3a - Radiotherapy Procurement Solution	82,882	82,882	0	82,882	82,882	0
Capital Pay Total	**1,091,584**	**1,077,002**	**14,582**	**1,576,498**	**1,592,937**	**-16,439**
NON-PAY						
nVCC Project Delivery	44,790	41,078	3,712	84,000	81,518	2,482
Project 1b - Enabling Works FBC	6,382,205	5,822,053	560,152	15,200,014	14,279,737	920,278
Project 2a - New Velindre Cancer Centre OBC	627,015	1,261,984	-634,969	731,127	1,627,894	-896,767
Project 3a - Radiotherapy Procurement Solution	95,119	95,119	0	95,119	95,119	0
Capital Non-Pay Total	**7,149,128**	**7,220,233**	**-71,105**	**16,110,260**	**16,084,267**	**25,993**
CAPITAL TOTAL	**8,240,713**	**8,297,235**	**-56,523**	**17,686,758**	**17,677,204**	**9,554**

REVENUE	Year to Date			Financial Year		
	Budget Nov-22	Spend Nov-22	Variance Nov-22	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	164,559	164,559	0	286,809	286,809	0
Project 6 - Service Change Team	207,150	207,328	-178	288,000	288,000	0
Revenue Pay total	**371,709**	**371,887**	**-178**	**574,809**	**574,809**	**0**
NON-PAY						
nVCC Project Delivery	21,332	21,332	0	30,000	30,000	0
nVCC Judicial Review	33,000	33,000	0	33,000	33,000	0
Programme Management Office	6,300	6,300	0	13,191	13,191	0
Project 6 - Service Change Team	178	0	178	23,000	23,000	0
Revenue Non-Pay Total	**60,810**	**60,632**	**178**	**99,191**	**99,191**	**0**
REVENUE TOTAL	**432,519**	**432,519**	**0**	**674,000**	**674,000**	**0**

APPENDIX 2: TCS Programme Funding for 2022/23

Description	Funding Type	
	Capital	Revenue
Programme Management Office	**£0m**	**£0.300m**
Commissioner's funding		£0.300m
Pay Award Funding – assumed (September 2022)		£0.010m
Pay Award Funding – reversed (November 2022)		-£0.010m
Enabling Works OBC	**£15.420m**	**£0m**
2022/23 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£21.813m	
Virement of funds from 2022/23 to 2023/24 financial year (May 2022)	-£1.900m	
Virement of funds from 2022/23 to 2023/24 financial year (August 2022)	-£1.472m	
Virement of funds from 2022/23 to 2023/24 financial year (October 2022)	-£3.021m	
New Velindre Cancer Centre OBC	**£2.089m**	**£0.073m**
2022/23 CEL from Welsh Government funding for nVCC OBC (March 2021	£2.089m	
Trust revenue funding from reserves		£0.063m
Integrated Radiotherapy Procurement Solution	**£0.178m**	**£0m**
Trust Discretionary Capital Allocation	£0.434m	
Reduction in requirement of capital funding	-£0.256m	
Radiotherapy Satellite Centre	**£0m**	**£0m**
No funding requested or provided for this project to date		
SACT and Outreach	**£0m**	**£0m**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0m**	**£0.311m**

Description	Funding Type	
	Capital	Revenue
Commissioner's funding Trust revenue funding from reserves Pay Award Funding – assumed (September 2022) Pay Award Funding – reversed (November 2022)		£0.120m £0.191m £0.010m -£0.010m
VCC Decommissioning No funding requested or provided for this project to date	**£0m**	**£0m**
Total	**£17.687m**	**£0.684m**

TRUST BOARD

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Strategic Development Committee	**8.12.2022**	**Discussed**
Audit Committee	**12.1.2023**	**Discussed**
Quality, Safety & Performance Committee	**17.1.2023**	**Discussed**

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

1. SITUATION / BACKGROUND

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

- The status of the Principal Risks identified in the Trust Assurance Framework (TAF) included at ***Appendix 1,*** which may affect the achievement of the Trust's Strategic Objectives, and the level of assurances in place to evidence the effectiveness of the management of those risks.
- The ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework across the organisation, since the last meeting of the Trust Board.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Key points discussed by Quality, Safety and Performance Committee and Audit Committee in January 2023 were:

- Where there are gaps in 2nd and 3rd line of defence across the TAF risks, executive leads to ensure cross reference to all 2nd and 3rd line related activity is captured
    - Each executive lead to consider whether captured all currently
    - Risk and Assurance team to support on cross-check to audit tracker and Legislative and Regulatory tracker in place going forwards.
- If there are gaps, this to be explicitly addressed in the actions, articulating what action is to be taken or recording the recommendation of no action required with an explanation.

- Executive leads to ensure any partial assurance ratings or gaps in controls have clear corresponding actions.

- The template development to support clearer view of:
    - Action taken since last review
    - Impact of that action in relation to target risk score.

- Further executive lead review and challenge of the risk scores which have been fairly static.

2.2 Trust Assurance Framework Strategic Risks – Next Steps

In addition, as previously reported to the Trust Board, the following next steps are currently underway:

- Links to Risk Register, Performance Framework and Quality Framework
- Revised reporting mechanism - Integration of Trust Assurance Framework into Datix.
- Mapping Trust Assurance Framework to Committee governance cycle.
- Embedded into mechanisms of cycles of business and agenda setting.

- Link to Audit tracker, including actions and progress to complete, linked to assurance levels.

Further development work, as discussed the Trust Board Development meeting in November 2022:

- Further work as Executive Management Board, Senior Leadership Team/Senior Management Team and Extended Leadership Team to develop articulation of strategic risks, aligned to the Integrated Medium Term Plan (IMTP) process. Agreed will plan for Trust Board approval, following endorsement by Strategic Development Committee in March 2023.

- It was agreed that two reverse stress testing exercises be undertaken utilising a tailored approach aligned to each of the core service divisions, i.e. Welsh Blood Service and Velindre Cancer Service. These will be planned for February 2023 and the outcomes reported through the March reporting cycle.

2.3 Trust Assurance Framework Dashboard

- The updated Trust Assurance Framework Dashboard Report is included at ***Appendix 1.***

- Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since November 2022.

- To also note that in the November Strategic Development Committee the summary of each strategic risk was discussed and reviewed, in line with the scope of that Committee to ensure that the Principal Risks are being managed in an effective way in order to enable the realisation of the Trust's strategic objectives.

	NO REVIEW TAKEN PLACE
	REVIEWED – NO CHANGES
	REVIEWED AND UPDATED

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

- **Actions on specific strategic risks**

  - **TAF 01: Demand and Capacity**
    - **Residual Risk Score –** 12. This remains unchanged since the previous review and there is no specific evident trend emerging in the data.
    - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
      - **Sources of Assurance –** There have been no changes to the sources of assurance.
      - **Action Plan for Gaps Identified –** The action plan has been updated is largely progressing on target.

  - **TAF 02: Partnership Working and Stakeholder Engagement**
    - **Residual Risk Score –** 8.This remains unchanged since the previous review. The residual risk has decreased from 12 to 8 since September 2022.
    - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
    - **Sources of Assurance –** There have been no changes to the sources of assurance.
    - **Action Plan for Gaps Identified –** There have been additional actions included since the last review, no updates and no changes.

  - **TAF 03: Workforce Planning**
    - **Residual Risk Score –** 12. The residual risk increased from 9 to 12 in the September 2022 governance reporting cycle and has remained at this level since that time.
    - **Overall Level of Control Effectiveness –** This remains as Partially Met (PE)
    - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
    - **Action Plan for Gaps Identified –** The action plan has been updated to provide a further level of detail and assurance on the planned timetable for delivery of the associated programme of work to mitigate this risk.

  - **TAF 04: Organisational Design**
    - **Residual Risk Score –** 9. This remains unchanged since the previous review with no trend emerging since March 2022.
    - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
    - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
    - **Action Plan for Gaps Identified –** The action plan has been updated with progress reports. The due dates on the action plan have been reviewed.

- **TAF 05: Organisational Culture**
  - **Residual Risk Score –** 12. This remains unchanged since the previous review with no trend emerging since March 2022.
  - **Overall Level of Control Effectiveness –** A thorough review of the levels of control effectiveness has been carried out resulting in an overall Control Effectiveness rate of Partially Met (PE)
  - **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review
  - **Action Plan for Gaps Identified –** There have been no changes or updates to the action plan in cycle of review.

- **TAF 06: Quality and Safety**
  - **Residual Risk Score –** 15. This remains unchanged since the previous review with no trend emerging since March 2022.
  - **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE), unchanged since the last review.
  - **Sources of Assurance –** Gaps in assurance remain unchanged since the last review.
  - **Action Plan for Gaps Identified –** The action plan remains unchanged since the last review.

- **TAF 07: Digital Transformation**
  - **Residual Risk Score –** 12. This remains unchanged since the previous review with no trend emerging since March 2022.
  - **Overall Level of Control Effectiveness –** This remains as Partially Effective (PE) despite a shift in some key control ratings individually.
  - **Sources of Assurance –** There have been no changes made to the sources of assurance.
  - **Action Plan for Gaps Identified –** The action plan has been reviewed and progress noted, including review of due dates.

- **TAF 08: Trust Financial Investment**
  - **Residual Risk Score –** 12. The residual risk decreased from 16 to 12 in the July 2022 governance reporting cycle and has remained at this level since that time.
  - **Overall Level of Control Effectiveness -** This remains as Partially Met (PE)
  - **Sources of Assurance –** There have been no changes to the sources of assurance.
  - **Action Plan for Gaps Identified –** There have been no changes to the gaps in assurance.

- **TAF 09: Future Direction of Travel**
  - **Residual Risk Score –** 8. 12. The residual risk decreased from 12 to 8 in the November 2022 governance reporting cycle and has remained at this level since that time.

- **Overall Level of Control Effectiveness -** This remains as Partially Met (PE).
- **Sources of Assurance –** There have been no changes or additions to the sources of assurance since the previous review.
- **Action Plan for Gaps Identified –** There have been no changes or additions to the action log since the last review.

- **TAF10: Governance**
  - **Residual Risk Score –** 12. This remains unchanged since the previous review with no trend emerging since March 2022. However, this is anticipated to decrease in line with the development and implementation of the Governance, Assurance and Risk Programme of work across the Trust.
  - **Overall Level of Control Effectiveness –** This remains as 'Effective' (E).
  - **Sources of Assurance –** No amendments have been made nor additions since the last review.
  - **Action Plan for Gaps Identified –** A formal programme of work for Governance, Assurance and Risk continues and reports into the wider Organisational Development programme for the Trust, this encompasses 20 key projects underpinning the further development and operationalisation of the Trust Assurance Framework.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Trust Board is asked to:

a. **DISCUSS AND REVIEW** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework, as outlined in section 2.

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

RISK ID:	TAF 01	We fail to deliver sufficient capacity leading to deterioration in service quality, performance or financial control as a result of capacity or demand planning or the operational service challenges
LAST REVIEW	Sep-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Oct-22	RISK DOMAIN Performance and Sustainability
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS / SOURCES OF ASSURANCE

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

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

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

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
LAST REVIEW	Nov-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Jan-22	RISK DOMAIN: Partnership
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

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

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

GAP IN CONTROLS							GAPS IN ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
1.1	System structures – core cancer services commissioning arrangements		X			PE	Commissioning contracting reporting	IA	Strategic Development Committee/Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
1.2	Strategic partnerships which support effective delivery of working/ work programmes			X		PE	Supply and demand reporting	IA	Strategic Development Committee/ Quality Safety and Performance Committeee	IA	Wales Audit Office/Welsh Government	PA
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA

2.1	Blood - core blood services commissioning arrangements			X		PE	Commissioning contracting reporting	IA	Strategic Development Committee/ Quality Safety and Performance Committeee	IA	Regulatory scope re MHRA tbc	PA
3.1	Local Partnership Forum		X	X		PE	Feedback from LPF	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office	PA
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region		X			PE	Agreed to model for next phase	PA	Strategic Development Committee/ Quality Safety and Performance Committeee	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Linked to developments in ways of working for the Trust, the actions to enhance the effectiveness of the controls will be specifically developed and reported on.	Complete

1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James		Complete
1.3	Development of CCLG leadership and goverancne arrangements: towards Alliance System: agree next steps with CEOs	Carl James		Complete

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience
NEXT REVIEW	Nov-22	RISK DOMAIN Workforce and Organisational Development
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS

SOURCES OF ASSURANCE

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

TAF DASHBOARD

WORKFORCE PLANNING

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

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

TAF DASHBOARD

WORKFORCE PLANNING

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Attraction, Retention and Recruitment Programme established to deliver outputs to support the supply and shape of the workforce	Sarah Morley	The Programme Group has been established and a range of outputs defined to deliver between September 2022 and February 2023.	Feb-23
1.2	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	The annual workplan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff.	Dec-22
1.3	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	The Hybrid Working project is presenting the details of a desk top booking appraoch to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Workign Toolkit has been developed in draft and will be finalised and published in February 2023.	Mar-23

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL DESIGN: Failure to establish effective systems and structures built around shared values and behaviours.**
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Nov-22	**RISK DOMAIN** **Performance and Service Sustainability**
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

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

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

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

TAF DASHBOARD

ORGANISATIONAL CULTURE

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

TAF DASHBOARD

ORGANISATIONAL CULTURE

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

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

TAF DASHBOARD ORGANISATIONAL CULTURE

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
LAST REVIEW	Nov-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
NEXT REVIEW	Jan-22	**RISK DOMAIN** **Performance and Service Sustainability**
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

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

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

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

1.4	Risk management framework / arrangements in place to identify/monitor/manage risks at corporate and service level	Lauren Fear		x		E	Executive Management Board review	PA	Strategy Committee/QSP/Internal Audt Review / CHC	PA	Audit Wales	PA
1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x			PE	Executive Management Board review / staff feedback	IA	Strategy Committee/QSP/Internal Audt Review / CHC	IA	Audit Wales	IA
1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x			PE	Executive Management Board review / staff feedback	IA	Internal Audt Review	PA	Audit Wales/HIW	PA

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	Not possible to fully determine whether the activities the Trust is undertaking are delivering the desired strategic outcomes at a Board level i.e. many of the outcomes for cancer and blood services are population based and the Trust currently does not get this information
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented (new quality metrics not sufficiently developed and/or utilised)	Inability to fully determine whether the services are maximising performance to deliver the desired outputs/outcomes at a service/Trust level
Not all supporting strategies approved by the Board e.g. Clinical and Scientifc strategy	Not yet able to d

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in May 2022 (on track for May 26th 2022). Trust strategy and enabkers developed and approved (with launch in Sept 2022)	Complete
Develop IMTP to provide priority for action and application of resource	Carl James	Final draft going to Board for approval March 2022	Complete
Information requirements being scoped	Cath O'Brien	First phase to support new performance measures (on track for September 2022)	Apr-23
Develop clinical and scientific strategy	Jacinta Abraham	Jaz Abrahams/Nicola Williams/Carl James will be jointly responsible. Initial scoping meetings commenced and resourcing being indentifed prior to commencing work	2023 (comple tion

Implement revised performance management framework	Carl James	New scorecards being finalised for implementation (on track for September 2022). Additional cycle agreed to test PMF (october board edevelopment session) - target date for live PMF Dec 22 / Jan 23 Cycle. PMF being trialed currently and will Go Live in April 2023 (using February 2022 data/cycle)	Apr-23

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust has just approved (July 2022) its integrated Quality & Safety Framework and is in the process of setting up the required mechanisms, systems, processes and datasets. This includes the ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust triangulated datasets and to systematically demonstrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. These are not currently in place and could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.		
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience		
NEXT REVIEW	Nov-22	Goal 1	RISK DOMAIN	Quality and Safety/ Comliance and Regulatory

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

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

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

TAF DASHBOARD

QUALITY AND SAFETY

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

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

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

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
LAST REVIEW	Oct-22	5 - A sustainable organisation that plays it part in creating a better future for people across the globe
NEXT REVIEW	Nov-22	**RISK DOMAIN** Performance and Service Sustainability
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

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

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

KEY CONTROLS

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

SOURCES OF ASSURANCE

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

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

TAF DASHBOARD

DIGITAL TRANSFORMATION

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

TAF DASHBOARD

DIGITAL TRANSFORMATION

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

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

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.		
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations		
NEXT REVIEW	Nov-22	**Goal 2**	**RISK DOMAIN**	**Financial Sustainability**

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

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

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

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

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

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

	Protected Enhanced rates secured for 22-23	David Osborne	Completed	Completed
	Contract currencies of concern identified and impact assessed	David Osborne	Impact of hyperfractionation reviewed	Completed
	Business Cases completed for Brachytherapy	David Osborne	Business case prepared and agreed	Completed
	Engage with National Funding Flows Group for contract agreements for future financial years	David Osborne	Ongoing, due November	Completed
1.3	**Establish Trust Investment Prioritisation Framework**	**Matthew Bunce**	**Initial proposals prepared, Executive discussions to shape and take forward**	Completed
	Benchmarking / good practice assessment	Chris Moreton	Work has been conducted to understand where good practice exists within other LHBs / wider NHS.	Completed
	Investment Categorisation	Chris Moreton	Draft set of categories have been produced which contain the Scale of Change; Type of Change; Source of Funding and Type of Funding. Draft categories to be reviewed and finalised / agreed as part of framework.	Mar-23
	Governance and processes	Chris Moreton	Terms of Reference for Strategic Capital Board have been reviewed by Chris Moreton with suggested updates aligned to the SFIs. Once SCB ToR agreed, Capital Financial Control Procedures to be updated. High level process review for capital investment in progress. Revenue investment review process to be completed.	Apr-23
	Prioritisation criteria	Chris Moreton	Criteria need to be developed and agreed - work in progress	May-23
	Business Case Templates and Decision Support Tools	Chris Moreton	Updated draft investment categories have been incorporated within the Trust Board report template. Gap analysis of business case templates and decision support tools to be completed.	Jul-23

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.								
LAST REVIEW	Oct-22	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations								
NEXT REVIEW	Nov-22	Goal 2			RISK DOMAIN			Research and Development		
EXECUTIVE LEAD	Carl James	RISK SCORE (See definitions tab)								
		INHERENT RISK			RESIDUAL RISK			TARGET RISK		
		Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
		3	4	12	2	4	8	2	3	6

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			E	Executive Management Board review	PA	Strategic Development Committee	PA	Audit Wales Reviews	PA
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE	Executive Management Board review	NA	Strategic Development Committee	IA	Audit Wales Reviews	PA
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE	Executive Management Board review	IA	Strategic Development Committeen and performance management framework	IA	Audit Wales Reviews	PA

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

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of clinical and scientific strategy	New PMF not yet in place with revised measures to track delivery of Trust strategy
Limited commercial expertise (capacity) within the Trust	Local commissioning/regional commissioning processes unchanged with no new ways of measuring effectiveness
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	
Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capability to leverage the strategic oppor	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James	On track for May 2022. The overarching Trust Strategy "Destination 2032" was approved in the January Trust Board. The Enabling Strategies were subsequently approved, as outlined below, in the May 2022 Trust Board.	COMPLETE
1.2	Board decision on strategic areas of focus/to pursue	Board	Final enabling strategies on track for may 2022 - allowing prioritisation to occur in future IMTPs. Trust Enabling Strategies were approved by the Trust Board in May 2022.	COMPLETE
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board decisions)
1.4	development of clinical and scientific strategy	Jacinta Abraham		tbc

1.5	Development of KPIs and PMF to track strategy delivery	Carl James	Draft KPIs developed and PMF being plioted	Dec 22/January 23 Board reporting cycle
1.5	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions)

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.									
LAST REVIEW	Oct-22	1 - Outstanding for quality, safety and experience									
NEXT REVIEW	Nov-22	**Goal 1**			**RISK DOMAIN**		**Compliance and Regulatory**				
EXECUTIVE LEAD	Lauren Fear	**RISK SCORE (See definitions tab)**									
		INHERENT RISK			**RESIDUAL RISK**			**TARGET RISK**			
		Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	
		4	4	**16**	3	4	**12**	2	4	**8**	

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

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

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

TAF DASHBOARD GOVERNANCE

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

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

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

TRUST BOARD MEETING

INFECTED BLOOD INQUIRY

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	N/A

PREPARED BY	Suzanne Jones, Project Support Officer
PRESENTED BY	Cath O'Brien, Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Quality, Safety and Performance Committee	17/01/2023	The Report was Noted

ACRONYMS	
IBI	Infected Blood Inquiry
NHSBT	National Health Service Blood and Transplant (England)
NIBTS	Northern Ireland Blood Transfusion Service

SNBTS	Scottish National Blood Transfusion Service
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 The Infected Blood Inquiry is the independent public statutory inquiry into the use of infected blood particularly since the 1970's.

1.2 The Inquiry has been established to examine why men, women and children in the United Kingdom were given infected blood and / or infected blood products; the impact on their families; how the authorities (including government) responded; the nature of any support provided following infection; question of consent; and whether there was a cover-up.

1.3 The Welsh Blood Service (WBS), VUNHST has core participant status in the Inquiry.

1.4 The Inquiry has been in operation for over 4 years and has been taking evidence from those affected and infected together with a number of individuals representing relevant organisations. The activity of the IBI has continued during the COVID 19 pandemic. We are now approaching the stage of the inquiry that will enable Core Participants to submit a written statement in response to the evidence that has been heard.

1.5 During the majority of the period under review, WBS was legally an entity within a number of Welsh NHS organisations and operated in effect as a regional center under a collaborative working arrangement across England and Wales. As such, the evidence given by NHSBT has in the main covered England and Wales.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Written submissions to IBI

VUNHST submitted a Final Written Statement, as agreed to the Inquiry by the deadline of 16th December 2022 (**Appendix 1**).

This statement was written by the Lead Counsel representing the Trust and stated that WBS agreed with and endorsed the comprehensive submissions and recommendations advanced to the Inquiry by NHSBT. This was in the main due to the fact there was no neat separation between the blood services in England and Wales for the periods the Inquiry has been considering. For much of it, the Welsh service was in effect a constituent centre of the English service

The statement did not seek to duplicate what had been submitted but did observe that, in Wales, headway is already being made in areas which overlap some of the recommended actions.

An apology was included which recognised the utterly devastating impact upon the Infected and Affected of what had occurred, and apologised for the actions or inactions of its predecessor organisations

The statement confirmed that WBS would consider whatever recommendations the Inquiry makes, with a view to building on those improvements which have already started and would work in collaboration with the other UK blood services through the Blood Services UK Forum.

2.2 Hearings

The Oral Hearings resumed on the week commencing 16th January 2023, where the Inquiry will hear closing oral statements from those Core Participants who have requested to do so.

Following information from the IBI Legal Team and the meetings with the Trust's legal team, based on the advice of the Trust's Lead Counsel a decision was taken not to make a final oral statement on behalf of WBS.

Throughout the Inquiry WBS has had a reactive role in providing all the documents requested by the Inquiry. During the times being examined by the Inquiry the Welsh Regional Blood Service based in Cardiff acted as a region of England and as such did not make any independent decisions in relation to setting or following policy. This point will be made during the closing statement of NHSBT

The IBI legal team agreed this approach would be consistent with our submissions, the position to date and the fact that for the majority of the relevant time WBS was part of NHSBT or predecessor bodies. It would also be consistent with the statement of approach on closing submissions.

Following the conclusion of the Oral Statements the Chair will retire to consider the conclusions and recommendations he may wish to consider. As a Core Participant the Trust will have access to the final report prior to publication.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	The Inquiry relates to historic timelines.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	Standard 2.8 Blood Management
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	The Inquiry relates to historic timelines.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Inquiry will identify in relation to its' Terms of Reference, any individual responsibilities as well as organisational and systematic failures.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Funding for this work was confirmed with the Welsh Government to continue for the duration of the Inquiry

4. RECOMMENDATION

The Trust Board members are asked to NOTE the update.

INFECTED BLOOD INQUIRY

WRITTEN SUBMISSION OF THE WELSH BLOOD SERVICE, VELINDRE UNIVERSITY NHS TRUST ("WBS") TO THE INQUIRY FOLLOWING THE CLOSE OF EVIDENCE

1. This submission from WBS is made following careful consideration of the comprehensive submissions and recommendations that are to be provided to the Inquiry by NHSBT.

2. Today, WBS is a distinct service covering Wales. However, as traversed in the evidence received by the Inquiry, there was no such neat separation between the blood services in England and Wales for the periods the Inquiry has been considering. For much of it, the Welsh service was in effect a constituent centre of the English service. The history and relationship between the services has been set out in the following documents: the rule 9 response of Gail Miflin **[WITN0672006]**; the brief history of the establishment and management of the Welsh blood service **[WITN6876002]**; the Updated NHSBT Family Tree **[WITN0672007]**; the Counsel to the Inquiry presentation on the history of the blood services in the UK **[INQY0000307]**; the first rule 9 response of Catherine O'Brien **[WITN6876001]**; and the rule 9 response of Tony Napier **[WTN6915001]**.

3. As those documents demonstrate, a large part of Wales was served by the NHSBT through a regional transfusion centre in Liverpool up until 2016, and the south of Wales was served by a single regional transfusion centre under NBTS (Wales), which ultimately answered to the Welsh Office within the UK government until 1999.[1]

[1] The historically idiosyncratic nature of the blood service as described means that at times over the course of the Inquiry, the meaning of the phrase 'England and Wales' has been used where at times more appropriately it would have been 'England with North Wales', and where at other times it would have been 'England with North Wales, and additionally South Wales'.

4. Although WBS has accordingly been a smaller presence during the Inquiry compared to NHSBT, it has endeavoured to support the Inquiry to the best of its ability, including in respect of the sourcing and disclosure of historic documents, its provision of Rule 9 statements, and the giving of live evidence. WBS is a signatory to the Charter for Families Bereaved by Public Tragedy[2] and has endeavoured at all times to assist the Inquiry with openness, honesty and transparency.

5. At this closing stage, WBS agrees and endorses the comprehensive submissions and recommendations now advanced to the Inquiry by NHSBT. It does not seek to duplicate what has there been said, though observes that, in Wales, headway is already being made in areas which overlap some of the recommended actions, as a result of the Welsh-specific 'NHS Wales Blood Health Plan'[3], initially launched in 2017. WBS will consider with care whatever recommendations the Inquiry makes, with a view to building on those improvements which have already started. In doing so it will work in collaboration with the other UK blood services through the Blood Services UK Forum, which is the vehicle for co-ordination and promotion of consistency and collaboration between UK services.

6. WBS wishes to offer its own apology to the Infected and Affected before concluding this brief submission. WBS recognises the utterly devastating impact upon the Infected and Affected of what has occurred, and apologises, without reservation, for the actions or inactions of its predecessor organisations which have contributed to bringing about what occurred.

Debra Powell KC
Susanna Rickard
15 December 2022

[2] An Operational Division of Velindre University NHS Trust.
[3] https://bhnog.wales.nhs.uk/wp-content/uploads/2021/11/Welsh-Health-Circular-NHS-Wales-Blood-Health-Plan-2021-English.pdf - the first (2017) iteration of the plan is at https://bhnog.wales.nhs.uk/wp-content/uploads/2022/12/Welsh-Health-Circular-2017-028-NHS-Wales-Blood-Health-Plan-English.pdf

TRUST BOARD

Annual Equality Report 31 March 2022

DATE OF MEETING	31 January 2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Budgen: Head of Organisational Development,
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	**5.12.22**	**Endorsed for Committee approval**
QSP	**17.1.23**	**Endorsed for Board approval**

ACRONYMS	
VCC	Velindre Cancer Centre

WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 This report provides the equality monitoring data in line with the Equality Act 2010 and the Public Sector Equality Duty (2011). The equality duty was created under the Equality Act 2010. The equality duty replaced the race, disability and gender equality duties. The workforce statistics relating to protected characteristics as at 31 March 2022 can be seen in appendices 1 and 2. The data presented at Appendix 1 covers the full legal entity, including NHS Wales Shared Services, and the data presented at Appendix 2 is Velindre only, covering Velindre Cancer Centre, Welsh Blood Service and Corporate Services.

1.2 The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year. The essential purpose of the specific duties under the Equality Act, in relation to monitoring, is to help authorities to have better due regard to the need to achieve the three aims of the general duty, which are to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it;
- foster good relations between people who share a protected characteristic and people who do not share it.

Therefore, as a specific duty itself, the role of annual reporting is to support the Trust in meeting the general duty. It also has a role in setting out achievements and progress towards meeting the other specific duties. In particular, the annual report supports the Trust to have a better due regard to the duties by providing an opportunity to;

- Monitor and review progress;
- Monitor and review the effectiveness and appropriateness of arrangements;
- Review objectives and processes in light of new legislation and other new developments;
- Engage with stakeholders around these issues, providing partners and the public with transparency.

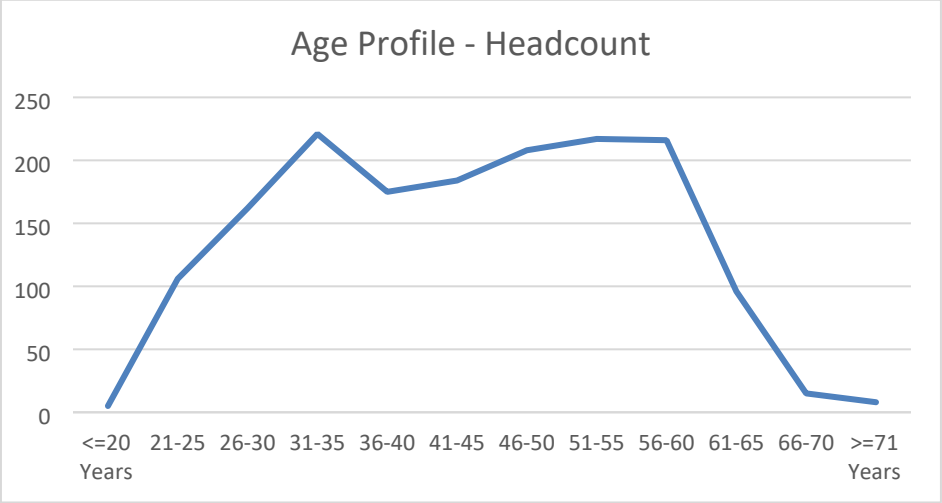
1.3 As well as meeting the Trust's obligations under the Public Sector Equality Duty, this data will inform the Trust's Workforce and OD actions, in the areas of recruitment, training and policy.

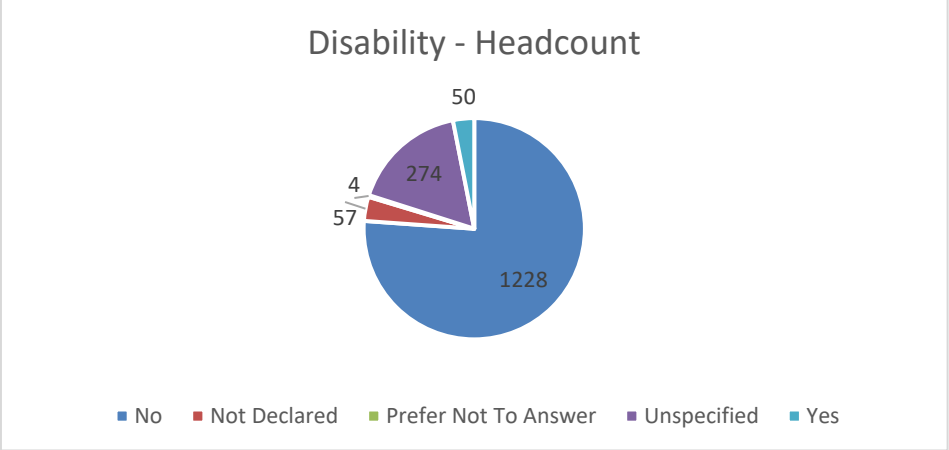
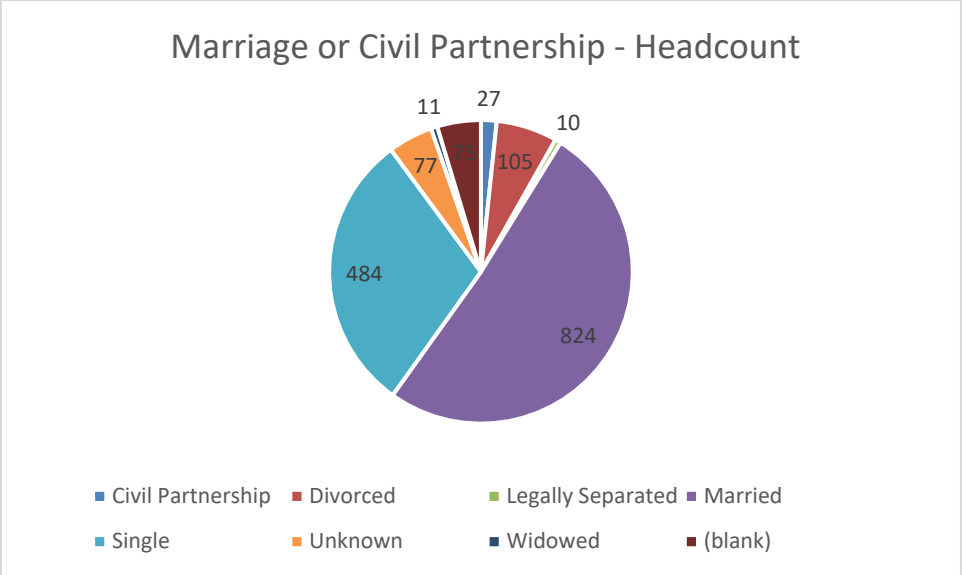
1.4 The report also includes a synopsis of progress made against the Trust's Strategic Equality Plan objectives, which run from 2020 to 2024.

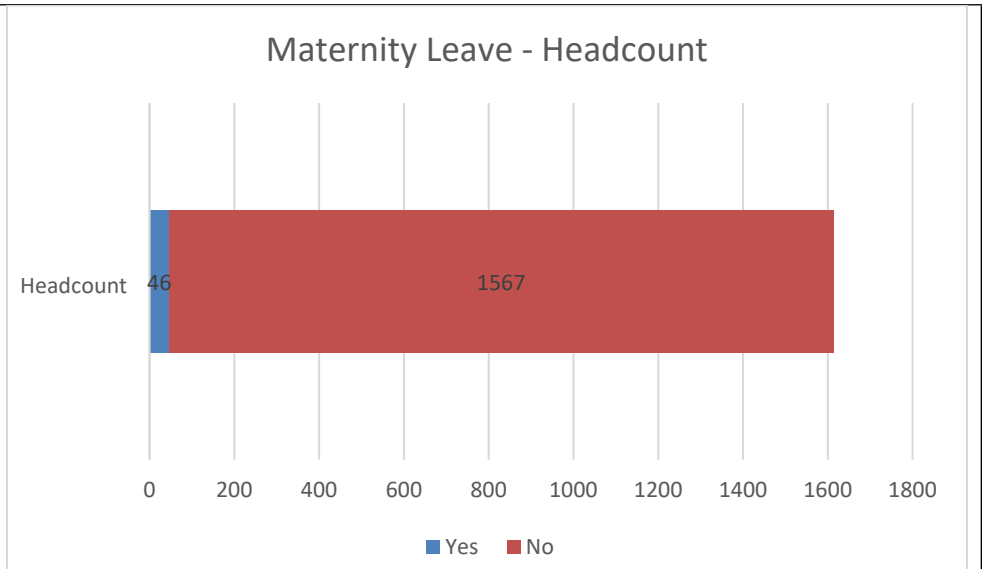
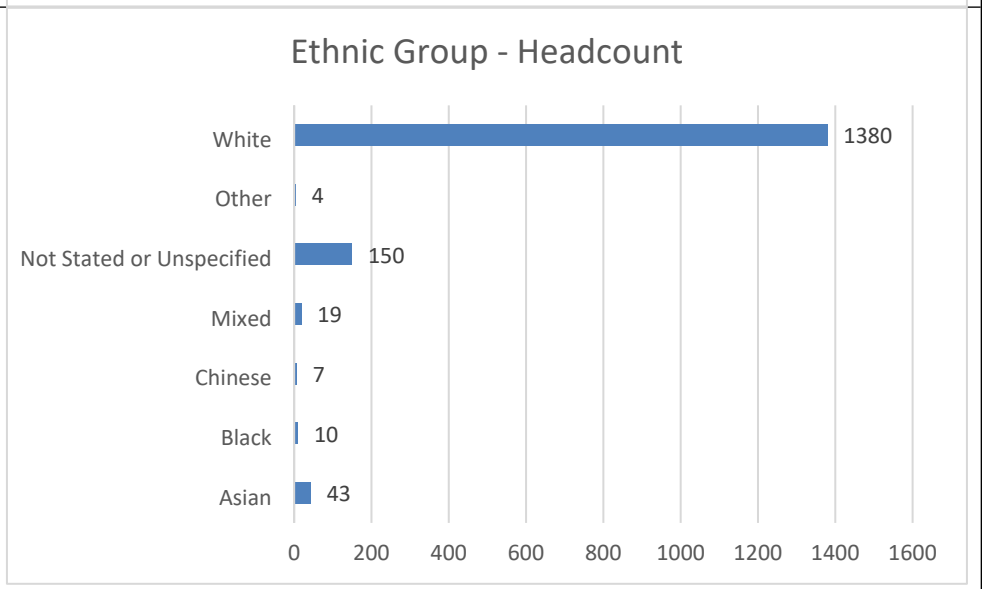
2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

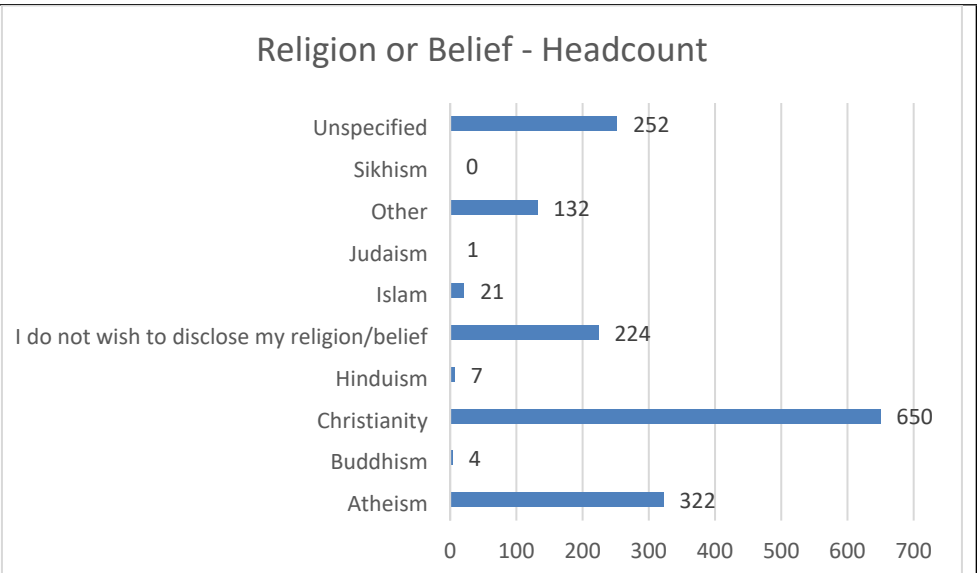
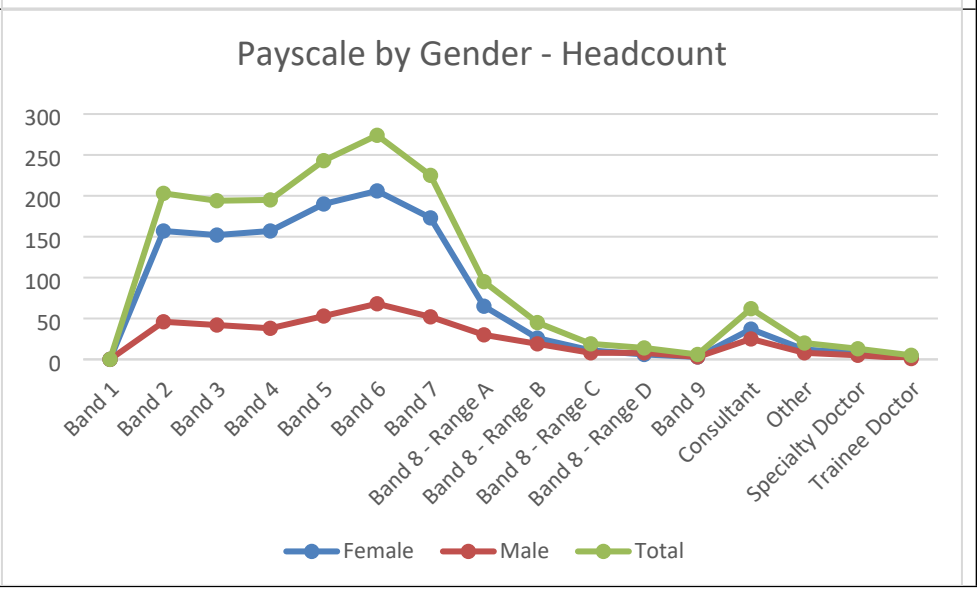
There are nine protected characteristics under the Equality Act 2010 which all public sector organisation report on annually. Statistics are neutral; it is the picture they paint that can help us understand difference in experience of employees from different backgrounds.

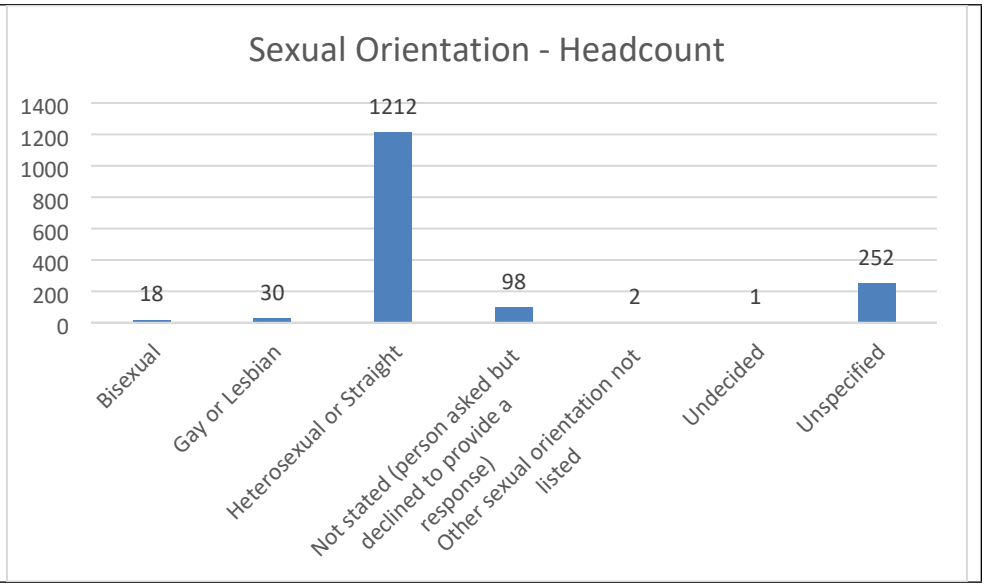
The data for the combined organisation of 6,505 people is available at Appendix 1. The analysis below focuses on the 1,613 people at Velindre (excluding hosted) only, shown at Appendix 2.

1	**Age** Spread between age 31 and 60, with a dip between 36 and 46. Lower numbers below the age of 30. This profile informs the Trust's Recruitment strategy with age profile data being used to identify future shortfalls in different professions as a result of retirements.	

2	**Disability** 3% of the workforce have declared a disability compared with around 16% of the working population. However, 21% are listed as Not Declared/ Prefer not to Answer/ Unspecified which needs to be reviewed. The Trust is registered as a Disability Confident Employer Level 2 and is working towards Level 3.	
3	**Gender Reassignment**	ESR does not record Gender Reassignment and therefore we do not hold statistics on this characteristic. Whilst we cannot present statistics on Gender Reassignment the Trust has a Supporting Transgender Staff Policy which provides a framework for staff who have transitioned or who are in the process of transitioning their gender.
4	**Marriage or Civil Partnership** Half the workforce is married and almost a third are single. Other categories make up the remaining 20%.	

5	**Pregnancy or Maternity** 2.85% of the workforce were on Maternity Leave on 31 March 2022 which reflects the public sector norm.	
6	**Race** 86% are recorded as White, with the second largest group being Asian at 3%. Attention needs to be given to updating the 9% of records which are currently Not Stated or Unspecified. The Trust is developing an Anti-Racist Plan including implementation of the Workforce Race Equality Standard which will give a more detailed picture of the experience of Black and Minority Ethnic staff.	

7	**Religion or Belief** 40% Christian, 20% Atheist, 14% Do Not wish to Disclose. 16% unspecified needs to be followed up. The Trust has set up a Multi Faith Room at the VCC and is designing one for WBS at Talbot Green.	
8	**Sex (Gender)** 75:25 split Female to Male. 58% of women have full time roles compared with 84% of men. Payscales for Men make a up a smaller proportion of jobs at Bands 7 and below than for Bands 8 and above. This area is dealt with more fully within the Gender Pay Gap report.	

9	**Sexual Orientation** 75% straight, 6% Not Stated and 15% Unspecified. This data gap needs to be followed up.	

2.1 Progress with the five objectives in the Strategic Equality Plan is outlined below.

2.1.1 Increase workforce diversity and inclusion

A Widening Access Coordinator postholder has been working with local colleges and the community to offer a wider variety of routes into working in healthcare. The Trust has provided Internships and Apprenticeships to local people to support their education and employment experience. The Trust is working with HEIW on national careers initiatives, for clinical and non-clinical roles.

The Trust is accredited at Level 2 of Disability Confident and is working towards Level 3.

Staff Networks have been operational from time to time although participation was hampered due to COVID and related restrictions. A new phase of work started in 2022 to establish the networks and engagement opportunities that staff are looking for.

The focus on individual staff needs and risks that was required during COVID has left a positive legacy in terms of how people's needs are considered at work. This has informed the Trust's approach to hybrid working where instead of rigid policies regarding working location being applied to all staff, there are fundamental principles in place showing that service needs determine what work needs to be done and then there can be flexibility about how or where that is done to reflect individual preferences.

2.1.2 Eliminate pay gaps

The focus has been on the Gender Pay Gap with the Trust reporting in line with national requirements. The reporting cycle for this has been brought forward in 2022 to allow the Trust earlier identification of issues and opportunities to reduce the pay gap. This will be

supplemented by calculating the Race Pay Gap in 2023 in line with the Anti-Racism Wales plan and the Trust will also implement the policy on pay gaps in relation to Disability once the details have been issued.

All new posts are evaluated through the All Wales Job Evaluation process to counteract bias relating to preconceptions of the value of different work. Recent improvements to the recruitment process have made it easier for new staff to apply for incremental credit on appointment which will reduce disparity in starting salaries between people with a protected characteristic and those without.

2.1.3 Engage with the community

Patient feedback is gathered in VCC in relation to the provision of cancer services and to understand people's views and experience. Similarly, Donor feedback is used by WBS to refine their processes. A specific example is the work done to increase the diversity of the Bone Marrow donor panel. Approximately 2% of the Welsh Bone Marrow Donor Registry (WBMDR) panel is identified as minority ethnic and this is reflected in the blood donor panel. In recognition of this under-representation and to encourage ethnic diversity on the stem cell donor panel, the WBMDR have introduced registration for non-blood donors using mouth swabs instead of blood samples. Consequently, the service can recruit from communities not actively giving blood strengthening the ability of the WBMDR to recruit donors from all communities.

The WBMDR is actively engaging ethnic minority communities to understand the barriers to joining the stem cell donor panel. This includes the Welsh Race Forum and the National Black Asian and Minority Ethnic Transplant Alliance.

Velindre University NHS Trust uses an integrated assessment process for equality, wellbeing and socio-economic impact. This rounded approach means that all issues are raised and reviewed at the early stage of any project. For example, a recent EQIA on the inclusive design of our new VCC hospital in Cardiff examined the impact on people from a wide range of perspectives. This aims to ensure that everyone is able to participate and relax and have equal access to treatment. This would be achieved through making the building accessible from the beginning, giving clear signposting and communication and providing an on-site car parking and bus stop and future public transport links. This has the potential to reduce health inequalities

2.1.4 We communicate with people in ways that meet their needs

The Trust has implemented the Active Offer in relation to the Welsh language in VCC and WBS. Improvements have been achieved in the range of ways patients and donors can access service through the medium of Welsh.

The Trust uses the Wales Interpretation and Translation service which provides 24/7 translation support in 135 languages including BSL. Staff can access this when it will assist in

communicating with patients who do not communicate effectively in English.

2.1.5 Ensure service delivery reflects individual need.

Equality Impact Assessments are used to support any service development or change. These are comprehensive assessments covering the protected characteristics, socio-economic duty and sustainability. They are a systematic approach to ensure service delivery reflects individual needs.

In addition to Equality Impact Assessments, work has been in hand in VCC and WBS to tailor services. One specific example of this relates to lifting the ban on Gay men from blood donation in 2021.

On 14 June 2021 the UK rules around blood donation changed, allowing more people than ever before to be eligible to donate including people from the Men who have Sex with Men (MSM) community. Dr Stuart Blackmore from WBS played a leading role in the research that led to this change.

Prior to the change in donation rules we announced the changes through media releases distributed to national and local outlets, including Welsh Government and LGBT+ groups. The announcement was shared through national news outlets such as ITV, BBC and S4C. Detailed information was also provided through the WBS channels such as dedicated webpages, FAQs and social media posts.

On the day of launch a donation session was arranged featuring a gay male couple, a gay male and regular blood donor and the First Minister of Wales. ITV and BBC both filmed on the day and media releases were sent publicly, including Welsh Government, Wales247 and more. Announcements were made on the day via WBS social channels featuring quotes from the donors including the First Minister.

After the launch, the WBS continued to promote the introduction of the new rule over a 16-week period (one full cycle for donors) via SMS and social media updates. WBS' Dr Stuart Blackmore also represented the Service at a live Q&A held by Pride Cymru for the LGBT+ community. A full review was carried out to analyse the success of the campaign during National Blood Donor Week. Over 235,000 accounts were reached during the week.

As a result of this change we no longer ask donors about their sexuality, this makes it difficult to quantify the number of previously excluded individuals who have now become donors. Anecdotal feedback immediately after the change was extremely positive and continues to be so.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The work described in this report supports the organisation in its achievements of its duties under Equality legislation which benefits people across all protected characteristics
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust is required to publish its Equality Monitoring Information of 31 March 2022 by 31 March 2023.
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 **APPROVE** this report.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 1

Equality Monitoring Data Velindre University NHS Trust

(including NHS Wales Shared Services Partnership)

Employment Category	Headcount	%
Full Time	5028	77.29
Part Time	1477	22.71
Grand Total	**6505**	**100.00**

Gender	Headcount	%
Female	3920	60.26
Male	2585	39.74
Grand Total	**6505**	**100.00**

Age Band	Headcount	%
<=20 Years	23	0.35
21-25	744	11.44
26-30	1287	19.78
31-35	1241	19.08
36-40	700	10.76
41-45	549	8.44
46-50	537	8.26
51-55	554	8.52
56-60	525	8.07
61-65	266	4.09
66-70	53	0.81
>=71 Years	26	0.40
Grand Total	**6505**	**100.00**

Sexuality	Headcount	%
Bisexual	67	1.03
Gay or Lesbian	91	1.40
Heterosexual or Straight	3979	61.17
Not stated (person asked but declined to provide a response)	355	5.46
Other sexual orientation not listed	4	0.06
Undecided	1	0.02
Unspecified	2008	30.87
Grand Total	**6505**	**100.00**

Religious Belief	Headcount	%
Atheism	1116	17.16
Buddhism	45	0.69
Christianity	2064	31.73

Staff Group	Headcount	%
Add Prof Scientific and Technic	79	1.21
Additional Clinical Services	403	6.20
Administrative and Clerical	2181	33.53
Allied Health Professionals	153	2.35
Estates and Ancillary	605	9.30
Healthcare Scientists	165	2.54
Medical and Dental	2675	41.12
Nursing and Midwifery Registered	241	3.70
Students	3	0.05
Grand Total	**6505**	**100.00**

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	2713	2315	5028
Part Time	1207	270	1477
Grand Total	**3920**	**2585**	**6505**

Pay Grade By Gender	Female	Male	Total
Band 1	1	1	2
Band 2	303	422	725
Band 3	486	233	719
Band 4	414	158	572
Band 5	369	153	522
Band 6	334	137	471
Band 7	267	120	387
Band 8 - Range A	114	62	176

Hinduism	97	1.49
I do not wish to disclose my religion/belief	661	10.16
Islam	342	5.26
Judaism	4	0.06
Other	393	6.04
Sikhism	15	0.00
Unspecified	1768	27.18
Grand Total	**6505**	**100.00**

Ethnic Origin	Headcount	%
Asian	446	6.86
Black	146	2.24
Chinese	31	0.48
Mixed	89	1.37
Not Stated or Unspecified	1491	22.92
Other	48	0.74
White	4254	65.40
Grand Total	**6505**	**100.00**

Disability	Headcount	%
No	5056	77.72
Not Declared	246	3.78
Prefer Not To Answer	5	0.08
Unspecified	1035	15.91
Yes	163	2.51
Grand Total	**6505**	**100.00**

Marital Status	Headcount	%

Band 8 - Range B	65	42	107
Band 8 - Range C	32	34	66
Band 8 - Range D	12	17	29
Band 9	5	10	15
Consultant	51	42	93
Other	23	21	44
Specialty Doctor	8	5	13
Trainee Doctor	1436	1128	2564
Grand Total	**3920**	**2585**	**6505**

Civil Partnership	72	1.11
Divorced	231	3.55
Legally Separated	30	0.46
Married	2294	35.27
Single	1762	27.09
Unknown	1389	21.35
Widowed	28	0.43
(blank)	699	10.75
Grand Total	**6505**	**100.00**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	54	25	79
Additional Clinical Services	291	112	403
Administrative and Clerical	1475	706	2181
Allied Health Professionals	129	24	153
Estates and Ancillary	146	459	605
Healthcare Scientists	100	65	165
Medical and Dental	1499	1176	2675
Nursing and Midwifery Registered	223	18	241
Students	3	0	3
Grand Total	**3920**	**2585.00**	**6505**

On Maternity	Headcount	%
Yes	160	2.46
No	6345	97.54
Grand Total	**6505**	**100.00**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	1731	1381	3112
Permanent	2189	1204	3393
Grand Total	**3920**	**2585.00**	**6505**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Appendix 2

Equality Monitoring Data Velindre University NHS Trust

(excluding NHS Wales Shared Services)

Employment Category	Headcount	%
Full Time	1045	64.79
Part Time	568	35.21
Grand Total	**1613**	**100.00**

Gender	Headcount	%
Female	1207	74.83
Male	406	25.17
Grand Total	**1613**	**100.00**

Age Band	Headcount	%
<=20 Years	5	0.31
21-25	106	6.57
26-30	162	10.04
31-35	221	13.70
36-40	175	10.85
41-45	184	11.41
46-50	208	12.90
51-55	217	13.45
56-60	216	13.39
61-65	96	5.95
66-70	15	0.93
>=71 Years	8	0.50
Grand Total	**1613**	**100.00**

Sexuality	Headcount	%
Bisexual	18	1.12
Gay or Lesbian	30	1.86
Heterosexual or Straight	1212	75.14
Not stated (person asked but declined to provide a response)	98	6.08
Other sexual orientation not listed	2	0.12
Undecided	1	0.06
Unspecified	252	15.62
Grand Total	**1613**	**100.00**

Staff Group	Headcount	%
Add Prof Scientific and Technic	54	3.35
Additional Clinical Services	275	17.05

Religious Belief	Headcount	%
Atheism	322	19.96
Buddhism	4	0.25
Christianity	650	40.30
Hinduism	7	0.43
I do not wish to disclose my religion/belief	224	13.89
Islam	21	1.30
Judaism	1	0.06

Administrative and Clerical	567	35.15
Allied Health Professionals	152	9.42
Estates and Ancillary	76	4.71
Healthcare Scientists	165	10.23
Medical and Dental	83	5.15
Nursing and Midwifery Registered	238	14.76
Students	3	0.19
Grand Total	**1613**	**100.00**

Employment Category By Gender	Headcount Female	Headcount Male	Grand Total
Full Time	703	342	1045
Part Time	504	64	568
Grand Total	**1207**	**406**	**1613**

Pay Grade By Gender	Female	Male	Total
Band 1	0	0	0
Band 2	157	46	203
Band 3	152	42	194
Band 4	157	38	195
Band 5	190	53	243
Band 6	206	68	274
Band 7	173	52	225
Band 8 - Range A	65	30	95
Band 8 - Range B	26	19	45
Band 8 - Range C	11	8	19
Band 8 - Range D	6	8	14
Band 9	3	3	6

Other	132	8.18
Sikhism	0	0.00
Unspecified	252	15.62
Grand Total	**1613**	**100.00**

Ethnic Origin	Headcount	%
Asian	43	2.67
Black	10	0.62
Chinese	7	0.43
Mixed	19	1.18
Not Stated or Unspecified	150	9.30
Other	4	0.25
White	1380	85.55
Grand Total	**1613**	**100.00**

Disability	Headcount	%
No	1228	76.13
Not Declared	57	3.53
Prefer Not To Answer	4	0.25
Unspecified	274	16.99
Yes	50	3.10
Grand Total	**1613**	**100.00**

Marital Status	Headcount	%
Civil Partnership	27	1.67
Divorced	105	6.51
Legally Separated	10	0.62
Married	824	51.08

Consultant	37	25	62	Single	484	30.01
Other	12	8	20	Unknown	77	4.77
Specialty Doctor	8	5	13	Widowed	11	0.68
Trainee Doctor	4	1	5	(blank)	75	4.65
Grand Total	**1207**	**406**	**1613**	**Grand Total**	**1613**	**100.00**

Profession by Gender	Female	Male	Total
Add Prof Scientific and Technic	39	15	54
Additional Clinical Services	208	67	275
Administrative and Clerical	417	150	567
Allied Health Professionals	128	24	152
Estates and Ancillary	38	38	76
Healthcare Scientists	100	65	165
Medical and Dental	52	31	83
Nursing and Midwifery Registered	222	16	238
Students	3		3
Grand Total	**1207**	**406**	**1613**

On Maternity	Headcount	%
Yes	46	2.85
No	1567	97.15
Grand Total	**1613**	**100.00**

Contract Type by Gender	Female	Male	Total
Fixed Term Temp	109	53	162
Permanent	1098	353	1451
Grand Total	**1207**	**406**	**1613**

Trust Board

Gender Pay Gap Report 2022

DATE OF MEETING	31 January 2022
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Claire Budgen: Head of Organisational Development,
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce
REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	5.12.22	ENDORSED FOR APPROVAL
QSP	17.1.23	ENDORSED FOR APPROVAL

ACRONYMS

1. SITUATION/BACKGROUND

1.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 apply to a list of 'specified public authorities' in relation to the publication of their gender pay gap data, which came into force on 31 March 2017. These regulations underpin the Public-Sector Equality Duty and require relevant organisations to publish their gender pay gap by 30 March each year. This includes the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile.

1.2 It is important for the Trust to analyse its pay data, to gain an understanding of any gaps, what this means for its workforce and as appropriate, use this information and data to develop an action plan that will respond to bridging any identified gender pay gaps.

1.3 The analysis of pay data as of 30 March 2022 was conducted earlier in the year than usual to allow the Trust to understand its current situation before developing the actions included in this report. The deadline for reporting these figures remains 30 March 2023.

1.4 The report attached therefore provides the Executive Management Board with the information to endorse for Board Approval the publication of the Trust Annual Gender Pay Gap Report.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The attached report provides data and narrative of activities for the mean and median gender pay gaps; the mean and median gender bonus gaps; the proportion of men and women who received bonuses; and the proportions of male and female employees in each pay quartile to ensure the Trust meets its legal requirements.

2.2 The report shows information of the summary of statistics below that are being detailed in the Gender Pay Gap Report.

The **Mean Gender Pay Gap** is £0.88 an hour. Women are paid 4% less than men. The mean average hourly rate is £19.83 for women and £20.72 for men.	The **Median Gender Pay Gap** is £0.44 an hour. Women are paid 2% less than men. The median average hourly rate is £17.94 for women and £18.38 for men.	Men's mean bonus payment is £3,113 more than women's, a **Mean Bonus Pay Gap** of 43%
		Men's median bonus payment is £307 more than women's, a **Median Bonus Pay Gap** of 9%

2.3 This report also analyses the situation for Velindre core services, when NHS Shared Services Partnership data is excluded. This level of detail has shown a different picture than that for the legal entity as a whole. In particular:

- The Mean Gender Pay Gap is 14%, not 4%. This is shown in context of Welsh Health Boards who have reported Gender Pay Gaps of 21%, 28% and 32% over the past two years.
- The Mean Bonus Gap is 47%, not 43%. However, the Median Bonus Gap falls from 9% for the combined figure to -7% for Velindre only, which means when looking at the median of bonus payments made to all staff, women are paid more than men. Thirty-four staff received a bonus in 2021-22, 20 women and 14 men, all within the Medical staff group.
- There is variation in the Gender Pay Gap depending on Staff Group. There is a gap for Medical and Dental of 3.2%, Estates and Ancillary of 4.5% and Nursing and Midwifery of 5.3%, all of which should be addressed. However, the key determinant of the 14% Gender Pay Gap is the 26.2% Gender Pay Gap for Administrative and Clerical where male staff are disproportionately represented in the higher pay bands.

2.4 Five actions were agreed in March 2022 linked to the previous Gender Pay Gap report. Progress with these actions over the past three months is listed below.

Actions set in March 2022	**Progress as at November 2022**
Pursue the Strategic Equality Objectives including eliminating pay gaps by 2024	All actions below support the elimination of gender pay gaps by 2024. This will be supplemented by consideration of the pay

	gaps for other groups, such as the Race Pay Gap, during 2022-23.
Undertake a programme of work offering opportunities for women to develop their leadership skills, build career aspirations and take on more senior roles. There will be a particular focus on female Medical staff in light of the bonus pay implication of the Clinical Excellence Award scheme.	Two delegates completed the HEIW Talent Management Practitioner programme to allow the Trust to move forward with building career pathways to more senior roles, including supporting under-represented groups such as women. This work is being led by the Executive Director of OD and Workforce and will benefit from the sponsorship from the Executive Ambassador for Gender. Nationally, the Clinical Excellence Award Scheme has been changed to the National Clinical Impact Award Scheme specifically to counteract the Gender Pay Gap that resulted from the previous scheme.
Improve recruitment processes and to ensure gender-sensitive language in adverts, gender-blind shortlisting and decision making and unconscious bias training for recruiting managers. Ensure all new staff understand how and when to apply for incremental credit on appointments.	The Attraction, Reward and Recognition project has been initiated to improve our approach to attracting and retaining talent. This includes reducing bias and promoting inclusivity. The process for applying for incremental credit on appointment has been revised and is now an integral part of the recruitment process.
To promote inclusive language when working externally in schools, colleges and within education and development training inside our organisation. To keep raising awareness and continue creating a culture of inclusivity.	The Trust has a Widening Access Coordinator who works with schools and colleges to improve access to NHS jobs and careers. The Inspire Leadership Development programme includes a module on Equality, Diversity and Inclusion which is supporting the development of an inclusive culture.
Supporting all staff equally in developing, through leadership, coaching and mentoring.	Leadership is one element within the Building our Future Together portfolio. During 2022-23 the Trust will be building resources for staff to access leadership development, coaching and mentoring. This will allow women, or other people who are currently underrepresented at more senior levels, to progress their professional development and their careers.

2.5 The actions for 2022-23 have been refined, taking into account the findings from the Gender Pay Gap as at March 2022 and these fall into six areas:

1. **Listening to women.** We will offer options for staff, male and female, to share their experiences and ideas relating to improving gender equality in the workplace. This will include options such as setting up an internal Gender Equality Network, joining other external Equality Networks and/or the introduction of Allyship in support of women.

2. **Implementing our Education Strategy in an equal and fair way**, supporting all staff in their personal and professional development. During the year we will develop a Talent Management approach based on principles of inclusion. This will be demonstrated through the range of leadership development and coaching and mentoring opportunities that are taken up by women and men. This will be offered in a way that does not unintentionally exclude any groups of staff, including on basis of gender or race. The allocation of funding for Study Leave will be reviewed to ensure fairness across the Trust.

3. **Utilising our development projects such as nVCC to create development opportunities for people at all levels of the organisation.** Where necessary, additional encouragement will be offered to offset any gender disparity in uptake. Project roles and responsibilities will be offered as development opportunities to existing staff, either as a secondment or as an addition to their current role.

4. **To deliver an Attraction, Recruitment and Retention project** to achieve effective and inclusive approaches to bringing people into our organisation and encouraging them to remain with us. This includes improving the recruitment processes to ensure that we use gender-sensitive language in adverts and use gender-neutral pronouns and clean language to prevent us from potentially putting women off from applying for positions. This will include highlighting all Agile working and family-friendly benefits and ensuring all new staff understand how and when they can apply for incremental credit on appointment. This will benefit all genders of applicants and offer an environment for more women to put themselves forward for employment.

5. **To promote inclusive language within education and development training inside our organisation, to keep raising awareness and continue to develop a culture of inclusivity**. Develop and deliver unconscious bias training that can firstly be delivered to managers so they can role model expected behaviours creating a peer-learning environment that models the values of the organisation.

6. **Monitoring of engagement with initiatives by gender.** The proportion of male and female staff taking up education programmes and development opportunities will be monitored to highlight if positive action is required. Analysis of recruitment will show whether job applications receive equal outcomes for men and women, from application, shortlisting and appointment.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The work described in the response to the gender pay gap analysis will benefit people on the basis of gender and also other protected characteristics
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal requirement to publish by 30 March 2023
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 **APPROVE** the report.

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

GENDER PAY GAP

2022 REPORT

FORWARD

Velindre University NHS Trust aims to ensure that people are treated fairly and equally at work. Our focus ensures that staff has the same access and opportunities to reward, recognition, and career development.

The Trust believes that it is important to analyse its pay data, to gain an understanding of any gaps, what this means for our workforce, and as appropriate, to use this information and data to develop an action plan that will respond to any identified gender pay gaps.

WHAT IS THE GENDER PAY GAP

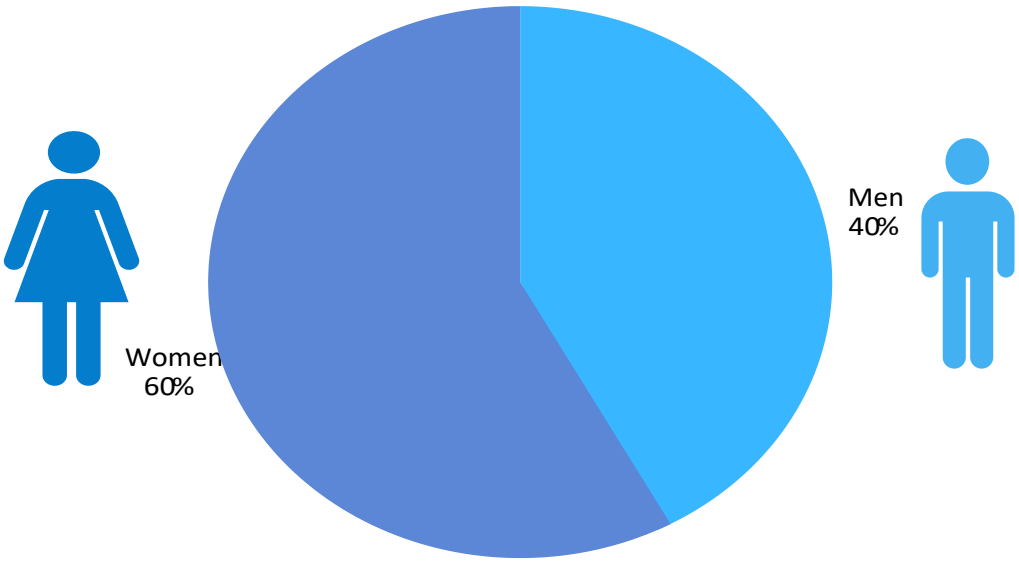
The gender pay gap shows the difference between the average (mean or median) earnings of male and female employees. It should be noted that gender pay gap analysis differs from that of equal pay issues, which deal with the pay differences between male and female employees who carry out the same jobs, or similar jobs, or work of equal value. It is unlawful to pay employees unequally because of their gender.

When gender pay reporting is used to its full potential, it provides a valuable tool to assist an organisation to assess levels of equality in the workplace, male and female participation, and how effectively talent is being maximised. A high gender pay gap can be an indication that there may be a number of issues that the organisation may need to deal with as a matter of priority. The individual gender pay calculations may help the organisation to identify what those issues are.

This document reports pay data on 31 March 2022. It represents Velindre University NHS Trust as a legal entity that also includes hosted organisations, NHS Wales Shared Services Partnership and Health Technology Wales. To better understand our pay gap, we have drilled down to some of the Divisions within the organisation and created actions to address issues which were not evident in the data for the composite organisation.

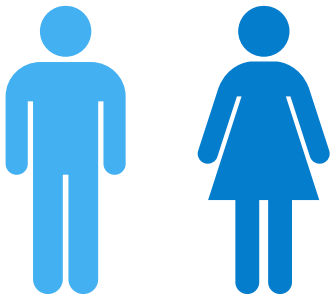
OUR GENDER PAY PROFILE 2022

On 31 March 2022 VUNHST employed 6,420 people, 40% male 60% female.



Mean and Median Pay

The **Mean Gender Pay Gap** is £0.88 an hour. Women are paid 4% less than men. The mean average hourly rate is £19.83 for women and £20.72 for men.



The **Median Gender Pay Gap** is £0.44 an hour. Women are paid 2% less than men. The median average hourly rate is £17.94 for women and £18.38 for men.

Bonus Pay

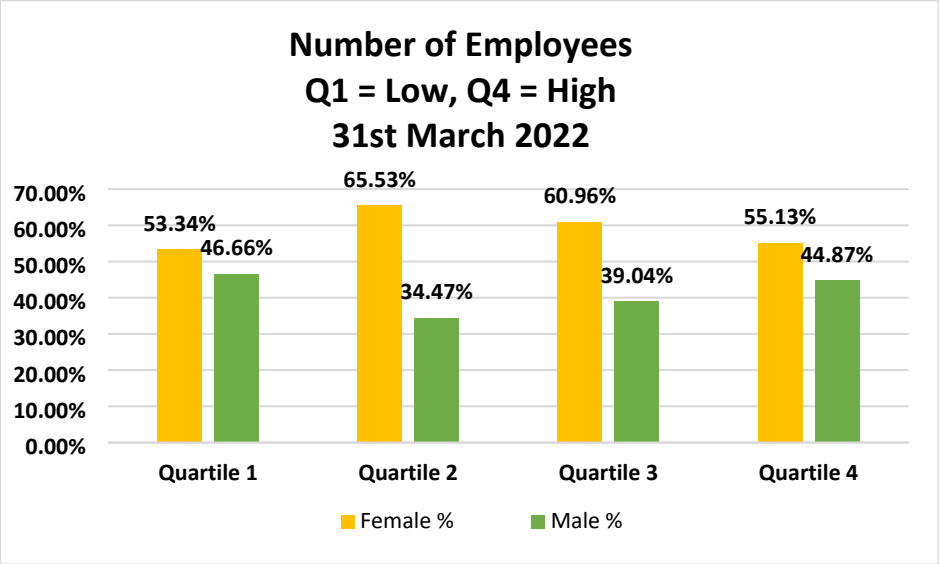
0.93% of men receive a bonus
1.53% of women receive a bonus

Men's mean bonus payment is £3,113 more than women's, a **Mean Bonus Pay Gap** of 43%

Men's median bonus payment is £307 more than women's, a **Median Bonus Pay Gap** of 9%

Quartile Range

When dividing the female workforce and the male workforce into four equal parts, men's pay and women's pay show different patterns with women being clustered in the middle quartiles and men more concentrated in the lowest and highest quartiles.

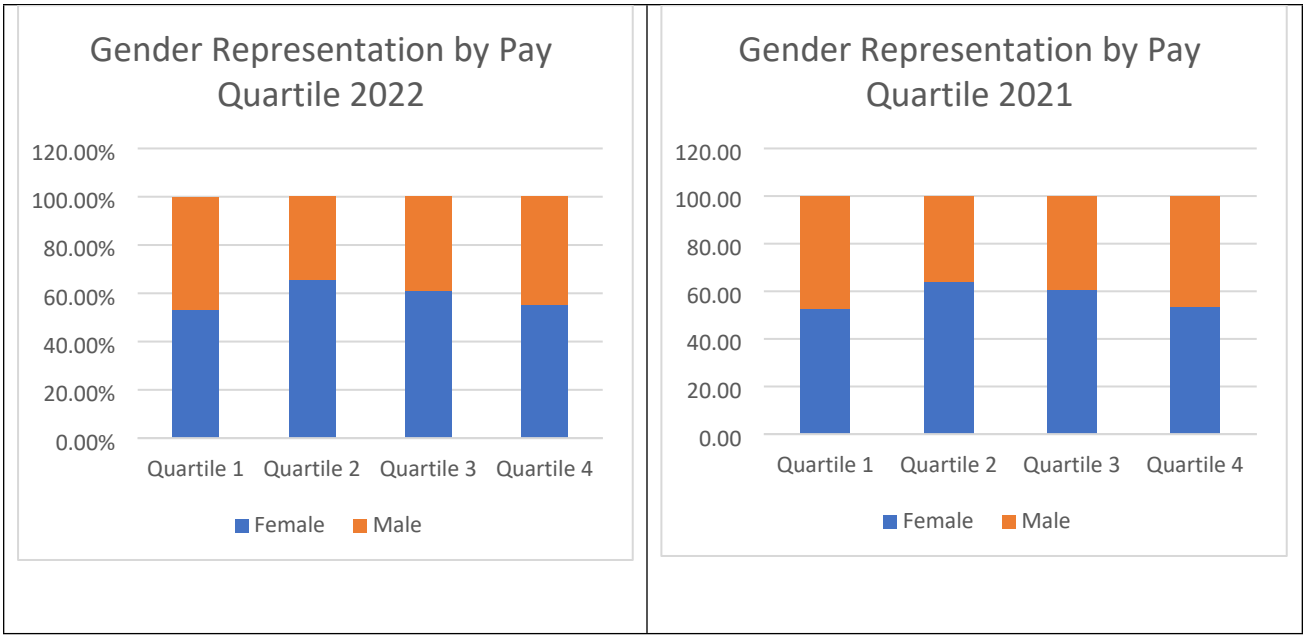


MOVEMENT BETWEEN 2021 AND 2022

The Mean Gender Pay Gap has stayed the same, at 4%. However, the Median Gap has decreased from 7% in 2021 to 2% in 2022.

The Mean Bonus Gap stayed the same at 43% whereas the Median Bonus Gap decreased from 22% to 9%.

The spread between the Quartiles for each gender is also very similar between 2021 and 2022 where we see Women clustered in Quartile 2 and 3 and Men tending to fall more towards either Quartile 1 or 4.



LOOKING BENEATH THE ORGANISATIONAL LEVEL DATA

The above report is based on the legal entity of 6,420 employees, 76% of whom work for NHS Wales Shared Services Partnership. If these people are taken out of the analysis, there are 1,567 employees in Velindre Cancer Centre, Welsh Blood Service and Corporate and other functions.

These 1,567 employees are spread between two Divisions and a combination of Corporate and other functions, as follows:

	Women	Men	Percentage Women	Percentage Men	Total Employees
Velindre Cancer Centre	595	176	77%	23%	771
Welsh Blood Service	315	116	73%	27%	431
Corporate and Other Functions	253	112	69%	30%	365
TOTAL	1,163	404	**74%**	**26%**	**1,567**

This shows that all three groupings are female dominated, with 77% of the Velindre Cancer Centre workforce, 73% of Welsh Blood Service and 69% of Corporate staff being Female.

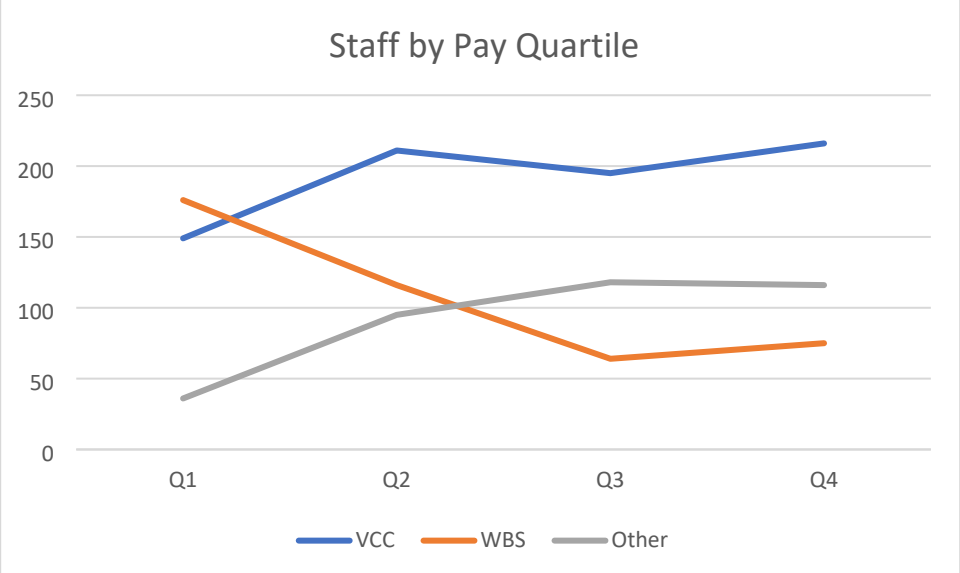
Similarly, all staff groups are predominantly Female, however this becomes particularly pronounced with Allied Health Professionals and Nursing and Midwifery. The Staff Groups are ranked in order of gender diversity below.

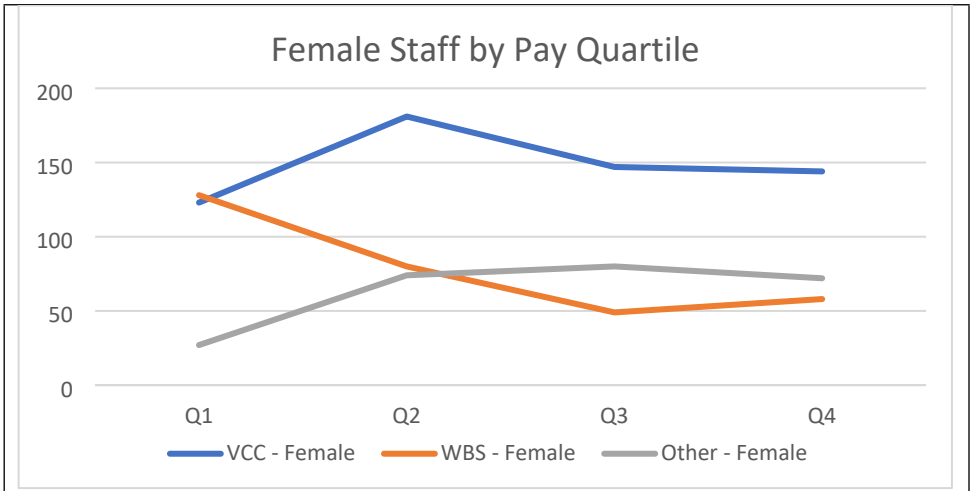
Staff Group	Female to Male Ratio
Estates and Ancillary	53:47
Medical and Dental	58:42
Healthcare Scientists	59:41
Additional Professional, Scientific and Technical	71:29
Administrative and Clerical	75:25
Allied Health Professions	82:18
Nursing and Midwifery	93:7

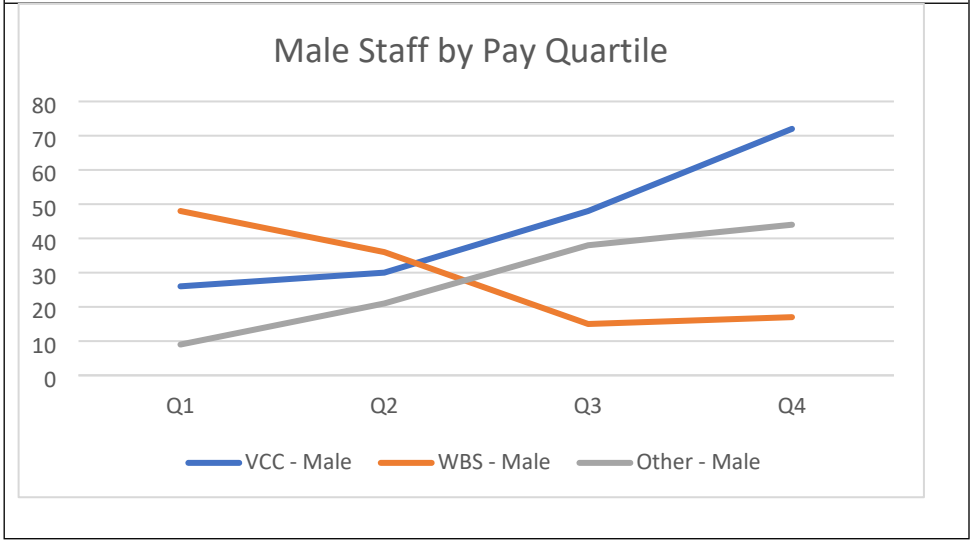
The key statistics for Gender Pay Gap reporting are shown below. This shows a marked difference between the Trust position as a whole and that for Velindre. The Mean Gender Pay Gap increases from 4% to 14% and the Median Bonus Gap changes from 9% to -7% (meaning Women are paid more than Men).

	2022	2022	2022
	Velindre	NWSSP	Combined
Mean Gap	£2.95 an hour	3p an hour	88p an hour
Mean Gap	14%	<1%	4%
Median Gap	65p an hour	0	44p an hour
Median Gap	4%	0	2%
Mean Bonus Gap	£6,648	£813	£3,113
Mean Bonus Gap	47%	25%	43%
Median Bonus Gap	-£434	£1,319	£307
Median Bonus Gap	-7%	37%	9%

When looking into the detail of the spread of pay for all employees we see a difference between Welsh Blood Service and Velindre Cancer Centre and Corporate/Other functions with a higher proportion of staff being with Quartile 1. This difference is not linked to gender, as the graphs below show a similar line for Female and Male staff in Welsh Blood Service.


Staff by Pay Quartile
250
200
150
100
50
0
Q1
Q2
Q3
Q4
VCC
WBS
Other


Female Staff by Pay Quartile
200
150
100
50
0
Q1
Q2
Q3
Q4
VCC - Female
WBS - Female
Other - Female


Male Staff by Pay Quartile
80
70
60
50
40
30
20
10
0
Q1
Q2
Q3
Q4
VCC - Male
WBS - Male
Other - Male

However, what is clear from these graphs is that there is a peak in Females in Velindre Cancer Centre in Pay Quartile 2, which is feeding into the overall pay structure within the Gender Pay Gap analysis.

CONCLUSIONS

- There has been very little change in our headline figures between 2021 and 2022. The Mean Gender Pay Gap stayed at 4% overall with a Mean Bonus Gap remaining at 43%. The Median figures have improved with the Median Pay Gap falling from 7% to 2% and the Median Bonus Gap going from 22% to 9% in the year. However, the gender split in the workforce has become slightly more polarised, going from 58% women in 2021 to 60% women in 2022. This reflects the picture for Velindre University NHS Trust, including NHS Wales Shared Services Partnership.

- When we drill down, we see that although the Mean Pay Gap for the Velindre University NHS Trust is 4%, when Shared Services are discounted it changes to 14%. This shows that specific actions are need in the clinical and corporate areas of the Trust.

- The Bonus Pay Gap reflects a small number of payments which tends to produce larger percentages. Despite there being an overall pay gap for the Trust, there is actually a negative Median Bonus Pay Gap in Velindre meaning that Women's median bonus payment is £434 higher than men's.

- All staff groups are female dominated and this is markedly so in Allied Health Professionals and Nursing and Midwifery. This does not necessarily cause a gender pay gap – it would depend on salaries earned being comparable to those in other staff groups. However, a more even gender balance would be desirable to create more diverse and inclusive teams and help reduce career-based gender stereotypes.

- Welsh Blood Service shows a different spread of people within the four Pay Quartiles, with an over-representation in Quartile 1 and a low representation in Quartiles 3 and 4 but this does not affect either gender specifically. Initiatives to improve career progression within the Welsh Blood Service can improve this trajectory so that the service has a more even distribution of pay.

- When comparing pay for men and women the key issue seen is a disproportionate representation of Women from Velindre Cancer Centre in Pay Quartile 2. This covers hourly salaries between £11.53 an hour and £16.18 an hour (base pay plus enhancements paid during the period) and includes people from all staff groups.

ACTIONS MOVING FORWARD FOR 2022 - 2023

The Trust is committed to its Strategic Equality Objectives including eliminating pay gaps by 2024. The action to achieve this over the next period are:

1. **Listening to women.** We will offer options for staff, male and female, to share their experiences and ideas relating to improving gender equality in the workplace. This will include options such as setting up an internal Gender Equality Network, joining other external Equality Networks and/or the introduction of Allyship in support of women.

2. **Implementing our Education Strategy in an equal and fair way**, supporting all staff in their personal and professional development. During the year we will develop a Talent Management approach based on principles of inclusion. This will be demonstrated through the range of leadership development and coaching and mentoring opportunities that are taken up by women and men. This will be offered in a way that does not unintentionally exclude any groups of staff, including on basis of gender or race. The allocation of funding for Study Leave will be reviewed to ensure fairness across the Trust.

3. **Utilising our development projects such as nVCC to create development opportunities for people at all levels of the organisation.** Where necessary, additional encouragement will be offered to offset any gender disparity in uptake. Project roles and responsibilities will be offered as development opportunities to existing staff, either as a secondment or as an addition to their current role.

4. **To deliver an Attraction, Recruitment and Retention project** to achieve effective and inclusive approaches to bringing people into our organisation and encouraging them to remain with us. This includes improving the recruitment processes to ensure that we use gender-sensitive language in adverts and use gender-neutral pronouns and clean language to prevent us from potentially putting women off from applying for positions. This will include highlighting all Agile working and family-friendly benefits and ensuring all new staff understand how and when they can apply for incremental credit on appointment. This will benefit all genders of applicants and offer an environment for more women to put themselves forward for employment.

5. **To promote inclusive language within education and development training inside our organisation, to keep raising awareness and continue to develop a culture of inclusivity.** Develop and deliver unconscious bias training that can firstly be delivered to managers so they can role model expected behaviours creating a peer-learning environment that models the values of the organisation.

6. **Monitoring of engagement with initiatives by gender.** The proportion of male and female staff taking up education programmes and development opportunities will be monitored to highlight if positive action is required. Analysis of recruitment will

show whether job applications receive equal outcomes for men and women, from application, shortlisting and appointment.

Gender
Velindre University NHS Trust

Catherine O'Brien, Chief Operating Officer

Executive Ambassador for Sex (Gender)

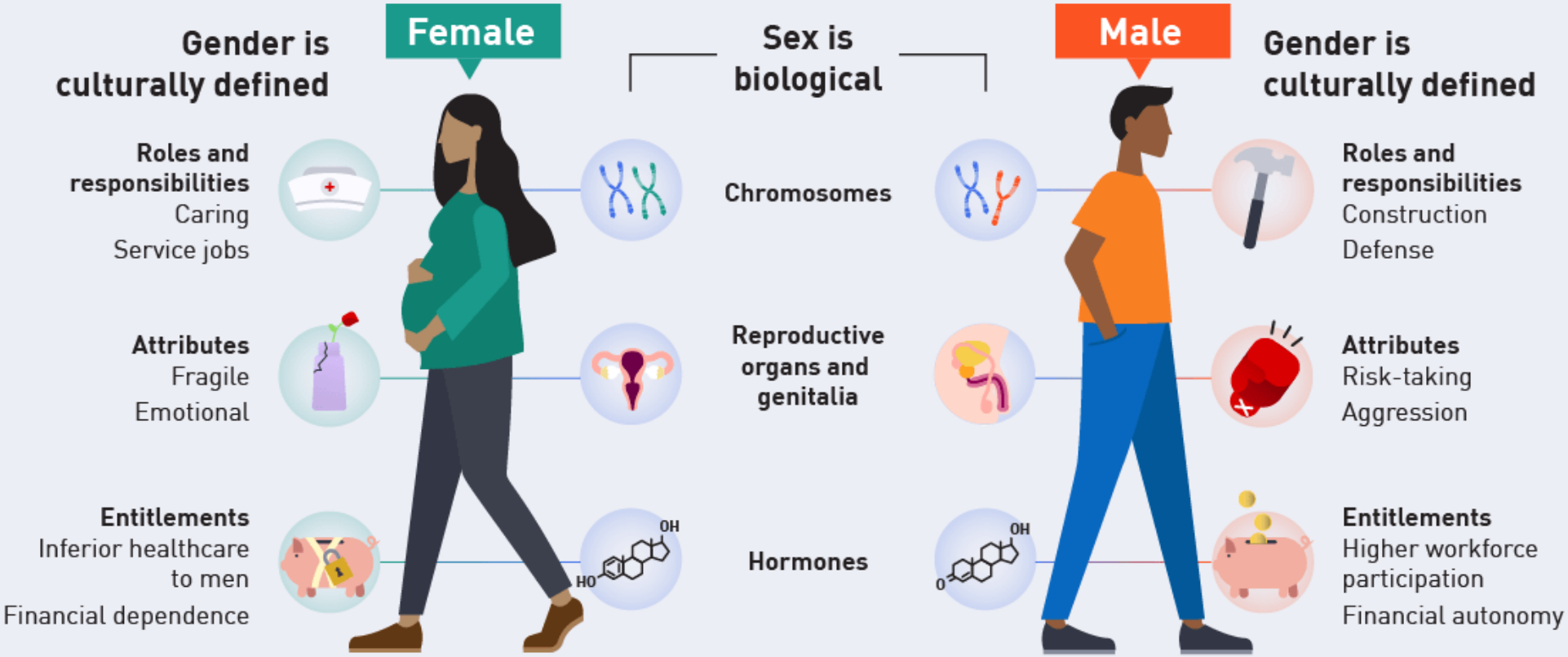
Definition

Sex- often related to biology is protected characteristic - in every-day language use the term Gender.

Gender *refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time.* -World Health Organisation

Where someone falls on the spectrum of gender identity is not automatically connected to their expression, sexuality, or assigned sex at birth.

Sex vs Gender



THE LANCET

Source: Lancet Series on Gender Equality, Norms and Health. Paper 1, 2019

Legal Obligation

- The **Sex Discrimination Act 1975** (c. 65) was an Act of the Parliament of the United Kingdom which protected men and women from discrimination on the grounds of sex or marital status. The Act concerned employment, training, education, harassment, the provision of goods and services, and the disposal of premises.
- **The Equality Act 2010 – replaced SDA -** legally protects people from discrimination in the workplace and in wider society.

Public Sector Equality Duty (April 2011)

- Public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.
- Due regard to the need to:
  - eliminate discrimination
  - advance equality of opportunity
  - foster good relations between different people when carrying out their activities

Gender matters because…

European Institute for Gender Equality

In reality, also men benefit from gender equality as they too face gender-specific issues such as lower life expectancy, bad health, lower education levels and rigid gender norms. It is essential that both women and men are aware of the benefits that gender equality brings to them as individuals and as members of communities and societies.

Gender matters because…

- Social construct - influence how you engage in healthcare
- It can affect how much you earn over your lifetime
- Biology (gender) can influence your response to standard medical interventions
- It can shape what is expected of you in life
- It can be used as a reason for discrimination against you (conscious and unconscious)

My experience – prejudice and learning!!

What does that mean for VUNHST policy, staff & services ?

What part does gender play in how we operate?

What part does gender play in how we engage with patients and donors and the care they receive ? …..(not only what we offer !)

Do we know? Is it hard wired into how what we are and how we do it ?

VUNHST Demographic Profile
31 March 2022

	Women	Men	Percentage Women	Percentage Men	Total Employee
Velindre Cancer Centre	595	176	77%	23%	771
Welsh Blood Service	315	116	73%	27%	431
Corporate and Other Functions	253	112	69%	30%	365
TOTAL	**1,163**	**404**	**74%**	**26%**	**1,567**

Gender Pay Gap

Trust – including hosted organisations
Under 4% in 2020 and 2021 and falling this year

Trust – excluding hosted organisations
Over 10% in 2021 and rising to **14%** this year

For comparison, the Gender Pay Gap in Health Boards can be up as far as 30%

Action

Women's Voice

Leverage key projects to offer development opportunities- service development, service improvement

Menopause Café

Monitoring how women and men progress

Equal uptake of educational opportunities

First class recruitment

Pay attention to language – watch out for unconscious bias

Patient care and outcomes – social or biological?

“Gender disparities in clinical practice: are there any solutions? Scoping review of interventions to overcome or reduce gender bias in clinical practice”

"Comparing rate of immunotherapy treatment change due to toxicity by gender."

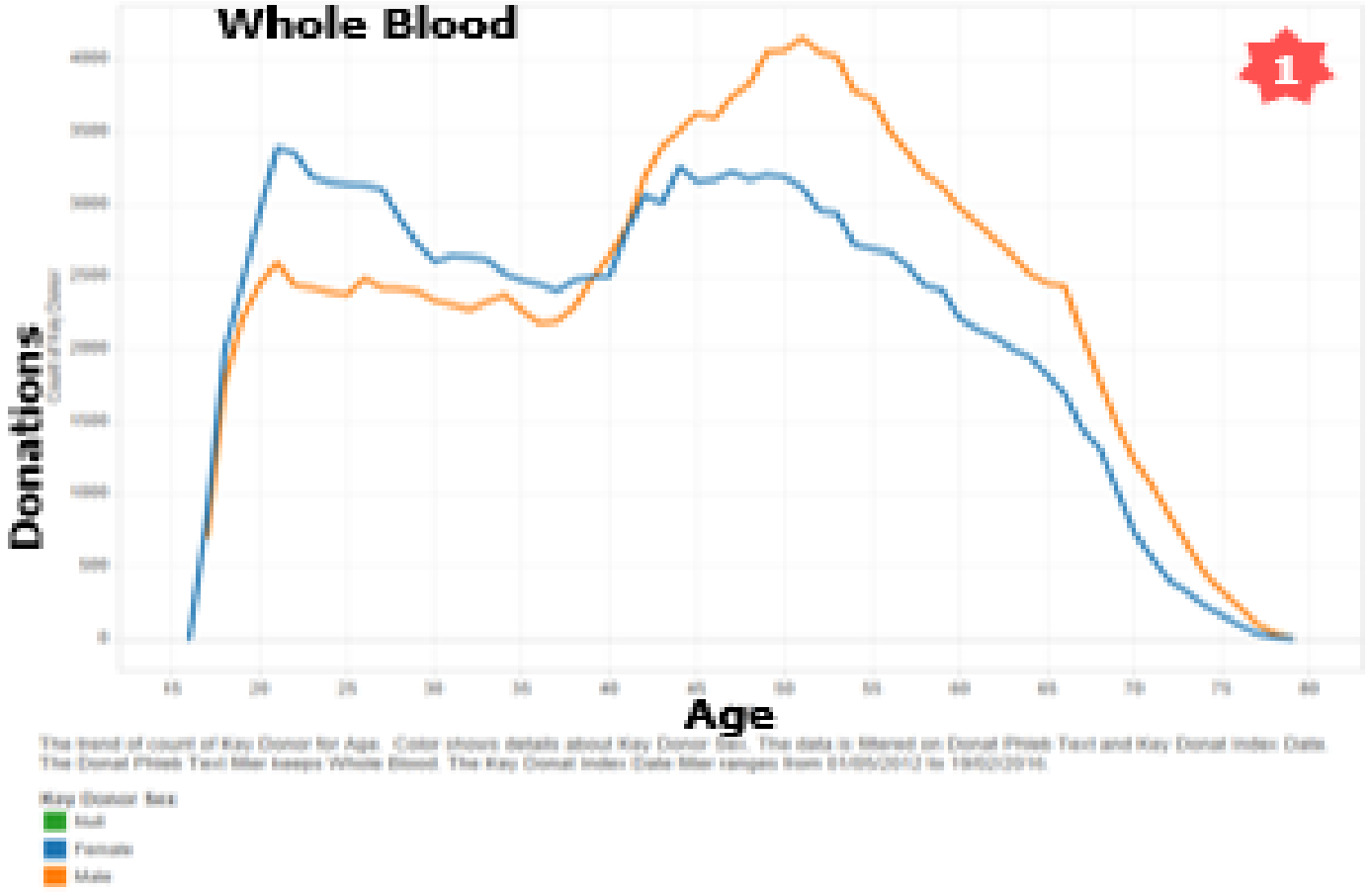
"Men receive more end-of-life cancer hospital treatment than women: fact or fiction?"

“The effect of gender on outcomes in esophageal cancer."

"Gender disparities in clinical presentation, treatment, and outcomes in metastatic spine disease."

Patient expectation and preference or our service pathways and models?

Donor Lifecycle



Next steps

- Learning from others
  - Equalities Leaders Group in NHS Wales
  - Chwarae Teg Gender Equality Charity
- Incorporating evidence into our developments (nVCC, Blood Service Modernisation)

  Patient Engagement Framework (Experience, Involvement, Information)

  Donor engagenment (in development)
- Review and assurance
  - Lived experience – patient, donor and staff stories at Board and Committee meetings, surveys and dialogue
  - Data and benchmarking
  - EQIA

TRUST BOARD

VUNHST INTERNAL ANNUAL SUSTAINABILITY REPORT

DATE OF MEETING	31/01/2023

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Rhiannon Freshney, Environmental Development Officer
PRESENTED BY	Rhiannon Freshney, Environmental Development Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EXECUTIVE MANAGEMENT BOARD	26/10/2022	ENDORSED
QUALITY, SAFETY AND PERFORMANCE COMMITTEE	17/01/2023	ENDORSED

ACRONYMS	
EMS	Environmental Management System

1. SITUATION/BACKGROUND

1.1 The attached report provides a summary of the Sustainability works from April 2021 – March 2022 within the Sustainability Team.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The purpose of the annual report is to provide an overview of the progress against key performance indicators, service improvement initiatives and approved relevant documentation throughout the year.

2.2 Throughout the year there has been significant progress in sustainability, both operationally and strategically. A few key achievements are highlighted in the report -

ISO14001:2015 – Recertification

Following a five day re-certification, the Trust successfully maintained the ISO14001:2015 Environmental Management System, with no non conformities identified.

Trust Travel Plan

A new Trust Travel Plan has been developed to inform and enact change in the everyday lives of our staff, in and outside the workplace. The plan will be in place from 2022-2027.

Green Social Prescribing

A new, free service has been introduced for anyone affected by cancer. The weekly sessions connect attendees with nature and embed the principles of the circular economy by using found and natural materials.

Industrial Placement Student

A first in NHS Wales, the Trust launched an Industrial Placement scheme, employing a Sustainability Placement student. The student working within the

Sustainability team and worked closely with the Transforming Cancer Services team.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with Environment (Wales) Act 2016 Contribution to Well-being of Future Generations (Wales) Act 2015
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 are asked to **APPROVE** the Internal Annual Sustainability Report 2021-2022.

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre

Velindre University NHS Trust

SUSTAINABILITY ANNUAL REPORT

2021 - 22

TABLE OF CONTENTS

INTRODUCTION

Human activity has caused rapid and widespread changes to Earth's systems, driven by increased concentrations of greenhouse gases. The NHS is responsible for 2.6% of the total carbon footprint in Wales. It has fallen behind other sectors when it comes to response and reducing environmental impact, when these responses are more important than ever.

At COP26, it was agreed we as global citizens must now move forward together and deliver on the expectations set out in the Glasgow Climate Pact. It is up to all of us to sustain our model of keeping 1.5 degrees within reach and to continue our efforts to get finance flowing and boost adaptation.

The consumption of resources is necessary for the provision of healthcare services and to provide a comfortable environment for patients, donors, staff and visitors. We also have a responsibility to be transition to a new, sustainable world which minimises the use of resources and creates wider value. The last two years have posed unprecedented challenges for the Trust and NHS Wales, which has had a significant impact on our consumption, most notably use of single use items such as masks.

Despite this, the Trust has continued to be ambitious with our sustainability aims. We have developed strategic & operational goals and initiatives to ensure we are mitigating our impact and consumption to ensure we act today, for a more sustainable tomorrow.

SUSTAINABILITY STRATEGY

The Trust has created a suite of enabling strategies to outline the future of the organisation. This includes a Sustainability Strategy, which embeds the Well-being of Future Generations Act at its core. The strategy outlines our sustainability aims and enables real action to create positive and significant change.

To align with the NHS Wales Decarbonisation Plan, we have used 2018/2019 as our baseline data which we will monitor our progress against.

Our Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. This is an exciting challenge for us which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity of across the country.

To develop the Trust Sustainability Strategy we have engaged with our staff, aligned with key legislation, and benchmarked against other NHS and private organisations. The strategy creates a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patients and carers. This will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

SUSTAINABILITY STRATEGY

To achieve this vision, we set out what we want to achieve together with ten themes which we will focus on to deliver our ambitions. These are driven by the United Nations Sustainable Development Goals and the Well-Being of Future Generations Act, which together ensure we achieve the our Trust Well-being Objectives.

Theme 1: Creating Wider Value: Our Organisational Approach

Theme 2: Sustainable Care Models

Theme 3: Eliminating Carbon

Theme 4: Sustainable Infrastructure

Theme 5: Transition to a Future of Renewables

Theme 6: Sustainable Use of Resources

Theme 7: Connecting with Nature

Theme 8: Greening our Travel and Transport

Theme 9: Adapting to Climate Change

Theme 10: Our People as Agents of Change

KEY ACHIEVEMENTS

Throughout the year there has been significant progress in sustainability, both operationally and strategically. A few key achievements have been highlighted below -

ISO14001:2015 - Recertification

Following a five day re-certification, the Trust successfully maintained the ISO14001:2015 Environmental Management System, with no non conformities identified.

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A new Trust Travel Plan has been developed to inform and enact change in the every day lives of our staff, in and outside the workplace. The plan will be in place from 2022-2027.

Green Social Prescribing

A new, free service has been introduced for anyone affected by cancer. The weekly sessions connect attendees with nature and embed the principles of the circular economy by using found and natural materials.

Industrial Placement Scheme

A first in NHS Wales, the Trust launched an Industrial Placement scheme, employing an Sustainability Placement student. The student working within the Sustainability team and worked closely with the Transforming Cancer Services team.

ISO14001:2015

Welsh Government sets a requirement for all NHS bodies to be accredited by the ISO14001:2015 standard, an Environmental Management System (EMS). The Trust has successfully obtained the ISO 14001:2015 standard for the last five years for all sites.

At the end of 2021, the Trust was due a recertification audit, a more in depth review of the EMS. Each year, a different selection of sites are chosen to be reviewed. As the audit was a recertification rather than a surveillance audit, more sites were under the scope of audit.

The following sites were under review -

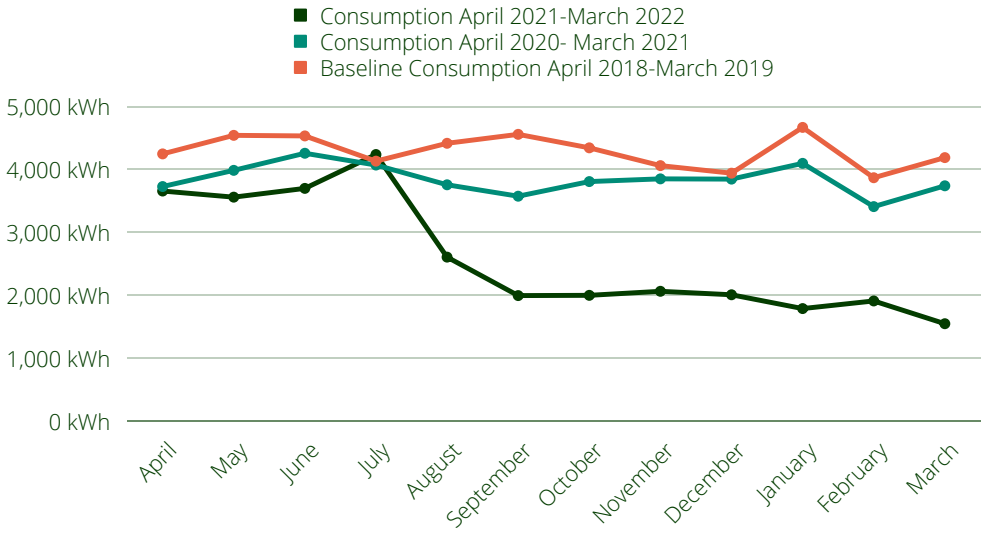
- Velindre NHS Trust Headquarters (1 day)
- Velindre Cancer Centre (2 days)
- Welsh Blood Service Talbot Green (1 day)
- Welsh Blood Service, Pembroke House (half a day)
- Welsh Blood Service, Unit 30, Llandegai Industrial Estate (half a day)

The Trust successfully obtained recertification and received zero non conformities. The external auditor noted, "The organisation have continued to maintain an effective Environmental Management System which is proactive in maintaining compliance with evolving processes to meet and exceed requirements set by regulators and governmental requirement. A plethora of information was discussed and evidenced by functional levels of the Management Team which was wholly delivered by an enthusiastic and competent personnel."

To continue the positive progress, an ISO14001:2015 Management Group has been formed to oversee all elements of the EMS. The group consists of key divisional colleagues who input into the Trust Environment Management System. The purpose of the group is to ensure sufficient and effective monitoring of the EMS. Members meet once a month and the agenda aligning with the Management Review timetable.

ELECTRICITY CONSUMPTION

TRUST HEADQUARTERS

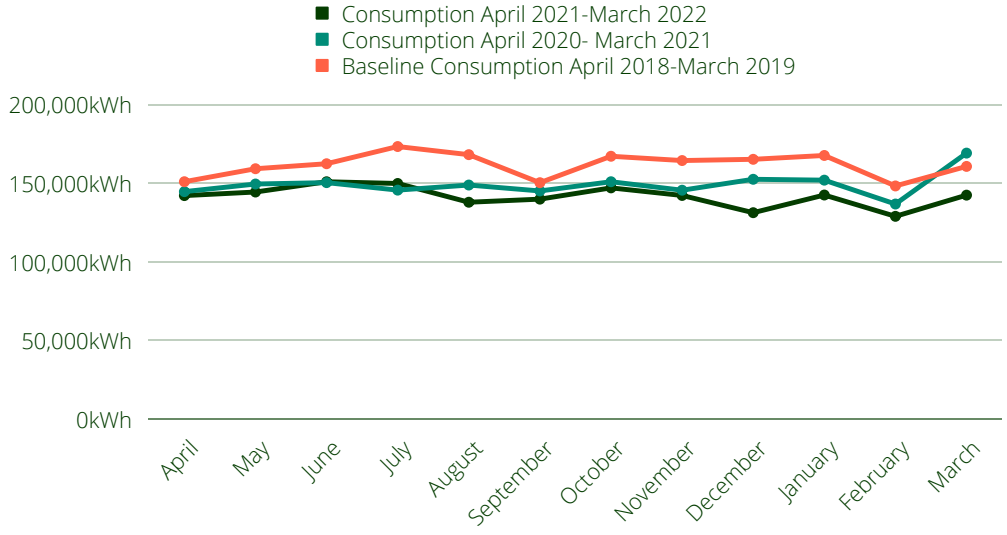


OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

39.5%

AGAINST BASELINE OF 2018/19

WELSH BLOOD SERVICE

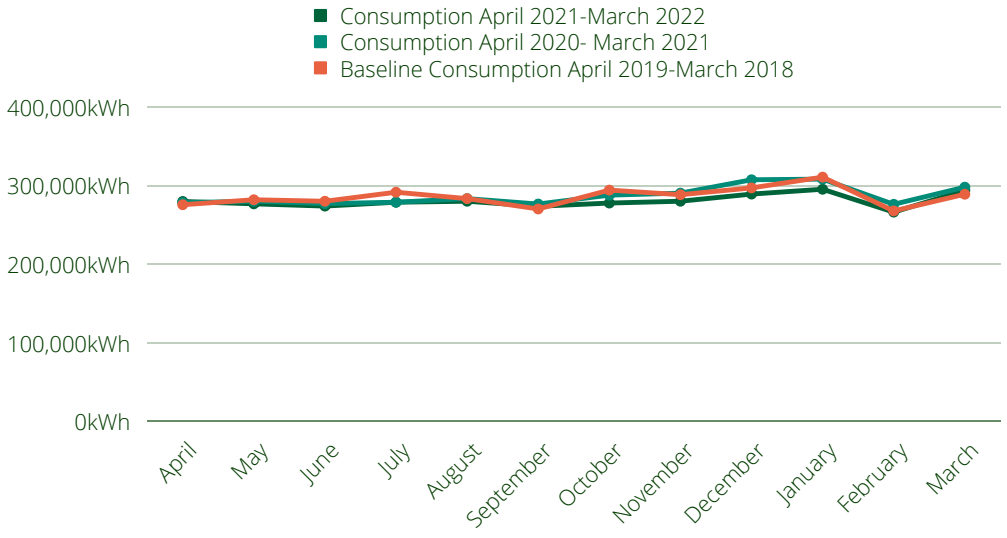


OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

12.29%

AGAINST BASELINE OF 2018/19

VELINDRE CANCER CENTRE



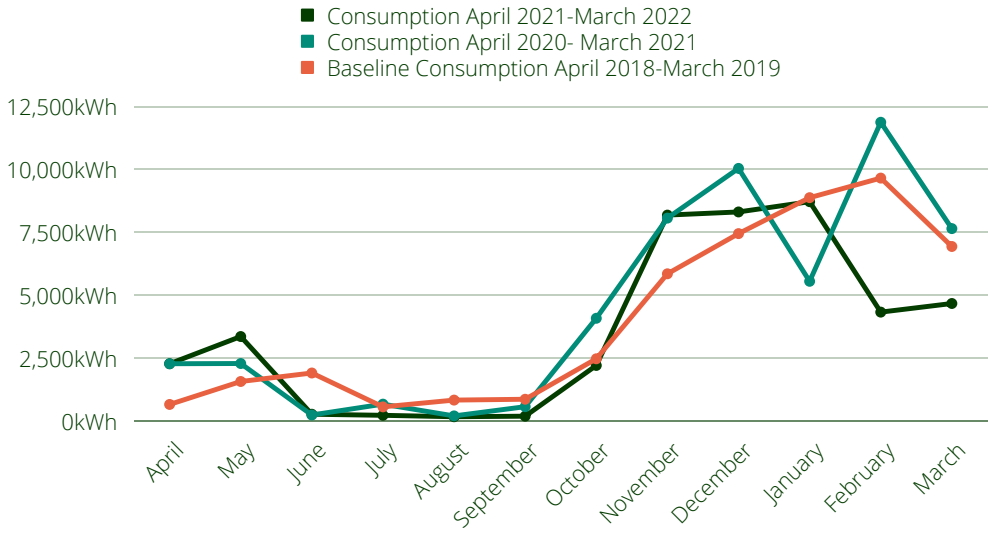
OUR ELECTRICITY CONSUMPTION HAS REDUCED BY

1.89%

AGAINST BASELINE OF 2018/19

GAS CONSUMPTION

TRUST HEADQUARTERS

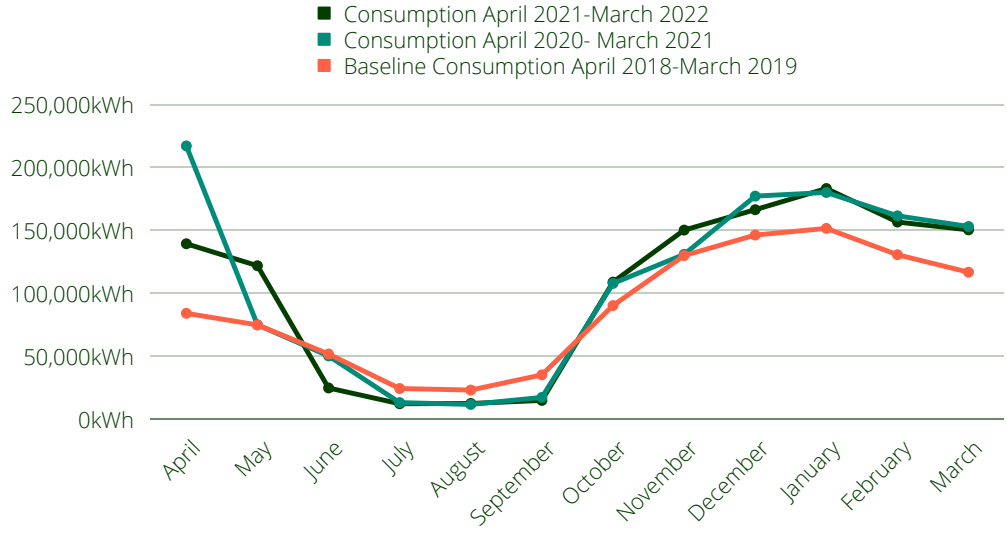


OUR GAS CONSUMPTION HAS REDUCED BY

19.63%

COMPARED TO 2020/21

WELSH BLOOD SERVICE

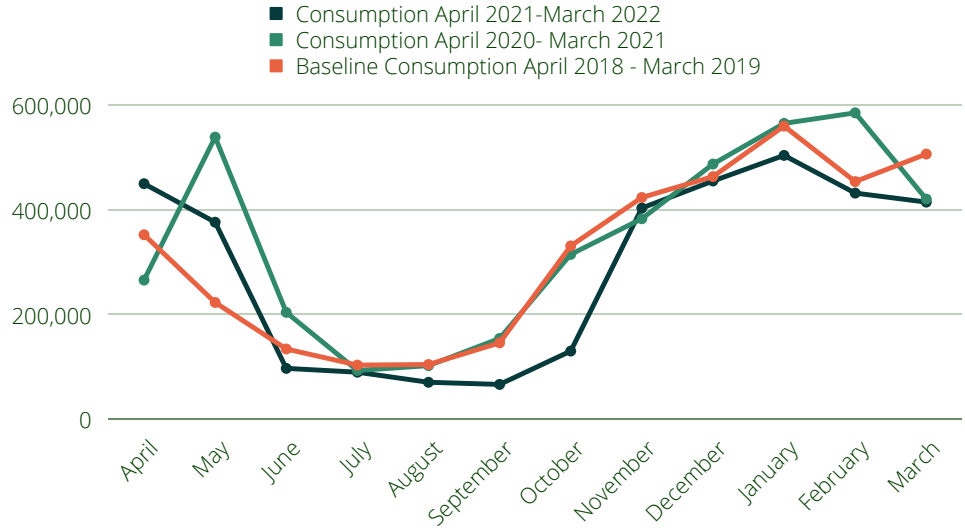


OUR GAS CONSUMPTION HAS REDUCED BY

4.15%

COMPARED TO 2020/21

VELINDRE CANCER CENTRE



OUR GAS CONSUMPTION HAS REDUCED BY

13.52%

COMPARED TO 2020/21

DECARBONISATION

The Trust was successful in obtaining bids in Welsh Governments Decarbonisation grant funds. The Trust has successfully obtained funding for the following –

- Velindre Cancer Centre Building Management System Upgrade
- Trust Headquarters LED Lighting Upgrade

Work was completed within the financial year 2021-2022 and monthly progress reports are submitted to Welsh Government via an EFAB tracker.

The LED lighting upgrades have continued across all sites, and where possible motion sensors and daylight sensors have been installed.

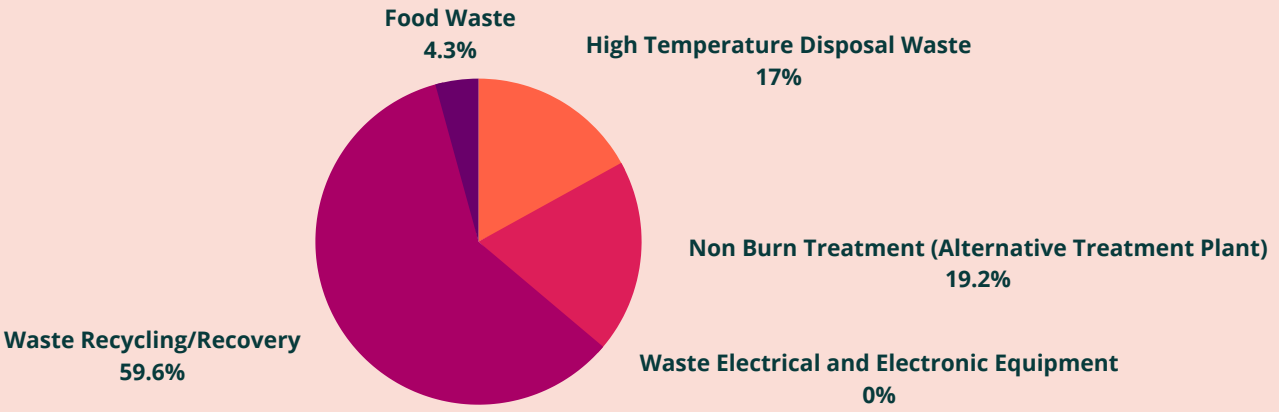
An in depth decarbonisation action plan as been developed which covers all aspects of our carbon footprint, ranging from transport to procurement. Aligning with the NHS Wales Decarbonisation Strategy, the detailed plan is an ambitious document which provides the Trust with a roadmap to be Net Zero by 2030.

Throughout the Trust, major capital programmes are being undertaken which will contribute significantly to our decarbonisation agenda. The Talbot Green Infrastructure upgrade project & new Velindre Cancer Centre will be large contributors. Throughout the year, the Sustainability team have provide sustainability advice & were directly involved in the Community Benefit workstreams to these capital programmes.

Our consumption reduction through projects and initiatives contributes to the Trust Well-being Objective, ***"Deliver bold solutions to the environmental challenges posed by our activities"***

WASTE

VELINDRE CANCER CENTRE



ZERO WASTE to landfill

OUR WASTE HAS INCREASED BY

8.17%

COMPARED TO 2020/21

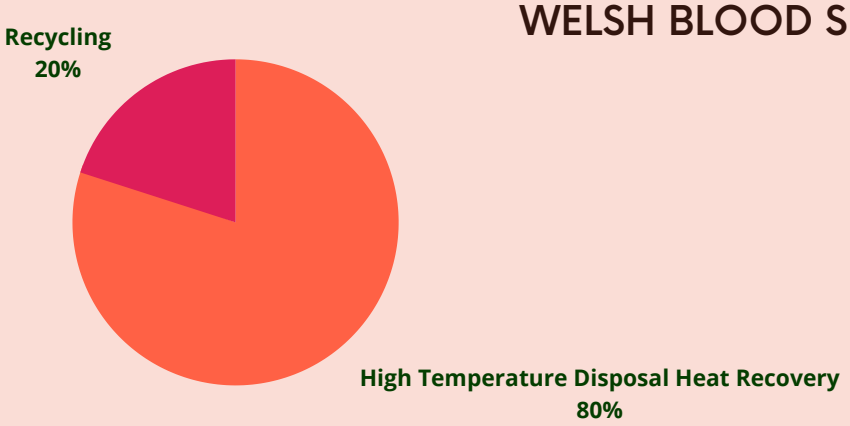
TOTAL WASTE WEIGHT WAS

171

TONNES

Waste has increased in the last financial year due to the impact of the pandemic. There has been a significant increase in PPE. Single use items had to be reintroduced on site due to adhere to necessary Infection, Prevention & Control measures implemented throughout the pandemic.

WELSH BLOOD SERVICE



OUR WASTE HAS INCREASED BY

3.54%

COMPARED TO 2020/21

TOTAL WASTE WEIGHT WAS

132

TONNES

ZERO WASTE to landfill

WASTE

VELINDRE CANCER CENTRE

As the pandemic entered a new phase, and with IP & C approval, there have been either new waste campaigns, or reintroduction of previous ones employed pre-pandemic. At the Cancer Centre, extensive work has been undertaken to reduce single use plastic where possible.

The following is just some of the successful campaign;

- new bins in the Velindre Café, clearly signposted to for correct waste segregation
- Eco to Go cups & water bottles were relaunched, any profits made were given to fundraising.
- VegeWare (compostable material) have replaced single use plastic containers
- biodegradable aprons, trialled on First Floor ward. The aprons were cheaper, better for the environment, and the quality was the same as the plastic ones!


WELSH BLOOD SERVICE

Across all of the Welsh Blood Service sites, waste initiatives have been introduced to tackle our waste consumption, both in offices & with our donors.

The following has been introduced;

- new bins with clear signposted across all sites
- reusable water bottle, coffee cup & bag were provided to all staff members across WBS to encourage reusing
- plastic stirrers & straws have been removed from donor clinics and wooden replacements have been introduced
- biodegradable cup have been successfully trialled on West Collections team

WATER CONSUMPTION

WELSH BLOOD SERVICE

OURWATER CONSUMPTION HAS REDUCED BY

16.20%

COMPARED TO 2020-21

TRUST HEADQUARTERS

OURWATER CONSUMPTION HAS REDUCED BY

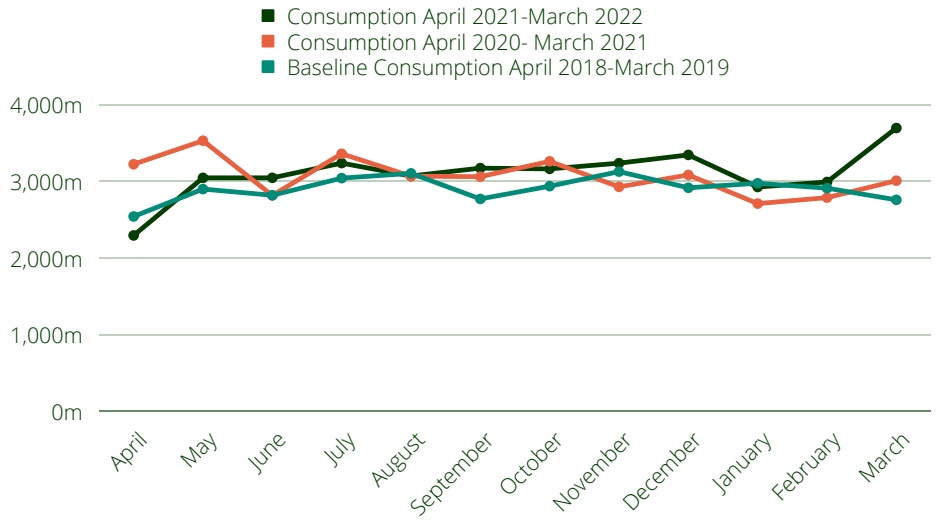
48.71%

COMPARED TO 2020-2021

There has been a reduction of water consumption at all Welsh Blood Service sites and Trust Headquarters.

WBS has recently reduced water tank storage capacity due to a compliance recommendation. Robust flushing regimes are now agreed with building users and agile working is still taking place in various departments, however flushing will still be required in these parts of the building to maintain a safe water practices. Furthermore, Trust Headquarters & WBS staff have, where possible, been encouraged to work from home during the pandemic, which has contributed to the reduction in consumption.

VELINDRE CANCER CENTRE



OUR WATER CONSUMPTION HAS INCREASED BY

2.95%

COMPARED TO 2020/21

The water consumption increase is due to an enhanced flushing regime in line with Water Safety guidelines & Infection, Prevention & Control measures.

BIODIVERSITY

As part of our compliance to the Environment (Wales) Act & specifically Section 6, we are enhancing biodiversity across all of our estate. To date we have had an external biodiversity audit undertaken and received recommendations which we are working towards to enhance ecosystems & local flora and fauna. There has been huge progress in this area in the past year, and a few highlights are listed below!

Biodiversity Enhancement Plans

Working in partnership with Crown Gardens, an action plan has been created to ensure we are enhancing biodiversity. Actions include reduction of mowing ('No Mow May' & 'Let it Bloom June'), sewing wildflowers and removal of invasive species.

Collaboration with South Wales Fire Service & Rescue

To celebrate NHS Sustainability Day for Action, run by NHS Sustainability Partnerships, and celebrated World Environment Day the SWFSR cleared the rubbish & debris by the river at Talbot Green - following assessment to ensure there is not nesting birds – to create a viewing area to the river. The team removed debris & rubbish. This area is fully accessible for staff and have recycled benches placed there for staff to have lunch or a break.

Nature Notices

To help give your audience an overview, this section can include a brief description of the goal, its relevance to your sector or industry, and the specific sub-targets your organization is addressing.

Alongside enhancing biodiversity, we aim to educate our community about its importance. Within the Environmental Awareness training a new biodiversity section has been introduced and infographics have been developed which are now included in the staff induction. Furthermore, the Trust has formed a partnership with Ray of Light, a South Wales-based charity who deliver weekly green social prescribing sessions., which contribute to our Well-being Objectives.

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person

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

Bring communities and generations together through involvement in the planning and delivery of our services

Nature Based Support

Ray of Light host free green social prescribing sessions designed for those affected by cancer. The sessions are always based around the therapeutic properties of nature, and are centred around the core principles of finding a use for everything, with nothing being wasted.

Leadership Support

Following endorsement from PLG, Dignity Group and approval from the Senior Leadership Team, the Sustainability Team organised a pilot event with staff. Following helpful feedback, weekly sessions began every Tuesday.

Well Attended

Each session consists of a main activity followed by a mindfulness session. The feedback from attendees has been overwhelmingly positive, with regulars & newcomers every week.

TRAVEL & TRANSPORT

Trust Travel Plan 2022- 2027

Travel Plans are the Government's recommended method to widen travel choice, to promote more sustainable travel choices and to reduce single-occupancy car travel. The newly published Travel Plan aims to inform, and enact change in the everyday lives of our staff, in and outside of the workplace.

With all staff engaged in the plan, and publicising your behavioural changes with friends and family, we can enact cultural changes towards decarbonisation of the public sector by 2030 in Wales. An imperative in the context of the climate emergency. Following extensive engagement, the Travel Plan was drafted in 2021, to run from 2022 - 2027.

The Travel Plan aligns with the following Trust Well-being Objectives:

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.

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.

The Staff Travel Survey was undertaken over the summer period in 2021 and accrued 438 responses. This enabled us to identify key trends across a number of different themes. Staff Travel Survey was conducted to establish a baseline in order to set targets and monitor progress, quantify how staff currently travel to work. It also helped us to understand the barriers preventing staff from travelling by more sustainable means.

Travel Plan Launch

The Travel Plan launch events were held in Velindre Cancer Centre & Talbot Green. There was spin bike challenges, Pin the Lock on the Bike & freebies to encourage more sustainable travel.

Next Bike

After being temporarily removed from Cardiff, Next Bike has returned and the Velindre Cancer Centre spot has been more popular than ever! To assist staff, a 'How To' guide & YouTube video has been created.

Cycle Confidence

Within the survey results many staff members noted they were not confident when cycling. In response, the Sustainability team worked with Cardiff Council to offer free Cycle Confidence training.

Electric Vehicle Fleet

At Welsh Blood Service, the first electric fleet vehicle is being trialled. The vehicle is part of a pilot and following review, will hopefully be rolled out across all of our Welsh Blood sites.

COMMUNICATION & ENGAGEMENT

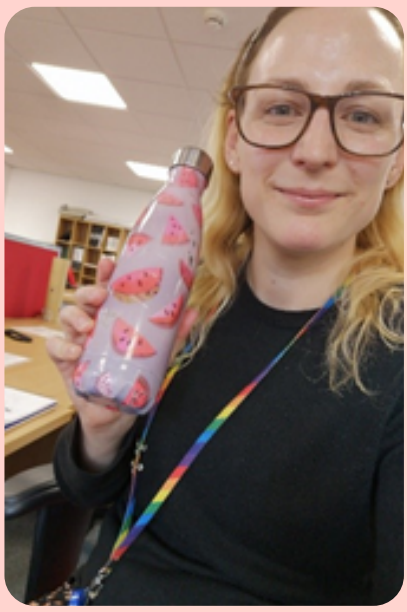
To keep staff motivated and engaged in sustainability, there are continuous communications via global email, divisional newsletters, events & more! The below highlights the most successful communication campaigns over the past year! A sustainability email address has been created for staff to ask questions, propose ideas or feedback on initiatives.

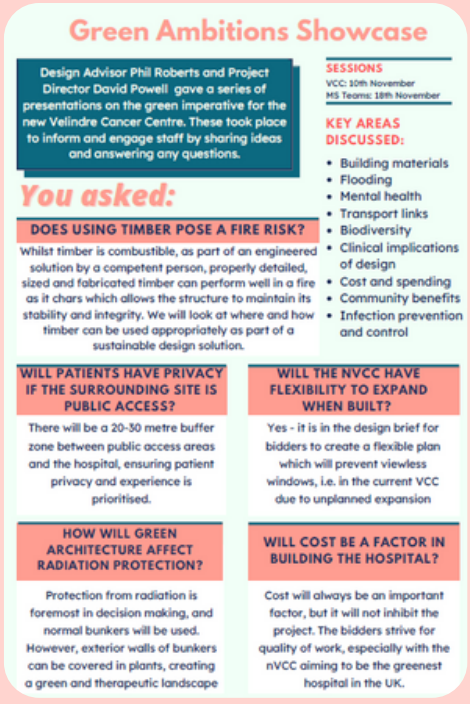
Events

Green Ambitions Showcase
Spring Clean Cymru
Pride Cymru - Sustainability
Travel Plan Launch
Litter Picks
Sustainability Day for Action

Communications

Recycle Week
Eat Seasonally
No Mow May
Plastic Free July
Secondhand September
All I Want for Christmas is...





ARTS IN HEALTH

To achieve the ambitions outlined in the Sustainability Strategy & to become an exemplar in the Future Generations Act, the Trust considers the wider opportunities available to it us as a healthcare provider, to enhance the performance of our primary functions and to increase the societal value it adds from discharging those functions. Arts and Culture have a material contribution to make to both of these opportunities.

ARTS MULTI DISCINPLINARY TEAM

The Arts Multidisciplinary Team (MDT) was created in autumn 2021, united by a passion for the arts, and a curiosity of how they can be beneficial in a healthcare setting. The MDT has grown to include members representing Oncology, Innovation, Sustainability, and more, leading to a communal varied and diverse skillset. Motivated by the Transforming Cancer Services programme, the MDT has been a fast paced, collaborative project.

SENIOR LEADERSHIP ENGAGEMENT

During a presentation to the Trust Board, at its development session in April, the breadth of the opportunities to improve patient experience and outcomes, and also to create to a higher quality working environment and experience for our workforce, from Art in Health activities. The presentation also highlighted the regional collaborative opportunities to work with our Health Board partners to integrate art in health across the cancer pathway and establish a research programme with academic partners.

RESOURCE & PARTNERSHIPS

The arts programme hsd begun to form partnerships on behalf of the Trust. There is a wealth of organisations within Wales, ranging from visual and performing arts groups and centres, to educational and research institutions, sporting groups, community wellbeing initiatives, and other healthcare organisations. A Regional Arts Board has been created with the Trust Commissioners. The Arts MDT has met with industry leads across to understand the opportunities and potential of the programme, which has been invaluable learnings.

The Trust has employed an Arts Consultant for the Transforming Cancer Services programme, drafted a job description for an Arts Coordinator & started an Arts in Health internship programme.

Cyngor Celfyddydau Cymru
Arts Council of Wales

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.

Strengthen the international reputation of the Trust as acentre of excellence for teaching, research and technicalinnovation whilst also making a lasting contribution toglobal well-being

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

EDUCATION & DEVELOPMENT

SSC STUDENTS

A number of Student Selected Component (SSC) medical students have worked with the Sustainability team to review & analyse different areas of the Trust. The projects ranged from single use plastic to carbon footprint of patient meals.

INDSUTRIAL PLACEMENT STUDENT

The Trust employed a student studying Geography with Sustainabilty during their Industrial Placement year. The placement student was based in the Sustainability department and the Transforming Cancer Services team. They will be undertaking their dissertation on the new hospital project.

ENVIRONMENTAL AWARENESS COMPLIANCE

81.33%

TRUSTWIDE COMPLIANCE

The overall compliance Environmental Awareness compliance is at 81.33% at the end of the financial year. When the Sustainability team began delivering training, compliance was below 30%.

This improvement is despite in person training being paused due to the pandemic. Teams training sessions & e-learning have been available to staff. To further support this area, infographics on the KPIs have been developed are included within the Trust staff induction.

CONCLUSION

The Trust has made significant improvements which we will continue to build on. Our Trust Strategy 'Destination 2032' outlines a clear ambition for the organisation over the coming years; the delivery of high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. This is an exciting challenge for us which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity of across the country.

The importance of environmental interventions, sustainable solutions and working with our communities to deliver safe, high quality services and our long-term goals cannot be overstated.

ENSURING WE CONTRIBUTE TO A BETTER WORLD FOR FUTURE GENERATIONS IN OUR COMMUNITY AND ACROSS THE GLOBE…

…acting today, for a more sustainable tomorrow

Questions? Contact us.

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