Public Trust Board

Thu 26 September 2024, 10:00 - 14:00

Velindre Trust Headquarters, Nantgarw / Zoom

Prof. Donna Mead OBE, Chair

Agenda

10:00 - 10:15
15 min

1. STANDARD BUSINESS

1.1. Welcome and Apologies

Prof. Donna Mead OBE, Chair

1.2. In Attendance

Prof. Donna Mead OBE, Chair

1.3. Declarations of Interest

Prof. Donna Mead OBE, Chair

1.4. Draft Minutes from Public Trust Board meetings

Prof. Donna Mead OBE, Chair

1.4.1. Extraordinary Public session held on 11th July 2024

1.4.1 FINAL Minutes PUBLIC Extraordinary Trust Board_11.07.24(v3)DM.pdf (7 pages)

1.4.2. Public session held on 30th July 2024

1.4.2 Draft Public Trust Board Minutes 30.07.2024.pdf (19 pages)

1.5. Action Log

Prof. Donna Mead OBE, Chair

1.5.0 PUBLIC TRUST BOARD ACTION LOG - SEPT 2024.pdf (5 pages)

1.6. Matters Arising

Prof. Donna Mead OBE, Chair

1.6.1. Fire Safety Training Update

Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital

1.6.1 HS Fire Training cover paper.pdf (8 pages)

10:15 - 10:30
15 min

2. KEY REPORTS

2.1. Chair's Report

Prof. Donna Mead OBE, Chair

2.1.0 Chair's update Trust Board 26.09.2024FINAL(DM).pdf (6 pages)

2.2. Vice Chair's Report

Stephen Harries, Vice Chair

2.2.0 20240926_Vice Chair Report.pdf (5 pages)

2.3. Chief Executive's Report

Carl James, Interim CEO

2.3.0 TRUST BOARD September 2024 Chief Executive's Report.pdf (5 pages)

10:30 - 10:30
0 min

3. INTEGRATED GOVERNANCE

**There are no items for discussion*

10:30 - 11:40
70 min

4. QUALITY, SAFETY & PERFORMANCE

4.1. VUNHST Risk Register

Non Gwilym, Interim Director of Corporate Governance

4.1.0 Trust Board September - Trust Risk Register v05.pdf (10 pages)
4.1.0a TRUST BOARD 26 September 2024 Trust Risk Register APPENDIX 1 v0.1.pdf (9 pages)

4.2. Trust Assurance Framework

Non Gwilym, Interim Director of Corporate Governance

4.2.0a TAF.pdf (27 pages)
4.2.0 Trust Board September TAF Cover Paper v01.pdf (9 pages)

4.3. Performance Management Framework (July 2024)

Anne Carey, Interim Chief Operating Officer, Supported by Alan Prosser, Director of Welsh Blood Service and Rachel Hennessy, Acting Director of Velindre Cancer Service

4.3.0 Performance Management Report - Master Document for Trust Board - 26.09.24- final.pdf (83 pages)

4.4. Financial Report (July 2024)

Matthew Bunce, Executive Medical Director

4.4.0 Month 4 Finance Report Cover Paper - Trust Board 26.09.2024.pdf (11 pages)
4.4.0a Appendix 1 - M4 VELINDRE NHS TRUST FINANCIAL POSITION TO JULY 2024 - Trust Board 26.09.2024.pdf (28 pages)
4.4.0b Appendix 2 - TCS Programme Finance Paper (July 2024) - Main Report.pdf (15 pages)

4.5. Staff Engagement Survey

Sarah Morley, Executive Director of Organisational Development and Workforce

4.5.0 Trust Board Staff Survey Results 26.09.24.pdf (10 pages)
4.5.0a Appendix 1 - NHS Staff Survey cross referenced actions 16.9.24.pdf (1 pages)

11:40 - 12:00
20 min

BREAK 11:40-12:00

12:00 - 12:05
5 min

5. ANNUAL REPORTS 2023-2024

5.1. Communications and Engagement Annual Report (2023-2024)

Non Gwilym, Interim Director of Corporate Governance

- 5.1.0 Trust Board 26 September 2024 Communications and Engagement Annual Report Cover Paper v0.1.pdf (7 pages)
- 5.1.0a Comms and engagement annual report 2023-24 v4.pdf (24 pages)

12:05 - 13:00
55 min

6. PLANNING AND STRATEGIC DEVELOPMENT

6.1. Clinical and Scientific Strategy

Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science and Dr Jacinta Abraham, Executive Medical Director

- 6.1.0 Clinical Scientific Strategy Paper.pdf (18 pages)

6.2. Strategic Planning Update

Lauren Fear, Interim Executive Director of Strategic Development, Planning & Digital

- 6.2.0 Strategic Planning Update - Sept 2024 - PH comments.pdf (8 pages)
- 6.2.0a 2024-07-26 JP to CJ Velindre University NHS Trust - Accountability Letter - IMTP 2024-27.pdf (3 pages)

6.3. Integrated Medium Term Plan - Quarter 1 2024-2025 Update

Lauren Fear, Interim Executive Director of Strategic Development, Planning & Digital

- 6.3.0 TRUST BOARD 26.09.24 IMTP 2024.25 Quarter 1 Update version Master 009.pdf (89 pages)

6.4. Compassionate Leadership Pledge

Sarah Morley, Executive Director of Organisational Development & Workforce

- 6.4.0 Trust Board Compassionate Leadership Pledge 26.09.24.pdf (10 pages)

13:00 - 13:30
30 min

7. CONSENT ITEMS

Prof. Donna Mead OBE, Chair

7.1. CONSENT FOR APPROVAL

7.1.1. Amendment to Standing Orders – Schedule 1 and 2

Non Gwilym, Interim Director of Corporate Governance

- 7.1.1 Revisions to SO-SFI-Schedules 1 & 2-Trust Board Cover Report_SEP 2024.pdf (6 pages)
- 7.1.1a APPENDIX 1 GC02a v40 SOs Schedule 1_SEP 2024 UPDATED.pdf (24 pages)
- 7.1.1b APPENDIX 2 GC02b v40 SOs Schedule 2_SEP 2024 UPDATED.pdf (81 pages)

7.1.2. Amendment to Standing Orders – Schedule 3 Annual Review Committee Terms of Reference

Non Gwilym, Interim Director of Corporate Governance

- 7.1.2 Amendment to Trust Standing Orders - Schedule 3 - Cover Paper_SEPT 2024.pdf (8 pages)
- 7.1.2a Appendix 1 QSP Committee TOR revision SEP 2024.pdf (12 pages)
- 7.1.2b Appendix 2 ToR CFIPR Sub Committee_SEP 2024.pdf (5 pages)

7.1.3. Chair's Urgent Actions Report

Non Gwilym, Interim Director of Corporate Governance

*There are no Chair's Urgent Actions for approval

7.1.4. Commitment of Expenditure Exceeding the CEO Limit

Non Gwilym, Interim Director of Corporate Governance

*There are no Committment of Expenditure items for approval

7.1.5. Annual and Three-Year Assurance Reports on compliance with the Nurse Staffing Levels (Wales) Act (2016)

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

7.1.5 Annual nurse staffing assurance report_.pdf (20 pages)

7.1.6. Workforce and OD Policies for Approval

Non Gwilym, Interim Director of Corporate Governance

- Appendix 1 - People Development Policy
- Appendix 2 - WF30 PADR Policy
- Appendix 3 - WF18 Alcohol and Substance Misuse Policy
- Appendix 4 - WF22 Professional Registration Policy

7.1.6 People and OD Polices and Processes Sep 24 Trust Board.pdf (7 pages)
7.1.6.a Appendix 1 New People Development Policy_V1.pdf (14 pages)
7.1.6b Appendix 2 WF30 PADR Policy_V2.pdf (12 pages)
7.1.6c Appendix 3 WF18 Alcohol Drugs Substance Policy_V4.pdf (23 pages)
7.1.6d Appendix 4 WF22 Professional Registration Policy_V3.pdf (10 pages)

7.1.7. Infection Prevention and Control Policy for Approval

- IPC03 Model Policy Aseptic Non-Toiuch Technique (ANTT)

7.1.7 IPC Policy Paper.pdf (34 pages)

7.2. CONSENT FOR NOTING

7.2.1. Approved Policies Update

Non Gwilym, Interim Director of Corporate Governance

7.2.1 TRUST WIDE POLICIES UPDATE SEPT 2024.pdf (5 pages)
7.2.1a Appendix 1 PP02 Security Policy_v2_Sept 2024.pdf (10 pages)
7.2.1b Appendix 2 QS02 Safety Alerts Policy_v2_Sept 2024.pdf (8 pages)

7.2.2. Remuneration Committee Highlight Report (05/09/2024)

Professor Donna Mead, Chair and Chair of Remuneration Committee

7.2.2 Highlight Report REMCOM 005.09.2024-V01_.pdf (2 pages)

7.2.3. Public Charitable Funds Committee Highlight Report (05/09/2024)

Professor Donna Mead OBE, Chair of the Charitable Funds Committee

7.2.3 Charitable Funds Committee Public Highlight Report 05 September 2024 final.pdf (4 pages)

7.2.4. Local Partnership Forum Highlight Report (17/09/2024)

Sarah Morley, Executive Director of Organisational Development and Workforce

7.2.4 17.09.2024 - LPF Highlight Report V01.pdf (5 pages)

7.2.5. Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report (23/07/2024)

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

7.2.5 Trust Board Highlight Report Public 23.07.2024 - NG-SH.pdf (4 pages)

7.2.6. Joint Commissioning Committee (JCC) Summary Report (16/07/2024)

Non Gwilym, Interim Director of Corporate Governance

7.2.6 JCC Briefing (Public) 16 July 2024.pdf (8 pages)

7.2.7. NHS Wales Shared Services Partnership Committee Assurance Report (18/07/2024)

Non Gwilym, Interim Director of Corporate Governance

7.2.7 SSPC Assurance Report 18 July 2024.pdf (7 pages)

7.2.8. NHS Wales Shared Services Partnership Audit Committee Highlight Report (25/07/2024)

Non Gwilym, Interim Director of Corporate Governance

7.2.8 NWSSP Audit Cttee Highlight Report 25 July 2024.pdf (13 pages)

7.2.9. NHS Wales Shared Services Partnership 2024/25 Approved Internal Audit Plan & Charter

Led by Emma Rees, Deputy Head of Internal Audit (NWSSP Audit & Assurance Services)

7.2.9 24-09-26 Board VEL 2425 Internal Audit Plan & Charter Cover Paper.pdf (8 pages)
7.2.9b 24-09-26 Board App 2 VEL 2425 IA Assurance over Strategic Risks.pdf (1 pages)
7.2.9a 24-09-26 Board App 1 VEL 2425 Approved Internal Audit Plan.pdf (23 pages)

7.2.10. Llais Cymru Report

Llais not in attendance - report for noting only

7.2.10 Llais Clinical Trials Report Final.pdf (16 pages)

7.2.11. Trust Seal Report

Led by Non Gwilym, Interim Director of Corporate Governance

7.2.11 Trust Seal Report 23.05.24-25.09.24.pdf (3 pages)

7.2.12. Quality, Safety & Performance Committee Highlight Report (12/09/2024)

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

7.2.12 Public QSP Highlight Report 12th September 2024 v2.pdf (5 pages)

13:30 - 13:30
0 min

8. ANY OTHER BUSINESS

Professor Donna Mead OBE, Chair

*Prior approval required by Chair

13:30 - 13:30
0 min

9. DATE OF NEXT MEETING

Prof. Donna Mead OBE, Chair

Thursday 28th November 2024

13:30 - 13:30
0 min

10. CLOSE

Prof. Donna Mead OBE, Chair

The Board is asked to adopt the following resolution:
That representatives of the press and other members of the public be excluded from the remainder of this meeting having

regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

13:30 - 13:30
0 min

11. The following items will be discussed / noted at the Private / Part B Session of the Trust Board

Prof. Donna Mead OBE, Chair

- Health Technology Wales Scope
- Lessons Learnt following Special Payment
- Scheme of Delegation
- Whitchurch Land Transfer
- Legal Matters
- Chairs Urgent Actions
- Commitments of Expenditure Exceeding CEO's Limit
- Private Committee Highlight Reports

MINUTES OF EXTRAORDINARY PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST
11th JULY 2024 (15:00-16:00)
VUNHST TRUST HEADQUARTERS, NANTGARW / VIA ZOOM

PRESENT	
Prof. Donna Mead OBE	VUNHST Chair *(Chair)*
Stephen Harries	VUNHST Vice Chair and Independent Member
Hilary Jones	Independent Member *(remotely)*
Prof. Andrew Westwell	Independent Member
Lindsay Foyster	Independent Member
Vicky Morris	Independent Member *(remotely)*
Gareth Jones	Independent Member *(remotely)*
Lauren Fear	Interim Executive Director of Strategic Transformation, Planning & Digital
Sarah Morley	Executive Director of Organisational Development and Workforce
Matthew Bunce	Executive Director of Finance
Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Science *(remotely)*
Jacinta Abraham	Executive Medical Director
Kyle Page	Business Support Manager *(Secretariat)*

1.0.0	**PART 1 - STANDARD BUSINESS**	**ACTION LEAD**
1.1.0	**Welcome and Apologies** Led by Prof Donna Mead OBE, Chair The Chair welcomed attendees to the Extraordinary Public Trust Board meeting, convened in order to approve the Trust's Annual Accounts, Accountability Report and Annual Performance Report. This meeting had been preceded by an Audit Committee held on the 10th July 2024, where papers presented at today's meeting had been robustly reviewed and discussed. The following apologies had been received: • Carl James, Interim Chief Executive Officer • David Cogan, Patient Representative	
1.2.0	**In Attendance:** Led by Prof Donna Mead OBE, Chair The Chair extended a warm welcome to the following additional attendees: • Steve Wyndham, Audit Manager, Audit Wales *(for item 3.1.0) (remotely)* • Simon Cookson, Director of Audit and Assurance (NWSSP) *(for item 4.1.0) (remotely)* • Emma Rees, Deputy Head of Internal Audit (NWSSP) *(for item 4.1.0) (remotely)* • Non Gwilym, Interim Director of Corporate Governance • Tracy Hughes, Head of Financial Operations (for item 2.1.2) *(remotely)*	

	• Philip Hodson, Assistant Director of Planning & Performance *(to support item 5.1.0)*	
1.3.0	**Declarations of Interest** Led by Prof Donna Mead OBE, Chair There were no declarations of interest pertinent to the items on today's agenda to be declared.	
2.0.0	**ACCOUNTABILITY REPORT AND ANNUAL ACCOUNTS 2023-2024**	
2.1.0	**Cover Paper for Accountability Report and Annual Accounts 2023-2024** Led by Matthew Bunce, Executive Director of Finance and Non Gwilym, Interim Director of Corporate Governance It was noted that NHS Bodies are required to publish, as a single document, a three-part Annual Report and Accounts, to include a Performance Report, Accountability Report and Financial Statements, in line with the structure stipulated in the Government Financial Reporting Manual 2023-2024. The contribution provided by a number of staff to this significant document was acknowledged and the Chair Extended thanks to Lauren Fear and the Corporate Governance Manager for the efficient collation and production of the report. The Chair welcomed the report and the Board **NOTED** the opinion and assurances provided by the Chair of the Sub-Committee.	
2.1.1	**Accountability Report 2023-2024** Led by Lauren Fear, as the Director of Corporate Governance and Chief of Staff for the reporting period Lauren Fear advised that the Accountability Report comprised three elements: • Corporate Governance Report (itself comprising Directors' Report, Statement of the Accounting Officer's responsibility and Governance Statement, which sets out the Governance Framework across Governance, Risk and Assurance matters). • Remuneration and Staff Report. • Senedd Cymru/Welsh Parliament Accountability and Audit Report. Lauren Fear referenced the importance of the Governance Statements of both the Trust's hosted organisations in support of the Accountable Officer's signing of the Governance Statement. It was noted that statements had been received from both NHS Wales Shared Services Partnership (NWSSP) and Health Technology Wales (HTW) as part of the recent Board Effectiveness Session. Lauren Fear confirmed that no specific feedback had been received following the review of the report at Audit Committee. The conclusions of the Board Effectiveness Session were summarised as follows: • The Board's assessment had concluded an overall maturity rating of level 4 for 2023-2024, which remains consistent with the previous year. • The main drivers of this conclusion were the positive progress made across the Governance Assurance and Risk programme of work (evidenced by an internal audit) and positive progress made on embedding the Duty of Quality and Candour across the Board's decision-making and culture.	

	• The following is required in order to achieve a level 5 rating:
	  o Continued development of the service improvement across Governance, Assurance and Risk is required and full achievement of a number of outcomes agreed by Board members during the next phase.
	  o Effective development of the Trust Assurance Framework (TAF) and Integrated Medium Term Plan (IMTP) alongside each other over the coming months, further enhancing the Board's clarity of alignment between Strategic Objectives and Strategic Risks.
	  o Further work regarding project level governance (nVCC) and Board oversight, as the Trust transitions from the procurement phase to management of a MIM (Mutual Investment Model) for 3 years.
	
	Vicky Morris reiterated the discussion at the Board Development Session, concurring with the level 4 rating, also noting that while the 6 month absence of the Trust Assurance Framework had been escalated via the Quality, Safety & Performance Committee / Audit Committee through to the Board, this had not been included in the report, but had been discussed at the Board Development Session. It was agreed to insert an additional sentence to reflect this.
	
	Staff and Remuneration
	Tracy Hughes advised the following:
	
	• The Remuneration report includes information in relation to the remuneration of senior management for the year 2023-2024, displayed in a number of salary and pension disclosure tables within the report, including information in relation to the previous year.
	• Disclosures had been shared with respective individuals prior to publication.
	• The report also includes details of exit packages, the relationship between the Chief Executive Officer's remuneration and the Trust's workforce, in addition to off-payroll engagements employed during the financial year.
	
	The Trust Board **NOTED** and **APPROVED** the content of the Accountability Report 2023 – 2024, noting that the Statement of Directors' Responsibilities would subsequently be signed on Monday 15th July upon the Interim Chief Executive Officer's return from annual leave.
		LF

2.1.2	**Velindre University NHS Trust Final Accounts 2023-2024** Led by Matthew Bunce, Executive Director of Finance and Tracy Hughes, Head of Financial Operations The Chair, on behalf of all Independent Members, extended thanks to all individuals for the significant work in collating this year's complex set of Accounts for the scrutiny of Internal Audit, Audit Wales and the Board. The Chair also noted that the Accounts had been endorsed at the Public Audit Committee for Trust Board approval. Matthew Bunce advised that the Trust had met all financial and administrative duties as part of the Accounts. Tracy Hughes provided the following overview: • Draft Accounts had been submitted by the stipulated deadline of the 3rd May 2024 and the Trust had since supported Audit Wales' remote	

	undertaking of work, utilising their secure digital portal for the provision of information.
	• Whilst Audit Wales had identified minor changes, outlined in the ISA 260 Report, none have resulted in any change to the bottom line.
	• The report sets out the Trust's performance against the 3 financial targets:
	  o The Trust has met its statutory duty to break even over a 3 year rolling period and achieved a surplus of £259k in 2023-2024.
	  o Duty to prepare a 3 year Integrated Medium Term Plan (2023-2026), which was submitted and approved by the Minister for Health & Social Services in September 2023.
	  o Creditor Payments – The Trust was required to pay 95% of non-NHS bills within 30 days of receipt of goods / invoices. This had been met at 96.8%.
	
	Tracy Hughes advised that the Accounts had been endorsed for Board approval, with the exception of one outstanding item, expected to conclude by the end of the week. Gareth Jones concurred that a number of issues had been discussed and resolved to the satisfaction of the Audit Committee.
	
	The Trust Board **APPROVED** the Velindre University NHS Trust Final Accounts 2023-2024, noting that this would be signed on Monday 15th July upon the Interim Chief Executive Officer's return from annual leave.	

2.1.3	**Appendix 1 - Letter of Representation 2023-2024** Led by Matthew Bunce, Executive Director of Finance The Trust Board **APPROVED** the Letter of Representation 2023-2024, noting that this would be signed on Monday 15th July upon the Interim Chief Executive's return from annual leave.	
2.1.4	**Appendix 2 - Trust Response to Audit Wales Regarding Trust Governance & Management Arrangements** Led by Matthew Bunce, Executive Director of Finance The Trust Board **APPROVED** the Trust response to Audit Wales Regarding Trust Governance & Management Arrangements.	
3.0.0	**AUDIT WALES AUDIT OF FINANCIAL STATEMENTS 2023-2024**	
3.1.0	**Audit Wales ISA 260 Report 2023-2024** Led by Steve Wyndham, Audit Manager, Audit Wales Following work undertaken by Audit Wales in accordance with statutory functions, the report outlined Audit Wales' current intention to issue an unqualified true and fair audit opinion of the Trust's accounts for the year ended 2023-2024. Steve Wyndham advised the following: • The report had been discussed in detail at the Audit Committee on 10 July 2024. • Audit Wales noted its intention to issue an unqualified opinion subject to obtaining retrospective approval from Welsh Government in relation to a settlement payment to a former senior manager during the financial year. It was confirmed that the amount in question had been fully disclosed in the Remuneration Report and approved by the Remuneration Committee. This should, however, have been approved by Welsh Government due to	

	its non-contractual nature. This could lead to one of three possible outcomes: o The payment is approved retrospectively and subsequent unqualified opinion. o Non-approval of the payment followed by the requirement for Audit Wales to qualify the opinion. o Should the decision be received post 15th July 2024, the decision will be placed with the Audit General. • Other audit work has concluded, with the exception of 2 minor areas to be resolved within the week (1) Completion of internal file review arrangements and (2) Clearance of performance report elements. • Auditor General is scheduled to certify on the afternoon of Monday 15th July. No further questions were raised and the Trust Board **APPROVED** the Audit Wales Report 2023-2024.	
4.0.0	**NWSSP AUDIT & ASSURANCE SERVICES**	
4.1.0	**Head of Internal Audit Opinion** Led by Simon Cookson, Director of Audit and Assurance (NWSSP) and Emma Rees, Deputy Head of Internal Audit (NWSSP) The report presented the 2023-2024 Head of Internal Audit Opinion and Annual Report. This had been based on 16 audits, in line with the agreed 2023-2024 Internal Audit Plan (the majority of which (13) were given 'reasonable assurance' opinions) Simon Cookson advised the following: • Work had been concluded and the Opinion presented to 10 July Audit Committee. • Of 16 audits, one had been given substantial assurance, 13 had been given reasonable assurance and two had been given limited assurance opinions. They were nVCC Enabling Works and Estates Management, both of which had been discussed at length at Audit Committee and appropriate actions plans implemented. Simon Cookson expressed thanks to the Board for their support with this work over the course of the year. The Trust Board **NOTED** the content of the 2023-2024 Head of Internal Audit Opinion and Annual Report.	
5.0.0	**ANNUAL PERFORMANCE**	
5.1.0	**Annual Performance Report 2023-2024** Led by Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital The Annual Performance Report formed part of the suite of Annual Report and Accounts documents intended for publication and inclusion in the Trust's Annual General Meeting in September 2024, providing transparent information regarding the performance of services provided by the Trust. Lauren Fear advised the following: • The Annual Report and Accounts comprised 3 elements (1) Accountability & Governance Report (2) Annual Accounts (3) Performance Report.	

	• A 'track changes' version had been included prior to the meeting to include comments noted during the Quality, Safety & Performance Committee also held on the morning of 11 July (corrections, inclusion of Trust Values, addition of narrative to address demand profile across services and the new Velindre Cancer Centre and link to the final Strategic Case for the nVCC Full Business Case). • The Trust's new Values will be added to the 'track changes' iteration. • A number of comments had been made by Audit Wales and Welsh Government regarding the Accountability and Performance Reports, relating to claims and disclosure around climate change. • The report covers the core performance and progress across both divisions, outlining a number of areas across the Trust (Putting Things Right, Workforce & Wellbeing, Digital, Sustainability, Welsh Language), summarised in an overview of these areas. Nicola Williams reported positive outcomes in relation to infection control, notwithstanding minor compliance issues which are being addressed. It was noted that the Trust is also leading the way in areas such as Aseptic Non-Touch Technique (ANTT). Vicky Morris advised that the Quality, Safety & Performance Committee had moved to utilising the 7 levels of assurance and that Infection Prevention & Control had gained level 6 assurance via the range of reports received. The reports had provided a range of levels of assurance, identifying where improvements were required, while also celebrating improvements achieved to date. Nicola Williams also advised that SACT performance is now subject to comprehensive review at each meeting of the Quality, Safety & Performance Committee (via Gold Command reporting), noting that the reduction in performance is the result of an increase in demand over and above what had been predicted. Plans are in place to enable demand to be met and improvement had been evidenced post-March 2024. The Chair requested the inclusion of additional narrative from the Gold Command report to provide additional public assurance. Phil Hodson expressed thanks to the team and Audit Wales' support in producing the report, noting that this would routinely be the responsibility of the Chief Operating Officer. The Trust Board **APPROVED** the Velindre University NHS Trust Annual Performance Report 2023-2024, subject to final amendments as discussed at today's meeting. This is to be circulated tomorrow with final 'track changes' discussed above.	**LF** **LF**
6.0.0	**Any other Business** Led by Prof Donna Mead OBE, Chair No other business was raised.	
7.0.0	**Date of next meeting** Led by Prof Donna Mead OBE, Chair The next public meeting of the Trust Board will take place on Tuesday 30th July 2024.	

8.0.0	**CLOSE** The Chair closed the meeting.	

MINUTES PUBLIC TRUST BOARD MEETING – PART A
VELINDRE UNIVERSITY NHS TRUST LIVE STREAMED
30th JULY 2024 AT 10:00AM

PRESENT	
Professor Donna Mead OBE (DM)	Velindre University NHS Trust Chair *(Chair)*
Stephen Harries (SH)	Vice Chair
Professor Andrew Westwell (AW)	Independent Member
Gareth Jones (GJ)	Independent Member
Lindsay Foyster (LLF)	Independent Member
Hilary Jones (HJ)	Independent Member *(attending remotely)*
Vicky Morris (VM)	Independent Member *(attending remotely)*
Carl James (CJ)	Interim Chief Executive Officer
Sarah Morley (SfM)	Executive Director of Organisational Development and Workforce
Lauren Fear (LF)	Interim Executive Director of Strategic Transformation, Planning & Digital
Nicola Williams (NW)	Executive Director of Nursing, Allied Health Professionals & Health Science
ATTENDEES	
Anne Carey	Interim Chief Operating Officer
Non Gwilym	Interim Director of Corporate Governance
Kyle Page	Business Support Manager *(Secretariat – attending remotely)*

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** The following apologies were noted: • Matthew Bunce, Executive Director of Finance • Dr Jacinta Abraham, Executive Medical Director • Susanna Whawell, Associate Independent Member	
1.2.0	**In Attendance** The Chair welcomed Anne Carey, the Trust's recently appointed Interim Chief Operating Officer and introductions were made. The Chair extended a warm welcome to the following additional attendees: • Bethan Davis (HEIW) (simultaneous Welsh translation service) • Chris Moreton, Deputy Director of Finance (deputising for Matthew Bunce) • Dr Edwin Massey, Medical Director Welsh Blood Service (deputising for Dr Jacinta Abraham) *(attending remotely)* • Alan Prosser, Director Welsh Blood Service • Rachel Hennessy, Interim Director Velindre Cancer Service • David Cogan, Patient Representative and Chair of Patient Liaison Group *(attending remotely)*	

1.3.0	**Declarations of Interest** There were no declarations of interest pertinent to today's agenda.	
1.4.0	**Draft Minutes from the previous Public Trust Board meeting held on 23rd May 2024** The following amendments were requested: • Page 6 of 16 – To replace 'two' successful Welsh Blood Donor Award ceremonies' with 'three', adding Wrexham to the list (Chair). • Page 6 of 16 – To correct the spelling of Caernarfon (Gareth Jones). • Page 15 of 15 – To add the date of the Public Audit Committee Highlight Report, to remain consistent with other reports. Amend Gareth Jones' role to Chair as opposed to Acting Chair (Gareth Jones). The Trust Board confirmed that the minutes of the meeting held on the 23rd May 2024 were an accurate and true reflection of proceedings, subject to amendments following the observations made above.	**Secretariat**
1.5.0	**Action Log** The Board was content that actions marked as closed was an accurate reflection. The status of open actions was reviewed as follows: • **3.1.0** – Utilisation of Committee Highlight Reports (30/01/2024 meeting) – rescheduled to the September meeting of the Trust Board. • **5.1.0** – Update Board regarding embedding of Trust Values (30/01/2024 meeting) – rescheduled to the September meeting of the Trust Board. • **4.1.0** – Provision of details for each phase of Recruitment Programme for Radiotherapy (26/03/2024 meeting) – Rachel Hennessy advised that a workforce strategy and recruitment log are in place. IRS appointments are successfully being integrated with the Satellite Unit workforce and further interviews are scheduled for this week. While it was noted that further detail in relation to numbers recruited to date/outstanding positions would be shared at September's Quality, Safety & Performance Committee, Rachel Hennessy agreed to provide this information to Board members in the interim. It was agreed to close this item once actioned. • **2.4.0** – Allocation of green rating to proportion of Welsh-speaking workforce (23/05/2024 meeting) – Sarah Morley advised that this nationally adopted target remains under review and a resolution is anticipated during the next reporting cycle. • **5.1.0** – Continued development of Trust Risk Register (23/05/2024 meeting) – Lauren Fear advised that a meeting had been scheduled for the 20th August 2024, to obtain input from Independent Members, reporting the outcome to the September 2024 meeting of the Trust Board. • **5.3.0** – Inclusion of number of days' delay to SACT and Radiotherapy treatment within Performance Management Framework (23/05/2024 meeting) – It was advised that this would be addressed under item 4.3.0 during today's meeting, and it was agreed to close the action. • **7.1.1** – Clarification of agreement with NHS Wales Shared Services Partnership (NWSSP) and NHS Resolution (23/05/2024 meeting) – Lauren Fear advised that this agreement had been addressed with NWSSP following questions raised at the previous meeting and, due to	**NG** **SfM** **RH** **SfM** **LF/NG**

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	the non-legal internal nature of the agreement, this had been presented at the May meeting of the Trust Board meeting erroneously. It was agreed to close the action. • **7.1.4** – Inclusion of reference to requirements to demonstrate quality-led decision-making through Quality Assessments in Revisions to Schedule 3 of Trust Standing Orders (23/05/2024 meeting) – It was advised that this would be included within the Corporate Governance Manual for the September 2024 meeting of the Audit Committee, following Executive Management Board endorsement in August 2024. This will return to the September 2024 meeting of the Trust Board.	**NG**
1.6.0	**Matters Arising** The Chair requested an update regarding the LTAs for the financial year. Carl James advised that following submission of the Trust's Integrated Medium Term Plan to Welsh Government (on the basis of financial planning assumptions with Local Health Boards), further discussion had emerged around the principle of the 3.67% discretionary uplift to be received by all organisations and how this may impact the LTAs. Chris Moreton advised that the 3.67% uplift had been disputed by two Health Boards. The Trust had followed Welsh Government guidelines in terms of arbitration which had resulted in escalation to Chief Executive level and a compromise with three Health Boards, therefore impacting the Trust's financial plan resulting in - a £317k reduction in recurrent discretionary income and - a £483k reduction in non-recurrent income in comparison to the plan submitted to the March 2024 Trust Board meeting. The Trust has since worked to address the shortfall and a review of the Trust's savings plan had resulted in an increase of £270k in savings within the financial year to compensate. Additionally, previously planned recurrent investments have been reviewed and frozen where appropriate. It was confirmed that arbitration with Welsh Government had been avoided. Chris Moreton advised that a process would be implemented to ensure that LTAs were successfully reached for 2025-2026, noting the intention of Welsh Government to gradually reduce the time lapse between submission of IMTP and signing of LTA agreements in future. Chris Moreton confirmed that the Trust will seek to secure early agreements for the next year, facilitated via an integrated finance and planning approach. Lauren Fear indicated that a key cause is the flow of cancer patients from the Trust's Commissioners' cancer services and that a Trust Planning Framework for 2025-2028 IMTP would be presented to the September Board, to include reference to how the LTA will operate during this period. In terms of LTA contract rebasing, Chris Moreton advised that the original implementation of the contract model was proposed and agreed by Directors of Finance in 2019-2020. As this was paused during the pandemic, it was stipulated in LTAs that this would be enacted during 2023-2024 (agreement of which was subsequently revoked by a small number of Health Boards); therefore, the Trust had resorted to historic arrangements, based on a percentage share. Whilst the correct process had been followed by the Trust, it was agreed to schedule a separate Board session to discuss the process, as it is the essential that a repeat of the situation is avoided.	**LF** **CM**

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1.6.1	**Llais Cymru Report following visit to Velindre Cancer Centre** The Board was advised that following a visit to Velindre Cancer Service by Llais Cymru, a subsequent report would be presented at the September 2024 meeting of the Quality, Safety & Performance Committee, followed by Trust Board.	
2.0.0	**KEY REPORTS**	
2.1.0	**Chair's Report** The report provided an overview of the Chair's activity since the previous meeting of the Trust Board. The Chair advised that two items had been omitted from the update in error and would be included in the September update: • Launch of Velindre Oncology Academy • Attendance at a Regional Planning Summit in conjunction with other Health Boards. Lauren Fear advised that a further joint Board Session would be scheduled between the 4 relevant Health Boards on the 1st October 2024 as a result. The Trust Board **NOTED** the content of the Chair's Update Report.	**DM**
2.2.0	**Vice Chair's Report** The report provided an overview of the Vice Chair's activity since the previous meeting of the Trust Board. Stephen Harries highlighted the following: • Attendance at the City Hospice 40th Anniversary celebrations, hosted at the Senedd. This had been an emotional yet uplifting experience and hearing a patient inform the public of his and his family's cancer journey provided a reminder of the significant impact of Trust staff in the provision of care during such difficult periods in individuals' lives. Lindsay Foyster queried whether any further learning could be obtained from the pilot (6 month) Associate Independent Member Mentee Scheme and if the aim of the scheme (increasing diversity in public appointments) had been achieved. Stephen Harries advised that the scheme had been designed and managed by Public Appointments as a learning opportunity and that engagement with other Trust Boards who had been assigned Mentees would be undertaken in relation to how future opportunities for diverse communities could be provided. Sarah Morley indicated that it is the intention to implement an Aspiring Board Members Programme, particularly aimed at Black, Asian and Minority Ethnic (BAME) communities, to further encourage diverse Board membership. The planning for this programme had been impeded for several reasons, however planning arrangements had now been re-instigated by Welsh Government and further detail would follow when available (during the next 6-9 months). It is the intention for the Trust Board participate in this scheme. The Trust Board **NOTED** the content of the Vice Chair's Update Report.	

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2.3.0	**Chief Executive's Report** The report provided information to the Board regarding a number of matters and activity since the previous meeting of the Trust Board. Carl James highlighted the following: • **Importance of Values and Behaviours** – on the 22nd July 2024, the Executive Team had hosted a virtual all-staff session to share perspectives and reflections on the Values and Behaviour Framework, which had been attended by over 150 staff; feedback to date had been positive and will be built on going forward. Lindsay Foyster queried whether staff would be provided the opportunity to voice their reservations regarding the launch of the values given that change may be challenging for some. Sarah Morley advised that the opportunity to do so had been facilitated via the session which had been welcomed and feedback had been received in a variety of ways, which would be made available at a future meeting of the Trust Board. • **Celebrating collective achievements** – A number of staff across the Trust had celebrated achievements and successes; Carl James wished to acknowledge Nigel Hill (Velindre Cancer Service Estates Team), who, following 38 years with the Trust, had received an outstanding achievement award. The Chair suggested that this section of the CEO update report should remain and that such individuals and teams should be informed that the Board had been informed of their achievements. The Chair agreed to write to Nigel Hill on behalf of the Board. Gareth Jones also wished to acknowledge the appointment of Non Gwilym to interim Director of Corporate Governance, as this had not been included. The Trust Board **NOTED** the content of the Chief Executive's Update Report.	**SfM** **Chair**
3.0.0	**INTEGRATED GOVERNANCE**	
	There were no items for discussion at the meeting.	
4.0.0	**QUALITY, SAFETY AND PERFORMANCE**	
4.1.0	**VUNHST Risk Register** The Trust Risk Register informed the Board of the latest position of reportable risks, in line with renewed risk appetite levels and progress against the Risk Framework and how these are currently managed across the Trust. Lauren Fear advised the following changes since the last reporting period: • Closure of risk (**3277**), regarding the new Velindre Cancer Centre financial risk in the lead up to Financial Close. • Two new Health and Safety risks (**3362** - *There is a risk to quality as result of failure of the WBS External Nitrogen Storage Tank leading to complete loss of liquid nitrogen* and **3366** - *There is a risk to the safety of staff due to lack of storage and cleaning space in the Therapies department, resulting in an increased trip, slip or falls risk within the shared Therapies storage, kitchen and corridor area.)* Actions in reference to these are noted in Datix. • Item 5.1.0 on the action log referred to a meeting with Independent Members scheduled for the 20th August 2024 to discuss and agree the format of the cover paper and risk reporting template. This will be sighted at the September 2024 Trust Board and will be subject to further review after 6 months.	

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	Gareth Jones raised the following points: • Point 2.2 states that the Trust Board had approved the Full Business Case/Management Case; it was noted that this is not accurate and that this should be recorded as noted, followed by receipt of Welsh Government comment, prior to approval. Lauren Fear agreed that the wording of this point should clarify that this had not yet been fully approved by Trust Board. • Point 3.1 states that a decision regarding next steps will need to be made by Trust, querying the nature of this decision. Lauren Fear advised that the all-Wales risk module of Datix under the governance of the all-Wales Datix programme, (now chaired by Carl James) is the only remaining module not yet agreed to date. Work by the Corporate Governance Directors' Peer Group has been ongoing to achieve a position where each organisation will be able to reach a decision and it is anticipated that an informal position will be agreed by each organisation during September. • Despite the significant amount of information included on the risk register, there is no indication of risk owners. Additionally, as there is no visibility of the risk trend is not visible (increasing, decreasing or remaining stable), it is not possible to identify whether action taken is addressing risks effectively. Lauren Fear advised that the meeting with Independent Members on the 20th August will address this. The Chair had previously been unaware of risk **3362** (storage of Liquid Nitrogen), requesting an update on action taken to date. Alan Prosser advised that the Estates Team had implemented a significant amount of mitigation, in addition to a large-scale infrastructure project to assess the Trust's Liquid Nitrogen requirement. This is being managed and maintained effectively and the Health & Safety Team is aware. It was agreed that this will remain on the Risk Register until entirely resolved. Stephen Harries queried whether risk **3337** (SACT patients at risk of being missed as a result of multiple lists) would be addressed within the Performance Report. Nicola Williams advised that a single list had been generated using automation which is currently being tested, with positive results so far. The Trust Board: • **NOTED** the risks level 15 and above, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTED** the on-going developments of the Trust's risk framework.	**LF/NG**
4.2.0	**Trust Assurance Framework (TAF)** The report summarised the latest view of the Trust Assurance Framework. Lauren Fear highlighted the following: • **Risk ID 05 (Digital Transformation)** – This had been discussed further at the July meeting of the Quality, Safety & Performance Committee, with evidence of positive progress. • **Risk ID 06 (Organisational and Clinical Governance)** – This will be presented to the September 2024 meeting of the Quality, Safety & Performance Committee as a deep dive, to align with the consideration of the governance of Assurance & Risk. • **Integration of IMTP objectives into the current iteration of the TAF** – Mapping between the IMTP and TAF has now been included within the template, with RAG ratings due to commence from the September	

	2024 reporting cycle. Additionally, the alignment of the IMTP with the TAF in future will form part of the September 2024 Trust Planning Framework. Gareth Jones referenced page 3 of the dashboard report, noting that the statement of 'complete' regarding a number of actions not yet completed was misleading. It was agreed to replace such instances with 'to be completed', as this refers to what is proposed for 2026-27. The Trust Board **DISCUSSED** the Trust Assurance Framework, **NOTING** developments already in place.	**NG**
4.3.0	**Performance Management Framework (May 2024)** The paper provided an update on Trust performance (including supporting analysis) for the month of May 2024, against a number of national targets. Alan Prosser reported the following in relation to Welsh Blood Service performance: • Sustained supply and positive reporting regarding quality and safety markers and donor satisfaction (at 98% against a 95% target), despite a challenging period. • Reporting of Serious Adverse Blood Reactions & Events (SABRE) to the Medicines and Healthcare products Regulatory Agency (MHRA) during May, resulting in a satisfactory conclusion and subsequent closure by the MHRA. • Provision of Mutual Aid support to England during national alert in relation to blood supply. • Challenges presented by the holiday period, an increase DNAs and issues posed to the cross-matching of demands by the cyber security issue across London; the situation is not expected to be resolved until September 2024. • Following the January 2024 introduction of the buccal swab, the service is significantly exceeding expectation in terms of bone marrow volunteer recruitment and is now targeting hard to reach and ethnic communities. Visits to educational establishments and key events such as this year's National Eisteddfod. As it has been widely assumed that Wales is experiencing similar issues to England (following England's declaration of Amber alert for a second time in two years), Alan Prosser advised that the Trust had issued a statement, clarifying Wales' position. The Chair requested a brief paper containing further explanation of Mutual Aid, to provide assurance to the Health Minister and re-iterating the importance of Mutual Aid for the UK as a whole. Lindsay Foyster queried why the May target for platelet wastage had not been achieved. Alan Prosser explained that this had resulted from the introduction of uncertainty in demand due to the two May Bank Holidays, noting that demand generally remains unpredictable. Rachel Hennessy reported the following in relation to the Velindre Cancer Service performance: • **Radiotherapy performance** – continued 100% compliance with Emergency Radiotherapy treatment, with a slight decline in Scheduled (74%) and Urgent (73%) due to challenges presented by the issue of an end-of-life notice on a specific Linac machine (LA1). An Impact	**AP**

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	Assessment has been undertaken to explore the utilisation of LA1 as a resilience machine and an extension to the end-of-life notice to May 2025 has been requested and granted. It is also the intention to implement LA3 (new Varian machine) during July 2024 to provide additional capacity. • All referrals continue to progress via the escalation and prioritisation process, with harm reviews undertaken where appropriate. • **Systemic Anti-Cancer Therapy (SACT) performance** – Emergency performance remained at 100% for the period, in addition to timely booking of all clinical trials. It had not been possible to confirm the end of May position in relation to delivery of non-emergency SACT due to ongoing challenges faced by the service (figures for May were not available in time for publication of the report due to the data validation process.) A planning group has been established which will report to a weekly SACT Gold Command meeting to improve performance in this area. It was advised that a key issue causing such challenges is capacity within Pharmacy. Further investment has been made into Pharmacy to facilitate further expansion, to be discussed further at Executive Management Board. • The appointment of a Service Improvement Lead has led to a significant amount of work regarding capacity planning and forecast. Challenges in relation to demand has resulted from additional lines of treatment, internally generated treatments and increased longevity of patients. • No **pressure ulcers** were reported for the third consecutive month. • No **avoidable falls** were identified for the 15th consecutive month. • **Delayed Pathways of Care** – Two patients had been delayed (by 5 and 4 days) due to awaiting repatriation to their local hospital. • Patient experience remains positive; however, this is based on limited information obtained via CIVICA. Volunteers have returned to the site since May to assist patients in providing feedback required by the Service for the implementation of improvements. Screens are also now utilised to communicate waiting times to patients. Nicola Williams advised that fortnightly SACT Gold Command meetings had been stood up and that the Executive Team would receive a comprehensive paper outlining work to date regarding investment required around Nurse staffing, Pharmacy staffing and changing ways of working to increase capacity within SACT. This will require a co-ordinated, long-term transformation programme of work over the course of the next year. A higher than predicted increase has been evidenced over the past month, which will be tracked by the Business Intelligence team, identifying trends in tumour sites and seeking to align with the wider position across the region. Oversight of harm is also being maintained where delays to treatment have occurred, while also ensuring effective communication of delays to patients. Stephen Harries raised the following points: • The report states that reported SACT waiting times reflects that February position, however this should state that this is the April position. This was agreed. • It is understood that the majority of patients have been unable to view waiting times for at least 6 weeks due to the malfunction of a display screen within the Outpatients' Department. • A comment on the 'you said……we did' board relates to the WRVS (Welfare Royal Voluntary Service) (which has been closed since the beginning of the COVID-19 pandemic). Stephen Harries queried whether this would be re-instated, or a similar facility be provided. Rachel Hennessy advised that Outpatient facilities would be reconfigured and that the service would be re-instated. It was agreed to provide a timeline for this.	**RH**

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	As it was recognised that the decline in performance would be noted by the public audience, Gareth Jones requested assurance that this is being addressed and that improvement will follow. Additionally, it was queried how improvements could be demonstrated to Gold Command in the absence of timely data? Nicola Williams acknowledged that the time taken to validate data is unacceptable and the process is currently under review as a matter of priority. Following a request from the Chair for the latest validated (May 2024) data for non-emergency SACT, Rachel Hennessy agreed to provide this to Board members. Hilary Jones noted continued low compliance with Fire Safety KPIs, expressing the importance of training uptake to ensure resilience within the Trust in the event of an incident. Lauren Fear advised that all legal and statutory requirements across all areas of Estates are not reported in one place, which will be addressed by the Estates team, with the aim of reporting more specifically on training. It was also noted that service pressures have impeded the release of staff to undertake this training. It was agreed to bring a detailed breakdown to the September meeting of the Trust Board. Sarah Morley provided the following update in relation to Workforce: • Sickness absence stands at 5.19%, reported for the year to 24th July 2024, a decrease in one percentage point over 12 months. A general decrease in long term sickness absence continues, while a slight increase in short term sickness absence has been seen. • A new Health and Wellbeing Coordinator is now in post, identifying areas requiring additional support. A new Psychologist will also start in October 2024. • PADR compliance stands at 73% (against an 85% target); this is being addressed via Senior Leadership Teams and a review of Workforce policies. A review of PADR paperwork and its purpose will also be undertaken, with the addition of the new Trust Values. • Statutory & Mandatory training stands at 87%. Compliance within relevant areas is noted in the associated Committee highlight report. Vicky Morris advised that the Board had previously agreed a Trust sickness absence target of 4.7%, against the national target of 3.54%, requesting the anticipated timescale for improvement to sickness levels. Sarah Morley advised that the current level of 5.19% is reasonably similar to the 4.7% target and the Trust continues an improved trajectory. Increased focus will now shift to the increase in the short-term sickness absence level. The Trust Board**:** • **DISCUSSED** and **NOTED** the May 2024 Performance Management Framework (May data was absent in some areas). • **NOTED** the targeted work being undertaken through business continuity arrangements in respect of the delivery of SACT.	**RH** **LF**
4.4.0	**Financial Report (May 2024)** In presenting the report outlining the financial position for the period ended (Month 2) 31st May 2024, Chris Moreton highlighted the following key points: • The Trust is currently forecasting a breakeven position for the end of the financial year 2024-2025. • The Trust is currently on track in meeting the Trust's Public Sector Payment Performance target.	

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	• Saving Schemes – There are now no Red Rated Schemes and savings have been increased (as per discussion under Matters Arising). • Risk remains to the Capital position in relation to funding for the new Velindre Cancer Centre and Enabling Works. Receipt of confirmation from Welsh Government is anticipated in September 2024. **Procurement Supply Chain saving schemes** - Stephen Harries queried whether other Health Boards would also be reliant on NHS Wales Shared Services Partnership to deliver their savings plans. Chris Moreton confirmed that this would be the case. The Trust Board **NOTED** the content of the May 2024 financial report, in particular: • The year to date and forecast outturn position. • The risks associated with the income that the Trust is expected to receive from our Commissioners. • The current position with Commissioners on the contract rebase agreement. • The latest position of the Trust savings schemes, and urgent action taken by Divisional and Executive Directors to ensure the reduction of schemes RAG rated as amber or red to green.	
5.0.0	**ANNUAL REPORTS** **It was noted that the Audit Committee Annual Report had been presented at the May 2024 meeting of the Trust Board.	
5.1.0	**Local Partnership Forum Annual Report (2023-2024)** The report summarised the key areas of Trade Union partnership activity undertaken by the Trust' Local Partnership Forum for the reporting period. Sarah Morley highlighted the following: • The Trust is now subject to the Social Partnership and Procurement Act, with the recruitment of a Lead Trade Union Representative and endorsement of the proposed recruitment process for a Social Partnership Lead. Lauren Fear advised that the Trust's Integrated Medium-Term Plan (IMTP) is routinely presented at the Local Partnership Forum and work is currently underway with Workforce to gain better understanding of the Social Partnership and Procurement Act and requirement to engage early in the process to shape priorities and plans with Trade Union and staff representatives. The Chair requested further explanation of this new legislation at the October 2024 Board Development Session. The Trust Board **APPROVED** the 2023-2024 Local Partnership Forum Annual Report.	**SfM**
5.2.0	**Gender Pay Gap Annual Report (2023-2024)** The report included the mean and median gender pay gaps and analysis of pay data for the reporting period. Sarah Morley highlighted the following:	

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	• The mean pay gap stood at 14% to end of March 2024 (the hourly rate for men in Velindre was 14% higher than the average for women). Analysis identified that this included senior staff across all groups. • Improvements in recruitment and staff development will help redress this gap, however a number of changes will need to be focused on women in their early careers to ensure they develop into the most senior roles at the same rate as men. • This work being reflected in the Strategic Equality Plan objectives, specifically to reduce pay gaps for gender, race and disability (the latter two are not currently reported). Andrew Westwell referenced the inclusion of average and median rates in Appendix 1 of the report, noting that the simple addition of these together to reach a combined figure was incorrect and that a weighted average should be applied across the organisation instead (this also applies to bonus figures noted on the subsequent page). It was also agreed to correct discrepancies within the headcount data. Sarah Morley agreed to correct the figures and re-circulate the document following the meeting. Stephen Harries requested a footnote clarifying the meaning of 'mean' and 'median' for the purpose of the public audience. Lindsay Foyster requested that the ratio split in section 3.1 should be corrected from 31:29 to 31:69. Additionally, in relation to specific actions included in section 4.4 to help reduce the gender pay gap, Lindsay Foyster queried whether assessing job application outcomes in relation to candidate gender is assessed at all stages of the process. Sarah Morley confirmed that this was the case. The Trust Board **CONDITIONALLY APPROVED** the 2023-2024 Gender Pay Gap Annual Report, subject to receipt of updated figures and responses to any consequential queries.	**SfM** **SfM** **SfM**
5.3.0	**Equality, Diversity & Inclusion Annual Report (2023-2024)** The report presented the overall picture of the workforce, demonstrating that whilst the workforce has increased, the spread of different protected characteristics has remained largely consistent with 2023. Sarah Morley highlighted the following: • The inclusion of comparisons with Census data (inclusion of LGBTQ data will be included when available). • The inclusion of an overview of Strategic Equality Objectives, which will remain going forward. The Objectives run across four years (2024-2028) and progress against each of these will be reported; the Annual Work Programme will be based around meeting these objectives. • The Trust had received its first racial equality report with a range of metrics specific to race, adding that a detailed report would be brought through the next governance cycle. This had identified a degree of under reporting / not declared and it was agreed that senior and Board level colleagues should be encouraged to declare their ethnicity via the Electronic Staff Record system. Lindsay Foyster noted the positive position of the Trust against Census data, indicating that staff felt safe to specify their sexuality:	

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	Census data (Wales)	Trust data
Identify as heterosexual	89.4%	82%
Identify as lesbian, gay, bisexual or other sexuality	3.1%	6%
No answer	7.6%	5%

The Trust Board **APPROVED** the 2023-2024 Equality, Diversity & Inclusion Annual Report.

5.4.0

Welsh Language Annual Report (2023-2024)

The report provided the Trust's annual compliance against the Welsh Language Standards. Sarah Morley extended thanks to Gareth Jones for proofreading the report and highlighted the following:

- A significant amount of activity and positive progress for the Trust had been undertaken in this area during the reporting period.
- Following receipt of two complaints from members of the public (relating to the accuracy of the Trust website and receiving/responding to telephone calls in Welsh), proactive steps had since been undertaken to rectify internal processes.
- Two official Commissioners' Investigations against compliance with the Welsh Language Standards had resulted in the development of an action plan, closely monitored by the Welsh Language Development Group.
- The introduction of the Trust's new bilingual Induction (Croeso) during the period, in addition to the development of the new (bilingual) Values and Behaviours.

The Chair had requested the provision of software for the purpose of checking spelling and grammar. Gareth Jones expressed an interest in obtaining this resource and Sarah Morley agreed to provide this. Gareth also indicated that he had not yet been able check the accuracy of amendments made to the updated report but would do so following the meeting.

The Trust Board **APPROVED** the 2023-2024 Welsh Language Annual Report, prior to publication on the Trust's website and being made available to the Welsh Language Commissioner.

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5.5.0

TCS Programme Scrutiny Sub-Committee Annual Report (2023-2024)

The report summarised the key areas of business activity undertaken by the TCS Programme Scrutiny Sub-Committee between 2023 and 2024. Stephen Harries noted an exceptionally busy period in the lead-up to Financial Close (March 2024), referencing the significant number of meetings undertaken by the Sub-Committee over the period (13).

Gareth Jones raised the following points:

- Section 6.3 states that the Full Business Case was approved in March 2024; however, this is yet to happen. Additionally, the date in this paragraph reads March 2023. It was agreed that this would be amended and reworded to include that the Board had been informed at each stage of development and the date of signoff.
- The following paragraph under 6.3 states that the Bone Marrow Transplant Strategic Outline Case had been endorsed by the TCS

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	Programme Scrutiny Sub-Committee, however this was not accurate, and this had been presented to the Strategic Development Committee. Lauren Fear advised that the Strategic Outline Case had been sighted by the TCS Programme Scrutiny Sub-Committee due to the link to the Nuffield Report recommendations. Stephen Harries agreed to clarify this. The Trust Board **APPROVED** the 2023-2024 TCS Programme Scrutiny Sub-Committee annual report, subject to the amendments noted above.	**SH**
5.6.0	**Quality, Safety & Performance Committee Annual Report (2023-2024)** The report summarised the key areas of business activity undertaken by the Quality, Safety & Performance Committee between 2023 and 2024. Vicky Morris highlighted the following: • the themes of Patient / Donor / Staff stories received over the period, which are presented at the beginning of each Committee. • one point of escalation for the period, relating to the Risk Register and Trust Assurance Framework, which had been acknowledged by the Board at the time. Nicola Williams thanked Vicky Morris for her commitment to shaping the Quality, Safety & Performance Committee over the period. The Trust Board **APPROVED** the 2023-2024 Quality, Safety & Performance Committee annual report.	
5.7.0	**Strategic Development Committee Annual Report (2023-2024)** The report summarised the key areas of business activity undertaken by the Strategic Development Committee over the reporting period. Stephen Harries highlighted the following: • Consideration and endorsement of a number of Business Cases (1) Plasma for Medicines Business Case (2) Velindre Oncology Academy Business Case (3) Radiology Informatics System Procurement Business Case. • Other items considered and endorsed by the Committee detailed under 6.4. Gareth Jones advised that the Audit Committee Annual Report had been presented at the May 2024 meeting of the Trust Board, advising that the items are currently under consideration. Lindsay Foyster indicated that the inaugural meeting of the Strategic Development Committee stated as May 2024 under 6.2 should read May 2023. Stephen Harries agreed to amend this. The Trust Board **APPROVED** the 2023-2024 Strategic Development Committee annual report, subject to the editorial corrections noted above.	**SH**
5.8.0	**Putting Things Right Annual Report (2023-2024)** The report included detail on a number of key areas for the reporting period, in particular concerns, redress matters, communication and administration issues and processes and reportable incidents. Nicola Williams highlighted the following, subsequent to detailed discussion at the July 2024 meeting of the Quality, Safety and Performance Committee:	

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	• A positive reduction in falls over the reporting period as a result of improvements implemented since the previous year. • The request for future reports to include a trending of themes to identify whether actions taken are resulting the desired outcomes. Stephen Harries referenced the number of patient and donor contacts detailed within the Executive Summary of the report (some 335,025), reiterating the significant volume of activity undertaken whilst continuing to treat each patient/donor/family as individuals. The Trust Board **APPROVED** the 2023-2024 Trust Putting Things Right Annual Report, prior to translation and publication on the Trust's website.	
5.9.0	**Duty of Quality Annual Report (2023-2024)** The first iteration of the report, developed in line with the Duty of Quality Statutory requirements, outlined steps taken by the Trust to comply with the Duty and improvements made across the Trust's services. Nicola Williams highlighted the following: • The report had been considered in detail at the July meeting of the Quality, Safety & Performance Committee and it is anticipated that a number of changes will be made to the future format of the report as it matures. • The report has been allocated a Level 2 assurance rating, recognising that the Quality Impact Assessment process for all strategic decision-making has not been embedded as robustly as anticipated this year. This will be prioritised, in addition to the Quality & Safety dashboard and harm / safety measures forming part of the Trust's Performance Management Framework. It was agreed that the Level 2 rating was appropriate and resolutions / improvements over the course of the coming year are expected. • Additional focus to be on how the Trust may actively interlink with the new Patient Engagement Board to ensure effective future provision of what patient requirements. The Trust Board **APPROVED** the first Trust Duty of Quality Annual Report (2023-2024), prior to translation and publication on the Trust's website.	
5.10.0	**Professional Registration / Revalidation Annual Report (2023-2024)** The report provided assurance to the Board in relation to regulation governance. Nicola Williams highlighted the following: • The report had been considered at the July meeting of the Quality, Safety & Performance Committee, receiving a Level 3 assurance rating as a result of a lapsed NMC registration during the period due to breach in the checking process. However, it was advised that the individual did not work whilst unregistered and that re-registration had been undertaken immediately. • As a result, a number of changes to the checking process had been implemented and the Quality, Safety & Performance Committee had requested an urgent review of the Professional Registration Policy, in addition to further assurance regarding the registration status of agency / locum staff (this was provided at the Committee).	

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	The Trust Board **NOTED** for assurance purposes the 2023-2024 position in respect of professional registration / revalidation compliance across all professional groups within Velindre University NHS Trust.	
5.11.0	**Patient and Donor Experience Annual Report (2023-2024)** The report provided experience feedback from patients in relation to care and treatment received through the Velindre Cancer Service and feedback from donors regarding their overall donation experience. Nicola Williams highlighted the following: • The report had been considered at the July meeting of the Quality, Safety & Performance Committee, receiving a Level 4 assurance rating. • It was recognised that further work to increase the volume of feedback received via Velindre Cancer Service is required. • Further discussion regarding 'you said, we did' boards within clinical areas had resulted in immediate action by senior staff to ensure these are updated on a regular basis. David Cogan indicated that raw data received from patients is overwhelmingly positive in the main, however it was acknowledged that the volume of feedback is low. David Cogan advised that the return of volunteers and revised Patient Liaison Group would provide the opportunity to obtain a greater volume of feedback to inform this report. It was agreed that a review of the capture of the patient / donor voice outside questionnaires is required (for example formalising informal discussions / recording feedback from Welsh Blood Service Donor Award events). It was agreed to explore this within each division. The Trust Board **APPROVED** the 2023-2024 Trust Patient and Donor Experience Annual Report, prior to translation and publication on the Trust's website.	**AP/NW/RH**
5.12.0	**Clinical Audit Annual Report (2023-2024)** The report provided an overview of the clinical audit activity and programme of work on clinical effectiveness across both divisions. Dr Edwin Massey highlighted the following: • The report had been considered at the July meeting of the Quality, Safety & Performance Committee, receiving a Level 4 assurance rating due to its robust action plan and evidence of delivery on a number of actions (e.g. widespread use of the Audit Management and Tracking (AMaT) system and significant number of national audits across a variety of services). • A higher volume of data in relation to cancer services was included within the report as a result of clinical audit activity. It was acknowledged that internal and external quality audit data from the Welsh Blood Service appears more widely in Quality, Safety and Performance Committee Papers. • The Infected Blood Inquiry had recommended the implementation of improved digital systems (in relation to transfusion services). Health Technology Wales (HTW) had additionally recommended that improved digital systems should be in place for safety and cost effectiveness; this is being addressed to trace individuals' receipt of blood and reasons for doing so. However, this is currently dependent	

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	on manual audit work undertaken by senior staff and a review of the information systems to improve transfusion practice is necessary. Andrew Westwell commented that the work detailed in the report may feasibly be considered as publishable Research. The Chair queried the process for deciding the programme of audits for the year. Edwin Massey advised that this is based on areas of risk, areas of change and nature of any incidents. Vicky Morris suggested that the Board may potentially join a bespoke grand round, to be sighted on the high-quality audit reports presented by Medical Students. The Trust Board **APPROVED** the 2023-2024 Velindre University NHS Trust Clinical Audit Report. The Chair extended her thanks to all report authors for the considerable amount of work reflected within the annual reports.	
6.0.0	**PLANNING AND STRATEGIC DEVELOPMENT**	
6.1.0	**nVCC Project Board Terms of Reference** The paper provided background information outlining the reasons for updating the Terms of Reference (ToR) for the new Velindre Cancer Centre, as noted in the Price Waterhouse Cooper (PwC) Governance and Capability Review recommendations. Lauren Fear highlighted the following main changes: • Combining of the Enabling Works and nVCC projects. • Changes to reporting lines. • Details of the delivery model for the construction phase for the Project Board over the next 3 years. • Membership – the role of Chair will be assumed by the SRO (once appointed), noting that the Executive Director of Finance would provide cover in the interim; an additional Executive Director will assume the role of Vice Chair. • Changes to attendees of the Project Board. Nicola Williams suggested that item 2.5 (the level of oversight requested of the nVCC Project Board) contained too much detail. Amended wording was requested, in particular regarding approving equipment specifications, tenders and the awarding of contracts and orders. Lauren Fear agreed that as this applies to orders of varying values, further specification in terms of values at Trust Board level, Project Board level and Work Stream level is required; therefore, three levels of sign off for equipment tenders will remain until such time that the delegation framework is amended. Nicola Williams also questioned whether oversight of the transition into the new hospital was sufficiently reflected in the ToR. Hilary Jones queried whether the ToR reflected the importance of the integrity of the design principles and asked for them to be strengthened in this respect. Carl James advised that this would be addressed in Part B of the meeting. **Gareth Jones advised the following:** • The title of the cover paper was missing the word 'Board'.	

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	• Paragraph 3.1 of the ToR should state that the Project Board is accountable to the Trust Board as opposed to the Chief Executive as currently stated, as paragraph 2.1 states that 'the Project Board will report directly to the Trust Board'. It was advised that the governance route (as the Project Board will possess similar decision-making powers to Executive Board) requires further agreement and that the Project Board should not operate 'dislocated' from the Board. It was agreed that the wording in relation to reporting lines / governance route would be amended to avoid misinterpretation and ambiguity. As the ToR form part of the Full Business Case, it was agreed to amend these as a matter of priority and, in the event of substantial changes, return to an extraordinary TCS Scrutiny Committee followed by an extraordinary Trust Board during August. The Trust Board was **not** in a position to **APPROVE** the Terms of Reference and it was agreed that a further meeting would be arranged to facilitate sign off, reflecting discussions noted above in an updated document.	**LF**
7.0.0	**CONSENT ITEMS**	
7.1.0	**CONSENT FOR APPROVAL**	
7.1.1	**Interim Amendments to the Trust Model Standing Orders** Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board **APPROVED** the adoption of the interim amendments to the Trust's Model Standing Orders, Reservation and Delegation of Powers following the establishment of the NHS Wales Joint Commissioning Committee.	
7.1.2	**Amendment to Standing Orders – Schedule 3 Annual Review Committee Terms of Reference** Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board **APPROVED** the revisions to the Terms of Reference for the Audit Committee (Appendix 1) which form part of Schedule 3 of the Trust's Standing Orders.	
7.1.3	**NWSSP Proposed Amendments to Financial Delegation** Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board **APPROVED** the proposed amendments to the NHS Wales Shared Services Partnership Scheme of Budgetary Delegation.	
7.1.4	**Refresh and Update of the Velindre University NHS Trust Well-Being of Future Generations (Wales) Act (WBFGA) Objectives** Led by Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital Lindsay Foyster requested a minor amendment to the grammar of the final paragraph under point 3.5 of the cover paper as it did not read correctly. The Trust Board **APPROVED** the Revised Trust Board Trust Well-Being Objectives.	**LF**

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7.2.0	CONSENT FOR NOTING	
7.2.1	**Public Quality, Safety & Performance Committee Highlight Reports (09/07/2024 & 11/07/2024)** Led by Vicky Morris, Independent Member and Chair of Quality, Safety & Performance Committee The Trust Board **NOTED** the key deliberations and highlights from the meetings held on the 9th and 11th July 2024.	
7.2.2	**Public Audit Committee Highlight Report (10/07/2024)** Led by Gareth Jones, Independent Member and Chair of Audit Committee The Trust Board **NOTED** the content of the Highlight Report.	
7.2.3	**Public Strategic Development Committee Highlight Reports (15/05/2024 & 18/06/2024)** Led by Stephen Harries, Vice Chair and Chair of Strategic Development Committee The Trust Board **NOTED** the content of the reports and actions being taken.	
7.2.4	**Public Charitable Funds Committee Highlight Report (20/02/2024)** Led by Professor Donna Mead OBE, Chair of the Charitable Funds Committee The Trust Board **NOTED** the content of the report.	
7.2.5	**Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (18/04/2024, 16/05/2024, 20/06/2024)** Led by Stephen Harries, Vice Chair and Chair of the TCS Scrutiny Sub-Committee The Trust Board **NOTED** the content of the reports and actions being taken.	
7.2.6	**Remuneration Committee Highlight Report (06/06/2024)** Led by Sarah Morley, Executive Director of Organisational Development and Workforce The Trust Board **NOTED** the content of the report.	
7.2.7	**Extraordinary Remuneration Committee Highlight Report (04/07/2024)** Led by Sarah Morley, Executive Director of Organisational Development and Workforce The Trust Board **NOTED** the content of the report.	
7.2.8	**Local Partnership Forum Highlight Report (04/06/2024)** Led by Sarah Morley, Executive Director of Organisational Development and Workforce The Trust Board **NOTED** the content of the report.	
7.2.9	**Joint Commissioning Committee (JCC) Summary Report (21/05/2024)** Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board **NOTED** the content of the report.	

7.2.10	**NHS Wales Shared Services Partnership Committee Assurance Report (16/05/2024)** Led by Non Gwilym, Interim Director of Corporate Governance The Trust Board **NOTED** the content of the report.	
8.0.0	**ANY OTHER BUSINESS** The Chair had not received prior notice of any other business.	
9.0.0	**Date of the next meeting -** The next meeting of the Public Trust Board will take place on Thursday 26th September 2024 at 10:00 hours.	
10.0.0	**CLOSE**	
11.0.0	It was noted that the following items would be addressed at the Private / Part B Session of the Trust Board: • Claims and Inquest Annual Report (2023-2024) • Whitchurch Land Transfer • nVCC Contractual Matters • nVCC Project Matters and Funding Arrangements • MIM Governance Protocol • Legal Matters • Chair's Urgent Actions • Commitment of Expenditure exceeding Chief Executive's Limit • Digital PROMs Solution – Business Case • Committee Highlight Reports • Private Claims Highlight Report	

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VUNHST PUBLIC TRUST BOARD MEETING SEPTEMBER 2024 – ACTION LOG

No.	Action	Owner	Target Date	Progress to date	Status (Open / Closed)
ACTIONS ARISING FROM 30/01/2024					
3.1.0	Executive Team members to discuss how Committee highlight reports could be utilised more effectively to summarise discussions and resulting actions to avoid repeat discussions at Board meetings.	Interim Director of Corporate Governance	**26/09/2024**	Updated Highlight / Assurance report template included in refreshed Corporate Governance manual which was endorsed by Executive Management Board in June 2024. Recommend that the action is closed on this basis. Corporate Governance Manual to be considered by Audit Committee in December 2024.	**CLOSED**
5.1.0	Board to be kept up to date regarding rollout of plan to embed Trust Values (plan currently being finalised).	Executive Director of Organisational Development & Workforce	**26/09/2024**	The Values and Behaviour Framework is on the Trust Board agenda for the 26th September. Work is continuing on the integration of the values in Trust, policies and procedures relating to staff. A further iteration of the Behaviour Framework is being developed which will go through the November Board governance cycle.	**CLOSED**
ACTIONS ARISING FROM 26/03/2024					
4.1.0	Detail for each phase of recruitment programme for Radiotherapy Physics Department to be provided via Vicky Morris / Quality, Safety & Performance Committee.	Interim Director of Velindre Cancer Service	**30/07/2024**	**Update for September Trust Board**: Recruitment on track. Detailed updates on the relevant issues are reported and monitored through IRS Project Board. Areas of concern escalated to Velindre Futures Board and where appropriate managed through Divisional Risk process.	**OPEN**
ACTIONS ARISING FROM 23/05/2024					
2.4.0	Minutes from the previous Trust Board (green rating allocated to proportion of Welsh speaking workforce). There is no target at present, however the number of Welsh speakers will be reported in the meantime.	Executive Director of Organisational Development & Workforce	**26/09/2024**	A target for completion of Welsh Language competencies has been added to the Performance Management Framework	**CLOSED**
5.1.0	Re development point 12 (Trust Risk Register) – action from QSP/Audit joint extraordinary	Interim Director of Corporate Governance	**~~26/09/2024~~** **14/11/2024**	Further improvements to Risk Management Framework to be captured as part of Governance, Assurance and Risk Programme Phase 2. Meetings with Independent Members scheduled for	**OPEN**

	Committee in relation to further input required by IMs to be facilitated.			October/November and the outcomes will inform internal discussions on risk reporting in time for the next reporting cycle (November) with a view to the agreed templates remaining in place for a six month period (new target date aligns with next QSP meeting).	
5.3.0	Performance Management Framework – Where delays to Radiotherapy and SACT treatment occur, include number of days' delay.	Interim Director of Velindre Cancer Service	**30/07/2024**	**Update July Trust Board** – Addressed at July Trust Board within Performance Management Report. Agreed to close action.	**CLOSED**
7.1.1	Commitment of Expenditure – to clarify agreement with NHS Wales Shared Services Partnership and NHS Resolution, prior to subsequent Board / out of Board approval.	Director of Corporate Governance & Chief of Staff	**30/07/2024**	**Update July Trust Board** – Addressed with NHS Wales Shared Services Partnership. Confirmed that this is not a legal agreement and was presented to May Trust Board in error. Agreed to close action.	**CLOSED**
7.1.4	Revisions to Schedule 3 of Trust Standing Orders – Terms of Reference for relevant Committees to be amended to include reference to requirements to demonstrate quality-led decision-making through receipt of Quality Assessments (at Committees where strategic decisions are undertaken).	Interim Director of Corporate Governance	**26/09/2024**	Updated Terms of Reference template for all Trust Board Committees to have proposed new wording which ensures that all matters, including Quality Impact Assessments, that need to be undertaken by the Trust Board in decision making, are referenced. (ie the Impact Assessment section of the cover paper). This is included in the Corporate Governance Manual for Audit Committee in December. Action to be reconsidered following Audit Committee meeting and consideration of manual. All ToR to be revised accordingly and considered as part of annual cycle.	**OPEN**
ACTIONS ARISING FROM 30/07/2024					
1.6.0	Matters Arising - Meeting to be arranged with Board Members to clarify the LTA rebasing process.	Deputy Director of Finance	**26/09/2024**	A meeting was arranged between the DoF and DDoF and SH to discuss in detail the LTA negotiations for 24-25, which also included the LTA re-basing issues and process. SH provided IMs at the QSP Committee with assurance around the LTA negotiations and the LTA re-basing issues and process (as the sub-committee responsible for providing assurance around financial performance). If all Board Members require a session to explain the LTA re-basing process that can be arranged separately.	**OPEN**

2.3.0	CEO update report - All feedback following the Trust Values and Behaviours Framework virtual session to be sighted at a future Board meeting.	Executive Director of Organisational Development & Workforce	**Ongoing (date TBC)**	Feedback from Executive Team Values session has been incorporated into Values and Behaviours Paper for September meeting.	**CLOSED**
2.3.0	CEO update report - Chair to write to Nigel Hill (Estates Team) on behalf of the Board regarding his receipt of outstanding achievement award.	Interim Director of Corporate Governance	**26/09/2024**	Congratulatory email sent.	**CLOSED**
4.1.0	Trust Risk Register – Rewording of point 2.2 required regarding approval of Full Business Case Management Case.	Interim Director of Corporate Governance	**26/09/2024**	Document amended.	**CLOSED**
4.2.0	Trust Assurance Framework – Items marked 'complete' on page 3 of dashboard report to be amended to 'to be completed'.	Interim Director of Corporate Governance	**26/09/2024**	Document amended.	**CLOSED**
4.3.0	Performance Management Framework – Paper to be provided to the Chair with explanation of Mutual Aid Agreement, for assurance purposes for Health Minister.	Director of Welsh Blood Service	**26/09/2024**	Document shared.	**CLOSED**
4.3.0	Performance Management Framework – Timeline to be provided in relation to re-configuration of Outpatients facilities.	Interim Director of Velindre Cancer Service	**26/09/2024**	The VCC Outpatient refreshment areas opened in September 2024 and will provide hot drink and snacks for patients. The facility is managed by the service.	**CLOSED**
4.3.0	Performance Management Framework – Provide Board Members with latest (May 2024) validated data for non-emergency SACT	Interim Director of Velindre Cancer Service	**26/09/2024**	Information included in the September PMF.	**CLOSED**
4.3.0	Performance Management Framework – Detailed breakdown of fire safety training requirements to be provided to September Board meeting.	Interim Executive Director of Strategic Transformation, Planning & Digital	**26/09/2024**	Paper included on September Trust Board agenda to provide the fire safety training breakdown and next steps.	**CLOSED**
5.1.0	Local Partnership Forum Annual Report – further explanation of new Legislation (Social Partnership and	Executive Director of Organisational	**28/11/2024**	A brief session on Trust responsibilities under the Social Partnership and Procurement Act is being	**CLOSED**

	Procurement Act) to be provided at October 2024 Board Development Session.	Development & Workforce		timetabled for the 17 December Board Development Session.	
5.2.0	Gender Pay Gap Report – Number of amendments to be made to the wording and figures contained in the report before full Board Approval can be secured.	Executive Director of Organisational Development & Workforce	**26/09/2024**	Update 12/08/2024 – Document updated / circulated to Board members and recorded as approved.	**CLOSED**
5.4.0	Welsh Language Annual Report – To provide link to Welsh Translation Software to Welsh Language Independent Member.	Executive Director of Organisational Development & Workforce	**26/09/2024**	The Trust Welsh Language Manager has sent the link and standard operating procedure to the Independent Member Welsh Language Champion.	**CLOSED**
5.5.0	TCS Programme Scrutiny Sub-Committee Annual Report – Rewording of Section 6.3 required in relation to approval of Full Business Case and confirmation of sighting of Bone Marrow Strategic Outline Case at TCS Scrutiny Sub-Committee.	Interim Director of Corporate Governance	**26/09/2024**	Document amended.	**CLOSED**
5.6.0	Strategic Development Committee Annual Report – Date of Inaugural meeting of the Strategic Development Committee to May 2023.	Interim Director of Corporate Governance	**26/09/2024**	Document amended.	**CLOSED**
5.11.0	Patient / Donor Experience Annual Report – explore capture of the patient voice outside of questionnaires (e.g. at WBS Donor Award events / formalising information discussions with patients).	Director of Welsh Blood Service / Executive Director of Nursing, AHPs and Health Science	**26/09/2024**	The exploration ow how the wider patient voice is underway within both Divisions and will feature in future annual patient and donor experience reports. WBS Donor Engagement team have been asked to consider how best to capture feedback about the service to support future Patient/Donor Experience reporting.	**CLOSED**
6.1.0	nVCC Project Board Terms of Reference – Document to be updated with all amendments / clarifications requested during July Trust Board meeting and signed off prior to September Trust Board meeting.	Interim Executive Director of Strategic Transformation, Planning & Digital	**August - PRIOR TO September Trust Board**	nVCC Project Board Terms of Reference approved by the Trust Board as part of nVCC Full Business Case.	**CLOSED**
7.1.4	Refresh and Update of the VUNHST Wellbeing of Future Generations Act	Interim Executive Director of Strategic	**26/09/2024**	Amendment made and will be carried forward to future papers.	**CLOSED**

	Objectives – Minor grammatical amendment to be made to final paragraph of point 3.5 to ensure this reads correctly.	Transformation, Planning & Digital			

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

TRUST BOARD

Fire Safety Training

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	STEPH WILLIAMS, HEAD OF HEALTH AND SAFETY
PRESENTED BY	Lauren Fear, Interim Executive Director of strategic Transformation, Planning and Digital
APPROVED BY	Lauren Fear, Interim Executive Director of strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Attached is an overview of current training compliance status for fire safety training within the Trust. It also outlines our future proposal for training delivery over the coming months and our strategy to engage more employees to ensure their compliance. This is to address Trust Board action 4.3.0.

RECOMMENDATION / ACTIONS	Recommendations: • Continue to provide support with the cleanse within ESR

	• Ensure that staff are allocated time to complete Statutory / Mandatory training. • Regularly evaluate the training program to ensure its relevance and effectiveness integrating feedback from participants to foster ongoing improvements. • TNA Fframework to be developed into Fire Protocol by Q4

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Public Trust board	(11/07/2024)
Trust Health, Safety & Fire Management Board	(20/09/2024)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS At its meeting on 30 July, the Trust Board received the annual report for Health, Safety and Fire, which included an update on the fire training status. This document outlines the efforts made to enhance fire training since the last discussion.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

APPENDICES	
n/a	

1. SITUATION

According to the Annual Report, Level 1 training has risen from 60% to 69%. While it is acknowledged that the Trust has not yet reached the target of 85% established by the Welsh Government, we have made progress to reach that goal since April

2024. Level 2 overall compliance has seen only a slight increase since then, though there has been a significant rise within the Corporate Division. Level 1 training is delivered as an e-learning package, while level 2 training is conducted face-to-face. Given that Level 1 is more accessible, it is expected the compliance figures seen would be higher.

2. BACKGROUND

The Annual Report highlighted the statutory and mandatory training requirements. It was noted that there had been a decrease in Level 1 – nonclinical training (3 Year Training). Despite some progress, additional enhancements were necessary to meet the target goal.

Each month, the Safety / Fire department have personally reached out to all senior managers within the corporate division, highlighting their individual dashboards to direct their attention to outstanding training areas. However, this is a time consuming process and the team acknowledge that it may not be the most efficient or effective, although it is possible to see a noticeable improvement across all training more recently.

	April	May	June	July	August
Corporate Division	84.8%	86.3%	87.0%	86.4%	89.3
RD&I	89.0%	87.0%	86.6%	87.0%	88.4
TCS	84.3%	83.6%	83.6%	84.2%	81.5
VCC	75.6%	77.4%	77.1%	77.9%	77.4
WBS	92.6%	93.7%	92.7%	90.9	91.1
Grand Total	81.6%	82.9%	82.6%	82.5%	82.6

Table shows all training compliance across the Trust.

From discussions, it became clear that additional courses were necessary to help individuals meet the statutory target of 85%.

Communications were sent out, informing the Trust that training would take place at HQ building, but attendance was less than satisfactory.

In August, after the holiday period, the Fire Safety Manager offered more courses via Teams and there was a noticeable increase in staff attendance.

Date of Course	Number of Additional Courses	Course Delivery	Number of people attended
26th June 2024	3 x 1hr Course	Face to Face HQ	3
August 29th 2024	3 x 1hr Course	Teams	34
September 23rd 2024	3 x 1hr Course	Teams	TBC
October 7th 2024	3 x 1hr Course	Teams	TBC
October 21st 2024	3 x 1hr Course	Teams	TBC
November 7th 2024	1 X 1hr Course	Face to Face VCC	TBC
November 12th 2024	1 x 1hr Course	Teams	TBC
November 18th 2024	1 x 1hr Course	Face to Face VCC	TBC
December 2nd 2024	1 x 1hr Course	Face to Face VCC	TBC
December 12th 2024	1 x 1 hr Course	Teams	TBC
December 18th 2024	1 x 1hr Course	Face to Face VCC	TBC

Table shows training we have provided and number of attendees.

As demonstrated by the figures below, the corporate division has successfully reached the 85% target this month, thanks to a variety of courses delivered over Teams provided by the Fire Safety Manager and the alternative timings offered.

Division & Compliance - NHS|CSTF|Fire Safety - 3 Years

Month	Total Compliance	WBS Compliance	VCC Compliance	TCS	RD&I	Corporate
August	80.10%	84.5%	76.9	80.0%	83.6%	85.1
July	80.10%	86.2%	77.8	80.0	80.0	78.3
June	80.3%	87.0%	77.3%	87.5%	79.00%	79.1%
May	80.8%	88.9%	77.3%	87.5%	85.2%	78.6%
April	80.9%	88.7%	77.4%	87.5%	88.3%	78.4%

Table above shows Non – Clinical Training compliance assurance (E-learning)

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Velindre University NHS Trust

Division & Compliance - NHS|CSTF|Fire Safety - 1 Year

Month	Total Compliance	WBS Compliance	VCC Compliance	TCS	RD&I	Corporate
August	69.3%	84.2%	65.9%	n/a	73.3%	50%
July	69.4	84.8	65.6%	n/a	73.3	75%
June	68.10%	88.4%	63.7%	n/a	64.5%	75.0%
May	65.3%	85.7%	60.9%	n/a	61.3%	75.0%
April	66.6%	86.5%	62.4%	n/a	61.3%	75.0%

Table above shows Clinical Training compliance assurance (Face to Face)

3. ASSESSMENT

For improved compliance, line managers must actively promote the significance and allocation of time for statutory mandatory training. The Fire Safety Manager has adjusted their approach to better meet the needs of the business by making face-to-face training more accessible and offering sessions outside of regular working hours to engage those who are harder to reach.

Currently we have a framework of task needs analysis that will be developed into a Fire Safety Protocol. This is also rated as priority 1 for the Impact needs matrix for the Trust. Following appropriate engagement, the revised Training Protocol is planned to be operational by December 2024.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Fire Safety Manager has recognised an existing problem with ESR. It has become clear that some employees have multiple fire training courses assigned to their names, resulting in several 'end dates' for training. Consequently, an employee may have more than one training course linked to their profile. Discussions are ongoing to assess the accuracy of these figures for the organisation and a data review and cleanse may be necessary.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☒ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). **Click or tap here to enter text**

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	There would be a need of resource or funding for resource to achieve some of the plans in the attachment **Source of Funding**: Divisional Budget Allocation Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not applicable
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

Current risks would be the lack of compliance of training of our staff

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

TRUST BOARD

CHAIR'S UPDATE REPORT

DATE OF MEETING	26th September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Prof. Donna Mead OBE, VUNHST Chair
APPROVED BY	Non Gwilym, Interim Director of Governance and Chief of Staff

EXECUTIVE SUMMARY	This report provides information to the Board regarding the Chair's activity since the previous meeting of the Trust Board.

RECOMMENDATION / ACTIONS	To **NOTE** the content of the Chair's update report.

GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE – N/A

APPENDICES – N/A

1. SITUATION

This paper provides the Trust Board with an overview of Chair's activity since the last meeting of the Trust Board.

2. BACKGROUND

2.1 Matters addressed in this report cover the following areas:

- Board Development Sessions
- Private Trust Board meetings (July/August/September 2024)
- Velindre Oncology Academy Launch Event (5th June 2024)
- Regional Clinical Summit (5th June 2024)
- National Eisteddfod (3rd-10th August 2024)
- Welsh Blood Service Donor Award Ceremony – Cwmbran (12th September 2024)
- Appointment of new Chief Executive Officer (13th September 2024)
- City of Cardiff Philharmonica's concert in aid of Velindre Cancer Centre – (14th September 2024)
- Volunteer Afternoon Tea Event – Whitchurch Rugby Club (18th September 2024)

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Board Development Sessions

No Board Development Sessions took place during the period.

3.2 Private Trust Board meetings:

30th July 2024 (regular) - Discussions at this private meeting of the Trust Board addressed the following items:

- Claims and Inquests Annual Report 2023-2024
- Whitchurch Land Transfer
- nVCC Contractual Matters
- nVCC Project Matters and Funding Arrangements
- MIM Governance Protocol
- Health Technology Wales Scope
- Chair's Urgent Actions Report
- Commitment of Expenditure Exceeding Chief Executive's Limit
- Business Case – Digital PROMs Solution
- Private Committee Highlight Reports

22nd August 2024 (extraordinary) – Discussions at this extraordinary private meeting of the Trust Board addressed the following items:

- nVCC Governance and Capability Review Management Action Plan
- nVCC Full Business Case (Management Case and Financial Case)
- Conditions Precedent
- nVCC Project Board Terms of Reference

3rd September 2024 (extraordinary) – Discussions at this extraordinary private meeting of the Trust Board addressed the following items:

- Enabling Works FBC Addendum
- Whitchurch Hospital Land Overview
- Consideration of non-material changes to nVCC Full Business Case Management and Finance Cases

3.3 Velindre Oncology Academy Launch Event – 5th June 2024 (omitted from July 2024 Chair's report)

The Velindre Oncology Academy hosted a special event to provide all staff the opportunity to hear about some of its exciting developments. The in-person event in the Noddfa gave colleagues the opportunity to meet the new team behind the initiative and sign up for some upcoming courses. There was also the opportunity to take an exclusive first look at the Academy's new brand going forward.

Thanks to the Academy, our staff can access state of the art curriculum content, delivered by experts in the field and quality-assured by an outstanding university.

3.4 Regional Planning Summit – 5th June 2024 (omitted from July 2024 Chair's report)

On the 5th June 2024, Executive Directors and chairs from across the South East Wales region met to progress the development of a single Regional Clinical Strategy and to reaffirm the partnerships to regional working. The next steps for the regional working approach is expanded on further in the Strategic Planning Paper in this meeting.

3.5 Welsh Blood Service and Velindre Cancer Service join forces at the National Eisteddfod

WBS staff were on the 'Maes' in Pontypridd all week encouraging visitors between the age of 16-30 to take a quick swab test and register as potential stem cell donors.

They were joined on Thursday by staff from VCC who were on hand to showcase the community benefits of the new Velindre Cancer Centre and encourage visitors to sign up to **Velindre Voices**, the centre's engagement community.

3.6 Welsh Blood Service Donor Award Ceremony (Cwmbran) – 12th September 2024

Unfortunately, I was unable to attend the WBS Donor Awards in Cwmbran this month and I was represented by Carl James. It was a fantastic event by all accounts, the highlight being an opportunity to mark Colin Bunston's outstanding lifesaving contribution of blood donated to the people of Wales, spanning some 47 years. Colin, a 78-year-old retired steelworker joined other 50 attendees who collectively made over 4,100 donations which potentially could have saved over 9,700 lives. Attending the event were 20 (50 whole blood donors), 16 (75 whole blood donors), 6 (100 whole blood donors), 2 (100 platelet donors), 2 (200 platelet donors) and 1 (1,000 platelet donor).

3.7 David Donegan appointed as the Trust's Chief Executive Officer – 13th September 2024

On 13 September, we announced that **David Donegan has been appointed as the Trust's Chief Executive Officer.** A clinician by background, David is currently the CEO of Cork University Hospitals Group, which includes the largest tertiary teaching hospital in the Irish Health System (CUH), a number of district general hospitals and a range of community clinics and facilities. David has successfully delivered improved clinical and operational performance, infrastructure, governance and leadership at CUH Group and has also led on the delivery of a number of national programmes in the south west of Ireland, including the National Trauma Strategy and the National Cancer Control Programme.

While originally from Ireland, he has spent most of his career in the NHS, including over a decade in board level positions in strategic health authorities, acute hospitals, and ambulance services in England. He has also worked as the Interim Director of Secondary Care for Betsi Cadwaladr University Health Board in Wales.

David will join the Trust at the beginning of December.

3.8 Fundraising Concert at the Millennium Centre – 14th September 2024

On 14th September it was my privilege to attend a fundraising concert at the Hoddinott Hall, Millenium Centre. One of our patients had a lifetime dream to conduct a full symphony orchestra and that dream came true for him. The Cardiff Philharmonic Orchestra and the City of Cardiff Symphony orchestra combined for the event. The programme included Malcolm Arnold Little Suite No 2; Fantasia on Welsh Nursery Tunes by Grace Williams and the rousing Theme of Raiders of the lost Ark by John Williams. After the interval Gustav Mahler' Symphony number 1 was played. The theatre was full and it's fair to say that the conductor had both the audience and the orchestra in his thrall throughout.

I was asked to make some introductory remarks and I took the opportunity to talk about some of the work at Velindre.

I had made the comment that we all know someone whose life was affected by cancer and that one in two of us could expect to develop cancer in our life time. This seem to strike a chord as so many people came to talk to me about their Velindre experience. It made me both humble and extremely proud as the comments were all so positive. The Trust was proud to share in one man's dream.

3.8 Volunteer Afternoon Tea Event (Whitchurch Rugby Club) - 18th September 2024

On the 18th September, I was fortunate to attend the Volunteer Afternoon Tea – a fantastic event bringing together the latest cohort of inspiring cancer centre volunteers. It was an opportunity to thank them for their time to support the Trust staff, induct them into the organisation and to involve them in some of our work as we develop the new Velindre Cancer Centre. The call to action to get volunteers back to the service has been so successful, we now have a waiting list and the management team is doing everything it can to ensure that there are opportunities for everyone to support the work our staff do day in, day out, to provide our patients with the best possible experience. Caroline Cooper, a volunteer at Velindre tor 25 years, joined us at the event and we took the opportunity to recognise this achievement. Recently, on her 80th Birthday, Caroline undertook a sky dive to fundraise for Velindre.

4 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report. **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report. **Click or tap here to enter text**

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

VICE CHAIR'S UPDATE REPORT

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Stephen Harries, Vice Chair, VUNHST
PRESENTED BY	Stephen Harries, Vice Chair, VUNHST
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	This report provides information to the Board regarding the Vice Chair's activity since the previous meeting of the Trust Board.

RECOMMENDATION / ACTIONS	To **NOTE** the content of the Vice Chair's Update report.

GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE – N/A

APPENDICES – APPENDIX 1 – FULL REPORT

1. SITUATION

This paper provides the Trust Board with an overview of the Vice Chair's activity since the last meeting of the Trust Board.

2. BACKGROUND

2.1 Matters addressed in this report cover the following areas (please refer to full report in **Appendix 1**):

- Trust Board and Committee Meetings
- Attendance at External Meetings
- Attendance at Internal Meetings

3 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

For more information: https://www.gov.wales/socio-economic-duty-overview	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Vice Chair's Update to Trust Board September 2024

This Report provides an update from the Vice Chair. For approximately 2 weeks of this period (mid August - early September 2024), I undertook the role of Acting Chair, during the planned absence of the Chair.

Trust Board & Committees

Since the last Public Board meeting:

I have (or will have) attended the following Board Meetings/Sessions:

- Extraordinary Private Board Meeting – 22 August 2024
- Extraordinary Private Board Meeting– 3 September 2024
- Extraordinary Private Board Meeting– 13 September 2024
- Trust Board Public and Private Meetings – 26 September 2024

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

- Extraordinary TCS Scrutiny Sub-Committee, Private Meeting – 20 August 2024
- Extraordinary TCS Scrutiny Sub-Committee, Private Meeting – 2 September 2024
- Extraordinary TCS Scrutiny Sub-Committee, Private Meeting – 12 September 2024
- TCS Scrutiny Sub-Committee, Public and Private Meetings – 25 September 2024

I have attended the following Committee meetings:

- Remuneration and Terms of Service Committee – 5 September 2024
- Quality, Safety and Performance Committee, Public Meeting & Private Meeting – 12 September 2024

External Meetings

On 6 September 2024 I was a member of the Interview Panel for the role of Trust Chief Executive. As a part of this process, I met with all the shortlisted candidates, on behalf of the Chair.

On 7 August 2024 I attended a Meeting of Vice-Chairs of Health Boards and Trusts.

On 13 August 2024 I attended a Meeting of Chairs of Health Boards and Trusts, on behalf of the Chair.

Internal Meetings

On 11 September 2024 I took part in a *15-Step Challenge* visit to the Blood Health Team at the Welsh Blood Service.

I have regular meetings and discussions with the Executive Director of OD & Workforce, and team, in my roles as the Trust's "*Speaking up Safely Board Independent Member (IM) Champion*", and *"Wellbeing Board IM Champion"* roles.

I have scheduled 1-1 monthly meetings with the Director of Strategic Transformation, Planning & Digital.

I receive monthly updates on Information Governance (IG) matters from the Head of IG, and meet with the Director of Finance and the Head of IG to discuss).

I have regular "Agenda Setting/Review" meetings as required, for the Committees or Sub-Committees which I Chair.

During the period, I have undertaken the additional role of IM Mentor to the Mentee assigned to the Trust as part of a Welsh Government pilot programme aimed at “developing and supporting applications for public appointments from a more diverse range of backgrounds and life experiences”. This scheme ended on 31 August 2024. On 22 August I joined colleagues from across public sector Wales to provide feedback on the scheme to the head of Welsh Government Public Appointments. I would like to take this opportunity to thank our Mentee for her involvement in the scheme.

Stephen Harries

Vice Chair

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

CHIEF EXECUTIVE'S UPDATE REPORT

DATE OF MEETING	26 September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Non Gwilym, Interim Director of Corporate Governance
PRESENTED BY	Carl James, Interim Chief Executive Officer
APPROVED BY	Carl James, Interim Chief Executive Officer
EXECUTIVE SUMMARY	This report provides information to the Trust Board on a number of matters that the Interim Chief Executive Officer wishes to highlight for the period July-September 2024.
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the contents of the report.

GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE – N/A
APPENDICES – N/A

1. SITUATION/BACKGROUND

2. This report provides information to the Trust Board from the Interim Chief Executive on a number of matters and activities which occurred during the July-September period. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Approval of the Trust's 2024-25 Integrated Medium Term Plan

Following initial feedback received in July by the Welsh Government on our Integrated Medium Term Plan submission for 2024-25, I received confirmation in late July that the IMTP has been approved in accordance with a range of accountability conditions.

2.2 Cabinet Secretary visit to the Radiotherapy Satellite Centre in Nevill Hall, Abergavenny

On 23 August, the Cabinet Secretary for Health and Social Care visited the Satellite Radiotherapy Centre in Nevill Hall, Abergavenny to see how the development is progressing. The Cabinet Secretary met Nicola Prygodzicz, Chief Executive of Aneurin Bevan University NHS Board and myself and he was impressed with the progress made on the facility which remains on target to open in 2025.

2.5 Transplantation and Transfusion laboratories passes the UKAS ISO 15189 inspection

In August, the Welsh Blood Service's laboratories passed the third surveillance visit in the four-year accreditation cycle which included additional scope assessments. UKAS is the recognised body for assessing internationally agreed standards and the accreditation demonstrates confidence in the quality of WBS' medical laboratories. I am pleased to report that inspectors highly praised the staff's enthusiasm, knowledge and expertise. Congratulations to Alan and the team.

2.6 Drone technology takes off in Snowdonia

In July, the Welsh Blood Service and partners involved with the Welsh Drone Innovation Partnership Project visited Snowdonia Aerospace Centre in Llanbedr for a demonstration event showcasing the potential for a drone-based delivery network to enhance logistic services, including the transport of blood products between north and south Wales. The project is currently at a proof-of-concept stage and highlights the Trust's commitment to building robust innovation systems that enhance our capacity to foster transformative change.

2.7 The Hefyd summer roadshow.

Hefyd is the Trust's community programme in support of the development of the new Velindre Cancer Centre. Over the summer, the team has delivered weekly jamborees at the cancer centre roundhouse as opportunities for the community local

to the centre in Whitchurch to get involved with activities related to the arts, crafts and sustainability. However, in addition, this year, the team has also delivered a wider public engagement programme by attending a series of regional events that have widened the depth and breadth of our engagement with the south east Wales region which is the core geographical area of the cancer service's patient population. Supported by staff from various service departments, the team had a presence at the national Eisteddfod in Pontypridd in partnership with the Welsh Blood Service, Pride Cymru, the Caerphilly Big Cheese festival, the Velindre Fundraising Castle2Castle Run event, and the Whitchurch Festival.

2.8 Celebrating our collective achievements

Since the last report, many staff working across the Trust have celebrated a number of achievements and successes. These include:

100th Bone Marrow Donation – the registry reached its 100th peripheral blood stem cell collection at the VCC collection rooms	Welsh Bone Marrow Donation Registry and Velindre Cancer Centre staff
Nursing Times Awards - shortlisted at this year's Nursing Times Awards for the Ingrid Fuchs Cancer Nursing Award category which recognises nurses in oncology and the skilled clinical care and intensive support they provide. .	The team behind the Nurse-led Post-radiotherapy Follow-up Clinic at Velindre Cancer Centre.
Velindre University NHS Trust first ever Nurse consultants appointments	The new roles have been specifically created in the areas of acute oncology (AOS) and systemic anti-cancer therapy (SACT) and will be based at Velindre Cancer Centre.
WBS July 5 minute improvement award winner - for their improvement around 'Inputting Hospital Blood Stocks Using BSMS'	WBS Blood Health Team.
Successful application to Welsh Government's SMART Capital Equipment Fund - microfluidic research.	Component Development Research Laboratory, WBS RD&I Services and Velindre University NHS Trust's Innovation team.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
ADDITIONAL LEGAL IMPLICATIONS/ IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

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

TRUST BOARD

TRUST RISK REGISTER UPDATE

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	The main objectives of this report are to: • share the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 above for all other domains; • to allow the Trust Board to have effective oversight and assurance of the way in which risks are being managed across the Trust; • update the Trust Board with a summary of activity related to the status of the risks and associated movement.

RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above. • **NOTE** the on-going development of the Trust's risk framework. • **NOTE** the work underway to improve organisational management of risk reporting.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
WBS SLT	7 August 2024
VCC SLT	8 August 2024
EMB Run	29 August 2024
Quality, Safety and Performance Committee	12 September 2024
Audit Committee	16 September 2024

This paper takes into consideration the feedback from VCC and WBS leadership teams on their respective risks.

Quality, Safety and Performance: Members queried the scoring for Risk 3338 as it was showing the Inherent Risk as 16 and Current Risk at 20. It was reviewed and found to be reported incorrectly. The Committee emphasised the importance of considering thematic risks in The score in Appendix 1 now reflects the risk score on Datix.

Audit Committee:

1. The Committee reviewed a number of actions on the log in relation to risk. The discussion resulted in some completed actions being reopened and new actions arising. All open actions will be consolidated as part of the Governance, Risk and Assurance Programme Phase 2 Plan as SMART actions.

2. The Committee asked for urgent consideration of the cumulative effect of risks relating to specific areas of work/topics e.g. the cumulative effect of all risks challenging SACT service delivery, to allow the Committee to determine the strategic risk level.

3. The Committee requested a report on how sub-threshold risks could be treated thematically at service level and how they are being monitored and mitigated. The report will be presented to the Audit Committee in December. 4. The Committee emphasised the need for an assurance on risk awareness and training throughout the organisation so that operational risk management and mitigation is fairly and adequately reflected in the Committee and Board reports. 5. The Committee requested a paper outlining procedures for operational management of risk at its December meeting. 6. The Chair will meet with the Interim Director of Corporate Governance to agree on a specific list of actions relating to risk management and reporting, with he agreed list to be circulated to Audit Committee as soon as possible.

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

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

APPENDICES	
1	Trust Risk Domains
2	Trust Risk Register – July (data validated in August 2024)

1. SITUATION
1.1 Risk

This report informs the Trust Board of the status of reportable risks in line with the Board approved risk appetite levels and provides an update on progress to develop the Trust's risk framework.

The baseline information is provided by the Velindre Cancer Service (VCS) and Welsh Blood Service (WBS) monthly risk analysis reports, validated by their Senior Leadership Teams (SLT).

Trust risks are categorised into 11 domains noted in Appendix 1. Risks reported in this paper are:
1. risks in the safety/quality domain with a risk level of 12 and above;

2. risks in the non-safety domain risk level of 15 and above.

2. ASSESSMENT

2.1 Trust Risk Register

For the reporting period, there is a total of 14 risks to report in line with the Trust's risk appetite. This includes:

- 9 risks with a current score of 12 or above, reported in the safety/quality domain. 1 on the Welsh Blood Service (WBS) register, 8 on the Velindre Cancer Service (VCS) register.
- 5 other risks with a current score over 15 or above. Two each on the VCS and WBS registers and one on the Transforming Cancer Services register.

Further detail on the risks escalated to the Trust Risk Register can be viewed in Appendix 1.

2.2 Welsh Blood Service – based on July 2024 data and analysis by the WBS Senior Leadership Team on 7 August 2024

Key changes since the July reporting cycle:

- Following robust feedback by the WBS Senior Leadership Team and the Executive Board, risk 3362 "*Risk to quality as a result of the failure of the WBS External Nitrogen Storage Tank leading to complete loss of liquid nitrogen*" is being reviewed and its status re-categorised as a new risk rather than accepted risk.
- Risk 3193 "*There is a risk to Financial Sustainability as a result of a failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform, leading to a degradation of critical WBS (NHS Wales) blood supply chain activities*" and 3197 "*There is a risk to Quality as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software*

platform leading to degradation of critical WBS (NHS Wales) supply chain activities" have been reviewed and the current risk scores reduced to a score of 10 on the basis that whilst funding is still unclear, the procurement will go ahead therefore the likelihood of this risk materialising is lower.

2.3 Velindre Cancer Service – based on July 2024 data and analysis by the VCS Senior Leadership Team on 8 August 2024

Key changes since the July reporting cycle:

- Risk 3392 (Workforce domain) "*There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care*" has been reduced to 12 and therefore isn't reported on the Trust Risk Register. This is because recruitment into vacant posts is now underway.

2.4 Project and programme risk reporting

The new Velindre Cancer Centre project recently reviewed its risk profile and mitigation strategy. The updated position was approved by the Project Board at its August meeting. A meeting to align the project's approach to Trust risk reporting is planned for early September. Further meetings to establish the alignment of programme risk reporting, specifically Velindre Futures and Welsh Blood Service Futures and Transforming Cancer Services, will take place in mid-September.

The Transforming Cancer Services risk noted in Appendix 1 is under review.

3. KEY MATTERS - Summary of Actions Taken/ In Plan from Recent Governance Cycle

3.1 All Wales Datix module

Whilst the workstream has met regularly, in the update received 31 July, the Once for Wales Central Team considers there to be a lack of alignment across Wales in the terminology, matrices and workflow used within the risk management area.

The team is also of the opinion that the new Datix module achieves the specification established by the programme and anticipates that the opportunity to further refine the module will naturally arise as it is utilised fully by NHS Wales organisations.

With this in mind, the Programme Board recommended that all health bodies should prepare readiness reports with a plan to migrate to the Datix Cymru Enterprise Risk Management functionality (Risk Module), configured as established in the Demo System, from the 1st April 2025.

A meeting of organisational risk leads and Directors of Corporate Governance will take place in early September to map out the proposed approach for confirming individual organisational appetite to proceed.

3.2 Internal Improvements as part of the wider Governance, Assurance and Risk Programme

3.2.1 A newly developed Velindre Fundraising risk register was considered by the Trust's Charitable Funds Committee on 5 September. A meeting to map the alignment of the register with Trust Board risk reporting is scheduled for mid-September.

3.2.3 Following the appointment of the new Trust Risk and Assurance manager, we are re-establishing the Trust wide network to improve Trust risk reporting. Four key areas of focus over the next month include:

- a review of risk domains descriptors – to improve organisational understanding and aid accurate reporting;
- reviewing the procedure for de-escalating and closing risks;
- reviewing the procedure for the management of long-term risks;
- developing an agreed template for future risk reporting.

3.2.4 In addition, an audit of all open risks will be undertaken when the new Risk and Assurance Officer starts in post in October 2024. The work will start with a data cleanse exercise focusing on each risk to assess issues such as inactivity, target dates, last recorded review etc.

3.2.5 A benchmarking exercise comparing current and historic Trust risk reports against those compiled by other NHS Wales organisations is underway.

3.2.6 All improvements will be captured in phase two of the Governance, Assurance and Risk Programme as part of the Building our Future Together initiative. Any changes or improvements will be considered in the context of the current Risk Policy and supporting documents, and their approval will be subject to internal governance.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to:

- **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above.

- **NOTE** the on-going developments of the Trust's risk framework.
- **NOTE** the work underway to improve organisational management of risk reporting.

3 IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒

	The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required
	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.
	There are no direct well-being goal implications or impact in the current risks in this paper.
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail belowNo - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text.

4 RISKS

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

Appendix 1: Trust risk domains.

Risk domains
Quality
Safety
Compliance (Regulatory)
Research and Development
Reputation
Performance and Service Sustainability
Financial Sustainability
Workforce
Partnerships
Information Governance /GDPR
Environment

TRUST RISK REGISTER

v01 September Governance Cycle
Public Audit Committee

July 2024 Data – governed by SLTs in August 2024

ID	DIRECTORATE		RISK OWNER	RISK TITLE	INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	RISK OPENED	REVIEW DATE	PROGRESS SINCE LAST REPORTING PERIOD	OUTSTANDING ACTIONS
Velindre Cancer Centre												
12+ Risks in the Quality and Safety domains												
3337	SACT & Medicines Management	Safety/ Quality	RH	There is a risk that patients are missed as a result of multiple lists being used to manage booking leading to clinical harm	16	12	8		13.02.2024	16.09.2024	09/07/2024 - demo of single patient list taking place week commencing 08/07/2024 to assess and identify any additional work required prior to roll out 01/08/2024 - single patient list remains in building stage. Digital colleagues working closely with the booking team and wider SACT scheduling team to ensure the list is fit for purpose. Daily escalation meetings remain in place. Unscheduled list is completed on a weekly basis to mitigate against the risk Digital colleagues and bookings team continue to work closely. List is in testing phase	No further actions noted on Datix

TRUST RISK REGISTER

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											with a few amendments to make. it is felt once the digital team have all they need to build the list it will take 2 weeks for the list to be ready for roll out. In the meantime, daily escalation meetings continue and the unscheduled list is actioned regularly	
3338	SACT & Medicines Management	Safety/ Quality	RH	There is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in patient treatment	16	20	12		13.02.24	09.09.24	02/07/24 - Pharmacy expansion Parenteral Product plan approved by SLT and Gold. Supporting paper outlining Pharmacy 04/07/24 - Efficiencies similarly developed and approved. Joint Pharmacy and Nursing paper presented to EMB August. 09/07/24 - business case scrutiny applications submitted for consideration at next panel (July 19) in anticipation of EMB approval	No further actions noted on Datix

											to reduce recruitment timeframe. MaH service expansion progressing as plan, however further capacity required (through additional staffing resource) to meet demand. Continue to progress plan.	
3366	Integrated Care	Safety	KB	There is a risk to the safety of staff due to lack of storage and cleaning space in the Therapies department resulting in an increased trip, slip or falls risk within the shared therapies storage, kitchen and corridor area.	8	12	4		04.04.24	30.08.24	Ongoing capital planning bid to relocate storage. Staff advised to use cups with lids when carrying hot drinks in the room and throughout the department. 2 person maximum sign to be re-instated on the door to the kitchen/store room Large signage to inform staff i.e.. “all spillages must be cleaned immediately”. This is just to re-enforce the existing guidance located by the door. An additional sign may be better placed on the opposite wall next	No further actions noted on Datix

											to the window. When using the ladder to access stock items on the shelves a 'buddy' must be present, and stock moved out the way rather than overreaching because they are unable to get the ladder close to the item they are trying to retrieve. (I'll put a poster together for this which can be circulated to the team and displayed in the room). Ongoing capital planning bid to relocate storage.	
3230	Operation Service and Delivery (Medical Records)	Safety	AMS	There is a risk to patient safety as a result of variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care	12	12	4		09.10.2023	30.09.2024	01/07/24 - Risk reviewed by the Outpatient Management Group. VCC Service Improvement Team has established links with the C&V Service Improvement Team. Links with the Digital Team to agree technical solution of managing the sending and receipt of the pro	Explore options for short term central management of new patient referrals New Patient Waiting List to be developed to supporting the monitoring of referrals, which will include appointments booked, attended and waiting. Explore options for an electronic solution to manage and audit

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											forma (such as action point). Discussions underway.	new patient referrals
2465	Medical	Quality/ Safety	RH	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	16	12	4		05.11.2021	29.11.2024	15/07/24 - Head of Ops in post. Key priority to review audit recommendations and establish T&F group to take forward outstanding actions	T&F group to be established Audit reviewed Action plan developed for outstanding actions
2187	Radiation Service	Quality/Safety	RW	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	25	12	8		14.09.2020	29.11.2024	*No actions taken since last report. Review due in November 2024.*	Complete comprehensive 5 year workforce plan to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC. Re-advertise IRS implementation lead for the development of novel techniques.
3293	Radiation Service	Quality	IK	There is a risk to Quality, Performance and Service as a result of any delay in the new Velindre Cancer Centre (nVCC) leading to capacity at the current site not being sufficient to meet the demand, resulting in increased waiting time for radiotherapy, failure to meet All Wales time to radiotherapy metric and reduced patient experience.	20	12	4		21.12.2023	04.09.2024	Monitoring of capacity and demand. Development of breast escalation process to ensure patients are prioritised as per clinical need. Unlimited extended working hours on treatment	No further actions noted on Datix

											machines and other areas of the department in response to demand. Limited extended working hours on treatment machines and other areas of the department in response to demand. Limited to safe staffing, skills mix and age and configuration of the fleet. Agency radiographers in place to support additional hours. Unlimited replacement of new linear accelerators on current site. Policies and procedures on how to manage Radiotherapy scheduling and delays. Development of detailed transition plan to be implemented through NVCC project. Once plan is in place to assure operational service commence 2027, risk review may reduce current risk assessment.	

TRUST RISK REGISTER

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3431	Medical	Quality	CM	There is a risk that insufficient time to undertake an appropriate clinical assessment ahead of patients receiving their SACT for Skin/Melanoma, as a result of a significant gap between the demand and capacity in place for Pre SACT Assessments may lead to sub optimal clinical care for patients receiving SACT, missed/incomplete/incorrect or delayed patient related administration which can affect patient care and safety, poor patient experience for patients and an impact on the wellbeing of clinical staff.	20	20	4		24.07.2024	30.09.2024	*No update since last reporting cycle, however review is not due until 30.09.2024*	No further actions noted on Datix
15+ Risks in other domains												
2705	Operation Service and Delivery	Safety	MD	There is a risk to public and staff safety as a result of CCTV/Door access system failure at Velindre cancer Centre leading to assurance of functionality, as recording units' failure with no warning	15	15	2		08.09.22	01.02.2025	Intevo System operational, however there are several cameras not working presently Functionality of the system operating normally. Camera functionality is being assessed to ascertain number of cameras inoperable against number of cameras required in priority areas	Audit of CCTV being undertaken Digital, Ops and estates to create SOP to overcome out of hours authorised access to node rooms
3247	Medical	Workforce		There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of	16	16	9		08.11.23	30.09.24	One additional consultation room provided.	Fully review of demand and utilisation of capacity within OPD.

				clinics due to high demand the impact will be increased workload and increased patient waiting times.							One virtual hub provided. Capital monies requested to deliver two further consultation rooms submitted, outcome awaited.	Business case to be developed to obtain funding to covert accommodation to delivery an additional four consultation rooms Clinic templates to be reviewed to manage patient flow
Welsh Blood Service												
12+ Risks in the Quality and Safety domains												
2274	WBS	Quality/ Safety	AP	There is a risk to **quality and safety** as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	16	12	4		31.10.22	24.12.24	Next review date 24.12.2024	Discovery and planning Transformation Workstream: process redesign and system configuration Data workstream: migration of legacy data Application workstream: build of environments, database and interfaces
15+ Risks in other domains												
3350	WBS	Service Sustainability	AP	There is a risk to **performance and service sustainability** due to the Welsh Blood Service transport function being unable to deliver services due to operating an ageing fleet of commercial vehicles	15	15	12		04.03.24	14.08.24	Update due outside of reporting period	Review risk

TRUST RISK REGISTER

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3306	WBS	Performance and Sustainability	AP	There is a risk of **loss of performance and sustainability**, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	20	15	5		15.1.24	26.07.24	Review risk position.	Programme of works and design has been agreed. Now gathering total costs for the work.
Transforming Cancer Services												
15+ Risks in the Quality and Safety domains												
3227	TCS	Financial sustainability	DP	There is a risk to **financial sustainability** as a result of changes during the design development process leading to a design which costs more overall, increasing project costs.	8	16	8		16.10.23	31.10.23		Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial bootcamp is scheduled for 10/10/23 to try to finalise commercial position on various issues Ongoing

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE		CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN

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

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness:	RATING	PE	Overall Trend in Assurance	THIS WILL INCLUDE A

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual Service Level Agreement meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plans	PA	Welsh Government Quality, Planning and Delivery Review Internal Audit, Wales Audit Office, regulator audits.	PA
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government Emergency Preparedness, Resilience and Response (EPRR) for Health, Local Resilience Forum - Strategic Coordinating Group. Internal Audit, Wales Audit Office, regulator audits.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB to review.	PA	QSP committee and Board and external stakeholders if required. Internal Audit, Wales Audit Office, regulator audits.	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, Joint Professional Advisory Committee (JPAC) for UK blood services, The UK advisory committee on the Safety of Blood, Tissues and Organs (SaBTO). Regular liaison with Blood Policy and Tissue, Cells and Organs Policy team in Welsh Government.	Not Assessed	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	Not Assessed	QSP, SDC	Not Assessed

C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally.		A1.1
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inappropriate use of blood, which impacts demand.		A1.1

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	15	Risk Decreasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
A1	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	IA	Jul-25	National oversight group is currently discussing with C&V in light of new supplier for All Wales LIMS solution.	18.4.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
A1.1	Working with DCHW to support the Blood Transfution Module of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	IA		Discussions ongoing about funding solutions for blood tracking/fating to patient,	18.4.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	PA		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including	18.4.24	All Wales programmes which will ensure equity of care for patients.	
	review of outpatient activity to determine what could be repatriated back to Health Boards relasing capacity within the outpatient facility and providing care closer to home for the patient	Head of Medical Services			report to be received			
	formal demand and capacity operational group to be established to provide oversight of current and future plans, manage D&C plans and identify areas of concern with mitigations for escalation as appropraite	Head of Medical Services			Key objective for Head of Service onow commenced in role - as at Dec 2023			

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE
Strategic Goal 1 Outstanding for quality, safety and experience	1. Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) 2. Implementation of Integrated Radiotherapy Solution Programme by 2026/27 3. Implementation of Outreach Programme by 2025-26 4. Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services 5. Implementation of Regional Acute Oncology Delivery Model and Network Structure 6. Implementation of ePMA for Use by Velindre Cancer Services 7. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services 8. Implementation of the Approved Full Business case for the Development of the New Velindre Cancer (nVCC) 9. Implementation of National Programme for Palliative Care and End of Life in Line with National Timeframes 10. Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables 11. Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25 12. Implement Changes to the Nursing Workforce Which Ensure Compliance with Regulatory Requirements and Supports Delivery of Clinical and Scientific Strategy 13. Ensure the Viability of the Neuro- Oncology Service 14. Undertake Evaluation of SACT Service (to Include SACT Nursing, SACT Bookings and SACT Prepping). Define Recommendati ons, Develop and Deliver Improvement Plan	1. Project close and Radiotherapy Satellite Unit to 'go-live'. 2. Progress phase 3 objectives 3. Complete 4. Develop contingency plan to address scenario in which national implementation on of the TrAMs model is delayed beyond the opening of nVCC. 5. Complete 6. Project close following successful implementation. 7. Project close following successful implementation. 8. Develop plan to facilitate transition of brachytherap y service to nVCC. Develop interim business case for radiotherapy as part of contingency planning to address potential delays to wider infrastructure project to include commissioni ng a fourth linear accelerator, outsourcing,7-day working,etc. 9. Complete 10. Full programme implemented. Undertake post- implementation on programme review 11. Complete 12. Complete 13. Complete 14. Complete	1. Complete 2. Project close 3. Complete 4. Complete 5. Complete 6. Complete 7. Complete 8. Deploy workforce plan for operational and facilities services. Draw down identified funding from FBC to enable recruitment to necessary posts. 9. Complete 10. Complete 11. Complete 12. Complete 13. Complete 14. Complete

	15. Implement Recommendations from Peer Review of SACT Treatment Helpline 16. Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics 17. Implement New Molecular Radiotherapy Treatments at VCS 18. Review the Radiation Protection Service Resource to Enable Dynamic Response to National, Regional Partner Stakeholder and Internal Ambitions for Delivery of Expanded and Innovative Diagnostic and Therapeutic Clinical Services with Ionising Radiation Sources 19. Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme 20. Support Procurement of New Version of ChemoCare and Introduce the System for Use by Velindre Cancer Services 21. Develop and Implement Model for Clinical Leadership and Supporting Governance Structure 22. Design, Commission and Deploy Revised Patient Transport Model 23. Implement Pathway Improvement Programme 24. Undertake Digitisation of Medical Records 25. Implementation of New Services / Delivery Models 26. Implement DHCR Phase 2 by 2024/25 27. Implementation of Consolidated Document Management System Across VCS 28. Respond to Low / Limited Audit Assurance Findings 29. Implementation of Centre for Collaborative Learning and Innovation	15. Complete 16. Complete 17. Determine resource implications of the introduction of new Molecular Radiotherapy treatments at VCS in anticipation of NICE approval. Actively engage with commissioners. 18. Complete 19. Complete 20. Complete 21. Complete 22. Complete 23. Undertake evaluation of new models. 24. Establish project group. Identify service improvement s / opportunities for change. Identify additional resource requirements Undertake options appraisal. Develop supporting business case(s).Initiate phased delivery of the project. 25. Develop solutions for, develop service model for delivery of, identify resource implications and develop business cases to secure funding, where appropriate, to facilitate: Implementation on of new Internal Mammary Node (IMN) service, axillary radiotherapy service and partial breast radiotherapy service Implementation on no new extreme hypofractionation for prostate / SABR prostate service. Implement SABR treatments for new indications. Expansion of stereotactic radiosurgery (SRS) service. Palliative radiotherapy service. 26. Complete 27. Complete 28. Complete 29. Phased implementation on work to commence (initial proposals aligned to nVCC Full Business Case agreed).	15. Complete 16. Complete 17. Complete 18. Complete 19. Complete 20. Complete 21. Complete 22. Complete 23. Complete 24. Undertake post-project evaluatio 25. Complete 26. Complete 27. Complete 28. Complete 29. Complete
	WELSH BLOOD SERVICE	**WELSH BLOOD SERVICE**	**WELSH BLOOD SERVICE**
Strategic Goal 1 Outstanding for quality, safety and experience	1. Implement improved donor interaction by 2026/27. 2. Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model and its ambition by 2026/27. 3. Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma) 4. Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25. 5. Revised blood collection clinic portfolio by 2025/26. 6. Introduce clinically led collection team model by 2024/25 7. Develop and implement a platelet strategy by 2025/26. 8. To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system. 9. Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26 10. Procure new Blood Establishment Computer System (BECS) contract. 11. Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25. 12. Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2025/26. 13. Implementation of Foetal DNA typing by 2024/25. 14. Review and Develop strategy for Nucleic Acid Testing (NAT).	1. Complete introduction of a donor experience hub. Complete implementation on of a Customer Relationship Management t (CRM) System. Implement omni- channel software 2. Implement recommended strategies for maintaining growth of the registry such as collecting 3rd party cellular products or ATMP Starting materials. Continue to progress with the WBMDR replacement software project 3. Begin to implement new strategy 4. Complete 5. Complete development of options for introduction of a new fixed donation venue/complete review of existing blood donation venues 6. Complete 7. Development of the collection strategy for apheresis and whole blood platelet collection Development of the Horizon Scanning for fluctuations for optimal platelets supply. Development of the strategy to improve the on-shelf availability of all platelet types: Including expanding donor panel. Research and development of new components 8. Complete deployment (Q1) 9. Complete Data Migration (Q1).Training (Q1). Go Live (end of Q1) 10. New Contract Award (Q1).New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECs solution 11. Part of standard activity post implementation. 12. Implement Medical Devices Regulations (MDR) / In Vitro Diagnostic Devices (IVDDR) strategy (Qtr 1). Substances of Human Origin (SoHo) Regulations – develop strategy for WBS. 13. Scope expansion of service. 14. Implement new NAT strategy.	1. Implement tailored pathways for donors and advocates. New donor app implementation and create content. 2. Continue to implement recommended strategies for the expansion of stem cell collection services. Implement new WBMDR software. 3. Complete 4. Complete 5. Complete 6. Complete 7. Complete 8. Complete 9. Complete 10. BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28). Continue supporting existing BECS solution. 11. Part of standard activity post implementation. 12. Substances of Human Origin (SoHo) Regulations – WBS Strategy to be in place 13. Complete 14. Complete
	15. Introduction of West Nile Virus (WNV) Testing. 16. Assess and implement the recommendations of the Infected Blood Inquiry (IBI). 17. Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales. 18. Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. 19. Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.	15. Complete 16. Complete 17. Commence supply of frozen recovered plasma for fractionation from Q1 Receipt of first fractionated product from Q3. 18. Develop Full Business Case (FBC). 19. Implement recommend actions of review of workforce planning across WBS. 20. Implementation recommendations from the Inependent Blood Inquiry	15. Complete 16. Complete 17. Source Plasma TBC depending on policy decision and business case support. 18. Construction commence s - three- year programme 19. TBC

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: RATING **PE**

Overall Trend in Assurance THIS WILL HAVE A GRAPH

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight; new performance management	E	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in place with LB partners; regional/national	E	Strategic Development Committee/ Quality Safety	PA	Regulatory scope re MHRA tbc; clear stanadards for services understood and	E
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	E	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office	E
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region			X		PE	Agreed to model for next phase	NE	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;			X		E	Agreed to model for each organisation	PA	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office/Welsh Government	E
5.2	Partnerhsip with other stakeholders e.g. WAST, HEIW and University partnerships.		X			E	Good working relationships with regular communication	E	HIW	E	QSP	E
5.3	Effective regional /national commissioning of Trust services		x			PE	Regional commissioning groups in place and effective	PA	EMB; Strategic Development Committee; Quality, Safety		Wales Audit Office/Welsh Government	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
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	1.9; 1.7; 1.8
Establishment of new commissioning national commissioning function (WHSSC/EASC) regarding blood service commsissioning and specialsit cancer commissioning	Replace of CCLG not in place yet so no regioanl assurance regarding strategic alignment etc	1.9
Agreement of need for improved regionsal cancer commissiong (core services)		1.6; 1.8
Need for improved data/quality metrics to track perforamance	Provision of improved metrics to EMB; QSP and Trust Board	1.3; 1.4

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Phase 1 complete. Development of Phase 2 of PMF with additionalperfromance measures/quality metrics commenced - delivery dates require firming up. Phase 2 elements commenced with a range of new quality indicators proposed for WBS and wider quality dimensions - approved by EMB in May 2024 - for consideration by SDC in May 2024. Progress made on provision of outcome measures/resource utilisation dashboard for all Site Specific Teams in VCS and resource utilisation (nov 2024)	Lauren Fear	~~01/03/2024~~ Nov 2024	Previous timescale not met however the PMF packages of work are defined and set out in September 2024 QSP and Trust Board papers.	18/09/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce	Programme outputs to be confirmed	Programme established and staff on-boarded. Progress being made on a number of projects (Food mission; cancer dashboards etc. Progress made on provision of outcome measures/resource utilisation dashboard for all Site Specific	11/04/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Lauren Fear	Nov-24	First Regional Cancer Programme Board held in September 2024. Actions agreed by all partners to progress with forming core scope and approach by November 2024.	18/09/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase

1.7	WG review of NHS Wales strategic management / accountability arrangements will potentially identify how strategic alignment across the healthcare system can be stregthened. When completed the Trust will review and identify any actions which strengthen alignement	Carl James	April/May 2024	Trust received request to feed into the review process. Review in progress - NHS organisations have not received any further information at this stage. No further update received on the findings of the national review	14-May-24	Unknown at this state	The level of assurance should increase
1.8	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	Lauren Fear	Nov-24	Review completed in August 2024 of all regional governance and alignement to Trust. Feedback from key partners is a posistive improvement in engagement across the regional scope.	18/09/2024	Anticpated it will reduce the level of risk regarding strategic mis-alignment between the Trust/partners and the wider healthcare system.	The level of assurance should increase
1.9	Establishment of new national commissioning body (bringing WHSSC/EASC together)	Welsh Government	01-Apr-24	Implementation of new commissioing body well progressed. New Commissioning Body established and LIVE	14/05/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments	Action complete: increased level of assurance increased as national body with clear commissioning scope and powers

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 2 **An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations**	Working with our Health Partners: The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector. Our Agreed Programmes of Work: We are committed to working with patients, donors and our health and public service partners to understand, design and deliver services which are truly person focused and deliver the experience and outcomes that people value most. 1. Delivering the Fundamental Cornerstones of Healthcare Provision: • Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework and the National Clinical Framework to provide services of the highest possible quality • Delivering services that meet the national clinical quality and safety standards and provide an excellent experience • Treating patients as quickly as possible • Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales • Developing agile and flexible capacity plans which allow us to respond quickly to changes in demand for our services • Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past three years • Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working		
	2. Improving Population Outcomes and Reducing Inequalities: • Improving access to our services to increase uptake and reduce inequalities and ill-health • Strengthening our decision-making to consciously address poor outcomes and inequalities in the communities we serve • Working with our health partners where it is clear and compelling that we can add value and make a difference		
	3. Regional Working, Partnerships and Collaboration to Improve Outcomes • Work with Local Health Board partners to strengthen our support the delivery lead of improved cancer outcomes for patients in South East Wales • Develop the Velindre@ research hub philosophy across all LHB partners in South East Wales • Further develop the Blood Health Oversight Group work programme to improve the prudent use of blood and blood products across Wales 4. Delivery of Transformation Programmes Non-surgical Tertiary Oncology Services: • Implementing the final phase of the Acute Oncology Service regional model • Continue to improve pathways for unscheduled care patients • Delivery of the Cardiff Cancer Research Hub • Implementation of the Integrated Radiotherapy Solution in 2025 • Construction and delivery of the new Velindre Cancer Centre in Whitchurch, Cardiff in 2027 • Construction and opening of the Radiotherapy Satellite Centre, at Nevill Hall Hospital in Abergavenny, in 2025		
	Blood and Transplant Services • Laboratory Modernisation programme: • Refurbishment of the Talbot Green facility by 2027 • Plasma for Fractionation: developing the case for change and delivery of the Programme		

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E
C2	Approved Workforce Planning Methodology aligned to Trust Values and Beahviours	Susan Thomas	X			E
C3	Workforce planning - skills development	Susan Thomas	X			PE
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			E
C5	Educational pathways in place to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE
C6	Widening Access Programme to support development of new skills and roles	Susan Thomas	X			PE
C7	Monthly dashboard reports are provided to divisional SLTs to monitor performance, identify and manage any issues. Hotspot areas are identified and managead accordingly, such as establishment of Task and Finish Groups.	Susan Thomas	X			E
C8	Hybrid Working Principles established to support workforce planning methodology	Sarah Morley			X	E
C9	Consistent recruitment and selection process	Sarah Morley	X			PE

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 People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
Monthly Divisional Senior Leadership Team feedback	IA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	PA
Evaluation sheets	PA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	PA
People Development and Education Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	PA
People Development and Education Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	PA
Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	PA	Regular performance reports and Suply and Shape paper are submitted to EMB and QSP	PA	Internal Audit Reports - Managing Attendance at Work, Recruitment and Retention and Edication Strategy Audit (ongoing)	PA
Flexible Working Policy	PA	Supply and Shape paper to EMB then QSP	IA	Internal Audit	NA
Recruitment and Selection Policy	IA	Dashboards on recruitment and selection reported monthly to divisional SLTs. Supply and Shape paper to EMB then QSP	PA	Internal Audit	PA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Gaps are evident in understanding agreed service models – both internally and regionally		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND
3247	There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times.	16	16	9	No shift in risk rating
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	16	12	9	Risk has decreased from initial rating.

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.5	Development of a Trust workforce plan	Susan Thomas	IA	Sep-25	Initial plan was presented to EMB in Septemeber 2024, where Short and medium term actions were agreed. These actions will be reflected in Workforce Supply and Shape paper in November QSP.	18.09.2024	The impact will be reduced once the short and medium term actions are completed	
1.6	Development of a Nurse Retention Plan	Susan Thomas	IA	Sep-24	Nurse Retention Plan was approved by EMB in June 2024.	18.09.2024		
1.8	Embed workforce planning progress into monthly Divisional Senior Leadership Team Workforce reports	Amanda Jenkins	NA	Oct-24	New action	18.09.2024		
1.9	Staff educators to undertake HEIW train the trainer on workforce planning	Amanda Jenkins	NA	Jan-25	New action	18.09.2024		
1.10	Embed Hybrid working principles in training and reporting	Amanda Jenkins	NA	Jan-25	New action	18.09.2024		
1.11	Implementation of the Attraction and Retention Project	Amanda Jenkins	NA	Mar-25	New action	18.09.2024		
1.12	Implemention of the Nurse Retention Plan through the Professional Nursing Forum	Nicola Williams	NA	Apr-25	New action	18.09.2024		
1.13	Utilise the learning from implementation of the Nurse Retention to develop a Trust Retentaion Plan	Amanda Jenkins	NA	Oct-25	New action	18.09.2024		
	CLOSED ACTIONS							
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	PA	COMPLETE	The Healthy and Engaged workplan 2024-25 was agreed at the Healthy and Engaged Steering Group on 09.03.2024. The Healthy and Engaged Workforce Steering Group reports quarterly to EMB.	14.05.2024		Impact on assurance level was updated in the Supply and Shape paper presented to QSP on 09.05.2024.
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	PA	COMPLETE	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	21/12/2023	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	

1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	**IA**	COMPLETE	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	**PA**	COMPLETE	A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape	
1.7	Review Exit Interview Process	Susan Thomas	**IA**	COMPLETE	The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB	20.03.2024		

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	Planned ans Sustained Workforce Right people right place right time 1. Implement the Education Strategy Implementation Plan 24/25 2. Following the agreement of the Clinical and Scientific Skills Strategy develop Trust wide priorities and implementation plan for multi-disciplinary workforce model 3. Manage the successful implementation of the WL service provision (SLA) to support service bi-lingualism 4. Attraction and Retention 5. Agree a plan for the Widening Access Programme 6. Ongoing recruitment Marketing Campaigns for hard to fill roles 7. Working with Comms Trust wide recruitment campaign in place 8. Evaluate the International nurse Recruitment Programme 9. Develop a Nurse retention plan		
	Skilled and Developed Workforce Achieving Excellence through our staff 1. Component caring and capable workforce Deliver the Trust Training Plan 24/25 – clear KPIs to support evaluation 2. Transforming care pathways Working with the service agree training requirements for care pathways (HSCW, AP and Consultant) through the workforce planning process to shape a Multi-Disciplinary workforce Model 3. Developing our academic profile Through the training plan provide education, training, and development opportunities to enable staff to develop their knowledge and skills through life-long learning, through the Velindre Oncology Academy and the Collaborative Centre for Learning and Innovation 4. To create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology 5. Working with Digital - Provide training and sources of support to enable the workforce to be confident and competent in the use of new equipment, systems, and technology		

SECTION 1

RISK ID	04	RISK TITLE	There is a risk of failure to meet or exceed service expectations without the prevelance of a positive working environment, which is characterised by effective values and bahaviours, systems and processes	STRATEGIC GOAL	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	RISK SCORE TREND	
RISK LEADS	Sarah Morley			RISK THEME	Organisational Culture		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycles of business	PA	To be completed as per compliance/ reg tracker updates	PA
C2	Approved Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			E	People Development and Education Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	PA
C3	Management and Leadership development programmes in place based on compassionate leadership principles	Susan Thomas	X			PE	People Development and Education Steering Group	PA	Reporting though relevant Trust goverence processes and Trust Board cycles of business i.e Steering group highlight report to EMB and Committees.	PA	Internal Audit Reports	NA
C4	Trust Values and Behaviour Framework	Susan Thomas	X			PE	Healthy and Engaged Steering Group NHS Staff Survey	PA	Reporting though various Trust goverence processes and Trust Baord cycles of business i.e Steering group highlight report to EMB and Committees.	PA	Internal Audit Reports	NA
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	Reported through EMB to QSP	IA	Internal Audit Reports	IA
C6	Health and Wellbeing infustructure for the Trust to support physical and psychological wellbeing of staff	Susan Thomas	X			E	Healthy and Engaged Steering Group Trust Polices and Proceedures to support health and wellbeing	PA	Reporting though various Trust goverence processes and Trust Baord cycles of business i.e Steering group highlight report to EMB and Committees.	PA	Internal Audit Reports - Evalution of wellbeing activites, MAWW Audit	PA
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Workforce and OD steering groups and internal governance	PA	Steering Groups' highlight reports to Executive Management Board	PA	Internal Audit Reports	IA
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	Perfromance Managment Framework Report	PA	Exucutive Management Board	PA	Internal Audit Reports	IA

C9	Clear safe, effective and efficient services models to support role clarity aligned to compassionate leadership principles	Anne Carey	X			PE	Monthly Divisional Senior Leadership Meetings	IA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	NA
C10	Operational workforce plans developed to support agreed service models	Anne Carey	X			PE	SLT Meetings and Educationa and Training Steering Group	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	NA
C11	Employee Voice Framework	Sarah Morley	x			PE	Healthy and Engaged streerting group and Local Partenship Forum	PA	Reporting though various Trust goverence processes	PA	Internal Audit Reports	NA
C12	Avoidable employee harm prinicples are embedded into the management of beahviours within the Trust	Sarah Morley	X			PE	Healthy and Engaged streerting group and Local Partenship Forum	PA	Reporting though various Trust goverence processes	PA	Internal Audit Reports	NA

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	16	12	9	Risk has decreased from initial rating.

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.5	Undertake analysis of current employee voice mechanisms and develop an engagment action plan to improve voice mechanisms and encourage a culture of speaking up across the Trust.	Claire Budgen	IA	**Mar-25**	New Action			
1.6	Embed the Values and Behaviours Framework into Trust communications, policies and processes	Claire Budgen	IA	**Dec-24**	New Action			
1.7	Embedd the prinicples of the Social Partnership Duty into the Trust's strategic development and through the Trust Board cycles of business	Amanda Jenkins	IA	**Oct-24**	New Action			
1.8	Implement the Compassionate Leadership Pledge and action plan within the Trust	Claire Budgen	IA	**Mar-25**	New Action			
1.9	Develop outcome measures for the monitoring and analysis of Health and Wellbeing activies within the Trust	Claire Budgen	IA	**Dec-24**	New Action			
1.10	Implement the actions of the Trust Strategic Equality Plan, incuding embedding the Anti-Racist Wales Action Plan in the Trust	**Claire Budgen**	IA	**Mar-25**	New Action			
	CLOSED ACTIONS							
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley	PA	COMPLETE	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A	20/06/2024	The outputs from the WT Sessions are being mapped into the Refresh of the Building Our Future Together Organisational Development Approach. New Sessions are now being scheduled which will cover staff across the bases in Wales	Identification of the needs for an Employee Voice Framework

1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley	PA	COMPLETE	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey have begun to be distilled to further develop our work programme	20/06/2024	We received the Trust level data from the 2023 staff survey with the more detailed dahsboards following in May. This data will be used to over lay with other feedback. The areas of data have been mapped onto the current workstreams and management groups to ensure that this will enusre action is taken under the appropriate workstream.	This will encompased I nthe revised BOFT approach in the Trust way of working.
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	PA	COMPLETE	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
1.4	Promotion of the Speaking Up Safely Framework	Sarah Morley	PA	COMPLETE	The initial task and finish group to establishe the Speaking up Safely Framework in Velindre has been completed. Communication and governance processes are in place.	14/05/2024	Initial programme completed - ongoing work to trianguate with wider cultural work	

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 2 **An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations**	Healthy and Engaged Workforce Our staff will feel valued and supported and promote a culture of true inclusivity, fairness and equity across the workforce. 1. Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence 2. Implement the Values and Behaviour framework project 3. Triangulate culture work, staff feedback themes and leadership work to deliver an aligned Culture Programme of work that addresses Organisational issues reflects our values and allows staff to speak up freely 4. Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working 5. Deliver an action plan 24/25 commitment in the Trust Anti- Racist Action plan 6. Monitor Welsh Language Standards, working with Divisions on improvement plans 7. Implement the WL Culture plan 8. Update all WOD related policies and procedures 9. Deliver an infrastructure to support Industrial Action and wellbeing offer for staff during IA		
	People Function Cultural Development – People and Relationships Model 1. Develop an engagement plan for the function to support the engagement and alignment with service development 2. Implementation of the holistic People and Relationships model 3. Engagement and Commitment from EMB 4. Promote the principles of hybrid working and undertake regular pulse surveys to gain feedback		

SECTION 1

RISK ID	5	RISK TITLE	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	STRATEGIC GOAL	ALL
RISK LEADS	Lauren Fear	Carl Taylor		RISK THEME	Digital Transformation
RISK SCORE TREND	No change to risk score since previous reporting period				

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness:	RATING	PE	Overall Trend in Assurance	THIS WILL BE A GRAPH

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		E						
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA	Chief Digital Officer		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board	PA	EMB Shape / National Programme Boards	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital Officer	X			PE	Staff feedback - KLAS Survey	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback	IA	EMB Shape / Digital	IA	SIRO Reports/ Strategic Development	Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP Trust Capital Programme	IA	EMB Shape / EMB Run	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services	PA
C7	Digital inclusion in wider community	Chief Digital Officer	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales Accreditation	PA
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	PA	EMB Shape / EMB Run / Cyber Action Plan	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Cyber Resilience Unit	PA
C11	Trust digital Governance	Carl James		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	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	EMB Run	PA	SIRO Reports/ QSP Committee/ Internal Audit / WG IQPD	PA

C13	Cyber Assurance Controls in place	Chief Digital Officer		X		E	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	EMB Shape / EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/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 Board Digital Design Authority being established	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Assurance Arrangements for Digital Architecture will need to be established -	
C9 - Change Advisory Board - is formed and has now met twice	Data and Insight prioritisation as this becomes part of the Digital Services team -	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
92	There is a risk to COMPLIANCE as a result of the inadequate oversight of supplier contracts, procurement governance etc., leading to difficulties in complying with internal governance for contract management, renewals and procurement activity.	12	Risk trend is increasing with capacity constraints in the procurement teams supporting the Trust
3193/3197 (BECS)	There is a risk to QUALITY as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degredation of critical WBS (NHS Wales) supply chain activities	15	Trending down - Funding letter received for 24/25
R008 (WHAIS)	There is a risk that the LIMS solution will not support the required interactions between WHAIS and WBMDR because commercial H&I solutions are not designed to support an integrated donor registry. If no workaround is identified this would prevent WHAIS from being able to maintain its current HSCT clinical services.	20	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. This includes identifying the future relationship between WHAIS and WBMDR. Appropriate requirements will be stimulated in the URS.
2651	There is a risk to Financial Sustainability as a result of the introduction of a new interfacing policy by MAK-System for devices connected to ePROGESA, leading to organisational cost pressures, reputational damage and/or delays in realising IMTP and other strategic benefits.	12	Additional funding needs to be made available for a Blood Establishment Computer System re-procurement through to 2027

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	IA	Oct-24	Terms of reference drafted for approval at Aug Digital Programme Board Public Health Wales briefing on their establishment of a design authority	Aug-24	Terms of reference for the Digitial Programme include the creation of Digital Design Authority which is in the process of being stood up in Q4 23/24. Digital Design Authority is still to formally meet.	The level of asurance should increase.
1.5	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer	IA	Oct-24	Strategic Development Committee Data and Insight incuded as part of the Change Advisory Board for C9	Aug '24	Will contribute to reduction in likelihood of risk	C9 would move to Effective
1.7	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer	IA	Oct-24	Digital Strategy has been reviewed for presentation to the August Digital Programme Board	Aug-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
1.7	Introduce a Change Advisory Board (CAB) to manage digital changes to service.	Chief Digital Officer	IA	Oct-24	Scope fror CAB has been established CAB has now met twice	Aug-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice, around C9
					CLOSED ACTIONS			
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer	PA	Complete	Digital Programme has now been established from Oct '23 Now meets on a bi-monthly basis	May-24	As the Programme continues to develop the overall level of risk should reduce by reducing the likelihood scores	The level of asurance should increase.
1.3	Approve the Digital Inclusion plan so that it can be used as the control point	Chief Digital Officer	IA	Complete	Plan approved at EMB/SDC Quality Impact Assessment Completed and Approved	May-24	improvement in the position on C7	The level of asurance should increase.
1.4	C13 - Embed new Head of Cyber Security	Chief Digital Officer	IA	Complete	Head of Cyber Security has been appointed from Dec '23	May-24	Dedicated post now in place to lead on cyber - will still be a single point of failure - Request into Trust reserves for a	C13 to move to Effective
1.6	Identify external benchmark / standards for the Digital Services (e.g. ISO27001 ./ ITIL)	Chief Digital Officer	IA	Complete	IT Infrastructure Library (ITIL) will form the basis of standards for Digital	May-24	Will contribute to reduction likelihood of risk	agreed frameworks and best practice to measure assurance against

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27

Strategic Goal 5 **A sustainable organisation that plays it part in creating a better**	**2. "Agile" Delivery Squads introduced to Digital target operating model**	**1. ongoing development of call centre solution and support** **2. Scale model to new areas**	**1. Transition to nVCC** **2. Complete**
	13. Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre **14. Performance Management Framework (Quality Measures) dashboard** **16. National Data Resource roadmap** **17. Trust wide Data and Insight plan** **18. New Velindre Cancer Centre (nVCC) digital enablement** **19. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services** **20. Digital enablement of the integrated Radiotherapy Solution Programme by 2026/27** **21. Implementation of electronic prescribing and medicines administration (ePMA) for Use by Velindre Cancer Services** **22. Digital Enablement of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)** **24. Upgrade Video Consultation platform to support Pathway Improvement Programme**	**13. WBS Donor system** **14. Further PMF dashboard development** **15. Complete** **16. Scale NDR roadmap** **17. Complete** **18. Design and implementation of nVCC Digital infrastructure and systems delivered by Velindre Scrutiny of ProjectCo Digital systems** **19. Project close following successful implementation.** **20. Progress phase 3 objectives.** **21. Project close following successful implementation.** **22. Project close and Radiotherapy Satellite Unit to 'go-live'** **23. Complete** **24. Complete**	**13. Complete** **14. Further PMF dashboard development** **15. Complete** **16. Scale NDR roadmap** **17. Complete** **18. Design and implementation of nVCC Digital infrastructure and systems &Transition of digital into nVCC** **19. Complete** **20. Complete** **21. Complete** **22. Complete** **23. Complete** **24. Complete**
	25. Undertake Digitisation of Medical Records **26. Digital Enablement of Regional Acute Oncology Delivery Model and Network Structure** **27. Electronic Patient Record – Phase 2** **28. VCS Service Changes – Other digital activities in support of the VCS plan** **29. WHAIS Digital: Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.** **30. WBMDR Digital: Digital enablement of the strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2026/27** **31. BECS Procure new Blood Establishment Computer System (BECS) contract and implement digital system.** **32. NEQAS: Implement new digital solution for National External Quality Assessment Service (NEQAS).** **33. WLIMS 2.0: To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system** **34. Plasma for Medicines: Digitally enable the Plasma for Medicines programme** **36. Foetal D: Digital enablement of Foetal DNA typing.** **37. Live Connectivity: Introduce live connectivity for the blood collection teams** **38. Donor Interaction and Appointments: Digitally enable improved donor interaction by 2026/27.**	**25. Undertake options appraisal. Develop supporting business case(s).Initiate phased delivery of the project.** **26. Complete** **27. Complete** **28. Complete** **29. Complete Data Migration (Q1).Training (Q1).Go-Live (end of Q1).** **30. Continue to progress with the WBMDR replacement software project.** **31. New Contract Award (Q1). New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECS solution.** **32. Go Live with new NEQAS system. Close Project.** **33. Final deployment activity (Q3)** **34. Adapt digital systems (BECS) to work with the Plasma for Medicines model once agreed** **35. Close down DHCW service** **36. Scope expansion of service.** **37. Complete** **38. Complete introduction of a donor experience hub. Complete implementation of a Customer Relationship Management (CRM) System. Implement omni-channel software**	**25. Undertake post-project evaluation** **26. Complete** **27. Complete** **28. Complete** **29. Complete** **30. Implement new WBMDR software.** **31. BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28) Continue supporting existing BECS solution.** **32. Complete** **33. Complete** **34. Complete** **35. Complete** **36. Complete** **37. Complete** **38. Implement tailored pathways for donors and advocates. New donor app implementation and create content.**
	25. Undertake Digitisation of Medical Records 26. Digital Enablement of Regional Acute Oncology Delivery Model and Network Structure 27. Electronic Patient Record – Phase 2 28. VCS Service Changes – Other digital activities in support of the VCS plan 29. WHAIS Digital: Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26. 30. WBMDR Digital: Digital enablement of the strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2026/27 31. BECS Procure new Blood Establishment Computer System (BECS) contract and implement digital system. 32. NEQAS: Implement new digital solution for National External Quality Assessment Service (NEQAS). 33. WLIMS 2.0: To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system 34. Plasma for Medicines: Digitally enable the Plasma for Medicines programme 36. Foetal D: Digital enablement of Foetal DNA typing. 37. Live Connectivity: Introduce live connectivity for the blood collection teams 38. Donor Interaction and Appointments: Digitally enable improved donor interaction by 2026/27.	25. Undertake options appraisal. Develop supporting business case(s).Initiate phased delivery of the project. 26. Complete 27. Complete 28. Complete 29. Complete Data Migration (Q1).Training (Q1).Go-Live (end of Q1). 30. Continue to progress with the WBMDR replacement software project. 31. New Contract Award (Q1). New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECS solution. 32. Go Live with new NEQAS system. Close Project. 33. Final deployment activity (Q3) 34. Adapt digital systems (BECS) to work with the Plasma for Medicines model once agreed 35. Close down DHCW service 36. Scope expansion of service. 37. Complete 38. Complete introduction of a donor experience hub. Complete implementation of a Customer Relationship Management (CRM) System. Implement omni-channel software	25. Undertake post-project evaluation 26. Complete 27. Complete 28. Complete 29. Complete 30. Implement new WBMDR software. 31. BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28) Continue supporting existing BECS solution. 32. Complete 33. Complete 34. Complete 35. Complete 36. Complete 37. Complete 38. Implement tailored pathways for donors and advocates. New donor app implementation and create content.

SECTION 1

RISK ID	06	RISK TITLE	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	Currently static. Actions planned for September/October should result in further movement.
RISK LEADS	Non Gwilym			RISK THEME	Organisational and Clinical Governance		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: Refer to 7 Levels of Assurance (see definitions tab)	RATING	E	Overall Trend in Assurance Refer to 7 Levels of Assurance (see definitions tab)	THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)	Non Gwilym		X		PE	Risk reporting arrangements at divisional, project/programme level	4	QSP/Audit Committees, Trust Board	6	Internal Audit Reports	4
C2	Annual Assessment of Board Effectiveness	Kay Barrow			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Audit Committee Trust Board	6	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Non Gwilym	X			E	Internal Audit Review	4	Audit Committee Trust Board	4	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	4
C4	Board Development Programme	Non Gwilym	X			PE	Programme established	4	Trust Board in Board Development	4	Specialist external input as required, for instance on Socio-economic Duty	4
C5	Quality of assurance provided to the Board	Non Gwilym	X			PE	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4
C6	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Non Gwilym	X			PE	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	4	Governance, Assurance & Risk Steering Group and Trust Board in Board Development input	4	Benchmarking input	4

C7	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework	Lauren Fear	X			NE	Exercise to be completed	1	Trust Board in Board Development	1		

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
None	Third line of defence in respect of C4 - Board Development Programme	Refreshed programme to be discussed and agreed in February 2024 Board Development session

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.0	Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Non Gwilym	4	Jun-24	Phase 2 GAR programme in development for EMB consideration in October 2024 following endorsement of GAR Steering Group. August 2024 update: Phase 2 GAR refresh underway. Initial thoughts captured at GAR group meeting in August. Refreshed phase two for GAR group consideration in October 2024.	23.08.24	Impact to be asseessed when Phase 2 of programme delviered	
3.0	Revised reporting mechanism to be developed	Non Gwilym	4	Oct-24	Progress delayed - Refresh of Phase 2 of GAR underway to be defined and agreed by mid Octover 2024, to include revised reporting mechanisms as per below: *Project TAF 3.0 within the 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. Good progress made however*	23.08.24	Impact to be asseessed when delviered	
5.0	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Non Gwilym	4	Nov-24	Dates amended to reflect benchmarking exercise underway but to be progressed by newly appointed Risk and Assrnace Manager from 1 October 2024.	22.08.24	Impact to be asseessed when programme delviered	
7.0	Develop new plan for phase 2 GAR programme	Non Gwilym	2	Nov-24	Plan presented to Audit Commitee 17.9.24 with detailed timetable.	11.09.24	Impact to be asseessed when plan for phase 2 is delviered	
					CLOSED ACTIONS			
2.0	Refresh of Trust Assurance Framework risks	Lauren Fear	6	Complete	Project TAF 2.0 within the GAR Programme is due to complete in January 2024 Trust Board, risks then to be reviewed on a monthly basis and reported through governance routes accordingly	11.4.24	Requirement for C7 to be put in place	
4.0	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Complete	Work is complete to map 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	11.4.24	Requirement for C7 to be put in place	

6.0	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework to be completed and agreed with Trust Board	Lauren Fear	6	Complete	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	11.4.24	Impact to be asseessed when delviered	

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	**Our Strategic Delivery Framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation** **Trust Purpose and Vision, aligned to** **• Trust Strategic Goals** **• VCS Strategy and Priorities and Service Plans** **• WBS Strategy and Priorities and Service Plans** **• Support Functions Strategies and Plans**		
	Building our Future Together 'Destination 2033' BOFT is an organisational development approach which is designed to identify and develop the leadership, culture, behaviours, processes and systems that we want to be. **BOFT Programme** **1. Ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as its golden thread** **2. Provide a way of working and shape to the organisation which enables us to maintain focus** **3. Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future** **4. Draw together our organisational developments with a common sense of purpose** **5. Improve our effectiveness, efficiency and value based approach** **6. Develop the mechanisms which enable us to prioritise where and when we focus our efforts** **7. Provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition** **8. Support realistic, authentic and compassionate leadership**		
	9. Re-assessing inter-related areas of work to ensure that together they provide the mechanisms to achieve our objectives **• Prioritisation & Co-ordination Arrangements** **• Values & Culture** **• Internal Staff Communication & Staff Engagement** **• Governance Risk and Assurance** **• Performance Management** **• Leadership Development** **• Value Based Healthcare** **• Quality Framework** **• Ways of Working** **• Clinical & Scientific Arrangements**		

SECTION 1

RISK ID	07	RISK TITLE	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience	RISK SCORE TREND	
RISK LEADS	Jacinta Abraham	Nicola Williams	Chief Operating Officer	RISK THEME	Patient Outcomes		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)			X		
C2	Capacity and demand planning and forecasting	Interim Director VCS / COO	As per TAF 01 C12			
C3	Multiprofessional Workforce Planning	Interim Director VCS / Director OD & Workforce	X	X		NE
C4	Quality and safety monitoring (Via PMF)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nurisng, AHP & HCS			X	NE
C5	Pathway delivery programme/Service Improvement Programmes: focus on delivery against national optimum pathways, reduction in variation, quality & safety priorities (via the Safe Care Collaborative), realignment of roles and responsibilities ensuring patients remain at centre of service delivery (also see TAF 01)	Interim Director VCS / COO	X			PE
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Interim Director VCS / Exec Director Nursing, AHP & HCS			X	PE
C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	NE
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	NE
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		NE
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE
C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	PE

SOURCES OF ASSURANCE

ID	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1						
C2	As per TAF 01 C12					
C3	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C4	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	NE
C5	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C6	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C7	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C8	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C9	VOA Implementation Group	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C10	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C11	VCS Quality & Safety Group / VCS SLT	PE	Integrated Quality & Saefty Group / Executive Management Board	PE	Quality, Safety and Perfromance Committee	PE

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Service level to Board monitoring of national standards delivery eg. NICE	Quality & Safety Tracker continues to be refined - not at its optimum	A1
Service level to Board intergrated dashboards	Quality Metrics under development	A2
Patient reported outcome measures across all SSTs, with service level to Board reporting	PROMa not in place	A3

Robust and consistent administrative processes for referrals and bookings		A4, A5, A6,A7

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors.- key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	15	Risk Stable
2465	Number of emails medics are receiving, especially those related to clinical tasks.	16	Risk Stable
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	15	Risk Stable
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	15	Risk Stable
2612	Acute Oncology Service (AOS) Workforce Gaps	15	Risk Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
Actions also aligned with TAF 01 re capacity and demand mapping and service reconfiguration								
A1	An electronic mechanism to be introdcued to monitor compliance with relevant national standards and guidance, including NICE, delivery plans and national frameworks.	Interim Director VCC	0	Sep-24	Q-pulse being procured. Options appraisal to be undertaken to consider Blue light, Q-Pulse and AmAT systems and agree on which system would be the most effective and efficient	22.3.24	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	Enhanced control and assurance
A2	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	2	Mar-24	AmAT rolled out and all open improvement plans moved across onto the system. Some teams require ongoing support to keep tracker live and up to date.	22.3.24	Change will reduce risk by having effective mechanisms to ensure that identified quality and safty improvements have been implemented and had the desired impact	Enhanced control and assurance
A3	Intergrated Quality and Safety dashboards to be developed that align with PMF	Exec Director Transofrmation, planning, performance and	2	Aug-24	Initial quality, safety and outcome metrics& implementation plan agreed	22.3.24	Should reduce risk	Enhanced control and assurance
A4	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implemented)	Exec Medical Director / Exec Finance Director	2	Mar-26	Working Group established within VCS, Lead by the VBHC Team Business Case for digital PROMS approved with procurement due in Q3 of 24/25. Work underway with clinical teams to agree SST specific PROM sets where national PROMS have not been set. The programme is collaborating with WCN on this. Breast national set newly agreed, When PROMS data is collected digitally it will be available within the data warehouse for analytical and reporting purposes, including at Board level. This is expected in Q4 24/25 for the areas which will have PROMS deployed	01/08/2024	Should long term reduce risk	Enhanced assurance
A5	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	Mar-25	Work commenced	22.3.24	Reduce risk	Enhanced control
A6	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS / Head of Nursing	1	Sep-24		22.3.24	Reduce risk	Enhanced control
A7	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	1	Sep-24	SACT telephone helpline report received and action plan developed	22.3.24	Change will reduce risk by further enhancing safety of the SACT Telephone helpline	Enhanced control

A8	Transformational multi professional workforce plans across all areas of the cancer service	Director OD & Workforce	1	Mar-26	Opportunities for mult-professional consultant posts being considered	22.3.24	Reduce risk	Enhanced control
A9	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transofrmation, planning, performance and digital	1	Jun-24	Data tool in development, system validation issues identified	22.3.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
A10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	Benchmarking undertaken and Trust process have been reviewed based on benchmarking outcomes and review of national standards	15.5.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance
A11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	Mar-25	Project group being established, project leads identified. Trust wide Q-Pulse system procured	22.3.24	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	Enhanced control and assurance
A12	Implementation of the patient engagement framework	Director Corporate Governance e	2	Mar-25		22.3.24	Reduce risk	Enhanced control and assurance
A13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Exec Medical Director / Exec Director Nursing, AHP &	2	Aug-24	Clinical & Scientific Board established. Terms of Reference endorsed by EMB. Long Term Management Support to be secured.	15.05.2024	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making.	Enhanced control
A14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Exec Medical Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed to commence consultation in may 2024. Long Term Management Support to be secured to drive forward delivery of the startegy (same post as one described above)	15.05.2024	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
A15	Undertake a review of the manaement of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	0	Aug-24	Regional working group established and proposals due to VCC SLT & EMB in May 2024.	15.05.2024	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	Enhanced control

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	**Clinical Quality and safety Priorities:** **1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.** **2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.** **3. To Integrate Clinical Audit within VCS Quality and Safety function** **4. Development of robust Site- Specific Quality Metrics** **5. To improve incident and risk management.** **6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System** **7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service.** **8. Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma-derived medicines.** **9. Review and improvement of donor selection and screening processes** **10. Introduction of all Wales foetal D Screening for RhD negative pregnant women.** **11. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results.** **12. Achieve JACIE accreditation for the WBMDR** **13. Commencing rollout of live connectivity of the BECS at community- based donation clinics** **14. Enablement of DATIX, QPULSE connectivity on community- based clinics for incident, risk and concerns recording at point of contact** **15. Increase in staff psychological safety (target TBC) scores within VUNHST Staff Survey results.** **16. Implement an outcome recording system for patients (digital PROMS)**		
	The Quality Impact Assessment (QIA) focuses on Three Main Areas: **1. Patient / Donor / Staff Safety – the avoidance of unintended or unexpected harm to people during the provision of health care.** **2. Clinical Effectiveness – the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients.** **3. Patient / Donor / Staff Experience – the way a patient or donor feels about their care based on all interactions, before, during and after delivery of care, or how a member of staff may feel whilst providing the care**		
	Strategic Equality Plan and Equality Impact Assessments (EQIA) **• Objective 1: Increase workforce diversity & inclusion, and eliminate Pay Gaps** **• Objective 2: Engage with the community** **• Objective 3: Communicate with people in ways that meet their needs** **• Objective 4: Ensure service delivery reflects individual need**		

SECTION 1

RISK ID	08	RISK TITLE	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience 5 - A sustainable organisation that plays it part in creating a better future for people across the globe	RISK SCORE TREND	
RISK LEADS	Matthew Bunce			RISK THEME	Financial Sustainability and Long-Term Value		

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	not assessed	Executive Finance Reports; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	PA	Internal Audit / External Audit	PA
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	PA	Welsh Government / NHS Executive (FP&D) / External Audit	PA
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	not assessed	Collective Commissioning Group LTA reporting	IA	LHB Commissioners	IA
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE	Executive Budget Holders / Programme SROs	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	not assessed	LHB Commissioners / Welsh Government / Internal Audit / External Audit	IA

FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E	Executive Budget Holders / Programme SROs	not assessed	Trust Board and Committees	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			PE	Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	not assessed	Trust Board and Committees; Delegated Financial Limits	PA	Internal Audit / External Audit	IA
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE	Value Based Healthcare project leads; VBH programme SROs	not assessed	Value Based Healthcare steering committee / Executive Management Board, Strategic Development Committee	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Requisitioners / Budget Holders	not assessed	Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	PA	Internal Audit / External Audit	PA
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Budget Holders; Private Patients lead; reports	not assessed	Debtors Reporting; Senior Finance Team;	PA	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	PA
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting			X	E	Budget Holders; Heads of Division; Divisional Directors	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Fixed Assets Register Reporting	PA	Internal Audit / External Audit	PA
FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board	IA	Internal Audit / External Audit	IA
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E	Budget Holders, reports and training	not assessed	Counter Fraud Reports; Audit Committee	PA	Internal Audit / External Audit	PA
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E	Budget holders, requisitioners, reports and training	not assessed	Financial Operations Team; VAT working group	PA	External Advisory (EY) / Internal Audit / External Audit / HMRC	PA
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE	Exec Directors, Divisional Directors, Budget Holders, reporting and training	not assessed	Procurement Compliance reporting; Audit Committee	PA	Internal Audit / External Audit	IA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Scheme of Delegation and Governance Framework for the nVCC to prepare for post financial close	Investment Appraisal assurance process improvement to ensure high quality of business case submissions and education of organisation with regards to appropriate funding routes for service developments and initiatives	F6 (Controls); F4 (Assurance)
	Medicines management requires more clarity on governance, decision making processes and financial implications including links between NWSSP, National forums and impact on local decision making in VCS.	F2

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
F1	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Ongoing	VBH Programme of work under way overseen by the VBH Steering Group. Opportunity Pipeline presented at April 2024 EMB Shape identified 4 potential initiatives to take forward. These require further development including identification of Senior Responsible Officers to take accountability at Exec level to oversee the development and delivery. Digital PROMS Business Case approved by Trust Board	13.08.2024	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	tbc
F2	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	EDoF / DDoF	4	Ongoing	Pharmacy review has been conducted and will be presented to Exec Management Board early in 2024. Following this a review of medicines management governance (including financial aspects), will be conducted by September 2024. Finance and Investment Enhanced Monitoring reporting continues with key risks highlighted regarding Long Term Agreements.	13.08.2024	Identification of opportunities for new savings initiatives and disinvestments / choices will support financial sustainability	tbc
F3	Development and review of Financial Control Procedures	EDoF / DDoF	6	Ongoing	Capital financial control procedure approved by Audit Committee. Financial Control Procedure update plan and pipeline for review in development. Internal Audit scope of review for Key Financial Controls has been agreed. The indicative timeline suggests that fieldwork will commence in September and the report will be presented to Audit Committee in December 2024.	13.08.2024	Strengthened control procedures will support risk mitigation	tbc
F4	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Dec-24	Presentation made to April 2024 EMB Shape for the development of criteria for assessing investment opportunities. This included Strategic Fit, Deliverability and Value and Sustainability. Next steps are to develop criteria aligned to the 3 areas identified. Progress delayed due to lack of finance resource	13.08.2024	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	tbc
F5	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Dec-24	Cardiff Cancer Research Hub market engagement exercise completed. Programme plan drafted and in the process of being reviewed. Private patient cash collection and pricing continues to be developed and progress being made in the backlog of cash collection.	13.08.2024	Attracting external / alternative sources of income will decrease pressure on WG allocation of funds	tbc
F6	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Nov-24	Scheme of Delegation and Governance Framework was approved in June-23 by the Trust Board. A Scheme of Delegation and Governance Framework is being developed for nVCC, which will integrate findings from DLA Piper and PwC reviews. Progress to be taken forward through the nVCC Taskforce established in April 2024. nVCC FBC has been delayed and not expected to be approved by WG until Sep 24 therefore SoD will be reviewed once FBC is approved.	13.08.2024	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	tbc

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27

Strategic Goal 1 **Outstanding for quality, safety and experience**	Value & Sustainability In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements through EMB Shape. The Trust will continue to review and integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. More specifically, this will include: • Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit. • VBH Pre-operative anaemia pathway work with Health Boards will release bed capacity and plans for further expansion of the pathway to include other patient cohorts will further increase Health Board bed capacity freed-up. • Plasma for Medicine Business case if approved and funded by WG / WHHSC has potential to save c £1.5m in phase 1 on blood derived medicines used by Health Board and if phase 2 approved up to £2m saving to Health Boards. • Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach. Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre 1. Pre-op anaemia programme: This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10 procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).		
	Estates and Sustainability Plan 'Estates Excellence' The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in. 1. Provide an estate which enables the delivery of high quality clinical services 2. Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience 3. Provide healthy buildings which support and enhance individual well-being 4. Minimise the impact of our estate on the environment 5. Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve Estates Actions • Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs • Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces • Investing additional resources in the maintenance of the existing estate to maintain a Category B • Implementing our estates, digital, workforce and sustainability strategies • Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles • Identifying innovative ways to adopt renewable energy sources to service our requirements • Identifying facilities we can share the use of with other public bodies and wider partners		
	• Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets • Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services • Delivering a number of transformative capital programmes which have sustainability at their centre of design: • Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025 • Refurbishment / development of new outreach facilities by 2024/2025 • Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024 • Opening of the new Velindre Cancer Centre by 2025		
	Sustainability Actions • Developing clinical service models which support sustainability • Implementing our sustainability strategy • Applying the principles of the circular economy into our business processes through design, procurement, re-use and lifecycle. • Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Implementation of our carbon reduction plan which will see us achieve Net Zero and transition to renewable energy for our services and facilities. • Investing in a range of refurbishments and new buildings which will support our carbon reduction and healthier buildings and healthier people approach. These include:		

	• Major refurbishment of the Welsh Blood Service, Llantrisant site, by 2025 • Construction of a Radiotherapy Satellite Centre at Neville Hall by 2024 • Construction of a new Velindre Cancer Centre by 2025 • Implementing an attractive approach to agile working for our staff which reduces avoidable travel, improves well-being and offers the potential to support money going into local communities • Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Using our procurement activities and NHS Wales Shared Services capability to drive a sustainable approach and achieve wider ethical and social value in areas including local employment and prosperity; carbon reduction; anti-slavery and unethical practices. • Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprenticeships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Governments Foundational economy		

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

TRUST ASSURANCE FRAMEWORK UPDATE

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	To provide the Trust Board with the opportunity to review the updates to the Trust Assurance Framework and the actions planned for the next period.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the current status and on-going development of the Trust Assurance Framework.

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COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
EMB Run	29 August 2024
Quality, Safety and Performance Committee	12 September 2024
Audit Committee	17 September 2024

DUE TO THE RESCHEDULED DEADLINE OF THE AUDIT COMMITTEE MEETING, A VERBAL UPDATE OF THE QUALITY SAFETY AND PERFORMANCE COMMITTEE DISCUSSION WILL BE PRESENTED.

Quality, Safety and Performance Committee

1. The Committee raised the need to report closed actions accurately e.g. TAF 03 closed actions should move to the closed actions section.
2. The Committee also noted that there were risks raised to the Trust Board Risk Register Report that were not included in the TAF.
3. The Committee asked for a more succinct way of reporting the IMTP into TAF. The Chair had discussed this need with the CEX and Interim Executive Director of Strategic Transformation, Planning and Digital.

Audit Committee:

1. The Committee discussed the need to progress open actions regarding the development and management of TAF, and noted that VM would progress these and the matters raised at QSP Committee with the CEX, Interim Executive Director of Strategic Transformation, Planning and Digital and Interim Director of Corporate Governance.
2. Updated information uploaded by the Finance Department had been omitted from the version of TAF reported to the Audit Committee. They have been included in TAF 08 in Appendix 1 presented to the Trust Board.

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

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

APPENDICES

1	Strategic Risks
2	Trust, Assurance and Risk Framework August 2024

1. SITUATION

1.2 Trust Assurance Framework

The Trust Assurance Framework (TAF) was established in 2020. A dashboard was developed to record movement to TAF and support ongoing management of strategic risks by nominated Executive Leads.

The Trust Assurance Framework template was reviewed and updated further in consultation with the Audit Committee in early 2024. A refreshed Trust Assurance Framework, detailing eight strategic risks, was approved by Trust Board in March 2024.

The eight strategic risks are included as Appendix 1.

2. ASSESSMENT

Trust Assurance Framework

At the Quality, Safety and Performance Committee in July 2024, TAF 05 Digital – *"There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security"* was discussed at length as a deep dive exercise providing an opportunity to discuss matters raised.

The mapping of the IMTP and the Trust Assurance Framework has been reviewed and considered as part of the template. The tracking of the performance against these objectives, in line with the standard IMTP quarterly reporting, will be included in the next reporting cycle.

The longer term "Phase 2" approach re-orientate the Trust Assurance Framework according to strategic objectives. The template and approach for this will be outlined and considered by the Governance, Assurance and Risk group in October, for agreement in November in order to allow the development of the 2025-2028 Integrated Medium-Term Plan and Trust Assurance Framework to progress on this basis during Quarter 3 and 4.

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Summary of Actions Taken/ In Plan

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe
1	Populate refreshed TAF on Power BI template	Work completed in background on Power BI and refreshed information to be populated from March reporting cycle.	Although issue with lack of risk/assurance resource continues, it has been possible to progress the development work is complete and there is a usable version of the dashboard on SharePoint. Next steps are to migrate the dashboard through the Power Automate Exporting Tool. Expect to be available to start migration by November.
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Full update in paper in section 2.2 above	Phase 1 – July reporting cycle. Phase 2 – aligned to 2025/6 Integrated Medium Term Plan development
4	Deep dive of two risks at Quality, Safety & Performance Committee going forwards	Following reporting of refresh framework of strategic risks, this will recommence from the next reporting cycle.	TAF 05 Complete – included in July reporting cycle. New TAF risk to be considered for deep dive.
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional	July 2024 - in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

		Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may include further Board development time etc.	
6	Tracked changes	Tracked changes will be highlighted more clearly to show recent updates. In addition, the cover paper will be developed to include clearer commentary of key changes.	July reporting cycle – This will be automated based on migration to Power BI template as per improvement action 1 above.
7	Risk Score Trend	Review of approach to managing updated on Risk Score Trend to be reviewed by Executive Management Board	September Executive Management Board (29 September)

3 SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board is asked to **NOTE** the current status and on-going development of the Trust Assurance Framework.

4 IMPACT ASSESSMENT

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RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒ The risk register and associated risk framework are imperative to quality and safety in the organisation.
	Not required

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	There are no socio-economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report

3 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the TAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Consideration of the impact of the actions outlined in this paper on the current scoring of the strategic risks will be managed by the Executive Management Board at its monthly Run meetings.
BY WHEN?	Ongoing

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1 – Trust Strategic Risks

01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.
02	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.
03	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.
04	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes
05	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security
06	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.
07	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.
08	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.

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TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT AND SUPPORTING ANALYSIS FOR JULY 2024/25

Date of meeting	26 SEPTEMBER 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
Prepared by	Peter Gorin, Head of Strategic Planning and Performance. Rachel Hennessy, Acting Director of Velindre Cancer Services, Sarah Richards, Head of Planning and Performance Services
PRESENTED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital, Anne Carey, Interim Chief Operating Officer, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	**PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW** The report now includes an overview of the development of the Performance Management Framework. For this report, there is a summary of the work packages provided. From the November report, the PMF will be based on exception reporting.

	THE PERFORMANCE HIGHLIGHTS FOR THE PERIOD TO JULY 2024/25 ARE: **Velindre Cancer Service** **SACT Services:** • The June performance was 100% for emergency SACT and 88% for SACT non-emergency. • Currently the July position is undergoing validation and is 65%, which is slightly ahead of the June 'unvalidated' position. • However, non-emergency performance continues to be challenging. In response to this business continuity plans are still in place. A biweekly VCS SACT demand planning group has been established reporting to a biweekly SACT GOLD, chaired by the Executive Director of Nursing. **Radiotherapy Services:** • Radiotherapy performance for July was 82% for Scheduled, 74% for Urgent, 100% for Emergency and 98% for elective delay. All against a 100% compliance target. Performance continues to be challenging during the Linac replacement programme. **Welsh Blood Service** • WBS met all clinical demand in July and were able to support NHSBT with 70 units of 0- as part of mutual aid. Performance for this metric has remained stable since April, despite recurring staffing pressures within the Collection Teams, including increased sickness and annual leave arrangements affecting capacity. The service remains under pressure in terms of supply matching demand and is working up a resourcing plan to increase collections across Wales. • The recovery plan for bone marrow volunteer recruitment is showing encouraging results again for July since the launch of buccal swab drives in late January 2024. Performance increased with 676 donors added to the panel for July (against a target of 333). • For donors recruited on swab drives during July (who shared their ethnicity), donors from a black, Asian, mixed or minority ethnic heritage made up 15% of the total monthly recruitment (against current population ethnicity data in Wales of 5.8%).
RECOMMENDATION / ACTIONS	**The Trust Board is asked to:** • **NOTE and DISCUSS the July 2024 Performance Management Framework** • **NOTE the targeted work being undertake through business continuity arrangements in respect of the delivery of SACT.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**

WBS SMT / Performance Review	15 August 2024
VCS SLT / Performance Review	20 August 2024
Executive Management Board – Run	29 August 2024
Quality Safety & Performance Committee	12 September 2024

Summary and outcome of previous governance discussions

The report has been considered and endorsed at by the VCS and WBS divisions, EMB Run, QSP Committee and is presented to the Trust Board for information and noting.

The main points to note from the Velindre University NHS Trust QSP Committee are summarised below:

- The QSP Committee noted the continued development of the PMF and that the narrative reposts were provided in more detail for this reporting cycle.
- The Interim Director of Strategic Transformation, Planning and Digital highlighted that a new section had been incorporated into the PMF which provides an overview of PMF developments and the seven associated work packages. Assurance was provided to the QSP Committee that an implementation plan, with agreed timescales, is currently being developed and will be available in time for the next meeting. Further assurance was provided a number of these work packages have already been delivered e.g. reporting on compliance metrics. The Interim Chief Operating Officer also provided assurance that all PMF developments would be delivered in partnership with both services and support services.
- The QSP Committee asked for additional detail in relation to the small percentage patients who had breached the radiotherapy waiting time target. Assurance was provided by the Velindre Cancer Centre Interim Director that reviews are undertaken for all patients who breach the agreed target and remedial actions are taken when needed. However, it was agreed that further information would be provided at future QSP Committee meetings with a focus on key themes which had emerged from the patient reviews. It was also agreed that this should apply to other service waiting time breaches e.g. SACT to ensure a consistent approach.
- The QSP Committee highlighted the current level of staff sickness and how the Trust is managing staff well-being. The Executive Director of Organisational Development and Workforce confirmed that staff sickness is currently in the region of 5% and this is slightly higher than our performance target. However, assurance was provided that the Organisational Development and Workforce team are working closely with the services to understand the reasons for staff sickness and also to support any staff who have been impacted. Further assurance was provided that a key focus of work is to provide additional well-being support for all staff and that the recent appointment of the Trust well-being co-coordinator would provide additional capacity to support this Trust priority.
- The QSP Committee noted the continued positive performance from the Welsh Blood Service. However, the Director of the Welsh Blood Service highlighted that the service has experienced supply chain pressures during August and which were continuing in September.
- The QSP Committee highlighted the percentage compliance in relation to manual handling which is below the Trust required target. Assurance was provided from Trust executive officers that remedial actions were in place and that a more detailed update would be provided at the next committee meeting.
- A request was made that a more detailed update was provided in relation to Planned Preventative Maintenance for the next QSP Committee meeting.

The Velindre University NHS Trust Quality, Safety and Performance Committee endorsed the Performance Management Report for July 2024.

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

APPENDICES	
1	Performance Management Framework supporting KPI Data Graphics and Analysis
2	Clinical Outcome Quality and Safety KPIs being considered/developed for PMF Scorecards 2023/24
3	Analysis of Current Range of PMF Performance Measures and Level of Statutory Compliance

ACRONYMS	
VUNHST	**Velindre University NHS Trust**
QSP	**Quality Safety and Performance Committee**
EMB	**Executive Management Board**
SLT	**Senior Leadership Team**
PMF	**Performance Management Framework**
QSF	**Quality Safety Framework**
KPI	**Key Performance Indicators**
SPC	**Statistical Process Control Charts**
SMART	**Relating to goal setting – "Specific, Measurable, Achievable, Relevant, Time-based"**

1. SITUATION AND BACKGROUND

VELINDRE NHST PERFORMANCE REPORT FOR JULY 2024

The following section provides an overview of our Trust-wide performance against key national performance targets and best practice standards through to the end of July 2024 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance.

PMF Development Overview

Overview of PMF Development Work Packages:

1.1 Analysis of Current Range of PMF Performance Measures and Level of Statutory Compliance

An exercise has been undertaken to show the current level of compliance against the whole range of VCS, WBS and Trust-wide support functions performance measures (KPIs) across statutory/mandatory, best practice/benchmarks and locally determined stretch targets.

The result of this exercise is given in **Appendix 3** which shows that out of the total 111 KPIs (54 statutory; 17 best practice; 40 local) we are compliant with the majority of targets with only 17 areas of non-compliance. The areas of statutory non-compliance are in VCS RT and SACT timeliness and PADR and sickness targets.

However, the Health and Social Care (Quality and Engagement) Wales Act which came into force on 1 April 2023 places a number of additional reporting requirements. The mechanisms to report on these areas are being developed. In particular, the Quality Act requirement for 'always on' reporting on key performance areas.

1.2 Wider inclusion of Quality Metrics into the PMF

Appendix 2 provides an overview of the Duty of Quality & Always On reporting requirements and Trust current levels of compliance. The Quality and BI teams are working to implement the requirements as previously agreed by Executive Management Board (EMB). At time of paper circulation an overview of timings has not been agreed however, this will be further worked on and a verbal update provided in Quality, Safety & Performance Committee (QSP) and also Trust Board. This will then be included in the full project plan for November reporting cycle, however it is expected that progress will have already been made.

1.3 Single Source of the Truth for Data, Mapped to Pathways

It is agreed that regionally this is an important priority and links to actions in the Cancer Improvement Plan 2023-6.

<u>Extract from Cancer Improvement Plan:</u>

"In Wales, data on cancer patients is fragmented and is collected and held by a number of different organisations with varying roles and responsibilities. There is no single organisation that has ownership of the responsibility to use data for patient benefit. This accounts for the high levels of frustration, built up over many years, from a wide range of stakeholders, about the lack of a cancer

intelligence function in Wales with responsibility for analysing data at cancer site, population and provider level with sufficient granularity to actually enable service change. The development of innovative digital solutions must be a key component of the recovery of Cancer Services. Minimal progress has been made on delivering the actions set out in the Cancer Information and Intelligence Framework; A Digital Health Strategy for Cancer in Wales 2017-2020. A key component of this strategy was improved data sharing and collection to benefit patients, professionals and the system. Direct patient access or held summaries of their treatment will help enable the balancing of healthcare pathways, activity and decision making between the professional and patient: a key component of the quadruple aim in A Healthier Wales (Welsh Government, 2019)15. Wales urgently needs to make progress in taking forward the actions set out in the Framework and address the deficit in the availability of cancer intelligence to improve care and outcomes. The Wales Cancer Network will lead development of a refreshed Digital Cancer Plan deriving this from the refreshed National Digital Healthcare Plan."

The Trust is working with Commissioning Health Boards and via the Regional Cancer Board to ensure that the regional is effectively prioritising this development; working effectively with Public Health Wales, Wales Cancer Network and Digital Health and Care Wales on the responsibilities to deliver effective cancer data; taking specific action as a region and individual organisations promptly to address this issue. Again, further details will be provided to EMB, QSP and Trust Board and included in the PMF Plan.

1.4 Inclusion of all Targets

For the next reporting cycle, any metrics without a target will include a target or a date by which the target will be agreed and rationale for delay.

1.5 Exception/ Threshold Reporting

At the Board Development in October, there will be a discussion on how to most effectively start either exception or threshold reporting. This will then be enacted from the November reporting cycle onwards. To inform the discussion, mock ups of the options based on September data will be drafted.

1.6 Future PMF Development Plans

All VCS and WBS Directorates and Trust-wide functions are reviewing their metrics to discuss proposed changes with the Trust Board. This to include any further additional Quality metrics. Any changes to PMF would then be governed via Executive Management Board and Strategic Development Committee into Trust Board.

1.7 PMF Automation

Work is also progressing to 'automate' the production of the PMF performance report to reduce the current level of manual interactions in the current process. This work with the support of Business Information colleagues plus associated transition training will be completed from the November reporting cycle.

2. Cancer Centre Services Overview

Radiotherapy

- 100% of patients requiring emergency radiotherapy treatment began treatment within required timescale (target 100%).
- 82% of patients referred for scheduled radiotherapy treatments began treatment within 21-days of the decision to treat in July. This was an increase in performance from 76% in June 2024.
- Compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy treatment improved from 72% in June 2024 to 74% in July 2024 against a target of 100%.

There has been an increase in performance since the extended service contract has been sourced for LA1 1st May 2024, therefore increasing capacity available.

Plans are in place to mitigate the impact of the Linac replacement programme, but this is expected to be challenging for the service.

In addition to capacity challenges, a review of referrals that did not achieve treatment within mandatory target identified trends in relation to change in patient conditions resulting in requirement for patients to be rescanned and re-planned, Linac breakdown, and delay in delineation as a result of staffing capacity.

Longest waits

Scheduled	Number referrals	297
	% within 21 days (target 100%)	243 (82%)
	Longest wait	38 days
	97% (288) patients seen within 28 days*	
Urgent SC	Number of referrals	46
	% within 7 days (target 100%)	33 (74%)
	98% (45) patients seen within 14 days*	

**previous JCCO guidance*

Patients are prioritised and offered the first available appointment in response to the clinical urgency of their pathway- whilst taking into account the patients' needs and in accordance with the access to treatment procedure.

When demand exceeds capacity, all referrals are submitted through escalation where prioritisation and clinical harm assessment is undertaken to ensure that patients are treated in accordance with clinical priority. Where developments/ upgrades of systems continue as part of the IRS programme impacting on capacity, a risk assessment is undertaken identifying appropriate mitigation to reduce the risk of breaching the radiotherapy standards of care.

All failures to meet WG time to radiotherapy standards are investigated at pathway level to identify maximum wait and understand the root cause. Themes coming through as part of the root cause analysis and use to design mitigations where possible.

Service level pathway development identifying best practice and efficiencies is ongoing, this has been integral to the development of care paths.

Through the All Wales Cancer Performance Management group, it has been established that the three Cancer Centres in Wales have historically utilised inconsistent data definitions for the Emergency Time to Radiotherapy measures. The agreed future definition will include measuring the 24-hour timescale from the point of receipt of the referral to radiotherapy. Velindre Cancer Centre has always adopted this measure.

SACT

Delivery of non-emergency SACT continues to be challenging. This is as a result of constrained pharmacy capacity against an increase in demand. Annual forecasting for inclusion in Integrated Medium-Term Plan (IMTP) anticipated an increase in demand between 8%-12% over the next 12 months based on outturn at 31st March 2024.

For the month of June 2024:

- 100% of emergency patients were all treated within the target of 5 days, maintaining the 100% performance of the last 12 months.
- Non-emergency patient performance improved from 76% compliance to 88% compliance, with a reduction in breaches from 107 to 41. The longest patient waited 35 days.
- July 65% ('unvalidated' position)
- All patients within a trial are booked as per the trial timeframes.

Longest Waits Non-Emergency

Wait time	referrals	percentage
0-7 days	132	39.8%
8-14 days	44	13.3%
15-21 days	133	23.1%
22 - 28 days	32	10.7%
29 - 35 days	9	5.1%
36 – 42 days	0	0%
43 – 49 days	0	0%
50 – 52 days	0	0%
Total	**341**	

Daily escalation meetings are taking place and patients are being clinically prioritised and will undergo a harm review if deemed clinically appropriate.

Business continuity plans have been initiated in January 2024 and are still in place. A VCS SACT demand planning group has been established and has developed plans to increase capacity across the service. It reports into the GOLD command meeting chaired by the Executive Director Nursing, to give Executive oversight and support in respect of SACT performance.

This level of rigour is anticipated to positively impact performance by August/September 2024, with some interim improvements supporting marginal improvement in capacity from late June. Work is continuing with Digital Insight team to develop a 'single source of truth' for each patient pathway as well as understanding the demand for individual components of the service including oral and parental SACT, pharmacy, nursing and booking.

The greatest risk to achieving and sustaining our required level of performance relates to SACT Pharmacy provision. A number of mitigating actions have been identified. These include buying in pre-prepared SACT, additional third-party support and increasing VCC pharmacy capacity to manufacture and dispense treatment agents. As part of a benchmarking exercise, the team have been speaking with other SACT providers in Worcester and Swansea and have identified some key target areas of service redesign and process review. These will add to the other initiatives to improve pathways and reduce waiting times for patients.

The longer-term plan regarding TrAMs will provide increased long-term resilience.

Pressure Ulcers
There was 1 Avoidable Pressure Ulcer reported for July, the first for 7 months.

Falls
No Avoidable Falls were identified for the 17th consecutive month.

Delayed pathways of care
There was one patient with a delay of 21 days, due to awaiting a package of care to support their discharge home.

Patient Experience
Both Patient experience measures reported 98% and 96% compliance against an 85% target. Responses are anonymous so we do not have significant details to follow up. Key themes link to waiting times in outpatient clinics. There are multiple pieces of work focussing on outpatient improvement including the work linked to SACT GOLD. Volunteers have returned to outpatients in May 2024. Screens are being utilised to communicate length of waits to patients within the area.

1.2 Welsh Blood Service Overview

All clinical demand was met in July. While O+ blood levels were under pressure on 1st July and A+ in the final week of the month, no alerts for customer hospitals were necessary.

Performance in quality incidents closed within 30 days continues to exceed target (90%) at 97% this month. No adverse events were submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) or the Human Tissue Authority (HTA) in July.
Donor satisfaction continues to exceed the target (95%) reaching 97% in July. 7,827 donors were registered at donation clinics with 3 informal concerns being raised (0.03% of all donors registered). All 3 concerns were managed within the 2-day timescale required under the 'Putting Things Right' guidelines. There were no formal concerns raised in July.

All clinical demand for platelets was successfully met, reflecting strong performance in this area. Platelet wastage, which reached 10%, has significantly improved, achieving the target of 10% in July. WBS is actively analysing issuing data to identify demand trends and make necessary adjustments to platelet production. Additionally, a review of the Platelet Strategy is currently in progress as part of the WBS Futures initiative.

Collection efficiency performance decreased slightly in July (1.13) against a target of 1.25. Performance this month can be attributed to staffing pressures including an increase in staff absence due to sickness and annual leave. Five new staff were recruited to the Bangor Collection Team in July which will support increased resilience going forward.

There were 4 Peripheral Blood Stem Cell (PBSC) collections in July against a target of 7 collections per month. The total cell provision for the service in July was 9 (4 stem cell collections from Welsh donors, and 5 cell imports for the University Hospital of Wales). Performance is expected to be maintained or improve in August and September with 10 stem cell collections planned.

With the launch of the buccal swab 'drives' in late January 2024, the recovery plan for bone marrow volunteer recruitment is building. Overall performance for July was 532 (Cheek Swab) plus 144 (recruited on blood clinic) giving a total of 676 (against a target of 333).

2.1 Workforce and Wellbeing

Sickness

Current rolling sickness absence is 5.22% to July 2024, which is above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%. A number of interventions to manage sickness are in place to mitigate the risk to staff wellbeing and there has been a downwards trend in sickness absence over the last 12 months. Work is ongoing with service managers to support staff.

PADR's (staff appraisals)

Trust wide PADRs this month is 74% (target 85%). This is an improved performance over the last three months.

Statutory & Mandatory Training

Statutory and Mandatory training remains above target at 87% (target 85%) and has been consecutively on target for the whole year to date.

<u>A full summary of workforce interventions to mitigate workforce risks and to support effective Supply and Shape of the workforce is summarised in the Supply and Shape Paper April 2024, an updated version will be provided in August 2024</u>

2.2 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys. Performance against 'Would you recommend us?' was 98% and 'Your Velindre experience?' was 96% both set against the 85% target.

The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 97% which continues to meet the target (95%).

2.3 Digital Services

Steady performance in July 2024, with marginal changes only.

Main area of concern remains the number of significant IT business continuity incidents – the number of incidents in the latest 12-month period has increased to 14, a consequence of a number of outages associated with national, DHCW-managed IT systems. These are being reviewed via the relevant national Service Management Boards, to identify opportunities to prevent re-occurrence.

Target achieved in respect of the % of service requests resolved within SLA – 85% in July 2024. % of incidents resolved within SLA dropped slightly, to 79% in July 2024. Improvement Plan now established for Digital Services 1st and 2nd line support teams.

Reporting arrangements for two indicators are still in development:

- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Delivery of routine reporting has been delayed due to competing priorities within the team.

- % of Trust expenditure in digital – to aim was to report this metric from May 2024 (April data) (DIG.73); however, the Digital Services team are waiting on the 2024/25 data to be shared by Finance. The definition for the metric has been agreed with the Finance team.

The reporting of one further indicator is currently in the process of being established:

- Hours saved through digitisation / automation of paper-based manual processes – publication date TBC.

2.4 Estates Infrastructure and Sustainability

The Estates department has encountered substantial challenges due to prolonged staff absences. Despite this, the team successfully met benchmark compliance for Planned Preventative Maintenance (PPM) across all sites, except for Velindre Cancer Centre, where the transition to a new CAFM system and the introduction of additional PPMs affected performance.
However, the targets for Reactive Maintenance were not achieved during this period. Moving forward, the focus will be on enhancing Reactive Maintenance performance to meet the required benchmarks by planning PPMs and reactive tasks in accordance with deadlines.

Energy prices have decreased following the energy crisis. Team Sigma provide billing & consumption verification for the Trust, alongside comprehensive reporting. Gas and electricity consumption across VUNHST Estate during 23/24 has been lower than baseline 18/19 year. The Trust continues to manage energy consumption with constant monitoring via the Building Management System. Water consumption during 23/24 has increased at VCC. The water consumption increase against the baseline at VCC is due is due to an enhanced flushing regime in line with Water Safety guidelines & Infection, Prevention & Control measures. This action has resulted in an external audit awarding "Substantial Assurance" for water safety, for the first time on site.

The KPIs for fire safety training remains below target figure of 85%. The Trust fire safety manager is working with both the ESR and WOD teams to review the current provision of fire safety training and also to review and streamline the delivery of fire safety training down to five [5] competency levels and remove duplicate competencies. The fire safety manager has continued to work with SLT leads and staff supervisors to emphasise the importance of prioritising attendance at future training events and has run additional sessions through June / July to improve this area of compliance.

Health & Safety

Overall, we have seen a slight increase in incidents this month with an overall number of 10 split between WBS and VCC. We have also received a couple of late reported incidents one of 18 days and another of 6 days. Communication between the safety department and the divisions is taking place to ensure when we have any incidents that they are reported as soon as possible as this could result in late reporting to the HSE if significant enough. We must again highlight the decrease in training for patient manual handling as we don't have the ability to deliver the training currently. Talks are happening to address this soon. In relation to the statistics and language surrounding H&S incidents, this will be included in a paper to EMB for 29th August.

2.5 Finance

The overall position against the profiled revenue budget to the end of July 2024 is underspent by £0.008m and at this stage is currently expecting to achieve an outturn forecast of Breakeven.

The Trust received agreed commitment from HBs to proceed with the contract rebasing at the collective commissioner's group which was reflected in the LTAs issued by the Trust in March, however in April the Trust received letters from 2 HBs which outlined their disagreement with the rebasing proposal. The other 4HBs and JCC are in agreement to proceed but subject to all HBs agreement the contract rebase. As commissioners were not able to reach a consensus before the 30th June deadline the Trust had to revert back and prepare LTAs on an historic basis.

In order to avoid arbitration, discussions between Chief Executives led to a compromise position and the financial impact to the Trust for 2024/25 is as follows:

- £318k reduction in recurrent discretionary income compared to plan.
- £483k reduction in non-recurrent income compared to plan with a further risk to non-recurrent position still to be confirmed but not expected to be material.

In line with the overall financial plan an in-depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage.

Several new schemes were identified, which replaced those schemes that had either failed or not yet progressed. The revised target of £2.875m was required in order to help compensate for the loss of income from the LTA agreements. One Scheme within VCS remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

In order to achieve a balanced financial position, the savings target set for 2024-25 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.

The approved Capital Expenditure Limit (CEL) as of July 2024 is £19.250m. This represents all Wales Capital funding of £17.339m, and Discretionary funding of £1.911m. The Trust reported Capital spend

to July'24 of £6.322m and is forecasting to remain within the CEL of £19.250m, subject to the Trust receiving support from WG for the schemes identified at this stage without agreed funding but are in discussion with WG such as the nVCC Capital cost requirement for 2024-25.

During July'24 the Trust (core) achieved a compliance level of 98.3% (June 95.2%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of 96.93% at the end of month 4, and a Trust position (including hosted) of 97.1% compared to the target of 95%.

3. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION VELINDRE NHST PERFORMANCE SCORECARDS FOR JULY 2024

3.1 The Performance Management Framework (PMF) Scorecards, in this Section, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.

3.2 Navigating our PMF Performance Report

The following PMF Scorecards incorporate hyperlinks to supporting Key Performance Indicator (KPI) data and analysis, enabling switching between the high-level positions to detailed analysis provided in **Appendices 1 to 3**

Each QSF domain in the PMF scorecards is populated with a range of KPIs for VCC and WBS services plus a range of KPIs for Support Services functions. Performance is assessed as either 'within standard' □ or 'outside standard' □ against any particular target or best practice measure for the current month, plus an assessment of the 15 month 'rolling data trend' seen, as either 'improving' □

or ‘stable or fluctuating or ‘declining’ The actual performance for each KPI is measured against a national standard or local stretch target on a monthly, quarterly or annual improvement basis.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Trust Board Scorecard as at July (Month 04) 2024/25

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 04 (July 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	87%	85%	87%	✓		WOD.19
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓		KPV.02
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓		KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA Bacteraemia	National	Monthly	0	0	0	✓		KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA Bacteraemia	National	Monthly	0	0	0	✓		KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa Bacteraemia	National	Monthly	0	0	0	✓		KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp Bacteraemia	National	Monthly	0	0	0	✓		KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓		KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli Bacteraemia	National	Monthly	0	0	0	✓		KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓		KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	1	✗		KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	96%	✗		KPV.08
	Number of National VCS Reportable Incidents recorded with Welsh Government	National	Monthly	0	0	0	✓		KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	0	✓		KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	10	✓		H&S.55
	Number of Duty of Candour Incidents recorded	National	Monthly	0	0	0	✓		KPV.63

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 04 (July 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	Number of 'Never Events' recorded	National	Monthly	0	0	0	✓		KPV.64
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	205.7 C/m3 Dec	137.4 C/m3 Dec	✓		EST.06
Effectiveness	Number of Pathway of Care Delays	National	Monthly	1	0	1	✗		KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	102%	✓		KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%	✓		KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	122%	✓		KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	0%	✓		KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	4	✗		KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.24%	✗		WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	74%	✗		WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	85%	98% 96%	✓		KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓		KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓		KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	100%	N/A	✓		KPI.03
Timeli	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	25% 82%	✗		KPV.14

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 04 (July 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	11% 74%	✗		KPV.15
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	100% 100%	✗		KPV.16
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	National	Monthly	27% 32%	80% 100%	93% 98%	✗		KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days **June position**	National	Monthly	98%	98%	88%	✗		KPV.20
	% Patients Beginning Emergency SACT within 5 days **June position**	National	Monthly	100%	98%	100%	✓		KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	95%	✓		KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	100%	✓		KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.008 m	✓		FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£6.322 m	£6.322 m	✓		FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.138 m	£0.222 m	✗		FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£0.831 m	£0.831 m	✓		FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	97%	✓		FIN.60
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	5%	13.85%	N/A	N/A	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	6.18%	✓		WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	5.79%	✗		WOD.80

QSF Domain	Trust Board Performance Scorecard			Performance as at Month 04 (July 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	% of Workforce declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	93.53%	✗		WOD.81
Symbols Key: In Month = Compliant Non-compliant Cumulative data trend (15 months) = Improving stable fluctuating deteriorating									

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4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

	Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	PMF report is focused upon monitoring performance against statutory and local stretch targets
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	The Performance Management Framework reports the performance of the organisation across a number of areas but is not the mechanism for managing risks identified within the report.
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	

BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	
All risks must be evidenced and consistent with those recorded in Datix	

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Appendix 1: Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

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Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual Number	2	0	3	5	5	3	5	3	6	8	2	5	3	2	3	4
Avoidable Falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

No avoidable falls in July 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

SPC Chart Analysis
The SPC chart shows common cause or normal variation over the last 15 months.

KPI Indicator KPV.01

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Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug23	Sep23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar24	Apr 24	May 24	June 24	Jul 24
Actual Number	0	0	0	2	2	3	0	2	2	1	0	0	0	0	0	3
Avoidable Ulcers	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	1
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

There was 1 avoidable pressure ulcer in July 2024.
The learning identified following the investigation was:

- To consider the most appropriate mattress on admission dependent on skin assessment.
- To ensure staff are documenting that they have offloaded patient heels as part of the patient's daily skin care plan and assessment.

The learning has been communicated with the ward nursing team.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:
-Identified members of the nursing team to receive individual teaching/updates by the TVN. -Updated communications in the daily Big 4	End of January 2024	Ward Manager

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

SPC Chart Analysis
The SPC chart shows common cause or normal variation over the last 15 months

Expected Performance gain – longer-term

Risks to future performance

KPI Indicator WOD.19

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Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	My 23	Jun 23	Jul y 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun e 24	Jul y 24
Actual %	87	88	88	88	87	86	86	86	86	85	86	86	87	86	87
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:

- Compliance target is being met

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
	Ongoing	People and OD Team

SPC Chart Analysis
The SPC chart shows common cause or normal variation averaging 86.5% against the 85% target, with the target being met for the last year.

Continue to support managers in monthly 121's ensuring compliance is regularly reviewed		

Expected Performance gain - immediate
Improved performance with all areas across the Trust above the target level.

Service Improvement Actions – tactical (12 months +)

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

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

Risks to future performance

Set out risks which could affect future performance

- Future predicated concerns from IPC (i.e. COVID or outbreaks of other contagious illnesses) may affect staffing levels and ability to release staff to undertake training.

KPI Indicator KPV.07

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

Target: NIL | **SLT Lead: Clinical Director**

Current Performance against Target or Standard | **Performance**

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

VCC	Apr 23	May 23	Jun23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24

Assessment of current performance, set out key points:
On target for the month

Service Improvement Actions – Immediate (0 to 3 months)

Hospital Acquired Thromboses	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target Nil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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

KPI Indicator KPV.04

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Healthcare Acquired Infections (Inpatients)	
Target: NIL	**SLT Lead: Head of Nursing**
Current Performance against Target or Standard	**Performance**
Incidence of Healthcare Acquired Infections for the period Oct 2022 to Dec 2023	**Assessment of current performance, set out key points:** • RCA for all reported infections in progress • There is no evidence of VCC transmission in the RCA's to date.

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24

C.diff	1	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0
MRSA	0	0	0	1	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	0	0	0
E.coli	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0
Klebsiella	1	1	0	1	1	0	0	0	0	0	0	0	0	0	1	0
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg	3	1	1	3	1	1	1	0	0	0	0	0	0	0	1	0

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.08

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

Target: 100% | **SLT Lead: Clinical Director**

Current Performance against Target or Standard | **Performance**

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24

Assessment of current performance, set out key points:

- Performance is on target

VCS Hand Hygiene			100 %	100 %	99 %	99.6 %	100 %	99 %	100 %	97.5 %	98.9 %	98 %	98 %	97 %	93 %	93 %
WBS Hand Hygiene			100 %	99.2 %	99 %					99.8 %	99 %	100 %			100 %	100 %
Trust Hand Hygiene			100 %	100 %	99 %		99 %	93 %	100 %	98.6 %	99.4 %	99 %	99 %	93 %	97 %	96 %
IPC Validation			100 %	100 %	100 %	99.4 %	100 %	96 %	100 %	100 %	99 %	99 %	93 %	87 %	91 %	95 %
Target l00%	0	0	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %

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

Plus Infection Prevention Control Team Validation Audits % compliance

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.60

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Number of National Reportable Incidents(NRIs) recorded with Welsh Government in a calendar month	
Target: NIL and as a % of Overall Activity (to be agreed)	SLT Lead:
Current Performance against Target or Standard	Performance

	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24
Actual NRI Recorded											0	0	0	0	0	0
% NRI over VCS Activity																
Target NRI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target % NRI									TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA

Assessment of current performance, set out key points:
No incidents met the criteria for NRI in July 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

KPI Indicator KPI.30

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

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual	0	2	0	1	2	1	0	4	1	0	1	2	1	1	0	0
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

Assessment of current performance, set out key points:
No adverse events were submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in July.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Lead:**
The completion of Corrective Actions and Preventative Actions (CAPA), for SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub. Managers continue to explore opportunities to share learning through formal staff engagement sessions, and a Task & Finish group (reporting to the WBS Integrated Quality & Safety Hub) is working on removal of complexity from the donor eligibility assessment process.	Peter Richardson **Timescale:** Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.

Expected Performance gain – immediate - N/A

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term - N/A

Risks to future performance

	N/A

KPI Indicator H&S.55

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

Target: 103

SLT Lead: Lauren Fear

Current Performance against Target or Standard - Level

	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun e 24	July 24
VCC	3	4	6	9	6	4	7	4	5	3	3	6	6	4	4
WBS	10	1	9	6	8	7	4	2	5	6	11	7	4	4	6
Corp orate	0	1	0	2	0	0	0	0	0	0	3	0	1	0	0

Performance - Stable

Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incidents investigated. H&S incident investigation training complete	

Expected Performance gain

As per the annual report we have identified a target of 103 incidents for the year. We have a base line of 1.98 incidents per week and are currently exceeding our target. Efforts will be made to observe and tackle trends

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale:**

Expected Performance gain

Risks to future performance

Incomplete incident investigation – ongoing monitoring

KPI Indicator EST.06

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

Target: -16% by 2025

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24
Actual Number	130.20	111.83	86.13	85.33	86.37	85.36	105.00	117.56	137.40						
Target (-3% from previous year emissions)	160.9681	130.2845	95.03259	99.91858	95.86	102.66	132.22	187.67	205.74						

Performance

Assessment of current performance, set out key points:

- Carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.
- Issues have been raised during the transition form British Gas to EDF & Total Energies. Notably, meter reads. Therefore, these and consumption graphs for the previous 2 months may be subject to change and January's figures are incomplete

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Expected Performance gain – immediate
Ongoing communication and engagement with staff to reduce consumption.
Amendments to the BMS across all sites for better controls.
Integration of Sigma into the billing & consumption verification process to better monitor carbon emissions.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term
Reduced carbon footprint
Improvement across sites from the capital projects – namely nVCC and Talbot Green Infrastructure.

Risks to future performance
Set out risks which could affect future performance
•

EFFECTIVENESS

KPI Indicator KPV.05

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Number of Pathway of Care Delays

Target: NIL | **SLT Lead: Head of Nursing**

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun e 24	Jul 24
Actual PoCDs Number	1	4	3	8	3	3	3	3	2	3	1	1	1	2	1	1

Performance

Assessment of current performance, set out key points:
There was 1 Pathway of Care delay reported in July 2024.

Patient 1: Awaiting package of care to support discharge home, delay of 21 days.

Service Improvement Actions – Immediate (0 to 3 months)

Days Delayed				32	19	43	73		5			19	26		21	21
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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

Actions: what we are doing to improve	Timescale:	Lead:
Data is now being uploaded nationally to the Pathways of Care Delays National system. Individual patient discussions are taking place daily with HB and community teams to progress any delays. It is acknowledged that there are bed pressures across the whole system which impacts on patient discharge/transfer.		Matthew Walters Operational Senior Nurse

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Meeting with Cwm Taf Health board to observe their daily 'Safe to Start' meeting which supports with patient flow and early discharge planning.		Matthew Walters Operational Senior Nurse

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.04

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% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	104	97	110	105	102	95	101	107	97	109	106	94	111	103	102	102
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Performance

Performance met target in July. The average weekly demand in July was 1445 compared to June average of 1469 units per week.

PLEASE NOTE: this metric is under active review as part of the review of the WBS KPI's.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain. At the meetings, business intelligence data is reviewed and facilitates operational responses to the challenges identified.	**Timescale:** Daily **Lead:** Jayne Davey / Georgia Stephens
Expected Performance gain - immediate. Reviewed daily to support responses to changes in demand.	
Service Improvement Actions – tactical (12 months +)	
Actions: what we are doing to improve T&F group set up to review capacity to collect whole blood and identify actions to increase it in the short and longer term.	**Timescale:** TBC **Lead:** Jayne Davey
Expected Performance gain – longer-term N/A	
Risks to future performance	
Set out risks which could affect future performance. **N/A**	

	SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 12 month period. Performance continues to fluctuate. However, the overall trend shows performance exceeding target.

KPI Indicator KPI.26

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

Target: Maximum Wastage 10%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	10	8	9	12	12	11	11	10	10	9	7	10	12	20	16	10
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

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

Performance

Assessment of current performance, set out key points:
At 10%, performance improved in July, meeting target.
Platelet demand was higher in the first half of the month which resulted in upwards adjustment in the production. However, the higher demand did not persist into the later part of the month.

WBS will continue to analyse issuing data to identify trends in demand and translate them into adjustments in platelet production.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

	Service Improvement Actions – tactical (12 months +)	
	Actions: what we are doing to improveA workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q3 2024/25	**Timescale:** Q3 2024/25 **Lead:** Jayne Davey/ Georgia Stephens
	Expected Performance gain – longer-term. Platelet expiry reduction using a risk-based approach, balancing platelet expiry against ability to supply platelets for clinical needs.	
	Risks to future performance	
	Set out risks which could affect future performance. Unexpected increases in clinical need - noting unexpected spike in demand may require imports. Future Bank holidays.	
	SPC Chart Analysis	

The SPC chart which shows an improved performance from Apr. 2023 to Feb 2024. However, there has been recent fall in performance leading to a special cause variation of 20% in May.

KPI Indicator KPI.05

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

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	127	117	114	120	125	121	122	115	125	115	118	121	129	134	132	122
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

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

Performance

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate.

Daily agile responses to variations of stock levels and service needs.
Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:** Q3 2024/25 **Lead:** Georgia Stephens
A workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q3 2024/25	

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

Risks to future performance
Fluctuations in platelet demand.
Advances in clinical practice and patient care which affect the platelet demand (if not communicated to WBS)

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 12 month period. The average performance of 120% consistently exceeding the 100% target.

KPI Indicator KPI.25

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Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured	
Target: Maximum Wastage 10%	**SLT Lead: Georgia Stephens**
Current Performance against Target or Standard	**Performance**

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	10	8	9	12	12	11	11	10	10	9	7	10	12	20	16	10
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

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

Assessment of current performance, set out key points:
At 10%, performance improved in July, meeting target.
Platelet demand was higher in the first half of the month which resulted in upwards adjustment in the production. However, the higher demand did not persist into the later part of the month.

WBS will continue to analyse issuing data to identify trends in demand and translate them into adjustments in platelet production.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Lead:** Georgia Stephens **Timescale:** Daily (BAU) Timelines to be confirmed as part of WBS Futures
d. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings. e. A Platelet Strategy is being developed. This will sit under WBS Futures under the Lab Services Modernisation Programme. f. Develop a forecasting tool to inform decisions around pooled platelet manufacture. This action has been delayed due to insufficient capacity within the Business Intelligence Team.	

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improveA workstream for the review of the WBS Platelet Strategy has been initiated under the	**Timescale:** Q3 2024/25 **Lead:**

	WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q3 2024/25	Jayne Davey/ Georgia Stephens
	Expected Performance gain – longer-term. Platelet expiry reduction using a risk-based approach, balancing platelet expiry against ability to supply platelets for clinical needs.	
	Risks to future performance	
	Set out risks which could affect future performance. Unexpected increases in clinical need - noting unexpected spike in demand may require imports. Future Bank holidays.	
	SPC Chart Analysis	

The SPC chart which shows an improved performance from Apr. 2023 to Feb 2024. However, there has been recent fall in performance leading to a special cause variation of 20% in May.

KPI Indicator KPI.13

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

Target: 80 per annum | **SLT Lead: Deborah Pritchard**

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Cumulative Actual	3	6	12	18	21	26	33	35	38	45	48	53	3	5	8	12
Cumulative Target p/a	7	14	21	28	35	42	49	56	63	70	77	80	7	14	21	28

Performance

Transplant centre demand for Stem cell collections was met, but failed to meet collection target, with 4 Peripheral Blood Stem Cell (PBSC) collections July.

The Welsh Bone Marrow Donor Registry (WBMDR) has 10 stem cell collections booked over August/September at the time of writing.

The Service experiences a cancellation rate of ~ 17-25%. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
The collection target of 80 in the short-term is under review. An updated recruitment strategy for new donors for the Register has commenced, which is increasing the number of donors on the Registry (see KPI.20). Over time this will increase the number of collections.	Q4 **Lead:** Deborah Pritchard

Expected Performance gain - immediate. As above

Service Improvement Actions – tactical (12 months +)	
Implementation of the five-year strategy as part of WBS Futures.	**Timescale:** 2024/25 **Lead:** Deborah Pritchard

Expected Performance gain – longer-term.
Improved recruitment of new donors to the Register which over time will increase the number of collections

Risks to future performance

Set out risks which could affect future performance.
Identified risks are being managed.

KPI Indicator WOD.37

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Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70% | **SLT Lead: WOD Director**

Current Performance against Target or Standard | **Performance**

Trust Position	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24
Actual %	5.99	5.84	5.71	5.70	5.75	5.70	5.63	5.50	5.35	5.28	5.17	5.16	5.22	5.24	5.22
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70

Assessment of current performance, set out key points:
There is a continued decline in sickness stats as the People and Relationship Team continue to support managers in the application of the MAWW policy.

Short-term absence remains relatively low across the Trust.

National Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

SPC Chart Analysis

The SPC chart shows an improving trend over the last 12 months. However, the overall average 5.7% sickness level remains higher than the 4.7% Local target and the 3.54% National target

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engagement sessions in Autumn 2022 the following actions are being taken over the coming 12 months • Staff wellbeing support survey • Developing a Menopause friendly culture • Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation	30/04/2025 Ongoing	Head of OD Head of OD and Trust Board

Expected Performance gain – longer-term

The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.

Risks to future performance

Set out risks which could affect future performance

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

KPI Indicator WOD.36

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Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	My 23	Jun23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24
Actual %	72	73	74	74	74	71	72	74	74	74	72	74	73	74	74

Performance

Assessment of current performance, set out key points:
A full review of the policy, process and procedure is scheduled to take place by the People and OD Team in their work plan for 2024.
The performance trend of departments has been examined over April – June. There are 93 instances of departments falling below 50% (red), covering 39 different

Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

SPC Chart Analysis
The SPC chart shows a stabilising trend over the last 12 months. However, averaging 72%, consistently falling short of the 85% target.

departments/teams. 11 teams have coded red on all four months, 7 teams on three of the four.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve:	Timescale:	Lead:
Regular monthly monitoring and action plans are in place for hotspot areas.	Monthly	People and Relationship Team
PADR training for managers who undertake the process.	Quarterly	People and Development Trainers POD
SLT at all divisions are regularly reported to on compliance against targets, with action plans drawn up for hotspot areas – this will focus on those trending as red across several months.	Monthly	Senior Business Partners

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Launch a PADR review programme, considering the policy, procedure and current best practice.	April 2025	Head of OD
NHS Wales are currently reviewing the All Wales Capability Policy for management of performance considers.	April 2025	Head of Workforce

Expected Performance gain – longer-term
A review of the current procedure will ensure Staff and Managers are fully aware of Trust expectations to personal performance.

Risks to future performance

Set out risks which could affect future performance

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

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

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% of Patients that Rate Experience at Velindre at Good or above	
Target: 85%	**SLT Lead: Head of Nursing**

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Would you recommend us? %	95	98	96	97	97	95	95	94	95	89	97	96	92	93	98	98
Your Velindre Experience? %	82	68	71	91	94	63	83	87	95	98	94	94	92	96	93	96
Target CIVICA 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

TARGET RATIONALE to ensure consistency
Friends and Family (would you recommend us?) target = good or above (Good + very good)
Very Good 89.80% + Good 8.16% = 97.96%
Your Velindre Experience target = good or above (good + very good +excellent)
Excellent (10/10) 79.59% + Very good (9/10) 10.20% + Good (8/10) 6.12% = 95.91%
Reset Target to CIVICA 85%

Performance

Assessment of current performance, set out key points:
There are two surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience'.
The 'Would you recommend us?' survey uses categories such as Very good, good etc
The Your Velindre experience survey uses 0-10 in the question about rating VCC

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

Survey: VCC - Friends and Family

Create new action

Available Answers	Responses	Score (%)
Very good	88	89.80%
Good	8	8.16%
Neither good nor poor	2	2.04%
Poor	0	0.00%
Very poor	0	0.00%
Don't know	0	0.00%
Total	**98**	**100%**

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

Survey: Your Velindre Experience

Create new action

Available Answers	Responses	Score (%)
10 (Excellent)	39	79.59%
9	5	10.20%
8	3	6.12%
7	0	0.00%
6	1	2.04%
5 (Neutral)	0	0.00%
4	0	0.00%
3	0	0.00%
2	1	2.04%
1	0	0.00%
0 (Very Bad)	0	0.00%
Total	**49**	**100%**

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Outcomes from CIVICA are reviewed monthly and form part of SLT Q&S highlight report and the QSP report Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback Directorates to develop plans to increase response rate. Q+S team to work with each directorate to provide further analysis on responses CIVICA working group established with attendees from each directorate Q+S team to review the difference in positive percentages for both surveys	Ongoing Ongoing Ongoing	Head of Nursing/SLT SLT/Directorate Managers SLT/Directorate Managers Q+S manager

Expected Performance gain – immediate
Introduction of the Civica Implementation group across VCC to increase participation across the teams

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Patient Engagement Hub to work with Q&S team to continue to find new/different ways of engaging patients and seeking feedback. This is currently ongoing.	December 2023	Head of Patient Engagement

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

KPI Indicator KPI.09

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

Target: 95% | **SLT Lead: Jayne Davey**

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	97	97	97	97	96	94.9	96.7	95.1	95.6	96.3	96.7	96.5	95.1	96.3	95.6	96.9
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

Assessment of current performance, set out key points:
At 96.9%, donor satisfaction increased slightly and remains above target in July. In total there were 1,008 donor survey respondents, 198 from North Wales (scoring a satisfaction rate of 96.2%), and 801 from South or West Wales (scoring satisfaction rate of 97.0%).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:
Findings are reported at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams. 'You Said, We Did' actions are also reported.	Business as usual, reviewed monthly **Lead:** Jayne Davey
Expected Performance gain - immediate	
Service Improvement Actions – tactical (12 months +)	
N/A	
Expected Performance gain – longer-term. N/A	
Risks to future performance	
Set out risks which could affect future performance. N/A	

KPI Indicator KPV.12

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Number VCC formal complaints received under Putting Things Right within 30 days	
Target: 85%	**SLT Lead: Head of Nursing**
Current Performance against Target or Standard	**Performance**

VCC	Apr 23	May 23	Jun23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24

Assessment of current performance, set out key points:

Actual %	100	100	100	100	100	100	100	100	100	100	0	100	33	100	71	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve	Timescale:	Lead:
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve	Timescale:	Lead:
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance		

KPI Indicator KPI.03

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

Target: 100% — **SLT Lead: Edwin Massey**

Current Performance against Target or Standard

WBS	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual	N/A	N/A	N/A	N/A	N/A	N/A	100 %	100 %	N/A	N/a	N/A	N/A	N/A	N/A	N/A	N/a

Performance

Assessment of current performance, set out key points:

The 1 formal concern received in May 2024, related to the number of deferrals on a Donor's record due for closure in July was closed on the 7th of June 2024.

%																
Target %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance.

Closely monitor and have oversight of concerns management in line with PTR to eliminate future risk.

TIMELINESS

KPI Indicator KPV.14

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Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days

Target: 80% within 14 Days and 100% within 21 Days	SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard

18% of RT patients breached the 100% referral to treatment within 21 days target

82% of RT patients (243) met the 100% referral within 21 days target

25% of RT patients met the 80% referral to treatment within 14 days target

Chart Analysis

The above chart represents the spread of Scheduled RT performance against the 14 and 21 day targets with a significant improvement in >21 day breaches over the last 6 months.

Performance

Assessment of current performance, set out key points:
Ongoing challenges post DHCR in establishing a fully validated position.
Validation resources currently insufficient to address range of issues identified.

Number of referrals	297	
treated within 14 days of referral (80% target)	73	25%
treated within 21 days of referral (100% target)	243	82%

Breach reasons:
27 breaches were due to LINAC capacity.
3 breaches were due to booking capacity
26 Breaches were due to pathway management issues. These included 8 for delays in the pathway, 6 for rescans required, 1 where the patient did not attend an agreed appointment, 3 for complex planning and 1 for referral process. The longest wait was 38 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve		Lead:
Retraining for clinical teams to ensure categorising of the referrals is correct.	Ongoing	Helen Payne/Tom Rackley
Complete commissioning of LA3 Halcyon unit to extend Varian Halcyon capacity	Complete	Tony Millin
Securing extended service contract for LA1	Ongoing	Tony Millin

Expected Performance gain – immediate
Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
IRS implementation group in place to address changes in capacity provision to meet revised patient demand per SST.	April 2026	Tony Millin/ Thomas Rackley/ Helen Payne

Expected Performance gain – longer-term
Changes to patient pathway in line with time to radiotherapy timings

Risks to future performance

Set out risks which could affect future performance
Linac replacement programme which has commenced

KPI Indicator KPV.15

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Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days

Target: 80% within 2 Days and 100% within 7 days	SLT Lead: Head of Radiation Services / Clinical Director
Current Performance against Target or Standard	**Performance**

Chart Analysis
The above chart represents the spread of Urgent RT performance against the 2 and 7 day targets with a significant improvement in >7 day breaches over the last 6 months but some recent reduced performance.

Assessment of current performance, set out key points:
Issues as Scheduled elective patients above

Number of referrals	46	
treated within 2 days of referral (80% target)	5	11%
treated within 7 days of referral (100% target)	34	74%

Breach reasons:
3 breaches were due to LINAC capacity.
1 breach was due to booking capacity
8 Breaches were due to pathway management issues.
. The longest wait was 20 days.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve:		
Implementation of revised Urgent Symptom Control Definition	**Complete**	Helen Payne/ Thomas Rackley

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
•

KPI Indicator KPV.16

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Emergency Radiotherapy Patients Treated Within 1 Day	
Target: 80% within 1 Day and 100% within 2 Days	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Chart Analysis
The above chart represents the spread of Emergency RT performance against the 1 and 2 day targets with the majority of patients being treated consistently within target.

Assessment of current performance, set out key points:
Target Achieved

Number of referrals	21	
80% treated within 1 day of referral	21	100 %
100% treated within 2 days of referral	21	100 %

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

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

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

Chart Analysis
The above chart represents the spread of Elective Delay RT performance against the 7 and 14 day targets with a significant improvement in >14 day breaches over the last 6 months.

Assessment of current performance, set out key points:
Issues as Scheduled elective patients above

Number of referrals	44	
treated within 7 days of referral (80% target)	41	93%
treated within 14 days of referral (100% target)	43	98%

Breach reasons:
4 were due to Linac Capacity and 1 was due to clinician capacity
4 Breaches were due to pathway management issues. These included
2 were due to replan required, 1 was as a result of patient failing to attend an agreed appointment, and 1 was as a result of the patient being too ill to attend

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve •		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.20

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Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Actual %	98	93	90	90	94	92	90	98	85	90	64	79	91	75	76	88	
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	
More than 21 days	8	26	40	40	25	32	35	10	57	29	160	95	33	90	107	41	
Within 21 days	409	343	354	378	370	380	323	414	329	251	283	362	323	271	338	300	

The number of patients scheduled to begin non-emergency SACT treatment in Dec 2023 was 280.

Parenteral Attendances (excludes patients on single agent oral SACT regimens; emergency and non-emergency)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,186	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,558	2486	2463	2572	2297	2455	2162	2557
2023/24 Attendances	2,233	2,554	2,657	2,529	2,712	2,510	2,688	2,819	2,432	2760	2625	

Performance

June position: 88% Performance – 341patients treated with 41 breaches.

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	32	9	0	0

The longest wait was 35 days.

Breaches – 41 non-emergency patients waited over 21 days. 32 of those patients were treated WITHIN 28 days. all waits were capacity related.

9 patients waited > 28 days. A clinical harm review process is being led by the Medical Business Manager to identify if harm may have been caused to any patients affected by the extended waits.

Demand continues in excess of predicted levels.

Pharmacy capacity remains the main challenge to delivering required activity levels to meet demand.

All patients within a Trial are booked within Trial timeframes.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve:	Timescale	Lead
Increased pharmacy production capacity through:		
1) Reconfiguration of accommodation to deliver increased aseptic capacity following capital approval received December 2023. Build completion expected March 2024. Capacity increase expected July 2024.	31/07/2024 31/05/2024 31/07/2024	BT BT
2) Agreed increase on mobile unit from 14 to 20 patients daily x 2 days weekly.	MD/MRM	
3) provide cleaning provision from operations to allow for potential release pharmacy staff on		

SPC Chart Analysis
The SPC chart shows fluctuating performance from January to May 2024.

weekends to produce additional regimens		

Expected Performance gain – immediate

Not until July 2024

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**	**Lead:**
• Nursing: international nurse recruitment and preceptorship recruitment	01/05/24	AB
• Develop outsource model in advance of TrAMS implementation	TBC	
• Realign working patterns at outpatient clinics to maximise daily throughput.	31/05/24	BT NH/CM

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- Resource to deliver future growth across nurse/pharmacy/bookings not yet articulated/ secured; demand planning required.
- Current vacancies within SACT booking team
- Recent increase and complexity of in-patient SACT demand has impacted on pharmacy capacity to support day case workload

KPI Indicator KPV.21

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Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	100	100	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	100	100	100	
More than 5 days	0	0	0	0	2	0	0		1	0	0	0	0	0	0	
Within 5 days	5	0	12	10	5	8	4		7	9	5	2	6	5	8	

SPC Chart Analysis
The SPC chart shows consistent achievement of target, however note small numbers involved.

Performance

June position:
Target achieved – all 8 patients treated in target.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

		Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPI.18

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

Target: 90%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	96	95	98	97	96	96	96	92	95	97	96	97	96	96	94	95
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Performance

Assessment of current performance, set out key points:
At 95% the turnaround time performance for routine Antenatal tests continued to exceed target in July 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance.

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 12 month period. However, whilst the performance decreased in November it remained above target, the average performance continued to exceed the 90% target averaging 96%.

KPI Indicator KPI.17

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

Target: 90% per quarter

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	97	98	97	98	99	100	99	100	98	100	92	100	100	100	100	
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Performance

There was continued excellent performance during Quarter 1 which is consistent with 2023-24 performance.

Service Improvement Actions – Immediate (0 to 3 months)

	Timescale:	Lead:
N/A		

Expected Performance gain - immediate.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.

SPC Chart Analysis

The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter four 2023. However, the average performance of 95% exceeds the 90% target overall in Q3 2023.

EFFICIENT

KPI Indicator FIN.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

Current Performance against Target or Standard

Trust Position (core)	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual (Cumm) £k	30	5	7	**8**	8								
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	0

Trust-wide Revenue Position as of July 24

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(15.267)	(15.264)	0.003	(41.858)	(41.858)	0.000
RD&I	0.114	0.106	(0.008)	0.394	0.394	0.000
WBS	(7.130)	(7.128)	0.002	(20.961)	(20.961)	0.000
Sub-Total Divisions	**(22.283)**	**(22.286)**	**(0.003)**	**(62.425)**	**(62.425)**	**0.000**
Corporate Services Directorates	(4.199)	(4.197)	0.002	(12.602)	(12.602)	0.000
Delegated Budget Position	**(26.482)**	**(26.483)**	**(0.001)**	**(75.027)**	**(75.027)**	**0.000**
TCS	(0.173)	(0.163)	0.010	(0.635)	(0.635)	0.000
Health Technology Wales	(0.031)	(0.031)	(0.000)	(0.092)	(0.092)	0.000
Trust Income / Reserves	26.686	26.686	0.000	75.700	75.700	0.000
Trust Position	0.000	0.009	0.008	(0.053)	(0.053)	0.000

Performance:

The core Trust has reported a nil in-month movement on the position during July'24, which maintains a cumulative year to date position of **£0.008m** underspent and an outturn forecast of **Breakeven.**

The Trust received agreed commitment from HBs to proceed with the contract rebasing at the collective commissioner's group which was reflected in the LTAs issued by the Trust in March, however in April the Trust received letters from 2 HBs which outlined their disagreement with the rebasing proposal. The other 4HBs and JCC were in agreement to proceed but subject to all HBs agreement the contract rebase.

As commissioners were not able to reach a consensus before the 30th June deadline the Trust had to revert back and prepare LTAs on an historic basis.

Following discussions between Chief Executives, and in order to avoid arbitration, a compromise position was agreed on the LTA which has led to a financial impact to the Trust for 2024/25 as follows:

£318k Reduction in recurrent discretionary income compared to plan.

£483k Reduction in non-recurrent income compared to plan with a further risk to non-recurrent position still to be confirmed.

The shortfall in LTA income has been recovered through a combination of an increased savings target and pausing previously agreed investment decisions.

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage.

Several new savings schemes were identified, which replaced those schemes that had either failed or not yet progressed. The

	revised target of £2.875m was required in order to help compensate for the loss of income from the LTA agreements. The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the planned savings targets are achieved, and that all financial risks are mitigated during 2024-25.
	Service Improvement Actions – Immediate (0 to 3 months)
	Actions: what we are doing to improve / **Timescale:** / **Lead:**
	Expected Performance gain - immediate
	Service Improvement Actions – tactical (12 months +)
	Actions: what we are doing to improve / **Timescale:** / **Lead:** • Recurrent savings plans and delivery to be addressed through Divisional senior leadership teams / 31.03.2025 / SLT & SMT •
	Expected Performance gain – longer-term
	Risks to future performance
	Set out risks which could affect future performance

KPI Indicator FIN.73

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Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual(Cum)	31.002	0.416m	2.113m	4.925m	6.322m								
Target £18.500m CEL		0.416m	2.113m	4.925m	6.322m								

Capital Position as of July 2024

	Approved CEL 2024/25 £m	YTD Spend £m	Budget Remaining @ M4 £m	F'cast Spend 2024/25 £m	Year End Variance 2024/25 £m
All Wales Capital Programme					
IRS - Integrated Radiotherapy Solution	5.164	2.042	3.122	5.164	0.000
IRS RSC - Radiotherapy Satellite Centre	11.265	0.854	10.411	11.265	0.000
nVCC Enabling Costs	0.000	2.289	(2.289)	3.368	(3.368)
nVCC Project Fees	0.000	0.719	(0.719)	3.622	(3.622)
nVCC Whitchurch Hospital Site	0.000	0.003	(0.003)	3.636	(3.636)
nVCC Governance Review	0.000	0.140	(0.140)	0.140	(0.140)
nVCC Governance Review Implementation (PW	0.000	0.000	0.000	0.350	(0.350)
WBS TGI	0.000	0.000	0.000	0.363	(0.363)
Digital - WHAIS	0.000	0.000	0.000	0.442	(0.442)
Digital - RISP	0.160	0.000	0.000	0.160	0.000
BECS	0.750	0.000	0.000	0.750	0.000
WBS Electrical Resilience - Backlog Maintenanc	0.000	0.000	0.000	0.350	0.000
WBS Liquid Nitrogen	0.000	0.000	0.000	0.000	0.000
Total All Wales Capital Programme	17.339	6.047	10.382	29.610	(11.921)
Discretionary Capital	1.911	0.275	1.636	1.911	0.000
	19.250	6.322	12.018	31.521	(11.921)

Performance

The approved 2024-25 Capital Expenditure Limit (CEL) as of July 2024 was £19.250m. This includes All Wales Capital funding of £17.339m, and discretionary funding of £1.911m.

A total of £11.116m is now forecast to be required to support the nVCC enabling, project, Governance review costs and to make good the Whitchurch Site during 2024-25. WG are aware of the total requirement and are looking to put a request to the Minister imminently.

Discussions are ongoing with WG colleagues around securing the funding requirement in relation to WHAIS and the costs associated with the WBS TGI OBC, with WG having supported these projects up to this date.

In addition, the Trust has been awarded funding from WG towards the WBS electrical resilience, however the Trust received confirmation during July that the WBS Liquid nitrogen scheme which was initially supported was not approved by the Minister. The Trust will now be looking to secure funding either from year end capital spend should it become available, or the scheme will be included within next year's IMTP plans with a view to secure funding before the contract ends.

The finance team are in conversation with WG colleagues to ensure that the funding for all of the above Capital Schemes form part of the CEL for 2024-25.

The discretionary allocation of £1.911m represents an increase of 12% on the £1.683m provided during 2023-24.

The discretionary programme was fully allocated from previous decisions other than a £0.100m contingency, however following confirmation of funding towards the WBS Electrical resilience Scheme £0.230m (which was the original funding requirement) has now been released and will be considered for use against priorities schemes. WHAIS (£0.494m) continues to be ringfenced from discretionary with the expectation that if All Wales Capital funding can be secured, then a further £0.494m can be released back into the discretionary pot.

	A review of the recent conditions survey of the VCC site is currently underway and will require funding support from the discretionary programme. This is currently estimated to be c£0.160m. *The CEL will be fixed by WG at the end of October, after this point the Trust is expected to manage any slippage on the Capital programme.* **Performance to date** The actual expenditure to July 2024 on the All-Wales Capital Programme schemes was £6.047m, this is broken down between spend on the nVCC schemes of £3.151m, the IRS £2.289m, and RSC £0.854m. The current spend on the Discretionary Capital programme as of July 2024-25 is £0.275m. **Year-end Forecast Spend** The year-end forecast outturn is currently expected to be managed to a breakeven position subject to the Trust securing funds for the nVCC and other projects on WG radar.
	Service Improvement Actions – Immediate (0 to 3 months) **Actions: what we are doing to improve** • Aim to secure funding from WG to support unfunded schemes — **Timescale:** 30.09.2025 — **Lead:** M Bunce **Expected Performance gain - immediate** **Service Improvement Actions – tactical (12 months +)** **Actions: what we are doing to improve** • — **Timescale:** XX/XX/XX — **Lead:** AN Other **Expected Performance gain – longer-term** **Risks to future performance** • Risk if funding is not secured to support nVCC.

KPI Indicator FIN.72

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Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual £k	1.323	46	107	169	222								
Target (per IMTP) £0.179m Forecast		39	78	117	138	159	179	0	0	0	0	0	0

Performance

The spend on agency for July'24 was **£0.063m** (June £0.062m) which gives a cumulative year to date position of **£0.222m** and a current forecast outturn spend of circa **£0.322m** (£0.775m 2023/24).

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance &Investment Enhanced monitoring arrangements the Trust is aiming to move away from the reliance on agency by the end of quarter 2 as reflected in the IMTP. Whilst this is still the ambition there are some challenges with recruitment in areas such as Medical Physics and Radiotherapy as we establish the Integrated Radiotherapy Solution (IRS) and Radiotherapy Satellite Centre (RSC). In addition, Medical agency is required in the short term to support vacances and increased activity, and an AHP in Radiotherapy cannot be released until the end of November when core staff training is complete. There has also since been an additional ask of facilities for cleaning support within the septic unit which will require short term agency support.

Where possible the Trust will aim to utilise bank staff in order to reduce reliance on agency and the premium costs associated.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Times cale:	Lead:
• Actions addressed via Divisional action plans		SLT / SMT

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

KPI Indicator FIN.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP | **SLT Lead: Finance Director**

Current Performance against Target or Standard

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual Cumm	1.800	0.162m	0.324m	0.497m	0.831m								
Target £2.875m Forecast		0.162m	0.324m	0.497m	0.831m	1.077m	1.334m	1.591m	1.848m	2.105m	2.362m	2.619m	2.875m

Overall VUNHST Cost Improvement Programme £2.875m (previously £2.6M)

Performance

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system.

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.876m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed or not yet progressed. The revised target of £2.876m was required in order to help compensate for the loss of income from the LTA agreements.

Of the revised £2.876m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, most of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2024-25.

The private patients scheme remains in amber as the Trust is assessing the external expert private patient management support it requires to facilitate delivery of the scheme, however we expect that once the external support contract is signed the income generation will be realised turning the scheme

green. If not, a replacement savings scheme will be found, or the Trust can utilise one of the opportunities such as the emergency reserve mitigating any risk.

It is extremely important that divisions review their current savings schemes, and where delivery may not be achieved, alternative schemes are implemented to ensure that the savings target is met for 2024-25.

KPI Indicator FIN.60

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

Target: 95%

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Capital & Revenue Invoices	97	96	97	96	97								
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	

Performance

During July'24 the Trust (core) achieved a compliance level of **98.3%** (June 95.2%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **96.9%** at the end of month 4, and a Trust position (including hosted) of **97.1%** compared to the target of 95%.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Work between Finance, NWSSP and the service will continue throughout 2024-25 in order to maintain performance.	31/03/2025	M Bunce

Expected Performance gain – longer-term.
Ensured compliance

Risks to future performance

Set out risks which could affect future performance

EQUITABLE

KPI Indicator WOD.81

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% of Workforce who have declared Welsh Language Listening/Speaking capability

Target: 100%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24	July 24
Actual %	-	89.70	-	-	90.19	-		90.59			92.50			93.53	
Target %	-	100 %	-	-	100 %	-		100 %			100 %			100 %	

Trust
Welsh Language (Listening/Speaking)
30-Jun-24

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1181	1763	66.99%
1 - Entry/ Mynediad	238	1763	13.50%
2 - Foundation / Sylfaen	69	1763	3.91%
3 - Intermediate / Canolradd	43	1763	2.44%
4 - Higher / Uwch	55	1763	3.12%
5 - Proficiency / Hyfedredd	63	1763	3.57%
Capability Stated	1649	1763	93.53%
Not Stated	114	1763	6.47%
Grand Total	**1763**	**1763**	**100%**

Performance

Assessment of current performance, set out key points:
- Welsh Language declaration 'not stated' recorded quarterly
- Target agreed as 0% non-declaration

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
- insert text

KPI Indicator WOD.78

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Mean Gender Pay Gap – Annual

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual %	13.85	-	-	-	-	-	-	-	-	-	-	-	
Target TBA%	TBA	-	-	-	-	-	-	-	-	-	-	-	TBA

Trust Gender Pay Gap 31st Mar 2024		
Gender	Mean Hourly Rate	Median Hourly Rate
Male	£23.60	£19.13
Female	£20.33	£17.95
Difference	£3.27	£1.18
Pay Gap %	13.85%	6.15%

Mean Gender Pay Gap – 13.85% as at March 2024. This will be updated in March 2025. There is no target set, other than the objective to remove pay gaps within the time of the Strategic Equality Plan, ie by March 2028.

Performance

Assessment of current performance, set out key points:

- Gender pay gap position recorded as at March 2023
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

KPI Indicator WOD.79

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Diversity of Workforce – % Black, Asian and Minority Ethnic people

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	My 23	Jun23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24	July 24
Actual %	-	4.56	-	-	5.45	-		5.62			5.96			6.18	
Target TBA%	-	TBA	-	-	TBA	-									

Trust
Ethnic Origin
30-Jun-24

Ethnic Origin	Headcount	%
Asian	56	3.18%
Black	23	1.30%
Chinese	13	0.74%
Mixed	17	0.96%
Not Stated	28	1.59%
Other	15	0.85%
Unspecified	71	4.03%
White	1540	87.35%
Grand Total	**1763**	**100%**

BAME %
6.18%

Performance

Assessment of current performance, set out key points:
- Staff ethnic origin recorded quarterly
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

KPI Indicator WOD.80

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Diversity of Workforce – % People with a Disability within workforce

Target: TBA%	SLT Lead: Director of Workforce and OD
Current Performance against Target or Standard	**Performance**

Trust Position	Ma 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24	July 24
Actual %	-	4.9	-	-	4.9	-		5.33			5.74			5.79	
Target TBA%	-	TBA	-	-	TBA	-									

Assessment of current performance, set out key points:

- Staff disability recorded quarterly
-

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

Trust
Disability
30-Jun-24

Disability	Headcount	%
No	1457	82.64%
Not Declared	45	2.55%
Prefer Not To Answer	14	0.79%
Unspecified	145	8.22%
Yes	102	5.79%
Grand Total	**1763**	**100%**

APPENDIX 2

Clinical Outcome Quality and Safety KPIs being considered/developed for PMF Scorecards 2023/24

QSF Domains	Executive Management Board PMF Scorecard.		
	Potential KPI under Consideration	Type	Target
Safety			
VCS	Number & rate per 100k comparison of Velindre acquired (avoidable) patient pressure ulcers	National	NIL / Rate per 100k TBA
	Number & rate per 100k comparison of VCC Inpatient (avoidable) falls	National	NIL / Rate per 100k TBA
	Number & rate per 100k comparison of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	NIL / Rate per 100k TBA
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) MRSA	National	NIL / 20 per 100k TBA(10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) MSSA	National	NIL / 20 per 100k TBA(10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) P. aeruginosa	National	NIL / Rate per 100k TBA (10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) Klebsiella spp	National	NIL / Rate per 100k TBA (10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) C Difficile	National	NIL / 25 per 100k TBA(10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) E Coli	National	NIL / 67 per 100k TBA(10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired (HAIs) Gram negative bacteraemia	National	NIL / Rate per 100k TBA(10% reduction on 2017/18)
	Number of 'Never Events' recorded and reported.**(now included)**	National	NIL

QSF Domains	Executive Management Board PMF Scorecard.		
	Potential KPI under Consideration	**Type**	**Target**
	Number of National Serious Untoward Incidents (SUIs) recorded with Welsh Government	National	NIL
	NICE Guidance compliance with relevant cancer standards	Best practice	100%
Effectiveness			
VCS	% RT patient mortality within 30 days of first definitive treatment.**(now included)**	National	< 0.5% TBA
	% SACT patient mortality within 30 days of first definitive treatment .**(now included)**	National	< 1.0% TBA
	VCC Inpatient Mortality .**(now included)**	National	< 1.0% TBA
	Antibiotic usage Compliance with the principles of 'Start Smart then Focus'.	Best Practice	= or < 55% of WHO 'access category'
	Patient Reported Outcome Measures (PROMS)	National	TBA
	% treatments carried out Close to Home	Best Practice	TBA
	Turnover rate for Nurse and Midwifery registered staff leaving NHS Wales	National	Improvement against 2019/20 baseline
Experience			
VCS	Patient Reported Experience Measures (PREMS)	National	TBA
Timely			
VCS	% Outpatients seen within 30 minutes of scheduled time (revised methodology)	Local	100%
Efficient			

QSF Domains	Executive Management Board PMF Scorecard.		
	Potential KPI under Consideration	**Type**	**Target**
VCS	% of Clinical episodes coded within one month post episode discharge end date	National	95%
	% of Clinical coding errors corrected by the next reporting month following identification	National	90%
Equity			
VCS	Equity of patient access to treatment (RT, SACT and Therapies)	Local	TBA
	The Workforce Race Equality KPI's are not going to be available to us until at least June next year as they are dependent on the national implementation of the Workforce Race Equality Standard (WRES)	National	TBA

Duty of Quality & Always On reporting requirements and VUNHST compliance 23.08.24

Duty of Quality

'NHS bodies may choose to use various qualitative and quantitative data and information to support their quality reporting duty. They should focus on information that will demonstrate the duty of quality in decision-making, action taken following learning, quality improvement and ultimately, improved outcomes for the population.

'Examples of evidence to be used to assess the duty of quality and the extent of any improvement in outcomes includes …. '. The report then lists the requirements as in column 1 below:

Duty of quality requirement	VUNHST compliance	Comment
Existing performance, outcome and delivery indicators and measures from the quality management system	Currently reporting on statutory KPIs	Work in progress to develop Quality metrics for each area – phased approach

Patient Reported Outcome Measures and Patient Reported Experience Measures (PROMS and PREMS)	Patient & donor experience results presented No specific PROMs in place / reported on	PROMS development in progress Could start to present Prostate PROMS in the PMF as this data is being collected
Mortality data	SACT 30 day mortality is in our PMF, Not yet capturing Radiotherapy Mortality Reporting on the MES in patient deaths via IQSG report and quarterly integrated Q&S report	VCC team is working to capture Radiotherapy mortality data
Information contained within the Once for Wales Concerns Management System such as incidents and concerns.	Reporting within PMF, in IQSG report and quarterly integrated Q&S report and annual PTR reports	
Patient and staff stories	Taking place at QSP	Could build % compliance into our PMF / QOF
Strategic decision-making that has been driven by the Health and Care Quality Standards	QIAs undertaken re any strategic decisions made. Information re this was provided in the Trust's Duty of Quality Annual Report 2023/24 Not captured currently in PMF / QOF	Could build % compliance into the PMF eg consider a quarterly % score where we list the strategic decisions that been made and whether they have all had a QIA undertaken
Reports following external reviews or inspections by inspectorate and licensing bodies.	Reports from any external review / inspections are captured on AMAT as well as the recommendations required Progress against the actions are reviewed at IQSG and are reported in the IQSG report, Integrated Q&S report	Not currently captured on the PMF, but we could look to develop this eg % compliance
Consideration of the recommendations and implications of significant national reports, for example, following national inquiries.	Takes place - mainly via the appropriate group eg Safeguarding, and then IQSG, into EMB then QSP, or directly into EMB. Recommendations proposed for VUNHST (ie recommendations that we ourselves advise) are not currently tracked on AMAT, but could and should be	Could consider presenting compliance with actions from any inquiries in the PMF/QOF

APPENDIX 3

Analysis of Current Range of PMF Performance Measures (KPIs) & Level of Statutory Compliance (average/usual level)

VUNHST Services	Statutory / Mandatory KPIs		Best Practice / Benchmark KPIs		Locally Determined / Set KPIs	
Velindre Cancer Services (VCS) KPIs Safety (18); Effective (8); Patient Experience (3); Timely (8); Efficient (7)	Measuring in PMF & compliant	23	Measuring in PMF & compliant	5	Measuring in PMF & compliant	8
	Measuring in PMF & non-compliant	8 (see below) 2	Measuring in PMF & non-compliant		Measuring in PMF & non-compliant	
	Measures currently absent from PMF	Quality Act (see below) 1	Measures currently absent from PMF		Measures currently absent from PMF	
Total 44 VCS KPIs		**31**		**5**		**8**
Welsh Blood Services (WBSS) KPIs Safety (8); Effective (11); Donor Experience (7); Timely (4); Efficient (9)	Measuring in PMF & compliant	10	Measuring in PMF & compliant	12	Measuring in PMF & compliant	6
	Measuring in PMF & non-compliant	1 (see below) 3	Measuring in PMF & non-compliant		Measuring in PMF & non-compliant	
	Measures currently absent from PMF	Quality Act (see below) 1	Measures currently absent from PMF		Measures currently absent from PMF	
Total 39 WBS KPIs		**11**		**12**		**6**
Trust-wide Services (CORP) KPIs Safety (11); Effective (5); Staff Experience (3); Timely (45; Efficient (10); Equity (4)	Measuring in PMF & compliant	10	Measuring in PMF & compliant	0	Measuring in PMF & compliant	21
	Measuring in PMF & non-compliant	2 (see below) 3	Measuring in PMF & non-compliant		Measuring in PMF & non-compliant	5 (see below) 4
	Measures currently absent from PMF	Quality Act (see below) 1	Measures currently absent from PMF		Measures currently absent from PMF	
Total 38 CORP KPIs		**12**		**0**		**26**
Grand Total VUNHST 111 KPIs		**54**		**17**		**40**

Notes

1 Quality Act 2023

2 VCS RT and SACT Statutory timeliness targets plus PADR and Sickness targets

3 WBS and Trust-wide PADR and Sickness targets

4 Trust-wide Health & Safety and Fire Training Local Stretch Targets

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

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31 JULY 2024 (M4)

DATE OF MEETING	26/09/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

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

EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of July 2024. The three main issues are highlighted below: **1. LTA's & Contract Rebase** • The Trust received agreed commitment from HBs to proceed with the contract rebasing at the collective commissioner's group which was reflected in the LTAs issued by the Trust in March, however in April the Trust received letters from 2 Health Boards (HBs) which

	outlined their disagreement with the rebasing proposal. The other 4 HBs and Joint Commissioning Committee (JCC) were in agreement to proceed but subject to all HBs agreement to the contract rebase. • As commissioners were not able to reach a consensus on the rebasing before the 30th June deadline to agree LTAs the Trust had to revert back and prepare LTAs on the historic baseline. • To avoid arbitration, discussions between Chief Executives led to a compromise on the LTA financial settlement. The financial impact to the Trust for 2024/25 is: £318k reduction in recurrent discretionary income (£145k ABUHB, £115k CTMUHB & £58k reverting to old baseline) compared to plan. £483k reduction in non-recurrent income compared to plan. The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP. **2. IMTP – Financial Plan / Forecast** • The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024. • Following agreement on the LTA the Trust financial plan was revised and the shortfall in LTA income has been recovered through a combination of increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures thus ensuring that the Trust continues to have a balanced financial plan.

	3. Key Financial targets / KPIs • The Trust is currently reporting a small underspend on revenue and is forecasting to achieve an outturn position of Breakeven. • The Trust is currently overachieving and expected at this stage to meet the Public Sector Payment Performance (PSPP) target of paying 95% of non-NHS invoices within 30 days for 2024-25. • The Trust is expecting to achieve the Capital Expenditure Limit (CEL), however a risk remains as funding has not yet been secured from WG for several schemes including the nVCC, Enabling Works and Whitchurch Hospital and land matters.

RECOMMENDATION / ACTIONS	The **TRUST BOARD** is asked **NOTE** the contents of the July 2024 financial report and in particular: • The year to date and forecast revenue out turn position and PSPP performance. • The agreed position on LTA income for 2024-25 from our Commissioners. • The position with commissioners on the contract rebase agreement. • That the Trust is still waiting to secure Capital funding from WG in relation to the nVCC, Enabling Works and Whitchurch Hospital and land matters for 2024-25.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**

Executive Management Board	29.08.2024
Quality, Safety and Performance Committee	19.09.2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The paper was received and noted at EMB on the 29 August 2024 and QSP on the 19 September 2024.	

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

APPENDICES	
Appendix 1	Trust Finance Report – July 2024
Appendix 2	TCS Finance Report – July 2024

1. SITUATION/ BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of July 2024.

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.000	0.008	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.397	6.322	31.521
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.4%	96.9%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven however there are risks associated in achieving this.

The overall position against the profiled revenue budget to the end of July 24 is an underspend of **£0.008m.**

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

LTA Contract Position

The Trust obtained agreement from all HBs to proceed with the contract rebasing from 2024-25 at the collective commissioner's group meetings in January and February which was reflected in the LTAs issued by the Trust in March. However, in April the Trust received letters from 2 HBs which outlined their disagreement with the rebasing proposal. The other 4 HBs and JCC were in agreement to proceed but subject to all HBs agreement to the contract rebase.

As commissioners were not able to reach a consensus on the contract rebasing before the 30th June deadline to agree LTAs the Trust had to revert back and prepare LTAs on the historic basis.

Following discussions between Chief Executives, and to avoid arbitration, a compromise position was agreed on the LTA financial values which has led to a financial impact to the Trust for 2024-25 as follows:

- £318k Reduction in recurrent discretionary income compared to plan.
- £483k Reduction in non-recurrent income compared to plan.

The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP.

The shortfall in LTA income has been recovered through a combination of increased savings target, pausing previously agreed investment decisions and mitigating cost pressures.

The Trust is reporting a year end forecast revenue breakeven position, however this assumes that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2024-25.

2.3 Savings

In conjunction with the overall financial plan an in-depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage.

Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875m was required to help compensate for the loss of income from the LTA agreements.

One Scheme within VCS remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

2.4 PSPP Performance

During July 2024 the Trust (core) achieved a compliance level of **98.3%** (June 95.2%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **96.9%** at the end of month 4, and a Trust position (including hosted) of **97.1%** compared to the target of 95%.

2.5 Covid Expenditure

The Trust is currently not expected to draw down any covid funding support during 2024-25.

2.6 Reserves

The financial strategy for 2024-25 has enabled the establishment of a recurrent and non-recurrent reserve to support the Trust investment, transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income is received, planned savings schemes are delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.500m.

The use of investment reserves has been on hold while the Trust reached an agreement with our commissioners around the 3.67% baseline LTA uplift. However, following a review of the overall Trust financial position £0.808m of funding was made available to support investment decisions / choices which were agreed at EMB on the 25th June 2024.

2.7 Financial Risks

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2024-25. As of the end of July some risks have either been mitigated such as, turning the Red RAG rated savings schemes Green, removing the risk of the 2023-24 pay award and the costs associated with the Whitchurch site following confirmation of funding from WG, or the risk has crystallised such as the 3.67% baseline LTA uplift.

The reaming material risks which have been flagged to WG and considered to be either high or medium risk include Non Delivery of Savings (Amber schemes £0.150m), and the risk associated with the increased energy cost where current forecast exceeds budget.

There are several opportunities highlighted in the finance report including utilisation of the uncommitted investment reserves and the emergency reserve which would be used to support these risks should they crystallise. However, currently the non-recurrent reserve and emergency reserve are being used to cover the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs.

2.8 Capital

All Wales Programme

Capital funding has not yet been allocated to several capital schemes including the nVCC, Enabling Works and Whitchurch Hospital and land matters requirement for 2024-25. WG are fully aware of the requirement with an expectation that a request will go imminently to the Minister to secure funding.

All other schemes without agreed funding are under discussion with WG colleagues with confidence at this stage that Capital funding will be provided to support the schemes.

Other Major Schemes in development that are detailed in the finance report will be considered during 2024-25 or beyond in conjunction with WG.

Discretionary Programme

The discretionary programme was fully allocated from previous prioritisation decisions other than a £0.100m contingency, which following confirmation of WG funding towards the WBS Electrical resilience Scheme £0.230m (which was the original funding requirement) has now been released and will be considered for use against other prioritised schemes. WHAIS (£0.494m) continues to be ringfenced from discretionary with the expectation that if All Wales Capital funding can be secured, then a further £0.494m can be released back into the discretionary pot.

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

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐

• An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	08 - Trust Financial Investment Risk
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	**Choose an item**
	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A

	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of **£0.008m** underspend to July'24, whilst currently in line with the IMTP plan there are risks associated as outlined in the paper.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

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

Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED JULY 2024/25

TRUST BOARD
26/09/2024

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 2024-25

2. Background / Context

The draft Trust IMTP Financial Plan for the period 2024-2027 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024.

- For 2024-25 the Plan included;
  - A balanced position brought forward from 2023-24,
  - FYE **of new cost pressures / Investment** of **-£19.973m,**
  - offset by **new recurring Income** of **£18.671m,**
  - and Recurring FYE **savings schemes** of **£1.302m,**
  - Allowing **a balanced position** to be carried into 2025-26.

- **A significant risk is currently associated with the income that the Trust is expected to receive from its commissioners in relation to the 3.67% discretionary uplift, which could impact on the plan and the ability to achieve a balanced financial position.**

- **In order to achieve a balanced financial position the savings target set for 2024-25 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**

Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2024/25	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.000	1.302	18.671	-19.973	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	0.000	0.008	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.397	6.322	31.521
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.4%	96.9%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	0.000	0.000	0.000

Revenue

The core Trust has reported a nil in-month position for July'24, which give a cumulative year to date position of **£0.008m** underspent and an outturn forecast of **Breakeven.**

Following discussions between Chief Executives, and in order to avoid arbitration, a compromise position was agreed on the LTA which has led to a financial impact to the Trust for 2024/25 as follows:

- £318k Reduction in recurrent discretionary income compared to plan.
- £483k Reduction in non-recurrent income compared to plan. The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP.

The shortfall in LTA income has been recovered through a combination of an increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures.

Capital

The approved Capital Expenditure Limit (CEL) as of July 2024 is **£19.250m**. This represents all Wales Capital funding of **£17.339m**, and Discretionary funding of **£1.911m.** The Trust reported Capital spend to July'24 of £6.322m and is forecasting to remain within the CEL of £19.250m, subject to the Trust receiving support from WG for the schemes identified at this stage without agreed funding but are in discussion with WG such as the nVCC Capital cost requirement for 2024-25.

The Trust's current CEL is broken down as follows:

	£m
Discretionary Capital	**1.911**
All Wales Capital:	
IRS	5.164
IRS RSC	11.265
Digital RISP	0.160
BECS	750
Total All Wales Capital	**17.339**
Total CEL	**19.250**

PSPP

During July'24 the Trust (core) achieved a compliance level of **98.3%** (June 95.2%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **96.9%** at the end of month 4, and a Trust position (including hosted) of **97.1%** compared to the target of 95%.

Efficiency / Savings

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875 was required to help compensate for the loss of income from the LTA agreements.

One Scheme remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

Revenue Position

Cumulative				Forecast		
£0.008m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(70.216)	(70.698)	0.482	(214.898)	(214.898)	0.000
Pay	29.231	29.445	(0.214)	85.612	85.612	0.000
Non Pay	40.985	41.244	(0.259)	129.285	129.285	0.000
Total	**0.000**	**(0.008)**	**0.008**	**0.000**	**0.000**	**0.000**

The overall position against the profiled revenue budget to the end of July 2024 is an underspend of **£0.008m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

The Trust is reporting a year end forecast revenue breakeven position, however this assumes that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2024-25.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

As per the IMTP Financial Plan the Trust brought a balanced position into 2024-25 and is expected to maintain this position over the course of the 3-year planning period.

In order to retain a balanced position, the Trust will be required to manage all current and new financial risks, deliver the agreed savings target, and mitigate or remove any cost pressures that may emerge over the course of the period.

Income

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

WBS overachievement on Plasma sales had been significantly impacted by supplier payment issues which has been referred to CCI debt management. However, Since the referral the Trust has negotiated a re-payment plan with the supplier Randox and the first instalment was received at the beginning of August.

VCS Long Term Agreement (LTA) Contract Performance

The Trust has undertaken discussions with LHB Commissioners in accordance with a number of important principles: -

- national guidance from WG regarding the principle of pass through (which for 2024/2025 was 3.67%).
- working in partnership to support all organisations to thrive and deliver safe services of a high quality.

The key differences in LHB Commissioner positions relate to the pass through of the Recurrent Discretionary uplift of 3.67%.

A clause was included within all signed 2023/24 LTAs to proceed with the contract rebase exercise and it was expected that this could be implemented from 2024/25 onwards in line with signed agreements. However, LHB Commissioners have not reached consensus on this matter with areas for resolution as follows:

- The baseline year for activity (currently set at 2019/20)
- The allocation adjustment to be applied to maintain cost neutrality at a system level.
- Transfer of Non Specialist services and High Cost Drugs from JCC to LHBs

Consequently, the Trust has had to prepare LTAs on an historic basis, which is not reflective of the population's utilisation of Velindre's services for LHB Commissioners. Further, the lack of agreement regarding the transfer of service has created a contractual risk to the Trust. In order to manage and mitigate this, the Trust has needed to negotiate a second contract with JCC (value £24m) whilst the matter is resolved.

In order to avoid arbitration, discussions between Chief Executives led to a compromise on the LTA financial settlement. The financial impact to the Trust for 2024/25 is as follows:

- £318k Reduction in recurrent discretionary income (£145k ABUHB, £115k CTMUHB & £58k reverting to old baseline) compared to plan.
- £483k Reduction in non-recurrent income compared to plan with a further risk to non-recurrent position still to be confirmed but not expected to be material. The £483k will become recurrent in 2025/26 with a further reduction of c£360k which will need to be considered as part of the financial plan included within the IMTP.

The contract model rebase is still required to align with the new contracting model so that allocations from WG to LHBs are aligned with spend on Velindre's services on local population basis. Discussions with Commissioners will continue in 2024-25 to resolve the matter.

Pay Highlights / Key Issues

The Trust has now received confirmation from WG via the pay matrix that the full 2023-24 consolidated pay award will be funded.

The Trust is yet to receive formal confirmation from WG on the pay award for 2024-25, however at this stage we would assume that it would be fully funded, albeit with some risk until confirmed.

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work will continue during 2024-25 to update the likely cancer activity demand forecasts and associated income to help mitigate the financial risk exposure.

On top of the savings plans VCS (£0.450m), WBS (£0.450m) and Corporate (£0.150m) hold a recurrent vacancy factor target, which will need to be achieved in order to balance the financial plan for 2024-25.

Non Pay Key Issues

Per the allocation letter the Trust has received £0.563m of recurrent funding from WG to support the increase in energy prices during 2024-25. The latest forecast schedule from NWSSP suggests that the full year energy costs will be c£1.745m, this will leave a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provided by WG) which is held by the Trust.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust revised savings target for each division has been updated as VCS £0.939m, WBS £0.569m (previously £0.650), RD&I £0.230m and Corporate £1.138m (previously £0.787m) for 2024-25.

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

4.2 Pay Spend Trends (Run Rate)

As of July 2024, the current staff in post is 1,602 WTE (June 1,588). The number of vacancies is 73 WTE, which represents a vacancy rate of 4.4% (4.3% June) against the budget of 1,660 WTE. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting each of the division's vacancy factor savings target.

The level vacancies fell over the course of 2023-24 across several services areas, in particular due to the recruitment of 17wte Nurses via the international recruitment scheme, which is demonstrated in the chart below and the historic trend line. As of July 24 vacancies have risen slighlty which is largely due to vacancies materialising from approved projects.

The total Trust vacancies as of July 2024 is 72wte (June 72wte), VCS (42wte), WBS (5wte), Corporate (9wte), R&D (14wte), TCS (1wte) and HTW (1wte).

The pay award for 2024-25 is yet to be agreed so these costs are not yet reflected in the pay spend.

The spend on agency for July'24 was **£0.063m** (June £0.062m) which gives a cumulative year to date position of **£0.222m** and a current forecast outturn spend of circa **£0.322m** (£0.775m 2023/24).

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance &Investment Enhanced monitoring arrangements the Trust is aiming to move away from the reliance on agency by the end of quarter 2 as reflected in the IMTP. Whilst this is still the ambition there are some challenges with recruitment in areas such as Medical Physics and Radiotherapy as we establish the Integrated Radiotherapy Solution (IRS) and Radiotherapy Satellite Centre (RSC). In addition, Medical agency is required in the short term to support vacances and increased activity, and an AHP in Radiotherapy cannot be released until the end of November when core staff training is complete. There has also since been an additional ask of facilities for cleaning support within the septic unit which will require short term agency support.

Where possible the Trust will aim to utilise bank staff in order to reduce reliance on agency and the premium costs associated.

4.3 Non Pay

Average non-pay spend for 2023/24 was £9.9m per month which is a £1.4m increase from the previous whole year average. Largest movement was in drug spend which has increased by £10m in total or £0.9m average per month when compared with the previous year's spend for the same period. Other notable increases year on year include WBS Wholesaling £3.3m or £0.3m average per month and depreciation charges of £1.2m or £0.100m per month.

Non- Pay average so far for 2024/25 is currently £10.3m which is currently £0.4m higher than the average for last year. NICE and HCD drugs costs (£0.2m), and blood wholesale costs (£0.6m) have seen the largest average increase when compared to last year's average for the same period.

The graphs provided below show the change in non-pay spend split by expenditure category over the period from April 2023 to July 2024.

Establishment Expenses includes expenditure such as travel, lease cars, education, printing, postage, stationary, mobile phone charges, and other miscellaneous expenditure.

*Other spend in period M12 23-24 includes a provision for legal fees which has been partly released in 24-25.

*The graph excludes one off spends which incurred in period M12 23-24 such as the £7.35m AZ income received and transferred as expenditure to the Charity, along with the pass back contribution to WG which supported the overall NHS position.

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

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Where possible the Trust will aim to utilise bank staff in order to reduce reliance on agency and the premium costs associated.

4.4 Covid-19

The Trust is currently not expected to draw down any covid funding support during 2024-25. However, if at any point in the future the Trust is required to support the LHBs with any further vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

4. Savings

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system.

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.876m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.876m was required in order to help compensate for the loss of income from the LTA agreements.

Of the revised £2.876m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, the majority of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2024-25.

The private patients scheme remains in amber as the Trust is assessing the external expert private patient management support it requires to facilitate delivery of the scheme, however we expect that once the external support contract is signed the income generation will be realised turning the scheme green. If not, a replacement savings scheme will be found, or the Trust can utilise one of the opportunities such as the emergency reserve mitigating any risk.

It is extremely important that divisions continually review their current savings schemes, and where delivery may not be achieved, alternative schemes are implemented to ensure that the Savings target is met for 2024-25.

Cummulative monthly savings achieved compared to target
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500,000
£1,000,000
£1,500,000
£2,000,000
£2,500,000
£3,000,000
Cumulative Achieved Savings
Cumulative Target Savings

Savings achieved by month compared to target by RAG status
Mar
Feb
Jan
Dec
Nov
Oct
Sep
Aug
July
June
May
April
£0
£500,000
£1,000,000
£1,500,000
£2,000,000
£2,500,000
£3,000,000
£3,500,000
Active (Green)
In-Progress (Amber)
Achieved in month

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**939**	**199**	**199**	**0**	**939**	**0**
			100%		**100%**	
WBS TOTAL SAVINGS	**569**	**223**	**223**	**0**	**569**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**1,137**	**332**	**332**	**0**	**1,137**	**0**
			100%		**100%**	
RD&I TOTAL SAVINGS	230	**77**	**77**	**0**	**230**	**0**
					100%	
TRUST TOTAL SAVINGS	**2,875**	**831**	**831**	**0**	**2,875**	**0**
			100%		**100%**	

Scheme Type	Division	Recrrent / Non-Recurrent	RAG Rating	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Radiation Services - Agency Reduction	VCS	NR	Green	50	17	17	0	50	0
Establishment Control	VCS	R & N/R	Green	234	75	75	0	234	0
Service Workforce Redesign	VCS	R & N/R	Red						
Procurement - Supply Chain	VCS	R	Green	50	6	6	0	50	0
Establishment Control	WBS	R	Green	54	42	42	0	54	0
Stock Control - Scan for Safety Enabled	WBS	NR	Green	150	50	50	0	150	0
WBS Demand Planning	WBS	R	Red						
WBS Demand Planning	WBS	NR	Green	75	20	20	0	75	0
WBS Productivity Efficiencies	WBS	NR	Red						
Procurement - Supply Chain	WBS	R	Green	50	6	6	0	50	0
Service Workforce Redesign	WBS	R	Red						
Departmental CIP	Corporate	R	Green	50	17	17	0	50	0
Establishment Control	Corporate	R & N/R	Green	75	25	25	0	75	0
R&D Establishment Control	RD&I	R & N/R	Green	80	27	27	0	80	0
New / Replacement Schemes					0		0	0	0
Productivity Efficiencies	VCS	R & NR	Green	35	4	4	0	35	0
SACT Provision	VCS	R	Green	150	30	30	0	150	0
Creditor Review	WBS	NR	Green	100	100	100	0	100	0
Budget Efficiences	WBS	NR	Green	40	4	4	0	40	0
Total Saving Schemes				**1,193**	422	422	0	1,193	0
Income Generation									
Private Patients - Recovery of Debt	VCS	NR	Green	150	50	50	0	150	0
Private Patients - Contract Renewal	VCS	R	Amber	150	0	0	0	150	0
Productivity Efficiencies	VCS	R	Red						
Sales of Plasma	WBS	R	Green	100	1	1	0	100	0
WBS Productivity Efficiencies	WBS	R	Red						
Bank Interest	Corporate	R & N/R	Green	662	221	221	0	662	0
R&D Commercial Income	RD&I	R	Green	150	50	50	0	150	0
New / Replacement Schemes					0		0	0	0
Private Patients	VCS	NR	Green	70	8	8	0	70	0
Maximising Income	VCS	R	Green	50	10	10	0	50	0
Bank Interest	Corporate	R	Green	350	70	70	0	350	0
Total Income Generation				**1,682**	409	409	0	1,682	0
TRUST TOTAL SAVINGS				**2,875**	**831**	**831**	**0**	**2,875**	**0**
						100%		**100%**	

5. Reserves

The financial strategy for 2024-25 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust investment, transformation, and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.500m.

The use of investment reserves has been on hold while the Trust reached an agreement with our commissioners around the 3.67% baseline LTA uplift. However, following a review of the overall Trust financial position undertaken in June £0.808m of funding was made available to support investment decisions / choices which were agreed at EMB on the 25th June 2024.

The non-recurrent reserve and emergency reserve are currently being used to cover the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs.

6. End of Year Forecast / Risk & Opportunity Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however several financial risks that could impact on the successful delivery of a balanced position for 2024-25, although the majority have now either been reduced in risk or mitigated completely. The remaining key financial risks & opportunities which have been highlighted to Welsh Government are provided below.

Risks

LTA – *(£0m to £0.100m) Likelihood – Low (Risk reduced following LTA agreements and some crystallisation of income loss)*

The Trust has undertaken discussions with LHB Commissioners in accordance with a number of important principles: -

- national guidance from WG regarding the principle of pass through (which for 2024/2025 was 3.67%).
- working in partnership to support all organisations to thrive and deliver safe services of a high quality.

The key differences in LHB Commissioner positions relate to the pass through of the Recurrent Discretionary uplift of 3.67%.

A clause was included within all signed 2023/24 LTAs to proceed with the contract rebase exercise and it was expected that this could be implemented from 2024/25 onwards in line with signed agreements. However, LHB Commissioners have not reached consensus on this matter with areas for resolution as follows:

- The baseline year for activity (currently set at 2019/20)
- The allocation adjustment to be applied to maintain cost neutrality at a system level.
- Transfer of Non Specialist services and High Cost Drugs from JCC to LHBs

Consequently, the Trust has had to prepare LTAs on an historic basis, which is not reflective of the population's utilisation of Velindre's services for LHB Commissioners. Further, the lack of agreement regarding the transfer of service has created a contractual risk to the Trust. In order to manage and mitigate this, the Trust has needed to negotiate a second contract with JCC (value £24m) whilst the matter is resolved.

In order to avoid arbitration, discussions between Chief Executives led to a compromise LTA Financial settlement The financial impact to the Trust for 2024/25 is as follows:

- £318k Reduction in recurrent discretionary income (£145k ABUHB, £115k CTMUHB & £58k reverting to old baseline) compared to plan
- £483k Reduction in non-recurrent income compared to plan with The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will be considered within the IMTP as part of the financial plan.

The contract model rebase is still required to align with the new contracting model so that allocations from WG to LHBs are aligned with spend on Velindre's services on local population basis. Discussions with Commissioners will continue in 2024-25 to resolve the matter.

Non-Delivery of Savings – (*£0.150m) Likelihood - Medium*

The Trust has identified a revised savings target of £2.875m to be achieved during 2024-25. The savings target was originally set to ensure that the Trust had the ability to mitigate against the significant cost pressures with the service, and then increased in order to help support the loss of income from the LTA agreements.

One Scheme remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

Whitchurch Hospital Site Transfer – Financial Consequences – (Low)

The Trust submitted a paper to the WG Health Strategy Board (HSB) held on 8th March setting out all the cost implications of the land & hospital transfer and future disposal / development. WG HSB approved in principle the proposed approach and funding of the costs. The annual revenue costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer is imminent and is expected to take place in the next couple of months once we finalise the detail. Once the land is transferred to the Trust, the annual revenue cost pressure would remain on a recurrent basis, until the disposal or development of the residual Whitchurch estate. It is expected that the Trust will need to incur future capital cost to make good and dispose of the site.

The annual costs include site security, utilities and maintenance/upkeep of the Whitchurch hospital and site based on information provided by C&VUHB. These are forecast to be £0.640m (Exc VAT). The Trust doesn't have a formal funding letter yet, however the Deputy Chief Executive NHS Wales confirmed in a letter to VUNHST CEO and Cardiff and Vale LHB CEO on 26 March 2024 that the Health Strategy Board is aware of the on-going revenue costs that are linked to the site which will initially be covered by the Welsh Government but will be offset against any future disposal receipts for the site. The proposed funding model for this arrangement will need to be agreed between WG and VUNHST as the Trust will require revenue funding to cover the annual costs, whereas the proposed funding source is a future capital receipt on disposal. At the Trust WG CRM in May 2024, WG's Deputy Director for NHS Capital, Estates and Facilities confirmed the Trust should invoice the Capital Finance team for the revenue costs incurred so therefore the risk has been reduced to low.

The site surveys, transaction and disposal costs are estimated at £0.300m (Exc VAT) and the make safe cost for the Whitchurch Hospital is estimated at between £1.65m - £2.73m (Exc VAT) subject to negotiations with WG and Cardiff Council. These costs require agreed capital funding as part of the All Wales Capital Funding Programme.

Rise in Energy Prices above forecast MTP plans - *(£0.142m) Likelihood – High*

Latest forecast schedule from NWSSP suggests that the Trust energy costs for 2024-25 will be c£1.745m this will leave a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provide by WG) which is held by the Trust.

Management of Operational Cost Pressures - *(£0.500m) Likelihood - Low*

There are several cost pressures that are already within the service which are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that these current pressures may be beyond divisional control which is being recognised within the table.

In addition, new cost pressures may materialise over the period which may be beyond divisional control or ability to manage through the overall Trust funding envelope.

Opportunities

Vacancy Turnover – (Low)

Further vacancy turnover savings above the vacancy factor held in divisions.

Emergency Reserve – (Medium)

It is important that the Trust keeps a reserve for emergency cost pressures which may arise over the course of the year, however, if this reserve is not required during 2024-25 then like in 2023-24 the Trust may be in a position later in the year to release this funding on a non-recurrent basis.

Reduction in Energy Prices – (Low)

At this stage the funding received to support the increase in energy prices is expected to be required by the Trust, however whilst unlikely given the latest forecast position from NWSSP if costs were to reduce then an opportunity may crystalise.

Savings Opportunities Pipeline

The Trust has identified some initial opportunities that could be explored but these require further development but are highlighted below:

Pre-Operative Anaemia Pathway Project (Health Board savings)

Value Based Healthcare project led by WBS where all patients undergoing elective major surgery in Wales will be screened pre-operatively and offered treatment with intravenous Iron as required

prior to surgery. Savings to be established and delivered via Health Boards and represents WBS / VUNHST contribution to system wide financial performance.

Medicine Unit Supply

Identify opportunities to increase use of NWSSP Medicines unit to identify further potential cost savings for high cost drugs. Note that any cost savings are passed through to LHB Commissioners

Workforce Re-design

Review of workforce models and pathways to identify opportunities to deliver services more efficiently in addition to the schemes outlined in the savings tracker.

Procurement

Procurement working with divisions on a regular basis to review non pay spend and ensure delivery of savings target and identify other cost improvement opportunities above the savings target.

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 2024/25 £m	YTD Spend £m	Budget Remaining @ M4 £m	F'cast Spend 2024/25 £m	Year End Variance 2024/25 £m
All Wales Capital Programme					
IRS - Integrated Radiotherapy Solution	5.164	2.042	3.122	5.164	0.000
IRS RSC - Radiotherapy Satellite Centre	11.265	0.854	10.411	11.265	0.000
nVCC Enabling Costs	0.000	2.289	(2.289)	3.368	(3.368)
nVCC Project Fees	0.000	0.719	(0.719)	3.622	(3.622)
nVCC Whitchurch Hospital Site	0.000	0.003	(0.003)	3.636	(3.636)
nVCC Governance Review	0.000	0.140	(0.140)	0.140	(0.140)
nVCC Governance Review Implementation (PW	0.000	0.000	0.000	0.350	(0.350)
WBS TGI	0.000	0.000	0.000	0.363	(0.363)
Digital - WHAIS	0.000	0.000	0.000	0.442	(0.442)
Digital - RISP	0.160	0.000	0.000	0.160	0.000
BECS	0.750	0.000	0.000	0.750	0.000
WBS Electrical Resilience - Backlog Maintenanc	0.000	0.000	0.000	0.350	0.000
WBS Liquid Nitrogen	0.000	0.000	0.000	0.000	0.000
Total All Wales Capital Programme	17.339	6.047	10.382	29.610	(11.921)
Discretionary Capital	1.911	0.275	1.636	1.911	0.000
	19.250	6.322	12.018	31.521	(11.921)

The approved 2024-25 Capital Expenditure Limit (CEL) as of July 2024 was £19.250m. This includes All Wales Capital funding of £17.339m, and discretionary funding of £1.911m.

A total of £11.116m is now forecast to be required to support the nVCC enabling, project, Governance review costs and to make good the Whitchurch Site during 2024-25. WG are aware of the total requirement and are looking to put a request to the Minister imminently.

Discussions are ongoing with WG colleagues around securing the funding requirement in relation to WHAIS and the costs associated with the WBS TGI OBC, with WG having supported these projects up to this date.

In addition, the Trust has been awarded funding from WG towards the WBS electrical resilience, however the Trust received confirmation during July that the WBS Liquid nitrogen scheme which was initially supported was not approved by the Minister. The Trust will now be looking to secure funding either from year end capital spend should it become available, or the scheme will be included within next year's IMTP plans with a view to secure funding before the contract ends.

The finance team are in conversation with WG colleagues to ensure that the funding for all of the above Capital Schemes form part of the CEL for 2024-25.

The discretionary allocation of £1.911m represents an increase of 12% on the £1.683m provided during 2023-24.

The discretionary programme was fully allocated from previous prioritisation decisions other than a £0.100m contingency, which following confirmation of WG funding towards the WBS Electrical resilience Scheme £0.230m (which was the original funding requirement) has now been released and will be considered for use against other prioritised schemes. WHAIS (£0.494m) continues to be ringfenced from discretionary with the expectation that if All Wales Capital funding can be secured, then a further £0.494m can be released back into the discretionary pot.

A review of the recent conditions survey of the VCC site is currently underway and will require funding support from the discretionary programme. This is currently estimated to be c£0.160m.

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

Performance to date

The actual expenditure to July 2024 on the All-Wales Capital Programme schemes was £6.047m, this is broken down between spend on the nVCC schemes of £3.151m, the IRS £2.289m, and RSC £0.854m.

The current spend on the Discretionary Capital programme as of July 2024-25 is £0.275m.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position subject to the Trust securing funds for the nVCC and other projects on WG radar.

Major Schemes in Development

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

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund.

The latest position of schemes that was included in the IMTP for 2024-25 is provided in the table below:

All Wales Approved and Unapproved Capital Schemes	2024-25 £m	2025-26 £m	2026-27 £m	2027/28 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works		1.547				1.547
Integrated Radiotherapy Solution (IRS)	5.164	2.040	15.800	0.839		23.843
Radiotherapy Satellite Unit	11.265					11.265
Total Approved Capital Schemes	**16.429**	**3.587**	**15.800**	**0.839**	**0.000**	**36.655**
All Wales Unapproved Schemes						
TCS nVCC	15.791	11.000	36.962	1.741		65.494
TCS nVCC Enabling works	2.900		0.600			3.500
Digital - IT Infrastructure	1.086	0.688	0.680	0.400		2.854
WHAIS	0.494	0.092				0.586
WBS Electrical Resilience	0.320					0.320
Liquid Nitrogen Vessel	0.500					0.500
Welsh Plasma - Medicine	0.970	0.064	0.064	0.203		1.301
Talbot Green - Infrastructure	0.303	1.346	10.633	10.640	19.707	42.629
WBS Fleet Replacement		0.373	1.112	1.285		2.770
WBS Asset Replacement	0.100	0.494	0.121		1.560	2.275
First Floor Ward Ventilation	0.370					0.370
Condition Survey Recommendations	0.250	0.200	0.150			0.600
BECS Blood Mangagement System	0.100	0.200	0.200	1.000		1.500
Total Unapproved Capital Schemes	**23.184**	**14.457**	**50.522**	**15.269**	**21.267**	**124.699**
Total All Wales Capital Plans	**39.613**	**18.044**	**66.322**	**16.108**	**21.267**	**161.354**

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 24	Closing Balance End of Jul-24	Movement from 1st April Jul-24	Forecast Closing Balance End of Mar 25
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	226.135	227.366	1.231	227.366
Intangible assets	10.893	10.894	0.001	10.894
Trade and other receivables	1,316.876	1,310.213	(6.663)	1,310.213
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,553.904	1,548.473	(5.431)	1,548.473
Current Assets				
Inventories	31.227	31.466	0.239	31.466
Trade and other receivables	530.547	538.454	7.907	549.166
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	20.956	27.646	6.690	16.934
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	582.730	597.566	14.836	597.566
TOTAL ASSETS	2,136.634	2,146.039	9.405	2,146.039
Current Liabilities				
Trade and other payables	(229.886)	(239.720)	(9.834)	(239.720)
Borrowings	(1.020)	(1.020)	0.000	(1.020)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(338.517)	(589.436)	(250.919)	(589.436)
Current Liabilities sub total	(569.423)	(830.176)	(260.753)	(830.176)
NET ASSETS LESS CURRENT LIABILITIES	1,567.211	1,315.863	(251.348)	1,315.863
Non-Current Liabilities				
Trade and other payables	(3.330)	(3.330)	0.000	(3.330)
Borrowings	(31.785)	(31.785)	0.000	(31.785)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,320.849)	(1,069.027)	251.822	(1,069.027)
Non-Current Liabilities sub total	(1,355.964)	(1,104.142)	251.82	(1,104.142)
TOTAL ASSETS EMPLOYED	211.247	211.721	0.474	211.721
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	35.956	35.956	0.00	35.956
PDC	155.832	155.924	0.092	155.924
Retained earnings	19.459	19.841	0.382	19.841
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	211.247	211.721	0.474	211.721

9. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the ongoing uncertain situation and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however issued the additional stock and the £4.5m was repaid to WG during February '23.

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

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	**Income from other Welsh NHS**	50.519	42.117	43.016	40.489	48.599	47.599	47.299	46.099	45.499	46.699	45.499	42.499	545.931
2	**WG Revenue Funding**	10.504	31.147	45.405	20.761	18.500	28.453	20.200	22.529	31.399	42.659	11.399	21.529	304.483
3	**Short Term Loans**													0.000
4	**PDC**							0.000					13.957	13.957
5	**Interest Receivable**	0.179	0.143	0.186	0.158	0.144	0.144	0.144	0.144	0.144	0.144	0.144	0.144	1.818
6	**Sale of Assets**													0.000
7	**Other**	6.657	7.151	4.914	19.701	3.200	3.900	5.600	6.154	5.450	5.800	5.450	5.625	79.603
8	**TOTAL RECEIPTS**	**67.860**	**80.558**	**93.521**	**81.109**	**70.443**	**80.096**	**73.243**	**74.925**	**82.491**	**95.301**	**62.491**	**83.753**	**945.791**
	PAYMENTS													
9	**Salaries and Wages**	25.845	35.256	35.185	35.848	35.635	35.618	35.632	35.625	35.604	35.639	35.618	35.618	417.123
10	**Non pay items**	31.288	30.780	81.237	33.050	38.542	54.602	32.241	36.042	46.537	53.525	29.384	32.156	499.382
11	**Short Term Loan Repayment**													0.000
12	**PDC Repayment**		0.000											0.000
14	**Capital Payment**	2.880	3.178	0.977	0.833	1.500	2.164	2.357	2.429	2.066	7.378	3.543	4.003	33.309
15	**Other items**													0.000
16	**TOTAL PAYMENTS**	**60.013**	**69.214**	**117.399**	**69.731**	**75.676**	**92.384**	**70.230**	**74.096**	**84.207**	**96.542**	**68.545**	**71.777**	**949.813**
17	**Net cash inflow/outflow**	7.846	11.344	(23.878)	11.378	(5.234)	(12.288)	3.013	0.830	(1.715)	(1.241)	(6.054)	11.976	
18	**Balance b/f**	20.956	28.802	40.146	16.268	27.646	22.413	10.125	13.138	13.968	12.253	11.012	4.958	
19	**Balance c/f**	28.802	40.146	16.268	27.646	22.413	10.125	13.138	13.968	12.253	11.012	4.958	16.934	

DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(15.267)	(15.264)	0.003	(41.858)	(41.858)	0.000
RD&I	0.114	0.106	(0.008)	0.394	0.394	0.000
WBS	(7.130)	(7.128)	0.002	(20.961)	(20.961)	0.000
Sub-Total Divisions	**(22.283)**	**(22.286)**	**(0.003)**	**(62.425)**	**(62.425)**	**0.000**
Corporate Services Directorates	(4.199)	(4.197)	0.002	(12.602)	(12.602)	0.000
Delegated Budget Position	**(26.482)**	**(26.483)**	**(0.001)**	**(75.027)**	**(75.027)**	**0.000**
TCS	(0.173)	(0.163)	0.010	(0.635)	(0.635)	0.000
Health Technology Wales	(0.031)	(0.031)	(0.000)	(0.092)	(0.092)	0.000
Trust Income / Reserves	26.686	26.686	0.000	75.700	75.700	0.000
Trust Position	0.000	0.009	0.008	(0.053)	(0.053)	0.000

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**26.222**	**26.515**	**0.293**	**81.403**	**81.403**	**0.000**
Expenditure						
Staff	16.927	17.149	(0.222)	49.069	49.069	0.000
Non Staff	24.562	24.630	(0.068)	74.192	74.192	0.000
Sub Total	**41.489**	**41.779**	**(0.290)**	**123.261**	**123.261**	**0.000**
Total	**(15.267)**	**(15.264)**	0.003	**(41.858)**	**(41.858)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of July 2024 was a small underspend of **£0.003m**, and an expected outturn position expected at this stage of **breakeven**.

Income at Month 4 represents a surplus of **£0.293m**. An overachievement on private patient drug income and VAT Savings from delivering drug homecare, which is offsetting the release in a provision for legal costs from last financial year which directly correlates with a reduction in non-pay expenditure.

VCS have reported a year to date overspend of **£(0.222)m** against staff. Snr Medical costs continue to cause a significant cost pressure to the division which is offsetting the vacancies that

remain across several services despite the recruitment push during 2023-24. The vacancies being carried is above both the vacancy factor and savings target held in the Division.

Non-Staff Expenditure at Month 4 was **£(0.068)m** overspent which is largely due to an increase in facilities management expenses (mainly Postage), the SLA increase in pathology with C&V and the divisional management savings target, partly offset by a release of the legal provision counteracted with income, and other small variances across service areas.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**11.646**	**11.727**	**0.081**	**30.747**	**30.747**	**0.000**
Expenditure						
Staff	5.908	6.087	(0.178)	17.042	17.042	0.000
Non Staff	12.868	12.769	0.099	34.666	34.666	0.000
Sub Total	**18.776**	**18.855**	**(0.080)**	**51.708**	**51.708**	**0.000**
Total	**(7.130)**	**(7.128)**	0.002	**(20.961)**	**(20.961)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of July 2024 was a small underspend of **£0.002m** with an outturn forecast position of **breakeven** currently expected.

Income overachievement of **£0.081m is** due to increased activity on plasma sales, partly offset by underachievement on bone marrow.

Whilst Plasma Sales activity has been increasing deliveries to Randox have now been suspended due to the supplier not making payment. A bad debt provision of £0.366m was created at the end of last financial year however, the debt continued to rise at the start of the financial year prior to the suspension which has now been referred to CCI debt management. Since the referral the Trust has negotiated a re-payment plan with the supplier Randox and the first instalment was received at the beginning of August.

There has been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, however, is starting to show signs of recovery with significantly more swab tests taking place over the last quarter. The payback from the additional swabs should start to be realised later in this financial year. WBS continue to run campaigns in order to try and grow the panel in sites such as schools and universities, and also raise awareness through advertising on platforms such as social media.

Staff overspend of **£(0.178)m** is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source. Work continues to be underway within WBS SLT to either secure additional funding to support these posts or continue to look into options of migrating staff into vacancies to help mitigate the current risk exposure. There is a focused WBS SLT away day scheduled for the 12th September where this will be discussed, and actions agreed to address the issue.

Non-Staff reported an underspend of **£0.099m** as at month 4. There are overspends in areas such as room hire costs which are no longer funded by WHSSC, temporary additional security costs at the rear of the building, additional spend within molecular genetics for test kits and the Divisional non pay CIP. Expectation is that security at the site can be removed in the short term. The cost pressures are being offset by underspends in Apheresis harnesses volume and price savings, price savings from bulk purchase of test kits, reduced spend on fuel due to the delay in lease vehicles being introduced, and reduced costs from lower activity on bone Marrow which is a direct correlation with income under performance.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**1.355**	**1.512**	**0.156**	**4.443**	**4.443**	**0.000**
Expenditure						
Staff	4.541	4.382	0.159	13.884	13.884	0.000
Non Staff	1.013	1.327	(0.314)	3.161	3.161	0.000
Sub Total	**5.554**	**5.709**	**(0.155)**	**17.045**	**17.045**	**0.000**
Total	**(4.199)**	**(4.197)**	0.002	**(12.602)**	**(12.602)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of July 2024 was an overspend of **£0.002m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

Staff expectation is that vacancies within the division, will help offset use of agency, the Head of Communications which has been temporarily appointed at risk and the divisional savings target.

A non-pay overspend is again expected and largely relates to divisional CIP target and the increased running costs associated with the hospital estate. Funding was set aside as part of the Trust IMTP to partly support the Estates costs on a non-recurrent basis during 2024-25.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**1.435**	**1.404**	**(0.030)**	**4.554**	**4.554**	**0.000**
Expenditure						
Staff	1.129	1.118	0.011	3.630	3.630	0.000
Non Staff	0.192	0.181	0.011	0.531	0.531	0.000
Sub Total	**1.321**	**1.298**	**0.023**	**4.160**	**4.160**	**0.000**
Total	**0.114**	**0.106**	(0.008)	**0.394**	**0.394**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of July 2024 was a small **£0.008m** overspend with a current forecast outturn position of **breakeven**.

Clinical Trials and Charitable funds income will fluctuate and is expected be drawn down in line with expenditure.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.028**	**0.028**	**0.000**	**0.028**	**0.028**	**0.000**
Expenditure						
Staff	0.187	0.180	0.007	0.621	0.621	0.000
Non Staff	0.014	0.011	0.003	0.042	0.042	0.000
Sub Total	**0.201**	**0.191**	**0.010**	**0.663**	**0.663**	**0.000**
Total	**(0.173)**	**(0.163)**	0.010	**(0.635)**	**(0.635)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of July 2024 is **a £0.010m** underspend with a forecasted outturn position of **Breakeven.**

Escrow bank interest is being brought into the position which is resulting in a year to date surplus position.

HTW (Hosted Other)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.549**	**0.531**	**0.019**	**1.649**	**1.649**	**0.000**
Expenditure						
Staff	0.538	0.530	0.008	1.614	1.614	0.000
Non Staff	0.042	0.032	0.010	0.127	0.127	0.000
Sub Total	**0.580**	**0.562**	**0.019**	**1.741**	**1.741**	**0.000**
Total	**(0.031)**	**(0.031)**	0.000	**(0.092)**	**(0.092)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of July 2024 was **breakeven,** with a forecasted outturn position which will be managed to a **breakeven** position.

HTW is funded directly via WG other than the pay award which is passed through the Trust commissioners in the same way as the core Trust.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

APPENDIX 2

TCS PROGRAMME FINANCE REPORT 2024-25

Period Ending 31st July 2024

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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 2024-25, outlining spend against budget as at 31st July 2024 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 2024-25 as at 31st July 2024 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	2024-25 Full Year		
		Budget	Forecast	Variance
Capital	£3.148m	£0	£7.132m	-£7.132m
Revenue	£0.192m	£0.666m	£0.668m	-£0.002m
Total	**£3.340m**	**£0.666m**	**£7.800m**	**-£7.134m**

2.2 The overall forecast outturn for the Programme is an overspend of £7.134m for the financial year 2024-25 against a budget of £0.666m.

2.3 No capital funding has been allocated yet for the projects for financial year, resulting in the aforementioned overspend. A funding request for the nVCC Project has been submitted to WG for c£3.8m and the EW Project funding request will be as part of the EW FBC Addendum.

2.4 The main financial risk to the TCS Programme at present is the lack of funding for the capital projects, which is being mitigated by the aforementioned funding request.

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 2024, the Welsh Government (WG) had provided a total of £63.295m funding (£60.246m capital, £3.049m revenue) to support the TCS Programme. In addition, the Trust had provided £0.264m from its discretionary capital allocation and £0.512m non-recurrent revenue funding.

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

3.4 The current funding provided to support the TCS Programme in 2024-25 is £0.663m revenue, with no capital funding allocated as yet. This is outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding

Initial Allocation (as at 1st April 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Current Allocation (as at 31st July 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Sources of Revenue Funding

Initial Allocation (as at 1st April 2024)

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0.240m	£0.078m	£0	£0.318m
EW Project	£0	£0	£0	£0
nVCC Project	£0	£0	£0	£0
SDT Project	£0.180m	£0.140m	£0	£0.320m
Total	**£0.420m**	**£0.218m**	**£0**	**£0.638m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0	£0	£0	£0
EW Project	£0	£0	£0.028m	£0.028m
nVCC Project	£0	£0	£0	£0
SDT Project	£0	£0	£0	£0
Total	**£0**	**£0**	**£0.028m**	**£0.028m**

Current Allocation (as at 31st July 2024)

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0.240m	£0.078m	£0	£0.318m
EW Project	£0	£0	£0.028m	£0.028m
nVCC Project	£0	£0	£0	£0
SDT Project	£0.180m	£0.140m	£0	£0.320m
Total	**£0.420m**	**£0.218m**	**£0.028m**	**£0.666m**

4. CAPITAL POSITION

4.1 The current capital funding for 2024-25 is outlined below:

- Enabling Works Project £0m
- nVCC Project £0m
- Whitchurch Hospital Site £0m

Total £0m

4.2 The capital position as at 31st July 2024 is outlined below, with a forecast overspend of £7.132m for 2024-25. This is due to the lack of capital funding being allocated to the projects to date this financial year.

Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£2.288m	£0	£3.368m	-£3.368m
nVCC Project	£0.857m	£0	£3.762m	-£3.762m
Whitchurch Hospital Site	£0.003m	£0	£0.003m	-£0.003m
Total	**£3.148m**	**£0**	**£7.132m**	**-£7.132m**

4.3 A funding request for the nVCC Project has been submitted to WG for c£3.8m, and the EW Project funding request will be as part of the EW FBC Addendum.

5. REVENUE POSITION

5.1 The revenue funding for 2024-25 is outlined below:

- PMO £0.318m
- Enabling Works Project £0.028m
- nVCC Project £0m
- SDT Project £0.320m

Total £0.663m

5.2 The revenue position as at 31st July 2024 is outlined below, with a forecast overall overspend of £0.002m for 2024-25 against a budget of £0.666m.

Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
PMO	£0.096m	£0.318m	£0.318m	£0
EW Project	£0	£0.028m	£0	£0.028m
nVCC Project	£0.009m	£0	£0.030m	-£0.030m
SDT Project	£0.086m	£0.320m	£0.320m	£0
Total	**£0.192m**	**£0.666m**	**£0.668m**	**-£0.002m**

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The actual capital spend to date is £2.288m, with a run rate to date lower than the planned spend.

6.2 The capital cash flow for the **nVCC Project** is outlined below. The actual capital spend to date is £0.857m, with a run rate to date similar to the planned spend.

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

7. PROJECT FINANCE UPDATES

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

Programme Management Office

7.2 The current revenue funding for the PMO for 2024-25 is £0.318m, with £0.240m of this provide from NHS Commissioners' funding and £0.078m from the Trust Reserves.

7.3 There is no capital funding requirement for the PMO in 2024-25.

7.4 The revenue position for the PMO as at 31st July 2024 is shown below, with a forecast breakeven position for the year against a budget of £0.318m.

PMO Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.095m	£0.317m	£0.316m	£0
Non Pay	£0.002m	£0.002m	£0.002m	£0
Total	**£0.096m**	**£0.318m**	**£0.318m**	**£0**

7.5 There are currently no financial risks associated with the PMO for 2024-25.

Enabling Works Project

Capital

7.6 There is currently no capital funding for the Enabling Works Project for 2024-25.

7.7 The Project's financial position for 31st July 2024 is shown below. The forecast position reflects an expected overspend of £3.368m for this financial year.

Enabling Works Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.079m	£0	£0.239m	-£0.239m
Non-Pay	£2.210m	£0	£3.129m	-£3.129m
Total	**£2.288m**	**£0**	**£3.368m**	**-£3.368m**

7.8 The Project spend relates to the following activities:

Enabling Works FBC Project Capital Budget & Spend Summary 2024-25

Description		Year to Date Budget Jul-24 £	Year to Date Spend Jul-24 £	Year to Date Variance Jul-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY							
Project 1b - Enabling Works FBC		0	78,682	-78,682	0	239,173	-239,173
Pay Capital Total		**0**	**78,682**	**-78,682**	**0**	**239,173**	**-239,173**
NON-PAY							
EF02	Utility Costs	0	400,000	-400,000	0	480,000	-480,000
EF03	Supply Chain Fees	0	149,824	-149,824	0	291,324	-291,324
EF04	Non Works Costs	0	11,200	-11,200	0	76,200	-76,200
EF05	ASDA Works	0	1,106,849	-1,106,849	0	1,106,849	-1,106,849
EF06	Walters Design & Build	0	523,788	-523,788	0	1,129,588	-1,129,588
EF08	Section 278	0	0	0	0	0	0
EF09	Off Site Habitat	0	-211	211	0	-211	211
EFQR	Quantified Risk	0	0	0	0	100,000	-100,000
EFQS	QRA - SCP	0	0	0	0	0	0
EFRS	Enabling Works FBC Reserves	0	18,255	-18,255	0	-55,079	55,079
Enabling Works FBC Project Capital Total		**0**	**2,209,704**	**-2,209,704**	**0**	**3,128,671**	**-3,128,671**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**0**	**2,288,386**	**-2,288,386**	**0**	**3,367,844**	**-3,367,844**

7.9 To date this financial year no capital funding has been provided by WG for the Enabling Works Project. The EW Project funding request will be as part of the EW FBC Addendum, which needs to be submitted to outline the revised scope of the enabling works activities and Payable. The additional works activities are outlined below:

- Water main diversion
- S278 Works Longwood Drive
- HV Intake Room
- Offsite Habitat Creation

7.10 Indicative additional costs for these works were **c£2.9m**, which have been previously reported and this is set out below:

Water Main Diversion	£0.850m inc VAT
S278 Works – Longwood Drive	£1.200m inc VAT
Off Site Habitat Creation	£0.400m inc VAT
HV Intake Room	£0.450m inc VAT
TOTAL	£2.900m inc VAT

7.11 However, latest costings indicate increased requirements for S278 works on Longwood Drive; fees; and offsite habitat creation. As such the increased costs could be up to **c£4.8m** and this will be outlined in the EW FBC Addendum.

7.12 This would increase the EW FBC funding request from c£28.089m to **c£32.9m**. It should be noted that this excludes any QRA or contingency required for these works.

Revenue

7.13 There is currently revenue funding of £0.028m for the Enabling Works nVCC Project for 2024-25. This is provided from the interest earned from the Enabling Works Escrow bank Account for the ASDA works.

7.14 The revenue financial position for the Enabling Works Project for 31st July 2024 is shown below, reflecting a current underspend of £0.028m for the year.

Enabling Works Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0	£0.028m	£0	£0.028m
Total	**£0**	**£0.028m**	**£0**	**£0.028m**

7.15 There is a risk of an underspend of £0.028m for the revenue element of the Enabling Works Project this financial year. However, this will be used to offset the expected revenue overspend in the nVCC Project.

New Velindre Cancer Centre Project

Capital

7.16 There is currently no capital funding for the nVCC Project for 2024-25. A funding request has been submitted to WG for this financial year.

7.17 The Project's financial position for 31st July 2024 is shown below. The forecast position reflects an expected overspend of £3.762m for this financial year.

Enabling Works Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.441m	£0	£2.170m	-£2.170m
Non-Pay	£0.416m	£0	£1.591m	-£1.591m
Total	**£0.857m**	**£0**	**£3.762m**	**-£3.762m**

7.18 The Project spend relates to the following activities:

nVCC FBC Project Capital Budget & Spend Summary 2024-25

Description	Year to Date Budget Jul-24 £	Year to Date Spend Jul-24 £	Year to Date Variance Jul-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC	0	112,443	-112,443	0	416,208	-416,208
Project 2d - New Velindre Cancer Centre FBC	0	328,866	-328,866	0	1,754,154	-1,754,154
Pay Capital Total	**0**	**441,309**	**-441,309**	**0**	**2,170,362**	**-2,170,362**
NON-PAY						
nVCC Project Delivery	**0**	**13,043**	**-13,043**	**0**	**63,304**	**-63,304**
Work Packages						
VF01 RDD Process	0	93,263	-93,263	0	449,708	-449,708
VF02 Construction Phase	0	9,075	-9,075	0	503,075	-503,075
VF03 Professional Advisors (Call-off Basis)	0	0	0	0	100,000	-100,000
VF04 Reviews	0	160,000	-160,000	0	240,000	-240,000
VFRS nVCC FBC Reserves	0	140,276	-140,276	0	235,276	-235,276
nVCC Project Capital Total	**0**	**402,614**	**-402,614**	**0**	**1,528,059**	**-1,528,059**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**856,966**	**-856,966**	**0**	**3,761,725**	**-3,761,725**

7.19 The nVCC FBC was submitted to WG at the end of June 2024. Funding should be released upon the approval of the FBC. The Trust has recently submitted the updated FBC Management Case, which indicated that the Project Delivery costs required for 2024-25 is c£3.8m.

7.20 However, it should be noted that in the financial year 2023-24, the nVCC Project incurred additional costs of c£0.646m associated to achieving Financial Close. The additional costs relate to advisory support. These costs were funded by the EW Project, and it is imperative that this funding is re-provided for the EW Project in 2024-25. The funding needs to be confirmed with WG under separate cover.

Revenue

7.21 There is currently no revenue funding for the nVCC Project for 2024-25.

7.22 The revenue financial position for the nVCC Project for 31st July 2024 is shown below, reflecting a current overspend of £0.00m for the year.

nVCC Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0.009m	£0	£0.030m	-£0.030m
Total	**£0.009m**	**£0**	**£0.030m**	**-£0.030m**

7.23 There is a risk of an overspend of £0.030m for the revenue element of the nVCC Project this financial year. However, this will be offset the expected revenue underspend in the Enabling Works Project.

Whitchurch Hospital Site

7.24 There is currently no capital funding for the nVCC Project for 2024-25.

7.25 The Project's financial position for 31st July 2024 is shown below. This spend relates to legal fees associated with the Whitchurch Hospital Site. The forecast position reflects an expected overspend of £0.003m for this financial year.

Whitchurch Hospital Site Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0.003m	£0	£0.003m	-£0.003m
Total	**£0.003m**	**£0**	**£0.003m**	**-£0.003m**

7.26 To date there is no funding provided by WG for the Whitchurch Hospital Site, however at present the risk to the Programme is low. The associated costs will be reimbursed by WG.

Service Delivery and Transformation Project

7.27 The revenue funding for the Project for 2024-25 is £0.180m from NHS Commissioners' funding and £0.140m from Trust reserves. The resulting budget is £0.320m for this financial year.

7.28 There is no capital funding requirement for the Project in 2024-25.

7.29 The SDT Project revenue position for 2024-25 is shown below, with a forecast breakeven position for the year against a budget of £0.320m.

SDT Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.086m	£0.306m	£0.306m	£0
Non-Pay	£0.000m	£0.014m	£0.014m	£0
Total	**£0.086m**	**£0.320m**	**£0.320m**	**£0**

7.30 There are currently no financial risks associated with the Project for 2024-25.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 The main financial risk to the TCS Programme at present is the lack of funding for the capital projects. A funding request for the nVCC Project has been submitted to WG for c£3.8m and the EW Project funding request will be as part of the EW FBC Addendum.

9. TCS SPEND REPORT SUMMARY

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

9.2 Appendix 3 provides cumulative report to 31st March 2024. The report for the first quarter of 2024-25 will be published in the August 2024 finance report.

9.3 The cumulative report shows a total spend for the TCS Programme of £68.635m (£63.443m Capital, £5.192m Revenue). The total pay costs for this period were £15.239m.

9.4 The spend to 31st March 2024 for each Project within the Programme is summarised below.

Programme Management Office £2.187m
Project 1 Enabling Works £34.735m
Project 2a nVCC.....£26.221m
Project 2c Whitchurch Hospital Site £0.051m
Project 3a Integrated Radiotherapy Solution.....£0.1.049m
Project 3b Digital Strategy £0.200m
Project 4 Radiotherapy Satellite £0.393m
Project 5 SACT and Outreach £0.002m
Project 6 Service Delivery and Transformation £3.798m
Project 7 Decommissioning £0m

9.5 The spend to 31st March 2024 for each financial year is summarised below.

2014-15 .....£0.328m
2015-16 .....£2.398m
2016-17 .....£6.168m
2017-18 .....£3.909m
2018-19 .....£4.267m
2019-20 .....£2.928m
2020-21 .....£3.924m
2021-22 .....£6.429m
2022-23 .....£17.365m
2023-24 .....£20.918m

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

Construction Costs £19.842m
ASDA Works.....£6.660m
Competitive Dialogue £6.196m
Advanced Design and Works £6.016m
Project Control.....£5.198m

APPENDIX 1: TCS Programme Budget and Spend as at 31st July 2024

TCS Programme Budget & Spend 2024-25

CAPITAL	Year to Date Budget Jul-24 £	Year to Date Spend Jul-24 £	Year to Date Variance Jul-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC	0	112,443	-112,443	0	416,208	-416,208
Project 1b - Enabling Works FBC	0	78,682	-78,682	0	239,173	-239,173
Project 2d - New Velindre Cancer Centre FBC	0	328,866	-328,866	0	1,754,154	-1,754,154
Capital Pay Total	**0**	**519,991**	**-519,991**	**0**	**2,409,535**	**-2,409,535**
NON-PAY						
nVCC Project Delivery	0	13,043	-13,043	0	63,304	-63,304
Project 1b - Enabling Works FBC	0	2,209,704	-2,209,704	0	3,128,671	-3,128,671
Project 2c - Whitchurch Hospital Site	0	2,772	-2,772	0	2,772	-2,772
Project 2d - New Velindre Cancer Centre FBC	0	402,614	-402,614	0	1,528,059	-1,528,059
Capital Non-Pay Total	**0**	**2,628,134**	**-2,628,134**	**0**	**4,722,806**	**-4,722,806**
CAPITAL TOTAL	**0**	**3,148,125**	**-3,148,125**	**0**	**7,132,341**	**-7,132,341**

REVENUE	Year to Date Budget Jul-24 £	Year to Date Spend Jul-24 £	Year to Date Variance Jul-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Programme Management Office	95,574	94,518	1,056	316,500	316,440	60
Project 6 - Service Change Team	91,256	85,842	5,414	306,246	306,246	0
Revenue Pay Total	**186,830**	**180,359**	**6,470**	**622,746**	**622,686**	**60**
NON-PAY						
Enabling Works FBC	28,434	0	28,434	28,434	0	28,434
nVCC FBC	0	9,355	-9,355	0	30,000	-30,000
Programme Management Office	1,500	1,560	-60	1,500	1,560	-60
Project 6 - Service Change Team	3,532	259	3,273	13,754	13,754	0
Revenue Non-Pay Total	**33,466**	**11,173**	**22,292**	**43,687**	**45,314**	**-1,626**
REVENUE TOTAL	**220,296**	**191,533**	**28,763**	**666,434**	**668,000**	**-1,566**

APPENDIX 2: TCS Programme Funding for 2024-25

Description	Date	Funding Type	
		Capital	Revenue
Programme Management Office		**£0**	**£0.318m**
Commissioner's Funding	01 April 2024	£0	£0.240m
Trust Revenue Funding	01 April 2024	£0	£0.078m
Enabling Works FBC		**£0**	**£0.028m**
WG Funding - tbc	-	£0	£0
Escrow Bank Account Interest	04 June 2024	£0	£0.028m
New Velindre Cancer Centre FBC		**£0**	**£0**
WG Funding - tbc	-	£0	£0
Whitchurch Hospital Site		**£0**	**£0**
WG Funding - tbc	-	£0	£0
Radiotherapy Satellite Centre	**-**	**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
SACT and Outreach		**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
Service Delivery, Transformation and Transition		**£0**	**£0.320m**
Commissioner's Funding	01 April 2024	£0	£0.180m
Trust Revenue Funding	01 April 2024	£0	£0.140m
VCC Decommissioning		**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
Total		**£0**	**£0.667m**

APPENDIX 3: TCS Cumulative Spend Report to 31st March 2024

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2024

SPEND PER PROJECT PER YEAR

SPEND FOR EACH PROJECT ACROSS ALL YEARS

SPEND FOR EACH YEAR ACROSS ALL PROJECTS

TOTAL SPEND BY PROJECT TO DATE	£68,635,053
Programme Management Office	£2,186,915
Project 1 - Enabling Works	£34,734,803
Project 2 - nVCC	£26,220,533
Project 2c Whitchurch Hospital Site	£50,807
Project 3a - Integrarted Radiotherapy Solutions	£1,049,425
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£393,293
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,797,583
Project 7 - Decommissioning	-

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

1	Payroll	£15,238,592
2	Walters	£14,593,900
3	Sacyr	£6,009,453
4	Asda	£5,856,199
5	Mott MacDonald	£5,840,369

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

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

TRUST BOARD

NHS Staff Survey 2023

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	CLAIRE BUDGEN, HEAD OF ORGANISATIONAL DEVELOPMENT
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	The NHS Staff Survey 2023 reflects the views of staff in VUNHST and NHS Wales. The Trust had a higher response rate than the last survey in 2020 and showed a higher level of staff engagement than the NHS Wales average. However, there was a decline in experience between 2023 and 2020 on the majority of questions where comparison was possible. This data has been triangulated with other forms of staff feedback and now informs a range of development programmes for improving organisational culture and experience for staff.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** this report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29.8.24
Quality, Safety and Performance Committee	13.9.24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report was noted by EMB. QSP requested revisions to the action plan. Changes in response to the need for SMART actions are reflected in Appendix 1 with work being done in subsequent plans to move to outcome measures where possible.	

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

APPENDICES	
1	VUNHST Staff Survey Results 2023
2	Table of Actions and Progress Report

1. SITUATION

1.1 NHS Wales conducted a national staff survey in October 2023, the first since 2020. The Trust level results were received on 23 February 2024 followed by Divisional and demographic results in May 2024. The key findings at Trust level were shared with EMB on 18 March 2024. The themes were considered in light of a range of other staff feedback and considered at a Board Development Session on 23 July 2024. This paper summarises key findings, agreed actions and progress to date with those actions.

2. BACKGROUND

2.1 There has been an increased interest in measuring and understanding staff experience across NHS organisations in Wales over the past three years. This led to the previous NHS Staff Survey being expanded to encompass 10 themes, broadly in line with the staff survey used by NHS England since 2003.

2.2 Health Education and Improvement Wales (HEIW) coordinated the development and delivery of the survey on behalf of health organisations. There is a commitment to run this annually in future to allow the aggregation of results in the Trust and nationally over time. This will offer a rich source of information about the experience of staff as a basis for making improvements.

2.3 The NHS Staff Survey has been positioned in Velindre University NHS Trust as a positive tool for engaging with staff and building dialogue, leading to trust and stronger working relationships. It is seen as part of the work on developing a positive organisational culture in support of delivering Destination 2033.

3. ASSESSMENT

3.1 Key points that arise from the results are set out below.

- The Trust had a response rate of 34% compared with the NHS Wales response rate of 21%. This was also higher than the Trust response rate of 25% in 2020.

- The Trust Engagement Score of 76% was higher than the NHS Wales score of 73%. However, both these scores had decreased since 2020, when the Trust scored 78% and NHS Wales 75%.

- Compassionate culture was rated highly by staff, reflecting views about how we respond to patients, service users and colleagues in distress. However, the scores for compassionate leadership, how my line manager listens to my

problems and helps me overcome them, were lower.

- Burnout is hidden in the figures yet Burnout and Health and Safety Climate are the joint worst scoring sub-themes overall.

- Morale, which is the lowest scored theme, is a product of all the experiences at work and possibly outside of work. It measures work pressure and those thinking of leaving the organisation. Responses in this category will only improve through taking action across the other themes so that pressure is lower and staying with the Trust is a more appealing prospect.

- Responses to 'having time to reflect and learn' has been a positive change for the Trust.

- There is a generally worse experience being reported compared with the 2020 survey.

- A Trust-wide focus on staff retention is essential to help build a stable and motivated workforce, offering professional and career development where possible.

- There is a degree of unplanned work in the organisation which is being picked up in a variety of ways. Moreover, it is virtually as common as not to stay on at work even with no pay; this risks burnout and poor morale.

4. SUMMARY OF MATTERS FOR CONSIDERATION - TAKING THIS FORWARD

4.1 These results have been triangulated with a number of other forms of staff feedback:

Board interviews on values and culture 2022
CQC review of NHSBT report
Working Together Listening Exercise Feedback
Exit interviews themes
Health Inspectorate Wales Inspection Report, First Floor Ward, VCC July 2022
Values Survey
Analysis of sickness and leavers statistics
Retention Project engagement and feedback
Speaking up Safely Task and Finish group

The feedback can be summarised through three priorities within the People Strategy: Leadership, Healthy and Engaged Workforce.

Leadership

- Face to face contact is lost.
- No connection on Vision across the 3 Divisions.
- Working relationships strained at senior levels.
- Variability in strength of connection between senior leaders and staff in all roles at all levels.
- Values need to be seen in action.

Quotes from staff

The survey is difficult to complete - my immediate line manager is extremely supportive and respectful of me as a person and my professional abilities. However, senior managers with whom I interact frequently do not respect me, my department or my profession.

There is a disjoint between senior management and operational work. Most people on the shop floor don't know what the function of the senior management is, who they are, what they look like.

Management don't seem to care about our personal health and wellbeing at all.

Healthy Workforce

- Staff are tired or burnt out.
- Pace of change difficult – having to change whilst delivering higher volumes of work.

Quotes from staff

Demands on teams can sometimes be unrealistic and then over longer times turns into burnout.

I never get home on time! And as long as my work is done the organisation do not care what time you leave.

I feel like on the whole this department is a good place to work. However, short staffing levels and increased number of patients is making the workload unbearable and morale is low because people don't feel particularly valued in their role.

Team members are struggling like never before. Dedication is high, colleagues are 'on the edge' - doing more and more but are struggling. I really worry about what the future holds.

Engaged Workforce

- Face to face contact is lost.
- We need an organised and structured programme of engagement, which is visible and owned by staff.
- We need structured, regular evaluation of staff feedback, shared with staff with clear management response.
- Staff feedback shows that staff do not always feel that leadership is present.

Quotes from staff

People do not engage and provide feedback to the junior staff that need it to progress work. There is no team feeling, no care amongst colleagues, the fun of work and looking forward to going in has declined.

It is felt that staff are not valued trusted or listened to, there is never feedback or explanation, the atmosphere destroys morale and drive it just breaks people.

This used to be an amazing place to work where I felt truly appreciated and people cared about each other and we all worked well as a team. Sadly, I have not felt that in the last few years and in the last 12 months I feel it has got worse.

If our voices were being heard and we had the resources to put into our team, then we wouldn't be losing very experienced staff.

4.2 An integrated programme of work has been agreed at the Healthy and Engaged Steering Group as one that will support improvement of staff experience and therefore contributing towards improved Staff Survey scores in 2024.

Theme	**Action 2024 - 25**
Morale	Develop Retention Plan for all staff groups
Patient Safety	Build a data set measuring psychological safety and run Pulse Surveys Approve Incident Management Framework and Learning Framework
Staff Engagement	Develop a staff engagement framework
Compassionate and inclusive	Adopt Values and Behaviour Framework. Leaders to be visible and accessible. Training for staff to support the roll out of the values
Recognising contributing	Run the Employee Excellence Awards 2024
Able to Speak Up	Test and develop methods and feelings around Speaking Up
Stronger Together	Review resources for team development
Healthy Working Environment	Identify examples of long hours culture
Champion Flexible Working	Develop managers' understanding of flexible working and hybrid working
Continuously learning and improving	Review People Development Policy and PADR Policy.

The complete plan including progress as at 16 September 2024 is included as Appendix 2.

4.3 The staff survey results are assisting in the implementation of Our Vision for Equality, in the Strategic Equality Plan 2024 to 2028. This sets the context of work around Staff Survey results. It is in relation to this point that a Deep Dive analysis is taking place on the Bullying and Harassment data and comments from the 2023 survey in September to October 2024. This will lead to actions targeted at reducing the incidence of bullying and mitigating its impact.

4.4 It is noted that undertaking the survey has been hard work, for colleagues across Wales, VUNHST managers and everyone who participated and submitted their views. It is important that this initial investment of effort is not squandered and that we follow through with continued efforts for the 2024 survey and annual surveys thereafter.

4.5 There is a particular need to gain feedback from any groups in the workforce who may experience disadvantage so that actions can be targeted to create an inclusive workplace. For example, progress with our Anti Racist Action Plan, as measured through the Workforce Race Equality Standard, is dependent on paticipation from Black, Asian and minoritised ethnic staff.

4.6 Alongside the annual NHS Staff Survey, there is a commitment to running pulse surveys to measure aspects of working life, including perceptions of psychological safety. This is being developed through the work of the Corporate Quality Hub where expertise from all corporate functions is coming together with a focus on improving quality.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 - Organisational Culture

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☐ Effective ☒ Equitable ☒ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	This report sets out feedback from staff together with an outline plan of action. There is no difference in relation to Socio Economic status.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	A More Equal Wales – a society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This report sets out feedback from staff together with an outline plan of action. There is no difference in relation to protected characteristics.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

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6. RISKS

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

Theme	Action 2024-25	Measure	Cross reference	Lead	Progress as at 16.9.24
Morale	Develop Retention Plan for all staff groups	An agreed retention plan in place.	Retention Action Plan	Retention Lead	Draft Nurse Retention Action Plan accepted by EMB (25 June 2024) as 1st phase in Trustwide Staff Retention Plan
Patient Safety	Build a dataset based on NHS Staff Survey report showing psychological safety and run Pulse Surveys	Results are extracted, Pulse Surveys in place, results fed back to staff regularly	SCC Leadership Project	Head of OD	Initial discussion with Digital Lead has taken place. Next steps - plan sampling methodology, ideintfy questions for pulse surveys and publicise to staff by 31.10.24.
Patient Safety	Approve Incident Management Framework and Learning Framework	Frameworks approved and in place	Integrated Quality and Safety workplan	Head of Quality and Safety	Frameworks have been approved and are in place.
Staff Engagement	Develop an Employee Voice framework for staff engagement including, but not limited to, the Staff Survey results and Working Together outputs.	Employee Voice staff engagement framework approved and in place	OD Programme	Head of Communiciations	First draft of Employee Voice document available by end of October 2024 for discussion with staff. To be fully agreed by end December 2024.
Compassionate and Inclusive	Adopt Values and Behaviour Framework	Values and Behaviour Framework approved and in place	OD Programme	Head of OD	Values approved January 2024. Working Together staff briefing took place 22 July 2024. All People policies will be updated by the end of October 2024.
Compassionate and Inclusive	Leaders are visible and accessible in all work areas - from Executive level down to Team Leader	Staff feedback show people feel that leadership is present.	OD Programme	Executive Director of OD and Workforce	Compassionate Leadership Pledge adopted in September 2024. Leadership action plan to be delivered in support of Compassionate Leadership.
Compassionate and Inclusive	Briefings and training for all staff to support the roll out of Values, to include communication skills and speaking up when	Sessions are held through a range of mediums and times.	OD Programme	Head of OD	To be achieved through the development of an Employee Voice framework October - December 2024.
Compassionate and Inclusive	Implement Anti Racist Action plan	Anti-racist action plan is monitored and implemented.	Strategic Equality Plan action plan	ED&I Manager	WRES report received into the Trust and shared with EMB and QSP. Recommendations are being taken forward by the People and OD function with a team session on 3 October 2024. Undertake a Deep Dive into feedback on bullying and harassment, considering Staff Survey results and other forms of feedback held by the Trust (October 2024).
Recognising Contribution	Run the Employee Excellence Awards 2024	Event takes place, increased nominations from 2023	Wellbeing Action Plan	Head of OD	Task and Finish Group in place. Nominations closed with over 200 received (up from 2023). Event booked for 8 October 2024.
Able to Speak Up	Test and develop methods and feelings around Speaking Up	Improvement in Staff Survey ratings for Speaking Up	Healthy and Engaged Work Plan	Deputy Director of WOD	Communication programme pushing our messages on the imprtance of speaking up safely, updated Intranet page to explain the process to speaking up safely, IM Champion appointed, improved reporting on cases.
Stronger Together	Review resources for team development	Examples of where connections have been made between issues and resources have been shared to good effect.	SCC Leadership Project	Head of OD	Support for OD Commissioning Space confirmed at Education Steering Group on 25 June 2024. Next steps - set up and run as 6 month pilot.
Healthy Working Environment	Capture employees' expreince of long hours culture and issues which lead to burnout.	Case studies avaiable for EMB discussion.	Retention Action Plan	Retention Lead	Draft paper written detailing the key themes identified through staff stories and exit discussions for further refinement and discussion before submitting widely
Champion Flexible Working	Develop managers' understanding of flexible working and hybrid working	Improvement in Staff Survey ratings for Flexible Working	POD Workplan	Deputy Director of WOD	The Hybrid Working Toolkit has been developed with staff input and is avaiable to all on the intranent. This now needs to be reflected in Inspire and management development opportunities.
Continuously Learning and Improving	Approve People Development Policy and implement processes	6 month progress report after approval of Policy.	Education Strategy Audit	Head of OD	Policy to be approved at Trust Board 26.9.24. Digital forms and refreshed training will be in place by 31.12.24.
Continuously Learning and Improving	Review and approve PADR policy and processes	6 month progress report after approval of Policy.	Education Strategy Audit	Head of OD	Policy to be approved at Trust Board 26.9.24. Digital forms and refreshed training will be in place by 31.12.24.

2024-25 is where we are putting in the foundations for positive employee expereince.

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TRUST BOARD

Communications and Engagement Annual Report

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	JON ELLIS, INTERIM HEAD OF COMMUNICATIONS LISA MILLER, HEAD OF PATIENT ENGAGEMENT ANDREW HARRIS, INTERIM HEAD OF DONOR ENGAGEMENT
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	The Communications and Engagement Annual Report (Appendix 1) provides the Trust Board with a summary of the key activities delivered by the Communications and Engagement team over the past twelve months.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the Communications and Engagement Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	**04/09/24**
Quality, Safety and Performance Committee	**12/09/24**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Quality, Safety and Performance Committee endorsed the Communications and Engagement Annual Report on 12 September 2024.	

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

APPENDICES	
Appendix 1	Communications and Engagement Annual Report

1. SITUATION

Effective communications and engagement support is key to the successful delivery of the Trust's work. Our communications and engagement activities must aim to be purposeful, effective, and accessible with the needs of our audiences and stakeholders at the heart of everything we do.

This document provides the Trust Board with a summary of some, not all, of the activities delivered over the past twelve months to support the Trust's communications and engagement with:

- staff,
- donors,
- patients and their carers,
- volunteers,
- the community local to the Velindre Cancer Centre in Whitchurch,
- and the wider public.

2. BACKGROUND

It was agreed that a Communications and Engagement Annual Report should be complied as part of the Trust's annual reporting cycle.

3. ASSESSMENT

The Communications and Engagement Annual Report, available as Appendix 1, summarises some of the key activities the Trust has undertaken over the past twelve months, including:

1. how we have supported the process of bringing our vision, purpose, and values to life,
2. communications and engagement with our stakeholders, and
3. supporting our Armed Forces.

As a team, we would like to thank all our colleagues across the Trust who have supported us during the reporting period to deliver high-quality, purpose driven communications and engagement. We recognise that without their support, this would not be possible.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board to **APPROVE** the Communications and Engagement Annual Report.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report directly support the achievement of the Trust's strategic goals:

YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	02 - Partnerhips Working / Stakeholder Engagement
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☒ The Communications team across the Trust has a key role in supporting clinical colleagues to deliver safe services, sharing relevant messages and updates on current service delivery. The Patient Engagement team plays a key role in supporting the organisation to deliver equitable and patient centred services via engagement with the Patient Cared Partnership Board and the Velindre Voices forum.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result An EQIA was undertaken in support of the Patient Engagement Strategy and implementation plan.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Wales of Cohesive Communities - Attractive, viable, safe and well-connected communities. If more than one Well-being Goal applies please list below: All goals.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Choose an item
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
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Communications and Engagement Annual Report 2023-24

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Foreword

I am proud to present this 2023/24 annual report which showcases some of the ways in which the Trust's Communications and Engagement teams have supported the Trust's work over the past 12 months.

The past year has been a busy one for the Trust. We launched our new ten-year strategy, *Destination 2033* and four enabling strategies to help us realise our ambitions across digital, workforce, sustainability, and estates. We also developed a new set of organisational values that were created in partnership with staff, service users and partners to help guide our behaviours as Velindre employees.

We have achieved a great deal in a short space of time and the communications and engagement team have been beside us every step of the way, ensuring our stakeholders' voices are heard and helping to share our stories with all who are interested.

The team has also demonstrated an admirable commitment to professional development, with a number going through the Trust's very own leadership and development programme, *Inspire.*

While much has happened in the past 12 months, the next year promises to be just as exciting for the Trust. I look forward to seeing the quality of our communications content and engagement work improve further, focused on the needs of our internal and external audiences, especially our staff, patients and donors.

Lauren Fear
Director of Corporate Governance and Chief of Staff

Bringing our vision, purpose, and values to life...

Our communications and engagement activity is always aligned with the Trust's purpose, vision and values as we strive to support the organisation on its journey to *Destination 2033*.

Every opportunity is strategically assessed to ensure our activity contributes to the Trust's ambitions.

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Ein pwrpas:
Gwella bywydau

Our purpose:
To improve lives

Ein gweledigaeth:
Gofal ardderchog, dysgu ysbrydoledig, pobl iachach

Our vision:
Excellent care, inspirational learning, healthier people

Ein gwerthoedd:
Gofalgar, parchus, atebol

Our values:
Caring, respectful, accountable

Internal communications and engagement

Informing, involving, improving and celebrating

This year has seen us deliver a step change to the way we inform and celebrate our collective engagement. A new focus on improving systems to capture information, greater collaboration with our management teams to recognise their information needs, and understanding what it means to work in our organisation today have been priorities for the year.

We have achieved this by:

1. Supporting the launch of our organisational strategy

In 2023, the Trust launched its strategy: Destination 2033. The new strategy supports the Trust to deliver excellent care, provide inspirational learning and contribute towards making people healthier. The communications and engagement team were involved from the outset, delivering a comprehensive suite of staff and external stakeholder engagement to ensure the contents of the strategy was informed by our staff, our service users, and our partners.

2. Discussing, agreeing and launching our new values

Following a comprehensive period of engagement to understand the values that resonated most with our staff and service users, the communications team supported the launch of a new set of values that capture what is important to us and how we should all behave.

Caring – We are always kind, supportive, approachable and show compassion to all.

Respectful – We seek to understand other people's perspectives. We are always open and transparent.

Accountable – We always take personal responsibility for what we do and how we do it.

3. Celebrating Excellence

The Velindre Employee Excellence awards were a great success, with a record 183 nominations received across the defined categories – double the number of nominations received the previous year. The communications team ran an extensive campaign to encourage nominations by showcasing previous award winners and driving traffic to bespoke intranet pages designed for the occasion. In total, the Employee Excellence pages of the intranet received more than 4,250 views in the three months prior to and after the awards event.

4. The Trust's Wall of Thanks

2023 saw the launch of the Trust's Wall of Thanks, an internal platform to showcase the positive feedback received on a daily basis from our service users. The dedicated Wall of Thanks area of the intranet quickly became a popular destination for sharing uplifting words of gratitude received from patients and donors, with more than 2,500 views during the year. In total, 113 positive comments and compliments were received and shared relating to Velindre Cancer Centre, and 90 relating to the Welsh Blood Service.

5. Informing each other

During the year, we sent weekly newsletters to every member of staff to update them on activity across the Trust. In addition, the Welsh Blood Service and Velindre Cancer Centre sent bespoke weekly newsletters to their employees each week to provide a more localised update for staff at each of our services. We have consolidated systems that empower staff to inform us about their news with a total of 266 notifications received over the 12 months!

6. Working Together to Build our Future

Everyone should feel safe and have the opportunity to thrive at work.

That's why, in the autumn of 2023, we launched the Working Together initiative, bringing Trust staff together to focus on a series of wide-ranging questions in face-to-face and virtual sessions. We wanted to better understand what it feels like to work for the Trust today and find ways of improving the way we connect and support each other in delivering for our patients and donors.

We talked about:

- how can we create safe, accessible, honest opportunities to discuss the things you and/or your teams find challenging at work?
- how do you feel about what's achievable for us as a Trust in the future and how we check in with each other to review the position regularly
- how do you think we can maintain the conversation and engagement between us all in a way that helps build trust within our organisation.

Gweithio Gyda'n Gilydd
Working Together

Chaired by either the Executive Director of Workforce and Organisational Development or the Director of Corporate Services and Chief of Staff, the activities were designed and supported by the Working Together Steering Group which included representatives from the Trust's services. The initiative was developed in a way that is aligned with and complementary to other staff wellbeing and engagement initiatives such as Speaking Up Safely, Staff Values and NHS Wales Staff Survey. Informal feedback was shared regularly with the Executive Board and the Extended Leadership Group.

13 sessions were held from mid-September until the end of December. 423 members of staff attended the sessions in total. 29 attended face to face sessions, 394 attended virtual sessions. A new framework to govern the development of our internal engagement is in development, informed by the findings of the Working Together sessions.

7. Getting involved with the new Velindre Cancer Centre project

Un Peth Bach

Un Peth Bach (Just One Thing) was designed to break down some of the key topics of interest in relation to the new Velindre Cancer Centre into manageable bitesize chunks, supported by weekly online polls and pop-up engagement sessions. Ten topics, 144 poll responses and 350 staff interactions ensured that staff voices were heard loud and clear.

Staff design sessions

Creating space for staff to review, feedback and influence the design of the new Velindre Cancer Centre was fundamental to ensuring that the new building meets the needs of staff. A series of workshops and drop-in sessions enabled teams to closely review floorplans and make suggestions for improvements. The plans were updated and refined based on this input, with an ongoing cycle of engagement.

8. Bringing volunteers back to Velindre Cancer Service

A key priority for the 2023/2024 was the reintroduction of volunteers into Velindre Cancer Centre (VCC), in line with our practices pre-COVID.

The Trust recognises the unique and important contribution volunteers make in complementing the services it provides, and a new framework has been developed to ensure volunteers are recruited, trained and supported in a safe and inclusive way.

A user friendly recruitment and role development process, along with a bespoke training programme are now in place, delivered in partnership with our teams at the cancer centre. Recruitment commenced during the reporting period with volunteers scheduled to return to VCC during June 2024.

The Trust was awarded a grant by the Wales Council for Voluntary Action (WCVA) which supports its ambitious plan for volunteer services. This will allow us to measure the social value from volunteering activities and the impact upon the volunteers themselves.

Data: 1 June 2023 - 31 May 2024

A summary of our year in **numbers**

1) Social media

274 posts	**231** posts	**86** posts
1,599 comments	**1,865** mentions	**715** mentions
16,563 reactions	**2,036** likes	**273** likes
2,804 shares	**610** retweets	**96** retweets
55,013 engaged users	**6,789** engagements	**1,446** engagements
5.75% engagement rate	**2.44%** engagement rate	**2.55%** engagement rate
876 net new followers	**145** net new followers	**272** net new followers
2,097,140 impressions	**347,230** impressions	**56,307** impressions

Popular posts

2) Website

Top website page views

52,009 Velindre Cancer Centre

13,856 Working for the Trust

9,519 Trust vacancies

285,000 website views

77,766 users

97 secs avg session time

55 news articles

Top 5 common themes
- Awards/accreditations
- Clinical trials/research
- Launches
- Corporate updates
- WBS campaigns

3) Intranet news and publishing

692 news items (posts and links)	**768** news items (posts and links)
29 staff trained to edit intranet	**28** staff trained to edit intranet
52 staff newsletters	**52** staff newsletters

266 **News Capture Forms completed** by staff from across the Trust.

External Communications and Engagement

Sharing our work with our communities of interest

Better systems supporting the capture of our news and achievements has in turn allowed us to focus on sharing those with a wider range of stakeholders – particularly patients, donors, supporters, media and the wider public. The remainder of this document provides insight on some, and far from all of the campaigns and opportunities on which we have collaborated with internal and external partners over the past 12 months.

1. Shining a light on awareness days

Awareness days provide an opportunity to focus on the different services we provide as a Trust. These days give us an opportunity to hear from experts across the organisation who are able to explain how their teams support our patients and donors.

- Acute Oncology Services awareness week – developed a suite of filmed content to help raise awareness of the importance of acute oncology services.
- World Cancer Day – delivered a comprehensive suite of social media content to showcase some of the faces behind cancer care at Velindre. Three days of social media activity generated 1,300 positive engagements. On the same day, Welsh Blood Service (WBS) promoted the new age range for bone marrow donors changing to 16-45, the campaign was supported by Emma Capps in the USA, after she received a lifesaving donation from a stem cell donor living in Wales.

- National Cancer Clinical Nurse Specialist (CNS) day – filmed interviews with four clinical nurse specialists discussing the contribution their roles make to our patients.

- National Healthcare Estates and Facilities Day - produced filmed content for internal and external platforms to celebrate the non-clinical roles across our services that help ensure patients, donors and staff can receive and deliver care in safe and pleasant environments
- World Blood Donor Day – in June 2023, WBS featured twins Frankie and Jax. Their mother Jodie shared the story of complications during and after pregnancy resulting in the need for blood for baby Jax. Both boys have now fully recovered. The post reached 444,636 accounts.

- World Bone Marrow Donor Day – in September 2023, the WBS promoted the story of Kirstie and Taisha. After a search of over 40 million volunteer bone marrow donors from Registries across the world, fifteen-year-old patient Taisha Taylor found an incredibly rare match just 30-minutes' drive from her home.

2. Supporting our nurses

Velindre University NHS Trust's second nursing conference took place in May this year, aligned with International Day of the Nurse. The event, which took place in the Cardiff City Stadium, brought together registered nurses, health care support workers and Clinic Collection Assistants (CCAs) from across the Trust to celebrate past successes and get excited about future achievements. To support the event, the communications team ran a series of promotional activity across internal channels to generate interest in the event, resulting in 130 attendees on the day – up from 105 the previous year.

The team provided comprehensive communications support at the event, including vox pop filming and post-event content not only to celebrate but also to enable those unable to attend because of their working commitments to learn and share what was a fabulous occasion.

3. Showcasing research

In 2023 the Trust employed its first ever communications officer dedicated to promoting research and innovation across the organisation. During the year, our team produced multiple packages of content to promote high-profile clinical trials and research activities, including:

- ARISTOCRAT – BBC coverage secured to announce the recruitment of the first patient in Wales onto the ARISTOCRAT clinical trial, a trial which explores whether a cannabis-based oral spray can help patients with brain cancer.
- FAKTION – content produced to promote a clinical study to investigate if we could safely combine standard hormone therapy with AstraZeneca's AKT inhibitor capivasertib to improve patient outcomes. In December 2023, the USA's Federal Drug Agency (FDA) announced it will license the treatment for use in patients with ER positive, HER2 negative advanced breast cancer.

4. Explaining our Nantgarw Support Unit

Our Nantgarw Support Unit is a valuable service that delivers anti-cancer medication in a light, warm and friendly setting away from the Cancer Centre. By delivering medication from the unit we have been able to increase the number of patients we treat each week, while offering patients the opportunity to receive their care in a safe and convenient setting. The communications team supported the pharmacy team by developing a suite of content, including a flyer and an explainer video, to promote the Support Unit and showcase its features to patients who may not be familiar with the facility.

5. Supporting high-profile media productions: Rhod Gilbert: A Pain in the Neck

Rhod Gilbert: A Pain in the Neck was an intimate and inspiring documentary that followed Velindre Patron, Rhod Gilbert, through an emotional 18 months as he confronted his illness. Much of the documentary was filmed at Velindre Cancer Centre and the communications team worked closely with the production company to support filming activity across the site. The documentary was broadcast in late 2023 as part of Channel 4's Stand up to Cancer campaign.

6. Building the new Velindre Cancer Centre

In March, the Trust announced that the final agreement has been reached between the Trust and Acorn consortium to design, build and maintain the new Velindre Cancer Centre (nVCC). The announcement was a key milestone in the nVCC project and the communications team worked closely with the Acorn consortium to produce an announcement pack that was shared with all local and wider stakeholders.

7. Celebrating 75 years of the National Health Service

In July 2023, the NHS celebrated turning 75. A Trust wide campaign included Welsh Blood Service content aimed at encouraging blood donors to 'give before they go' on holiday. The campaign was supported by the launch of the new JD Cymru Leagues and Adran Leagues season and continued to promote sign-ups to the Welsh Bone Marrow registry. The campaign reached a total of 200,586 accounts across social media.

8. Promoting changes to tissue and cell donation in Wales

In September 2023, as part of a four-nation agreement, the Welsh Government announced that restrictions preventing some LGBTQ+ people from donating tissue, surgical bone and stem cells will be lifted in Wales. Following a review by the FAIR (For the Assessment of Individualised Risk) steering group, a UK-wide collaboration including representatives from all UK blood services, medical, scientific and academic experts, LGBTQ+ groups, as well as a selection of patients, donors and their families. Working closely with the Welsh Government, the NHS Blood and Transplant teams and other organisations involved with donation and transplant, during the reporting period, the Welsh Blood Service worked together to change the eligibility questions asked during the tissue and cell donation process and further promote the introduction of fairer eligibility criteria to tissue and cell donation.

External engagement

1. Delivering our patient engagement strategy

During 2023, the patient engagement team has focussed on developing improved working relationships with patients, carers and the public. This led to the development and implementation of Velindre Voices, and the development of strategic and operational relationships with external stakeholders including Llais, cancer charities, third sector organisations and national organisations such as the Wales Council for Voluntary Action (WCVA), Genomics Partnership Wales and many more.

Within the organisation, collaborative discussions between Velindre Cancer Centre, Welsh Blood Service (WBS) and Velindre Cancer Charity identified opportunities to define clear pathways to enable long-term engagement with donors and patients. The result is the development of the Umbrella of Giving shown below. The Umbrella of Giving identifies clear pathways that an individual can choose to navigate depending on how they wish to engage with any or all the areas within the Trust. It allows flexibility and variety for the individual, whilst also bringing the main service areas within the Trust together to offer opportunities, with the main hope that no-one should feel unable to engage with us in whatever way suits them.

2. Velindre Voices

Velindre Voices provides an opportunity for anyone, whether they are current or past patients, their loved ones, carers, members of the public and local community, to register on a digital platform to become a member of our engagement community. We have recruited over 200 people to the forum.

During 2023/24, members of Velindre Voices:

- Attend focus groups and sit on panels
- Share their personal stories
- Highlight and become involved in service improvement
- Review business cases/proposals
- Help influence our work on the new Velindre Cancer Centre

3. Giving voice to patient views

Below are two examples of how we have delivered workshops to support our colleagues with their ambition to give voice and influence to patients' views.

Next: Health Technology Wales Focus Group exploring the use of AI in a cancer diagnosis

Brief: To capture the honest reactions of patients, family members and carers in response to two proposed uses of Artificial Intelligence in a cancer diagnosis

Target Audience:
1. Service users of Velindre Cancer Centre (past and present)
2. Family members of VCC service users (past and present)
3. Carers of VCC service users (past and present)

Delivery:
Two focus groups have been organised, one online and one in person with approx. 30 participants.

Output:
The findings will be included in Health Technology Wales' final proposal to Welsh Government about the potential use of AI in cancer care.

4. Reviewing and revitalising the Patient and Carer Partnership Board

One of the key priorities in the Trust's Patient Engagement Strategy was strengthening the provision for patients and carers' voices to influence the Trust's work, building on the work of the Patient Liaison Group (PLG) established in 2004.

During the latter half of 2023, co-productive conversations took place with the members to redefine the name, purpose, role and recruitment process for the group.

This led to the development of a new Patient and Carer Partnership Board (PCPB), approved by Executive Board in February 2024. Recruitment for the new Board is scheduled for quarter one of 2024. The Board's work will be supported by the output of the Listening Post initiative, designed to ensure members of the Board are able to gather and represent the views from a wider group of patient and carers.

5. Consolidating and developing our work with children and young people

The Trust is proud of the work it does to support and give voice to children and young people affected and inspired by the work that we do. During the reporting period, we continued to undertake key activities with children and young people, including:

Young Ambassadors

The Trust has a Young Ambassadors scheme that originated via those raising funds for Velindre Fundraising. The cost of living crisis meant that the ability for some Young Ambassadors, their families, communities and schools to raise funds became more difficult. It has been important to redefine the support programme for Young Ambassadors in this context, which has led to more visits to the centre, greater interaction with patients and support for school activities such as discussing specific topics with School Councils and Assemblies.

Welsh Joint Education Committee (WJEC) Victory for Velindre Skills Challenge

Since 2021 the Trust has offered an Enterprise and Employability Challenge – the Victory for Velindre Challenge available as part of the Welsh Baccalaureate.

To support a range of communities, and recognising the cost of living crisis, this challenge was expanded during 2023 to offer both fundraising and non-fundraising options. The 2023/24 challenge was to Create a Product or Service that Positively impacts Velindre Cancer Centre or the Trust Charity.

The annual challenge was hugely successful with many brilliant and innovative ideas being generated by the young people involved, including:

Canolfan Ganser Felindre
Velindre Cancer Centre

Not for profit Model ideas:

Virtual Reality Headsets for patients who are unable to leave hospital but want to experience a change of scenery.

An app that can keep patients entertained during waiting rooms through a variety of games/activities.

A positivity wall where patients can leave quotes and words of encouragement for other patients.

A walking group or other activity that encourages patients to meet others and talk about their feelings.

Well being boxes that can be picked up by patients who are feeling low. Can contain something to boost their mood.

A product that supports young children when their loved one is receiving treatment.

A series of head scarfs or hats to boost the confidence and comfort of chemotherapy patients who experience hair loss.

Art or music activities that help patients express their feelings in a creative way.

Charity Model ideas:

An item to sell:

Branded merchandise that can be sold by Velindre charity such as water bottles, clothing or medals etc.

Cakes, ice lollies, badges, smoothies, knitted items, raffle tickets for prizes, jewellery, key rings, confectionary.

Activity stall that charges per go, eg: pie the teacher, hook a duck, tin can alley and other popular fair ground games.

A hosted event:

A charity sports match that can take place at the school.

A seasonal fair that offers crafts related to the time of year, eg: Christmas, Easter, Summer etc.

A fun run or sponsored walk that can include staff, students and families.

An end of year/term event for lower year groups such as a disco or fun day.

A sponsored challenge:

A sponsored fitness challenge which could be a walk, run, bike ride, football keep it up challenge etc.

A world record attempt.

A fundraising target focussed activity such as, Mr Evans will shave his head if we raise £500.

A group challenge like a walk-a-thon or sponsored silence.

Building on this work, a key objective for the Trust is the development of a new Youth Engagement Strategy. Initial scoping work has been undertaken to map the current relevant activities across the Trust. Our objective is to ensure that the Trust meets its obligations under the Wellbeing of Future Generations Act, and the United Nations Convention on the Rights of the Child, with clarity, consistency and creativity putting the safety and wellbeing of children and young people at the heart of everything we do.

6. Co-production and the New Velindre Cancer Centre

Over the past 12 months, we have supported many opportunities for the public to find out more and get involved with the new Velindre Cancer Centre project.

Children and Young People Workshops

In November and December 2023 the patient engagement and nVCC engagement teams undertook a number of engagement events with young people to seek their views on designs and facilities for the new Cancer Centre.

We visited a number of schools and hosted workshops to ensure the views of those with specific needs were captured. Involving experts by experience added rich and vibrant feedback, including the team at LATCH and the Teenage Cancer Trust Youth Forum.

Below are some examples of their feedback.

Inclusive Design Workshop and the New Velindre Cancer Centre

In September 2023, the patient engagement and nVCC engagement teams hosted an Inclusive Design workshop. Representatives from Wales Council for the Blind, British Deaf Association, Cardiff Learning Disability Team, Teenage Cancer Trust, Llais and Trust Ambassadors attended actively providing feedback on the current design and their requirements.

Hefyd work programme

Hefyd is the Trust's community value and benefits initiative. As a programme of work, Hefyd includes a series of activities supporting the Trust's arts, green social prescribing, sustainability agenda and community engagement. One of the key activities are regular Jamboris hosted on the site of Velindre Cancer Centre during school holidays for children and local families. These sessions not only improve relationships within the community but also enable the team to share key messaging about the new centre project and opportunities to get involved in an accessible, engaging and entertaining way. Hosted in the Velindre Roundhouse, which was built by a team of volunteers taking part in our green woodworking course, each Jambori will continue to provide free family fun in the fresh air!

Supporting our Armed Forces

EMPLOYER RECOGNITION SCHEME
CYNLLUN CYDNABOD CYFLOGWYR

GOLD AWARD 2023
GWOBR AUR 2023

Proudly Supporting those who serve.
Falch o gefnogi'r rhai sy'n gwasanaethu.

During the reporting period, the Trust was successful in achieving the prestigious Gold Defence Employer Award which recognises its support and advocacy for the Armed Forces and its members.

The Trust continued to foster its relationship with 203 (Welsh) Field Hospitals through the development of a formal Memorandum of Understanding (MoU) which describes the wider collaborative opportunities between us, including employment opportunities, training, education and research opportunities. Velindre Cancer Centre also provided a clinical space for blood tests to be taken pre-deployment.

Recognising the importance of attracting future employees, the Trust introduced the Royal College of Nursing (RCN) Prince of Wales Cadet Scheme which provides nursing cadets structured placements at VCC and the Welsh Blood Service (WBS). This scheme is run in conjunction with all cadet forces. The scheme aims to develop and prepare young people (16-25) for life and to support them towards employment in nursing.

To further progress its commitment to providing employment opportunities the Trust has joined the Career Transition Partnership and are committed to implementing a guaranteed interview process for those that meet essential skills criteria.

In June 2023, Armed Forces Week and Day were actively celebrated across the Trust with a range of events highlighting the work of the Armed Forces, providing leadership exercises for staff and actively promoting stories of its staff who have served in the Armed Forces and Reservists. Armistice Day was observed and supported across the Trust again this year.

Useful links

Destination 2033

Digital and Data Strategy

Estates Strategy

People Strategy

Sustainability Strategy

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

Velindre University NHS Trust

Communications and Engagement Annual Report 2023-24

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

Clinical & Scientific Strategy

DATE OF MEETING	26/09/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Nicola Wiliams, Executive Director Nursing, AHP & Health Science
PRESENTED BY	Nicola Wiliams, Executive Director Nursing, AHP & Health Science & Jacinta Abraham, Executive Medical Director
APPROVED BY	Nicola Wiliams, Executive Director Nursing, AHP & Health Science & Jacinta Abraham, Executive Medical Director

EXECUTIVE SUMMARY	The Trusts first Clinical and Scientific Strategy has been developed with full engagement and consultation with over 850 internal and external stakeholders resulting in the collation and analysis of over 1000 pieces of information. The strategy's vision is 'Be at the forefront of clinical science delivering excellent, high-quality, person-centred care' and has four strategic aims: • Strengthen clinical and scientific leadership and collaboration to drive the clinical and scientific agenda • Deliver high quality evidence-based, person-centred care to improve experience & outcomes. • Drive clinical & scientific advancements through innovation, research, & development. • Adapt, develop and empower a sustainable, diverse multi-professional clinical and scientific workforce.

RECOMMENDATION / ACTIONS	Trust Board is asked to ***APPROVE*** the Trusts Clinical and Scientific Strategy.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Clinical & Scientific Strategy Board – Consulted on through development process and endorsed final version	2023 / 2024
Executive Management Board Shape – Consulted on through development process and final draft brought to July meeting – no final feedback received Endorsed for onward approval pending one minor amendment- subsequently made	2023 / 2024 12/08/2024
Strategic Development Committee – Endorsed for onward approval. Identified the need for a clear process in respect of how prioritised developments become embedded in the IMTP process.	13/09/2024

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

APPENDICES	
1.	Clinical & Scientific Strategy
2.	Quality Impact Assessment

1. BACKGROUND

The Clinical & Scientific Strategy has been developed to ensure that the Trust is, and continues to be, clinically and scientifically driven with robust mechanism for horizon scanning and the clinical and scientific requirements driving prioritisation and IMTP development. The strategy outlines the key clinical and scientific priorities for the next five years. Delivery against the strategy will be monitored through the Clinical and Scientific Board and reported through to the Trust Board.

2. ASSESSMENT

Since October 2023 extensive work has been undertaken to develop the Trusts first Clinical and Scientific Strategy (attached in ***Appendix 1***).

A multi-faceted approach has been used to engage with over 850 stakeholders (including staff) using questionnaires, listening workshops, engagement events and by attending meetings and forums. Throughout the engagement process over 1000 pieces of information have been collated and some common themes have emerged:

- The strategy should be ambitious and aspirational but also needs to be realistic and achievable. Whilst new programmes and initiatives are welcomed over 30% of stakeholders highlighted the need to 'focus on the basics' and ensure the delivery of more effective, efficient, and sustainable core services.
- The strategy needs to clearly articulate the Trusts clinical and scientific direction and act an effective enabler to support delivery of operational plans as well as the overarching Trust strategy.
- The aims and objectives within the strategy need to reflect the priorities identified by our stakeholders and the language used should be clear and easy for everyone to understand.

This information has been considered alongside the feedback generated from the multi-professional engagement sessions that were held in May, where members of the multi-professional teams from both divisions had the opportunity to review the draft strategy and provide feedback that has been used to refine the final version of the draft strategy.

The strategy has been endorsed through the Trust governance including the divisional senior leadership Teams.

Once approved a robust delivery plan will need to be developed to ensure that the strategy aims and objectives are met.

Llais have been supporting the strategy development.

A key output from the Strategy and Clinical and Scientific Strategy Board is to clinically and scientifically frame future IMTP development and prioritisation. The process for this is being worked through by the Interim Director of Strategic Transformation, Planning and Digital and will be included in a future Board strategic planning paper.

3. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Quality Impact Assessment is attached (***appendix 2***).
SOCIO-ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies, please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies, please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There may be financial implications as the strategy is implemented these will need to be incorporated within the IMTP planning process.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Approved by the Trust Equality Team.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	There are risks of not having this strategy in place. Positive impact only in respect of the strategy and will overall have a risk reducing impact.
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	
All risks must be evidenced and consistent with those recorded in Datix.	

Final Version 13.08.2024

Velindre University NHS Trust Clinical & Scientific Strategy (2025-2030)

FINAL DRAFT

Welcome to our Clinical & Scientific Strategy

Velindre University NHS Trust strives to be at the forefront of research, development, and innovation by delivering transformational change across its specialist cancer, blood, and transplant services. Our principal aim is to ensure the delivery of high quality, safe and effective, person-centered care and to provide services that are scientifically based and clinically led as we drive forward improvements in quality, safety and patient and donor experience.

To achieve this, we must work collaboratively within and across our divisions and in partnership with health boards, academic institutions, and industry, building on our strengths and achievements as a regional specialist tertiary center for oncology and as a specialist national blood service that supports transplantation services. We recognise the need to learn from lived experiences and address those areas that require improvement, maximising opportunities to work differently and harnessing research, development, and innovation, whilst creating more resilient, responsive, and sustainable services that will meet the needs of our population.

Strong clinical and scientific leadership and governance is critically important. At the cornerstone of our services is the expertise of our highly specialist dedicated clinical and scientific workforce who deliver the very best care for our patients and donors, ensuring that the quality and ongoing development of our services remains at the forefront of our decision-making.

Velindre is a highly specialised, unique organisation within the Welsh healthcare system, with the scientific and clinical expertise and skills to drive research and innovation, implement and disseminate evidence-based innovations and new technologies on an All-Wales basis and advance the delivery of patient and donor care.

In 2023 we launched the Trusts overarching strategy “Destination 2033”, which supported by the Velindre Cancer Strategy (2016-2026) and the Welsh Blood strategy “Blood and Transplantation Services for the future” (2023-2028), sets out the organisations vision, strategic aims, and objectives which includes delivering several highly complex transformation programmes. As part of a suite of enabling strategies, the Clinical and Scientific Strategy supports the delivery of our divisional and Trust strategies, by setting the clinical and scientific direction for our services over the next 5 years. Through horizon scanning we understand the emerging trends, new innovations, developments, drugs, and technologies, which have the potential to transform care and improve outcomes and experience for our patients and donors. This insight has been used to inform our clinical and scientific strategy and will ensure that the organisation keeps abreast of new research and developments and can prepare for the future delivery of innovative new service models, treatments, and technologies.

The strategy was written by and for our clinical and scientific workforce. We adopted a multi-faceted approach to engage with our clinical and scientific communities, partners, and stakeholders, calling on their wealth of knowledge, expertise, and forward-thinking ideas to inform our shared vision, ambitious strategic aims, and objectives.

In recognition of the fast pace at which the healthcare landscape is changing Velindre University NHS Trust is committed to staying ahead of the curve, delivering cutting edge new and innovative care and being able to respond to increasing demands upon our clinical and scientific services. As the landscape is rapidly changing this is a 5-year strategy which will regularly be reviewed to ensure that we remain aligned with the regional and national context and can continue to respond to meet the changing needs of our workforce and the population.

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Why do we have a Clinical & Scientific Strategy?

Advances in science and technology are developing at pace and we recognise the need to keep abreast of new developments and innovations so we can deliver the very best care, experience, and outcomes for all our patients and donors. We therefore need a mechanism through which we can drive the Clinical and Scientific agenda and inform prioritisation and decision making.

This strategy will strengthen our position as a Trust and articulate the role that we will play as an organisation within the regional and national context and through horizon scanning, clearly articulate the clinical and scientific strategic direction for the organisation over the next 5 years, which will inform the development and evolution of our clinical and scientific services.

Our Clinical and Scientific Strategy will:

- Promote our shared vision & strategic aims over the next 5 years based on our priorities
- Reinforce our role as system leaders
- Deliver data driven, evidence-based, clinically led care that is outcome focused
- Inform strategic planning & operational delivery
- Inform the evolution of our clinical & scientific services.
- Through Horizon Scanning ensure the Trust keeps abreast of new research & developments.
- Strengthen clinical & scientific leadership & empower the workforce
- Drive the clinical & scientific agenda, innovation & transformational change

Our Drivers & Challenges

Our Clinical and Scientific Strategy has been developed within the context of key local and national drivers, and current and predicted challenges. Like other NHS providers the organisation is facing several key challenges, some of which are particularly relevant to Velindre University NHS Trust. The local and national drivers and challenges were at the forefront of developing the strategy and setting our strategic aims.

Local Drivers

- Trust strategy '*Destination 2033', Velindre Cancer & Welsh Blood Strategies*
- Patient and donor experience & outcomes
- Demographic changes & population need.
- Increasing demand and complexity.
- Patients living longer with Cancer.
- Priorities of commissioning Health Boards
- Need to reduce variation, inequity & inequalities.
- Fast paced developments in cancer treatments and options for care delivery
- New advances in science & technology

National Drivers

- A Healthier Wales (2018)
- Well-Being of Future Generations Act (2015)
- Health and Social Care (Quality and Engagement (Wales) Act (2020)
- National Clinical Framework (2021)
- Quality Statement for Cancer (2022)
- Cancer Improvement Plan for Wales (2023-2026)
- National Blood Health Plan (2017 & 2024)
- Value based & prudent healthcare.

Challenges

- Deliver sustainable & responsive services
- Limited resources
- Keep abreast of new developments & technologies.
- Timely response to increased demand
- Tackle health inequalities & support population health
- Improve access & reduce waiting times
- Recruit & retain clinical & scientific workforce
- Access robust data and insight through digital solutions

Our Clinical & Scientific Strategy at a Glance

Vision

Be at the forefront of clinical science delivering excellent, high-quality, person-centered care.

Strategic Aims

- Strengthen clinical and scientific leadership and collaboration to drive the clinical and scientific agenda
- Deliver high quality evidence-based, person-centred care to improve experience & outcomes.
- Drive clinical & scientific advancements through innovation, research, & development.
- Adapt, develop and empower a sustainable, diverse, multi-professional clinical and scientific workforce.

Core principles

- Improve synergy & partnership working
- Reduce variation, inequalities, and inefficiencies, through value-based healthcare.
- Ensure patients and donors at the centre of everything we do
- Listen and learn from experience and others
- Strengthen the clinical & scientific voice and leadership at all levels.
- Optimise opportunities for research, innovation & quality improvement.
- Empower & equip the workforce to get the basics right.
- Create agility in new technology, treatments, and ways of working.
- Deliver digitally enabled, data driven care.
- Invest in training and developing the workforce.

Values

- Caring
- Respectful
- Accountable

Enablers

- Collaboration
- Infrastructure
- Data & insight
- Digital & IT
- Estates
- Research
- Finance
- Workforce

Leadership & Collaboration

Strategic aim: Strengthen clinical and scientific leadership and collaboration to drive the clinical and scientific agenda.

Our Strategic Objectives:

- **Enhance our role** as a specialist provider at a local, regional, national, and international level.
- Optimise opportunities for **collaborative working** to deliver person focused, sustainable, efficient, and effective services.

To achieve our strategic objectives, we will:

• Strengthen working relationships with Health Technology Wales, **partnerships** and maximise opportunities to collaborate with health boards, academia, third sector and supportive services.	• Collaborate with partners across the life science sector and undertake **horizon scanning** to keep abreast of technological, clinical, and scientific advances ensuring preparedness for implementation.	• Expand **networks** and ensure strong clinical and scientific representation at regional, national, international, and European strategic groups.
• Improve the synergy and collaboration between divisions, maximising opportunities for **cross divisional learning**.	• Adopt a more system-focused approach to the design and delivery of services.	• Working with partner organisations ensure that **strategic priorities align** and develop coordinated regional plans to adapt care pathways and services.
• Working with system partners to understand and address **inequalities** of access to tertiary care across the region.	• Promote and strengthen clinical and scientific **leadership** all levels to drive forward the clinical and scientific agenda.	Enhance our role as an active participant, collaborate and **leader** in national and UK wide initiatives for blood, cancer, and transplantation.

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Strategic Aim: Deliver high quality evidence-based, person-centred care to improve experience & outcomes.

Our Strategic Objectives:		
• Through **service transformation** deliver high quality, equitable and sustainable services to meet the needs patients and donors.	• Optimise patient outcomes, experience by embedding the principles of **value-based healthcare** within all services.	• Deliver data driven, **evidence-based clinically led care** that is outcome focused and underpinned by research, expert clinical and scientific knowledge.
To achieve our strategic objectives, we will:		
• Build **capacity and capability** through development of the clinical infrastructure in preparation for delivering new treatments.	• Implement **new ways of working,** ensuring Team around the Person approach, empowering patients and donors to make care choices, delivered where possible close to home.	• Improve **engagement** with patients and donors, working together to ensure the delivery of high-quality services based on population need.
• Embed a **safety critical culture**, with a focus on listening, learning and quality improvement to minimise harm and optimise experience and outcomes.	Ensure that all services are consistently compliant with professional **standards of care**, meets regulatory and statutory requirements, NICE guidance, national and international recommendations.	• Work with Health Boards to streamline the delivery of seamless **clinical pathways** that are patient focused from point of referral to end of treatment
• Work in collaboration with delivery and commissioning partners to ensure preparedness for implementing **precision medicine.**	• Ensure a robust **infrastructure** to deliver and clinically manage all therapies including new and emerging therapies (eg: advanced therapies)	• Ensure quality management of personalised **cancer therapies** and **treatment toxicities.**
• Exploit opportunities to deliver new and **innovative treatments** and therapies	• Apply an **evidence-based approach** to developing and improving access and the delivery and quality of care and services.	• Improve the safety and traceability throughout the supply chain for blood and transplantation products.
• Apply an evidence-based approach to developing services based on the behaviors that drives donor, addressing barriers to donation.	• Enhance the use of outcome and experience data (**PROMS and PREMS**) for patients and recipients of products throughout the care pathway through a digitally integrated system.	• Develop a clinically digitally enabled workforce, optomising the use of **digital solutions,** including **artificial intelligence** to improve outcomes
• Invest in **digital systems** to improve patient and donor safety.	• Invest in world class state-of-the-art **equipment** and keep abreast of new developments, research, and technology.	• Expand our role in health education and promotions to enable patients, donors and the public to improve their own health and maximise outcomes

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4 Research, Development & Innovation

Strategic Aim: Drive clinical & scientific advancements through innovation, research, & development.

Our Strategic Objectives:

• Empower the clinical and scientific workforce to drive **transformation and quality improvement** initiatives by engaging in research, development, and innovation.	• Keep abreast of the pace of change in science and technology, ensuring **preparedness for new developments.**

To achieve our strategic objectives, we will:

• Embed a research driven **culture,** creating opportunities for patients, donors, and staff to engage in research, development, and innovation.	• Build clinical and scientific **knowledge** and expertise through **shared learning** and continuous improvement.	• Actively seek external support and secure **investment** from commercial partners to drive forward new research and innovation.
• Build **capacity and capability** to ensure that the workforce has the skills, time, and resources to engage in research, development, and innovation.	• Maximise opportunities for **collaborative research** and **clinical trials** providing a translational pipeline between the laboratory and clinical areas	• Maximise opportunities to improve the number and diversity of participants engaging in **research and clinical trials.**
• Develop **research leaders** to work alongside research champions to promote the research agenda and provide advice, expertise, and mentorship to the workforce.	• Accelerate the implementation of new scientific discoveries into clinical practice, through **translational research.**	• Promote the role of **principle investigator** and expanding the role to include other members of the multi-professional team.

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Workforce

Strategic Aim: Adapt, develop, and empower a sustainable, diverse, multi-professional clinical and scientific workforce.

Our Strategic Objectives:		
• Build capacity and capability to deliver a multi-professional, **clinically led model** to ensure that the right professional has the right knowledge and skills to deliver the right care in the right time and place.	• **Equip the clinical and scientific workforce** with the knowledge and skills to respond to changes in care and treatment and harness the use of new equipment, systems, and technology.	• Create a professionally **equitable, fully engaged, empowered** workforce that can meet the delivery challenges working within supportive and **psychologically safe culture.**
To achieve our strategic objectives, we will:		
• Adopt a multi-professional clinically led workforce model that focuses on maximising the use of **specialist skills.**	• Develop **career pathways** for all clinical and scientific professions with a focus on growing our workforce and developing a more diverse pipeline of specialist roles.	• Implement **enhanced, advanced and consultant career pathways** (Nursing, AHP and HCS) to allow staff to continuously develop and progress in their careers.
• Implement an innovative, prudent, and flexible approach to workforce modernisation through the **introduction of key roles.**	• Embed the **advanced practice framework**, maximising the use of advanced practice and associate practitioner roles.	• Embed a **psychologically safe** and support culture of compassionate, inclusive, and collective model of clinical and scientific leadership.
• Develop skills and capacity across the workforce through **education, training,** and development opportunities within a supportive culture.	• Deliver a comprehensive programme of **continuous professional development** for all professions, providing opportunities for shared learning and development.	• Work with universities and maximise use of the **Velindre Oncology Academy** and the **Collaborative Centre for Learning and Innovation.**
• Adopt a multi-faceted approach to improve **recruitment, retention, and succession planning** across all clinical and scientific professions.	• Work with Health Boards, HEIW and academic partners to ensure a **sustainable** multi-professional clinical and scientific **workforce.**	• Improve access to **leadership development programmes**, learning and continual professional development.

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How we will deliver our Clinical & Scientific strategy?

We have established a Clinical and Scientific Strategic Board which provides strategic oversight to ensure that the organisation is clinically and scientifically driven, keeps abreast of emerging evidence and developments, strengthens leadership. Together the infrastructure and Clinical and Scientific strategy will empower the clinical and scientific workforce from operational teams to the Trust Board to drive the agenda and strive for excellence through innovation, transformation, and research.

The Velindre Futures and Welsh Blood Futures Programmes are the planning framework through which each of the Divisions will deliver their future clinical model as part of their local, regional, and national service configuration. The Clinical and Scientific Strategy compliments the Programmes and supports the Cancer, Blood, and Transplantation services to deliver safe, effective, evidence-based, person-centered care.

The clinical and scientific strategy will align to the Trust wide enabling strategies for Digital, Research, Nursing and People which outline how we will deploy the latest technologies to improve efficiency and effectiveness; promote and facilitate research development and innovation; and develop, equip, and retain our multi-professional clinical and scientific workforce in line with Velindres overarching strategy 'Destination 2033'.

The Clinical and Scientific Board will work collaboratively with the Divisional Senior Leadership teams and enabling teams to ensure that the clinical and scientific strategy underpins the Divisional and organisational plans and the Integrated Medium-Term Plan, as the delivery mechanism for the plans.

A Clinical and Scientific Strategy Delivery Pan will be developed and driven by the Clinical and Scientific Manager in conjunction with the Clinical and Scientific Board and services across the Trust. The Clinical and Scientific Strategic Board will oversee the prioritization and delivery of this plan, monitor progress and provide delivery reports to the Executive Management Board and Trust Board as we strive towards achieving our vision, which is to be at the forefront of clinical science delivering excellent, high-quality, person-centered care.

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Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	Agree the Clinical and Scientific Strategy for the Trust.
QIA completed by / on date	Joanna Doyle, Clinical & Scientific Strategy Lead. 18.06.2024
QIA agreed by / on date	Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists & Dr Jacinta Abraham, Executive Medical Director

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

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

Clinical Executive 1 sign off / date	Nicola Williams, Executive Director Nursing, AHP & Healthcare Scientists 09/08/2024
Clinical Executive 2 sign off / date	Dr Jacinta Abraham, Executive Medical Director 09/08/2024

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

1. Broadly outline what is being proposed and the decision that needs to be made
A Trust wide Clinical and Scientific Strategy has been developed and needs to be agreed by the Trusts governance process.
2. Why is the proposal / decision needed?
The Clinical and Scientific Strategy is needed to ensure that the Trust is clinically and scientifically driven, setting out the clinical and scientific vision, strategic aims and objectives for Trust over the next 5 years.
3. What are the drivers and influencing factors around the decision to be made? (e.g. legislation, national policy, professional body guidance, cost savings, ministerial priorities)

- Destination 2033 (VUNHST, 2023)
- A Healthier Wales (WG, 2018)
- National Cancer Strategy "Together for Health: Cancer Delivery Plan" (WG, 2012-2016)
- Quality Statement for Cancer (WG, 2022)
- Well-Being of Future Generations (Wales) Act (WG, 2015)
- Health and Social Care (Quality and Engagement) (Wales) Act (WG, 2023)
- Cancer Improvement Plan for Wales (Wales Cancer Network, 2023-2026**).**

4. Who is directly affected by this proposal / decision?
Please also consider people who may be indirectly affected

A wide range of stakeholders including, patients/donors and the wider public, commissioning health boards, staff and third sector.

5. How have you engaged with the people affected?
If you have not yet engaged, what are your plans?

Widespread engagement has been undertaken with stakeholders and a range of engagement events have been held. Over 850 people (internal and external to the organisation) have engaged, and their views have helped to inform the strategy

6. What are the main benefits of this proposal / decision?

- Provide a shared vision, strategic aims & priorities, with a focus on areas requiring improvement over the next 5 years
- Lead & drive the clinical & scientific agenda, innovation, and transformational change
- Strengthen leadership and the voice of clinical & scientific communities
- Improve collaborative working to deliver sustainable services & improved outcomes for our patients and donors.

7. i) What are the main risks of implementing this proposal / decision?
ii) What are the main risks of not implementing it?

- Lack of clinical and scientific direction and clarity on shared aims and objectives that is required to inform prioritisation and decision making
- Resources note used efficiently and effectively in accordance with commitment to delivering value-based healthcare.

8. How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?

The Trust wide Clinical and Scientific Strategy is a requirement of the Trusts overarching strategy 'Destination 2033' and is required in response to both local and national drivers and strategic objectives. *(Refer to drivers listed in section 3)*

9. Is the proposal / decision planned to be temporary or permanent?

The strategy covers a 5 year period from 2024-2029 and will be subject to review.

Part 4: Quality Impact Assessment

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

Health and Care Quality Standards	Briefly outline how the proposal / decision impacts on each of the Health and Care Quality Standards What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact?	Identify if the overall impact of the proposal / decision is **positive, neutral or negative**
Safe **Timely** **Effective** **Efficient** **Equitable** **Person-centred**	The strategy will ensure the deliver of safe, timely, effective, and efficient, equitable, person centred care to patients and donors. Delivering the strategy is reliant upon the development and delivering of a robust & co-ordinated delivery plan. The key enablers include data and insight, digital & IT, finance, workforce, estate, research and collaboration. The CCS Board working in collaboration with the divisional SLT will developing and delivering a co-ordinated plan, monitoring & reporting progress and early identification and mitigation of risk. Some key outcome measures have been identified within the strategy which will be used alongside other metrics to monitor impact and evaluate outcomes.	Positive
Leadership	The strategy aims to strengthen the clinical and scientific voice and leadership This is reliant upon developing a psychologically safe and supportive culture and a strong governance structure from the ward/laboratory to the Board. The revised governance structure will support this.	Positive
Workforce	The strategy was written by and for the clinical and scientific workforce within the Trust and will set the clinical and scientific direction over the next 5 years based on shared priorities. The workforce have been engaged in the development	Positive

Health and Care Quality Standards	Briefly outline how the proposal / decision impacts on each of the Health and Care Quality Standards What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact?	Identify if the overall impact of the proposal / decision is **positive, neutral or negative**
	of the strategy and need to be supported, empowered and equipped to develop the strategy.	
Culture	The strategy highlights the needs for a psychological safe and supportive environment that empowers the workforce to support delivery of the strategy.	Positive
Information	Extensive work has been undertaken to raise awareness and highlight the benefits of developing and delivering a trust wide clinical and scientific strategy. Information about how the strategy will be delivered will be set out in the delivery plan that needs to be shared widely with staff. Further information and support can be obtained from the Clinical and Scientific Manager.	Positive
Learning, improvement and research	Research, development, innovation and continuous improvement through learning is an integral part of the clinical and scientific strategy and one of the strategic aims within the strategy. The strategy aligns to the Trusts education, RDI strategies.	Positive
Whole systems approach	When developing the strategy the impact of the strategic aims and objectives on the whole system have been considered	Positive

Part 5: Summary of the Quality Impact Assessment

Based on the assessment in Section 2, what are the key messages, risks and recommendations for the clinical review and sign-off process?
It is imperative that the Clinical and Scientific strategy is agreed, signed off through the governance framework and the strategy is widely publicised.
What are the proposed monitoring arrangements and frequency of QIA Review?
A clinical and scientific manager (band 7, 1wte) is being appointed to support the CSSB and delivery of the Clinical and Scientific strategy and they will be responsible for working with the CSSB and divisional SLTs to monitor progress in delivering the strategy and reviewing the QIA.

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TRUST BOARD

STRATEGIC PLANNING UPDATE

DATE OF MEETING	26.09.24

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	GAVIN BRYCE, ASSOCIATE DIRECTOR OF PROGRAMMES; PHIL HODSON, DEPUTY DIRECTOR OF PLANNING AND PERFORMANCE
PRESENTED BY	LAUREN FEAR, INTERIM EXECUTIVE DIRECTOR OF STRATEGIC TRANSFORMATION, PLANNING AND DIGITAL
APPROVED BY	LAUREN FEAR, INTERIM EXECUTIVE DIRECTOR OF STRATEGIC TRANSFORMATION, PLANNING AND DIGITAL

EXECUTIVE SUMMARY	This paper provides a regular bi-monthly summary of key Strategic Planning matters for the Trust Board.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the update for assurance purposes.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
This is an introductory first report and will be updated to include the matters highlighted below for consideration at the October Executive Management Board and subsequent Trust Board cycle.	N/A

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

APPENDICES	
1	Integrated Medium Term Plan 2024-2027: Accountability Conditions – 23 July 2024 letter

1. BACKGROUND

This paper provides an overview across key strategic planning matters:

- Trust Framework for Integrated Medium-Term Planning
- Regional Cancer Planning Update

2. ASESSMENT

2.1 Trust Framework for Integrated Medium-Term Planning

2.1.1 The Integrated Medium-Term Planning (IMTP) approach will be based on an agreed Trust IMTP Framework. This Framework will incorporate the NHS Wales National Planning Framework requirements and the specific feedback the Trust has received through mechanisms such as the current IMTP accountability conditions (see section 2.1.6).

2.1.2 The draft Framework will be shaped by the Executive team in a workshop in early October and then formally considered in the October Executive Management Board meeting. This will be brought to the Strategic Development Committee in October for further shaping by Committee members and then to the Trust Board for approval in November 2024.

2.1.3 The approval in November 2024 is likely to be subject to the final National Framework being published, however, the Trust will have had access to draft versions leading up to this and it is not expected that there will be significant further changes to govern.

2.1.4 The Trust has been advised to work on basis of a 31 March 2025 submission for the 2025-2028 IMTP.

2.1.5 Below is a brief summary of the draft shape of the Trust IMTP Framework 2025-28:

Strategic Context:
- A Healthier Wales – updated version expected November 2024
- Trust long term strategy - Destination 2033 and enabling strategies
- Clinical and Scientific Strategy
- Cancer and Blood Service five year strategies
- Trust Assurance Framework
- Embedding of core legislation and national standards

Core Assumptions:
- Demand modelling, including population health factors and Blood Health Plan
- Long Term Agreement approach with Commissioners

Clinically and Scientifically Led:
- The plan will be led by clinical and scientific priorities
- Explicit link between clinical and scientific horizon scanning to planning
- Integration of research and development into core planning approach
- Integration of Charity objectives into core planning approach
- Outcome based

Staff Based:

- Explicit link to staff feedback through Staff Survey and Working Together engagement
- Integration of Speaking Up Safely actions and themes
- Integration of Healthy and Engagement Steering Group actions and themes
- Integration of Diversity and Inclusion actions and themes

Engagement:
- Patient and Carer Board
- Llais
- Social Partnership Act

2.1.6 The NHS Executive is developing a Planning Maturity Matrix and this will be considered alongside finalising the Trust Framework during the October and November governance cycles. Trust Board Members will have an opportunity to contribute to our self-assessment and this will provide further assurance on the quality of the Trust IMTP Framework.

2.1.7 The Trust IMTP Framework will also explicitly link to and address formal feedback received via:
- Integrated Medium Term Plan 2024-2027: Accountability Conditions. The letter of 23 July is attached as Appendix 1. There were four key areas identified for focus, as well as additional in-year Key Performance Indicators in Annex 1 of the letter. The Accountability conditions will be tracked in year in the usual way through the Quality, Safety and Performance Committee. The key areas identified, which will also be taken into account for the 2025-2028 Trust IMTP Framework are:
    - Implementation of recruitment and retention strategies.
    - Ensure patients' mental health and emotional wellbeing is appropriately supported alongside their treatment and ongoing care, and ensure mechanism for evidencing this is in place.
    - Ensure the potential impacts from the Infected Blood Inquiry recommendations are enacted.
    - Agree LTAs with other organisations, working collaboratively to avoid arbitration.

- NHS Oversight and Escalation Arrangements - In line with the NHS oversight and escalation framework, escalation levels are considered at least twice a year. This includes an assessment of each health organisation against six escalation domains, and discussions with partners around the current issues, concerns and progress since the last review.

- In letter on 12 July, it was confirmed that there was no change to escalation status for the Trust and it was to remain in lowest level 1 (routine arrangements). There were three specific matters raised: delivery of major strategic programmes; communication with donors in the Welsh Blood Service; and nursing staff turnover.

2.1.8 As previously agreed by the Trust Board, the Trust's strategic risks in the Trust Assurance Framework will be reviewed to ensure clear and straightforward alignment to the objectives agreed through the IMTP. The Trust IMTP Framework will also outline this approach for Trust Board agreement.

2.2 South East Regional Planning Update

2.2.1 In 2020 a south east Wales Regional Planning Partnership was established for specific programmes of work: Ophthalmology, Diagnostics, Orthopaedics and Stroke. The Trust joined the partnership in August 2023 marking the creation of a fifth regional programme – cancer. The Cancer Programme is hosted by Aneurin Bevan University Health Board and, following the initial Cancer Programme Board in early September 2024, it has been agreed that the Trust will be taking on a key leadership role in this work. The agreed initial steps are:

- Compilation of a regional cancer blueprint, drawing on the existing national quality statement, the 2023-6 Cancer Improvement Plan and respective organisational cancer strategies.
- Agreed regional strategic shape for existing programmes of work and agreed mechanisms for effective collective visibility of progress and escalation mechanisms for any blockers.
- Agile, rapid progress on agreed focused number of initial priorities.

2.2.2 Each programme of work complies a highlight report and these are shared with other regional Health Boards to support a culture of collective working with consistent information. The cancer programme dashboard has previously been reporting red as there was delayed progress to establishing the Programme Board and the agreement of the Programme Definition Document. Going forwards, as this regional highlight report is populated, it will be appended to the Strategic Planning paper.

2.2.3 This work is in addition to the development of a south east Wales Clinical Services Strategy. The planned joint Board session on 1st October has been postponed until

early 2025 to allow for further progress to be made by Executive teams across the region on proposed models and ways of working prior to this session.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	09 - Future Direction of Travel
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	All strategic planning matters will require a Quality Impact Assessment and this will be included in the Trust IMTP Framework.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	All strategic planning matters will require a Socio-economic duty assessment and this will be included in the Trust IMTP Framework.

For more information: *https://www.gov.wales/socio-economic-duty-overview*	
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Yes - please Include further detail below, including funding stream
	Source of Funding: Welsh Government **Type of Funding:** **Revenue and Capital Funding** **Scale of Change** **Type of Change** **Other (please explain)**
	Choose an item
FINANCIAL IMPLICATIONS / IMPACT	Financial Planning core to Trust IMTP Framework
	Yes (Include further detail below)
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	All strategic planning matters will require an Equality Impact Assessment and this will be included in the Trust IMTP Framework
N/A	

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Mapping to Trust Assurance Framework required

WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Agreement to proceed with commission
All risks must be evidenced and consistent with those recorded in Datix.	

Cyfarwyddwr Cyffredinol Grŵp Iechyd, Gofal Cymdeithasol a'r Blynyddoedd Cynnar / Prif Weithredwr GIG Cymru

Director General Health, Social Care & Early Years Group / NHS Wales Chief Executive

Carl James
Interim Chief Executive
Velindre University NHS Trust
Trust Headquarters
2, Charnwood Court
Parc Nantgarw
Cardiff
CF15 7QZ

26 July 2024

Dear Carl

Integrated Medium-Term Plan 2024-27: Accountability Conditions

I am pleased to note that your Board was able to submit a balanced integrated medium-term plan (IMTP) for 2024-27 in line with section 175(2A) of the National Health Service (Wales) Act 2006 (as amended by NHS Finance (Wales) Act 2014) and in accordance with the NHS Planning Framework.

The Cabinet Secretary for Health, Social Care and Welsh Language is currently considering approval of your plan. In the meantime, and in order to ensure there is an ongoing focus on delivering and strengthening your plan, a number of accountability conditions have been identified. Following the Cabinet Secretary's decision there may be additional requirements. If that is the case, we will provide an update for you in due course.

I expect organisations to deliver the commitments set out within their plans, particularly in relation to the Ministerial priorities. This includes delivery of financial balance as set out in the organisations plan, and the organisation should continue to progress improvements of a clear triangulated financial position and key trajectories. This is fundamental to the successful delivery of your Board supported IMTP.

Organisations must lever improved efficiency and productivity to continue with significant efforts in order to achieve financial and service sustainability that will deliver demonstrable benefits and patient outcome for the allocation uplift provided to organisation this year.

There are a number of areas which were identified as accountability conditions through the formal review of your plan:

- Implement your recruitment and retention strategies;

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Gwefan • website: www.wales.gov.uk

- Ensure patients' mental health and emotional wellbeing is appropriately supported alongside their treatment and ongoing care, and ensure mechanism for evidencing this is in place;
- Ensure the potential impacts from the Infected Blood Inquiry recommendations are enacted; and
- Agree LTAs with other organisations, working collaboratively to avoid arbitration.

The Cabinet Secretary for Health, Social Care and Welsh Language has set some additional in-year Key Performance Indicators (KPIs) – Annex 1. Resources must be identified to support delivery in these areas, while maintaining overall financial delivery. In addition, should in-year expectations be required this will be communicated to you and your organisations will still be expected to deliver in line with quality statements.

I expect the Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year. A copy of your Board updates setting out progress of the plan during the year, should be forwarded on a quarterly basis to HSS-PlanningTeam@gov.wales. This should be accompanied by a refreshed Minimum Data Set (MDS) making clear any changes to the trajectories and goals at each quarter.

Accountability conditions and delivery of plans will also form the agenda for our Joint Executive Team (JET) meetings going forward. Performance and delivery discussions on areas of priority and risk will continue to be scrutinised via the regular Integrated Quality Planning and Delivery (IQPD) meetings and those that the NHS Planning Team have with planners. Where this necessitates any material changes to the plan in year, you will be required to advise me of these changes through an 'Accountable Officer' letter.

I trust that this letter provides clarity on our expectations, but should you have any queries then please do not hesitate to contact me.

Yours sincerely

Judith Paget CBE

cc: Nick Wood, Deputy Chief Executive, NHS Wales
Samia Edmonds, Director of Strategic Planning
Hywel Jones, Director of Finance
Jeremy Griffith, Director of Operations

Annex 1

Key Performance Indicators
Whilst I recognise you may not be directly responsible or accountable for all of these, there will be some areas where you can contribute and support health boards. I want to see that support is made readily available through the monitoring process so that I am assured your organisation is playing its part as a system leader.

Key Performance Indicators	Definition and Target
Urgent and Emergency Care	Number of patients who spend 12 hours or more in all major and minor emergency care facilities from arrival to admission, transfer or discharge March 2024 baseline 20% Reduction by September 2024 Further 20% Reduction by March 2025 Number of ambulance patient handovers over 1 hour March 2024 baseline 30% Reduction by December 2024
Cancer	Percentage of Patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route) 60% performance by December 2024 70% performance by March 2025
Diagnostics	Number of patients waiting more than 8 weeks for a specified diagnostic. 95% to be zero by December 2024
Elective Care	Number of patients waiting over 52 weeks for a new outpatient appointment March 2024 baseline 40% reduction by end of September 2024 Zero by March 2025 Number of patients waiting more than 104 weeks for referral to treatment Zero by end of December 2024
Mental Health	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged 16 years. Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults aged 18 years or over. 80% for both by December 2024

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TRUST BOARD

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY (Q1) ACTIONS FOR 2024 / 2025

Date of meeting	26/09/24

PUBLIC OR PRIVATE REPORT	**Public**

IF PRIVATE PLEASE INDICATE REASON	**Not Applicable - Public Report**

REPORT PURPOSE	**INFORMATION / NOTING**

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	**NO**

Prepared by	**Peter Gorin, Head of Strategic Planning and Performance**
PRESENTED BY	**Phil Hodson, Deputy Director of Planning and Performance**
APPROVED BY	**Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**1. VELINDRE NHST IMTP PROGRESS 2024/25** 1.1 This report provides an update (position as of 30th June 2024) of progress against the actions (April to June 2024) which were included within the IMTP for 2024/25 as at Quarter 1. 1.2 These updates are provided in the form of the monitoring templates for WBS, VCS and Trust-wide (See Appendix 1, Appendix 2 and Appendix 3). 1.3 Good progress has been made again against IMTP actions as at Quarter 1.

RECOMMENDATION / ACTIONS	The Trust Board is asked to: • **NOTE the progress made in the delivery of the agreed IMTP (2024 – 2027) actions as at Quarter 1 for both the Velindre Cancer Service, the Welsh Blood Service and Trust-wide services.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCS SLT / Performance Review	**20 August 2024**
Executive Management Board – Run	**29 August 2024**
Summary and outcome of previous governance discussions: **The report has been considered and endorsed at the VCS & WBS Performance Review and EMB Run, QSP Committee and is presented to the Trust Board for information and noting.**	

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

APPENDICES	
1	**Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 1 at 30/6/24.**
2	**Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 1 at 30/6/24.**
3	**Trust-wide Initiatives - IMTP Quarterly Progress Report 2023/24 for Quarter 1 at 30/6/24.**

ACRONYMS and INITIALISM	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

2. SITUATION/BACKGROUND

2.1 The Integrated Medium Term Plan (IMTP) 2024/25-2026/27 was submitted to the Welsh Government on 28st March 2024. Integral to the successful delivery of our IMTP were a number of actions to support the delivery of the Trust's Strategic Aims, across both cancer services and blood and transplant services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The timing of the end of Quarter 1 (April to June 2024), gave only a short time for a detailed assessment of progress against IMTP actions by EMB during early July to meet an earlier Trust Board reporting cycle.

3.2 The table below gives a high-level overview of progress made in the delivery of actions at Q1 for WBS, VCS and Trust-wide.

BRAG Rating	Progress Categories Definitions	Welsh Blood Services IMTP 2024/25 Actions	Velindre Cancer Services IMTP 2024/25 Actions	Trust-wide Initiatives IMTP 2024/25 Actions
BLUE	Action successfully completed with benefits being realized	**2 Q actions**	**1 Q Actions**	**1 Q actions (1 Digital)**
GREEN	Satisfactory progress being made against action in line with agreed timescale	**16 Q actions**	**14 Q actions**	**107 Q actions (24 Digital, 27 Workforce, 6 VBHC 22 Clinical, 14 Estates & 6 Sustainability, 8 Finance)**
YELLOW	Issues with delivery identified and being resolved with remedial actions in place		**13 Q actions**	**11 Q actions (10 Digital, 1 VBHC)**
AMBER	Delays in implementation / action paused due to external issues beyond our control	**2 Q actions**	**1 Q actions**	**1 Q actions (1 Digital)**
RED	Challenges causing problems requiring recovery actions to be identified			
Total IMTP 2024/25 Quarterly (Q) Actions		**20 Q actions**	**29 Q actions**	**120 Full Year Actions**

3.3 WBS are making satisfactory progress, categorized as '*blue* (16) or *green (2) with 2 amber* ', against their 20 actions as at Q1, **see Appendix 1.**

The two WBS amber actions, defined as *'Delays in implementation / action paused due to external issues beyond our control*' relate to:

- National Wales Laboratory Information System (WLIMS) 2.0 hyperlink to (page 12)
- Plasma for Medicines service model for Wales hyperlink to (page 19)

3.4 VCS are also making satisfactory progress, categorized as 'blue (1), or *green (14) or yellow (13) with 1 amber* ', against their 29 actions as at Q1 **see Appendix 2.**

The one amber action, defined as *'Delays in implementation / action paused due to external issues beyond our control*' is:

- Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) (page 29)

3.5 There are 120 Trust-wide actions or 'themes' (Digital 36 (1 blue, 24 green, 10 yellow, 1 amber); Workforce & OD 27 (all green); Estates 14 (all green); Clinical & Safety 22 & Sustainability 6 (all green); VBHC 7 (6 green, 1 yellow) and Finance 8 (all green); Good progress is again being made against these actions as at Q1, **see Appendix 3.**

The one Digital amber action, defined as *'Delays in implementation / action paused due to external issues beyond our control*' relates to:

- Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre hyperlink to (page 50)

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒

• A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organization that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	Quality and Safety considerations form an integral part of the Trust PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

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

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APPENDIX 1

Welsh Blood Service - IMTP Quarterly Progress Report 2024/25 for Quarter 1 as at 30/6/2024.

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2033 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2026/27. 	• Personalised donor experience • Wider communication choice for donors. • Increased donor retention. • Improved information (for sharing/decision- making). • Increased levels of efficiency/ Productivity.	Introduce updated WBS brand toolkit. Continue to support Digital with development of refreshed booking portal.	Implement refreshed booking portal.	Begin introduction of a co-design forum for donors and advocates.	Begin introduction of a donor experience hub. Begin implementation of a Customer Relationship Management (CRM) System. Continue with introduction of a co-design forum for donors and advocates.	The WBS brand toolkit has been developed and is now in effect. Work ongoing to develop refreshed booking portal with validation about to commence. On track to implement in Q2.	
	Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model	• Sustained growth and retention of the stem cell donor panel. • Increase in stem cells supply.	Introduce Self-Administration of G-CSF as part of the modernisation of Clinical Services.	Continue to develop model for bone marrow collections in Wales. Review of clinical model	Review and develop of clinical model for apheresis collections. Continue to develop model	Implement identified and developed strategies for maintaining growth of the registry such as collecting 3rd party cellular	Self-Administration model for G-CSF successfully implemented into the WBMDR operating model.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	and its ambition by 2026/27. WBS Futures	• Increased diversity in the donor panel. • Improved resilience in stem cell supplies. • Improved clinical outcomes nationally • / inter nationally. • Increased income levels.	Develop model for bone marrow collections in Wales. Investigate digital replacement solution for WBMDR software.	for apheresis collections. Implement JACIE Accreditation for stem cell collection services. Develop model for stem cell donor medicals. Continue to develop URS and engage with digital suppliers to replace current WBMDR Software	for stem cell donor medicals. Produce and process tender to replace current WBMDR software	products or ATMP starting materials. Follow tender process to replace current WBMDR Software.	The development of a model for bone marrow collections in Wales is currently underway. Work ongoing to scope suitable digital solution. User Requirements Specification (URS) completed and formal tender process to commence.	
SP2: To provide a world class donor experience **(Link to Trust Destination**	Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma) WBS Futures	• Right size/shape donor panel/s. • Increased resilience for supply of products across Wales. • Improved levels of	Re-submit new donor and advocate strategy for approval.	Begin to develop recommendations for systems, processes and people required to deliver the strategy.	Complete recommendations paper for systems, processes and people required to deliver the strategy		The donor and advocate strategy has been approved and is now being actively implemented.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)		efficiency / productivity • Reduced importation and costs. • Increased brand awareness and reach. • Wider population/donor education. • Development of rich data to improved insights and focus efforts in right areas						
SP3: Drive the prudent use of blood across Wales	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25. WBS Futures	• Improved clinical outcomes for patients post operatively. • Reduced length of stay post-surgery. • Prudent use of (reduced	Evidence of compliance with Health Board action plans issued in July 2023.	Dataflow for treatment data established. Incorporate costing data into Dashboard development.	Health Board Benchmarking to be incorporated into treatment data to evidence compliance with NICE QS138.	Current funding stream ends 31/12/24.	Gap analysis and dashboard data is evidencing health board compliance, along with Preoperative Anaemia Pathway screening across all Health Boards.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 4 and 5)		demand for blood). • Increased equity of care and outcomes. • Reduction in clinical complications associated with receiving blood products. • Compliance with the NICE guidance. • Improved efficiency. • Cost efficiencies.					Ongoing data capture of treatment and access to transfusion data from WLIMS legacy repository and pilot IV iron data. Welsh Government confirmation of recurrent funding for the programme awaited.	
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2033 – Trust Strategic**	Revised blood collection clinic portfolio by 2025/26. 	• Increased • /Sustainable collection model. • Improved access for service users. • Improved collection efficiency. • Reduction in costs. • Improved access to	Complete implementation of tours for North Wales teams.	Begin to develop options for introduction of a new fixed donation venue/s. Begin review of existing blood donation venues.	Continue to develop options for introduction of a new fixed donation venue/s. Continue to explore options for introduction of a new fixed donation	Continue to develop options for introduction of a new fixed donation venue/s. Continue review of existing blood donation venues.	Business Case for implementation of tours drafted and North Wales Tours Plan completed. Employee engagement initiated.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Goals 1, 2, 4 and 5)		donors for recruitment to the Welsh Bone Marrow Donor Registry.			venue/s. Continue review of existing blood donation venues.			

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Introduce clinically led collection team model by 2024/25. WBS Futures	• Improved leadership capability. • Standardization of terms and conditions across collection teams. • Improved quality. Improved safety. • Reduction in staff turnover. • Improved collection efficiency.	Continue to undertake a workforce review, to include roles and responsibilities.	Continue to undertake a workforce review, to include roles and responsibilities Develop new job descriptions.	Begin to implement workforce review in line with Organisational Change Policy (OCP).	Continue to implement workforce review in line with Organisational Change Policy (OCP).	Options Appraisal process has begun to review business needs and workforce requirements.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Develop and implement a platelet strategy by 2025/26. 	• Improved levels of efficiency. • Improved alignment between capacity and demand. • Reduction in avoidable waste. • Reduce wastage.	Development and implementation of the validated Demand and Capacity tool. Implement new platelet pooling packs. Implement apheresis in Platelet Additive Solution (PAS).	Continue development and Implementation of the validated Demand and Capacity tool. Continue with implementation of new platelet pooling packs. Implement apheresis in PAS. Research and development of new components.	Development of the collection strategy for apheresis and whole blood platelet collection Optimize the clinical efficacy of platelet supply including substitutions. Research and development of new components.	Continue development of the collection strategy for apheresis and whole blood platelet collection Optimize the clinical efficacy of platelet supply including substitutions. Research and development of new components.	Demand and Capacity tool in final stages of development. Phase 1 trial for pooling packs completed with trial report in draft. Follow up trial to identify optimum PAS/Plasma ratio is ongoing.	
	To work with the National Wales Laboratory Information System (WLIMS) 2.0	• Modernise patient management software with robust digital support.	Completion of DHCW collaborative development.	System Integration Testing (SIT).	Completion of SIT. Formal Validation.	Commence deployment.	One month delay to build phase, correction plan in place. No change to overall delivery timescales.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	programme to make sure the needs of the WBS are delivered through the National system by 2025/26. 	• Connectivity to national database. • System improvement. • Increased patient safety. • Access to blood usage data to inform demand planning.					Work ongoing to confirm arrangements for Health Board deployment of 'blood tracking' solutions.	
	Implementation of Welsh Histocompatibility and Immunogenetics Service IT system (WHAIS IT) by 2025/26. 	• Improved availability of information. • Increased efficiency • / Productivity. • Improved patient experience. • Reduced turnaround times. • Reduction in avoidable waste	Completion of discovery phase. Commence Implementation. Commence Data Migration.	Commence Environments set-up.	Complete implementation n. Complete Environments set-up.		All work proceeding to plan. On-site supplier visits took place in June 2024.	
	Procure new Blood Establishment Computer	• Regulatory compliance.	New contract procurement commences – Competitive	New Contract Procurement Business	New Contract Procurement .	New Contract Procurement ends.	Prior Information Notice published, and initial supplier	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	System (BECS) contract. 	• Resilient / supported platform. • Operational efficiency.	Dialogue. Recruitment of SMEs. Analyse Semester patch feasibility. Analyse and test Maintenance Patch. Virtualisation of existing infrastructure.	Analysis – ways of working/service mapping. Implement Maintenance patch. Continue analysis of Semester patch. Continue virtualization of existing infrastructure.	Business Analysis – ways of working/service mapping. Analysis of Semester patch if required. Prepare new hardware. Plan and prepare Delta Release.	Continue analysis and testing of Semester patch. Implement Delta Release.	engagement sessions underway. Funding confirmed by Welsh Government for 2024/25, procurement activity. Funding arrangements for implementation and 'BAU' costs yet to be agreed.	
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales. • Compliance with SaBTO recommendations.	Submit data required for review by SaBTO.	Review updated recommendation from SaBTO and agree an organizational response.	Implement any changes in practice recommended by SaBTO.	Implement any changes in practice recommended by SaBTO.	Data is being submitted to SaBTO as required.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	of transmission of Hepatitis B infection as required 2024/25.							
	Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2025/26	• Maintain compliance with regulatory standards. • Improved quality. • Improved safety. • Improved donor experience.	Complete process reviews and system configuration for new eQMS. System validation for new eQMS to commence. Implement DocuSign Enterprise solution (including staff education / Support).	System validation for new eQMS to be completed. Staff training for new eQMS to be completed. Embed DocuSign Enterprise solution across all WBS. ISO:15189 – gap analysis to be completed and submitted to UKAS.	Development of Medical Devices Regulations (MDR) / In Vitro Diagnostic Devices (IVDDR) Strategy.	Development of Medical Devices Regulations (MDR) / In Vitro Diagnostic Devices (IVDDR) Strategy.	Completed process reviews for all modules. Simplification need identified with solutions being designed. Validation Plan is being finalised to begin in August 2024. DocuSign "Enterprise Edition" available without 'Single Sign On'. Use of an alternative platform is being explored.	
	Implementation of Foetal DNA	• Reduction in avoidable administration	Undertake digital developments to support reporting	Implement all Wales service for Cell Free	Embed service.		Completed – service went live in May 2024.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	typing by 2024/25. WBS Futures	of anti-D immunoglobulin to pregnant women. • Improved safety. • Improved patient experience. • Reduction in avoidable waste/costs.	of results. Complete validation and implementation of new test.	Foetal DNA screening.				
	Implement new digital solution for National External Quality Assessment Service (NEQAS) by 2024/25. WBS Futures	• Digital solution will increase free up staff time to deal with marketing and development activities without the employment of additional staff. • Capacity to expand customer base. • Flexibility to develop and	Begin validation of new NEQAS system.	Continue validation of new NEQAS system.	Complete validation of new NEQAS system.	Go live with new NEQAS system. Close project.	Implementation approach options appraisal is ongoing. Implementation anticipated to start late 2024 /early 2025.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		change the service. • Capacity to expand service provision. • Improved sustainability as system doesn't rely on paper records. • Complete digital audit trails. • Removal of potential errors caused by manual data entry by NEQAS staff. • Digital platform for EQA will reduce turnaround times.						
	Review and Develop strategy for Nucleic Acid	• Robust Service Provision	Develop User Requirement Specification. Identify preferred	Continue procurement of new NAT analyzers.	Continue procurement of new NAT analyzers.	Commence validation and implementation of NAT testing platform.	User Requirements Specification (URS) to be finalised in September 2024.	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Testing (NAT) by 2025/26. WBS Futures	• Enable income generation. • Service Development.	service model. Procurement process.				Procurement timelines agreed in collaboration with SNBTS.	
	Introduction of West Nile Virus (WNV) Testing. WBS Futures	• Ensure minimal impact on the Blood Supply chain due to the projected increase in deferrals with the spread of WNV in Europe • Ability to maintain WBS blood supply chain • Decrease in requirement for importation of blood products to meet demand	eProgesa development work to create test codes and trigger requirement for WNV testing. Develop clinical algorithm. Validate Roche platform for WNV testing. Implement WNV testing.				Completed – service went live in May 2024.	
	Assess and implement the recommendatio	• Learning from the findings of the inquiry and	Attend the launch of the report, review	Commence implementati on of the			IBI report launch attended by VUNHST CEO,	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	ns of the Infected Blood Inquiry (IBI).	optimizing the safety of blood components as recommended. • Maintained compliance.	the recommendations and draft an action plan	action plan and populate the predicted timescales for actions for the IMTP 2024-27.			WBS Director and WBS Medical Director. WBS informing and supporting national discussions (WG, UK Forum etc.) as required.	
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales. WBS Futures *(Quality Priority: Introduce leucodepletion filters, Hepatitis A and Parvo B19 testing)*	• Secure the supply chain for Immunoglobulins in Wales. • Reduces need for importation. • Cost • Avoidance/reduction. • Avoids patient rationing.	Complete validation of leucocyte filtration (NQT) blood packs. Continue procurement of Hepatitis A and Parvo b19 testing.	Scope clinical pathway for Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG governance arrangements are clear. Develop robust shipping documentation for fractionator.	Commence validation and digital implementation of Hepatitis A and Parvo B19 testing.	The wider Plasma for Medicines programme remains on hold awaiting a policy decision and funding from the Welsh Government. Supporting activity for the procurement of a new NAT testing platform is ongoing to ensure funding delays do not impact the critical path. Validation of leucocyte filtration packs delayed, to commence in	

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							August 2024, with no impact to the critical path.	
SP6 Sustainable services that deliver the greatest value to our communities **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2 and 5)**	Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. WBS Futures	• Improved • donor satisfaction. • Improved staff well- being. • Increased service resilience. • Reduction in energy consumption and utilization. • Reduction in carbon emissions. • Compliance with statutory requirements. • Improved efficiency, reduction in waste and carbon emissions.	Development of Outline Business Case.	Outline Business Case completed & internal approval process commences.	Trust Board approval and submission of Outline Business Case to Welsh Government.	Welsh Government review of Outline Business Case.	Welsh Government (WG) approached to consider combined OBC/FBC. Currently engaging with Specialist Estate Services regarding cost proposals prior to seeking formal confirmation from WG.	
SP7 Develop great people and a	Develop a sustainable workforce model which provides	• Enhanced workforce capacity &	Support Collection Teams workforce	Support Collections Teams workforce	Support implementation of Collections	Support implementation of Collections	Paper drafted for extension of temporary	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
great place to work **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)** 	leadership, resilience and succession planning by 2025/26.	capability to meet need. • Enhanced Leadership capacity & capability. • Improved staff satisfaction. • Improved staff well- being. • Improved service quality, safety and donor satisfaction.	review. Commence review of workforce planning across WBS. Plan and deliver training / team development sessions with new Senior Leadership Team (SLT).	review. Continue review of workforce planning across WBS.	Team workforce review in line with Organisational Change Policy (OCP). Continue review of workforce planning across WBS.	Team workforce review in line with Organisational Change Policy (OCP). Continue review of workforce planning across WBS.	Recruitment and Retention Premia Decision expected in Q2 from Welsh Partnership Forum. Informal staff engagement plans in place to start at the end of Q2. Wider WBS departmental workforce planning taking place. SLT team development sessions are occurring.	

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

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APPENDIX 2

Velindre Cancer Service - IMTP Quarterly Progress Report 2024/25 for Quarter 1 as at 30/6/2024 (TO BE UPDATED)

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patient satisfaction •	Complete development of service specification and Service Level Agreement (SLA). Develop workforce plan.	• Initiate deployment of new workforce plan. Define model for delivery of outreach activity.	Define and implement necessary digital infrastructure to enable effective and efficient operation of the new Satellite Unit.	Develop and deploy plan for operational handover following successful completion of the construction phase.	Multiple clinical pathway meeting scheduled throughput Aug and Sept to confirm patient pathways and unwell patient. Two additional internal workshop established for Radiation and Finance SLA Completion date under review by ABHB and Construction Team	
Trust Strategic	**Implementation of Integrated**	• Improved patient outcomes	Second new linear accelerator	•Implementation of InSightive	Third new linear accelerator and associated		Third linear accelerator clinincally	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Goals 1, 2, 3, 4 and 5	**Radiotherapy Solution Programme by 2026/27**	• Improved quality of care • • Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	commissioned and in clinical use. Assess implications of commissioning fourth new linear accelerator to enter service on the current Velindre site and consider alternative options to maintain service provision. Develop contingency plans to ensure maintenance of treatment capacity in the event of catastrophic machine breakdown.	radiotherapy analytics tool. • Develop capital equipment procurement contingency plan to determine options to enable the timely replacement of equipment in the event of failure, etc. before the opening of nVCC site. Develop plan to support transition of brachytherapy service to nVCC site.	infrastructure commissioned and made available for clinical use.		commissioned and in use treating patients at VCC. Capacity and phasing workstream assessing capacity and planning fully underway to deliver phase 2 of the programme – 2 linear accelerators into SRU.	
Trust Strategic Goals 1, 2,	**Implementation of Outreach**	• Increase care close to home. • Improved access.	Engage` with health boards,	Define model for delivery of care		Develop workforce model.	Scoping workshop held in August. Key	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
3, 4 and 5	**Programme by 2025-26**	• Improved equity. • Improved patient experience. • Reduction in carbon emissions.	agree intention and principles. Establish programme board.	on outreach contexts.			outputs of meeting include; • Clarity on scope • Identification of key stakeholders • Early engagement with patients • Continued engagement with all local HBs Project Initiation Document shared with HBs – awaiting feedback. Key workstreams identified. Further meeting with HB representatives	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							scheduled for early October.	
Trust Strategic Goals 1, 2 3 and 4	**Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services**	• Increased service resilience • Increased workforce resilience • Increased levels of efficiency and productivity • Reduced costs • Improved access to medicines in a timely manner	Work with regional stakeholders to support design and delivery of radio pharmacy delivery model. Review governance structure in the context of interim requirements and contingency planning pending delivery of TrAMs model. Secure interim support pending delivery of TrAMs. Identify resource to support clinical and scientific infrastructure for	Develop and assess possible delivery models which will ensure the sustainable delivery of pharmacy services prior to the full implementation of the TrAMs model.	Identify funding stream to support the expansion of pharmacy services in anticipation of future TrAMs dependent requirements.		Timelines for the TrAMS SE Wales Hub OBC and FBC have been revised to take account of the pace of progress in agreeing revenue funding characteristics. Current submission of FBC to Welsh Government date is September 2025. Focus is now on the preparation of the SE Wales Hub OBC, where VCC are working on baseline and ambitious workforce models.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			national programme.				Clinical readiness project activities are progressing on the VCC centralized clinical verification process and Meds at home direct model. Review of internal JDs. In line with the National review, is almost complete. OCP 2 will not commence until an investment decision has been made.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Regional Acute Oncology Delivery Model and Network Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes. • Reduction in avoidable admissions.	Regional service coordinator recruited and in post. Project board re-established and revised governance	Develop proposal for OS network structure and implementation.	• Develop work plan to enable delivery of remaining project objectives aligned to Wales Cancer Network	• Undertake review of data requirements. Undertake review of existing	• Acute Oncology Network Manager recruited and in post. • Acute Oncology	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	Objective	Expected Benefits	Key Specific Quarterly Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
		• Improved patient experience. • Reduction in carbon footprint.	structure defined. Undertake benchmarking exercise to facilitate assessment of similar delivery models. Undertake baseline review of current position and activity relative to the Acute Oncology project model. Undertake review of service implementation within VCS. Identify funding stream to support on-going delivery of the service at VCS.		service specification. AOS network board and supporting infrastructure in place. Data sharing agreements and memoranda of understanding (MOUs) in place.	policies and standard operating procedures (SOPs). Develop shared policies and SOPs, where appropriate.	project group re-established (to begin meeting in September 2024).	

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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2 and 5	**Implementation of ePMA for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved information (access to and sharing of). • Improved levels of efficiency and productivity. • Reduction in carbon emissions.	Procure system following approval of Full Business Case (FBC) by Welsh Government. Undertake recruitment to externally funded posts required to support implementation.	Commence system implementation following approval of FBC and subsequent award of contract.	Continue implementation of system.		Preferred bidder confirmed. Awaiting WG review of FBC – due for late-July 2024.	
Trust Strategic Goals 1, 2 3 and 4	**Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services**	• Improved diagnostics information. • Better information sharing and enhanced clinical decision- making. • Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety.		• Implement new system and undertake testing. • Undertake data migration to the new system. Develop and deploy training	Full implementation of electronic test requesting.		Supporting national discussions, as required. Revised go-live timescales for VCC, following delay to national pre-implementation activities. Local implementation planning underway.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved productivity and efficiency levels. • Improved patient satisfaction.		package to facilitate maximize with new system.				
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of the Approved Full Business case for the Development of the New Velindre Cancer (nVCC)**	• Improved quality. • Improved patient safety. • Improved patient dignity and experience. • Increased levels of efficiency and productivity. • Reduced waiting times. • Improved staff attraction and retention. • Improved staff well-being. • Reduction in carbon emissions • .Reduced staff sickness. •	Develop transition plans for all services. Develop and deploy plans to maintain capacity during commissioning of replacement linear accelerators and other capital equipment. Undertake digital enablement work - scoping / business analysis of new systems and ways of working, e.g. patient self-check-in / patient flow, hybrid mail	Develop plans to support the transition to the nVCC site and for dual-site running for all clinical and operational services.			Working groups and structure established to enable the development of transition plans for all services. Plans to mitigate capacity loss for Radiotherapy have been developed as part of the IRS programme implementation this is fully engaged with nVCC programme board. Digital scoping has commenced.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			solution and call centre.					
Trust Strategic Goals 1, 2 and 4	**Implementation of National Programme for Palliative Care and End of Life in Line with National Timeframes**	• Improved quality of care. • Reduction in avoidable admissions. • Improved patient experience.	Identify scope of palliative radiotherapy within VCS and as part of a regional model.	• Identify opportunities for workforce redesign and develop associated workforce plan. Identify possible funding options.				
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables**	• Improved quality. • Improved patient safety. • Reduction in cancelled treatments. • Improved patient health and well-being. • Improved clinical outcomes. • Improved patient experience.	Continue engagement with Prehab to Rehab south- east Wales collaborative and WCN national prehabilitation group. Review funding streams and commissioning models to facilitate prehabilitation	Develop and deploy local implementation and improvement plan.			• An internal prehabilitation project board and working group have been set up. • Phase 1 has completed scoping of prehabilitation services at VCC, understanding	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			service development				of prehabilitation amongst staff, bench-marking and the development of a VCC prehabilitation webpage. • Participation in national prehabilitation groups ongoing.	
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25**	• Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety. • Improved productivity and efficiency levels.	Identify and secure consistent funding to support service delivery. Develop business case.				• Working group established to identify financial means to support on-going delivery of the immunotherapy toxicity service.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Reduction in avoidable admissions. • Improved patient satisfaction.						
Trust Strategic Goals 1 and 2	**Implement Changes to the Nursing Workforce Which Ensure Compliance with Regulatory Requirements and Supports Delivery of Clinical and Scientific Strategy**	• Improved patient outcomes. • Improved quality of care. • Improved patient safety. • Improved patient satisfaction. • Reduction in avoidable admissions.	Develop business cases to secure funding to support nursing workforce innovations and developments.	•Implementation of recommendation of Cancer Nurse Specialist (CNS) review. Undertake evaluation of the CNS Navigator role and implement recommendation Introduce Advanced Clinical Practitioner	• Develop Practice Educator role to facilitate person centred care. Define and implement Model for Clinical Supervision (CNO Mandate).	Evaluate requirement for nursing support in radiotherapy.	-Business case development -CNS review underway	
	Ensure the Viability of the Neuro-	• Improved patient outcomes. • Improved quality of care.	Develop business case and secure				-business case development has been initiated	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Oncology Service	• Improved patient safety. • Improved patient satisfaction. • Reduction in avoidable admissions.	funding to maintain service.					
Trust Strategic Goals 1, 2, 4 and 5	**Undertake Evaluation of SACT Service (to Include SACT Nursing, SACT Bookings and SACT Prepping). Define Recommendations, Develop and Deliver Improvement Plan**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved levels of efficiency and productivity. • Reduced costs. • Improved patient experience.	Service delivery manager recruited and in post.	Baseline assessment complete of SACT service. Service delivery plan developed. Undertake review of booking processes and identify nature and level of Business Intelligence support required to minimize clinical risk.	Alignment of SACT booking processes with wider booking processes. Complete SACT demand profiling exercise		-Work being undertaken as part of the initiation of SACT gold - transition to a BAU group of which this will continue to drive and deliver improvement plans.	
Trust Strategic Goals 1 and 2	**Implement Recommendations from Peer Review of SACT**	• Improved quality. • Improved patient safety. • Improved access. • Improved clinical outcomes.	Receive and prepare response to peer review and determine plan for				-improvement plan developed	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Treatment Helpline	• Reduced waiting times. • Improved patient experience.	implementation (further details to be developed following the receipt of the review).					
Trust Strategic Goals 1, 2 and 5	**Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics**	• Provision of care at home/close to home. • Reduced patient needs to travel. • Increased patient experience / satisfaction.	Development of costed business case to support service expansion. Identify appropriate funding stream to support provision in the longer term.	Deployment of service expansion plan subject to ability to secure funding.	Establish means of service monitoring following deployment of the service expansion plan.	Undertake a review of the service to inform determination of future service delivery model.	-Expansion case has been approved - Work is underway to mobilize this with longer term funding models being developed.	
Trust Strategic Goals 2 and 4	**Implement New Molecular Radiotherapy Treatments at VCS**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity. • Reduced waiting times. • Improved staff attraction and retention. • Improved staff well-being.	Progress the phased implementation of new Peptide Receptor Radionuclide Therapy (PRRT) service from quarter 1 (dependent upon WHSSC undertaking to commission service and	Actively engage All- Wales Molecular Radiotherapy Advisory Group (AWMOL) on development of all-Wales strategy for Molecular radiotherapy.	Develop plan to increase Molecular Radiotherapy clinical trial participation to expand capacity and capability.		• VCC formally recognised by the Joint Commissioning Committee (JCC) as a preferred provider of PRRT. • Working group established to develop and	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Enhanced organizational reputation for quality of service.	availability of discretionary capital to facilitate procurement of equipment). Undertake recruitment of of new PRRT service. Additional workforce to support full implementation				implement plan for delivery of PRRT at VCC.	
Trust Strategic Goals 2, 4 and 5	**Review the Radiation Protection Service Resource to Enable Dynamic Response to National, Regional Partner Stakeholder and Internal Ambitions for Delivery of Expanded and**	• Improved quality.		Development of resource requirement plan for design and construction and implementation at nVCC.	Undertake service development options appraisal exercise.	Identify appropriate funding stream to support sustainable. Long-term service delivery.	No planned update for Q1.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Innovative Diagnostic and Therapeutic Clinical Services with Ionising Radiation Sources							
	Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Develop and deploy operational delivery plan for pharmacy which responds to previously undertaken external service reviews.	Complete development of new strategy for the pharmacy service.			-Development of plans has begun inline with outputs of previous reviews and current service demands.	
Trust Strategic Goals 1, 2 and 3	**Support Procurement of New Version of ChemoCare and Introduce the System for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Establish project group to direct local implementation of upgraded system. Actively engage with all- Wales procurement of upgrade.	• Complete worksheets and labels upgrade. • Undertake testing of new upgrade.	Complete operational implementation of upgrade.		- Project group established and plans in development for upgrade. -Regional engagement in place	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
				Develop and deploy staff training plan.				
Trust Strategic Goals 1, 3 and 4	**Develop and Implement Model for Clinical Leadership and Supporting Governance Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Develop new divisional clinical governance structure. Establish revised Site- Specific Team (SST) governance structure. Appoint new SST lead and new deputy Clinical Director.	• Implementation of clinical decision-making framework to support wider service delivery. Embed clinical and scientific strategy.	Site-Specific Team (SST) activity and performance dashboard.		• Prospective new SST governance structure in development. Senior Leadership Team to consider and agree changes early-autumn 2024.	
Trust Strategic Goals 1 and 3	**Design, Commission and Deploy Revised Patient Transport Model**	• Improved patient experience. • Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes.	Develop revised service model to include effective transport of patients undergoing emergency radiotherapy treatments.	Develop business case.	Identify funding and commission revised service.		• Working group to be established at start of quarter 2 to consider service requirements.	

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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2 and 4	**Implement Pathway Improvement Programme**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes. • Improved patient experience.	Develop and deploy plan to improve capacity and flow in the Outpatients department. Develop implementation plan for replacement video consultation solution. Actively engage in video consultation solution design dialogue facilitated by Tech Cymru.	• Identify services which might be repatriated to local health board contexts. • Introduce interim process for managing electronic referrals. Introduce revised appointment booking Standard Operating Procedures (SOPs). • Introduce revised telephone standards (to include appropriate consideration of the Welsh	• Develop options for amalgamation of booking teams across VCS. Complete full roll-out of new video consultation system.	Implement 'Hospital 2 hospital' system to support standardisation of patient referral processes and to promote efficiencies.	- an initial service improvement led work has commenced which will inform a wider outpatients strategic review Work has commenced in terms of scoping services that can be repatriated in order to otimise treatment capacity and align with patient feeback	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
				language) and system across VCC. • Identify opportunities to improve access to Welsh language training for patient-facing staff. Deploy training plan for clinicians and administrative staff to support introduction of replacement video consultation solution.				
Trust Strategic Goals 1, 2 and 5	**Undertake Digitization of Medical Records**	• Improved patient safety • Improved access to information (for sharing / decision- making)					Scoping due to commence in Q3. WG request for separate business case to cover	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved levels of efficiency/productivity • Reduced carbon emissions					'digitisation' costs, outside of nVCC FBC.	
Trust Strategic Goals 1, 2, 3 and 4	**Implementation of New Services / Delivery Models**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity. • Reduced waiting times. • Improved staff attraction and retention • Improved staff well-being. • Enhanced organisational reputation for quality of service.	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service developments. Implement interim model for delivery of palliative radiotherapy				• Pharmacy horizon scanning group established. • New model for prioritisation developed. Engagement with Senior Leadership Team and Site-Specific Team Leads to be undertaken (September 2024) prior to full implementation . • Proposal for new service	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							development group developed. Proposal to be considered and agreed by Senior Leadership Team and Site Specific Team leads (early quarter 2).	
Trust Strategic Goals 1 and 2	**Implement DHCR Phase 2 by 2024/25**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Review learning from phase 1 to support implementation of further phases. Establish revised governance, reporting and delivery structure for VCS agreed scope and prioritisation of VCS-specific elements for phase 2.	Clarify scope and service delivery requirements.	Develop work plan to support implementation.		Closure of DH&CR Phase 1 scheduled for July 2024. Scoping / prioritization of phase 2 requirements underway. Phase 2 governance yet to be agreed.	

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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goal 1	**Implementation of Consolidated Document Management System Across VCS**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Identify priority areas / services for introduction of new system. Commence deployment of implementation plan.				• Project working group established. • Implementation plan developed. • Project oversight board to be established (September 2024).	
Trust Strategic Goal 1	**Respond to Low / Limited Audit Assurance Findings**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Develop and deploy remedial action plan to address recommendation of CCTV audit Develop and deploy remedial action plan to address recommendation of e-mail audit.				All audits described have established TAF groups, and senior leadership sponsor and a timeline of improvement and recommendation that can take place and embed and improved BAU practice.	

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			Develop and deploy remedial action plan to address recommendation of medical records storage incident..					
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Centre for Collaborative Learning and Innovation**	• Creation and sharing of knowledge across Wales/wider to improved cancer care. • Development of network of partners to tackle key issues. • Creation of knowledge economy and innovation across Wales. • Physical space to support innovation and development working across the					Established project team in place to map out plans and timescales to achieve key benefits.	

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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	Objective	Expected Benefits	Key Specific Quarterly Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
		region/Wales/wider.						

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

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APPENDIX 3

Trust-wide Initiatives - IMTP Progress Report 2024/25 for Quarter 1 as at 30/6/2024.

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Digital Initiatives **Trust Strategic Goals 1, 2, 5** **Digital Strategy: Ensuring our Foundations**	Trust-Wide Telephony including Call Centre Solution	• Improve telephony resilience • New call Centre capability to support improved services for VCS / WBS	Scope	Procure	• Build UAT	• Validate Go-Live		
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Organisation**	"Agile" Delivery Squads introduced to Digital target operating model	• Improved delivery of value-adding Digital services • Improved time to value for Digital services • Digital staff attraction and retention • Alignment with industry best-practice	Discovery	• Pilot – Microsoft 365 Pilot – Digital Inclusion	• Pilot – Microsoft 365 • Pilot – Digital Inclusion •	•	**Trust Strategic Goals 1, 2** **Digital Strategy: Digital Organization**	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 5 **Digital Strategy: Insight Driven**	Digitally enable Value-Based Healthcare through digital services for the Value Intelligence Centre	• Enable the benefits for the Trust Value Based Healthcare programme	• Data driven sense making • Data Maturity Technical developmen t of SST Dashboards	• Data driven sense making • Data Maturity Technical development of SST Dashboards	• Data driven sense making • Data Maturity • Technical developmen t of SST Dashboards	• Data driven sense making • Data Maturity • Technical developme nt of SST Dashboard s		
Trust Strategic Goals 1, 2, 3 **Digital Strategy: Insight Driven**	New Patient Reported Outcome Measures (PROMS) system for Value Based Healthcare	• Digital system in place for capturing PROMS from patients • Improved efficiency over current PROMS collection methods		Business Case	• Procure	• Build of PROMS • Go-live		
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Organizatio n**	Robotic Process Automation (RPA)	• Reduced burden of administrative tasks • Efficiency and effectiveness of processes •	• Establishme nt of PoCs / pilots for non-clinical	Commence set up of RPA service.	• Establish RPA service (non-clinical workflows only). • Clinical coding pilot	• Transfer to BAU	PoCs commenced. Procurement of commercial RPA platform ongoing. Microsoft PowerAutomate already being used	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							to support various use cases.	
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Inclusion**	Digital Inclusion Plan	Digitally connect our donors, patients, and carers and staff to our services 24/7 Place information which is uncomplicated and accessible information into the hands of patients and donors to enable them to make better decisions about the services and support they require. Deliver the technology which supports the provision of more services at home and as locally as possible.	• Digital Inclusion Charter Accreditation Digital Inclusion Plan Q1 Delivery	Digital Inclusion Plan Q1 Delivery	• Digital Inclusion Plan Q3 Delivery	• Digital Inclusion Plan Q4 Delivery	Digital Inclusion plan approved via Trust Board in Q1 2024/25. Process to achieve accreditation underway.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		Provide our staff with the technology to work from a wide range of locations across Wales. • Reduce digital exclusion of people across Wales.						
Trust Strategic Goals 1, 2, 5 **Digital Strategy: Safe and Secure Systems**	New Trust-Wide Network	• Improved network resilience & capacity • New network services available (e.g. location tracking) to support new services for users • Decreased costs for network equipment	Complete design	Commission central network components	• Radiotherapy Satellite Unit on new network	•	Design completed. Technical 'lab' created in WBS to support upskilling of Digital Services team. First deployment scheduled for RSC in Q3 2024/25.	
Trust Strategic Goals 1, 2, 5	IT Service Management (ITSM) Tool - Halo	• Improved efficiency of ITIL processes • Improved visibility of IT	• Build of core ITIL processes UAT	• Validate	• Transition • Go-Live	•	Implementation underway, currently on plan for initial September 2024 launch.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Digital Strategy: Ensuring our Foundations		Assets for Cyber and Information Governance • Compliance with best practice approaches for ITSM						
Trust Strategic Goals 1, 2 **Digital Strategy: Safe and Secure Systems**	Deploy a range of preventative cyber security tools and services, including staff education programme, to reduce likelihood of cyber breach – Cyber Security Strategic Development Plan (CSSDP)	• Improved resilience • Reduced number of Cyber security incidents • Staff are more confident dealing with Cyber threats			•	•	Bi-monthly phishing campaigns now established. Annual update to Cyber Security Strategic Plan agreed via QSP Committee in June 2024.	
Trust Strategic Goals 1, 2 **Digital Strategy:**	Server refresh/virtualization and refresh backup/storage	• Reduction in legacy technology in use • Improved infrastructure resilience	Scope Server refresh/virtualization	• Procurement Server refresh/virtualization Scope Backup/Storage	• Build / UAT / go-live Server refresh/virtualization • Procurement	• Build / UAT / go-live Backup/Storage •	Work ongoing.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Safe and Secure Systems		• Simpler infrastructure changes to support new services			Backup/Storage			
Trust Strategic Goals 1, 2, 4 **Digital Strategy: Digital Organization**	Introduce new Digital Training Platform	• Improved efficiency of training to colleagues • Enablement of the Trust Digital Inclusion Plan	Go-live for digital training platform	Transfer to Business as Usual	•	•	LMS 365 deployed – work ongoing to scale / adopt.	
Trust Strategic Goals 1, 2 **Digital Strategy: Safe and Secure Systems**	Windows 10 to Windows 11 migration and common user/device experience	• Improved Cyber Security • Simplified management of devices	• Win 11 Build Single Sign-On	Win 11 Transition plan	• Win 11 Go-live	•	Migration of users to Win11 commenced.	
Trust Strategic Goals 1, 2 **Digital Strategy:**	Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre	• Improved digital capabilities to manage fundraising donors/WBS donors	• Funding raising scope WBS Donor scope	• Funding raising Procurement • Fundraising Build	• Funding raising Go-Live •	•	Prior Information Notice drafted. In discussion with Procurement to determine procurement	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Digital Organization		• Digitally enabled service plans					approach / timescales. Trust-wide procurement preferred.	
Trust Strategic Goals 1, 2 **Digital Strategy: Insight Driven**	Performance Management Framework (Quality Measures) dash board	• Improved efficiency in performance reporting • Automated processing of metrics • Improved data driven decision making	Phase 1 Measures available in PMF dashboard	Phase 2 Measure dashboard definition	• Phase 2 Build • Phase 2 go-live	•		
Trust Strategic Goals 1, 2, 3, 5 **Digital Strategy: Insight Driven**	Transition to VXRails data warehouse platform as the Local Data Repository (LDR)	• Improved performance of Data and Insight jobs • Improved infrastructure resilience	• LDR go-live Transition from existing Data Warehouse (VCC + WBS)	Transition from existing Data Warehouse (VCC + WBS)	•	•	VCC migration completed, planning underway to migrate WBS service.	
Trust Strategic Goals 1, 2, 3	National Data Resource roadmap	• Whole system cancer pathway • Support service improvement re-design • Enable VBHC	• Local Data Repository to National Data Repository connectivity	• Velindre NDR Google Cloud Slice commissioned	• NDR Pilots • Integration of local and national datasets	• NDR Pilots • Integration of local and national datasets		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Digital Strategy: Insight Driven				NDR Roadmap Agreed				
Trust Strategic Goals 1, 2, 3 **Digital Strategy: Insight Driven**	Trust wide Data and Insight plan	• Creation of a Trust wide service for Data and Insight • Improved business intelligence for decision making • Improved data quality	• Agree Plan for Data and Insight Service • WBS Priority Data and Insight Workplan VCS Priority Data and Insight Workplan	• Transition to Data and Insight Service • WBS Data and Insight Workplan in Place • WBS Data and Insight Workplan in Place	• Transition to Data and Insight Service • WBS Data and Insight Workplan delivery • VCS Data and Insight Workplan delivery •	• WBS Data and Insight Workplan delivery • VCS Data and Insight Workplan delivery •		
Trust Strategic Goals 1, 2, 3, 4, 5 **Digital Strategy: Ensuring our Foundations**	New Velindre Cancer Centre (nVCC) digital enablement	• SMART hospital as set out in the nVCC strategic case • Modern, secure digital infrastructure • Improved patient experience of digital • Improved colleague	Recruitment of nVCC Digital team	• Scrutiny of ACORN Digital systems • Design and Procurement of Trust Digital Systems	• Patient check implementation into VCS • Scrutiny of ACORN Digital systems • Design and Procurement of Trust Digital Systems	• Scrutiny of ACORN Digital systems • Design and Procurement of Trust Digital Systems •	Digital workstream of nVCC established – currently scoping ways of working, priorities etc.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		digital experience • Flexible Digital infrastructure to support service redesign			•			
Trust Strategic Goals 1, 2 3 and 4	**Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services**	• Improved diagnostics information. • Better information sharing and enhanced clinical decision-making. • Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety. • Improved productivity and efficiency levels.		• Implement new system and undertake testing. • Undertake data migration to the new system. • Develop and deploy training package to facilitate maximize with new system.	• Full implementation of electronic test requesting. •	•	Supporting national discussions, as required. Revised go-live timescales for VCC, following delay to national pre-implementation activities. Local implementation planning underway.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved patient satisfaction.						
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of the Integrated Radiotherapy Solution Programme by 2026/27**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	• Quadris Datacenters commissioned Upgraded Varian solution available to support service design	Integration of IRS into National Architecture	• Integration of IRS into National Architecture	•	Work ongoing to finalise integration requirements for phase 1 of IRS solution. Significant amount of scoping and development required.	
Trust Strategic	**Implementation of electronic prescribing**	• Improved quality.	• Procure system following approval of Full	• Commence system implementation	• • Continue implementat	• • Continue implement	Preferred bidder confirmed.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Goals 1, 2 and 5	**and medicines administration (ePMA) for Use by Velindre Cancer Services**	• Improved patient safety. • Improved information (access to and sharing of). • Improved levels of efficiency and productivity. • Reduction in carbon emissions.	Business Case (FBC) by Welsh Government. • Undertake recruitment to externally funded posts required to support implementation.	following approval of FBC and subsequent award of contract.	ion of system.	ation of system.	Awaiting WG review of FBC – due for late-July 2024.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)**	• Increased patient access. • Increase in uptake of radiotherapy. • Reduced patient travel times. • Improved clinical outcomes. • Improved equity of care regionally. • Increased patient satisfaction.	Scope and procure PSBA network connectivity		• Define and implement necessary digital infrastructure to enable effective and efficient operation of the new Satellite Unit. • PSBA network connectivity in place •	• Digital Infrastructure build at RSU •	Work progressing to plan.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2 and 3	**Support Procurement of New Version of ChemoCare and Introduce the System for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	• Establish project group to direct local implementation of upgraded system. • Actively engage with all-Wales procurement of upgrade.	• Complete worksheets and labels upgrade. • Undertake testing of new upgrade. • Develop and deploy staff training plan.	• • Procurement for SACT ePrescribing completed	•	Awaiting update from Procurement re: next steps.	
Trust Strategic Goals 1, 2 and 4	**Upgrade Video Consultation platform to support Pathway Improvement Programme**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes. • Improved patient experience. •	• Develop implementation plan for replacement video consultation solution. • Actively engage in video consultation solution design dialogue facilitated by Tech Cymru.		• • Complete full roll-out of new video consultation system.	•	Contract for current AttendAnywhere platform extended. Scoping work ongoing to determine 'next steps' for VCC.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2 and 5	**Undertake Digitization of Medical Records**	• Improved patient safety • Improved access to information (for sharing / decision-making) • Improved levels of efficiency/productivity • Reduced carbon emissions			• Scoping	• Establish project group. • Identify service improvements / opportunities for change. • • Identify additional resource requirements	Scoping due to commence in Q3 2024/25	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of Regional Acute Oncology Delivery Model and Network Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes. • Reduction in avoidable admissions. • Improved patient experience. • Reduction in carbon footprint.	• support project board re-establishment • support baseline review, benchmarking, and VCS implementation		• Develop digital work plan to enable delivery of remaining project objectives. • • Data sharing agreements and memoranda of understandi	• Undertake review of data requirements. •		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
					ng (MOUs) in place.			
Trust Strategic Goals 1 and 2	**Electronic Patient Record – Phase 2**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	• Scope Digital Health Care Record Phase 2 Requirements and investment case • Cancer Informatics Programme – palliative care		• Support Cansic decommissioning •	• • Implement 'Hospital 2 hospital' system to support standardization of patient referral processes and to promote efficiencies.	Closure of DH&CR Phase 1 scheduled for July 2024. Scoping / prioritization of phase 2 requirements underway.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**VCS Service Changes – Other digital activities in support of the VCS plan**	• Improved patient safety. • Improved clinical outcomes.	• Agree PSA Tracker Phase 2	• Transfer RITA chatbot service into business as usual	•	• VCS Call Centre on new telephony platform •		
	WHAIS Digital: Implement a new Laboratory Information Management	• Improved availability of information. • Increased efficiency	Completion of Discovery Phase.	Commence Environments set-up.	Complete implementation.	•	All work proceeding to plan.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.	/productivity through Improved patient experience. • Reduced turnaround times. • Reduction in avoidable waste.	Commence Implementation. Commence Data Migration.		• Complete Environments set-up.		On-site supplier visits took place in June 2024.	
Trust Strategic Goals 1 and 5	**WBMDR Digital**: Digital enablement of the strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2026/27.	• Increased stem cell donor panel. • Increase in stem cells supply. • Improved resilience in stem cell supplies. • Improved clinical outcomes in Wales / globally. • Increased income levels. •	Investigate digital replacement solution for WBMDR software.	Continue to develop URS and engage with digital suppliers to replace current WBMDR software,	• Produce and process tender to replace current WBMDR software.	• Follow tender process to replace current WBMDR software.	Work ongoing to scope suitable solution. A first draft of the URS has been completed. The URS completion will allow us to move to a formal tender process.	
	BECS: Procure new Blood Establishment Computer System (BECS) contract and	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	New contract procurement commences – Competitive Dialogue.	New Contract Procurement. Business Analysis – ways of	New Contract Procurement. Business Analysis – ways of	New Contract Procurement ends. Continue analysis and testing of	Prior Information Notice has been published and initial supplier engagement sessions are underway.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	implement digital system.		Recruitment of SMEs. Analyze Semester patch feasibility. Analyze and test Maintenance patch. Virtualization of existing infrastructure.	working/service mapping. Implement Maintenance patch. Continue analysis of Semester patch. Continue virtualizations of existing infrastructure.	working/service mapping. Analysis of Semester patch if required. Prepare new hardware. • Plan and prepare Delta Release.	Semester patch. • Implement Delta Release.	Funding made available by WG for 2024/25, to support procurement activity. Funding arrangements for implementation and 'BAU' costs yet to be agreed.	
	NEQAS: Implement new digital solution for National External Quality Assessment Service (NEQAS).	• Digital solution will free up staff time to deal with marketing and development activities without the employment of additional staff. • Capacity to expand service provision. • Improved sustainability as system doesn't rely on paper records.		Begin Validation of new NEQAS system.	• Continue Validation of new NEQAS system.	• Complete Validation of new NEQAS system.	Options appraisal re: implementation approach ongoing.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Complete digital audit trails. • Removal of potential errors caused by manual data entry by NEQAS staff. • Digital platform for EQA will reduce turnaround times.						
	WLIMS 2.0: To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system.	• Modernize patient management software with robust digital support. • Connectivity to national database. • System improvement. • Increased patient safety. • Access to blood usage data to inform demand planning.	Completion of DHCW collaborative development.	System Integration Testing (SIT).	Completion of SIT. Formal Validation. 1st deployment activity. •	•	Build phase delayed by one month, correction plan in place. No change to overall delivery timescales. Work ongoing to confirm arrangements for Health Board deployment of 'blood tracking' solutions.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
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Trust Strategic Goals 1, 2, 3, 4 and 5	**Plasma for Medicines**: Digitally enable the Plasma for Medicines programme	• Secure the supply chain for Immunoglobulins in Wales. • Reduces need for importation. • Cost avoidance/reduction. • Avoids patient rationing.	Support procurement of Hepatitis A and Parvo b19 testing.	Support the Scope of the clinical pathway for Hepatitis A and Parvo B19 testing.	•	Commence validation and digital implementation of Hepatitis A and Parvo B19 testing. •		
Strategic Goals 1, 2	**Prometheus**: Migrate digital solution from DHCW once service support ceases as part of WLIMS 2.0 programme	• Continuity of the Prometheus messaging platform after LIMS 2.0	Scope service requirements	Procure new service arrangements	Build new hosting platform • Test new hosting platform	Validate new hosting arrangements • Transition and go-live	Supplier engagement commenced. Options appraisal of deployment approaches underway. Target Q3 2024/25 migration of service.	
	Foetal D: Digital enablement of Foetal DNA typing.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women. • Improved safety.	Undertake digital developments to support reporting of results.	Support the implementation of all Wales service for Cell Free Foetal DNA screening.	• Embed service.	•	Completed – service live.	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved patient experience. • Reduction in avoidable waste/costs. •	Complete validation and implementation of new test.					
Strategic Goals 1, 2	**Live Connectivity:** Introduce live connectivity for the blood collection teams	• Improved connectivity to systems •	Pilot live connectivity system	Scale live connectivity system to all teams	•	•	Pilot in progress with Collections 'West' team. Aim to extend service across all collection teams in Q2.	
Strategic Goals 1, 2	**Donor Interaction and Appointments**: Digitally enable improved donor interaction by 2026/27.	• Personalized donor experience • Wider communication choice for donors. • Increased donor retention. • Improved information (for sharing/decision-making). • Increased levels of efficiency/ • Productivity.	Development of refreshed booking portal.	Implement refreshed booking portal.	•	Begin introduction of a donor experience hub. Begin implementation of a Customer Relationship Management (CRM) System. •		

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Workforce and Organizational Development **Strategic Goal 1** Outstanding for quality, safety and experience	**Theme 1: Wellbeing and Engagement** **Theme 2: Supply and Shape** **Theme 3: Skilled and Developed People** **Theme 4: Leadership and Succession Planning** **Theme 5: Digital Ready People** **Theme 6: Attracting and Retaining the Best Talent**	• Implementing a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement. • Implementing our education strategy to support staff to grow professionally and offer internal and external pathways to gain experience and knowledge • Develop a new Trust Strategic Equality Plan that supports the implementation of our Anti-	**Annual Actions continuous throughout 2024/25** **Planned and Sustained Workforce** **Right people right place right time** 1. Implement the Education Strategy Implementation Plan 24/25 2. Following the agreement of the Clinical and Scientific Skills Strategy develop Trust wide priorities and implementation plan for multi-disciplinary workforce model 3. Manage the successful implementation of the WL service provision (SLA) to support service bi-lingualism 4. Attraction and Retention				Satisfactory progress being made against these Annual Actions in line with agreed timescale Quarterly breakdown to be provided next year	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		Racist Action Plan and other aligned anti-discriminatory practices • Implementing an agile approach to working • Targeting an increase in bi-lingual recruitment to grow our Welsh speaking workforce • Improving the ways we celebrate success ensuring our staff feel highly valued for the amazing work they do • Growing the Trust Inspire Leadership and Management Programme	5. Agree a plan for the Widening Access Programme 6. Ongoing recruitment Marketing Campaigns for hard to fill roles 7. Working with Comms Trust wide recruitment campaign in place 8. Evaluate the International nurse Recruitment Programme 9. Develop a Nurse retention plan					

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Strategic Goal 1 Outstanding for quality, safety and experience	•	**Skilled and Developed Workforce Achieving Excellence through our staff** 1. Component caring and capable workforce Deliver the Trust Training Plan 24/25 – clear KPIs to support evaluation 2. Transforming care pathways Working with the service agree training requirements for care pathways (HSCW, AP and Consultant) through the workforce planning process to shape a Multi-Disciplinary workforce Model 3. Developing our academic profile Through the training plan provide education, training, and development opportunities to enable staff to develop their knowledge and skills through life-long learning, through the Velindre Oncology Academy and the Collaborative Centre for Learning and Innovation 4. To create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology 5. **W**orking with Digital - Provide training and sources of support to enable the workforce to be confident and competent in the use of new equipment, systems, and technology				Satisfactory progress being made against these Annual Actions in line with agreed timescale Quarterly breakdown to be provided next year	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Strategic Goal 2 An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	•	**Healthy and Engaged Workforce** Our staff will feel valued and supported and promote a culture of true inclusivity, fairness and equity across the workforce. 1. Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence 2. Implement the Values and Behaviour framework project 3. Triangulate culture work, staff feedback themes and leadership work to deliver an aligned Culture Programme of work that addresses Organisational issues reflects our values and allows staff to speak up freely 4. Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working **5.** Deliver an action plan 24/25 commitment in the Trust Anti- Racist Action plan 6. Monitor Welsh Language Standards, working with Divisions on improvement plans 7. Implement the WL Culture plan 8. Update all WOD related policies and procedures 9. Deliver an infrastructure to support Industrial Action and wellbeing offer for staff during IA				Satisfactory progress being made against these Annual Actions in line with agreed timescale Quarterly breakdown to be provided next year	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
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	Strategic Goal 2 An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	•	**People Function Cultural Development – People and Relationships Model** 1. Develop an engagement plan for the function to support the engagement and alignment with service development 2. Implementation of the holistic People and Relationships model 3. Engagement and Commitment from EMB 4. Promote the principles of hybrid working and undertake regular pulse surveys to gain feedback				Satisfactory progress being made against these Annual Actions in line with agreed timescale Quarterly breakdown to be provided next year	

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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Clinical Quality and Safety **Strategic Goal 1** Outstanding for quality, safety and experience		•	**Annual Actions continuous throughout 2024/25** **Clinical Quality and safety Priorities:** 1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience. 2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice. 3. To Integrate Clinical Audit within VCS Quality and Safety function 4. Development of robust Site- Specific Quality Metrics 5. To improve incident and risk management. 6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System 7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service. 8. Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma- derived medicines. 9. Review and improvement of donor selection and screening processes					

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Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			10. Introduction of all Wales foetal D Screening for RhD negative pregnant women. 11. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results. 12. Achieve JACIE accreditation for the WBMDR 13. Commencing rollout of live connectivity of the BECS at community-based donation clinics 14. Enablement of DATIX, QPULSE connectivity on community- based clinics for incident, risk and concerns recording at point of contact 15. Increase in staff psychological safety (target TBC) scores within VUNHST Staff Survey results.					
	The Quality Impact Assessment (QIA) focuses on Three Main Areas:	•	**Annual Actions continuous throughout 2024/25** • Patient / Donor / Staff Safety – the avoidance of unintended or unexpected harm to people during the provision of health care. • Clinical Effectiveness – the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. • Patient / Donor / Staff Experience – the way a patient or donor feels about their care based on all interactions, before, during and after delivery of care, or how a member of staff may feel whilst providing the care					

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Strategic Equality Plan and Equality Impact Assessments (EQIA)	•	**Annual Actions continuous throughout 2024/25** • Objective 1: Increase workforce diversity & inclusion, and eliminate Pay Gaps • Objective 2: Engage with the community • Objective 3: Communicate with people in ways that meet their needs • Objective 4: Ensure service delivery reflects individual need					
Value Based Healthcare (VBHC)	**Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre** **Pre-op anaemia programme** This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10	Reduced post-operative LOS, Reduced demand for blood transfusions for surgery. Eliminating unwarranted variation through implementing a consistent approach to anaemia management across Wales, • Improved patient outcomes	Progress with WBS access to transfusion data Consultation on All Wales Preoperative Anaemia Pathway	All Wales Preoperative Anaemia Pathway guidance issued Promotion of programme aims through conferences, training and senior leadership fora.	Ongoing monitoring of Pre-op anaemia pathway adherence, continued provision of training. Initial preparation for widening scope of programme to allow earlier intervention for patients	Major Surgery dashboard revised to include costing information. Financial benefit of programme to be costed	Pre-operative anaemia pathway launched. POAS test set embedded with impact monitored. Improvement seen in the identification of patient anaemia since project initiation.	

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	procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).							
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre Training, Engagement and Communicatio n: Creating, sharing and delivering developmental content to staff.	• Increased engagement and confidence with the aims and principles of VBHC			Communication strategy created. Case study catalogue underway	Implementatio n of Communicatio n Plan including engagement sessions with Patients and Staff on the digital PROMS system	Engagement sessions held across the Trust with clinical and non-clinical staff.	

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	This includes generating case studies of value in action projects.							
	Value Intelligence Centre Technical Development: Ensuring that linked data sets (e.g. activity, outcomes, and use of resources) are accessible to services to inform decision making. This takes the form of information tools such as dashboards which will be iterated to meet service needs	• Accessible data for decision making for clinical services. • Provides the ability to compare treatments.	Development of SST dashboard in conjunction with VCS division	SST Dashboard Launched with demonstration sessions to support staff to engage with this tool.	Ongoing refinement of SST Dashboard and use of tool to understand variation within treatment algorithms.	Embedding usage	Holistic SST Dashboard in place enabling users to look at activity, outputs and use of resources for different patient cohorts.	

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	Value Intelligence Centre Data Maturity: This theme focuses on ensuring that the accuracy and completeness of data within patient IT systems is sufficient to enable meaningful analytics. Working with service areas to identify and resolve the most common and critical issues.	• Improved accuracy of key patient pathway data, this improves patient safety, accuracy of income and analysis of activity	Data Quality issues relating to open pathways identified	Clinical requirement for comprehensive metastatic breast patient cohort identified and initial assessment of options undertaken	Data Quality Management Framework agreed	Focused Data Quality Management group in place for SACT	Open pathway issue identified and escalated. With support in place to resolve. Diagnostic work for identifying Metastatic Breast Cancer patients initiated.	
	Digital PROMs Platform: To enable the systematic digital collection of patient reported outcome	Increased time spent on what matters to patients Enhances research and quality initiatives,		Business Case approved by Trust Board	Implementation of digital solution into 3 clinical areas	Ongoing implementation of system within VCS	Options appraisal completed. Business Case written and approved.	

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	measures (PROMs) to capture and understand the quality of life and symptom burden that our patients experience.	driving innovation Supports a reduction in unwarranted variation • Improved patient engagement and treatment adherence						
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre **Patient Outcomes:** We need to agree the questions to be asked. This ensures consistency across pathways and the ability to analyse aggregated data	• Consistent questions in place across Wales that meet the needs of patients and clinicians for each tumour site.	Approach for reaching consensus on a National PROM set agreed. Process initiated for Breast Cancer	Workshop held for Breast PROMS with initial set proposed as an outcome. Review of nationally agreed PROMS for “fit”.	Agreement reached for national set for Breast. Process initiated for CUP and Gynae	Support the creation of the national Breast Set (including timelines), Agree national set for CUP	Consensus reached on approach to agreeing national PROMS through close collaboration with WCN and WVIH. This includes a “road map” of priority services based on volume.	

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	to assess the benefits or the negative side-effects that treatments can have. These parameters are already agreed nationally for some cancer sites, e.g. Lung Cancer. The Value Intelligence Centre is working with our Clinical Teams, the Welsh Cancer Network, and the Welsh Value in Health Centre to agree validated PROMs tools (sets of questions to capture Patient Reported Outcome Measures) for							

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	different types of cancer							
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre **Food Mission:** Velindre's Food Mission sets a long-term ambition to provide our people with access to affordable, healthy food with an objective to source 70% of Velindre's food from Welsh, environmentally friendly or globally responsible providers by 2035.	• It is expected that this will improve the wellbeing of patients, donors, staff, and their families. Further, it will support the delivery of Velindre's wider Value Based Healthcare, Workforce and Sustainability Strategies, the Trust's Wellbeing Objectives, and its ambition to reach Net Zero by 2030. •	Food Mission approved by Trust Board	Preparation for Value Lab and the implementation of a staff veg box scheme. Collaboration with Menter Mon initiated	Value Lab held to create action plan Launch of Veg Box scheme	Implementation of Food Mission action plan, monitoring impact of changes.	Stakeholders identified and planning completed for Food Mission Value Lab	

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The Estates Plan	**Theme 1: A safe and high quality estate which provides a great experience** **Theme 2: Healthy buildings and healthier people** **Theme 3: Minimizing our impact to the environment** **Theme 4: Using our estate to deliver the maximum benefit and social value to the community we serve**	**Estates and Sustainability Plan 'Estates Excellence'** The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in.	**Annual Actions continuous throughout 2024/25** **Estates Actions** 1. Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs 2. Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces				1) Regular stakeholder operational meetings are being held to discuss and address operational needs. We are currently in the process of developing the scope of work to enhance the clinical facility requirements. 2) Our Arts in Health coordinator is planning projects to engage patients in creative activities, including a writing program for palliative care patients, bedside activities for those on the ward, and a creative support group at St Fagans. These initiatives will launch in Q2, aiming to enhance	

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							patient well-being through artistic expression.	
			3. Investing additional resources in the maintenance of the existing estate to maintain a Category B				3) We have recently completed condition surveys of the VUNHST estate and are currently reviewing the results to ensure that all areas are risk-assessed. This review process will continue into Q2.	
			4. Implementing our estates, digital, workforce and sustainability strategies				4) We are currently planning implementation meetings for the site improvement plans (SIP) to enhance and align with our sustainability strategies.	
			5. Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles				5) A travel survey was completed in Q1 to identify trends and staff	

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							transportation modes. In Q2, we will assess these results to determine and plan the next steps for interventions.	
			6. Identifying innovative ways to adopt renewable energy sources to service our requirement				6) Further progress has been achieved through ongoing energy optimization service visits by external contractors. We are also holding regular meetings with energy suppliers to ensure the effective purchase of green energy.	
			7. Identifying facilities we can share the use of with other public bodies and wider partners				7) Ongoing community events like the Sustainable Summer Jamboree emphasise sustainability and nature, offering staff, the	

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			8. Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets 9. Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services				community, patients, and their family's opportunities to engage in eco-friendly activities on site. 9) A comprehensive Arts in Health program has received approval and funding. In Q2, the program will offer creative writing courses, music on the wards, and staff choirs throughout the Trust. We are partnering with the Arts Council for Wales to further support these efforts, and the BBC Orchestra has already performed on the wards, with continued	

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			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			10. Delivering a number of transformative capital programmes which have sustainability at their centre of design: 11. Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025 12. Refurbishment / development of new outreach facilities by 2024/2025				collaboration at St Fagan's. 10) Ongoing progress being made with nVCC & TGI running through RDD and RIBA2 stages with good progress being made with sustainability being the main focus. 11) TGI Programme benefits meetings taken place, further progress to be made on the combined OBC - FBC to be made in Q2. 12) No progress has been made in this area. Q2 to reestablish update program.	

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			13. Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024 14. Opening of the new Velindre Cancer Centre by 2027				13) Good progress has been made in Q1 on SRU, currently working through partial completion Programme to establish commissioning dates of SRU, Q2 will provide specific dates of commissioning. 14)Date to be changed to 2027	
The Sustainability Plan	**Theme 1: Creating Wider Value** **Theme 2: Sustainable Care Models** **Theme 3: Carbon Net Zero**	**Estates and Sustainability Plan 'Estates Excellence'** The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our	**Sustainability Actions** 15. Implementing our sustainability strategy 16. Applying the principles of the circular economy into our business	• Implementing our sustainability strategy • Providing a comprehensive education and learning programme which provides	• Implementing our sustainability strategy • Providing a comprehensive education and learning programme which provides	• Developing clinical service models which support sustainability • Implementing our sustainability strategy	Good progress being made against all actions	

	Theme 4: Sustainable Infrastructure **Theme 5: Transition to a Renewable Future** **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**	patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in.	processes through design, procurement, re-use and lifecycle. 17. Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day').	staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Implementation of our carbon reduction plan which will see us achieve Net Zero and transition to renewable energy for our services and facilities.	staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Working with partners and the local community	• Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day')		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			18. Continuous work on major capital projects including the TGI, RSU & nVCC. 19. Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport 20. Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society	• Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprentices hips, the use of our buildings and facilities	to identify ways in which we can deliver wider benefits and value to society through employment and apprentices hips, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement	• Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Using our procureme nt activities and NHS Wales Shared Services capability to drive a sustainabl e approach and achieve wider ethical and		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			through employment and apprentices hips, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Government s Foundationa l economy	as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Government s Foundationa l economy o	to maximise the reach of the Trust within the Government s Foundationa l economy o	social value in areas including local employme nt and prosperity; carbon reduction; anti-slavery and unethical practices. • Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employme		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
						nt and apprentice ships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programm es); becoming an anchor institution in place making; and procureme nt to maximise the reach of the Trust within the Governme		

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
						nts Foundational economy		
The Financial Plan	**Strategic Goal 5** A sustainable organization that plays it part in creating a better future for people across the globe	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive. **These actions are all annual and ongoing through the year to year end**	**Annual Actions continuous throughout 2024/25** **Value & Sustainability** • In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures. • In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures. • In line with the Trust's decision to rescind income protection from marginal currency rates and volumes in 2023/24 and work undertaken with NWSSP Medicines Unit to enable supply of two immunotherapy drugs from their Medicines Unit at lower cost than from the incumbent provider, we will continue to explore ways to relieve financial pressures on the system in 2024/25 and beyond. • The Trust will continue to integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. • Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit. • VBH Pre-operative anaemia pathway work with Health Boards will release bed capacity and plans for further expansion of the pathway to include other patient cohorts will further increase Health Board bed capacity freed-up. • Plasma for Medicine Business case if approved and funded by WG / WHHSC has potential to save c £1.5m in phase 1 on blood derived				Good progress being made against these annual actions – all on track	

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			medicines used by Health Board and if phase 2 approved up to £2m saving to Health Boards. • Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.					

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

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TRUST BOARD

Compassionate Leadership Pledge 2024

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Oghogho Oyan, Workforce Development Manager and Claire Budgen, Head of Organisational Development
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	Health Education and Improvement Wales launched the Compassionate Leadership Pledge in June 2024. The objective is to embed compassionate leadership in our behaviours. It focuses on relationships through careful listening to understand, empathise with and support other

	people, enabling those we lead to feel valued, respected and cared for so they can reach their potential and do their best work.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** this paper and agree to sign the Velindre University NHS Trust Compassionate Leadership Pledge.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Run	29/08/2024
Quality, Safety and Performance Committee	12/09/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS EMB stated that the way in which we use the pledge is crucial. The behaviour indicators were seen as the possible starting point for a Board Development Programme and should be reflected in the Executive Team objectives. EMB also emphasised the need for the Board to put the compassionate leadership principles and Trust values at the heart of its agenda with a re-balancing of board time spent on all elements of its remit. QSP endorsed the paper and added that the pledge should be displayed clearly at Velindre Cancer Centre, Welsh Blood Service Headquarters in addition to Trust Headquarters. The dates within the original action plan were clarified, which has been reflected in section 3.3 of this paper.	

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

APPENDICES

None	

1. SITUATION

1.1 The NHS was created in 1948 to be compassionate and inclusive. Having a compassionate leadership translates to compassionate cultures, which in turn translates to highly motivated teams that provide compassionate health care to people of Wales. NHS Wales has followed Compassionate Leadership principles for several years and that thinking has underpinned our current leadership and management development programmes and the NHS Staff Survey. Health Education and Improvement Wales have now built on this philosophy by launching a Compassionate Leadership Pledge for organisations, teams/departments and individuals to tangibly demonstrate their understanding of and commitment to leading others with compassion.

1.2 More recently, the NHS Wales Chief Executive has written to all organisations to encourage senior leaders to use the Nurturing Kindness and Inclusion behavioural indicators from the NHS Wales Success Profile for current and aspiring CEOs (see below) as a tool for self-reflection and identifying areas of development.

	Nurturing kindness and inclusion - this is about taking personal responsibility for embedding an inclusive and compassionate culture where staff, partners and citizens are valued for their uniqueness and the differences between individuals are celebrated.
16.	Genuine, able to connect with people at a personal level, and interested in the lives and aspirations that extend beyond their day-to-day work.
17.	Brave and uncompromising in tackling discrimination, bullying or prejudice, whether within their own Health Board, local system or at a national level.
18.	Champions and models the benefits of inclusion and diversity for all aspects of team, organisational and system effectiveness.
19.	Builds trust and creates psychological safety through expressing personal vulnerability, sharing their shortcomings, and demonstrating forgiveness.
20.	Works proactively with their Chair and Board members to shape a culture that values empathy and support as much as candor and a willingness to challenge.

2. BACKGROUND

2.1 The report proposes that the Trust formally signs the Compassionate Leadership Pledge in order to foster a culture of compassion throughout the workforce by implementing the compassionate leadership principles. This approach aims to dismantle barriers that impede compassionate behaviours towards oneself and colleagues. Research evidence shows the importance of this initiative,

demonstrating that exclusion has detrimental effects on individuals' health and well-being. Moreover, a lack of compassion correlates with diminished performance, highlighting the integral role of compassion in both personal welfare and organisational effectiveness.

3. SUMMARY OF CONSIDERATIONS

3.1 Compassionate Leadership Pledge

There are seven key elements of the compassionate leadership pledge:

- Developing supportive and effective team working
- Creating environments where collective leadership thrives
- Improving equality, inclusion and diversity
- Establishing the conditions for continuous improvement and innovation
- Agreeing on direction and ensuring alignment and commitment
- Enabling safe, trusting and engaging systems and cultures
- Managing difficulties and challenges positively, openly, courageously and ethically.

3.2 Actions to achieve sign-off of the Compassionate Leadership Pledge

Organisational culture starts at the top therefore the Trust Board has a particular role in supporting and enacting the Compassionate Leadership Pledge. At the

same time, every staff member is considered a leader and all staff should sign the Compassionate Leadership Pledge. To facilitate this signing, the following actions will be taken.

3.2.1 Organisational Level - Sign-off by the Trust Board

All Board members will formally sign a paper copy of the pledge which will be displayed in Trust Headquarters. A formal statement of endorsement will be recorded in the minutes of the Trust Board meeting of 26 September 2024 demonstrating the organisational-level signing of the pledge.

3.2.2 Team/Departmental Level - Compassionate Leadership team discussions

Teams will be asked to discuss the Pledge as part of their regular pattern of meetings. This will provide an opportunity to reinforce the principles of empathy, support and inclusivity, ensuring that compassionate leadership remains a living, breathing part of our organisational culture. By regularly revisiting these values, we empower our staff to lead with compassion in every interaction, fostering a more understanding and collaborative work environment. This continuous commitment to compassionate leadership will not only enhance team dynamics but also positively impact our service to the community.

3.2.3 Individual Level – Sign-off at Croeso Induction Programme

Croeso Induction will now incorporate the Compassionate Leadership principles, ensuring that every newly recruited staff member is introduced to the pledge from the outset. By signing the pledge during their induction, new employees will recognise these values early in their employment, making compassionate leadership an integral part of their professional roles and daily interactions. This commitment will foster a culture of empathy, understanding and support, enriching both the workplace and the broader community we serve.

3.2.4 Individual Level - Sign off at Inspire Leadership Programme

During the Inspire training session on Leadership, attendees will sign the pledge, giving upcoming managers the opportunity to commit to compassionate leadership. This step ensures that they not only understand but also embody the principles of empathy, support, and inclusivity as they grow into their managerial roles. By doing so, we cultivate a leadership culture grounded in compassion, which will positively influence their teams and the overall organisation.

3.3 Actions that embed the Compassionate Leadership Pledge

Our existing leadership development and equality programmes are rooted in compassionate principles and are therefore a vehicle for us to demonstrate the pledge in action.

Ref No	Principle	Benefits to the Trust	Actions	Trust Lead	Completion Date
1	Improve equality, inclusion and diversity, consciously removing barriers and boundaries	Enhanced employee morale and retention. Broader range of perspectives and ideas.	Issue a staff communication to state that diversity and inclusion is an essential component of the Inspire Management Development Programme and the Croeso Induction programme.	Workforce Development Manager	30.9.24
2	Improve equality, inclusion and diversity, consciously removing barriers and boundaries	Enhanced employee morale and retention. Broader range of perspectives and ideas.	Submit a generic template for People Policies Equality Impact Assessments to the People Policies Review and Development Group which highlights the connection between Compassionate Leadership and inclusion.	Head of Organisational Development	30.9.24
3	Strengthen respect, voice, influence, and choice	Increased employee engagement. Improved decision-	Introduce Terms of Reference for staff Diversity networks. Launch networks and act on staff feedback.	OD Manager – Equality, Diversity and Inclusion	31.12.24

Ref No	Principle	Benefits to the Trust	Actions	Trust Lead	Completion Date
		making processes			
4	Strengthen respect, voice, influence, and choice	Increased employee engagement. Improved decision-making processes	Reflect Compassionate Leadership principles in the emerging staff engagement framework so that it is clear how Compassionate Leadership supports employees having open two-way communication.	Head of Organisational Development	31.3.25
5	Develop supportive and effective team and inter-team working	Higher productivity and efficiency. Better problem-solving and innovation	Issue guidance to teams for holding Compassionate Leadership discussions and facilitate team-building activities and celebrate milestones and encourage cross-departmental projects and collaborations.	Workforce Development Manager	31.3.25
6	Enable safe, trusting and engaging systems and cultures	Reduced workplace conflicts and stress. Higher levels of trust and collaboration	Use the Nurturing and Kindness Behaviour indicators as a foundation for Board Development utilising self-assessment and group discussion to further embed those behaviours.	Executive Director of Organisational Development and Workforce	31.12.24

Ref No	Principle	Benefits to the Trust	Actions	Trust Lead	Completion Date
7	Manage behaviour positively, openly, courageously, and ethically	Enhanced organisational reputation. Increased trust and respect among employees.	Roll out training and briefings to embed the new Values and Behaviours so that all staff are aware of the content and benefits of the framework.	Head of Organisational Development	31.12.24
8	Establish the conditions for our workforce to reflect, learn, continually improve and innovate	Continuous improvement and innovation. Better adaptability to change.	Implement the Trust Quality Priorities 2024-25, including implementing the Incident Management Framework and the Learning Framework	Head of Quality and Safety	31.3.25
9	Create environments where collective leadership thrives	More resilient and adaptable teams. Distributed decision-making leading to faster responses	Update leadership development activities to reflect shared decision making and responsibility.	Workforce Development Manager	31.3.25

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☐ Effective ☒ Equitable ☒ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	A More Equal Wales – a society that enables people to fulfil their potential no matter what their background or circumstances

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Signing the Compassionate Leadership pledge confirms commitment to an existing model of leadership rather than proposing a change.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

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

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TRUST BOARD

REVISIONS TO THE MODEL STANDING ORDERS, RESERVATION AND DELEGATION OF POWERS FOR NHS TRUSTS; AND MODEL STANDING FINANCIAL INSTRUCTIONS

DATE OF MEETING	26 September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager Tracy Hughes, Interim Head of Financial Operations
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance Matthew Bunce, Executive Director of Finance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	This report advises the Trust Board of revisions to Schedule 1 Model Scheme of Reservation and Delegation of Powers and Schedule 2 Standing Financial Instructions which form part of the Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts in Wales.

	The changes relate to the response to the matter raised by Welsh Government relating to the special severance payment made to a member of the Trust Senior Team that had been highlighted as part of the audit of the Annual Accounts by Audit Wales.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the revisions to the Trust's Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Model Standing Financial Instructions for Trust Board Approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	09/09/2024
Audit Committee	17/09/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Executive Management Board and Audit Committee **ENDORSED** the revisions to the Trust's Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Model Standing Financial Instructions for submission to the Audit Committee	

7 LEVELS OF ASSURANCE - N/A

APPENDICES	
Appendix 1	Schedule 1 Model Scheme of Reservation and Delegation of Powers
Appendix 2	Schedule 2 Standing Financial Instructions

1. SITUATION

Velindre University National Health Service Trust is a statutory body that came into existence on 1st December 1993 under the Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838), as amended, "the Establishment Order".

Velindre University NHS Trust has a duty under Regulation 19(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990 to make Standing Orders for the regulation of their proceedings and business. It is important to note that the Trust is able to vary or suspend its own Standing Orders, providing that it is able to satisfy that it complies with the relevant regulations.

2. BACKGROUND

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales. All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

3. ASSESSMENT

3.1 In March 2024 the Trust made an ex-gratia payment of £39,745.50 to a member of the Trust senior team. This was approved by the Remuneration Committee on the 19th March 2024.

3.2 It was identified during the audit of the annual accounts that the process followed in making this payment fell outside the financial management process set out in the Manual for Accounts. This has led to the qualification of the Trust Accounts on a regularity opinion.

3.3 The circumstances that led to this payment being made were that the Remuneration Committee approved the payment based on the SOs and SFIs Losses & Special Payments scheme of delegation, as Trust officers had assessed that this case should be categorised as an Ex Gratia payment (other) for which the Trust has delegated approval limit of £50k. The Trust Officers were not aware at the time, of the Manual for Accounts letter from Welsh Government setting out the delegation limit for non-contractual settlement agreements being zero. If this had been known the Trust would have submitted the case to Welsh Government seeking approval before the proposed payment was made.

3.4 The Trust did make a retrospective case to Welsh Government on 4th July 2024 but this was not approved.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Following this issue, the Executive Director of Finance and Executive Director of OD and Workforce have led a 'lessons learned exercise' to identify actions that will be taken to ensure the Trust complies fully with all required policy, processes and SFOs/SFIs going forward. This has involved looking at the original circumstances leading to the resignation by the member of staff and the assessment relating to the Manual for Accounts in relation to the payment.

4.2 The following amendments have been made to the Trust's Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Model Standing Financial Instructions:

- **Schedule 1 – Model Scheme of Reservation and Delegation of Powers:**
  - Page 12 – Item 34 Schedule of Matters Reserved for the Board – Updated narrative 'FULL - except where Chapter 6 ***of the Welsh Government Manual of Accounts*** specifies appropriate to delegate to a committee, Chief Executive or Officers'.

  - Page 12 – item 34 Decision Reserved To The Board – Updated narrative 'Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers ***but only up to the Trust limits in Schedule 1 Model Scheme of Reservation and Delegation of Powers LOSSES & COMPENSATION LIMITS of the Standing Orders. For special payments relating to end of employment refer to Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors – Appendix 1 in Schedule 2.1: Standing Financial Instructions.***

  - Page 24 – Losses & Compensation Limits – Item (7)(e) Other – footnote added to signpost to ***Refer to Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors – Appendix 1 in Schedule 2.1: Standing Financial Instructions.***

- **Schedule 2 - Standing Financial Instructions:**
  - Page 7 – Addition to the contents page – ***Appendix 1 Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors***.
  - Section 17 Disposals and Condemnations, Losses and Special Payments Page 70:
    - 17.2.14 additional narrative ***Refer to Appendix 1 – Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors dated 24th May 2022).***
    - Additional bullet ***17.2.15 Appendix 1 of these SFI's details the Welsh Government approval requirements from a Financial Governance perspective for individual end of employment payments.***

4.3 The Trust Board is asked to **APPROVE** the revisions to the Trust's Model Standing Orders, Reservation and Delegation of Powers for NHS Trusts and Model Standing Financial Instructions for Trust Board Approval.

4.4 Following Trust Board approval, these changes will be enacted with immediate effect and published on the Trust website.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.

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

6. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**

Schedule 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

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MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders

Introduction

As set out in Standing Order 2, the Board - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Trust may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The Board may delegate functions to:

(i) A Committee, e.g., Quality and Safety Committee;

(ii) A sub-Committee e.g., a locality based Quality and Safety Committee taking forward matters within a defined area. Any such delegation would, subject to the Board's authority, usually be via a main Committee of the Board; and

(iii) Officers of the Trust (who may, subject to the Board's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the Board is notified of any matters that may affect the operation and/or reputation of the Trust.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Schedule of matters reserved to the Board;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officers.

all of which form part of the Trust's Standing Orders.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The Board will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- ***Everything is retained by the Board unless it is specifically delegated in accordance with the requirements set out in SOs or SFIs***

- ***The Board must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management***

- ***Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility***

- ***The Board must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development***

- ***The Board must take appropriate action to assure itself that all matters delegated are effectively carried out***

- ***The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes***

- ***Except where explicitly set out, the Board retains the right to decide upon any matter for which it has statutory responsibility, even if that matter has been delegated to others***

- ***The Board may delegate authority to act, but retains overall responsibility and accountability***

- ***When delegating powers, the Board will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.***

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Board

The Board will formally agree, review and, where appropriate revise schedules of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Chief Executive

The Chief Executive will propose a Scheme of Delegation to Officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The Board must formally agree this scheme.

In preparing the scheme of delegation to officers, the Chief Executive will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles)
- Their personal responsibility and accountability to the Chief Executive, NHS Wales in relation to their role as designated Accountable Officer
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Chief Executive may re-assume any of the powers they have delegated to others at any time.

The Director of Corporate Governance

The Director of Corporate Governance will support the Board in its handling of reservations and delegations by ensuring that:

- A proposed schedule of matters reserved for decision by the Board is presented to the Board for its formal agreement;
- Effective arrangements are in place for the delegation of Trust functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the Board for revision, as appropriate.

The Audit Committee

The Audit Committee will provide assurance to the Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated

Individuals will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity; and
- Exercising any powers delegated to them in a manner that accords with the Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Director of Corporate Governance and Chief of Staff of their concern as soon as possible in so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will be exercised by the individual to whom that officer reports, unless the Board has set out alternative arrangements.

If the Chief Executive is absent their nominated Deputy may exercise those powers delegated to the Chief Executive on their behalf. However, the guiding principles governing delegations will still apply, and so the Board may determine that it will reassume certain powers delegated to the Chief Executive or reallocate powers, e.g., to a Committee or another officer.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of control and other established procedures within the Trust.

SCHEDULE OF MATTERS RESERVED TO THE BOARD[1]

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
1	FULL	GENERAL	The Board may determine any matter for which it has statutory or delegated authority, in accordance with SOs.
2	FULL	GENERAL	The Board must determine any matter that will be reserved to the whole Board. These are detailed in Schedule 2.
3	FULL	GENERAL	Approve the Trusts Governance Framework.
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ SOs; ▪ SFIs; ▪ Schedule of matters reserved to the Trust; ▪ Scheme of delegation to Committees and others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.
5	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Chief Executive in accordance with Standing Order requirements.
6	NO – Audit Committee	OPERATING ARRANGEMENTS	Formal consideration of report of Director of Corporate Governance on any non-compliance with Standing Orders, making proposals to the Board on any action to be taken.

[1] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
7	FULL	OPERATING ARRANGEMENTS	Receive report and proposals regarding any non-compliance with Standing Orders, and where required ratify in public session any action required in response to failure to comply with SOs.
8	FULL	OPERATING ARRANGEMENTS	Authorise use of the Trust's official seal
9	FULL	OPERATING ARRANGEMENTS	Approve the Trust's Values and Standards of Behaviour Framework Policy.
10	NO - Chair on behalf of Joint Committee, Vice-Chair on behalf of Joint Committee if Chair is declaring interest	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of Board members' interests, in accordance with advice received, e.g. From Audit Committee or Director of Corporate Governance
11	FULL	STRATEGY & PLANNING	Determine the Trust's strategic aims, objectives and priorities
12	FULL	STRATEGY & PLANNING	Approve the Trust's key strategies and programmes related to: ▪ The development and delivery of patient and population centred health and care/clinical services ▪ Improving quality and patient safety outcomes ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans)

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
13	FULL	STRATEGY & PLANNING	Agreement of Well-being objectives in accordance with the requirements of the Well-being and Future Generations (Wales) Act 2015
14	FULL	STRATEGY & PLANNING	Approve the Trust's Integrated Medium Term Plan, including the balanced Medium Term Financial Plan
15	FULL	STRATEGY & PLANNING	Approve the Trust's budget and financial framework (including overall distribution and unbudgeted expenditure)
16	FULL	OPERATING ARRANGEMENTS	Approve the Trust's framework and strategy for performance management.
17	FULL	STRATEGY & PLANNING	Approve the Trust's framework and strategy for risk management and assurance.
18	FULL	OPERATING ARRANGEMENTS	Ratify policies for dealing with raising concerns, complaints and incidents in accordance with the Putting Things Right and health and safety requirements.
19	FULL	OPERATING ARRANGEMENTS	Agree the arrangements for ensuring the adoption of standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the Trust, including standards/ requirements determined by Welsh Government, regulators, professional bodies/others, e.g. National Institute of Health and Care Excellence (NICE).
20	FULL	STRATEGY & PLANNING	Approve the Trusts patient, public, staff, partnership and stakeholder engagement and co-production strategies.
21	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the Board determines it so based upon its contribution/impact on the achievement of the Trust's aims, objectives and priorities.

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
22	NO – Remuneration and Terms of Service Committee (For Chief Executive Committee to consist of Chair and non-Officer Members, for all other Officer members as above and to include Chief Executive)	ORGANISATION STRUCTURE & STAFFING	Appointment of the Chief Executive and Executive Directors (officer members of the Board)
23	NO – Remuneration and Terms of Service Committee (see above)	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of any other Board level appointments and other senior employees, in accordance with Ministerial Instructions e.g. the Director of Corporate Governance
24	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Termination of appointment and suspension of officer members in accordance with the provisions of Regulations

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
25	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider appraisal of officer members of the Board
26	NO – Remuneration and Terms of Service Committee	ORGANISATION STRUCTURE & STAFFING	Consider and approve redundancy and Early Release Applications, noting that where the settlement is £50,000 or above subsequent agreement of Welsh Government is required.
27	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the Trust's top level organisation structure and corporate policies
28	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss Trust Committees directly accountable to the Board
29	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any Committee or Group set up by the Board
30	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the Board on outside bodies and groups
31	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the standing orders and terms of reference and reporting arrangements of all Committees and groups established by the Board
32	NO – Audit Committee	OPERATING ARRANGEMENTS	Approve arrangements relating to the discharge of the Trust's responsibility as a bailee for patients' property

THE BOARD		AREA	DECISIONS RESERVED TO THE BOARD
33	FULL - except where Chapter 6 specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with the provisions of Annex 4 to Chapter 6 of the Welsh Government Manual for Accounts
34	FULL - except where Chapter 6 of the Welsh Government Manual of Accounts specifies appropriate to delegate to a committee, Chief Executive or Officers	OPERATING ARRANGEMENTS	Approve individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and officers but only up to the Trust limits in this Schedule 1 Model Scheme of Reservation and Delegation of Powers LOSSES & COMPENSATION LIMITS of the Standing Orders. For special payments relating to end of employment refer to Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors – Appendix 1 in Schedule 2.1: Standing Financial Instructions
35	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the Trust
36	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee of funds held on trust in accordance with the provision of Paragraph 20 of the Standing Financial Instructions.
37	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Chief Executive set out in the Standing Financial Instructions

38	FULL	PERFORMANCE & ASSURANCE	Approve the Trust's audit and assurance arrangements
39	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trust's Executive on progress and performance in the delivery of the Trust's strategic aims, objectives and priorities and approve action required, including improvement plans, as appropriate.
40	FULL	PERFORMANCE & ASSURANCE	Receive reports from the Trusts Committees, groups and other internal sources on the Trust's performance and approve action required, including improvement plans, as appropriate.
41	FULL	PERFORMANCE & ASSURANCE	Receive reports on the Trust's performance produced by external regulators and inspectors (including, e.g., Audit Wales, etc.) that raise significant issue or concerns impacting on the Trust's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of Trust Committees (as appropriate)
42	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the Trust's Chief Internal Auditor and approve action required, including improvement plans
43	FULL	PERFORMANCE & ASSURANCE	Receive the annual management report from the Auditor General for Wales and approve action required, including improvement plans
44	FULL	PERFORMANCE & ASSURANCE	Receive assurance regarding the Trusts performance against the Health and Care Standards for Wales and the arrangements for approving required action, including improvement plans.
45	FULL	REPORTING	Approve the Trust's Reporting Arrangements, including reports on activity and performance to citizens, partners and stakeholders and nationally to the Welsh Government where required.
46	FULL	REPORTING	Receive, approve and ensure the publication of Trust reports, including its Annual Report and annual financial accounts in accordance with directions and guidance issued.

ADDITIONAL AREAS OF RESPONSIBILITY DELEGATED TO CHAIR, VICE CHAIR AND INDEPENDENT MEMBERS			
	CHAIR		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. An Independent Member will be identified to be represented as members on the Board Committees/Sub Committees as outlined in Schedule 3.
	VICE CHAIR		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. An Independent Member will be identified to be represented as members on the Board Committees/Sub Committees as outlined in Schedule 3.
	CHAMPION/ NOMINATED LEAD		In accordance with statutory and Assembly Government requirements, Independent Members will be nominated to chair the following Board Committees/Sub Committees as outlined in Schedule 3. Independent Members will be identified as Champions/Leads for the following areas: • Armed Forces and Veterans • Digital • Hosted Organisations • Infection Prevention • Mental Health • Patient Information • Patient and Donor Engagement and Experience • Performance Framework • Research, Development and Innovation • Sustainable Development and Design • University Trust • Violence and Aggression • Vulnerability • Welsh Language

DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Standing Order 2 provides that the Board may delegate powers to Committees and others. In doing so, the Board has formally determined in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

- The composition, terms of reference and reporting requirements in respect of any such Committees; and
- The governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others.

The Board has delegated a range of its powers to the following Committees and others:

- Remuneration & Terms of Service Committee
- Audit Committee
- Quality, Safety & Performance Committee
- Strategic Development Committee
  - Transforming Cancer Services Programme Scrutiny Sub-Committee
- Charitable Funds Committee
  - Charitable Funds Investment Performance Review Sub-Committee
  - Research, Development & Innovation Sub-Committee
- Advisory Consultants Appointment Committee (to be established for each consultant medical staff appointment as appropriate to the specialist nature of the post, in accordance with guidance from Welsh Government)
- Academic Partnership Board
- NHS Wales Shared Services Partnership Committee (established as a direct result of Welsh Government regulations)
  - NHS Wales Shared Services Partnership Audit Committee

The scope of the powers delegated, together with the requirements set by the Board in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the Trust's Scheme of Delegation to Committees.

Full details of the Committee structure established by the Board, including detailed terms of reference for each of these Committees are set out in Schedule 3.

SCHEME OF DELEGATION TO EXECUTIVE DIRECTORS, OTHER DIRECTORS AND OFFICERS

The Trust SOs and SFIs specify certain key responsibilities of the Chief Executive, the Director of Finance and other officers. The Chief Executive's Job Description, together with their Accountable Officer Memorandum sets out their specific responsibilities, and the individual job descriptions determined for Executive Director level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the schedule of additional delegations below and the associated financial delegations set out in the SFIs form the basis of the Trust's Scheme of Delegation to Officers.

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Directors	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Executive Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	Directors	Yes	Authorisation matrix. Financial policies & procedures
Reimbursement of patient monies	Directors	Yes	Authorisation matrix. Financial policies & procedures
Management of Grant Agreements	Executive Director of Finance	No	Not Applicable.
Management of Legacy Income	Executive Director of Finance	No	Not Applicable.
Engagement of staff within funded establishment	Directors	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Chief Executive	Nominated deputy	In absence of Chief Executive
Staff re-grading and awarding of incremental points	Executive Director of Organisational Development & Workforce	Yes	Written authority to suitably qualified HR staff

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of overtime	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of compassionate leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of leave without pay	Directors	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Reserved for Board Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Executive Director of Organisational Development & Workforce	No	
Approval of relocation costs	Executive Director of Organisational Development & Workforce	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • Directors • Other staff	Reserved for Board Directors / Divisional Directors	No	

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of redundancy, early retirement and ill-health retirement	Chief Executive	Yes	Authorisation matrix. HR policies & procedures
Dismissal of staff	Executive Director of Organisational Development & Workforce	Yes	Authorisation matrix. HR policies & procedures
Management of clinical and other operational capacity	Directors	Yes	Authorisation matrix. Annual Operating Framework and operational plans
Approval to procure goods and services within budget	Directors	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Chief Executive	Nominated deputy	In absence of Chief Executive
Approval to commission healthcare services from other NHS bodies	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission healthcare services from voluntary sector	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission healthcare services from private and independent providers	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Chief Executive	Yes	Authorisation matrix. Commissioning policies & procedures

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval to amend the drugs formulary	Executive Medical Director	No	
Approval to prescribe drugs outside the formulary	Executive Medical Director	Yes	Prescribing policies & procedures
Authorisation of sponsorship	Chief Executive	No	Sponsorship policies & procedures
Approval of clinical trials	Executive Medical Director	Yes	Clinical policies & procedures
Approval of research projects	Chief Executive	Yes	Research policies & procedures
Management of complaints	Executive Director of Nursing, Allied Health Professionals & Clinical Scientists	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	Director of Corporate Governance	Yes	Communication policies & procedures
Investment of charitable funds	Executive Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval for use of charitable funds	Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose equipment	Directors	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation (except for personal effects)	Directors	No	Within authorised limits set by WG.

Delegated Matter	High Level Delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	Small claims panel Director of Finance Chief Executive Approval by WG	No No No No	
Approval of Clinical negligence and personal injury claims	Executive Director of Nursing, Allied Health Professionals & Health Sciences	Yes	Authorisation matrix and within limits set by WG.
Approval of staff tenancy agreements	Directors	Yes	Authorisation matrix. HR policies & procedures
Approval of capital expenditure	Chief Executive / Executive Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	Executive Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Chief Executive	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Executive Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Service Directors.
The calling down of new public dividend capital as identified in the Trust's External Financing Limit (EFL).	Executive Director of Finance	Yes	Further delegations subject to authorisation matrix. Financial policies and procedures.

This scheme only relates to matters delegated by the Board to the Chief Executive and their Executive Directors, together with certain other specific matters referred to in SFIs.

Each Executive Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Standing Financial Instructions detail the requirements for Budgetary Control, including:

- Budget Setting
- Budgetary Delegation
- Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Chief Executive will delegate the following Income and Expenditure budgetary responsibility:

- Velindre Cancer Centre budgets to Velindre Cancer Centre Divisional Director
- Welsh Blood Service budgets to Welsh Blood Service Divisional Director

In addition the Income and Expenditure budgetary responsibility for hosted organisations are delegated to the relevant Director/Senior Manager.

The Chief Executive and Divisional Directors will, in turn, delegate budgetary responsibility to other Directors and managers. The detailed schedule of this second tier delegation will be reviewed, revised and reapproved on an annual basis by the Executive Board as part of the annual Financial Strategy and Budget Setting process.

Within the budgetary delegation there are delegated powers of budget virement

- Budget virements between Divisions must be approved by the Chief Executive.
- Budget virements between budgets within the same Division must be approved by the Divisional Director.
- Budget virements between staff and non-staff within the same budget must be approved by the Budget Holder.
- These delegated powers of virement, from the Chief Executive to Divisional Directors and Budget Holders, assume that the Trust is achieving its financial targets and can be revised, in year, by the Chief Executive in the light of adverse financial performance.
- Budget virements within Divisions can be authorised by Divisional Director and Director of Finance up to the limit of £60,000.

FINANCIAL LIMITS

(All values exclude VAT)

Financial Limits	Revenue £'000	Capital £'000	Charitable Funds £'000
Corporate Services:			
Trust Board	No Limit	No Limit	0
Charitable Funds Committee	0	0	>25
Delegated Charitable Fund Holders	0	0	5
Chief Executive or Executive Director of Finance	100	100	25
Cancer Services:			
Director of Cancer Services, Director of Operations & Chief Pharmacist – for Pharmaceuticals	150	0	0
Blood Wholesale Products Chief Executive Executive Director of Finance WBS Director WBS Medical Director WBS Deputy Director WBS Assistant Director of Operations	800	0	0

Further delegated financial limits which are **less than £100k** will be agreed by the Chief Executive and the Executive Management Board.

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF DELEGATION
Please refer to the Shared Services Partnership Committee Standing Orders contained within Schedule 5.

LOSSES & COMPENSATION LIMITS

NB All amounts are exclusive of VAT.	DELEGATED LIMITS							
	Trust Limit	Trust Board	Chief Executive	Director of Nursing	Director of Finance	Divisional Directors	Claims Manager / Q&S Manager	Small Claims Panel
	£	£	£	£	£	£	£	£
1. LOSSES OF CASH DUE TO:-								
a) Theft, Fraud etc.	50,000	50,000						
b) Overpayment of Salaries, Wages, Fees & Allowances	50,000	50,000						
c) Other causes, including un-vouched or completely vouched payments, overpayments other than those included under 1b; physical losses of cash and cash equivalents e.g. stamps due to fire (other than arson), accident and similar cause	50,000	50,000						
(2) FRUITLESS PAYMENTS (including abandoned capital schemes)	250,000	250,000						
(3) BAD DEBTS AND CLAIMS ABANDONED:-								
(a) Private Patients	50,000		50,000		10,000			
(b) Overseas Visitors	50,000		50,000		10,000			
(c) Causes other than a) – b)	50,000		50,000		10,000			
(4) DAMAGE TO BUILDINGS, THEIR FITTINGS, FURNITURE AND EQUIPMENT AND LOSS OF EQUIPMENT AND PROPERTY IN STORES AND IN USE DUE TO:-								
(a) Culpable causes e.g. theft, arson or sabotage whether proved or suspected, neglect of duty or gross carelessness	50,000	50,000						
(b) Other causes	50,000	50,000						
(5) COMPENSATION PAYMENTS UNDER LEGAL OBLIGATION	FULL	FULL	100,000					
(6) EXTRA CONTRACTUAL PAYMENTS TO CONTRACTORS	50,000	50,000						
(7) EX GRATIA PAYMENTS:-								
(a) To patients and staff for loss of personal effects	50,000		50,000	50,000	10,000			1,000
(b) For Clinical Negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied	1,000,000 (Inc. Plaintiff Costs)	>100,000 – 1,000,000	100,000	100,000	5,000	5,000		
(c) For Personal Injury claims involving negligence where legal advice obtained and relevant guidance has been applied	1,000,000 (Inc. Plaintiff Costs)	>100,000 – 1,000,000	100,000	100,000	5,000	5,000		
(d) Other clinical negligence and personal injury claims including Putting Things Right Arrangements - Concerns	50,000		50,000	50,000			5,000	
(e) Other[2], except cases of maladministration where there was no financial loss by the claimant	50,000		50,000	50,000				
(f) Maladministration where no financial loss by claimant	Nil							
(g) Patient referrals outside UK and EEA guidelines	Nil							
(8) EXTRA STATUTORY AND EXTRA REGULATIONARY	Nil							

[2] Refer to Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors – Appendix 1 in Schedule 2.1: Standing Financial Instructions

Schedule 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Schedule forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Trust framework

The Trust's governance and accountability framework comprises these SOs, incorporating schedules of Powers reserved for the Board and Delegation to others, together with the following documents:

- ***SFIs*** *(see Schedule 2.1 below)*
- ***Standards of Behaviour Framework Policy***
- ***Trust Assurance Framework***
- ***Key policy documents***

agreed by the Board. These documents must be read in conjunction with the SOs and will have the same effect as if the details within them were incorporated within the SOs themselves.

These documents may be accessed by the Trust intranet site or from the Director of Corporate Governance.

NHS Wales framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual, which can be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/. Directions or guidance on specific aspects of Trust business are also issued electronically, usually under cover of a Welsh Health Circular.

Schedule 2.1

MODEL STANDING FINANCIAL INSTRUCTIONS FOR NHS TRUSTS

This Schedule forms part of, and shall have effect as if incorporated in the NHS Trust Standing Orders (incorporated as Schedule 2.1 of SOs)

Foreword

These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. Designed to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability in the conduct of business, they translate statutory and Welsh Government financial requirements for the NHS in Wales into day to day operating practice. Together with the adoption of Standing Orders (SOs), a Schedule of decisions reserved to the Board and a Scheme of delegations to officers and others, they provide the regulatory framework for the business conduct of the Trust.

These documents form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All Trust Board members and officers must be made aware of these Standing Financial Instructions and, where appropriate, should be familiar with their detailed content. The Director of Finance will be able to provide further advice and guidance on any aspect of the Standing Financial Instructions. The Board Secretary will be able to provide further advice and guidance on the wider governance arrangements within the Trust. Further information on governance in the NHS in Wales may be accessed at https://nwssp.nhs.wales/all-wales-programmes/governance-e-manual/

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APPENDIX 1: Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors

Velindre University NHS Trust

1. INTRODUCTION

1.1 General

1.1.1 These Model Standing Financial Instructions are issued by Welsh Ministers to NHS Trusts using powers of direction provided in section 19 (1) of the National Health Service (Wales) Act 2006. NHS Trusts in Wales must agree Standing Financial Instructions (SFIs) for the regulation of their financial proceedings and business. They shall have effect as if incorporated in the Standing Orders (SOs) (incorporated as Schedule 2.1of SOs).

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by **Velindre University National Health Service Trust** "the Trust". They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Welsh Government policy in order to achieve probity, accuracy, economy, efficiency, effectiveness and sustainability. They should be used in conjunction with the Schedule of decisions reserved to the Board and the Scheme of delegation adopted by the Trust.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial control procedure notes. All financial procedures must be approved by the Director of Finance and Audit Committee.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Board Secretary or Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

1.2 Overriding Standing Financial Instructions

1.2.1 Full details of any non compliance with these SFIs, including an explanation of the reasons and circumstances must be reported in the first instance to the Director of Finance and the Board Secretary, who will ask the Audit Committee to formally consider the matter and make proposals to the Board on any action to be taken. All Board members and Trust officers have a duty to report any non compliance to the Director of Finance and Board Secretary as soon as they are aware of any circumstances that has not previously been reported.

1.2.2 **Ultimately, the failure to comply with SFIs and SOs is a disciplinary matter that could result in an individual's dismissal from employment or removal from the Board.**

1.3 Financial provisions and obligations of NHS Trusts

1.3.1 The financial provisions and obligations for NHS Trusts are set out under Schedule 4 to the National Health Service (Wales) Act 2006 (c. 42). The Board as a whole and the Chief Executive in particular, in their role as the Accountable Officer for the organisation, must ensure the Trust meets its statutory obligation to perform its functions within the available financial resources.

1.3.2 The financial obligation as set out in paragraph 2 of Schedule 4 is as follows:

(1) Each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to revenue account.

(2) Each NHS trust must achieve such financial objectives as may from time to time be set by the Welsh Ministers with the consent of the Treasury and as are applicable to it.

(3) Any such objectives may be made applicable to NHS trusts generally, or to a particular NHS trust or to NHS trusts of a particular description.

2. RESPONSIBILITIES AND DELEGATION

2.1 The Board

2.1.1 The Board exercises financial supervision and control by:

a) Formulating and approving the Medium Term Financial Plan (MTFP) as part of developing and approving the Integrated Medium Term Plan (IMTP);

b) Requiring the submission and approval of balanced budgets within approved allocations/overall income;

c) Defining and approving essential features in respect of important financial policies, systems and financial controls (including the need to obtain value for money and sustainability); and

d) Defining specific responsibilities placed on Board members and Trust officers, and Trust committees and Advisory Groups as indicated in the 'Scheme of delegation' document.

2.1.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the 'Schedule of matters reserved to the Board' document. The Board, subject to any directions that may be made by Welsh Ministers, shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the Health Board may be carried out effectively, and in a manner that secures the achievement of the organisations aims and objectives. This will be via powers and authority delegated to committees or sub-committees that the Trust has established or to an officer of the Trust in accordance with the 'Scheme of delegation' document adopted by the Trust.

2.2 The Chief Executive and Director of Finance

2.2.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

2.2.2 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Welsh Government, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that financial provisions, obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

2.2.3 It is a duty of the Chief Executive to ensure that Board members and Trust officers, and all new appointees are notified of, and put in a position to understand their responsibilities within these SFIs.

2.3 The Director of Finance

2.3.1 The Director of Finance is responsible for:

a) Implementing the Trust's financial policies and for co-coordinating any corrective action necessary to further these policies;

b) Maintaining an effective system of internal financial control including ensuring that detailed financial control procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and

d) Without prejudice to any other functions of the Trust, and Board members and Trust officers, the duties of the Director of Finance include:

(i) the provision of financial advice to other Board members and Trust officers, and to Trust committees and Advisory Groups,

(ii) the design, implementation and supervision of systems of internal financial control, and

(iii) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

2.3.2 The Director of Finance is responsible for ensuring an ongoing training and communication programme is in place to affect these SFIs.

2.4 Board members and Trust officers, and Trust Committees

2.4.1 All Board members and Trust officers, and Trust committees, severally and collectively, are responsible for:

a) The security of the property of the Trust;

b) Avoiding loss;

c) Exercising economy, efficiency and sustainability in the use of resources; and

d) Conforming to the requirements of SOs, SFIs, Financial Control Procedures and the Scheme of delegation.

2.4.2 For all Board members and Trust officers, and Trust committees who carry out a financial function, the form in which financial records are kept and the manner in which Trust Board members and officers, and Trust committees, Advisory Groups and employees discharge their duties must be to the satisfaction of the Director of Finance.

2.5 Contractors and their employees

2.5.1 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

3. AUDIT, FRAUD AND CORRUPTION, AND SECURITY MANAGEMENT

3.1 Audit Committee

3.1.1 An independent Audit Committee is a central means by which a Board ensures effective internal control arrangements are in place. In addition, the Audit Committee provides a form of independent check upon the executive arm of the Board. In accordance with SOs the Board shall formally establish an Audit Committee with clearly defined terms of reference. Detailed terms of reference and operating arrangements for the Audit Committee are set out in Schedule 3 to the SOs. This committee will follow the guidance set out in the NHS Wales Audit Committee Handbook.
nwssp.nhs.wales/a-wp/governance-e-manual/governance-e-manual-documents/useful-documents/nhs-wales-audit-committee-handbook-june-2012/

3.2 Chief Executive

3.2.1 The Chief Executive is responsible for:

a) Ensuring there are arrangements in place to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

b) Ensuring that the Internal Audit function meets the Public Sector Internal Audit Standards and provides sufficient independent and objective assurance to the Audit Committee and the Accountable Officer;

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

c) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

d) Ensuring that an annual Internal Audit report is prepared for the consideration of the Audit Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with the requirements of the Public Sector Internal Audit Standards.

- major internal financial control weaknesses discovered,
- progress on the implementation of Internal Audit recommendations,

- progress against plan over the previous year,
- a strategic audit plan covering the coming three years, and
- a detailed plan for the coming year.

3.2.2 The designated internal and external audit representatives are entitled (subject to provisions in the Data Protection Act 2018 and the UK General Data Protection Legislation) without necessarily giving prior notice to require and receive:

a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) Access at all reasonable times to any land or property owned or leased by the Trust;

c) Access at all reasonable times to Board members and officers;

d) The production of any cash, stores or other property of the Trust under a Board member or a Trust official's control; and

e) Explanations concerning any matter under investigation.

3.3 Internal Audit

3.3.1 The Accountable Officer Memorandum requires the Chief Executive to have an internal audit function that operates in accordance with the standards and framework set for the provision of Internal Audit in the NHS in Wales. This framework is defined within an Internal Audit Charter that incorporates a definition of internal audit, a code of ethics and Public Sector Internal Audit Standards. Standing Order 10.1 details the relationship between the Head of Internal Audit and the Board. The role of the Audit Committee in relation to Internal Audit is set out within its Terms of Reference, incorporated in Schedule 3 of the SOs, and the NHS Wales Audit Committee Handbook.

3.4 External Audit

3.4.1 Pursuant to the Public Audit (Wales) Act 2004 (c. 23), the Auditor General for Wales (Auditor General) is the external auditor of the Trust. The Auditor General may nominate his representative to represent him within the Trust and to undertake the required audit work. The cost of the audit is paid for by the Trust. The Trust's Audit Committee must ensure that a cost-efficient external audit service is delivered. If there are any problems relating to the service provided, this should be raised

with the Auditor General's representative and referred on to the Auditor General if the issue cannot be resolved.

3.4.2 The objectives of the external audit fall under three broad headings, to review and report on:

a) Whether the expenditure to which the financial statements relate has been incurred lawfully and in accordance with the authority that governs it;

b) The audited body's financial statements, and on its Annual Governance Statement and remuneration report [1];

c) Whether the audited body has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

3.4.3 The Auditor General's representatives will prepare a risk-based annual audit plan, designed to deliver the Auditor General's objectives, for consideration by the Audit Committee. The annual plan will set out details of the work to be carried out, providing sufficient detail for the Audit Committee and other recipients to understand the purpose and scope of the defined work and their level of priority. The Audit Committee should review the annual plan and the associated fees, although in so doing it needs to recognise the statutory duties of the Auditor General. The annual audit plan should be kept under review to identify any amendment needed to reflect changing priorities and emerging audit needs. The Audit Committee should consider material changes to the annual audit plan.

3.4.4 The Auditor General's representative should be invited to attend every Audit Committee meeting. The cycle of approving and monitoring the progress of external audit plans and reports, culminating in the opinion on the annual report and accounts, is central to the core work of the Audit Committee.

3.4.5 The Auditor General's representatives will liaise with Internal Audit when developing the external audit plan. The Auditor General's representative will ensure that planned external audit work takes into account the work of Internal Audit to avoid duplication wherever possible and considers where Internal Audit work can be relied upon for opinion purposes.

3.4.6 The Auditor General and his representatives shall have a right of access to the Chair of the Audit Committee at any time.

3.4.7 The Government of Wales Act 2006 (GOWA) provides that the Auditor

[1] The Healthcare Inspectorate Wales will review and report on the Annual Quality Statement.

General has statutory rights of access to all documents and information, as set out in paragraph 3.2.2a of these SFIs, that relate to the exercise of many of his core functions, including his statutory audits of accounts, value for money examinations and improvement studies. The rights of access include access to confidential information; personal information as defined by the Data Protection Act 2018 and the UK General Data Protection Legislation; information subject to legal privilege; personal information and sensitive personal information that may otherwise be subject to protection under the European Convention of Human Rights; information held by third parties; and electronic files and IT systems. Paragraph 17 of Schedule 8 to GOWA operates to provide the Auditor General with a right of access to every document relating to the Trust that appears to him to be necessary for the discharge of any of these functions. Paragraph 17(3) of Schedule 8 also requires any person that the Auditor General thinks has information related to the discharge of his functions to give any assistance, information and explanation that he thinks necessary. It also requires such persons to attend before the Auditor General and to provide any facility that he and his representatives may reasonably require, such as audit accommodation and access to IT facilities. The rights apply not just to the Trust and its officers and staff, but also to, among others, suppliers to the Trust.

3.4.8 The Auditor General's independence in the exercise of his audit functions is protected by statute (section 8 of the Public Audit (Wales) Act 2013), and audit independence is required by professional and ethical standards. Accordingly, the Trust (including its Audit Committee) must be careful not to seek to fetter the Auditor General's discretion in the exercise of his functions. While the Trust may offer comments on the plans and outputs of the Auditor General, it must not seek to direct the Auditor General.

3.4.9 The Auditor General will issue a number of reports over the year, some of which are specified in the Auditor General's Code of Audit and Inspection Practice and International Standards on Auditing. Other reports will depend on the contents of the audit plan.

The main mandatory reports are:

- Report to those charged with governance (incorporating the report required under ISA 260) that sets out the main issues arising from the audit of the financial statements and use of resources work
- Statutory report and opinion on the financial statements
- Annual audit report.

In addition to these reports, the Auditor General may prepare a report on a matter the Auditor General considers would be in the public

interest to bring to the public's attention; or make a referral to the Welsh Ministers if significant breaches occur.

3.4.10 The Auditor General also has statutory powers to undertake Value for Money Examinations and Improvement Studies within the Trust and other public sector bodies. At the Trust he also undertakes a Structured Assessment to help him assess whether there are proper arrangements for securing economy, efficiency and effectiveness in the use of resources. The Auditor General will take account of audit work when planning and undertaking such examinations and studies. The Auditor General and his representatives have the same access rights in relation to these examinations and studies as they do in relation to annual audit work.

3.5 Fraud and Corruption

3.5.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Welsh Ministers on fraud and corruption.

3.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by Directions to NHS bodies on Counter Fraud Measures 2005 (as amended).

https://nwssp.nhs.wales/a-wp/governance-e-manual/knowing-who-does-what-why/supporting-good-governance/nhs-counter-fraud-service-wales/

3.5.3 The LCFS shall report to the Trust Director of Finance and the LCFS must work with NHS Counter Fraud Authority (NHSCFA) and the NHS Counter Fraud Service Wales (CFSW) Team in accordance with the Directions to NHS bodies on Counter Fraud Measures 2005.

3.5.4 The LCFS will provide a written report to the Director of Finance and Audit Committee, at least annually, on proactive and reactive counter fraud work within the Trust.

3.5.5 The Trust must participate in the annual National Fraud Initiative (NFI) led by Audit Wales and must provide the necessary data for the mandatory element of the NFI by the due dates. The Trust should participate in appropriate risk measurement or additional dataset matching exercise in order to support the detection of fraud across the whole public sector.

3.6 Security Management

3.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the Welsh Ministers on

NHS security management.

3.6.2 The Chief Executive has overall responsibility for controlling and coordinating security.

4. FINANCIAL DUTIES

4.1 Legislation and Directions

4.1.1 The Trust has two statutory financial duties, to:

- First Duty - A breakeven duty, to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period
- Second Duty - A duty to prepare a plan to secure compliance with the first duty and for that plan to be submitted to and approved by the Welsh Ministers

The first duty is provided for under paragraph 2(1) of Schedule 4 of the National Health Service (Wales) Act 2006, although this should be read in conjunction with 'Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts' which sets out the duty to break even over a three-year period. The second duty arises as a result of the Welsh Ministers' powers to set financial objectives for the Trust under paragraph 2(2) of Schedule 4 of the National Health Service (Wales) 2006 Act. The planning requirement, which by virtue of being set as a financial objective becomes a statutory financial duty, was previously set by the Welsh Ministers and has been retained by Welsh Health Circular 2016/054 – Statutory Financial Duties of Local Health Boards and NHS Trusts. Further details of the WHC can be obtained from the HSSG Director of Finance' hywel.jones38@gov.wales

4.2 First Financial Duty – The Breakeven Duty

4.2.1 The Trust has a statutory duty to ensure that its revenue is not less than sufficient to meet outgoings properly chargeable to revenue account in respect of each rolling three-year accounting period, that is to breakeven over a 3-year rolling period.

4.2.2 Trusts must ensure their boards approve balanced revenue and capital plans before the start of each financial year.

4.2.3 The Director of Finance of the Trust will:

a) Prior to the start of each financial year submit to the Board for approval a report showing the total funding received, assumed in-year funding and other adjustments and their proposed distribution to delegated budgets, including any sums to be held in reserve;

b) Ensure that any ring-fenced or non-discretionary funding are disbursed in accordance with Welsh Ministers' requirements;

c) Periodically review any assumed in-year funding to ensure that these are reasonable and realistic; and

d) Regularly update the Board on significant changes to the initial funding and the application of such funds.

4.2.4 The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that it meets its First Financial Duty.

4.3. Second Financial Duty – The Planning Duty

4.3.1 The Trust has a statutory duty to prepare a plan, the Integrated Medium Term Plan (IMTP), to secure compliance with the first duty, and for that plan to be submitted to and approved by the Welsh Ministers.

4.3.2 The Integrated Medium Term Plan must reflect longer-term planning and delivery objectives and should be continually reviewed based on latest Welsh Government policy and local priority requirements. The Integrated Medium Term Plan, produced and approved annually, will be 3 year rolling plans. In particular the Integrated Medium Term Plan must reflect the Welsh Ministers' priorities and commitments as detailed in the NHS Planning Framework published annually by Welsh Government.

4.3.3 The NHS Planning Framework directs Trusts to develop, approve and submit an Integrated Medium Term Plan (IMTP) for approval by Welsh Ministers. The plan must

- describe the context within which the Trust will deliver key policy directives from Welsh Government.
- demonstrate how the Health Board are
  - delivering their well-being objectives, including how the five ways of working have been applied
  - contributing to the seven Well-being Goals,
  - establishing preventative approaches across all care and services
- demonstrate how the Trust will utilise its existing services and resources, and planned service changes, to deliver improvements in population health and clinical services, and at the same time demonstrate improvements to efficiency of services.
- demonstrate how the three-year rolling financial breakeven duty is to be achieved.

4.3.4 An Integrated Medium Term Plans should be based on a reasonable expectation of future income, service changes, performance improvements, workforce changes, demographic changes, capital, quality, funding, income, expenditure, cost pressures and savings plans to ensure that the Integrated Medium Term Plan (including a balanced Medium Term Financial Plan) is balanced and sustainable and supports the safe and sustainable delivery of patient centred quality services.

4.3.5 The Integrated Medium Term Plan will be the overarching planning

document enveloping component plans and service delivery plans. The Integrated Medium Term Plan will incorporate the balanced Medium Term Financial Plan and will incorporate the Trusts response to delivering the

- NHS Planning Framework,
- Quality, governance and risk frameworks and plans, and
- Outcomes Framework

4.3.6 The Integrated Medium Term Plan will be developed in line with the NHS Planning Framework and include:

- A statement of significant strategies and assumptions on which the plans are based;
- Details of major changes in activity, service delivery, service and performance improvements, workforce, revenue and capital resources required to achieve the plans; and
- Profiled activity, service, quality, workforce and financial schedules.
- Detailed plans to deliver the NHS Planning Framework and quality, governance and risk requirements and outcome measures;

4.3.7 The Chief Executive has overall executive responsibility to develop and submit to the Board, on an annual basis, the rolling 3 year Integrated Medium Term Plan (IMTP).

4.3.8 The Board will:

a) Approve the Integrated Medium Term Plan prior to the beginning of the financial year of implementation and in accordance with the guidance issued annually by Welsh Government. Following Board approval the Plan will be submitted to Welsh Government prior to the beginning of the financial year of implementation.

b) Approve a balanced Medium Term Financial Plan as part of the Integrated Medium Term Plan, which meets all financial duties, probity and value for money requirements; and

c) Prepare and agree with the Welsh Government a robust and sustainable recovery plan in accordance with Welsh Ministers' guidance where the Trust plan is not in place or in balance.

4.3.9 The Board approved Integrated Medium Term Plan will be submitted to Welsh Government, for approval by the Minister, in line with the requirements set out in the NHS Planning Framework.

4.3.10 The finalised approved Integrated Medium Term Plan will form the basis of the Performance Agreement between the Trust and Welsh Government.

5. FINANCIAL MANAGEMENT AND BUDGETARY CONTROL

5.1 Budget Setting

5.1.1 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval and delegation by the Board. Such budgets will:

a) Be in accordance with the aims and objectives set out in the Board approved Integrated Medium Term Plan, and Medium Term Financial Plan, and focussed on delivery of safe patient centred quality services;

b) Be in line with Revenue, Capital, Commissioner, Activity, Service, Quality, Performance, and Workforce plans contained within the Board approved balanced IMTP;

c) Take account of approved business cases and associated revenue costs and funding;

d) Be produced following discussion with appropriate Directors and budget holders;

e) Be prepared within the limits of available funds;

f) Take account of ring-fenced or specified funding;

g) Include both financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents);

h) Be within the scope of activities and authority defined by the National Health Service (Wales) Act 2006, including pooled budget arrangements;

i) Take account of the principles of Well-being of Future Generations (Wales) Act 2015 including the seven Well-being Goals and the five ways of working; and

j) Identify potential risks and opportunities.

5.2 Budgetary Delegation

5.2.1 The Chief Executive may delegate, via the Director of Finance, the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements under Regulations made in accordance with section 33 of the National Health Service (Wales) Act 2006 (c. 42). This delegation must be in writing, in the

form of a letter of accountability, and be accompanied by a clear definition of:

a) The amount of the budget;
b) The purpose(s) of each budget heading;
c) Individual or committee responsibilities;
d) Arrangements during periods of absence;
e) Authority to exercise virement;
f) Achievement of planned levels of service; and
g) The provision of regular reports.

The budget holder must sign the accountability letter formally delegating the budget.

5.2.2 The Chief Executive, Director of Finance and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

5.2.3 Budgets must only be used for the purposes designated, and any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

5.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

5.2.5 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled and managed appropriately.

5.2.6 All budget holders will sign up to their allocated budgets at the commencement of the financial year.

5.2.7 The Director of Finance has a responsibility to ensure that appropriate and timely financial information is provided to budget holders and that adequate training is delivered on an on-going basis to assist budget holders managing their budgets successfully.

5.3 Financial Management, Reporting and Budgetary Control

5.3.1 The Director of Finance shall monitor financial performance against budget and plans and report the current and forecast position, and financial risks, on a monthly basis and at every Board meeting. Any significant variances should be reported to Trust Board as soon as they come to light and the Board shall be advised on any recommendations and action to be taken in respect of such variances.

5.3.2 The Director of Finance will devise and maintain systems of financial management performance reporting and budgetary control. These will include:

a) Regular financial reports, for revenue and capital, to the Board in a form approved by the Board containing sufficient information for the Board to:
   - Understand the current and forecast financial position
   - Evaluate risks and opportunities
   - Use insight to make informed decisions
   - Be consistent with other Board reports

   As a minimum the reports will cover:
   - Current and forecast year end position on statutory financial duties
   - Actual income and expenditure to date compared to budget and showing trends and run rates
   - Forecast year end positions
   - A statement of assets and liabilities, including analysis of cash flow and movements in working capital.
   - Explanations of material variances from plan
   - Capital expenditure and projected outturn against plan
   - Investigations and reporting of variances from financial, activity and workforce budgets.
   - Details of corrective actions being taken, as advised by the relevant budget holder and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
   - Statement of performance against savings targets
   - Key workforce and other cost drivers
   - Income and expenditure run rates, historic trends, extrapolation and explanations
   - Clear assessment of risks and opportunities
   - Provide a rounded and holistic view of financial and wider organisational performance.

b) The issue of regular, timely, accurate and comprehensible advice and financial reports to each delegated budget holder, covering the areas for which they are responsible;

c) An accountability and escalation framework to be established for the organisation to formally address material budget variances

d) Investigation and reporting of variances from financial, activity and workforce budgets;

e) Monitoring of management action to correct variances;

f) Arrangements for the authorisation of budget transfers and virements.

5.3.3 Each Budget Holder will

- be held to account for managing services within the delegated budget
- investigate causes of expenditure and budget variances using information from activity, workforce and other relevant sources
- develop plans to address adverse budget variances.

5.3.4 Each Budget Holder is responsible for ensuring that:

a) Any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Chief Executive subject to the Board's scheme of delegation;

b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;

c) No permanent employees are appointed without the approval of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

5.3.5 The Chief Executive is responsible for identifying and implementing cost and efficiency improvements and income generation initiatives in accordance with the requirements of the Medium Term Financial Plans and SFI 9.1.

5.4 Capital Financial Management, Reporting and Budgetary Control

5.4.1 The general rules applying to revenue Financial Management, Reporting and Budgetary Control delegation and reporting shall also apply to capital plans, budgets and expenditure subject to any specific reporting requirements required by the Welsh Ministers.

5.5 Reporting to Welsh Government - Monitoring Returns

5.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the Welsh Ministers in accordance with published guidance and timescales.

5.5.2 All monitoring returns must be supported by a detailed commentary signed by the Director of Finance and Chief Executive. This commentary should also highlight and quantify any significant risks with an assessment of the impact and likelihood of these risks maturing.

5.5.3 All information made available to the Welsh Ministers should also be made available to the Board. There must be consistency between the Medium Term Financial Plan, budgets, expenditure, forecast position and risks as reported in the monitoring returns and monthly Board reports.

6. ANNUAL ACCOUNTS AND REPORTS

6.1 The Board must approve the Trust's annual accounts prior to submission to the Welsh Ministers and the Auditor General for Wales in accordance with the annual timetable.

6.2 The Chair and Chief Executive have responsibility for signing the accounts on behalf of the Trust. The Chief Executive has responsibility for signing the Performance Report, Accountability Report, Statement of Financial Position and the Governance Statement.

6.3 The Director of Finance, on behalf of the Trust, is responsible for ensuring that financial reports and returns are prepared in accordance with the accounting policies, guidance and timetable determined by the Welsh Ministers, as per Welsh Government's Manual for Accounts, and consistent with Financial Reporting Manual (FReM) and International Financial Reporting Standards.

6.4 The Trust's annual accounts must be audited by the Auditor General for Wales. The Trust's audited annual accounts must be adopted by the Board at a public meeting and made available to the public.

6.5 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at its Annual General Meeting. The annual report must also be sent to the Welsh Ministers. The Board Secretary will ensure that the Annual Report is prepared in line with the Welsh Government's Manual for Accounts. The Annual Report will include

- The Accountability Report containing:
  - Corporate Governance Report
  - Remuneration Report and Staff Report
  - Accountability and Audit Report

- The Performance Report, which must include:
  - An overview
  - A performance Analysis

7. BANKING ARRANGEMENTS

7.1 General

7.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Welsh Ministers. NHS Trusts are required to use the Government Banking Service (GBS) for its banking services.

7.1.2 The Board shall approve the banking arrangements.

7.2 Bank Accounts

7.2.1 The Director of Finance is responsible for:

a) Establishing bank accounts and ensuring that the Government Banking Service is utilised for main Trust business transactions;

b) Establishing additional commercial accounts only exceptionally and where there is a clear rationale for not utilising the Government Banking Service;

c) Establishing separate bank accounts for the Trust's non-exchequer funds;

d) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

e) Ensuring accounts are not overdrawn except in exceptional and planned situations.

f) Reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

g) Monitoring compliance with Welsh Ministers' guidance on the level of cleared funds.

7.2.2 With the exception of Project Bank Accounts, all bank accounts should be held in the name of the Trust. No officer other than the Director of Finance shall open any account in the name of the Trust or for the purposes of furthering Trust activities.

7.2.3 Any Project Bank Account that is required may be held jointly in the name of the Trust and the relevant third party contractor.

7.3 Banking Procedures

7.3.1 The Director of Finance will prepare detailed instructions on the operation of bank accounts, that ensure there are sound controls over the day-to-day operation of bank accounts, which must include:

a) The conditions under which each bank account is to be operated;

b) Those authorised to sign cheques or other orders drawn on the Trust's accounts.

c) Effective divisions of duty for employees working within the banking and treasury management function to minimise the risk of fraud and error.

d) Authorised signatories are identified with sufficient seniority, and in the case of e banking approvers, together with an appropriate payment approval hierarchy.

e) Procedures are in place for prompt banking of money received.

f) Ensure there are physical security arrangements in place for cheque stationery, e banking access devices and payment cards.

g) Cheques and payable orders are treated as controlled stationery with management responsibility given to a duly designated employee.

h) Frequent reconciliations are undertaken between cash books, bank statements and the general ledger so that all differences are fully understood and accounted appropriately.

i) Commercial bank accounts should only be used exceptionally where there is a sound rationale and demonstrates value for money. Commercial accounts should be procured through a tendering exercise and the outcome reported to the Audit Committee on behalf of the Board.

7.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

7.3.3 The Director of Finance shall approve security procedures for any payable orders issued without a hand-written signature e.g. automatically printed. All Payable Orders shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

7.4 Review

7.4.1 The Director of Finance will review banking arrangements of the Trust at regular intervals to ensure they reflect best practice, that they are efficient and effective and represent best value for money. The results of the review should be reported to the Audit Committee.

8. CASH, CHEQUES, PAYMENT CARDS AND OTHER NEGOTIABLE INSTRUMENTS

8.1 General

8.1.1 The Director of Finance is responsible for:

a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

b) Ordering and securely controlling any such stationery, ensuring all cash related stationery treated as controlled stationery with management responsibility given to a duly designated employee;

c) The provision of adequate physical facilities and systems for officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

d) Establishing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

e) Ensuring effective control systems are in place for the use of payment cards,

f) Ensuring that there are adequate control systems in place to minimise the risk of cash/card misappropriation.

8.1.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs (informal documents acknowledging debt).

8.1.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

8.1.4 The holders of safe/cash box combinations/keys shall not accept unofficial funds for depositing in their safe/cash box unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

8.1.5 The opening of coin operated machines (including telephone, if applicable) and the counting and recording of takings shall be undertaken by two officers together, except as may be authorised in

writing by the Director of Finance and the coin box keys shall be held by a nominated officer.

8.1.6 During the absence (for example, on holiday) of the holder of a safe/cash box combination/key, the officer who acts in their place shall be subject to the same controls as the normal holder of the combination/key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.

8.2 Petty Cash

8.2.1 The Director of Finance will issue instructions restricting the use and value of petty cash purchases.

8.2.3 Petty cash use should be minimised and be subject to regular cash balance reviews in order to minimise cash levels held.

8.2.3 Petty cash should be operated under an imprest system and be subject to regular checks to ensure physical and book cash levels are consistent.

9. INCOME, FEES AND CHARGES

9.1 Income Generation and Participation in/Formation of Companies

9.1.1 The Trust shall only generate income for those goods and services that are approved by the Welsh Ministers. Any income generating activities must be complementary to the provision of NHS services and must be in accordance with the Welsh Ministers' policy and powers to raise money as set out in section 169 of the National Health Service (Wales) Act 2006 (c. 42).

9.1.2 The Trust can only form or participate in a company for income generation, improving health, healthcare care and health services, purposes with the consent and/or direction of Welsh Ministers. The Trust should obtain advice from Welsh Government officials prior to undertaking substantive work on formation or participation in any company.

9.2 Income Systems

9.2.1 The Director of Finance is responsible for designing and maintaining procedures to ensure compliance with systems for the proper recording, invoicing, and collection and coding of all monies due.

9.2.2 The Director of Finance is also responsible for ensuring that systems are in place for the prompt banking of all monies received.

9.3 Fees and Charges

9.3.1 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Welsh Ministers or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

9.3.2 All officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

9.4 Income Due and Debt Recovery

9.4.1 Delegated budget holders and managers are responsible for informing the Director of Finance of any income due that arises from any contracts, service levels agreements, leases, activities such as private patients or other transactions.

9.4.2 Delegated budget holders and managers must inform the Director of Finance when overpayment of salary or expenses have been made, in

order that recovery can be made.

9.4.3 The Director of Finance is responsible for recovering income due and for ensuring debt recovery procedures are in place to secure early payment and minimise bad debt risk on all outstanding debts.

9.4.4 Income not received should be dealt with in accordance with losses procedures.

9.4.5 Overpayments should be detected (or preferably prevented) and recovery initiated.

9.4.6 The Chief Executive and the Director of Finance are responsible for ensuring the Welsh Ministers' guidance on disputed debt arbitration is strictly adhered to.

10. NON PAY EXPENDITURE

10.1 Scheme of Delegation, Non Pay Expenditure Limits and Accountability

10.1.1. The Board must agree a Scheme of Delegation in line with that set out in its Standing Orders Scheme of Reservation and Delegation of Powers.

10.1.2. The Chief Executive will approve the level of non-pay expenditure and the operational scheme of delegation and authorisation to budget holders and managers within the parameters set out in the Trust's scheme of delegation.

10.1.3. The Chief Executive will set out in the operational scheme of delegation and authorisation:

- The list of managers who are authorised to place requisitions for the supply of goods, services and works and for the awarding of contracts; and
- The maximum level of each requisition and the system for authorisation above that level.

10.2 The Director of Finance's responsibilities

10.2.1 The Director of Finance will:

a) Advise the Board regarding the NHS Wales national procurement and payment systems thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SOs and SFIs;

b) Prepare procedural instructions or guidance within the Scheme of Delegation on non-pay expenditure;

c) Ensure systems are in place for the authorisation of all accounts and claims;

d) Ensure Directors and officers strictly follow NHS Wales system and procedures of verification, recording and payment of all amounts payable.

e) Maintain a list of Executive Directors and officers (including specimens of their signatures) authorised to certify invoices.

f) Be responsible for ensuring compliance with the Public Sector Payment policy ensuring that a minimum of 95 percent of creditors are paid within 30 days of receipt of goods or a valid invoice

(whichever is later) unless other payment terms have been agreed.

g) Ensure that where consultancy advice is being obtained, the procurement of such advice must be in accordance with applicable procurement legislation, guidance issued by the Welsh Ministers and SFIs;

h) Be responsible for Petty Cash system, procedures, authorisation and record keeping, and ensure purchases from petty cash are restricted in value and by type of purchase in accordance with procedures

10.3 Duties of Budget Holders and Managers

10.3.1 Budget holders and managers must ensure that they comply fully with the Scheme of Delegation, guidance and limits specified by the Chief Executive and Director of Finance, and that:

a) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of both any commitment being made and NWSSP Procurement Services being engaged;

b) Contracts above specified thresholds are advertised and awarded, through NWSSP Procurement Services, in accordance with EU and HM Treasury rules on public procurement;

c) Contracts above specified thresholds are approved by the Welsh Ministers prior to any commitment being made;

d) goods have been duly received, examined and are in accordance with specification and order,

e) work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct,

f) No requisition/order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board members or Trust officers, other than:

(i) Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars,

(ii) Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction with Standing Order 8.5, 8.6 and 8.7.

g) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

h) All goods, services, or works are ordered on official orders

i) Requisitions/orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

j) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

10.3.2 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance issued by the Welsh Ministers. The technical audit of these contracts shall be the responsibility of the relevant Director as set out in the Trust's scheme of delegation.

10.4 Departures from SFI's

10.4.1 Departing from the application of Chapters 10 and 11 of these SFI's is only possible in very exceptional circumstances. Trusts must consult with NWSSP Procurement Services, Director of Finance and Board Secretary prior to any such action undertaken. Any expenditure committed under these departures must receive prior approval in accordance with the Trust's Scheme of Delegation.

10.5 Accounts Payable

10.5.1 NWSSP Finance, shall on behalf of the Trust, maintain and deliver detailed policies, procedures systems and processes for all aspects of accounts payable

10.6 Prepayments

10.6.1 Prepayment should be exceptional, and should only be considered if a good value for money case can be made for them (i.e. that "need" can be demonstrated). Prepayments are only permitted where either:

- The financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%);
- It is the industry norm e.g. courses and conferences;
- In line with requirements of Managing Welsh Public Money

- There is specific Welsh Ministers' approval to do so e.g. voluntary services compact.

10.6.2 In **exceptional** circumstances prepayments can be made subject to:

a) The appropriate Executive Director providing, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their commitments;

b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the Public Contracts Regulations 2015 where the contract is above a stipulated financial threshold); and

c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11. PROCUREMENT AND CONTRACTING FOR GOODS AND SERVICES

General Information

11.1 Procurement Services

11.1.1 While the Chief Executive is ultimately responsible for procurement the service is delivered by NWSSP Procurement Services.

11.1.2 Procurement staff are employed by NHS Wales Shared Services Partnership (NWSSP) and provide a procurement support function to all health organisations in NHS Wales. Although NWSSP is responsible for the provision of a Procure to Pay service and provision of appropriate professional procurement and commercial advice, ultimate responsibility for compliance with legislation and policy guidelines remains with the Trust. Where the term Procurement staff or department is used in this chapter it should be read as equally applying to those departments where the procurement function is undertaken locally and outside of NWSSP Procurement Department, for example pharmacy and works who undertake procurement on a devolved basis.

11.2 Policies and procedures

11.2.1 NWSSP Procurement Services shall, on behalf of the Trust, maintain detailed policies and procedures for all aspects of procurement including tendering and contracting processes. The policies and procedures shall comply with these SFIs, Procurement Manual, and the Contract Notification Arrangements, included as **Schedule 1** of these SFIs.

11.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's Executive Directors, Independent Members and officers within the organisation strictly follow procurement, tendering and contracting procedures.

11.2.3 NWSSP Director of Procurement Services is responsible for ensuring that procurement, tendering and contracting policies and procedures

- Are kept up to date;
- Conform to statutory requirements and regulations;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development.

11.2.4 All procurement guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

11.3 Procurement Principles

11.3.1 The term "procurement" embraces the complete process from planning, sourcing to taking delivery of all works, goods and services required by the Trust to perform its functions, and furthermore embrace all building, equipment, consumables and services including health services. Procurement further embraces contract and/or supplier management, including market engagement and industry monitoring.

11.3.2 The main legal and governing principles guiding public procurement and which are incorporated into these SFIs are:

- Transparency: public bodies should ensure that there is openness and clarity on procurement processes and how they are implemented;
- Non-discrimination: public bodies may not discriminate between suppliers or products on grounds of their origin;
- Equal treatment: suppliers should be treated fairly and without discrimination, including in particular equality of opportunity and access to information;
- Proportionality: requirements and conditions in the procurement should be reasonable in proportion to the object of procurement and measures taken should not go beyond what is necessary;
- Legality: public bodies must conform to European Community and other legal requirements;
- Integrity: there should be no corruption or collusion with suppliers or others;
- Effectiveness and efficiency: public bodies should meet the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement;
- Efficiency: procurement processes should be carried out as cost effectively as possible and secure value for money.

11.4 Legislation Governing Public Procurement

11.4.1 There are a range of EU Directives which set out the EU legal framework for public procurement. These EU Directives have been implemented into UK law by statutory regulations which govern public sector procurement, the primary statutory regulations in Wales being 'The Public Contracts Regulations 2015 No. 102.' From 1 January 2021, all aspects of EU law in respect of the EU Directives relating to public procurement, except where expressly stated otherwise by domestic legislation, will continue to govern public sector procurement, although further amendments or developments of EU related procurement law following this will not be incorporated into domestic law. The Welsh Government policy framework and the Wales Procurement Policy Statement (WPPS) also govern this area. One of the key objectives of governing legislation is to ensure public

procurement markets are open and that there is free movement of supplies, services and works. Legislation, policy and guidance setting out procedures for awarding all forms of regulated contracts shall have effect as if incorporated in the Trust's SFIs.

11.4.2 The main Regulations (the Public Contracts Regulations 2015 No. 102) cover the whole field of procurement, including thresholds above which special and demanding procurement protocols and legal requirements apply. All Directors and their staff are responsible for seeing that those Regulations are understood and fully implemented. The protocols set out in the Regulations, and any Procurement Policy Notices, are the model upon which all formal procurement shall be based.

11.4.3 Procurement advice should be sought in the first instance from Procurement Services. The commissioning of further specialist advice shall be jointly agreed between the Trust and Procurement Services e.g. Engagement of NWSSP Legal and Risk Services prior to 3rd party Legal Service providers.

11.4.4 Other relevant legislation and policy include:

- The Well-being of Future Generations (Wales) Act 2015
- Welsh Language (Wales) Measure 2011
- Modern Slavery Act 2015
- Bribery Act 2010
- Equality Act 2010
- Welsh Government's Code of Practice for Ethical Employment in Supply Chains.
- The Producer Responsibility Obligations (Packaging Waste) Regulations 2007
- Welsh Government 'Towards zero waste: our waste strategy'
- The Welsh Government Policy Framework
- The Wales Procurement Policy Statement (WPPS)

11.5 Procurement Procedures

11.5.1 To ensure that the Trust is fully compliant with UK Procurement Regulations, EU Procurement Directives and Welsh Ministers' guidance and policy, the Trust shall, through NWSSP Procurement Services, ensure that it shall have procedures that set out:

a) Requirements and exceptions to formal competitive tendering requirements;
b) Tendering processes including post tender discussions;
c) Requirements and exceptions to obtaining quotations;
d) Evaluation and scoring methodologies
e) Approval of firms for providing goods and services.

11.5.2 All procurement procedures shall reflect the Welsh Ministers' guidance and the Trust's delegation arrangements and approval processes.

11.6 Procurement Consent and Notification

11.6.1 Paragraph 14(2) of Schedule 3 to the National Health Service (Wales) Act 2006 allows the Trust to:

- Acquire and dispose of property;
- Enter into contracts; and
- Accept gifts of property (including property to be held on trust, either for the general or any specific purposes of the NHS trust or for any purpose relating to the health service).

11.6.2 **Schedule 1** details the requirement process for contract notification for Trusts.

Planning

11.7 Sustainable Procurement

11.7.4 To further nurture the Welsh economy, in support of social, environmental and economic regeneration, Trusts must also be mindful to structure requirements ensuring Welsh companies have the opportunity to transparently and fairly compete to deliver services regionally or across Wales where possible. The principles of the Well-being of Future Generations (Wales) Act 2015 (WBFGA 2015) should be adopted at the earliest stage of planning. Procurement solutions must be developed embracing the five ways of working described within the Act and capture how they will deliver against the seven goals set out in the Act.

11.7.2 The WBFGA 2015 requires that bodies listed under the Act must operate in a manner that embraces sustainability. The Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change.

11.7.3 The 7 Wellbeing goals are:

- a prosperous Wales;
- a resilient Wales;
- a healthier Wales;
- a more equal Wales;
- a Wales of cohesive communities;
- a Wales of vibrant culture and thriving Welsh language; and
- a globally responsible Wales.

These goals have been put in place to improve the social, economic, environmental, and cultural well-being of Wales.

11.7.4 Public bodies need to make sure that when making their decisions they take into account the impact they could have on people living their lives in Wales in the future. The Act expects them to:

- work together better
- involve people reflecting the diversity of our communities
- look to the long term as well as focusing on now
- take action to try and stop problems getting worse - or even stop them happening in the first place.

11.7.5 The Trust is required to consider the Welsh Government Guidance on Ethical Procurement and the new Code of Practice on Ethical Employment in supply chains which commit public, private and third sector organisations to a set of actions that tackle illegal and unfair employment practices including blacklisting, modern slavery and living wage.

11.7.6 The Trust shall make use of the tools developed by Value Wales in implementing the principles of the WBFGA 2015. The Trust shall benchmark its performance against the WBFGA 2015. For all contracts over £25,000, the Trust shall take account of social, economic and environmental issues when making procurement decisions using the Sustainable Risk Assessment Template (SRA).

11.8 Small and Medium Sized Enterprises (SMEs), Third Sector Organisations (TSOs) and Supported Factories and Businesses (SFBs)

11.8.1 In accordance with Welsh Government commitments policy set out in the current WPPS and subsequent versions of this statement, the Trust shall ensure that it provides opportunities for these organisations to quote or tender for its business.

11.9 Planning Procurements

11.9.1 Trust must ensure that all staff with delegated budgetary responsibility or who are part of the procurement process for goods, services and works are aware of the legislative and policy frameworks governing public procurement and the requirement of open competition.

11.9.2 Depending on the value of the procurement, a process of planning the procurement must be undertaken with the Procurement Services and appropriate representative from the service and other appropriate stakeholders. The purpose of a planning phase is to determine:

- the likely financial value of the procurement, , including whole life cost
- the likely 'route to market' which will consider the legislative and policy framework set out above.
- The availability of funding to be able to award a contract following a successful procurement process.
- That the procurement follows current legislative and policy frameworks including Value Based Procurement.

11.9.3 The procurement specification should factor in the 4 principles of prudent healthcare:

- Equal partners through co-production;
- Care for those with the greatest health need first;
- Do only what is needed; and
- Reduce inappropriate variation.

Value based outcome/experience/delivery principles must also be included where appropriate ensuring best value for money, sustainability of services and the future financial position. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement**.**

11.9.4 Where free of charge services are made available to the Trust, NWSSP Procurement Services must be consulted to ensure that any competition requirements are not breached, particularly in the case of pilot activity to ensure that the Trust does not unintentionally commit itself to a single provider or longer term commitment. Regular reports on free of charge services provided to the Trust should be submitted by Board Secretary to Audit Committee.

11.9.5 Trusts are required to participate in all-Wales collaborative planning activity where the potential to do so is identified by the procurement professional involved in the planning process. Cross sector collaboration may also be required.

Joint or Collaborative Initiatives

11.9.6 Specialist advice should be obtained from Welsh Government and the opinions of NWSSP Procurement Services and NWSSP Legal and Risk prior to external opinion being sought where there is an undertaking to commence joint or collaborative initiatives which may be deemed as novel or contentious.

11.10 Procurement Process

11.10.1 Where there is a requirement for goods or services, the manager must source those goods or services from the Trust's approved

catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services. The use of suitable Welsh frameworks where access is permissible shall take precedence over frameworks led by Public Sector Bodies outside of Wales.

11.10.2 In the absence of an existing suitable procurement framework to source the required item, a competition must be run in accordance with the table below. Trust's must ensure the value of their requirement considers cumulative spend across the Trust for like requirements and opportunity for collaboration with other Trusts and Health Boards:

11.10.3 Agreements awarded are required to deliver best value for money over the whole life of the agreement. Value for money is defined as the optimum combination of whole-life cost and quality to meet the requirement.

Competition Requirements

11.11 Procurement Thresholds

11.11.1 The following table summarises the minimum thresholds for quotes and competitive tendering arrangements. The total value of the contract, whole life cost, over its entire period is the qualifying sum that should be applied (except in specific circumstances relating to aggregation and contracts of an indeterminate duration) as set out below, and in EU Procurement Directives and UK Procurement Regulations.

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
<£5,000	Evidence of value for money has been achieved	Purchase Order
>£5,000 - <£25,000	Evidence of 3 written quotations	Simple Form of Contract/Purchase Order
>£25,000 – Prevailing OJEU threshold	Advertised open call for competition. Minimum of 4 tenders received if available.	Formal contract and Purchase Order
>OJEU threshold	Advertised open call for competition. Minimum of 5 tenders received if available or appropriate to the procurement route.	Formal contract and Purchase Order

Goods/Services/Works Whole Life Cost Contract value (excl. VAT)	Minimum competition[1]	Form of Contract
Contracts above £1 million	Welsh Government approval required[2]	Formal contract and Purchase Order

[1] subject to the existence of suitable suppliers
[2] in accordance with the requirements set out in SO 11.6.

11.11.2 Advice from the Procurement Services must be sought for all requirements in excess of £5,000.

11.11.3 The deliberate sub-dividing of contracts to fall below a specific threshold is strictly prohibited. Any attempt to avoid these limits may expose the Board to risk of legal challenge and could result in disciplinary action against an individual[s].

11.11.4 Deliberate re-engagement of a supplier, where the value of the individual engagement is less than £5,000, must not be undertaken where the total value of engagements taken as a whole would exceed £5,000 and require competition.

11.12 Designing Competitions

11.12.1 The budget holder or manager responsible for the procurement is required to engage with the Procurement team to ensure:

- Required timescales are achievable
- Specifications are drafted which:
  - are fit for inclusion in competition documents;
  - are drafted in a manner encouraging innovation by the market;
  - are capable of being responded to and do not narrow competition;
  - deliver in line with legislative and policy frameworks;
  - include robust performance measures to effectively measure and manage supplier performance; and
  - consider the ability of the market to deliver.

11.12.2 Appropriate performance measures are included in agreements awarded, thus ensuring best value for money decisions taken that return maximum benefit for the organisation and ultimately the improvement of patient outcomes and wider health and social care communities.

11.12.3 Criteria for selecting suppliers and achieving an award recommendation must:

- be appropriately weighted in consideration of quality/price;
- consider cost of change where relevant;
- be transparent and proportionate;
- deliver value for money outcomes;
- fully explore complexity/risk; and
- consider whole life cost.

11.13 Single Quotation Application or Single Tender Application

11.13.1 In exceptional circumstances, there may be a need to secure goods/services/works from a single supplier. This may concern securing requirements from a single supplier, due to a special character of the firm, or a proprietary item or service of a special character. Such circumstances may include:

- Follow-up work where a provider has already undertaken initial work in the same area (and where the initial work was awarded from open competition);
- A technical compatibility issue which needs to be met e.g. specific equipment required, or compliance with a warranty cover clause;
- a need to retain a particular contractor for genuine business continuity issues (not just preferences); or
- When joining collaborative agreements where there is no formal agreement in place. Request for such a departure must be supported by written evidence from the Procurement Service confirming local agreements will be replaced by an all Wales competition/National strategy.

11.13.2 Procurement Services must be consulted prior to any such application being submitted for approval. The Director of Finance must approve such applications up to £25,000, the Chief Executive or designated deputy, and Director of Finance, are required to approve applications exceeding £25,000. A register must be kept for monitoring purposes and all single tender actions must be reported to the Audit Committee.

11.13.3 In all applications, through Single Quotation Application or Single Tender Application (SQA or STA) forms, the applicant must demonstrate adequate consideration to the Chief Executive and Director of Finance, as advised by the Head of Procurement, that securing best value for money is a priority. The Head of Procurement will scrutinise and endorse each request to ensure:

- Robust justification is provided;
- A value for money test has been undertaken;
- No bias towards a particular supplier;
- Future competitive processes are not adversely affected;
- No distortion of the market is intended;

- An acceptable level of assurance is available before presentation for approval in line with the Trust Scheme of Delegation; and
- An “or equivalent” test has been considered proving the request is justified.

11.13.4 Under no circumstances will Procurement Services endorse a retrospective SQA/STA, where the Trust has already entered into an arrangement directly.

11.13.5 As SQA/ STAs are only used in exceptional circumstances, the Trust, through the Chief Executive, must report each, including the specifics of the exceptional circumstances and the total financial commitment, in sufficient detail to its Audit Committee. The report will include any corrective action/advice provided by the Chief Executive, Director of Finance or NWSSP Director of Procurement Services to prevent recurrence by the Trust.

11.13.6 The Audit Committee may consider further steps to be appropriate, such as:

- Instruct a representative of the Trust to attend Audit Committee;
- Escalate to the Board;
- Request an internal Audit Review;
- Request further training; or
- Take internal disciplinary action.

11.13.7 No SQA/STA is required where the seeking of competition is not possible, nor would the application of the SQA/STA procedure add value to the process/aid the delivery of a value for money outcome. Procurement Manual details schedule of departures from SQA/STA where competition not possible.

11.13.8 For performance monitoring purposes, the NWSSP Procurement Service will retain a central register of all such activity including SQA/STA’s not endorsed by Procurement or any exceptional matters.

11.14 Disposals

11.14.1 Disposal of surplus, obsolete equipment/consumables is also subject to the competition rules.

11.14.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with applicable regulations and law at the prevailing time (e.g. Waste Electrical and Electronic Equipment (WEEE)) and the procedures of the Trust making use of any agreements covering the disposal of such items.

11.14.3 The Trust must obtain the best possible market price.

Approval & Award

11.15 Evaluation, Approval and Award

11.15.1 The evaluation of competitions via quotation or tender, must be undertaken by a minimum of 2 evaluators from within the operational service of the Trust. Evaluation Teams for competitions of greater complexity and value must be multi-disciplinary and reach a consensus recommendation for internal approval.

11.15.2 The internal approval of any recommendation to award a competition must follow the Board's Scheme of Delegation.

11.15.3 The communication of the external notification to the market to award the contract must be managed by the Procurement Service.

11.15.4 Information throughout the process must be handled and retained as 'commercial in confidence' and not shared outside of staff directly involved in the competition process.

11.15.5 All associated communication throughout the competition process must also be managed by the Procurement Service.

Implementation & Contract Management

11.16 Contract Management

11.16.1 Contract Management is the process which ensures that both parties to a contract fully meet their respective obligations as effectively and efficiently as possible, in order to deliver the business and operational objectives required by the contract and in particular, to achieve value for money. The relevant budget holder shall oversee and manage each contract on behalf of the Trust so as to ensure that these implicit obligations are met. This contract management will include:

- Retaining accurate records;
- Monitoring contract performance measures;
- Engaging suppliers to ensure performance delivery;
- Implementing contractual sanctions in the event of poor performance in conjunction with advice from Procurement Services; and
- Permitting stage payments as part of a formally agreed implementation/delivery plan which must be supported by written evidence issued by the budget holder.

11.16.2 Contract management on All Wales contracts will be provided by NWSSP Procurement Services.

11.16.3 Advice on best practice on Contract Management is available from NWSSP Procurement Services.

11.17 Extending and Varying Contracts

11.17.1 Extending, modifying or varying the scope of an existing contract is possible, if the provision to do so was included as an option in the original awarded contract, e.g. scope of requirement, further expenditure due to unforeseen circumstances, change in regulatory requirements, etc.

11.17.2 If there is no such provision, the Public Contracts Regulations 2015 define such limitations.

11.17.3 The Public Contracts Regulations 2015 provide further constraints on this matter, under which modifications/variations/extensions are capped at 50% of the original award value.

11.17.4 Further approval is not required to extend an agreement beyond the original term/scope where prior approval was granted as part of the procurement process.

11.17.5 If there was no provision to extend, further approvals are required from the Trust budget holder and the local Head of Procurement. Budget holders must also be mindful of the threshold under which the original contract was awarded. Any increase in the contract value may require a more senior level of approval in line with the Scheme of Delegation.

11.17.6 This ensures an appropriate identification and assessment of potential risks to the Trusts compliance of approvals being granted within the Scheme of Delegation and assurance that value for money continues to be delivered from public funds.

11.17.7 The budget holder must seek advice from NWSSP Procurement Services in advance of committing further expenditure to ensure the contract is reflective of requirements. The budget holder must assess whether there is sufficient evidence to support the justification and whether the budget is available to support the additional requirements.

Transactional Processes

11.18 Requisitioning

11.18.1 The budget manager in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. The budget holder will source those goods or services from the approved catalogue. Where a required item is not included within the catalogue, advice must be sought from the Procurement Services on opportunities to source those goods or services through public sector contract framework, such as National Procurement Service, NHS Supply Chain or Crown Commercial Services.

11.18.2 Where a required item is not on catalogue or on framework contract, the budget manager shall request the NWSSP Procurement Services to undertake quotation / tendering exercises on their behalf in line with SFI 11.11 thresholds.

11.18.3 All orders for goods and services must be accompanied by an official order number, available from the Procurement Department. In no circumstances must a requisition number be used as an order number.

11.19 No Purchase Order, No Pay

11.19.1 The Trust will ensure compliance with the 'No Purchase Order, No Pay' policy, the All Wales policy introduced to ensure that Procure to Pay continues to provide world-class services on a 'Once for Wales' basis.

11.19.2 The policy ensures that a purchase order is raised at the beginning of a purchase in circumstances where a purchase order is required under the policy. This follows industry standard best practice as it provides a commitment as to what is likely to be spent. The supplier must obtain a purchase order number for their invoice in order for it to be processed for payment.

11.20 Official Orders

11.20.1 Official Orders, issued following approved requisition and sourcing, must:

a) Be consecutively numbered;
b) State the Trust's terms and conditions of trade.

11.20.2 Official Orders will be issued on behalf of the Trust by NWSSP Procurement Services.

12. HEALTH CARE AGREEMENTS AND CONTRACTS FOR HEALTH CARE SERVICES

12.1 Health Care Agreements

12.1.1 The Chief Executive is responsible for ensuring the Trust enters into suitable Health Care Agreements (or Individual Patient Commissioning Agreements, where appropriate) for its provision of health care services.

12.1.2 All Health Care Agreements should aim to implement the agreed priorities contained within the Integrated Medium Term Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- The standards of service quality expected;
- The relevant quality, governance and risk frameworks and plans;
- The relevant national service framework (if any);
- The provision of reliable information on quality, volume and cost of service; and
- That the agreements are based on integrated care pathways.

12.1.3 All agreements must be in accordance with the functions conferred on the Trust by the Welsh Ministers.

12.2 Statutory provisions

The National Health Service (Wales) Act 2006 (c. 42) enables NHS Trusts to commission certain healthcare services. Section 7 sets out the definition of an NHS contract, being an arrangement under which one health service body arranges for the provision to it by another of goods or services which it reasonably requires for the purposes of its functions. It also provides a definition of a health service body.

12.3 Reports to Board on Health Care Agreements (HCAs)

12.3.1 The Chief Executive will need to ensure that regular reports are provided to the Board detailing performance, quality and associated financial implications of all health care agreements. These reports will be linked to, and consistent with, other Board reports on quality and financial performance.

13. GRANT FUNDING

It is a matter for Trusts to determine whether individual activities should be procured, or be eligible to receive grant funding, seeking legal advice as necessary. (Grants are defined as all non-procured payments to external bodies or individuals for activities which are linked to delivering policy objectives and statutory obligations. Payments are made to fund or reimburse expenditure on agreed items or functions in accordance with legally binding conditions.)

13.1 Legal Advice

13.1.1 Before the award of funding is made, legal advice where necessary must be sought to ensure that:

- The award does not breach the Trust's functions or its regularity of expenditure duty (that is, the activities for which the grant is made are within the scope of activities that the Trust has a legal remit to undertake);
- The activities would not be deemed to be normally subject to procurement legislation and policy; and
- A legally binding agreement is made with all delivery organisations.

See attached toolkit for grants v procurement:

Grant v Procurement.doc

13.2 Policies and procedures

13.2.1 The Trust shall maintain detailed policies and procedures for all aspects of grant funding. The policies and procedures shall comply with these SFIs, and where appropriate the Minister's Code of Practice to funding the third sector:

https://gov.wales/sites/default/files/publications/2019-01/third-sector-scheme-2014.pdf

13.2.2 The Chief Executive is ultimately responsible for ensuring that the Trust's grant procedures:

- Are kept up to date;
- Conform to statutory requirements;
- Adhere to guidance issued by the Welsh Ministers;
- Are consistent with the principles of sustainable development; and
- Are strictly followed by all Executive Directors, Independent Members and staff within the organisation.

13.2.3 The award of grant funding must comply with the policy and principles set out in the Procurement section of these SFIs and ensure that the award meets the requirements of regularity, propriety and value for money.

13.2.4 All grant guidance issued by the Welsh Ministers should have the effect as if incorporated in these SFIs.

13.3 Corporate Principles underpinning Grants Management

13.3.1 While there is a need to make the financial arrangements for awarding funding as simple and streamlined as possible, Trusts should also ensure that taxpayers' money is spent appropriately and that it provides good value for money.

13.3.2 The overarching principles for managing public resources in Wales are set out in Managing Welsh Public Money. The document states that the award of funding should be made in accordance with the law and the requirements of propriety, regularity and value for money.

13.3.3 Regularity requires compliance with appropriate authorities, regulations and legislation. Propriety requires both public authorities and funded bodies to deliver appropriate standards of conduct, behaviour and corporate governance. In addition, the public expects official decisions to be made fairly and impartially with public money spent wisely and appropriately, delivering value for money and ensuring that best use is made of resources.

13.3.4 The **corporate principles** of grants management are:

- The development of grant management processes and procedures that are transparent, accountable, proportionate and consistent;
- The delivery of a high quality regulatory framework that responds to demands but does not place unnecessary administrative burdens on Trusts or funded bodies;
- A regulatory framework that will take into consideration the need for proportionality, balancing the need for governance with the burden of administration, thus striking an appropriate balance between accountability and simplicity;
- An effective grant management process to ensure funded bodies spend the funding efficiently, transparently and for the purpose intended, with a view to maximising the impact and outcome from budgets;
- An appropriate evidence-based approach to underpin the design and development of all new funding programmes to ensure efficient and effective use of public funds, ensuring that the funding programme is the optimal solution and that funding is targeted where it is most needed and where it can have most impact;

- A consistent framework that will reinforce respect and effectiveness of the rules for both administrators and funded bodies; and
- Compliance of the grant funding with State aid requirements in accordance with the State aid rules.

13.4 Grant Procedures

It is vital that money is put to use in a way that delivers the maximum benefit to the people of Wales. Grants funding programmes need to be managed as efficiently and cost effectively as possible to make sure that every penny is spent appropriately and in an accountable manner. When establishing grant funding programmes, Trusts should ensure principles of good practice, available from a number of external sources, are considered and reflected in grant programmes.

13.4.1 Trusts must agree a clear purpose for each grant and how it will measure the delivery organisation's success in delivering those purposes. It should also agree appropriate targets with the delivery organisation.

13.4.2 For grant programmes that span a number of financial years, the Trust is responsible for evaluating the programmes to ensure they are fit for purpose, are achieving required outcomes and continue to provide value for money.

13.4.3 Trusts are responsible for ensuring that appropriate procedures exist in relation to all the grants and funding for which they are accountable. **They are also responsible for ensuring that any grant provided to an entity that engages in economic activity complies with the State aid rules.**

13.4.4 Trusts are required to undertake due diligence checks on all potential delivery organisations to determine the economic and financial viability of any organisation(s) to administer public funds, and the reliability of the organisation(s). These checks are important in order to identify any risks or issues that could expose the Trust to potential financial loss, fraud or reputational damage. A proportionate level of due diligence should be carried out, both prior to the award of any grant funding and throughout the life of the award.

13.4.5 The Trust must enter into legally binding funding agreements with all delivery organisations. When developing funding agreements, the Trust should ensure principles of good practice, available from a number of external sources, are considered and reflected.

13.4.6 The Trust is responsible for ensuring that all third party delivery organisations comply with and adhere to the terms and conditions of the Funding Agreement.

14. PAY EXPENDITURE

14.1 Remuneration and Terms of Service Committee

14.1.1 In accordance with SOs, the Board shall establish a Remuneration and Terms of Service Committee, with clearly defined terms of reference and operating arrangements that specify which posts fall within its area of responsibility. This Standing Financial Instruction should be read in conjunction with Standing Order 3.4.

14.1.2 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Directors and other senior employees, in accordance with the framework set by the Welsh Ministers. Minutes of the Board's meetings should record such decisions.

14.1.3 The Board will, after due consideration and amendment, if appropriate, approve proposals presented by the Chief Executive for the setting of remuneration and terms of service for those employees and officers not covered by the Committee.

14.1.4 The Trust will remunerate the Chair, Chief Executive, Executive Directors and Independent Members of the Board in accordance with instructions issued by the Welsh Ministers. Welsh Ministers approval will be required in the exceptional event that remuneration needs to be above the maximum of the salary band range, administratively this approval will be exercised by the Director General HSSG.

14.1.5 The Remuneration and Terms of Service Committee will consider cases of redundancy and Voluntary Early Release applications. The Remuneration and Terms of Service Committee will consider any novel employment and pay cases, such as compromise agreements and non-disclosure agreements, ensuring Welsh Government advice has been sought and considered.

14.2 Funded Establishment

14.2.1 The workforce plans incorporated within the approved Integrated Medium Term Plan will form the funded establishment, i.e, the budget for all approved posts. (The financial budgets (£) and workforce establishment budgets (budgeted whole time equivalents) as per SFI 5.1.1 g)

14.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or an officer with delegated authority.

14.3 Staff Appointments

14.3.1 Staff must only be engaged by authorised managers, in accordance with the Board's Scheme of Delegation. The engagement must be within the approved budget and funded establishment.

14.3.2 No Board member or Trust official may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration outside the limit of their approved budget and funded establishment unless authorised to do so by the Chief Executive.

14.4 Pay Rates and Terms and Conditions

14.4.1 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees in accordance with pay, terms and conditions set out in Ministerial directions on Agenda for Change and Medical and Dental pay, and any staff with pre-existing terms and conditions of service, following a TUPE transfer into employment or ad hoc salaried staff.

14.4.2 The Remuneration Committee will determine pay rates and conditions of services for board members, and other senior employees, in accordance with ministerial instructions.

14.5 Payroll

14.5.1 The Director of Workforce and Organisational Development has responsibility for securing an efficient, well-controlled payroll service from NHS Wales Shared Services Partnership that:

- pays the correct staff with the correct amount,
- all payments are supported by properly authorised documentation.

14.5.2 The Director of Workforce and Organisational Development has responsibility for:

a) The control framework and detailed procedures which are in place to:
   - To ensure all payments comply with HMRC, Pensions Agency and other regulation in relation to the deduction and payment of tax, national insurance, pension or other payments,
   - reduce the risk of fraud and error within the payroll function.

b) Specifying timetables for submission of properly authorised time records and other notifications;

c) The final determination of pay and allowances including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

d) Agreeing the timing and method of payment with the payroll service;

e) Authorising the release of payroll data where in accordance with the provisions of the applicable Data Protection Legislation (the Data Protection Act 2018 and the UK General Data Protection Legislation);

f) Verification and documentation of data;

g) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

h) Maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

i) Security and confidentiality of payroll information;

j) Checks to be applied to completed payroll before and after payment; and

k) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

14.5.3 The Chief Executive is responsible for:

a) Ensuring that arrangements for a payroll service from NHS Wales Shared Services Partnership (NWSSP) is supported by appropriate Service Level Agreements, terms and conditions, adequate internal controls and internal audit review procedures;

b) Ensuring a sound system of internal control and audit review of any internally provided payroll service; and

c) Maintenance and/or the authorisation of regular and independent reconciliation of pay control accounts.

14.5.4 Appropriately nominated managers have delegated responsibility for:

a) Submitting time records and other notifications in accordance with agreed timetables;

b) Completing time records and other notifications in accordance with the Service Level Agreements; and

c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce and Organisational Development and/or Chief Executive must be informed immediately. In circumstances where fraud is suspected, this must be reported to the Director of Finance.

14.6 Contracts of Employment

14.6.1 The Director of Workforce and Organisational Development must:

a) Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) Deal with variations to, or termination of, contracts of employment.

15. CAPITAL PLAN, CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

15.1 Capital Plan

15.1.1 Capital plans, and annual capital programmes, must be approved by the Board before the commencement of a financial year and should be in line with the objectives set out in the approved Integrated Medium Term Plan (IMTP) for the organisation. The capital plan and programmes must be delivered within Welsh Government capital external financing limit.

15.1.2 The Director of Planning (or nominated responsible director) will develop a capital plan, and detailed capital programme, for the organisation that sets out a detailed capital investment plan to support the objectives set out in the IMTP. The capital programme must be affordable and within the external financing limit, as set out by Welsh Government (WG) for the year, and the Trust must not exceed the external financing limit. There must be an approved revenue funding plan in place to support any revenue costs associated with the capital plan. Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.1.3 The Board must approve a three year Capital Plan, and an annual Capital Programme, as set out in the Integrated Medium Term Plan and Budgetary Control chapters of these SFI.

15.2 Capital Investment Decisions

15.2.1 Robust business case and capital investment appraisal must be undertaken prior to formal submission to Welsh Government, the level of detail within the appraisal commensurate with the value and risk of the investment. Capital investment decisions should be undertaken in line with Welsh Government requirements and guidance for the development of business cases as set out in:

- NHS Wales Infrastructure Investment Guidance (Welsh Health Circular WHC (2018) 043) https://gov.wales/nhs-wales-infrastructure-investment-guidance
- Better business cases: investment decision-making framework https://gov.wales/better-business-cases-investment-decision-making-framework

15.2.2 The Director of Finance must provide a professional opinion on the financial elements of the business case. Capital investment decisions will be taken by the organisation in line with the financial thresholds specified by Welsh Government and in the Trust's Scheme of Delegation.

15.3 Capital Projects

15.3.1 The Chief Executive shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received.

15.3.2 When capital investment decisions are taken and a Capital Programme is approved the project cannot be initiated until the authority to commit expenditure is formally delegated to a manager, in line with the organisation's Scheme of Delegation. The capital project must then be procured in line with normal procurement procedures or the Designed for Life or other approved procurement framework and in line with Welsh Government requirements and guidance and the applicable procurement legislation. Management control and financial reporting systems must be established to ensure that the project is:

- delivered on time;
- on budget; and
- within contractual obligations.

15.3.3 Project management controls and financial reporting systems must be established to ensure these objectives are met. Reporting requirements to Welsh Government will be set out in the approval letter provided post Ministerial approval.

15.3.4 Regular updates must be provided to the Board, and relevant Board Committees, during the financial year.

15.4 Capital Procedures and Responsibilities

15.4.1 The Chief Executive:

a) Shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

b) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

c) Shall ensure that any capital investment above the Welsh Ministers' delegated limit is not undertaken without approval of the Welsh Ministers and that confirmation of capital resources has been received;

d) Shall ensure that the three year Capital Plan, and detailed annual Capital Programme is adopted by the Board, as part of the IMTP, prior to the commencement of the financial year;

e) Shall ensure the availability of resources to finance all revenue consequences of the investment, including capital charges; and

f) Shall ensure that any 3rd party use of NHS estate is properly controlled, reimbursed and reported. This will include ensuring that appropriate security, insurance and indemnity arrangements are in place and that there is a written agreement as to each party's responsibilities and liabilities.

15.4.2 For every capital expenditure proposal the Chief Executive shall ensure:

a) That a business case is produced in line with Welsh Ministers' guidance and where appropriate the 5-case Model;

b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case and involved appropriate Trust personnel and external agencies in the process.

15.4.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management in accordance with the Welsh Ministers' guidance.

15.4.4 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any scheme.

15.4.5 The Chief Executive shall issue to the manager responsible for any scheme:

a) Specific authority to commit expenditure;

b) Authority to proceed to tender; and

c) Approval to accept a successful tender.

15.4.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the Welsh Ministers' guidance and the Trust's SOs.

15.4.7 The Director of Planning and Director of Finance shall issue detailed procedures governing the project, financial and contractual management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements and delegated limits for capital schemes set out in Welsh Ministers' guidance and approval letters. The procedures will also cover post project benefits realisation to ensure

benefits set out in the business case supporting the investment are delivered. The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

15.4.8 The Director of Finance shall ensure, for each capital project over £2m, that the Welsh Government Project Bank Accounts policy is applied unless there are compelling reasons not to do so. The Director of Finance should apply to Welsh Government officials for exemption from use of Project Bank Accounts, setting out the compelling reasons.

15.5 Capital Financing with the Private Sector

15.5.1 The Trust must not enter into any new capital financing arrangements with the private sector, including Private Financing Initiatives, Mutual Investment Model and 3rd Party Developments, without the consent of the Welsh Ministers.

15.6 Asset Registers

15.6.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Planning and Director of Finance, concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

15.6.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be in accordance with the Welsh Ministers' guidance and to satisfy the financial disclosure requirements for the Annual Accounts.

15.6.3 Additions to the fixed asset register must be clearly identified to the operational or departmental manager or delegated budget holder and be validated by reference to appropriate documentation to provide evidence of the financial value recorded, including:

a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) Lease agreements in respect of assets held under a finance lease and included on the Trust's balance sheet.

15.6.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each

disposal must be validated by reference to authorisation documents and invoices (where appropriate). Disposal receipts are to be treated in accordance with the Welsh Ministers' guidance and clearly set out in the over-arching business case.

15.6.5 The Director of Finance shall apply accounting policies for fixed assets in line with Welsh Government guidance and accounting standards and values recorded in the asset register, including depreciation and revaluations. The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in general ledgers against balances on fixed asset registers.

15.6.6 The value of each asset, and depreciation, shall be considered annually in accordance with valuation guidance and methods specified by the Welsh Ministers. Assets should be considered for early revaluation where there is the likelihood of impairment as a result in a change of valuation or asset life.

15.7 Security of Assets

15.7.1 The overall control of fixed assets is the responsibility of the Chief Executive.

15.7.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) Recording managerial responsibility for each asset;

b) Identification of additions and disposals;

c) Identification of all repairs and maintenance expenses;

d) Physical security of assets;

e) Regular verification of the existence of, condition of, and title to, assets recorded;

f) Identification and reporting of all costs associated with the retention of an asset; and

g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

15.7.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Planning and Director of Finance.

15.7.4 Whilst individual officers have a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior Trust officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

15.7.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and Trust officers in accordance with the procedure for reporting losses.

15.7.6 Where practical, assets should be marked as Trust property.

16. STORES AND RECEIPT OF GOODS

16.1 General position

16.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

a) Kept to a minimum;
b) Subjected to annual stock take; and
c) Valued at the lower of cost and net realisable value.

16.2 Control of Stores, Stocktaking, condemnations and disposal

16.2.1 Subject to the responsibility of the Director of Finance for the systems of financial control, overall responsibility for the control of stores shall be delegated to a senior officer by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental officers/managers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Manager; the control of any fuel oil and coal of a designated estates manager.

16.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Manager. Wherever practicable, stocks should be marked as health service property.

16.2.3 The Director of Finance is responsible for developing financial control systems and procedures for the regulation and operation of the stores, to include the accounting arrangements including records for receipt, issues, and returns of goods to stores and losses.

16.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

16.2.5 Where a complete system of controlled stores is not justified, alternative stores arrangements shall require the approval of the Director of Finance.

16.2.6 The designated officer/manager shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer/manager shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI 17, Disposals

and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

16.3 Goods supplied by an NHS supplies agency

16.3.1 For goods supplied via NHS Wales Shared Services Partnership – Procurement Services (NWSSP-PS) or any other NHS purchasing and supplies agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance or authorised officer who shall satisfy himself that the goods have been received before accepting the recharge.

17. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

17.1 Disposals and Condemnations

17.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets and goods, including condemnations, and ensure that these are notified to managers.

17.1.2 When it is decided to dispose of a Trust asset and goods, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

17.1.3 All unserviceable assets and goods shall be:

a) Condemned or otherwise disposed of by an officer, the Condemning Officer, authorised for that purpose by the Director of Finance;

b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the assets and good are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second officer authorised for the purpose by the Director of Finance.

17.1.4 The Condemning Officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

17.2 Losses and Special Payments

17.2.1 Losses and special payments are items that the Welsh Government would not have contemplated when it agreed funds for NHS Wales or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of the Welsh Government.

17.2.2 The Director of Finance is responsible for ensuring procedural instructions on the recording of and accounting for losses and special payments are in place; and that all losses or special payments cases are properly managed in accordance with the guidance set out in the Welsh Government's Manual for Accounts.

17.2.3 Any officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately

inform the Chief Executive and/or the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or the Chief Executive.

17.2.4 Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) and the CFS Wales Team in accordance with Directions issued by the Welsh Ministers on fraud and corruption.

17.2.5 The Director of Finance or the LCFS must notify the Audit Committee, the Auditor General's representative and the fraud liaison officer within the Welsh Government's Health and Social Services Group Finance Directorate of all frauds.

17.2.6 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must notify:

a) The Audit Committee on behalf of the Board, and

b) An Auditor General's representative.

17.2.7 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

17.2.8 The Director of Finance shall ensure all financial aspects of losses and special payments cases are properly registered and maintained on the centralised Losses and Special Payments Register and that 'case write-off' action is recorded on the system (i.e. case closure date, case status, etc.).

17.2.9 The Audit Committee shall approve the writing-off of losses or the making of special payments within delegated limits determined by the Welsh Ministers and as set out by Welsh Government in its Losses and Special Payments guidance as detailed in Schedule 3 of the SOs.

17.2.10 For any loss or special payments, the Director of Finance should consider whether any insurance claim could be made from the Welsh Risk Pool or from other commercial insurance arrangements.

17.2.11 No losses or special payments exceeding delegated limits shall be authorised or made without the prior approval of the Health and Social Services Group Director of Finance.

17.2.12 All novel, contentious and repercussive cases must be referred to the Welsh Government's Health and Social Services Group Finance Directorate, irrespective of the delegated limit.

17.2.13 The Director of Finance shall ensure all losses and special payments are reported to the Audit Committee at every meeting.

17.2.14 The Trust must obtain the Health and Social Services Group Director General's approval for special severance payments. Refer to **Appendix 1** – Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors dated 24th May 2022).

17.2.15 **Appendix 1** of these SFI's details the Welsh Government approval requirements from an accounting perspective for individual end of employment payments.

18. DIGITAL, DATA and TECHNOLOGY

18.1 Digital Data and Technology Strategy

18.1.1 The Board shall approve a Digital Data and Technology Strategy which sets out the development needs of the Trust for the medium term based on an appropriate assessment of risk. The Integrated Medium Term Plan shall include costed implementation plans of the strategy. The Board shall also ensure that a Director has responsibility for Digital Data and Technology .

18.1.2 The Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about the Trust that are made publicly available.

18.2 Responsibilities and duties of the responsible Director

18.2.1 The responsible Director for Digital Data and Technology has responsibility for the accuracy, availability and security of the Trust digital systems and data and shall:

a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection and availability of the Trust's digital systems and data for which they are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Network and Information Systems Regulations 2018, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018;

b) Ensure that, following risk assessment of threats, adequate (reasonable) controls exist over access to systems, data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) Ensure that an adequate management (audit) trail is maintained of access to digital systems and data and that such audit reviews as the Director may consider necessary to meet the organisational requirements under the Network and Information Systems Regulations 2018 are being carried out;

d) Shall ensure that policies, procedures and training arrangements are in place to ensure compliance with information governance law and the Network and Information Systems Regulations 2018; and

e) Shall ensure comprehensive incident reporting.

18.3 Responsibilities and duties of the Director of Finance

18.3.1 The Director of Finance shall need to ensure that new financial data and systems and amendments to current financial data and systems are developed in a controlled manner and thoroughly tested prior to implementation and business as usual phases. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation and business as usual phases.

18.4 Contracts for data and digital services with other health bodies or outside agencies

18.4.1 The responsible Director for Digital Data and Technology shall ensure that contracts for data and digital services for clinical, management and financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for:

- the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage, and
- the availability of the service including the resilience required to maintain continuity of the service.

The contract should also ensure rights of access for audit purposes.

18.4.2 Where another health organisation or any other agency provides a data or digital service for clinical, management and financial applications, the responsible Director for Informatics and Digital shall, to maintain the confidentiality, integrity and availability of the service provided, periodically seek assurances that adequate controls, based on risk assessment, are in operation.

18.5 Risk assurance

18.5.1 The responsible Director for Digital Data and Technology shall ensure that the risks to the Trust arising from the use of data, information and IT are effectively identified and considered and that appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate resilience plans, including both a business continuity and disaster recovery plan.

19. PATIENTS' PROPERTY

19.1 NHS Trust Responsibility

19.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of patients that lack capacity, or found in the possession of patients dead on arrival.

19.1.2 Where the Welsh Ministers' instructions require the opening of separate accounts for patient monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

19.1.3 In all cases where property, including cash and valuables, of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 (c. 32)), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

19.1.4 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

19.1.5 Where patient property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19.2 Responsibilities of the Chief Executive

19.2.1 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission, that the Trust will not accept responsibility or liability for patient property brought onto health service premises, unless it is handed in for safe custody and a copy of an official patient property record is retained as a receipt, by:

a) Notices and information booklets;

b) Hospital admission documentation and property records; and

c) The oral advice of administrative and nursing staff responsible for admissions.

19.3 Responsibilities of the Director of Finance

19.3.1 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patient property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

20. FUNDS HELD ON TRUST (CHARITABLE FUNDS)

20.1 Corporate Trustee

20.1.1 All business shall be conducted in the name of Velindre University National Health Service Trust, and all funds received in trust shall be held in the name of the Trust as a corporate Trustee. SFI 20.2 defines the need for compliance with Charities Commission latest guidance and best practice.

20.1.2 The discharge of the Trust's corporate trustee responsibilities for funds held on trust are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

20.1.3 The Trust shall establish a Charitable Funds Committee as set out in Standing Order 3.4 to ensure that each fund held on trust which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

20.2 Accountability to Charity Commission and the Welsh Ministers

20.2.1 The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds and to the Welsh Ministers for exchequer funds.

20.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

20.2.3 The Trust shall make appropriate arrangements for the Annual Accounts and audit of Funds held on Trust in accordance with Charity Commission requirements.

20.3 Applicability of Standing Financial Instructions to funds held on Trust

20.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

20.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

21. RETENTION OF RECORDS

21.1 Responsibilities of the Chief Executive

21.1.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with the Welsh Ministers' guidance, the UK General Data Protection Legislation and any relevant domestic law considerations via the Data Protection Act 2018 and the Freedom of Information Act 2000 (c. 36).

21.1.2 The records held in archives shall be capable of retrieval by authorised persons.

21.1.3 Records held shall only be destroyed in accordance with the applicable data protection laws and at the express instigation of the Chief Executive. Details shall be maintained of records so destroyed.

Schedule 1

REVISED GENERAL CONSENT TO ENTER INDIVIDUAL CONTRACTS

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Directors of Finance
Deputy Directors of Finance
Local Health Boards, NHS Trusts Wales, HEIW and DHCW

Our Ref: SE&IG/

Date: 31 March, 2022

Dear All,

This letter supercedes the consent guidance issued in our joint letter on 30 November 2020.

RE: PROCESSES FOR LOCAL HEALTH BOARDS AND NHS TRUSTS CONTRACTS, AND INTERESTS IN PROPERTY EXCEEDING £0.5M

Paragraph 13(3) of Schedule 2 to the National Health Service (Wales) Act 2006 places a requirement on Local Health Boards (LHBs) to obtain the consent of Welsh Ministers before:

- Acquiring and disposing of property;
- Entering into contracts; and
- Accepting gifts of property (including property to be held on trust).

Acquiring and disposing of property

WHC (2018) 043 NHS Wales Infrastructure Investment Guidance issued 22 October 2018 sets out at section 10.1:

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LHBs and HEIW
Contract approvals over £1m for individual schemes will be sought as part of the normal business case submission process where funding from the NHS Capital Programme is required. For schemes funded via discretionary allocations, a request for approval will need to be submitted to Chief Executive NHS Wales, copying in the Deputy Director of Capital, Estates & Facilities Division.

Detailed arrangements in respect of approval process linked to the acquisition and disposal of leases, where consent does not form part of the business case process will be included in a Welsh Health Circular WHC(2015)031. Organisations should ensure that the monitoring arrangements and the requisite forms and returns are included as part of their own assurance arrangements.

NHS Trusts
Whilst formal Ministerial consent is not required for Trusts as detailed above, general consent arrangements are still applicable in terms of relevant transactions. Detailed requirements in terms of appropriate notifications were sent in the Welsh Health Circular referenced above.

Guidance on disposals is contained in Section 11

WHC (2015) 031 issued 22 June 2015 clarified the approval process linked to the acquisition or disposal of a lease, where approval does not form part of a business case process. A lease being a property right requires the consent of the Welsh Ministers in accordance with paragraph 13(2) (a). The WHC set out for NHS Trusts and LHBs a notification and consent process mirroring the contract processes noted below.

Entering into contracts
Guidance was issued to NHS Wales bodies on 27th January 2017 in a letter to Directors of Finance issued jointly by the Deputy Directors of Finance and Capital Estates and Facilities. This letter now updates that guidance to reconfirm to all NHS Wales bodies that the authorisation and consideration of notified contracts and applications for the acquisitions or disposals of a lease or any interest in property are delegated to the Director General, Health and Social Services Group.

The Director General may, as with any other matter relating to the operation of the NHS in Wales, brief the Minister for Health and Social Services on any arrangement of particular policy note, or with a novel, contentious or innovative nature.

Accordingly any issues relevant to the exercise of the Minister for Health and Social Service's consent will, as a matter of course, be drawn to his attention.

The process which NHS Wales bodies entering into contracts must follow is:

- All NHS contracts (unless exempt) >£1m in total to be notified to the Director General HSSG prior to tendering for the contract;

- All eligible LHB and HEIW contracts >£1m in total to be submitted to the Director General HSSG for consent prior to award;
- All eligible NHS Trust contracts >£1m in total to be submitted to the Director General HSSG for notification prior to award; and
- All eligible NHS contracts >£0.5m in total to be submitted to the Director General HSSG for notification prior to award.

The requirement for consent does not apply to any contracts entered into pursuant to a specific statutory power, and therefore does not apply to:

(i) Contracts of employment between LHBs and their staff;
(ii) Transfers of land or contracts effected by Statutory Instrument following the creation of LHBs;
(iii) Out of Hours contracts; and
(iv) All NHS contracts; that is where one health services body contracts with another health service body.

Contracts entered into by HEIW for services which are the consequences of annual commissioning approved by the Minister e.g. annual education and training commissioning do not require further Ministerial notification or consent.

For non- capital contracts requiring DG approval, the request for approval or notification should be sent to Rob Eveleigh in the Financial Control and Governance team : Robert.Eveleigh@gov.wales

Kind regards,

Steve Elliot & Ian Gunney
Cyfarwyddwr Cyllid dros dro - Interim Director of Finance
Dirprwy Gyfarwyddwr, Cyfalaf Ystadau a Cyfleusterau - Deputy Director Capital Estates & Facilities
Finance Directorate / Cyfarwyddiaeth Cyllid
Y Grwp Iechyd a Gwasanaethau/Health and Social Services Group

Appendix 1

Annex 5 to Chapter 6 of the Manual for Accounts – Welsh Government's Director of Workforce and Corporate Business Letter to Workforce Directors

Y Grwp Iechyd a Gwasanaethau Cymdeithasol
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Workforce and OD Directors
Assistant Workforce Directors

24th May 2022

Dear All

I wanted to take this opportunity to write to you again to remind you of Andrew Goodall's Governance in Recruitment letter dated 25 June 2021 which is attached in the covering email.

As well as a reminder of the Goverance in Recruitment principles I thought it would be helpful to set out the circumstances in which Welsh Government approval is required from an accounting perspective for individual end of employment payments. These are set out in the NHS Wales Manual for Accounts under the Losses and Special Payments chapter but in summary these are:

Contractual Redundancy – organisations have delegated authority from a financial accounting perspective to pay contractual entitlements so Welsh Government approval is not needed. However, for Executive Directors, Welsh Government do need to be aware before any such contractual arrangements are signed off with the individual and approved by Judith Paget as Accounting Officer.

Voluntary Early Release Scheme (VERS) – organisations have delegated authority for payments up to £50,000 as set out on the VERS Model Scheme rule. Payment over this level require Welsh Government Accounting Officer approval, and there is a template Business Case to submit to Welsh Government for approval. Both documents are attached in the covering email.

Ex gratia / Settlement payment – any payment amount above contractual entitlement requires Welsh Government approval. Given that cases will be based on individual circumstances there is no set template, however we have developed a spreadsheet with options to demonstrate that the course of action is cost effective and demonstrates value for public sector money, as any such payments should only be exceptional. The Losses and Special payment chapter also outlines the principles to follow and the checklist that must be

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Rydym yn croesawu derbyn gohebiaeth yn Gymraeg. Byddwn yn ateb gohebiaeth a dderbynnir yn Gymraeg yn Gymraeg ac ni fydd gohebu yn Gymraeg yn arwain at oedi.

We welcome receiving correspondence in Welsh. Any correspondence received in Welsh will be answered in Welsh and corresponding in Welsh will not lead to a delay in responding.

completed and signed off. The team and I would be happy to talk through any such cases and provide advice.

In all of the above scenarios your Renumeration and Terms and Conditions Committee provide an essential role and must sign off the payment before coming to Welsh Government for final approval. It is also worth noting that whilst myself and the team will take action on any approvals as soon as possible, please do bear in mind that advice needs to be prepared for Judith (and in some novel or contentious cases further internal governance sign off) and this does take time and resource availability so providing us with as much notice as possible would be appreciated.

As always if you have any questions regarding such payments, please do speak to me or my team.

Yours sincerely

Helen Arthur
Director of Workforce and Corporate Business
Cyfarwyddwr y Gweithlu a Busnes Corfforaethol

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

AMENDMENT TO STANDING ORDERS – SCHEDULE 3 ANNUAL REVIEW COMMITTEE TERMS OF REFERENCE:

DATE OF MEETING	26 September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to outline the required changes to Schedule 3 of the Trust Standing Orders, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the: • Quality, Safety and Performance Committee ***(Appendix 1)*** • Charitable Funds Investment Performance Review Sub-Committee ***(Appendix 2)***
RECOMMENDATION / ACTIONS	The Trust Board is asked to **APPROVE** the revisions to the following Terms of Reference

	which form part of Schedule 3 of the Trust's Standing Orders: • Quality, Safety and Performance Committee ***(Appendix 1)*** • Charitable Funds Investment Performance Review Sub-Committee ***(Appendix 2)***

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Quality, Safety and Performance Committee ***(Appendix 1)***	12/09/2024
Charitable Funds Investment Performance Review Sub-Committee ***(Appendix 2)***	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Quality, Safety and Performance Committee **ENDORSED** the revisions to the Committee Terms of Reference for Approval by the Trust Board ***(Appendix 1).*** The Charitable Funds Investment Performance Review Sub-Committee **ENDORSED** the revisions to the Committee Terms of Reference for Approval by the Trust Board ***(Appendix 2).***	

7 LEVELS OF ASSURANCE - N/A

APPENDICES	
Appendix 1	Quality, Safety and Performance Committee Terms of Reference
Appendix 2	Charitable Funds Investment Performance Review Sub-Committee

1. SITUATION

1.1 Velindre University National Health Service Trust is a statutory body that came into existence on 1st December 1993 under the Velindre National Health Service Trust (Establishment) Order 1993 (S.I. 1993/2838), as amended, "the Establishment Order".

1.2 Velindre University NHS Trust has a duty under Regulation 19(2) of the National Health Service Trusts (Membership and Procedure) Regulations 1990 to make Standing Orders for the regulation of their proceedings and business. It is important to note that the Trust is able to vary or suspend its own Standing Orders, providing that it is able to satisfy that it complies with the relevant regulations.

2. BACKGROUND

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

2.2 All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

3. ASSESSMENT

3.1 The purpose of this report is to outline the required changes to Schedule 3 of the Trust Standing Orders, resulting from the Annual Review of the Terms of Reference and Operating Arrangements in respect of the following Committee and Sub-Committee:

- Quality, Safety and Performance Committee ***(Appendix 1)***
- Charitable Funds Investment Performance Review Sub-Committee ***(Appendix 2)***

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The amendments detailed in this report have been formally received and **ENDORSED** for Board **APPROVAL** by the Quality, Safety and Performance Committee ***(Appendix 1)*** and Charitable Funds Investment Performance Review Sub-Committee ***(Appendix 2)***.

4.2 **Table 1** provides a high level summary of the key changes to the Quality, Safety and Performance Committee Terms of Reference.

4.3 There are no proposed changes to the Charitable Funds Investment Performance Review Sub-Committee Terms of Reference.

4.4 The Trust Board is asked to **APPROVE** the following Terms of Reference which form part of Schedule 3 of the Trust's Standing Orders:

- Quality, Safety and Performance Committee ***(Appendix 1)***
- Charitable Funds Investment Performance Review Sub-Committee ***(Appendix 2)***

Table 1: Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements	Summary of Amendments
Quality Safety and Performance Committee	**2. Purpose** ***2.1:*** • Inclusion of compliance with the Duty of Quality and Duty of Candour legislation • Inclusion of the integrated and triangulated quality and safety outcomes • Inclusion of: o Infection prevention and control o Putting Things Right regulations o Quality and Safety Framework compliance o Mortality o Information governance o Divisional quality oversight o Trust Assurance Framework • Updated Health & Care Quality Standards to 2023
Quality Safety and Performance Committee	**3. Delegated Powers and Authority** ***3.1:*** • Inclusion of Duties of Quality and Candour • Amendment to bullet regarding risks: o Ensure there are robust risk identification reporting and escalation processes risks are actively identified and robustly managed at all levels of the Trust; • Update to Health and Care Standards bullet to reference change in legislation and compliance • Added 3.2 - Inclusion of reference to the Integrated Quality and Safety Group and its function • ***Authority*** - renumbered bullets 3.3 and 3.4 • ***Access*** - renumbered bullet 3.5 • ***Sub Committees*** - renumbered bullet to 3.6 ***3.2:*** • Inclusion of the reference to the Integrated Quality and Safety Group as follows:

	Integrated Quality & Safety Group 3.2 The monthly Integrated Quality & Safety Group will consider all matters relating to the Integrated Quality & Safety agenda and will produce a quarterly report to the Committee synthesising and analysing the outcomes to provide assurance and exception reporting to the Committee.
Quality Safety and Performance Committee	**4. Membership** ***4.2 Attendees*** • Addition of Deputy Director of Organisational Development and Workforce • Amendment to title of Quality and Safety Manager to Head of Quality and Safety Inclusion of an additional sentences "**As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:** • **Executive Director of Nursing, Allied Health Professionals and Health Science;** • **Executive Medical Director;** • **Executive Director of Finance;** • **Executive Director of Organisational Development & Workforce.** **Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.** ***4.3 By Invitation*** • Amendment to reflect change from Community Health Council to Llais.
Quality, Safety and Performance Committee	**Quorum** Inclusion of an additional sentences **"5.2 As a minimum there must be at least 2**

	Executive/Board Directors in attendance from the following: • **Executive Director of Nursing, Allied Health Professionals and Health Science;** • **Executive Medical Director;** • **Executive Director of Finance;** • **Executive Director of Organisational Development & Workforce.** **Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.** Remainder of section to be renumbered following inclusion of the additional sentence above.
Quality Safety and Performance Committee	**7. Reporting and Assurance** 7.1 "***presentation*** of an annual Quality, Safety & Performance Committee report" replaced with "***submission*** of…"

5. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, ensuring good governance within the Trust can support quality care.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the activity outlined in this report.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
	There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	*There is no direct impact on resources as a result of the activity outlined in this report.*
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this report.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is essential that the Trust complies with its standing orders.

6. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**

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

Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2024
Approved:	
Next Review Due:	

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. This will include (not limited to):

- Compliance with Duty of quality and Duty of Candour legislation
- Integrated and triangulated quality and safety outcomes, including:
    - safeguarding and vulnerable groups
    - patient, donor and staff experience
    - Health and Care Quality Standards (2023)
    - Infection prevention and control
    - Putting Things Right regulations
    - Quality and safety framework compliance
    - Mortality
    - Information governance
    - Divisional quality oversight
- all aspects regarding the workforce (including staff experience)
- digital and cyber security
- relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
- financial performance
- regulatory compliance
- organisational and clinical risk
- Trust Assurance Framework

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 there are robust risk identification reporting and escalation processes ensuring risks are actively identified and robustly managed at all levels of the Trust;

- 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 compliance with the Health and Care Quality Standards (2023);

- 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.

Integrated Quality & Safety Group

3.2 The monthly Integrated Quality & Safety Group will consider all matters relating to the Integrated Quality & Safety agenda and will produce a quarterly report to the Committee synthesising and analysing the outcomes to provide assurance and exception reporting to the Committee.

Authority

3.3 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.

3.4 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.5 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.6 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.

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 two 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 Service 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
- Executive Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Deputy Director of Organisational Development and Workforce
- Chief Digital Officer (*also cyber/data outages/performance)*
- Head of Quality & Safety
- Head of Corporate Governance

As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:

- Executive Director of Nursing, Allied Health Professionals and Health Science;
- Executive Medical Director
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce

Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.

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
- Llais (Citizens Voice Body)

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 organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two independent members must be present to ensure the quorum of the Committee. If the Committee Chair is not present an agreement as to who will chair from the independent members in their absence.

5.2 As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:

- Executive Director of Nursing, Allied Health Professionals and Health Science;
- Executive Medical Director
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce

Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.

Frequency of Meetings

5.3 Meetings shall be held no less than bi-monthly and otherwise, as the Chair of the Committee deems necessary.

Withdrawal of individuals in attendance

5.4 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 submission 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.

- 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)
Cynullio Group (formerly Estates and Facilities Management Group)
Welsh Language Task and Finish Group
WBS Local Partnership Forum (LPF)
CEG Meetings Collections General Services WTAIL 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

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Charitable Funds Investment Performance Review Sub Committee

Terms of Reference & Operating Arrangements

Reviewed:	September 2024
Approved:	
Next Review Date:	September 2025

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 The Charitable Funds Committee was established by the Board to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

1.3 As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

2. PURPOSE

2.1 The purpose of the Investment Performance Review Sub Committee ("the Committee") is to undertake the following tasks on behalf of the Committee:

- Ensure that when investing charitable funds Trustees achieve an appropriate balance for the Charity between the two objectives of:
  a) Providing an income to help the Charity carry out its purposes effectively in the short term; and
  b) Maintaining and, if possible, enhancing the value of the invested funds, so as to enable the Charity to carry out its purpose in the longer term.

- Ensure that the following standards as defined in **the Trustee Act are followed**, whether they are using the investment powers in that Act or not:
  a) That the Charity is discharging its general duty of care (as described in section 1 of the Trustee Act), which is the duty to exercise such care and skill as is reasonable in the circumstances. This applies both to the use of any power of investment and to the discharge of the specific duties which the Act attaches to the use of investment powers.
  b) Secondly, that the Charity is complying with the following **specific duties**:

    - Trustees must consider the **suitability** for the Charity of any investment. This duty exists at two levels. The Trustees must be satisfied that the type of any proposed investment (e.g. a common investment fund or a deposit account) is right for the Charity They also have a duty to consider whether a particular investment of that type is a suitable one for the Charity to make, based on the overall investment policy set by the Charitable Funds Committee Trustees

should, at both levels, try to consider the whole range of investment options which are open to them; how far they should go here will, of course, depend on the amount of funds available for investment.

- Trustees must consider the need for **diversification**, i.e. having different types of investment, and different investments within each type. This will reduce the risk of losses resulting from concentrating on a particular investment or type of investment.
- Trustees must periodically review the investments of the Charity. The nature and frequency of these reviews is up to the Trustees to decide, but the reviews should be proportionate to the nature and size of the Charity's investment portfolio. To review too infrequently may result in losses or missed opportunities; chopping and changing investments too frequently may incur unnecessarily high levels of transaction charges. A review of the investments should be carried out at least once a year.
- Trustees must monitor the overall performance of the portfolio and, in so far as it is possible, compare the rate of return with returns achieved by other similar organisations. The rate of return will need to be reported annually to the Charitable Funds Committee as part of its annual report.
- Before exercising any power of investment, and when reviewing the Charity's investments, Trustees must obtain and consider proper **advice** from a suitably qualified adviser.

3. DELEGATED POWERS AND AUTHORITY

The Committee has delegated responsibility to the sub-committee to review the performance and strategy for the Investment Portfolio in the context of the general and specific duties set out above and has delegated the authority to investigate all relevant aspects relating to this function.

4. MEMBERSHIP

Members:

The membership of the Charitable Funds' Investments Performance Sub Committee is as follows:

- Two Independent Members of the Board (Non Executive Director)
- The Chief Executive
- The Executive Director of Finance.

One of the independent members will be Chair of the Sub-Committee.

An invitation to attend these Sub Committee meetings has been given to representatives of the Trust's Investment Management Service Provider.

Attendees:

In attendance	The Committee may require the attendance for advice, support and information routinely at meetings from: • Deputy Director of Finance • Investment Advisors

Secretariat

The Sub Committee shall be serviced by a Secretary who shall not be a member of the Sub Committee with agendas and papers circulated at least 10 working days before meetings.

5. COMMITTEE MEETINGS

Quorum - At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member.

The Sub Committee should meet every six months or as required.

The Sub Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

Although the Board has delegated authority to the Charitable Funds Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

The Sub Committee is directly accountable to the Charitable Funds Committee for its performance in exercising the functions set out in these terms of reference.

The Sub Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights throughout the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

The Sub-Committee Chair shall arrange for a report formally, regularly and on a timely basis to the Charitable Funds Committee on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports following each meeting.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Sub Committee, other than in relation to the quorum requirements as specified in 5.1 above.

9. REVIEW

These terms of reference and operating arrangements shall be reviewed annually by the Sub Committee and the Charitable Funds Committee with reference to the Board.

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Trust Board

Annual and three-year Assurance Reports on Compliance with the Nurse Staffing Levels (Wales) Act 2016

DATE OF MEETING	26th September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Rhian Wright, Nurse Staffing Programme Lead
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	Section 25E of the Nurse Staffing Levels (Wales) Act 2016 requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward and paediatric inpatient wards This paper is to provide the Trust Board with both the annual (6th April 2023 to 5th April 2024) assurance and the three-year report covering April 2021 to April 2024. During 2023/24: • The planned roster was met and appropriate for the majority of shifts. • All reasonable steps were taken to maintain the nurse staffing level in line with the requirements of the Act. • **There have been no instances of reportable harm for pressure damage, falls or medication never events where staffing levels contributed.** • **There have been no instances where nurse staffing levels were thought to be a**

	contributory factor to harm or complaints. • The nursing establishment was sufficiently funded and appropriate to provide the planned roster for the First Floor Ward.

RECOMMENDATION / ACTIONS	The Trust Board is asked to ***APPROVE*** the 2023/2024 Nurse Staffing Levels Wales Annual Report, and the 2021/2024 Nurse Staffing Levels Wales 3-year report prior to onward submission to Welsh Government.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nursing Forum	01/08/2024
Executive Management Board	29/08/2024
Quality, Safety & Performance Committee	12/09/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Endorsed for onward approval	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full

APPENDICES	
Appendix 1	2023/2024 Nurse Staffing Levels Wales Annual Report
Appendix 2	2021/2024 Nurse Staffing Levels Wales 3-year report

1. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nursing and other staff; and;
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

The Velindre Cancer Service First Floor Ward was re-classified in April 2021 as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical ward and therefore, the ward and Trust are now required to meet the full reporting requirements of the Nurse Staffing Levels (Wales) Act 2016. Bi-annual nursing

establishment reviews of both 25A and 25B areas are carried out utilizing a triangulated approach. The full detailed report will follow however part of this is considered in the assessment/summary below.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Nurse Staffing Levels Act Reporting

To facilitate the preparation of the statutory three-yearly report to Welsh Government, there is an agreed All Wales requirement that both an annual and three- yearly assurance report be prepared to provide assurance to the Board that all statutory requirements are being met. The Nurse Staffing Levels (Wales) Act 2016 Annual Assurance Reports have been completed using the national reporting template and are attached in Appendix 1 and 2 and highlights:

- Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 biannual nursing establishment reviews have taken place using a triangulated approach in first floor ward, 25B area.
- Although not a requirement under the Act the same process of undertaking bi-annual establishment reviews is enacted for 25A areas.
- There has been no change in the nursing establishment for first floor.
- SafeCare has been utilised to record nurse staffing and acuity levels on first floor since March 2023 with a compliance rate during 2023/2024 of 93.2%.
- The planned roster was met and appropriate for the majority of shifts.
- All reasonable steps are utilised to maintain the nurse staffing level in line with the requirements of the Act.
- **There have been no instances of reportable harm for pressure damage, falls or medication never events. There have been no instances where nurse staffing levels were thought to be a contributory factor to harm or complaints.**
- During 2023/2024 there was only one complaint in relation to nursing care, related to discharge planning and communication with the family concerned. The concern has been communicated to ward staff and appropriate learning has been embedded.
- Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor.

2.2 Establishment Reviews

Following each national benchmarked acuity review (twice yearly) an establishment

review is undertaken across all areas of the Trust that employs registered nurses. The establishment reviews include all front-line care/treatment delivery (both Divisions) chaired by the Executive Director of Nursing, AHP & Health Science and supported by the relevant Head of Nursing and Senior Nurses. The establishment reviews are reported on a template for agreement at each level. Each establishment review includes an overview of:

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster
- Patient Feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
- KPI review
- Quality Indicators (25B)
- Service plans or Clinic Templates as applicable (not all areas)

In summary, there were no incidents relating to the quality indicators or complaints effecting care linked to nurse staffing levels for the reporting period for the. PADR compliance overall was good (100% in some areas) First Floor PADR compliance was excellent, reported at 97% in October 2023. Training compliance was overall good.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Nurse Staffing Levels (Wales) Act 2016 covers all aspects of safe, timely and effective care. Rostering of staff against demand considers equitable and efficient care to deliver patient centred delivery.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Socio-economic disadvantage and inequality of outcome is not relevant to this paper
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	To enable us to achieve a Healthier Wales and our organisational goals we need a sufficient workforce with the right skills and in the right place to be able to provide safe, timely and effective care to our patients and donors.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no evidence to suggest that the information in this paper could benefit or disadvantage any particular group of people.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Appendix 1

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Velindre University NHS Trust		
Date annual assurance report is presented to Board	The report is based on data from April 6th 2023 - April 5th 2024 *This annual report refers only to year 2023/ 2024* but this report forms part of the 3 yearly assurance report that will be presented to Welsh Government in October for the *reporting period from April 2021- April 2024.*		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	**1**	NA	NA
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been recalculated outside the bi-annual calculation periods	0	NA	NA
The process and methodology used to calculate the nurse staffing level.	The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews are carried out bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. The first floor establishment includes the required 26.9% headroom to account for sickness, study leave and annual leave. The ward manager remains supernumerary to the planned roster. A nurse co-ordinator is also remains surplus to the planned roster on each day shift. The designated person asks each ward/unit manager during the establishment review process if they have sufficient establishment to provide sensitive care to patients. The annual presentation of the nurse staffing level was presented to the Executive Board in December 2023. There have been no changes in establishment during the last 12 months reporting period. The ward has not changed its primary purpose during the reporting period and no recalculations have taken place outside of the bi-annual calculation cycle.		

Informing patients	Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward, informing patients and relatives of the nurse staffing numbers calculated for the identified period and the date that the calculation was undertaken and signed off by the designated person. The posters are amended following each bi-annual re-calculation. Bilingual easy read FAQ's are displayed alongside the informing patients posters. In addition, bilingual copies of the All-Wales FAQ's for Nurse Staffing Levels are available for patients and visitors to view on the ward. The Nurse Staffing Programme Lead regularly checks and updates the information displayed. Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

Extent to which the required establishment has been maintained within <u>adult acute medical and surgical wards.</u> NB: First cycle: spring 2022 following January audit Second cycle: autumn 2022: following June audit		**Period Covered …2023……**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during first cycle (May)	**1**	**28.42**	**14.21**
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following first (May) calculation cycle	**1**	**28.42**	**14.21**
	Required establishment (WTE) of adult acute medical and surgical wards <u>calculated</u> during second calculation cycle (Nov)	**1**	**28.42**	**14.21**
	WTE of required establishment of adult acute medical and surgical wards <u>funded</u> following second (Nov) calculation cycle	**1**	**28.42**	**14.21**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 1**		
	There has been no required change to the funded establishment during the current reporting period. In addition to the Ward Manager there is also a supernumerary nurse co-ordinator WTE 1.269 which is funded but excluded from the planned roster. The nursing establishment is sufficiently funded and appropriate to provide the planned roster for First			

Floor. There are no financial concerns in relation to the staffing of First Floor. After undertaking a review of the current funded nursing establishment against the required establishment for First Floor Ward, the Integrated Care Directorate is of the opinion that the current establishment is sufficient to manage and deliver care sensitively to patients nursed on First Floor up to the full capacity of 32 beds.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there are a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the planned roster has been maintained within <u>adult acute medical and surgical wards</u>

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	*682*	*593* *86.95 %*	26 3.81%	10 1.47%	53 7.77%	*93.2%*

There has been an overall improvement in the percentage of shifts where the planned roster was met and was appropriate. This is achievable as our beds are commonly not utilised to full capacity. Shifts where the planned roster was not met and not appropriate have significantly reduced from 20% in April 2023 to 7.77% currently. When the planned roster is not met temporary staffing is considered and often requested, however, this can be challenging if sickness has been reported close to the shifts commencement. On such occasions the nurse in charge will consider if there are any staff that are supernumerary to the planned roster that can be deployed to assist in direct patient care. Overall compliance for completing the data has improved to 93.2% from 89% last year.

Process & systems for capturing data on the extent to which the planned roster has been maintained on

Each health board/trust is committed to implementing Allocates Safecare system and each organisation is at different stages of implementing this system within their areas, prioritising section 25B wards. Health boards/Trusts have also been using the Health Care Monitoring system (HCMS) which has been adapted to ensure consistency in the data collection and analysis to aid reporting.

During this reporting period from April 2023 to April 2024, Velindre University NHS Trust has recorded acuity twice a day solely utilising the SafeCare system. The ward ceased using the Health Care Monitoring System in March 2023 for ease

wards where section 25B applies.	of use and to eliminate dual reporting.
Process for maintaining the Nurse staffing level	There are risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level required. Reasonable steps are considered and staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is utilised to help determine whether staffing levels are appropriate for the acuity of the patients and staff can raise red flags to highlight any concerns. Operational steps to maintain the nurse staffing level include: • Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills. • Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care. • Utilising bank and agency.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Hospital acquired pressure damage (grade 3, 4 and unstageable)		Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
	avoidable	unavoidable	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	0	1	0	0	1

Total number of incidents/ complaints not closed and to be reported on/during the next year	0	0	0	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	0	0	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster)was considered to have been a contributing factor	0	0	0	0	0

Additional narrative

There was only one complaint in relation to nursing care. There has been no change in the level of complaints as there was one reportable complaint during the previous reporting period. The complaint was in relation to discharge planning and communication with the patients family. The concern has been feedback to ward staff and appropriate learning has been embedded.
The fall that was open from last year has been reviewed by the learning panel and is now closed and does not reach the threshold for a reportable quality indicator. There has been no reportable medication never events linked to the ward. There is one pressure damage case that has been discussed at the pressure damage learning panel has been deemed as unavoidable. There have been no instances of reportable harm.

Revised national indicators / measures will come into effect at the beginning of the next reporting period i.e. from April 2024. The quality indicators for the adult medical and surgical wards will be as follows:

- *Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

The data to be reported for each of the above will be:

- *Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.*
- *Total number of incidents/ complaints not closed and to be reported on/during the next year*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *
Actions taken if the nurse staffing level <u>was not</u> maintained in wards where section 25B applies	When nurse staffing levels have not been maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g. the utilisation of temporary workforce, using a risk-based approach to redeploy staff. On several occasions the ward manager or the ward coordinator have stepped in to assist with direct patient care on the ward. Staff can raise red flags on SafeCare to indicate concerns in relation to staffing levels and the senior nurse is contactable via a bleep system. In addition: • All incidents related to inpatient falls and pressure damage are reviewed by monthly learning panels, nurse staffing levels are considered as a possible contributing factor of the investigations conducted. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are conducted to discuss complaints, concerns and compliance with the Putting Things Right process.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure	The establishment review process for section 25A areas follows the same process as our 25B ward. During the October 2023 establishment review process, it was highlighted that three 25A areas were possibly under established and that one area was carrying several nursing vacancies. These areas are 25A, however, this situation has impacted the ward (25B) area as staff have had to cover the service and it has adversely affected staff morale. A meeting was held in April 2024 to scrutinise the financial establishments verses the required roster in three 25A areas. It was deemed that there is

appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernisation required it will be Autumn 2024 before the quantification of any headroom deficit can be determined. There is a robust plan in place to recruit into registered nurse vacancies. Velindre University NHS Trust has joined student streamlining for the first time and has recently recruited three newly qualified nurses to a new 18-month rotation programme. The Trust has also for the first time signed up to the All-Wales International Recruitment Programme. The Trust has successfully recruited 14 nurses from Kerala who are currently undergoing a preceptorship programme. These posts will fill a large proportion of vacancies in the Cancer Centre although it will take time to embed the new staff into the organisation.
	Conclusion & Recommendations
	There have been no instances of reportable harm for pressure damage, falls or medication never events. There have been no instances where nurse staffing levels were thought to be a contributory factor to harm or complaints.

A summary of Nurse Staffing Levels for Wards where section 25B applies
Appendix 1: Annual Assurance Report

Health board/trust:	Velindre University NHS Trust
Period of the report	6th April 2023 - 5 April 2024
adult acute medical wards	1

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Adult Acute Medical Inpatient wards

	TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the start of this report (Spring calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the end of the period of this report (autumn calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Name of Ward		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
First Floor	1	28.42	14.21	1	28.42	14.21	Y	N	Not required	N			

Appendix 2

`	Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government		
Health board	Velindre University NHS Trust		
Reporting period	The reporting period is from the 6th of April 2021 to the 5th of April 2024. However, due to the timeframe for closing serious incident reports, the three-yearly report that go to Board in May 2024 will only include data relating to serious incidents closed by 31st January 2024 (A final, updated version of the report - including all serious incident reports that occurred prior to April 5th 2024 - which should by then be closed - will be presented to the Board in September 2024 and then Welsh Government in October 2024).		
	2021/2022	**2022/2023**	**2023/2024**
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board	28/7/2022 P:\board papers\Annual Assurance Report May NSA 2021-2022.docx	25/5/2023 Annual Assurance Report NSL 2023 NT Final.docx	Annual assurance report EMB run Aug 23-24 ver1.docx
Number of adult acute medical inpatient wards where section 25B applies	1	1	1
Number of adult acute surgical / Paediatric inpatient wards where section 25B applies	0	0	0
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**

Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards.	• During the COVID pandemic in 2020 bed capacity was reduced from 32 to 20 beds (to meet required bed spacing standards given patient vulnerability). There was no change in the primary purpose of the ward during this time. Due to the fact that there is only one inpatient ward there was no specific COVID ward. Suspected COVID patients were nursed in cubicles or cohorted to help reduce any spread of infection. • The ward was reinstated to full capacity of 32 beds in September 2022. • Nurse staffing was not a significant problem on the ward during this period due to the reduction in bed capacity.
Informing patients	• Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward, informing patients and relatives of the nurse staffing numbers calculated for the identified period, and the date that the calculation was undertaken and signed off by the designated person. The posters are updated following each bi-annual re-calculation. Bilingual easy read FAQ's are displayed alongside the informing patients posters. In addition, bilingual copies of the All-Wales FAQs for Nurse Staffing Levels are available for patients and visitors to view on the ward. The Nurse Staffing Programme Lead regularly checks and updates the information displayed. • Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.

Section 25E (2a) Extent to which the nurse staffing level is maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

	Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020)	**Number of wards: 1**		
		RN: 23.68		
		HCSW: 23.68		
Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards		**2021/2022**	**2022/2023**	**2023/2024**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during first cycle (May)	**Number of wards: 1**	**Number of wards:1**	**Number of wards:1**
		RN: 23.68	**RN: 23.68**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 23.68**	**HCSW: 14.21**
	WTE of required establishment of adult acute medical and surgical inpatients wards funded following first (May) calculation cycle	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 23.68**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 23.68**	**HCSW: 14.21**

	Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during second cycle (Nov)	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 28.42**	**RN:28.42**
		HCSW: 23.68	**HCSW: 14.21**	**HCSW: 14.21**
	WTE of required establishment of adult acute medical and surgical inpatients wards funded following second (Nov) calculation cycle	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 28.42**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 14.21**	**HCSW: 14.21**
		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 1**	**WTE: 1**	**WTE: 1**

The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor Ward. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews are carried out bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas.

The first-floor establishment includes the required 26.9% headroom to account for sickness, study leave and annual leave.
The ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift. The designated person asks each ward/unit manager during the establishment review process if they have sufficient establishment to provide sensitive care to patients.

- The planned roster was reduced during the pandemic to reflect reduced bed capacity.
- There has been no change in the planned roster since 2022.
- The band 7 ward manager is supernumerary and not included in the required establishment figures. First floor has a nurse co-ordinator role that is also additional to the planned roster.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the planned roster has been maintained within adult acute medical and surgical inpatients wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
2021/2022	*4745*	*3773* *80%*	*0*	*972* *20%*	*0*	*100%*
2022/2023	*652*	*414* *64%*	*36* *5%*	*72* *11%*	*130* *20%*	*89%*
2023/2024	*682*	*593* *86.95 %*	26 3.81%	10 1.47%	53 7.77%	*93.2%*

Year 1 and 2 data was extracted from the Health Care Monitoring System (HCMS). Year three data has been extracted from SafeCare. SafeCare was fully implemented and has been utilised to record nurse staffing and acuity data since March 2023.

The data highlights a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 86.95% in Year 3. There has also been an improvement in the number of shifts where the planned roster was not met and not appropriate reducing from 20% in Year 2 to 7.77% in Year 3.

Process for maintaining the nurse staffing level for Section 25B wards

There are established risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level required. Reasonable steps are considered and staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is utilised to help determine whether staffing levels are appropriate for the acuity of patients and staff can raise red flags to highlight any concerns. Operational steps to maintain the nurse staffing level include:

- Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills.
- Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care.
- Utilising bank and agency.

During the October 2023 establishment review process, it was highlighted that three 25A areas were possibly under established and that one area was carrying several nursing vacancies. These areas are 25A, however, this situation has impacted the ward (25B) area as staff have had to cover the service and it has adversely affected staff morale. A meeting was held in April 2024 to scrutinise the financial establishments verses the required roster in three 25A areas. It was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernisation required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.

	Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, Velindre University NHS Trust has had to rethink the workforce planning strategy and has joined student streamlining for the first time and has recently recruited three newly qualified nurses to a new 18-month rotation programme. The Trust has also for the first time signed up to the All-Wales International Recruitment Programme. The Trust has successfully recruited 14 nurses from Kerala who are currently undergoing a preceptorship programme. These posts will fill a large proportion of vacancies in the Cancer Centre although it will take time to embed the new staff into the organisation.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2)

Incidents of patient harm with reference to quality indicators and complaints about nursing care		Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e., 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
		TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	Year 1	0	0	0	5
	Year 2	0	0	0	1
	Year 3	0	0	0	1
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	TOTAL	0	0	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	Year 1	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	Year 1	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0

There has been no reportable harm in relation to the quality indicators during the last 3-year period. There have been no complaints or harm caused where nurse staffing levels were considered to be a contributing factor. There were 7 complaints about nursing care which were managed through the putting things right framework: 5 in year one, one in year 2 and one in year 3.	
Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate	
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	When nurse staffing levels have not been maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g., the utilisation of temporary workforce and using a risk-based approach to redeploy staff. On occasions the ward manager or the ward coordinator have stepped in to assist with direct patient care. Staff can raise red flags in SafeCare to indicate concerns in relation to staffing levels and the senior nurse is contactable via a bleep system. In addition: • All incidents related to inpatient falls and pressure damage are reviewed by monthly learning panels, nurse staffing levels are considered as a possible contributing factor of the investigations conducted. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are conducted to discuss complaints, concerns and compliance with the Putting Things Right process.
Conclusion & Recommendations	• During the COVID pandemic in 2020 the ward bed capacity was reduced to 20 beds, the ward was reinstated to full capacity of 32 beds in September 2022 • Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 the biannual nursing establishment reviews for First Floor ward (25B) have taken place using the triangulated approach • Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor • Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas • There has been no change in the planned roster since 2022. • The first floor establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift • HCMS was used to record and extract data in Year 1 and 2 of the reporting period. Year 3 data has been extracted from the SafeCare system which was fully implemented in March 2023 • There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 86.95% in Year 3. • There has been no reportable harm in relation to the quality indicators during the last 3-year period • There have been 7 complaints in total during the last 3 years relating to nursing care. There have been no complaints where nurse staffing levels were considered to be a contributing factor • All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act

	• Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, international nurse recruitment and student streamlining has been initiated. • In relation to 25A areas it was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernization required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.

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

TRUST BOARD

People and Organisational Development Policies and Processes

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Judy Stafford, People and Relationship Team Manager
PRESENTED BY	Amanda Jenkins, Head of People
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	This paper provides an overview of updates made to Workforce and OD Policies, bringing them up to date with current employment legislation and best practice.

RECOMMENDATION / ACTIONS	The Trust Board are asked to • **NOTE** the content of the report • **APPROVE** the following polices: o **Appendix 1**: New People Development Policy o **Appendix 2**: WF30 PADR Policy

	o **Appendix 3**: WF18 Alcohol and Substance Misuse Policy o **Appendix 4**: WF22 Professional Registration Policy

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nurse Forum	03/10/2023
Executive Management Board	28/08/2024
Quality Safety and Performance Committee	12/09/2024
Local Partnership Forum	17/09/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Professional Nurse Forum have commented specifically on the Professional Registration Policy suggesting minor amendments to wording following an incident investigation. The Executive Management Board **ENDORSED** all the polices for submission to the Quality, Safety and Performance Committee for Endorsement. The Quality, Safety and Performance Committee **ENDORSED** all the policies for submission to Trust Board for Approval. The Local Partnership Forum **NOTED** the polices for Trust Board Approval.	

APPENDICES	
1	New People Development Policy
2	WF30 PADR Policy
3	WF18 Alcohol and Substance Misuse Policy
4	WF22 Professional Registration Policy

1. SITUATION

This paper provides an overview of updates made to Workforce and OD Policies, bringing them up to date with current employment legislation and best practice.

2. BACKGROUND

Pending the introduction of a more systematic and sustained way to review People and OD policies that will take place from September 2024 onwards, the following polices have been developed or reviewed for legislative and best practice compliance.

3. ASSESSMENT

The following are the changes or additions to current policies to bring them up to date with current legislation and best practice that Trust Board are asked to approve:

3.1 People Development Policy

- Task and Finish Group in place since January 2024 and helped create new policy and archive the current Study Leave Policy.
- Document simplified
- Clear categorisation of approval levels
- Flexibility to delegate to Training Panel if budget holders decide
- Inclusion of Standing Financial Instructions requirement that decisions over £2,000 will be referred to Executive Director of OD and Workforce.
- Questions for the Study Leave application form are included at Appendix 1. They will be put into an MS Forms digital application process.
- Copied the wording about the repayment of fees from the previous policy under the section on learning contract and included a proforma learning contract
- Copied the wording about travel time from the previous policy

3.2 PADR Policy (WF30)

- Task and Finish Group established July 2024
- Toolkit to be designed and developed with digital support
- Policy document simplified
- PADR form covers core sections with optional extras in a PADR Toolkit, e.g. guidance notes on preparing for PADR, reflection, 360 feedback, talent mapping.
- Values question simplified to included new values and behaviour framework
- Prompt for revalidation reminder to cover all professions
- Prompt for review of Job Description every three years
- Clarification of interplay with Pay Progression Policy and process

3.3 Alcohol Drugs and Substance Misuse (WF18)

- Minor amendments to structure and language
- Amendment to level of management who can refer to professional body. Decreased level from Executive Director to appropriate Senior Manager and Divisional Director
- TU requested amendment to section 10.1 regarding if a member of staff is asked to attend work in emergency on-call situation and not as part of rota, should they not be able to attend that there would be no detriment to them
- All support organisations checked and updated

3.4 Professional Registration Policy (WF22)

- Minor amendment made by Professional Nurse forum which states: 'escalate situations of concern with registration to Head of department and if required to relevant executive lead'.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board are asked to

- **NOTE** the content of the report.

- **APPROVE** the following polices:
  - **Appendix 1**: New People Development Policy
  - **Appendix 2**: WF30 PADR Policy
  - **Appendix 3**: WF18 Alcohol and Substance Misuse Policy
  - **Appendix 4**: WF22 Professional Registration Policy

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒

	Efficient ☒ Patient Centred ☒
	Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of both employer and employee. Having well-articulated and clear directions for staff will can impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why)
	N/A – assessments completed on each policy
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation
	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Each policy has undergone an EQIA in line with the statutory requirements of assessing policy impact on Protected Characteristics. None of the polices outlined in this paper required further action.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not having well designed people polices could result in further challenge through employment tribunals.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	TAF 01 - There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources. TAF 03 - There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives. TAF 04 - There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes. TAF 06 - There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.
WHAT IS THE CURRENT RISK SCORE	Various as outlined on the Trust Assurance Framework
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of both employer and employee. Having well-articulated and clear directions for staff will can impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	NA – Specific risks aligned to the strategic Trust risks and reviews as part of the Trust Assurance Framework

ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Ensuing the right people are able to review and comment on the policy development. This will hopefully be mitigated by a new systematic review process that will commence in September 2024.
All risks must be evidenced and consistent with those recorded in Datix	

Ymddiriedolaeth GIG Felindre
Velindre NHS Trust

Ref: TBC

PEOPLE DEVELOPMENT POLICY

Executive Sponsor & Function	Executive Director of Organisational Development and Workforce
Document Author:	Head of Organisational Development
Approved by:	Trust Board
Approval Date:	TBC
Date of Equality Impact Assessment:	April 2024
Equality Impact Assessment Outcome:	No adverse impact on any protected characteristics
Review Date:	As required by legislative change
Version:	Version 1

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1. INTRODUCTION/AIM

Velindre University NHS Trust is committed to ensuring that staff have access to appropriate education, learning, development and training.

This applies across all job roles. It covers essential training that supports safe delivery of services within the immediate job role. It also includes professional development that allows people to grow into new areas and build new opportunities.

2. OBJECTIVES

This policy ensures:

- All employees are encouraged to develop and learn through the course of their work
- Decisions regarding development are made on clear criteria
- Resources for education and development are allocated in line with organisational priorities.

3. SCOPE OF POLICY

This Policy applies to all employees.

Equality of access to development opportunities should apply regardless of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex/gender or sexual orientation.

4. ROLES AND RESPONSIBILITIES

4.1 Executive Management Team

- Set out organisational priorities within the IMTP.
- Allocate financial resources at organisational level to support learning and development relating to known demands.

4.2 Budget Holders

- Plan training resources to meet current and future service requirements
- Consider applications in line with agreed decision-making criteria.
- Approve/reject applications with clear rationale.
- Apply conditions relating to the training, including any time away from work or the requirement to complete a Learning Contract.
- Monitor expenditure.
- May choose for efficiency and effectiveness to delegate Study Leave decisions to a local Training Panel.

- In line with Standing Financial Instructions, refer applications for more than set limit (£2,000 as at July 2024) to the Executive Director of OD and Workforce.
- Utilise the on-line study leave application to consider requests and record decisions.

4.3 Line Managers

- Discuss development opportunities with every employee as part of the Performance Appraisal and Development Review Process.
- Develop a supportive environment for learning and development in the team and helping reduce any barriers to learning or access to development.
- Approve/reject applications within their remit, following the requirements of the legal Right to Request Training (see Section 10).
- Confirm with the employee any conditions relating to the training, including any time away from work or the requirement to complete a Learning Contract.
- Support applications which require funding by referring them on to the relevant budget holder for decision.

4.4 Employees

- Maintain compliance with their statutory and mandatory training as listed in ESR.
- Actively engage in the Performance Appraisal and Development Review process by reflecting on their own learning and future plans.
- Cooperate with manager in ensuring the impact of absence in kept to a minimum.
- Participate in any learning activities to the best of their abilities.
- Fulfil agreed commitments including agreements regarding time away from the workplace or undertaking a Learning Contract.
- Provide feedback on their learning.
- Contribute to a supportive environment for learning within their workplace.
- Apply for study leave using the VUNHST electronic form (questions included for reference at Appendix 1).

4.5 Trust Trainers and Educators

- Deliver training in line with their professional remit to agreed organisational outcomes.
- Maintaining professional registration or certification as required.
- Comply with quality assurance requirements, including providing written records of course materials, recording attendance and gathering evaluation data.
- Contribute to organisational learning by sharing their learning and experience with other trainers.

4.6 People Development and Education Team

- Ensure statutory and mandatory training is available in line with job requirements.

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- Ensure statutory and mandatory training is accessible in line with individual requirements and reasonable adjustments.
- Provide recording and reporting system through ESR.
- Produce annual training plan outlining core training requirements and provision.
- Provide learning resources and advice to staff and line managers.
- Support quality assurance of training through developing effective approaches to training design, delivery and evaluation.
- Advise budget holders when considering part-funding courses or qualifications to build consistency in decision making.
- Annually review equity of access to training resources.

5. DECISION MAKING

5.1 All personal professional development requests must be referenced in the Performance Appraisal and Development Review. This may happen during the annual review or be added at a later date.

Decisions will be made in line with this table. Training requests for over £2,000 will be referred to the Executive Director of Workforce and OD for decision.

Time is allocated where the training falls within working time. Training hours outside of normal working hours will not normally be reimbursed.

Category of Training	**Allocation**
Statutory and Mandatory Training	100% time. No funding required. No Study Leave form required. Always approved.
Essential Training for current role	100% time. 100% funding. Study Leave form required. Always approved.
Non-accredited courses - Non-essential training for current role Training and development for future NHS role (non-accredited)	Time and funding negotiable, depending on attendance time required, cost to the Trust and benefit to the service. Study Leave form required. Applications can be deferred to next year. Reasons for rejection need to demonstrate adherence to the Right to Request Training criteria as set out in Section 10.

	Part-funding decisions need to be discussed with the People Development and Education Team to promote consistency in decision-making across the Trust.
Accredited courses including professional qualifications, Post Graduate Certificates and Diplomas, Masters qualifications.	Time and funding negotiable, depending on attendance time required, cost to the Trust and benefit to the service. Study Leave form required. Employees will be required to repay a proportion of the course fees if they leave within 2 years of the end of the course. Applications can be deferred to next year. Reasons for rejection need to demonstrate adherence to the Right to Request Training criteria as set out tin Section 10. Part-funding decisions need to be discussed with the People Development and Education Team to promote consistency in decision-making across the Trust. Spaces on centrally-funded accredited programmes (such as Advanced Practice) will be allocated by the relevant professional lead.
Conferences and training days	100% time. 100% funding where application approved. Study Leave from required. Approved subject to business need and availability of funds.

5.2 Travelling Time

It is recognised that attendance at some courses necessitates significant travelling time or overnight stay before, during or after the event. Neither the Working Time Regulations 1998 or relevant Department of Trade and Industry guidance provide a definitive resolution to the issue of whether time spent travelling before or after a study leave event is classed as ‘working time’. As such the following is provided as internal Trust guidance for local implementation within division/department as necessary:

- Where the course of study is agreed as being Essential or Desirable by the manager and member of staff (but not mandatory or statutory), it should be noted that time spent on the course, or travel time to it, outside of normal working hours will not be considered as working time.
- No payment, or time in lieu, will be granted in relation to time spent travelling time to or from, or overnight stay before, during or after a study leave event.
- Wherever possible travel to and from a study leave event should be undertaken within the 'normal' working hours for the member of staff attending. Staff who normally work part time hours may request an alteration to their 'normal' working hours for the purposes of travelling time. Managers are required to give all such requests due consideration and grant at their discretion and only if service demands.

5.3 Record Keeping

All professional development will be discussed during Performance Appraisal and Development Reviews and documented in the Personal Development Plan. This can be updated at any point in the year, should training and development needs arise.

All requests above statutory and mandatory levels will be entered into the on-line Study Leave application form which will provide a comprehensive record of development requests and decisions held by the People and OD department. This includes courses where no funding is required. This will be reviewed annually to examine equity of access to learning and development.

6 LEARNING CONTRACT

6.1 Managers must ensure as far as is possible, that any employee of the Trust who wishes to undertake training either involving regular release over one academic year or more and/or is applying for study leave where there is significant financial outlay, is intending to remain in the Trust for at least two years after the training/course is completed. Any employee who is thinking of undertaking such training and who may be entitled to financial assistance from the Trust must be made aware of the commitments they have to both completing the course and to the Trust itself. Serious consideration should be given to the possibility of reclaiming the financial assistance given if an employee fails to complete the course or leaves the Trust within two years of finishing it, without good reason. A pro=forma for a Learning Contract is provided at Appendix 2.

6.2 Reclamation rates are based on the following:

The period of time elapsed between final date of course attendance, assignment submission or examination attendance (whichever falls on the most recent date and /or	Percentage of the course cost, met by Velindre NHS Trust, for the total, or final year (in cases of Further or Higher education courses where attendance extends beyond a single

would be consider the 'end' of the course) and employee leaving Velindre University NHS Trust employment falls within the period:	academic year), fees to be repaid by the employee:
12 months	50%
18 months	25%
24 months	10%
NB: The pursuit of financial reclamation will be at Divisional Director's discretion.	

6.3 It is the authorising manager's responsibility to explain the conditions for granting leave and financial support with regard to continued employment in the Trust. It is recommended that the Authorising Manager obtain a signed agreement from the applicant confirming their intention of remaining in the Trust for two years and an understanding that the financial assistance or a proportion thereof may be reclaimed. Further advice and an appropriate agreement is available from the People and OD department. It is also a condition of financial support that members of staff who have been offered/have received financial assistance to attend training/education may have support withdrawn/be required to reimburse the Trust in certain other circumstances. In the case of monies being reclaimed, an appropriate sum may be deducted from the member of staff's salary. It is not possible to be totally prescriptive about this, since the circumstances of each individual case will vary. Before a decision is made the matter will be discussed with the individual, his/her manager, and where relevant the training/education provider and/or budget holder. During such discussion, the employee may be accompanied by a trade union representative, or a work colleague. Where monies are to be withheld/reclaimed, the Payroll Department must be notified as soon as possible by the employee's manager. However, no monies will be reclaimed whilst discussions are still in progress. The Trust reserves the right to withhold support/ask for reimbursement in the following circumstances, although the individual circumstances of each case will be assessed on its merits: Failure to Complete/Withdrawal From a Course Where a member of staff fails to complete a course, or withdraws from a course following commencement, the member of staff may be asked to make a repayment of the financial assistance provided by the Trust, unless there are exceptional circumstances, or a medical certificate is provided in the case of sickness. N.B.:

- Failure to sit exams or assignments after the normal period of instruction will count as failure to complete a course.
- Unsatisfactory Progress: where a member of staff is unsuccessful in examinations or assignments at the second attempt, the Trust will not provide any further assistance or time off.
- Unsatisfactory Level of Attendance : where attendance on a course falls below the minimum acceptable to the training/education provider/awarding body, taking into account illness, annual leave, and/or other extenuating circumstances, the employee may be asked to make a repayment of the financial assistance provided by the Trust

7. RESOURCES

Time, money and learning materials will be made available in line with the Education Strategy. These resources will be determined and funded through the use of the Trust Training Plan and other strategic workforce plans.

8. TRAINING

No specific training is required to support this policy. The process will be reflected in training for using the Performance Appraisal and Development Review.

9. IMPLEMENTATION AND COMPLIANCE

This policy will be implemented alongside the Performance Appraisal and Development Review process.

The central database of Study Leave requests may be measured periodically against the Training budget codes to identify whether training requests are being processed through the on-line system.

Equity of access to learning opportunities will be assessed annually.

10. REFERENCES

Right to Request Training

https://www.gov.uk/training-study-work-your-rights gives guidance on the legal right to request training. Key points are highlighted below but staff and managers should consult the website to view full details.

Employees should follow their organisation's rules to ask for time off. If there aren't any they can write to their employer saying it's a request 'under Section 63D of the Employment Rights Act 1996' with the following details:

- *the date*
- *the subject matter of the study or training*
- *where and when it would take place*
- *who'll be providing the training*
- *the name of the qualification they could get - if any*
- *why they think this study or training will help them do their job better and help their employer's business*
- *if they've made a request before and when*

An employer does not have to consider the request if all this information is not included.

Employees can only make 1 request a year.

The employer has 28 days to:

- *accept the request*
- *hold a meeting with the employee to discuss it*

This might be longer if the person who deals with these requests is off when the request is sent in.

The employee can take a trade union representative or colleague to the meeting. They can ask for the meeting to be postponed if this person can't make it.

If the employer decides to hold a meeting about it they must make a decision within 14 days of it, unless the employee agrees in writing to extend this time.

The employer can only turn down a request if:

- *the training would not benefit their business*
- *they would run up extra costs for the business*
- *they would not be able to meet customer demands*
- *they cannot re-organise the work among other members of staff*
- *they cannot recruit extra staff*
- *it would damage quality and business performance*
- *there would not be enough work for the employee to do at the times they intend to work*
- *it conflicts with planned structural changes*

The employer doesn't have to pay for the training or study. They can choose to pay all or part of the fees if they think it will benefit the business.

11. DUTY OF QUALITY

This policy supports the Workforce enabler within the Duty of Quality, specifically 'Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable workforce for the future'.

12. EQUALITY STATEMENT

The Trust is committed to ensuring that the way it provides services to the public and the way it treats its employees reflects their individual requirements and does not discriminate against individuals or groups.

An Equality Impact Assessment was completed which highlighted that the policy has to be communicated in a clear way and be easily available to all staff. Equally, it must be available in Welsh.

13. ENVIRONMENTAL IMPACT

Employees, Line Managers and Budget Holders are encouraged to make training decisions which minimise impact on the environment by considering local or virtual learning opportunities.

14. AUDIT

The People Development and Education Team will audit Study Leave applications annual to measure equity of access against protected characteristics.

15. REVIEW

The People and OD department will review the operation of the policy and make updates when required.

16. GETTING HELP

Help, advice and guidance is available from the People and OD department.

17. RELATED POLICIES AND PROCUDRES

- Performance Appraisal and Development Review
- All Wales Study Leave Policy for Doctors and Dentists in Training
- Section 63D of the Employment Rights Act (1996),

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APPENDIX 1

Application for Study Leave (this form will be digitised and include routing of decision making)

Employee Section
Name
E-mail
Employee Number
Job Title
Department
Division – drop down box
Pay Band – drop down box
Part time/Full time
Title of Course/Conference
Training / Education Provider
Start Date
End Date
Time away from the workplace
Benefits of attending – organisational and personal
How workload will be managed during training?
Contained in PADR Yes/No
Submit to Line Manager
Line Manager Section
Approved in full Yes/No
If not approved, give reason for non-approval.
Approved in part - specify what has been approved.
Does it require a Learning Contract? Yes/No
Provide specific dates and course fees subject to the Learning Contract.
Further approval required Yes/No – if yes, submit to Budget Holder/Training Panel
Budget Holder/Training Panel Section
Approved in full Yes/No If not approved, give reason for non-approval.
Approved in part – specify what has been approved
Notify Line Manager where a Learning Contract needs to be signed
Approval by Executive Director of OD and Workforce for fees over £2,000
Approved – Yes/No

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Appendix 2

Learning Contract

Course details	
Employee Name	
E-mail	
Employee Number	
Job Title	
Department	
Division	
Line Manager	
Title of Course/Conference	
Training / Education Provider	
Start Date	
End Date	
Course Fee Granted by VUNHST	

The period of time elapsed between final date of course attendance, assignment submission or examination attendance (whichever falls on the most recent date and /or would be consider the 'end' of the course) and employee leaving Velindre University NHS Trust employment falls within the period:	**Percentage of the course cost, met by Velindre NHS Trust, for the total, or final year (in cases of Further or Higher education courses where attendance extends beyond a single academic year), fees to be repaid by the employee:**
12 months	50%
18 months	25%
24 months	10%

Declaration by employee

I confirm I intend to remain in the Trust for two years after the end of my course and I understand that the financial assistance or a proportion thereof may be reclaimed if I leave before the two years has elpased.

It is also a condition of financial support that members of staff who have been offered/have received financial assistance to attend training/education may have support withdrawn/be required to reimburse the Trust in certain other circumstances including:

- Failure to sit exams or assignments after the normal period of instruction will count as failure to complete a course.
- Unsatisfactory Progress: where a member of staff is unsuccessful in examinations or assignments at the second attempt, the Trust will not provide any further assistance or time off.
- Unsatisfactory Level of Attendance: where attendance on a course falls below the minimum acceptable to the training/education provider/awarding body,

taking into account illness, annual leave, and/or other extenuating circumstances, the employee may be asked to make a repayment of the financial assistance provided by the Trust

I confirm that in the case of monies being reclaimed, an appropriate sum may be deducted from my salary.

SIGNED:

Employee: …….. Date: ……..

Line Manager: ……. Date: …….

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Ref: WF50

PERFORMANCE APPRAISAL AND DEVELOPMENT REVIEW POLICY

Executive Sponsor & Function	Executive Director of Organisational Development and Workforce
Document Author:	Head of Organisational Development
Approved by:	Trust Board
Approval Date:	TBC
Date of Equality Impact Assessment:	August 2024
Equality Impact Assessment Outcome:	No adverse impact on any protected characteristics
Review Date:	As required by legislative change
Version:	Version 2

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APPENDIX 1 PADR FORM

APPENDIX 2 PAY PROGRESSION DEFERRAL FORM

APPENDIX 3 VALUES AND BEHAVIOURS FRAMEWORK

1. Policy Statement

1.1 Velindre NHS Trust is committed to the performance management and continuous development of its employees in order to meet service needs and organisational ambitions. The process of Performance Appraisal and Development Review (PADR) is fundamental to achieving this aim.

2. Purpose

2.1 To provide a framework for meaningful work-based conversations between employees and their line managers. This includes setting out work objectives, enabling achievement of those goals and reviewing professional development, both within the immediate demands of the role and looking further ahead.

2.2 Appraisal of performance and reviewing development needs are fundamental to the delivery of healthcare services. It occurs informally throughout the year and is formalised annually in a PADR.

2.3 The policy aims to increase effectiveness and satisfaction at work by giving employees influence over what they do and how they do it and by regularly reviewing progress and resolving barriers.

3. Scope

3.1 This Policy will apply to all employees of the Velindre University NHS Trust who are subject to Agenda for Change terms and conditions of service.

3.2 For employees new to the Trust, the first formal PADR will take place after Induction activities are completed and no longer than 6 months after coming into post. For employees who transfer to new roles within the Trust, the PADR should be revised at the earliest opportunity to reflect objectives and development needs relevant to their new role.

3.3 From time to time, employees will be eligible for a pay step within their pay band under Agenda for Change pay arrangements. There are five standards in the Pay Progression Policy which must be met in order to progress through the pay gateway:

i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards
ii. There is no formal capability process in place
iii. There is no formal disciplinary sanction live on the employee's record.
iv. Statutory and mandatory training has been completed
v. For line managers only – appraisals have been completed for all staff.

The PADR is used as an opportunity to hold this Pay Progression review.

3.4 Where a capability issue has been identified it will be managed under the Capability Policy.

4. Aims and Objectives

4.1 To improve quality and effectiveness of work by:

- Clarifying expectations of what needs to be done and how it should be done
- Providing a forum for giving and receiving constructive and timely feedback
- Allowing space to review and improve services

4.2 To improve skills, knowledge and capabilities in all areas of the Trust through discussing and agreeing personal and professional development in line with the needs of the job, individual aspirations and in light of available resources.

5. Roles and Responsibilities

5.1 Executive Directors

- Monitor PADR activity and ensure it is being implemented in all areas of the Trust
- Nurture an organisational culture supportive of PADR
- Provide direction for workplace objectives through corporate plans and strategies, as relevant.

5.2 Line Managers

- Maintain regular dialogue with employees about work objectives, challenges and development opportunities
- Undertake PADR with each employee annually
- Undertake the Pay Progression confirmation section of the PADR process 12 weeks prior to the employee's pay step, when notified by ESR (this may be in addition to a previously timetabled PADR)
- Hold an open conversation on the challenges and opportunities that the individual experiences in their job role following Compassionate Leadership principles
- Review individual performance over the past 12 months incorporating review of any existing objectives
- Establish performance objectives for the next 12 months
- Agree a Personal Development Plan for the next 12 months
- Where applicable, confirm whether a member of staff has achieved their pay step in accordance with the All Wales Pay Progression policy
- Inform the Payroll Department using the Pay Progression Deferral Form (Appendix 2) if they are deferring an employee from receiving their increment in accordance with the Pay Progression Policy
- Seek to meet any specific needs to ensure that the process is fair for any member of staff with a disability or other specific need.
- Ensure that the member of staff understands the implications of the Trust Strategy and Integrated Medium Term Plan (IMTP) as relevant to their department, team and own role.
- Refresh the job descriptions with the member of staff every three years.

- Review the member of staff's training records to identify if mandatory and statutory training needs have been met.
- Confirm any professional body revalidation or quality processes are being undertaken in order to maintain registration
- Work jointly with the individual to identify challenging, yet achievable objectives for the coming 12 months, which align with IMTP and Trust Strategy.
- Identify examples of when the Trust values and behaviours have been demonstrated and consider how they will inform future objectives
- Work jointly with the individual to identify their learning and development needs.
- Record the date of the PADR on ESR.
- Record the date of a Pay Progression review on ESR.

5.3 **Employees**

- Play an active role in the discussion at PADR
- Help develop relevant objectives
- Commit to learning and development, including maintaining any statutory or mandatory learning
- Ensure that they have completed the mandatory and statutory training needs as required by their role
- Have an appropriate awareness of the Trust values and behaviours and their department's IMTP
- Reflect on their work performance and progress with objectives and be ready to discuss their views with their line manager
- Consider challenges and barriers which need to be addressed
- Consider examples of when they have used the Trust values in the course of their work and where there have been challenges in the workplace linked to the Trust values
- Consider what objectives they would like to work towards over the coming 12 months.
- Identify what learning and development will be of help over the next 12 months.

5.4 **PADR and the Welsh Language - Information for staff and Line Managers**

All staff have the right to access bilingual information, paperwork, and processes relevant to their yearly appraisal. The Welsh Language Standards support the bilingual rights of Welsh speaking members of staff. Staff have a legal right to use the Welsh Language in all aspects of their daily lives.

If the staff wishes to follow the PADR process through the medium of Welsh, then they should please consider appropriate discussions with their line manager at the earliest convenience. The staff should contact their line manager as soon as possible to discuss their requirements.

If the line manager cannot provide a bilingual discussion, then the Trust can support the needs via simultaneous translation. Line Managers who require further information or the process for booking translation, should please contact the Welsh Language Manager - Jo.williams5@wales.nhs.uk.

Further information on the Welsh Language Standards can be found on the Trust intranet pages.

6. Monitoring and Delegation

6.1 The People and OD team produce PADR reports monthly to allow managers to monitor compliance.

6.2 Where organisational structures or absence makes it difficult to organise PADRs for everyone in a team, the role can be delegated to someone else within their management structure as long as they are competent to act in that role and have sufficient authority to be able to arrange learning and development opportunities.

7. Equality

7.1 The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

7.2 The Equality Impact Assessment found that there was no detrimental impact to the equality groups mentioned and this policy will have a positive impact on all of the protected characteristic groups. The assessment highlighted that employees have the right have their PADR through the medium of Welsh. Managers will be able to seek advice from the Welsh Language Manager when this occurs. It was also highlighted that staff with some forms of disability may be disadvantaged if the policy is not communicated effectively.

8. Training

8.1 Line Managers and anyone with delegated responsibility are required to complete the Trust's PADR training module.

8.2 A Toolkit of resources will support this policy including guides on how to enter Appraisal dates and Pay Progression dates into ESR.

8.3 All employees are encouraged to complete the ESR PADR module.

9. Implementation

9.1 PADR is an ongoing cycle of review, planning, development and evaluation which links individual and organisational development needs. Whilst the objectives fall in with the annual business planning cycle of April to March each year, in reality work-based objectives may arise and be completed at any point in the year. Managers and staff are encouraged to meet regularly to update progress, add or change objectives and review learning events and the Personal Development Plan.

9.2 The process is an ideal time to explore how people are getting on at work and if their wellbeing is being promoted. Managers may need to pick up other conversations following on matters raised during the PADR to attend to wellbeing or stress at work.

9.3 Paperwork and Record Keeping

- The PADR form must be completed at least annually and copies retained by employee and line manager. It must include as a minimum a review of progress, objectives for the next period and a Personal Development Plan.
- A PADR Toolkit includes other resources which are optional and may be used in line with individual needs including forms for Reflection, Preparation, Talent Mapping, or 360 feedback.

10. Audit and Monitoring

10.1 It is the responsibility of the manager to record the date that the PADR is undertaken on ESR to allow for analysis and reporting.

10.2 The quality of PADR will be monitored by the People and OD team through sampling of documentation throughout the year.

11. Review

11.1 The Performance Appraisal and Development Review Policy will be reviewed three years, after approval.

12. Associated Policies

- Pay Progression Policy
- People Development Policy
- Wellbeing Guidelines (formerly Employee Mental Health and Wellbeing and Stress Management Policy)

Appendix 1

Performance Appraisal and Development Review

This form will be digitised

Section 1 - Introduction
Employee
Job Title
Department
Is Pay Step due within the next 12 weeks?
Line Manager
PADR meeting date
Appraisal Review Period (covering the last year)

Section 2 - Review of the last 12 months
Recognition of good work
How have things gone, what highlights and out, what were the challenges?
Progress with previous objectives, including discussion of reasons for things not going as planned
Discussion of constructive feedback regarding employee
Feedback from employee to line manager

Section 3 – Context
Review of Trust Values and Behaviours identifying examples of Caring, Respectful and Accountable behaviour
Discussion of Trust strategies and IMTP, as relevant to the role

Section 4 – Planning for next 12 months
Objectives need to be carried forward from last year and new objectives – SMART

Section 5 – Personal Development Plan
Recognition of achievement
Progress with pervious PDP
Career conversation – steady in current role or looking to move
New items for next PDP
Link to Study Leave application.

Section 6 – Reminders
Has the job description been updated in the last 3 years?
All registered professionals – are revalidation and registration processes in hand (this is the registrant's responsibility)

Section 7 – Pay Progression
If a pay step is due within the next 3 months, please confirm yes or no to these clauses:

i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards
ii. There is no formal capability process in place
iii. There is no formal disciplinary sanction live on the employee's record
iv. Statutory and mandatory training has been completed
v. For line managers only – appraisals have been completed for all staff.

Section 8 – Sign off
Employee name and date Line manager name and date

Appendix 2

Pay Progression Deferral Form

This form will be digitised

Department Section
Cost centre
Directorate
Department

Employee Section
Title
First name
Surname

Post Details
Job title
Pay band
Pay ste date

Pay step review outcome
I confirm that the outcome at the pay step was Unsatisfactory – has not met all the core organisation objectives and /or has not demonstrated the right behaviours and ways of working and/or has not shown how they have developed or imporvied their area of work. Therfore, no increment/pay step will be awarded.

Line Manager
Name
Job title
Email address
Date

Please email to Payroll and the Velindre Workforce and OD mailbox

Appendix 3

Velindre University NHS Trust
Values and Behaviour Framework
April 2024

Our values describe how we will work to achieve Our purpose, to improve lives, and towards Our vision, excellent care, inspiration learning, healthier people.

Caring
We are always kind, supportive, approachable and show compassion to all.

Respectful
We seek to understand other people's perspectives. We are always open and transparent.

Accountable
We always take personal responsibility for what we do and how we do it.

We bring the values to life in every aspect of work through our actions. Some examples of helpful actions are highlighted in our Behaviour Framework. There will be lots of other examples of positive actions that we take and these may vary from role to role. The list below covers things which are likely to be relevant to everyone. The ticks give a suggestion about which values the action reflects however feel free to see them from another point of view.

We always…	Suggested Values		
	Caring	Respectful	Accountable
Care for all: patients, donors and colleagues	✓	✓	✓
Collaborate with others to achieve positive outcomes		✓	✓
Communicate with people simply and respectfully		✓	
Consider the impact of how we speak to people	✓	✓	
Deliver on our commitments to each other	✓	✓	✓
Give and receive feedback in order to improve	✓	✓	✓
Help people when they are new and welcome their experiences and contribution	✓	✓	✓
Include everyone in discussions about things that affect them	✓	✓	✓
Listen when people speak up about things which concern them	✓	✓	✓
Listen to learn and improve	✓	✓	✓
Nurture our team and help it grow and develop	✓	✓	✓
Put patients and donors at the heart of what we do	✓	✓	✓
Respond in a timely manner		✓	✓
Role model the values	✓	✓	✓
Share information openly and transparently	✓	✓	✓
Show appreciation to others as a matter of course	✓	✓	
Strive to improve services for patients and donors	✓	✓	✓
Support each other	✓	✓	

Take responsibility for our actions			
Talk about barriers or problems in order to resolve them			
Tell people when they are doing a good job			
Treat people equally and fairly			
Trust each other to do a good job			

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Felindre Velindre NHS Trust

Ref: WF18

ALCOHOL, DRUGS AND SUBSTANCE MISUSE POLICY

Executive Sponsor & Function	Executive Director of Organisational Development and Workforce
Document Author:	People and Relationships Team Manager
Approved by:	Trust Board
Approval Date:	TBC
Date of Equality Impact Assessment:	August 2024
Equality Impact Assessment Outcome:	No adverse impact on any protected characteristics
Review Date:	As required by legislative changes
Version:	4

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1. INTRODUCTION

Velindre University NHS Trust is a provider of healthcare and associated services and promotes the highest standards of awareness, health and safety in the workplace. The Trust recognises the importance of the welfare of its staff in all matters and issues relating to substance misuse, in or out of work. The Trust treats alcohol and substance misuse and issues related to this condition as a health and wellbeing matter that requires advice, support and treatment.

For the purpose of this policy, "substances" are defined as alcohol, illegal or prescribed drugs and substances. Refer to Section 6 of the policy for the definitions.

1.1 The Trust expect all members of staff to adopt the highest standards of performance and conduct. Alcohol, drugs and substance misuse can adversely affect an individual's skill and judgement, which may detrimentally affect their performance and the standard of service delivery to patients, donors, service users and colleagues, potentially causing unacceptable levels of risk and harm;

1.2 The Trust has an obligation as a provider of health care and related services to minimise risks, dangers and complaints concerning the standards of health and wellbeing, conduct and capability of its workforce, in the context of alcohol, drugs and substance misuse.

2. POLICY STATEMENT

The purpose of the policy is to help protect our staff and others that use our services, by raising awareness of the consequences of substance misuse and to encourage those with a problem to seek help and support.

2.1 The Trust will offer support, guidance and access to services, to promote an honest, positive and caring approach to all staff regarding potential and actual problems of alcohol, drugs and substance misuse within and outside of the workplace;

2.2 Throughout the Policy, misuse refers to the use of psychoactive substances, including illegal drugs, alcohol, prescribed medicines and substances and there misuse, regardless of whether the use is deliberate or unintentional;

2.3 The term misuse refers to inappropriate use, habitual misuse and/or excessive use of alcohol, drugs including prescribed medicines and substances;

2.4 The Trust has a duty to ensure that a staff member's use of alcohol and substances outside of the workplace does not impair the safe and efficient delivery of our services, or results in risks to their health and safety and that of others, to comply with the health and safety legislation.

3. SCOPE OF POLICY

3.1 This policy applies to all Velindre University NHS Trust employees and workers (including hosted organisations) and anyone working on Velindre University NHS Trust premises. This list includes:

- Bank and Agency Workers;
- Contractors;
- Honorary Contract Holders;
- Secondees;
- Students;
- Volunteers;

NB. This list is not exhaustive

3.2 This policy covers misuse of psychoactive substances, including illegal drugs, alcohol, prescribed medicines, solvents and substances.

3.3 Staff issues concerning alcohol, drugs or substance misuse will be managed in accordance with this policy and in the strictest of confidence.

3.4 It is recognised that for some staff alcohol, drug or substance misuse is a medical condition.

3.5 Staff must not drink alcohol or use drugs or substances, other than prescribed medication, while on duty or on Trust premises. Should a member of staff be required to take prescribed medication and believe that is has the potential to or is affecting their performance or ability to carry out their role safely, they should bring the matter to the attention of their manager.

3.6 Staff must not be under the influence of alcohol, drugs or substances at the commencement of their working day or when they are required to work on call or be on standby. Staff are not permitted to drink alcohol, use drugs (other than prescribed medication, where appropriate and safe to do so) or substances when in work, including during a paid or unpaid break following which they are required to return to work. All staff should be aware of the time required for the body to recuperate from the effects of alcohol, drugs and substances.

3.7 Alcohol must not be consumed on Trust premises at any time.

3.8 Should a member of staff attend for work under the influence of alcohol, drugs, or substances, the Trust will make the necessary arrangements to ensure they get home safely.

3.9 All staff should be aware of the potential impact on patients etc. should they be able to smell alcohol on their breath. This can relate to concerns over their actual or

potential ability to perform effectively and safely in their role, their professional image and reputation and that of the Trust. This is an important consideration, as a large proportion of our staff have face to face contact with colleagues, patients, donors, carers, relatives, visitors and the public and they are required to exercise their professional skills and judgement to ensure the provision of safe and effective services.

3.10 A staff member who is required to discuss allegations of alcohol, drug or substance misuse in the workplace with their manager, an investigating officer, etc. will be entitled to be accompanied by their trade union representative or a workplace colleague, not acting in a legal capacity.

4. AIMS AND OBJECTIVES

The overall aim of the policy is to ensure that the Trust provides support and assistance to staff with alcohol, drugs, substance misuse related problems. The objectives include:

4.1 To minimise and ultimately eliminate risks and complaints concerning the standards of conduct, performance and capability of our staff;

4.2 To protect and maintain the health, safety and wellbeing of our staff, patients, donors, service users, visitors and the general public;

4.3 To promote the health and wellbeing of staff;

4.4 To ensure that the principles of equity and consistency are applied when dealing with staff who may have alcohol, drugs and substance misuse related problems;

4.5 To ensure that alcohol, drugs and substance misuse issues are addressed and treated as a health related issue.

4.6 To ensure that staff are treated sympathetically and offered appropriate support and assistance, to address their health related issue;

4.7 To balance the requirement of dealing with alcohol, drugs and substance misuse issue as a health related issue against the requirement to invoke the disciplinary policy, in instances of misconduct. Where the disciplinary policy is invoked, the disciplining officer will consider the mitigation and that the staff member may require a more understanding approach, due to their dependency.

5. ROLES AND RESPONSIBILITIES

5.1 The Manager

- To be aware of how to identify and deal with staff presenting for work showing signs of alcohol, drugs or substance misuse, as they have a duty of care for

their staff, patients, donors and service users etc. Managers should make themselves familiar with the Manager's Guide to Dealing with Alcohol and Drugs in Work;

- To ensure that all staff are aware of and adhere to this policy, and understand its implications;
- To manage staff with an alcohol, drug or substance misuse health issue in accordance with the provisions set out in this policy;
- To ensure that they treat all alcohol, drug or substance misuse related cases confidentially, with sensitivity and a compassionate approach;
- To provide support and assistance to staff in the workplace and encourage them to seek help voluntarily, in the first instance;
- To refer staff to external advice, support and / or counselling organisations, where appropriate;
- To ensure they know their staff and are aware of their health, safety and welfare needs.

5.2 The Employee

- To behave responsibly and to remember they must comply with their professional codes of practice, at all times;
- To be aware of their responsibilities under health and safety legislation, public interest disclosure and clinical governance in respect of the implications of being under the influence of alcohol, drugs or substances in the workplace.
- To report any concerns and seek advice from their manager or the People and OD Department immediately should they have concerns that a colleague may have a substance misuse health related issue. Under no circumstances should they try to “cover up” for a colleague in the workplace as this could endanger the health and safety of colleagues and service users;
- To be aware of their personal responsibility to report where the health and safety of staff or service users etc. may be at risk, where alcohol, drugs or substance misuse may be affecting a colleague’s performance, conduct etc.;
- To seek appropriate support and advice from their manager, Occupational Health Department, Employee Assistance Programme, the People and OD Team or their GP, as appropriate should they believe they have a substance misuse health related issue;
- To cooperate with the support and assistance offered by the Trust and / or support organisations working with them, to address their substance misuse issue;
- To take proactive steps to seek and obtain help and support for themselves should they believe that they have an alcohol, drugs or substance misuse related problem;
- To be aware of the potential implications of substance misuse in respect of other relevant Trust policies e.g. Capability Policy, Disciplinary Policy, Dignity at Work, Violence, Domestic Abuse and Sexual Abuse Workplace Policy,

5.3 The Occupational Health Department

- Provide an impartial and confidential service to staff;
- To provide general advice and support to managers and staff on substance misuse issues, as appropriate;
- To provide medical advice and support to staff with a performance, capability or conduct issue that may be related to substance misuse;
- To assess staff who self refer or are referred by their manager for substance misuse advice and support. This may include a medical assessment and / or a referral to an external advice, support or counselling substance misuse organisation;
- To provide timely, effective and appropriate communication in the form of medical reports, between staff and individual who are involved in the management of the case. This includes the line manager, Workforce Department, GP and any therapeutic organisation;
- To keep appropriate records;
- To advise the manager should a staff member not attend a planned appointment;
- To make staff aware of the policy and actively promote health promotion initiatives and awareness in relation to alcohol, drugs and substance misuse.

5.4 The People and OD Department

- To provide advice, guidance and support to managers and staff as and when required, in respect of the application of this policy and other relevant Trust policies e.g. Disciplinary Policy, Capability Policy etc.;
- To ensure that all staff with a substance misuse issue are treated fairly, consistently and with compassion.

5.5 Recognised Trade Union Representatives

- To ensure that their members are aware of the Policy and understand the implications of not adhering to it;
- To Inform their members of their rights and responsibilities under the policy;
- To offer and provide support and accompany their members to meetings conducted under the policy;
- To encourage and support their members to seek help for an alcohol, drug or substance misuse issue, where appropriate;
- To provide information of external organisations that can provide advice, support and counselling, to assist them with their misuse issue.

6. DEFINITIONS

6.1 Psychoactive Substances

The Psychoactive Substances Act 2016 captures all psychoactive substances that are not classified as illegal drugs. For the purpose of this policy, psychoactive substances are those ‘capable of producing a psychoactive effect in a person who consumes it’. Psychoactive substances include those, which are often misleadingly referred to as ‘legal highs.’ These substances are designed and produced to mimic the effects of drugs such as cocaine, cannabis and ecstasy but have been created so that their chemical structure is different enough to avoid being controlled under current drug laws. This includes inhalation of substances that can affect an individual’s coherence, health and wellbeing e.g. solvents.

6.2 Illegal Drugs

The Misuse of Drugs Act 1971, states that controlled drugs are those that are ‘dangerous or otherwise harmful’, primarily under a 3-tier system of classification, Classes A, B and C. The classification provides a framework within which criminal penalties are set with reference to the harm a drug has, or is capable of having, when misused and the type of illegal activity undertaken in regard to that drug.

6.3 Alcohol

Alcohol is a drug which when used in excess affects concentration, coordination and work performance. The misuse of alcohol interferes with an individual’s health and wellbeing and it may cause harm to colleagues, service users etc., as well as affecting the quality of the service as a whole. Drinking even small amounts of alcohol before carrying out work that is 'safety critical' will increase the risk of an accident. Alcohol can also affect those driving to work after a night of heavy drinking, as the staff member may have blood alcohol levels in excess of the legal limit and may therefore be unfit to drive and to work.

Staff are not permitted to consume alcoholic drinks, take illegal drugs or substances at any time during their working day. This includes all breaks during the working day whether paid or unpaid. It also applies to offsite retirement / leaving functions, which may take place during the working day.

6.4 Prescribed Medicines

This applies to the misuse and dependence on prescribed or over the counter medication. If a staff member believes that their prescribed or over the counter medicine has the potential to or has an adverse effect on their ability to perform their duties, they should stop working and report this matter to their manager immediately.

7. POLICY COMPLIANCE

7.1 In the context of work, not only does use of alcohol, drugs and substances damage the staff member's health and wellbeing, it can also affect their future employment as a result of:

- Safety concerns raised by colleagues, patients, donors, service users etc.;
- Loss of productivity and poor performance;
- Conduct issues;
- Lateness and absenteeism.
- The effect on team morale and staff relations;
- General concerns and negative publicity, which can result in reputational damage.

7.2 No member of staff should report to work either under the influence of or smelling of alcohol. Depending on the circumstances, which should be investigated, this may constitute a disciplinary offence under the Trust's Disciplinary Policy (see 11 below). All staff members are also expected to pay due consideration to their professional and personal accountability in this regard.

7.3 Where it is identified that a member of staff is in possession of using or suppling illegal drugs or psychoactive substances in the workplace, this will be investigated under the All Wales Disciplinary Policy. The matter will also be reported to the police.

7.4 If a manager suspects a member of staff may have an alcohol, drug or substance misuse issue they should firstly undertake a private and confidential meeting with them, to discuss their suspicions. The manager is required to ensure that they make and retain a written record of the meeting.

7.5 Should a member of staff be observed in work, in what their manager or colleagues considers to be an unfit / unsafe state, due to alcohol, drug or substance misuse, their manager will consider the situation, seeking advice from the People and OD Department. This situation may result in the member of staff being dealt with in accordance with the Disciplinary Policy, following an initial assessment of the case. The member of staff will be required to attend a meeting with their manager and a People and Relationships Advisor upon their return to work.

7.6 Where necessary, the member of staff will be taken home immediately. The manager will be responsible for ensuring that they are taken home safely. The manager will also ensure that the staff member has access to immediate support via the Employee Assistance Programme and / or Occupational Health, by providing them with their contact details.

7.7 Where a bank, agency or contractor worker is observed in work in what a member of staff or manager considers an unfit / unsafe state due to alcohol, drug or substance misuse, the matter must be reported to the responsible manager. The responsible manager will arrange to ensure that the worker is taken home safely, using a safe method of transport. The responsible manager will also be required to report the incident to the Bank Office, agency or contractor.

7.8 As soon as it becomes apparent that a member of staff has alcohol, drugs or substance misuse issue, the manager should immediately seek advice from the People and OD Department. Full consideration will be given to any information provided and suggestions put forward by the member of staff, as well as any actions that need to be taken immediately, to ensure the safety of colleagues, patients, donors, service users etc. The manager may consider the appropriateness of suspending the staff member from work, depending on the circumstances. The manager is required to write to the member of staff following the meeting to outline the issues discussed and the advice and support offered e.g. provided with a copy of the policy and advised of the potential implications, an Occupational Health referral, signposting to the Employee Assistance Programme and other external advice, support and counselling organisations.

7.9 The staff member must be referred to the Occupational Health Department as soon as possible to obtain advice on the extent of the alcohol, drugs or substance misuse related issue and to determine the potential and real effects on their ability to fulfil their duties and responsibilities of their role.

7.10 A member of staff who has identified or been identified as having an alcohol, drugs or substance misuse issue will be required to cooperate fully with any referral or treatment recommended by the Occupational Health Department.

7.11 The manager will consider the Occupational Health advice and will decide whether the member of staff should remain in work, taking into consideration the risks involved and the extent of the alcohol, drugs or substance misuse related issue.

8. IDENTIFYING AN ISSUE

8.1 Research suggests that the workplace is an appropriate place to create an environment in which individuals who misuse alcohol, drugs or other substances can be encouraged to make decisions, to change their behaviour. The potential of job loss and future career prospects can often be a prime motivating factor.

8.2 Alcohol, drugs and substance misuse concerns may come to the attention of a manager in a variety of ways. Managers must therefore be alert to the issue of substance misuse within their team and the wider organisation. Please refer to the Manager's Guide to Alcohol and Drugs in the Workplace;

8.3 Education and support in recognising signs of alcohol, drugs and substance misuse will be made available for managers.

8.4 All staff should be aware that they do not need to wait to be approached by their manager or a colleague before seeking help with a substance misuse issues. Staff may recognise themselves that they have a substance misuse issue before it comes to the attention of their manager. In this situation, staff are actively encouraged to seek help from the Occupational Health Department or the Employee Assistance Programme, voluntarily.

Issue Identified through General Observations

8.5 Where a manager reasonably suspects a member of staff has a potential alcohol, drugs or substance misuse issue through general observation they are obliged to explore the matter further with them.

8.6 The manager should discuss their concerns with the staff member in private. They should approach the matter in an honest, non-judgemental and empathetic manner, while understanding that these symptoms may have some other origin e.g. side effects from prescription drugs. During these discussions, the manager should always offer help and support, with reference to this policy and agree a written support plan. At the same time, the manager should remind the member of staff of their personal and professional responsibilities when reporting for work. The right to be accompanied by a trade union representative or a workplace colleague, to a meeting of this nature, would not ordinarily be refused.

8.7 All staff members are actively encouraged to voluntarily seek advice and support under this policy, should they believe that they have a potential alcohol, drugs or substance misuse problem, before it becomes an issue in the workplace.

8.8 Staff members who voluntarily seek help or are managed under this policy will normally be guaranteed confidentiality. However the Trust may have a duty to inform the appropriate authorities if there is evidence that suggests that the staff member's substance misuse issue has resulted in them breaking the law at work e.g. in roles which involve driving. It should also be noted that colleagues etc. who are aware that a staff member has a substance misuse issue that has the potential to or is having an impact on them undertaking their duties and responsibilities, must report the matter to the manager. This will ensure that appropriate action is taken to protect the health, safety and wellbeing of other colleagues, patient, donors and service users etc.

Issues of a Disciplinary Nature

8.9 Staff may be identified as having an issue with alcohol, drugs or substance misuse because of an incident or allegations of a disciplinary nature. Staff with an alcohol,

drugs or substance misuse issue cannot be excused from complying with the accepted standards of conduct, health and safety etc.

8.10 It is acknowledged some religions believe in the use of some drugs, as elements of their faith. While this is recognised, drugs such as marijuana (except for prescribed cannabinoids) are illegal and therefore staff under the influence of, or found to be using such drugs in the workplace will be managed under the Disciplinary Policy.

8.11 The policy has been developed to help identify early problems of alcohol, drugs or substance misuse and provides appropriate advice and support to staff to avoid their issue leading to a breach of the disciplinary rules. Staff must be aware that where a serious offence is committed, they will be subject to the All Wales Disciplinary Policy. This does not prevent a member of staff providing evidence of a substance misuse issue in their mitigation during a disciplinary investigation and hearing.

8.12 Staff who have an alcohol, drugs or substance misuse issue being managed under the All Wales Disciplinary Policy will continue to be offered advice and support in accordance with the provisions contained in this policy.

Issues with Registration with a Professional Body

8.13 Where a member of staff is registered with a professional body and it is identified and confirmed that they have an alcohol, drugs or substance misuse issue, the appropriate senior Manager/Director will decide whether they should be reported to them. Where it is deemed appropriate to report a member of staff, the Manager/Director will follow the relevant professional body's mechanism for notification of such circumstances.

8.14 In circumstances where a member of staff's substance misuse leads to the loss of their professional registration, which is an essential requirement for them to practice and work in their role, their employment with the Trust may be terminated. In such circumstances, redeployment may be sought as an alternative to termination of employment, in the first instance. If the Trust is unable to redeploy the member of staff to another role, the Trust will have no alternative other than to follow a fair dismissal procedure.

8.15 In circumstances where a member of staff's substance misuse leads to the loss of a licence e.g. driving licence or the loss of an essential requirement contained in the job description and person specification, which is necessary for them to work in their role, their employment with the Trust may be terminated. In such circumstances, redeployment may be sought, as an alternative to termination of employment, in the first instance. If the Trust is unable to redeploy the member of staff to another role, the Trust will have no alternative than to follow a fair dismissal procedure.

Issues for Staff Who Perform Driving Duties

8.16 All staff have a responsibility to ensure they are able to perform their duties in compliance with the law (***see Appendix 3***).

8.17 Staff must consider how the effects of alcohol, drugs or substance misuse may inhibit their ability to drive as part of their duties.

8.18 Where applicable staff should always plan if they are going to be drinking alcohol on the night etc. before attending for work, to ensure that they are fit to drive the following day and are not in breach of the drink and drive alcohol limits. This should also be considered by staff who drive, to and from work for business purposes. In such circumstance, they should consider using public transport, not attending work etc. to protect their health and safety and that of others.

8.19 Staff are required to consult with their GP etc. if they feel their ability to drive may be impaired by prescribed medication. Where a staff member's ability to drive is deemed to be impaired by a health professional, they have a duty to report the matter to their manager. They may also have a duty to inform the DVLA, upon the advice of their GP etc.

8.20 Staff have a duty to report to their manager if they feel their ability to drive is affected by alcohol, drugs or substances.

9. THE OFFER OF HELP

9.1 The offer of help will normally commence with referral to the Occupational Health Department. The Occupational Health Department will offer advice and support to the member of staff and they may suggest a referral to another external organisation. There is also the option of the staff member contracting the Employee Assistance Programme to obtain substance and alcohol misuse support and counselling EAP Contact Information.

9.2 In some circumstances it may be more appropriate or more acceptable for the staff member to contact the external organisation directly for advice and support. In these circumstances, it is appropriate for the manager to request that the chosen organisation provides written confirmation that the member of staff has accepted and will attend for treatment.

9.3 Staff who wish to voluntarily seek help for a substance misuse issue are encouraged to contact the Occupational Health Department directly Occupational Health Contact Information or the Employee Assistance Programme EAP Contact Information. The Occupational Health and Employee Assistance Programme Contact information is also available via the Trust's People and OD Intranet site. Staff and managers

should refer to ***Appendix 1*** of the policy for details of external organisations that offer advice on alcohol and substance misuse and counselling services.

9.4 Staff are also encouraged to seek advice and support from their General Practitioner.

9.5 Where a manager makes a referral to the Occupational Health Department, they will be provided with a written assessment of the staff member's fitness for work. Where treatment has been recommended, the Occupational Health Department will provide confirmation to the manager of the staff member's acceptance and continued attendance for treatment. Details regarding the treatment record of the staff member will remain strictly confidential.

9.6 Where a member of staff makes a self-referral to the Occupational Health Department the manager will not normally be provided with a medical report outlining their assessment or advice provided etc., unless they have been given express permission by the member of staff. Any disclosure will be made in accordance with the guidance on confidentiality, issued by the General Medical Council or Nursing & Midwifery Council or other relevant professional regulatory bodies.

9.7 The offer of support and help will be made with the understanding that if necessary, the staff member will be granted paid time off work to undergo face to face counselling or treatment, should it fall within their contractual hours. If the staff member is unfit to attend work during a period of ongoing treatment, the absence will be treated as absence in accordance with the All Wales Managing Attendance at Work Policy.

9.8 Where a member of staff has taken a period of sick leave following identification of an alcohol, drugs or substances misuse issue they will be able to return to the same post, unless this would be inconsistent with the long-term resolution of the employee's problem or they have had their professional registration, driving licence etc. suspended / removed. Where a return to the same post is not advisable, or possible, consideration will be given to redeployment, if appropriate.

10. EMERGENCY ATTENDENCE AT WORK

10.1 It is recognised that staff may unexpectedly be called into work to cover staff shortages or to comply with an unplanned emergency on-call situation. In such circumstances, staff are expected to behave responsibly. If a staff member is under the influence of alcohol, drugs or substances, as defined in this policy, they must not report for duty and must inform their line manager that they are unable to fulfil such duties without any detriment.

11. DISCIPLINARY ACTION

11.1 Consumption of alcohol or any other substances as outlined in Section 6 of this policy or presenting for work under the influence of these substances will be managed in accordance with the All Wales Disciplinary Policy, as appropriate.

11.2 Staff who may misuse alcohol or any of the other substances referred to in this policy cannot be excused from complying with the accepted standards of conduct, health and safety etc. at work. Any staff member who behaves contrary to the Trust's standards will be subject to the Disciplinary Policy.

11.3 In all cases where the Disciplinary Policy is used in connection with alcohol or substance misuse, the staff member concerned will also be offered advice and support with their issue, at each stage of the procedure.

12. PROMOTION AND AWARENESS

12.1 The philosophy of this policy is that education on alcohol and other substances should be part of a wider ongoing programme of health promotion and health and wellbeing at work, for the whole workforce. It is not only aimed at those who are identified as having issues with alcohol, drugs or substance misuse, but to raise staff awareness and interest in their health and wellbeing, to the extent that alcohol, drug and substance misuse issues may be prevented from occurring or may be prevented from developing into a worse dependence issue. Messages about healthy lifestyles and the benefits will be continually provided by the Trust for the benefit of all staff.

12.2 In practical terms this means having appropriate measures in place to regularly promote healthy living messages about reducing alcohol consumption etc. by means of campaigns, events, displays, leaflets, posters, newsletters and e-mails, which include factual information regarding the effects misuse of alcohol, drugs and substances can have on staff and families.

12.3 Managers have a responsibility to know their staff, as such they too have a responsibility to ensure that in addition to general health and wellbeing information, appropriate messages regarding alcohol, drugs and substances are targeted at their staff.

13. EQUALITY

The Trust recognises and values the diversity of our workforce. The Trust aims to provide a healthy and safe environment for our staff, where they are all treated fairly, consistently and with dignity and respect. The Trust recognises that the promotion of equality and human rights is central to its work both as a provider of healthcare and related services and as an employer.

13.1 Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative policy impact has been identified during the assessment process.

APPENDIX 1

EXTERNAL ORGANISATIONS OFFERING DRUGS AND ALCOHOL ADVICE AND COUNSELLING

Please click on the links to access services

City & County of Cardiff Community Alcohol and Drug Team
CAVAMH
Vale of Glamorgan
Newlands
26 Newland Street
Barry
CF62 8EA
Tel 01446 700943

Inroads - Cardiff Street Drugs Project
2-10 Holton road
Barry
CF63 4HD
01446 506079

96-98 Neville Street
Cardiff
CF11 6LS
029 2040 7407

Pen-yr Enfys Council on Alcohol Fitzhamon Centre
53b Fitzhamon Embankment
Riverside
Cardiff
CF11 6AN
Tel: 029 20 388003
Fax: 029 20 226660

Cardiff Alcohol and Drugs Team (CADT)
CADT
02920 788300

Betsi Cadwallader UHB Substance Misuse Service (SMS)
Link below
SMS
Wrexham
03000 859 444
Flintshire
03000 849 900
Denbighshire
03000 856 828
Conwy
01492 523 828
Gwynedd
03000 853 333
Anglesey
03000 853 355

Merthyr Home Detox
Merthyr Drugaid Needle Exchange
1st and 2nd floor, Oldway House
Merthyr Tydfil
CF47 8UX
Tel: 01685 721991

DASPA – Drug & Alcohol single point of access – 0300 333 0000

MIDAS Drugaid Merthyr
Midas House
2nd Floor, Oldway House
Castle Street,
Merthyr Tydfi;
CF47 8UX

Kaleidoscope Powys
(Substance Misuse Integrated Team)
01686 207111
Welshpool 2 Severn Street SY21 7AB 01938 555922

Newtown Severn House, Severn Square SY16 2AG 01686 610 422

Llandrindod Grosvenor Rd LD1 5NA 01597 825 102

Brecon 9 Castle St LD3 9DD 01874 622 33

Drugaid
16 Clive Street
Senghenydd
Caerphilly
CF83 1GE
Tel: 023 2086 8675

BCUHB substance Misuse Service
Gwynedd Substance Misuse Service

North West Wales NHS Trust Drug Service

Gwynedd Community Alcohol Service
Cyngor Alcohol Information Services (CAIS)

Cyswllt Ceredigion Contact
49 North Parade
Aberystwyth
Ceredigion
SY23 2JN
Tel: 01970 626470

PRISM Mid and West Wales Alcohol and Drug Advisory Service
Forestry House
Brewery Road
Carmarthen
SA31 1TF
Tel: 01267 231634

Gwent drug and Alcohol Service
Resolven House
St Mellons Business Park
Fortran Road
St Mellons
CF3 0EY
Tel: 01633 811950

West Glamorgan Council on Alcohol and Drug Abuse
Celtic Court
Tremains rd
Bridgend
CF13 1TZ
Tel: 01656 650999

Drugaid
59 Commercial Street
Abertillery
NP13 1DQ
Tel: 01495 211999

APPENDIX 2

NATIONAL SOURCES OF HELP AND ADVICE

Adfam National
The largest non-statutory organisation that works with and on behalf of families affected by drug and alcohol problems. This organisation is helpful for the family of an alcohol or drug user.
Helpline: 020 7553 7640

Alcoholics Anonymous
It is the largest self-help group for people who acknowledge they cannot handle alcohol and want a new way of life without it. Access to their services are free.
Helpline: 0845 769 7555
The comprehensive website explains the philosophy of AA, what to expect and details of local groups.

Cocaine Anonymous
A national self-help group specifically for cocaine users.
Helpline: 0800 612 0225, open 10:00am to 10:00pm

DAN 24/7
Free Bilingual Drug and Alcohol Helpline for Wales.
Telephone: 0808 808 2234

Drinkaware
Drinkaware is an independent charity working to reduce alcohol misuse and harm in the UK. They work to help people make better choices about drinking.
Telephone: 020 7766 9900
If you're unable to find the answer to your query on the website, then please email on contact@drinkaware.co.uk

Narcotics Anonymous
The largest self-help group for people who want to stop using drugs. Access to their services are free.
Helpline: 0845 373 3366
The website includes details of local groups.

Talk to FRANK
A Government funded free service, previously named the National Drugs Helpline. It provides advice to the drug user or anybody concerned about a drug user. It has a database of local support and treatment services that can help drug users. The focus of the helpline is for young people and concerned parents, but it will also assist adult drug users.
Helpline: 0800 77 66 00
The website provides detailed information on drugs that the non-specialist can understand.

APPENDIX 3

THE LEGAL POSITION

1. Velindre University NHS Trust has a duty under the **Health and Safety at Work etc. Act 1974** (HSW Act) to ensure, as far as is reasonably practicable, the health, safety and welfare at work of all staff and persons who use our services or enter our premises.

2. There is also a duty under the **Management of Health and Safety at Work Regulations 1999**, to assess the risks to the health and safety of our staff. The Trust is concerned for the good health and wellbeing of all staff to enable them to work safely and effectively, to ensure that the Trust's reputation is not damaged by incidents related to alcohol or substance misuse.

3. The **Road Traffic Act 1988** states that any person who, when driving or attempting to drive a motor vehicle on a road or other public place, is unfit to drive through drink or drugs shall be guilty of an offence. An offence is also committed if a person unfit through drink or drugs is in charge of a motor vehicle, in the same circumstances.

4. It is an offence under the **Misuse of Drugs Act 1971** for any person knowingly to permit the production, supply or use of controlled substances on their premises except in specified circumstances e.g. when they have been prescribed by a doctor or registered healthcare professional.

APPENDIX 4

ISSUES AT WORK CAUSED BY ALCOHOL, DRUGS AND SUBSTANCE MISUSE

Given the wide variety of roles within the Trust, some of the following issues may be relatively more important and significant than others, dependent on the responsibilities and duties undertaken by the member of staff. It is recognised that alcohol, drugs and substance misuse can cause severe issues, not only for the staff member and their family, but also for colleagues, patients, donors, service users etc. These issues can occur not just in the obvious area of health and safety, but also in unsatisfactory work performance, sickness absence, conduct and poor relationships at work.

It is important to recognise that issues can be caused by misusing alcohol, drugs and substances occasionally, in excess and because of chronic use and dependency.

Alcohol, drugs and substance misuse issues can manifest in some or all of the following ways, but it is important to be aware that the following issues can also be caused by other factors such as stress, mental health problems, physical illness or the use of prescribed medication.

1. Work Performance

- Poor decision-making.
- Absences from work i.e. more than normally expected.
- Overlong breaks.
- Decrease in concentration - jobs take longer, require greater effort.
- Difficulty in recalling instructions and details.
- Decline in quality and quantity of work and effort cannot be sustained.
- Increase in errors of judgement.
- Increased fatigue.
- Loss of interest in work.
- General unreliability and unpredictability.
- Improbable excuses for poor performance, lateness and absences.

2. Accidents

All staff have responsibilities and duties under the Health and Safety at Work Act to take reasonable care for their own and others' safety. Evidence suggests that alcohol, drugs and substance misusers can be between 3 to 4 times more likely to have or cause an accident at work, than someone without a problem of this nature. It should be noted that even "sensible limits" of alcohol could have significant effects on judgement and application of "motor" skills.

Problems can manifest themselves via:

- High accident rates in work.
- Accidents off the job, i.e. at home or travelling to and from work.

3. Poor Relationships with Colleagues

- Over reaction to real or imagined criticism.
- Unreasonable resentment.
- Irritability or aggression.
- Complaints from colleagues.
- Borrowing money from colleagues.
- Avoidance of manager and/or colleagues.

All of these can subsequently lead to poor performance, grievances and dignity at work complaints in the workplace.

4. Individual Behaviour

- Reporting to work smelling of alcohol.
- Increasingly unkempt appearance.
- Decline in personal hygiene.
- Sudden mood changes.
- Depression.
- Acts of aggression.

5. Non Attendance

This is perhaps the most obvious area, which causes difficulties for colleagues and ultimately patients, donors, service users etc. The cost to industry and business throughout the UK of alcohol abuse has been estimated by Public Health Wales to be approximately £7 billion for the NHS and estimated £21 billion because of sickness absence, unemployment, early retirement and premature death PHW Healthy working Wales

Non-attendance at work can manifests itself in a number of ways, for example:

- Unusually high levels of short-term and long-term sickness related absences, often accompanied by imprecise reasons on return to work self certificates, e.g. flu-like symptoms, colds, gastric problems, fatigue, nervous debility.
- Multiple instances of unauthorised days off work.
- Late applications for half or one day's annual leave.
- Excessive lateness at start of work or and after lunch breaks.
- Leaving early.
- Unauthorised breaks.

Ref: WF18

PROFESSIONAL REGISTRATION AND REVALIDATION POLICY

Executive Sponsor & Function	Executive Director of Organisational Development and Workforce
Document Author:	Head of Workforce
Approved by:	Trust Board
Approval Date:	TBC
Date of Equality Impact Assessment:	August 2024
Equality Impact Assessment Outcome:	No adverse impact on any protected characteristics
Review Date:	As required by legislative changes
Version:	3

1. Policy Statement

Velindre University NHS Trust recognises that professional registration and revalidation is intended to protect the public, ensuring that those who practice as a health professional are doing so safely. The purpose of this policy is to ensure that the Trust is fully able to exercise its duty to protect the public, patients and service users through the employment of registered staff.

It is a requirement that individuals who work within certain professional groups and who are employed and/or undertake work on behalf of Velindre University NHS Trust, are registered with their respective professional regulatory body. Some professional bodies also require their registrants to apply for revalidation as part of the registration process.

If a member of staff's professional registration lapses they will not, contractually and in many cases legally, be able to continue to carry out the duties of their post, if their post requires them to be registered.

In view of the professional and legal obligations, this policy sets out the Trust's requirements for all professionally registered staff to maintain their professional registration, and comply with revalidation requirements. In addition, this policy describes the process to be followed for checking employees' professional registration status of health practitioners employed or engaged by the Trust.

2. Scope of Policy

This policy applies to all staff within Velindre University NHS Trust, including hosted organisations whose employment requires them to be registered, and in some cases revalidate, with a respective professional regulatory organisation. The policy also applies to all staff engaged as a Bank Worker, Honorary Contract holders, Locum/Agency staff and contractors.

This policy also applies to individuals attending Trust premises as a trainee or on Work Placements.

3. Aims and Objectives

The aims of this policy is to provide guidance to;

- Staff on their contractual requirements to maintain their professional registration, if this is a requirement of the role they are employed in
- Managers on the processes for checking and recording professional registration during the recruitment of staff and ensuring that all staff employed or engaged with the Trust (whether on a substantive, temporary, fixed term contract, a bank worker or engaged on an honorary appointment etc.), maintains their registration during their employment or engagement with Velindre University NHS Trust.
- All staff on the actions which may be taken if it is discovered that a health professional's registration has lapsed.

4. Responsibilities

4.1 Employees/Bank Worker/Honorary Contract Holder/Contractor

The Trust regards it as the responsibility of the individual to register with their regulatory body and to ensure that they maintain such registration as is necessary to enable them to practice their profession.

As such, it is the responsibility of the individual to:

- provide evidence of statutory registration and qualifications, prior to commencing their employment/engagement with the Trust;
- renew their registration in a timely manner in accordance with the relevant professional bodies procedures ;
- ensure that they maintain their registration throughout their employment or engagement with the Trust, including;
- when on maternity, adoption, shared parental or paternity leave;
- long term absence from work due to sickness ;
- on secondment;
- on an employment break;
- any other period away from the workplace;
- take the responsibility of informing their line manager / Trust contact of any issues relating to their registration or re-registration and/or fitness to practice, such as being arrested or receiving a Police caution;
- ensure that their Manager/Trust contact is provided with sufficient evidence of their registration and the expiry date on renewal of their registration;
- inform the relevant statutory regulatory body and the Trust via Electronic Staff Survey (ESR) Self Service where possible, of any change in personal circumstances e.g. change of address, name, status etc.

4.2 Managers

Managers are responsible for checking and recording (on ESR/Personnel File) the professional registration of their staff who are required to register with a regulatory body.

Managers are also responsible for taking responsibility for ensuring that the follow-up process for checking statutory registration is undertaken and that registration numbers and renewal date records are maintained appropriately in ESR. This responsibility may be designated within their Department to an appropriate managerial level.

Responsible Managers must ensure that;

- they are familiar with the requirements of relevant legislation governing the employment of registered professional staff;
- they (or their nominee) verify the relevant qualifications and professional registration(s) of all employees, who require professional registration to undertake their duties, during the recruitment process following appointment;
- they have suitable arrangements in place for a systematic review and check of their registered professional staff's registration, in accordance with their relevant regulatory bodies' renewal schedule (also see section 5.3);
- checks are made on the professional registration of those staff returning from maternity, adoption, shared parental, paternity leave, employment break, long term

sickness absence, secondment or any other extended period away from the workplace to confirm no changes have occurred (also see section 5.3);

- they establish procedures within their department(s) to ensure that the registration of honorary contract holders, agency, locum, bank workers etc. are checked and verified, and appropriate records are maintained;
- they ensure that immediate action is taken to protect the interests of the public, patients and service users when a member of staff is found not to be appropriately registered (see section 5.6 below);
- managers should inform employees of the impact that any delay in registration will have in relation to salary banding (refer to section 5).
- escalate situations of concern with registration to Head of department and if required to relevant executive lead.

4.3 Workforce and Organisational Development (OD) Department

The Workforce Information Team will;

- monitor the ongoing registration, via the ESR, for professional bodies e.g. the General Medical Council (GMC), Health and Care Professions Council (HCPC) and Nursing & Midwifery Council (NMC);
- provide timely and accurate alert reports from ESR and notify Managers when their staff members' registration is due for renewal, reminding them of the need to instigate their local checking procedures;
- ensure that any lapses of registration flagged up on the ESR system are immediately reported to Workforce and the relevant line manager.

The Workforce and OD Department will;

- provide guidance and advice to Managers and staff should a member of staff's registration lapse, ensuring that swift action is taken to protect the interests of the public, patients and service users.

5. Implementation and Policy Compliance

5.1 Procedure for Validation of Statutory Registration

All existing and prospective employees of Velindre University NHS Trust are required to submit details of their professional qualifications and professional registration(s) (as appropriate), as part of the recruitment process. This also applies to Bank Workers.

Validation of professional qualifications and registration(s) will be undertaken by the Appointing Manager, or their nominee, during the interview and recruitment process ensuring that:

- The employee is registered with their appropriate regulatory body;
- The employee's registration covers the role being recruited to; and
- The employee's registration is not subject to any current restrictions or subject to any fitness to practice investigation(s).

This documentation will also be verified by the NHS Wales Shared Services Partnership (NWSSP) Recruitment Team, as part of the mandatory pre-employment check process. The NWSSP Recruitment Team will provide the Appointing Manager with a copy of all the pre-employment check documentation. The Appointing Manager should ensure a copy of this is retained on the individual's personal file.

Upon commencement of employment with Velindre University NHS Trust, the new employee will be required to provide their professional registration details. This information will be recorded in the ESR system and used to monitor the individual employees' registration compliance with their regulatory body.

Where an individual has been appointed to a post which requires them to be registered with a regulatory body and their registration cannot be verified, they will not be permitted to commence employment in that role with the Trust and the offer of employment may be withdrawn.

5.2 New Entrants to the Register

There may be occasions when newly qualified professional staff commence their employment within Velindre University NHS Trust prior to receipt of their registration.

In such circumstances, the individual will initially be employed and may work, under supervision, at the pay band for the relevant level for a Health Care Support Worker employed within the specific area, until the individual's registration is confirmed. Once registration has been confirmed, the employee's position and contract will be amended to reflect a registered post status. Pay will not be retrospectively adjusted, as the member of staff will not have worked to the job description of the registered post during this period.

In these instances advice should be sought from the Workforce Team before this position is agreed with an individual.

5.3 Existing employees

Each departmental manager must have an active follow-up process, which ensures that regular checks of its employee's statutory registration(s) are made. Managers should utilise ESR to support this process.

An expiry notification will be sent to the employee via ESR Employee Self Service four months and one month prior to the expiry of their professional registration informing them that they need to renew.

In addition, line managers will also receive a summary listing, showing all their staff with professional registrations due to expire in four months and one month before the expiry date

The appropriate Manager, or their appointed nominee, will confirm the current registration status, including the relevant part of the register where appropriate, using the correct registration confirmation service, either on-line, by telephone or in writing (Please see Appendix A).

5.4 Agency / Locum Workers / Contractors / Honorary Contract Holders

The relevant agency of locum provider, contractor or substantive employer must be asked to provide the Trust, via the relevant manager or Medical Staffing Department, with the appropriate registration details (registration number, renewal date and date of birth) of the individuals booked to fill any regulated healthcare professional vacancy. This must be verified before the individual is engaged with the Trust. The individual may also be required to present evidence of their registration when they commence their engagement with the Trust.

5.5 Trainees and Work Placements

All registered individuals attending the Trust to participate in specific work placements, or participate in training, will be required to be registered with the appropriate professional body.

The substantive employer of the individual will be required to verify the statutory registration and provide the Trust with the registration details (registration number, renewal date and date of birth), prior to the commencement of their work placement or training. The individual may also be required to present evidence of their registration when they commence their engagement with the Trust.

5.6 Dealing with instances of lapsed Professional Registration

Clear and robust audit mechanisms will ensure that there is adherence to registration and re-registration procedures, as outlined above.

From time to time, situations arise whereby registered professional staff allow their registration with the appropriate statutory professional body to lapse. Failure to have, or to renew, registration will result in the member of staff being managed and supported as follows;

5.6.1 Substantive employees

The employee will be advised that until they have been restored to the appropriate register, they cannot continue to undertake their professional duties as required in a registered role;

The employee will not be able to work in their registered capacity until their re-registration has been confirmed. To facilitate this, they may take annual leave that has been accrued and not taken up to the date of the lapse of registration, paid at the band/salary at which it was accrued;

Should the employee not have enough accrued annual leave, they will be required to take unpaid leave;

Any lapse of professional registration will be considered in accordance with the Trust's Disciplinary Policy, and may lead to disciplinary action including dismissal;

In circumstances where lapsed registration has occurred due to the failure of the statutory regulatory body, the appropriate Manager will clarify the position with the professional body concerned;

The subsequent return to work of the individual concerned and/or resumption of pay at their band/scale will be subject to the availability of confirmation of re-registration;

The individual's line manager, or their nominee, will be required to confirm re-registration, via the appropriate registration service, either on-line, via telephone or in writing.

5.6.2 Bank Workers/Honorary Contract Holders/Contractors/Trainee and Work Placements

In these instances the individual will be advised that until they have been restored to the appropriate register, they cannot continue with their engagement with the Trust.

Bank Workers will be provided with the opportunity to take any annual leave that has been accrued and not taken up to the date of the lapse of registration, paid at the band/salary at which it was accrued.

6 Removal from the register

If an employee is removed from the register by their own professional body, they will no longer be able to be legally employed by the Trust, in a professionally registered capacity. This will be managed in accordance with the Trust's Disciplinary Policy.

7 Reporting

In all cases of lapsed registration, an initial assessment will be undertaken in accordance with the Trust's Disciplinary Policy. The department manager will ensure that the lapse is reported to Workforce and OD, Divisional Director and the appropriate professional lead for the Velindre University NHS Trust e.g., Executive Medical Director or Executive Director of Nursing Allied Health Professions and Health Sciences.

8 Notification to Registered Bodies of breaches of Professional Codes of Conduct

In circumstances where a registered professional member of staff is proven to have breached their relevant Professional Code of Conduct, Velindre University NHST Trust will follow the relevant professional, regulatory bodies' notification mechanism.

8.1 Fitness to Practice

Registered professional staff have a responsibility to report to their Manager any matters that may arise, which may call into question their continued fitness to practice. The need for the staff member to be reported to the appropriate regulatory body will vary, dependent on the circumstances and the regulatory bodies agreed Code of Conduct/Standards. If a staff member is unsure whether they should report a matter to their Manager, they can discuss the matter with the appropriate regulatory body in the first instance.

Where a Manager judges that a registered professional staff member's fitness to practice has been called into question, they must discuss the matter with the relevant Trust Professional Lead, the Head of the Department and Workforce.

Where appropriate, a fitness to practice issue may be investigated, in accordance with the Velindre University NHS Trust's Disciplinary Policy, (where the matter is related to professional misconduct and calls into question the staff member's 'fitness to practice') or the Trust's Capability Policy, if this is found to be the case.

Where it is found, on the basis of probability or available evidence, that it is appropriate to call into question a member of staff's fitness to practice, the Trust Professional Lead or Head of Department should inform the appropriate Regulatory Body.

Prior to the Trust Professional Lead/Head of the Department informing the appropriate Regulatory Body of their concerns, he/she will write to the staff member concerned, advising them that their fitness to practice has been called into question, the reason(s) for this decision and informing them that the appropriate Regulatory Body will be informed of the breach.

9. Equality Impact Assessment Statement

The Velindre University NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees, reflects their individual needs and does not discriminate against individuals or groups.

The Velindre University NHS Trust has undertaken an Equality Impact Assessment (EQIA) and received feedback on this Policy and the way it operates. The Trust wanted to know of any possible or actual impact that this Procedure may have on any groups in respect of gender (including maternity and pregnancy, as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The EQIA Assessment found that there was no impact to the equality groups aforementioned.

10. References

- Disciplinary Policy - Disciplinary Policy WF 02
- Employment Break Policy - Employment Break Scheme
- Maternity, Adoption, Paternity and Parental Leave Policy - Maternity, Paternity, Adoption and Parental Leave Policy WF 29
- Shared Parental Leave Guidance - LINK
- Capability Policy - Capability Policy WF 09
- Equalities and Human Rights Act Legislation - Equalities and Human Rights Act

11. Getting Help

The Professional Registration Policy will be available via Velindre University NHS Trust intranet site. Where staff do not have access to the intranet, their line manager must ensure that they have access to a copy of this Policy

Further information and support is available from the Workforce Department.

The relevant Professional body will be able to provide advice and support to staff. A list of the contact details is available in Appendix A of this Policy.

12. Information, Instruction and Training

Whilst there are no formal training programmes in place to ensure implementation of this Policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Head of Nursing, Divisional Nurse, Departmental Manager and Head of Department(s) must ensure that Managers and all registered professional staff are made aware of the Policy provisions and that they are adhered to at all times.

13. Policy Review

This policy will be revised and updated to reflect any amendments to the staff groups who are required to register with a regulatory body to practice within their profession.

Appendix A

REGISTRATION BODIES

General Medical Council (GMC)

By law, Doctors need to be registered and hold a licence to practise medicine in the UK. Doctors renew their registration annually.

In addition, licensed doctors must be revalidated by the GMC every five years. This means that doctors will be asked to evidence that they have been practising medicine in line with the principles set out in the guidance booklet "Good Medical practice Full Registration", which permits doctors to engage in any form of professional employment within the United Kingdom.

Provisional Registration – is held by newly qualified doctors for one year, to enable them to complete their Foundation Programme Year 1 posts, within a hospital setting.

Contact Details	Website Address	Online Register
https://www.gmc-uk.org/contact-us	www.gmc-uk.org	www.gmc-uk.org/doctors/medical_register.asp

General Pharmaceutical Council (GPhC)

Pharmacist and Pharmacy Technicians Registration is renewable with the GPhC on an annual basis.

Contact Details	Website Address	Online Register
https://www.pharmacyregulation.org/contact-us	www.pharmacyregulation.org	www.pharmacyregulation.org/registers

Health and Care Professions Council (HCPC)

HCPC Practitioners Registration – Each profession covered by the HCPC renews at a set time. These times are the same every two years and are staggered throughout the year. The practitioner groups covered (as relevant to Velindre University NHS Trust) are;

- Biomedical Scientists
- Clinical Scientists
- Dietitians
- Operating department practitioners
- Occupational Therapists
- Practitioner psychologists

- Physiotherapists
- Practitioner Psychologists
- Radiographers
- Speech and Language Therapists

For the full list of practitioner groups registered with the HCPC and up to date information on the renewal deadlines for each profession, please visit the HCPC website; https://www.hcpc-uk.org/registration/registration-renewals/when-to-renew/

Contact Details	Website Address	Online Register
https://www.hcpc-uk.org/contact-us/	www.hcpc-uk.org	https://www.hcpc-uk.org/check-the-register/

- **Nursing and Midwifery Council (NMC)**

Nurse and Midwifery Registration – is renewable with the NMC on an annual basis.

All nurses, midwives and health visitors must be registered with the NMC. The register is split into three parts, 1) Nursing, 2) Midwifery, and 3) Specialist Community Public Health Nursing.

In addition, registered nurses must be revalidated by the NMC every three years. Revalidation provides assurances that that Nurses practice safely and effectively, encourage Nurses to reflect on the role of the Code in their practice and demonstrate that they are 'living' the standards set out within it

The revalidation requirements can be accessed via the NMC website; http://revalidation.nmc.org.uk/welcome-to-revalidation.1.html

Contact Details	Website Address	Online Register
https://www.nmc.org.uk/contact-us/	www.nmc-uk.org	https://www.nmc.org.uk/registration/search-the-register/

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

Infection Prevention & Control Policies: IPC 03 National Model Policy Aseptic Non-Touch Technique (ANTT), IPC 15 Control & Management of Multi Drug Resistant Bacteria Policy

DATE OF MEETING	26/09/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The National Model Policy Aseptic Non-Touch Technique IPC 03 has been reviewed and updated by the national team. The change relates to the path to accreditation. The National Control & Management of Multi-Drug Resistant Bacteria Policy expired in June 2024 and is currently being reviewed and updated at a national level. Until this has been completed, it is proposed that the existing national policy remains in use at the Trust, until December 2024.

RECOMMENDATION / ACTIONS	The Trust Board is asked to: • ***APPROVE*** the National Model Policy Aseptic Non-Touch Technique (ANTT) – IPC 03 for adoption across the Trust. • ***APPROVE*** the proposal for the current national Control & Management of Multi Drug Resistant Bacteria policy to remain extant until December

	2024 for the national policy review and consultation to be completed.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Infection Prevention and Control Management Group (IPCMG)	17/07/2024
Executive Management Board	05/08/2024
Quality, Safety & Performance Committee	12/09/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS • **ENDORSED** the national Model Policy Aseptic Non-Touch Technique (ANTT) for onward approval. • **ENDORSED** the proposal for the current national Control & Management of Multi Drug Resistant Bacteria policy to remain extant until December 2024 whilst the national policy review and consultation is completed.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
1.	IPC 03 – Model Policy Aseptic Non-Touch Technique (ANTT)

1. BACKGROUND

Both the model policy Aseptic Non-Touch Technique and Control and Management of Multi Drug Resistant Bacteria are national (NHS Wales) model Policies. As they are predicated on best practice standards, adoption across NHS Wales Organisations is expected.

2. ASSESSMENT

2.1 IPC 03 – Model Policy Aseptic Non-Touch Technique (ANTT)

- The Trust Infection Control Team were part of the original steering group to develop this national policy.
- No amendments were made to the clinical practices during this revision. The main change was to include the path to accreditation.
- A national EQIA has been completed.

2.2 *IPC Policy 15 – Control & Management of Multi Drug Resistant Bacteria*

This national policy expired in June 2024 and is currently undergoing a review and incorporation of new guidance from Public Health Wales. When completed, the revised policy will provide additional guidance on the management of Clinically Significant Antimicrobial Resistant Organisms (CSARO), however there is no impact to current practices.

A national EQIA was completed on the now expired policy, and a further EQIA will be undertaken nationally on the refreshed policy.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development, and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe. ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Trust IPCMG covers all aspects of Quality and Safety from an IPC perspective.
SOCIO-ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies, please list below:

	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies, please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	The EQIAs for the policies have been undertaken at a national level.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Appendix 1: IPC 03 – Model Policy Aseptic Non-Touch Technique (ANTT)

Model Policy
Aseptic Non-Touch Technique (ANTT®):
A national, standardised approach to aseptic technique

Date to be reviewed:	April 2026	**No of pages:**	30
Original Author job title(s):	Healthcare Associated Infection & Antimicrobial Resistance & Prescribing Programme (HARP), Public Health Wales (PHW) In Consultation with: • All Wales ANTT Steering Group • Higher Education Institute (HEI) sub-group • The Association for Safe Aseptic Practice • HCAI Delivery Board		
Responsible dept. / director:	HARP IP&C Team, Public Health Wales		
Approved by:	The all-Wales ANTT Steering Group & HEI sub-group The Association of Safe Practice (ASAP) HARP, Public Health Wales HCAI Delivery Board, Public Health Wales		
Original Date approved:	07 June 2019		
Original Effective Date (live):	04 July 2019		
Version:	FINAL Version 1 - 04 July 2019 FINAL Version 2 - July 2019 FINAL Version 3 – March 2023		
Date of Review	December 2022		
Date Verification form (1) completed:	24th March 2023		

Documents to be read alongside this model policy:	ANTT® Principles[1] NHS Scotland's National Infection Prevention and Control Model Policies NIPCM -on-line[2] Welsh Health Circular 2022/014 Amr-hcai-improvement-goals-for-2021-2023.(Welsh Government 01 March 2022)[3] Welsh Code of practice for the Prevention of Infection (Welsh Government, May 2014) Code-of-Practice [18] WHC 2015-26 ANTT Implementation (Welsh Government, 5thJune 2015)[19] WHC 2015-47 ANTT Follow up (Welsh Government, 9th Oct. 2015)[20] epic 3: National Evidence-Based Guidelines for the Prevention of Healthcare-Associated Infections in Hospitals in NHS Hospitals in England (Loveday et al, 2014)[9] The Royal Marsden Hospital Manual of Clinical Nursing Procedures 10th Edition (2020)[7] Procedures - Royal Marsden Manual (rmmonline.co.uk) National Institute of Clinical Excellence (NICE) Infection prevention and control of healthcare-associated infections in primary and community care (2017)[11] Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE

Executive Summary:

This model policy outlines the current national standardised approach for raising clinical standards of aseptic technique and achieving asepsis in non-invasive and invasive clinical procedures. The aim is to provide a standardised approach termed Aseptic Non-Touch Technique (ANTT®) and to reduce variation in aseptic technique and practice across Wales in the prevention of healthcare associated infections (HCAI). As agreed previously by Executive Nurse Directors, the intention is that this model policy is adopted as national policy by Health Boards and Trusts, including primary care and other health care organisation i.e., Care homes and independent hospitals within Wales. This policy requires relevant managers and leaders to organise and support its implementation and ongoing evaluation. This will ensure relevant clinical staff are appropriately trained and competency assessed in ANTT® so that it is embedded into everyday asepsis practice.

This ANTT Model policy was first published in July 2017, Emergency ANTT added in July 2019, version 3 /2023 all links refreshed, circulated for comment minor amendments and comments updating of appendices including ANTT Accreditation, terminology and updated framework information added into the appendix

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1. Introduction

Asepsis is generally considered to mean 'Freedom from pathogenic material in sufficient quantity to cause infection'.[14] During clinical procedures, the goal of asepsis is to prevent patient contamination by creating an environment that is low in microbe volume by using only sterile devices, materials and maintaining aseptic technique.

Aseptic technique is a core nursing and medical skill but is also used by other allied healthcare professionals (AHP) and healthcare support workers. The standard of aseptic technique practice can be inconsistent, and if not undertaken correctly may be instrumental in causing a healthcare-associated infection (HCAI) within primary, community, secondary and out of hospital care.

Historically, aseptic technique has been seen to be confusing and ambiguous with practice terms and principles having different meanings for different users. This has led to inconsistency and some substandard practices.

In the challenge to reduce HCAI, 'Aseptic Non-Touch Technique' (ANTT®) is used internationally as a safe and effective practice framework for aseptic technique for all aseptic clinical procedures.[19,20]

The Association of Safe Aseptic Practice (ASAP), in collaboration with Public Health Wales and supported by Welsh Government, have been providing ANTT® Resources practice and implementation support to all healthcare workers across Wales since June 2015.

Standardising aseptic technique with ANTT® across Wales will reduce variability in practice and further raise standards for the greater benefit of patients.

Welsh Government has directed all healthcare organisations to 'roll-out' ANTT® competency training to all relevant staff within their organisation.(WHC/2015/026) [19] The principles of ANTT® align with the principles of prudent healthcare[26] and a 'One Wales' agenda, Once For Wales approach. The need for asepsis, especially in the use of invasive procedures and wound management, is evidenced in the epic3 Guidelines.[9]

What is ANTT®?

The ANTT® Approach is an International Campaign designed to promote a clear understanding of asepsis and the essential elements of aseptic technique. This approach is a three-way 'partnership' between patients/service users, healthcare professionals and healthcare organisations, to actively promote the essential '6 Actions for Safe Aseptic Technique' (Appendix 4).

The ANTT® Practice Framework was originated by Stephen Rowley (2001),[15] and is defined as, *'A specific type of aseptic technique with a unique theoretical and clinical practice framework'*.[15]

The framework is applicable to all non-invasive and invasive clinical procedures including major surgery, the insertion and maintenance of indwelling medical devices, wound management and all primary, community and out of hospital-based care that requires aseptic practice.

ANTT® Practice Framework developments and dissemination are overseen by The Association for Safe Aseptic Practice (ASAP), a non-profit non-governmental organisation (NGO). The ASAP is working in partnership with NHS Wales and Public Health Wales to standardise aseptic technique across as a national standard and provides Welsh healthcare staff with updates to all ANTT® resources as they are reviewed and developed. The current resources and full ANTT® can be found following this link ANTT - Public Health Wales A summarised version is given in Rowley et al (2010).[16]

ASAP can be contacted for on-going support on practice and implementation issues via www.antt.org.

2. Purpose

The purpose of this national model policy is to support the implementation of the ANTT® practice framework to enable standardisation of technique and 'practice language' for all aseptic procedures. ANTT® must be embedded into every day clinical procedures as part of a robust commitment to reducing the risks of HCAI and need for antimicrobial prescribing to improve patient safety. Welsh Government set HCAI annual reduction expectations for *Clostridioides difficile*, *Staphylococcus aureus* bacteraemia and Gram-negative bacteraemia as well as expectations for antimicrobial prescribing. These expectations align to the ambitions outlined in the addendum to the 5 year UK National Action Plan (NAP) and the 20 year vision to achieve future reductions that include positively impacting on MRSA, MSSA Blood Stream Infections (BSI), Urinary Tract and Surgical Site Infection (SSI) rates. Compliance with ANTT® supports Health Boards/Trusts in reducing these and other HCAI's whilst improving patient experience and outcomes.

3. Aims and Objectives

This model policy provides a widely adopted evidence-based framework for establishing ANTT® as the safe and effective technique for all aseptic procedures in healthcare organisations across Wales.

Objectives are:

- To identify the role of ANTT® in the reduction of HCAI
- To identify key roles and responsibilities in ANTT® implementation

- To describe the implementation and uses of ANTT®
- To identify the principles of ANTT® and its application to practice
- To outline the requirements for learning and competency assessment for staff undertaking clinical aseptic procedures
- Provide resources and toolkit to support ANTT® in practice
- To be relevant in acute, community and primary care settings, including emergency out of hospital care

4. Scope of the Policy

This model policy is applicable in all settings that provide healthcare to patients and/or service users and to all healthcare workers (HCW) who perform a clinical procedure that requires an aseptic technique.

5. Roles and Responsibilities within Organisations

The Board and Chief Executive Officer (CEO) has ultimate responsibility for Infection Prevention and Control within Health Boards and NHS Trusts. This responsibility, together with responsibility for ANTT® is delegated to the Executive Team under the leadership of the Executive Director of Nursing.

5.1 The Executive Director of Nursing

- Has overall responsibility to ensure that ANTT® is fully implemented and effectively sustained within their organisation[19,20]
- Will ensure that this and local ANTT® policy/procedures are adhered to
- Will nominate an organisational lead for ANTT®
- Will review progress and report to the Board on ANTT® implementation and maintaining compliance in all groups of HCW's
- Will ensure there are adequate financial resource

The operational and professional responsibility lies with the individual performing the procedure.

5.2 Senior Clinical Leads, Departmental and Nurse Managers will

- Be responsible for the effective implementation and monitoring of compliance with ANTT®, ensuring appropriate action is taken when staff fail to comply with policy and required training
- Identify an ANTT® lead and key trainers and assessors for their area of responsibility
- Ensure additional resources and/or equipment is available to facilitate the HCW undertaking the theory and practice of ANTT®
- Facilitate completion of the All-Wales e-learning programme for ANTT® by all HCWs involved in aseptic procedures e.g., protected work time and access to a computer
- Facilitate completion of competency assessment for all HCWs undertaking any type of aseptic procedure
- Monitor and report on competency level of the team and report to the appropriate risk committee

- Support HCWs in achieving compliance with all statutory and mandatory training, including Standard Infection Prevention and Control Precaution (SICP) mandatory training
- Bring this model policy to the attention of all health professionals or workers involved in ANTT® including educational and specialist roles
- Embed ANTT® into routine aseptic practice and all teaching of clinical procedures that require asepsis

5.3 Healthcare Workers (HCWs) will

- Have a responsibility to be familiar with NIPCM policies[2] and adhere to this model policy and other relevant local IPC policies to reduce the risk of transmission of infection
- Always act in the patients' best interest
- Perform invasive and other procedures in accordance with the principles and process of ANTT® (appendices 2-5) and this policy.
- Take personal responsibility for attendance at mandatory training or completion of relevant e-learning and act in accordance with the Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections[18] in Wales
- Be accountable for their practice in accordance with their job description and professional codes of conduct, for example, NMC The Code - The Nursing and Midwifery Council[12] and GMC Good Medical Practice[8]
- Undertake the required ANTT® training and competency assessment if performing any aseptic clinical procedures
- Embed ANTT® into all aseptic practice

5.4 Primary and Community Care Healthcare Staff, including Welsh Ambulance NHS Trust (WAST)

In any out of hospital care settings (e.g., Community Nursing, Primary Care, Long Term Care Facilities, Welsh Ambulance Service) there may be challenges in the application of ANTT® principles relating to equipment and the environment. A local risk assessment (Appendix 7) should be undertaken to assess how the principles can be adopted and any adaption (if necessary) should be documented, minimising patient risk. Resources to assist with this risk assessment are available within the ANTT Framework on Public Health Wales website ANTT Framework.

Whilst recognising the application of ANTT® in challenging situations, it is still possible to aim to minimise patient risk by applying ANTT® '4 Actions for Safe Aseptic Technique' (Appendix 3). Tools and resources specific to community settings and ambulance staff can be accessed via this link Appendix 6 provides an example template for 'Ambulance Peripheral Cannulation Guideline'.
See also 8.6 – Emergency ANTT®

ANTT® principles will be applied and adapted to the management of chronic wounds. While it is recognised some chronic wound procedures e.g., leg

ulcer cleansing and dressing in a patients' own home, can be simplified, the aim is always asepsis, with the aim being not to introduce any further microorganisms into the wound. Guidance should be sought from the Tissue Viability Nurse on aspects that do require ANTT®.

5.5 Consultant Medical Staff will

- Undertake the required ANTT® training and competency assessment
- Be competent and keep your professional knowledge and skills up to date
- Comply with the Good Medical Practice Framework.[8] GMC Good medical practice
- Be responsible for ensuring their junior doctors and teams adhere to and embed the principles of ANTT® and undertake the required training and competency assessment

5.6 Infection Prevention and Control Team (IPCT), Tissue Viability Nurse (TVN), Continence Teams and Intravenous Access Teams

These specialist teams will participate in the National ANTT® Steering Group supporting ANTT® rollout across Wales. They have a pivotal role in assisting relevant organisational teams to coordinate ANTT® implementation, ensure training in their specialist fields conforms to ANTT principles as well as risk-management and evaluating effectiveness of its use.

The IPCT will:

- Provide expert advice in accordance with this policy
- Support managers and staff with the implementation of ANTT®
- Provide information, advice, and training to enable managers and users to undertake necessary risk assessment
- Support investigations in areas with specific risk to advise on safe practice
- Ensure local or adapted procedures/policy remains consistent with the evidence-base for safe practice and review/update local policy and procedures at least every 3 years
- Identify areas for improvement and report to Infection Prevention and Control Managers, local Infection Prevention and Control Committee, and local Clinical Risk or Patient Safety, Health and Safety and national groups
- Support education and training programme for ANTT® across primary and secondary care
- Report any impact of compliance identified during investigations related to an HCAI, in line with Duty of Quality and Duty of Candour. [29, 30] Assurance around shared learning from such investigation will be reported to the relevant governance, quality, and safety groups.

5.7 Nominated ANTT® Lead will

- Provide local leadership for the roll-out of ANTT®

- Participate in PHW-led all-Wales ANTT® Steering Group to enable sharing of best practice from and within their organisation
- Provide guidance to their organisation on future developments, e.g., primary care roll out, updated resources, standardised packs
- Ensure that all local training, policies, procedures, and guidelines are ANTT® compliant

5.8 Nominated Key-Trainers/Facilitators from each clinical area or professional group will:

- Facilitate completion of All Wales ANTT® e-learning training by all HCWs involved in aseptic processes
- Provide supplementary electronic/paper ANTT® training and competency assessment to relevant staff within their department
- Keep accurate records of staff trained
- Instil a culture for asepsis and of ANTT® practice across their clinical area/professional group
- Ensure compliance with ANTT® practice is achieved, challenging unsafe practice appropriately
- Maintain own compliance with ANTT® competence and practice
- Identify and support additional resources needed for compliance with ANTT® key principles
- Identify and address challenges and share areas of good practice via the Quality, Safety and Experience structures

5.9 Procurement Leads

Prior to purchase of any re-usable patient equipment, discussion must take place with manufacturers, local infection prevention and control leads, and local decontamination leads, where applicable, to ensure that such items can be safely decontaminated within the organisation. Equipment in use is required to facilitate ANTT® e.g., insertion packs, trays, trolleys. These should be made readily available and accessible across the organisation. There should be rationalisation and standardisation of equipment choices across Wales to help reduce practice variation in aseptic technique.

5.10 Higher Education Institutes (HEI):

Universities across Wales will work to standardise their curriculum regarding teaching and learning competencies in ANTT® for all healthcare professional students e.g., nursing, medical, podiatry, paramedics, and allied health in respect of ANTT®, at the point of registration.

6. Implementation of ANTT®

The implementation of ANTT® will require:

- Executive level commitment
- A robust ANTT® training and assessment programme
- Equipment and appropriate resources
- Raising ANTT® awareness across the whole organisation
- A locally agreed ANTT® audit programme

- External audit programme, as agreed with ASAP and HARP, PHW
- Robust monitoring and recording processes for compliance
- Key reporting mechanisms on impact or harm

6.1 ANTT® Accreditation for Healthcare Providers:
ANTT Accreditation Guide 2023 (PHW NHS. Wales) overseen freely by ASAP, provides healthcare organisations with a mechanism to demonstrate effective clinical governance for aseptic technique, and commitment to infection prevention and patient safety. This can be useful to demonstrate an organisations hard work in infection prevention to external regulators, patients/service users, and the public.
There are three levels of accreditation: Bronze, Silver, and Gold.

- ANTT Bronze Accreditation Workbook
- ANTT Silver Accreditation Workbook
- ANTT Gold Accreditation Workbook

Accreditation criteria is based upon the following pre-requisites for safe and best practice:

- ANTT® Policy
- ANTT® Education
- ANTT® Assessment
- ANTT® Monitoring

For support with ANTT® Accreditation please contact enquiries@antt.org

7. Training:

Wales commenced ANTT® programme roll out in June 2015(WHC/2015/026) [19] Substantial progress has been made across Wales despite limited resources to support this; however, all organisations are required to continue to aim for 100% compliance for those who will be performing procedures (regardless of job title) requiring the principles of aseptic technique.
As new employees join the organisation, compliance with ANTT® should be mandated as part of their induction programme.

Priority for training should be given to staff working within augmented care units, staff carrying out invasive procedures, and all new employees.

Professional registrants must recognise their accountability in accordance with their own code of conduct,[8,12] e.g. The Code (Nursing and Midwifery Council 2015)[12] states that nurses must have a good knowledge base before performing any clinical procedure, should be trained appropriately, and have achieved competency within their clinical area. The General Medical Council (Good medical practice-English 2014 (gmc-uk.org))[8] states that doctors must recognise and work within the limits of their competence, provide good standards of practice of care and keep professional knowledge and skills up to date.

- All HCWs across Wales who are involved in aseptic procedures will complete the nationally agreed ANTT® training in the principles and theory for ANTT® prior to competency assessment i.e., current e-learning module at learning@ NHS Wales: https://learning.wales.nhs.uk/
- ANTT® will also be taught locally within departments by means of trained key-trainers/facilitators/assessors, using ANTT® resources: ANTT resources (antt.org) within an implementation framework set out by the local organisation
- All taught procedures involving asepsis will be undertaken using ANTT®
- All HCWs performing ANTT® must be assessed as competent in the application of ANTT® utilising either the Standard ANTT® Competency Assessment tool (CAT) Standard CAT v1.5 or the Surgical Assessment tool Surgical CAT v2
- It is recommended that ANTT® competency assessment should be undertaken within 3 months of completing the ANTT® e-learning programme
- HCW's performing aseptic procedures must maintain their ANTT® competency with at least three-yearly practical competency assessment, monitored via local annual appraisal process and entered to ESR
- HCW's have an individual responsibility to ensure their competencies are maintained and must inform their line manager of any obstacles preventing them to achieve this, or lapse in competency
- Should a HCW change specialties or commence a new post within the HB/Trust requiring competence in different skill sets, the need for further ANTT® training/assessment must be risk assessed and agreed with their line manager. Advice can be sought from the local ANTT® Lead

For staff who are unable to access ANTT® eLearning programmes through either ESR or Learning@Wales, arrangements need to be made for electronic/paper educational resources, which must include the main principles of ANTT®.

It is acknowledged there remains a period of time when not all staff performing aseptic technique will have undergone the appropriate training and assessment in ANTT®. Therefore, existing aseptic practice skills, may be used to ensure service delivery is not affected, following individual local risk assessment with intention of becoming compliant as soon as practically possible.

8. Important basic infection prevention practice for aseptic technique:

This resource is not intended as a comprehensive educational tool, however, as well as providing an outline of the ANTT® Framework (see

appendix 9), some important general aspects of aseptic technique are outlined below.

8.1. Use of Standard Infection Prevention and Control Precautions (SIPCP) such as hand hygiene:

A pre-requisite to safe ANTT® is compliance with standard infection control precautions (SICP's):

SICPs should be performed in line with epic3 Guidelines[9] and the Scottish National Infection Prevention and Control Manual (NIPCM)[2] which is the resource adopted for use for healthcare in Wales. The 10 elements of SICP are:

- Patient Placement
- Hand Hygiene
- Respiratory cough and Hygiene
- Personal Protective Equipment
- Safe management of care equipment
- Safe management of care environment
- Safe management of linen
- Safe management of blood and body fluid spillages
- Safe disposal of waste
- Occupational safety: Prevention and Exposure management (e.g., sharps)

Key elements related to ANTT practice are hand hygiene, safe care of equipment and the environment, appropriate safe use of PPE and waste disposal.

8.2. Hand Hygiene

Hand hygiene is the single most effective way of preventing HCAI and cross infection from direct and indirect contact.[2,9,21] It is essential that hands are effectively decontaminated in accordance with the World Health Organisation (WHO) "MY five Moments of Hand Hygiene"[21] WHO SAVE LIVES Clean **YOUR** Hands. Technical Reference Manuel 2009 prior to, during (as required) and after all aseptic procedures are performed.

8.3. Use of personal protective equipment (PPE)

Gloves and other PPE provide a barrier between microorganisms on hands, clothing, and the susceptible sites but must be used in conjunction with good hand hygiene and donning and doffing technique.

Gloves use for ANTT:

- Must be donned and used as intended, changed at appropriate frequency and between procedures, and removed with care to prevent shedding or spreading of microorganisms
- Are **non-sterile** gloves for Standard-ANTT® procedures e.g., preparing and delivering intravenous medication, attaching

parenteral nutrition, venepuncture, and cannulation, as per local policies
- Are **Sterile** gloves for Surgical ANTT® procedures such as surgery, urinary catheterisation, or central venous catheter insertion

Aprons and Other PPE (aprons, gowns, masks, face protection) should be worn according to NIPCM and associated infection.

8.4. Environmental / Air contamination

Airborne particles in the clinical space will contain a range of microorganisms including those from the patient/service user, staff, and other sources. These have increasingly been shown to present a risk of transmission of a range of infections. Sensible precautions can be taken to reduce the risk of particle contamination of the aseptic site during ANTT procedures including:

- Preparation of drugs to be undertaken in an appropriate designated area away from the bedside and sink
- Where available, ANTT procedures i.e., changing of wound dressings, insertion of medical devices should be undertaken in a dedicated fit for purpose treatment/dressing/examination room away from the patients' bed area
- Do not undertake ANTT® when air particle movement levels are likely to be at their highest e.g., ward/department cleaning, adjacent to portable electric fans or close to open windows or building refurbishment
- Do not undertake ANTT® following recent bed making or patient undressing/dressing
- Advise patient of cough/sneeze etiquette e.g., use of tissues

8.5. Pre-requisite support of effective aseptic technique

The risk of microbiological contamination during ANTT® procedures can be reduced by important pre-requisite measures including:
- Effective environmental cleaning
- Safe storage of procedure equipment
- Compliance with decontamination procedures and policies
- Ergonomically designed clinical preparation areas
- Rationalisation and standardisation of procedure and equipment choices e.g., procedure packs, trays

8.6. Emergency ANTT

For WAST frontline emergency staff, including advanced paramedic practitioners, paramedics, advanced technicians, technicians, urgent care services staff, sub-contracted emergency staff, non-NHS organisations, Bank, and agency frontline staff.

The use of ANTT® is widespread within acute hospitals, yet ANTT's simple but robust practice principles are equally effective in the most challenging

and emergency situations and environments. Emergency life-saving time-critical procedures undertaken in the out of hospital environment justify reason for reduced compliance with all the principles of ANTT® and therefore Emergency ANTT® is the pragmatic approach to ANTT®, focusing specifically on:

- What is possible to deliver at that moment
- Prioritise the points at which 'Key-Parts' and 'Key-Sites' interact (the moments microbes can transfer)
- Dynamic risk assessment to determine preparation steps, and if they cannot be delivered, the most essential components of aseptic technique are prioritised first
- Recording the ANTT applied during the procedure e.g., Standard, emergency, surgical

The intention is not to dilute ANTT® or reduce standards, but to focus the practitioners' attention to the most important elements of safe practice first, in relation to time, setting and equipment permitting.

Emergency ANTT® should only be selected following risk assessment of the situation, for example: 'Do I have the time, the equipment, and the environment to apply Standard or Surgical ANTT?'
If the answer is 'yes' – use Standard or Surgical ANTT
If the answer is 'no' – use Emergency ANTT

It is important for the practitioner to document and handover when emergency ANTT is used and clarify if asepsis was maintained or compromised due to the 'emergency' situation. WAST have introduced the ANTT coded colour labels, which will be applied to any invasive procedures performed to alert receiving staff of ANTT procedures used (see Appendix 7).

9. ANTT Resources

9.1. ANTT® Procedure Guidelines

These simple picture-based procedure guidelines are a highly effective way for the organisation to make practice expectancy explicit, setting out procedure sequence and equipment. They should be displayed prominently in relevant clinical areas.

9.2. ANTT Approach Educational PowerPoint

'The ANTT-Approach' is an International Campaign designed to promote the essential elements of aseptic technique. This approach is a three-way 'partnership' between patients, HCWs and healthcare organisations to actively promote the essential '6 Actions for Safe Aseptic Technique' to be used every time.

Three posters simplify this framework:

- Patient poster – Appendix 3
- Clinical Staff Poster – Appendix 4
- ANTT® Clinical Practice Framework poster – *Appendix 5*

9.3. Steps for ANTT® procedure – see Appendix 2

10. Dissemination and Implementation

This revised and updated policy will be implemented via the following routes:

- Circulation to all Health Board/Trust Executive leads, IPCT leads, WAST leads, Primary & Community Care leads, HCAI DB
- Available via local Health Board/Trust Document library
- Available via PHW/HARP website
- Available to all HCWs via local Health Board/Trust intranet

Each Health Board/Trust is responsible for the full implementation of this revised policy and must ensure all relevant staff have access to the policy.

11. Audit and Monitoring of ANTT® Implementation

Monitoring will be undertaken through:

- The percentage of staff that have completed ANTT® theory and ANTT® Competency Assessments through ensuring records are updated centrally on ESR
- Audit observation of clinical practice and aseptic procedures
- Targeted patient feedback
- Documentation/policy review
- As part of the Improvement Cymru initiatives (Previously known as 1000 plus lives) e.g., bundle use and catheter-associated urinary tract infection (CAUTI) prevention, peripheral venous catheter (PVC) and central venous catheter (CVC) care, prevention of surgical site infection (SSI)
- Identifying impact and compliance levels of ANTT® on investigating HCAI, e.g., *Staphylococcus aureus* bacteraemia or surgical site infection (SSI), CAUTI through root cause analysis (RCA) and post-incident review (PIR)
- Annual IPC rolling programme of audit, including external audit by ASAP or ad hock audits by HARP team
- Target audit programmes, where deemed necessary following incident or outbreak
- Required changes in practice identified and actioned
- ANTT® accreditation

Any 'lessons learnt' should be shared locally and nationally across Wales to support and promote best practice.

12. Policy Conformance / Non-Compliance

If any Health Board employee fails to comply with this policy, the matter may be dealt with in accordance with their workforce and OD polices. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances, failure to follow this policy could be considered gross misconduct.

13. Distribution

The all-Wales policy will be available on the PHW/HARP internet site and via local Health Board/Trust Intranet site. Where staff do not have access to the intranet, their line manager must ensure that they have access to a current paper copy of this policy.

14. Review

This policy will be reviewed every 2 years or if guidance changes.

15. Legislation

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended), Health and Safety Executive, L5 (6th edition) 2013. Welsh Government Health and Care Standards 201529. The 2023 Health and Social Care (Quality and Engagement) (Wales) Act 2020.[30]

16. Equality

An Equality Impact Assessment has been undertaken at an all-Wales level on completion of version 1 (July 2017), Version 2 review (June 2019) and version 3 review (December 2022) with no change required.

A Verification report has been completed for HARP, Public Health Wales to support version 3 (December 2022).

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18. APPENDICES

Appendix 1: Definitions / Glossary

Asepsis
Freedom from pathogenic material in sufficient dose to cause infection.

Aseptic field
A working area that has been rendered aseptic to reduce the risk of contamination of procedure equipment.

Aseptic Technique
A generic term and variable process for describing the precautions taken to reduce the risk of infection during invasive clinical procedures.

Aseptic Non-Touch Technique (ANTT®)
A specific type of aseptic technique with a unique theoretical and clinical practice framework (NICE 2012).

Decontamination
Removing, or killing pathogens on an item or surface to make it safe for handling, re-use or disposal by cleaning, disinfection and/or sterilisation.

Direct contact transmission
Spread of infectious agents from one person to another by direct skin-to-skin contact.

Disinfectant
A cleaning chemical used to remove infectious agents from objects and surfaces.

Disinfection
A process, for example using a chemical disinfectant, to reduce the number of infectious agents from an object or surface to a level that means they are not harmful to your health.

Hand Hygiene (HH)
HH is the single most important procedure for preventing the spread of HCAI. Effective HH is essential to ANTT® and must take place prior to and after all invasive techniques. HH applies to hand washing, antiseptic hand wash, antiseptic hand rub or surgical hand antisepsis.

Healthcare-associated Infection (HCAI)
Any infection acquired by a person as a consequence of healthcare interventions regardless of where care is delivered.

Indirect contact transmission – The spread of infectious agents from one person to another via a contaminated object.

Invasive device – A device which penetrates the body, either through a body cavity or through the surface of the body. Central Venous Catheters (central line), Peripheral/ Arterial Lines and Urinary Catheters are examples of invasive devices.

Invasive Procedures
A medical/nursing procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body cavity.

Microorganism (microbe) – Any living thing (organism) that is too small to be seen by the naked eye. Bacteria, viruses, and some parasites are microorganisms.

Mode of transmission – The way that microorganisms spread from one person to another. The main modes or routes of transmission are airborne (aerosol) transmission, droplet transmission and contact transmission.

MRSA – Strains of the infectious agent (bacterium) *Staphylococcus aureus* that are resistant to many of the antibiotics commonly used to treat infections.

Personal Protective Equipment (PPE)
Equipment a person wears to protect themselves from risks to their health or safety, including exposure to infections e.g., disposable gloves and disposable aprons.

Spore
A form that some types of bacteria take under certain environmental conditions. Spores can survive for long periods of time and are very resistant to heat, drying and chemicals.

Sterile
Free from all live bacteria or other microorganisms.

Sterilisation
The procedure of making some object free of all germs, live bacteria, or other microorganisms (usually by heat or chemical means).

Appendix 2: Steps to an ANTT® procedure

Step 1.	ANTT® risk assessment: Does this procedure need the ANTT® principles applied? Is a Standard or Surgical-ANTT® required? Gain patient's consent and explain procedure Draw curtains around patient or take to appropriate room
Step 2	Decontaminate hands
Step 3	Clean trolley/tray with appropriate detergent wipe Gather equipment including alcohol hand rub
Step 4	Create suitable working environment. If procedure is performed at the bedside, ensure no cleaning or bed making are ongoing within the area for at least 30 minutes. Ensure windows are closed and no fans are on
Step 5	Decontaminate hands
Step 6	Apply single use disposable apron
Step 7	If required open dressing pack/sterile drape
Step 8	Open and prepare all equipment on the tray/trolley. Keep all equipment within their packaging. Identify Key-Parts
Step 9	Decontaminate hands
Step 10	Apply gloves if required
Step 11	Perform procedure using ANTT®
Step 12	Remove gloves and aprons and other PPE
Step 13	Dispose of waste
Step 14	Decontaminate hands
Step 15	Take patient back to the bedside if required and ensure patient is comfortable
Step 16	Clean trolley/tray/environment
Step 17	Decontaminate hands

Appendix 3: ANTT® Patient Poster

Protecting YOU Every Time with...
4 Actions for Safe Aseptic Technique

The ANTT-Approach

***Aseptic Technique** describes the measures we take to protect you from infection during invasive clinical procedures, such as surgery, insertion of medical devices and administration of intravenous medications. ANTT is a unique type of aseptic technique (NICE 2012).*

1 **Hand Cleaning**

We clean our hands immediately prior to commencing your procedure, and use protective equipment like gloves

2 **Using Aseptic Fields**

We protect procedure equipment from microorganisms by using a cleaned procedure tray and individual equipment covers or, for more complex procedures, use a sterilized drape

3 **Using Non-Touch Technique**

We avoid touching the 'Key-Parts' of procedure equipment & any open wound or procedure skin site. If we must touch them we wear sterilized gloves

4 **Preventing Cross Infection**

We remove our gloves and wash our hands immediately after we have tidied up your procedure

If you have questions or concerns about aseptic technique please ask the nurse in charge

www.antt.org

ASAP The Association for Safe Aseptic Practice

ANTT Aseptic Non Touch Technique

MRSA Action UK

Appendix 4: ANTT® Clinical Staff Poster

ASAP The Association for Safe Aseptic Practice

ANTT Aseptic Non-Touch Technique

MRSA Action UK

Appendix 5: ANTT® Clinical Practice Framework Poster:

ANTT®
Aseptic Non Touch Technique

www.antt.org

Aseptic Non Touch Technique
The ANTT Clinical Practice Framework
...for all invasive Clinical Procedures from Surgery to Community Care

Essential Theory Applied to Practice

First, do no harm

Copyright © 2015 The Association for Safe Aseptic Practice (The-ASAP) ANTT® All rights reserved. V4.0

Appendix 6: Example template for Ambulance Staff: Peripheral Cannulation Guideline (2017)

Appendix 7: Emergency ANTT Risk Assessment

Emergency-ANTT® Risk Assessment

It is important that emergency ANTT® is only selected when necessary

Decided by risk assessment ...

"Do I have the time, the equipment and the environment to apply Standard or Surgical-ANTT?"

If yes – use Standard or Surgical-ANTT

If no – use **Emergency-ANTT ®**

Document and handover whether you used Emergency-ANTT® and maintained asepsis, or had to use Emergency-ANTT and may have compromised asepsis

ANTT

ANTT® ©2016 www.antt.org enquiries@antt.org

Use of colour coded labels to alert receiving healthcare staff of ANTT procedure used:

Red Label applied to the procedure site. **ANTT not performed in optimal conditions. Date.**

ANTT not performed in optimal conditions ..../..../....

Green Label applied to the procedure site. **ANTT performed in optimal conditions. Date.**

ANTT performed in optimal conditions ..../..../....

Appendix 8: Standard Terminology

Aseptic technique is historically confused with ambiguous terms used interchangeably. The ANTT® Practice Framework defines aseptic practice explicitly:

- ***Sterile Technique***

ANTT® does not use the word "sterile" for describing technique; due to the natural multitude of organisms in the atmosphere, it is not possible to achieve a true sterile technique in any setting. The term sterilized is used to identify products and equipment that have been sterilized. However, once opened to air equipment and products are said to be aseptic.

- ***Asepsis / Aseptic technique***

The term 'asepsis' means, '*Freedom from pathogenic material in sufficient quantity to cause infection*'. It is possible to achieve asepsis in health care delivery by taking steps to reduce patient contamination. Aseptic technique is a generic term for aseptic practice and has no explicitly defined practice framework.

- ***Aseptic Non-Touch Technique (ANTT®)***

ANTT® is a specific type of aseptic technique with a unique theoretical and clinical practice framework.[10,11,12] The ANTT® Practice Framework includes a set of Principles and Safeguards that, if followed, will ensure asepsis for all types of invasive procedures 'from the operating theatre to the community setting'. It is based on a novel concept termed 'Key-Part and Key-Site Protection'.

The 'ANTT-Approach' involves a combination of methods aimed at achieving and supporting best practice aseptic technique; including the ANTT® Practice Framework, a set of ANTT® Guidelines for the most common invasive procedures and a standard implementation process.

- ***Non-Touch Technique***

Non-touch technique is not a technique in itself. It is however an important component of ANTT®.

Appendix 9: ANTT® Practice Framework outline

This model policy is not intended as an educational tool for ANTT®. It is important that Practice Leads refer to the full ANTT® Practice Framework available on the www.antt.org or Public Health Wales on ANTT Framework
A snapshot of the framework is outlined below:

- The aim of ANTT® is always asepsis (see appendix 8)
- **Key-Parts** are the critical parts of any equipment that come into contact with Key-Sites; any liquid infusion; or with any other active Key-Parts connected to the patient via a medical device. If contaminated during a procedure, Key-Parts provide a route for the transmission of pathogens onto or into the patient and present a significant infection risk.
- **Key-Sites**: open wounds, including insertion and puncture sites for invasive medical devices.
- **There are two types of ANTT® (Surgical and Standard) determined by a simple ANTT® Risk Assessment:**
- **Standard-ANTT®** is used for procedures that are technically simple to achieve asepsis. Typically, such a procedure will be of short duration and involve few small Key-Parts and Key-Sites. In Standard-ANTT, primarily non-touch technique and individual Micro Critical Aseptic Fields protect Key-Parts.
- **Surgical-ANTT®** is required for procedures that are technically complex to achieve asepsis, are of longer duration, involve large open-sites and large or numerous Key-Parts. In contrast to Standard-ANTT, in Surgical-ANTT, Key-Parts are managed on one main Critical Aseptic Field (sterile drape) and sterile gloves are essential.
- **Aseptic Fields in ANTT®**: the type of aseptic field and how it is managed is dependent upon the type of ANTT® being utilized.

ANTT® uses three types of aseptic field:

✓ **Critical Aseptic Field:** a large sterile drape that is managed 'critically'
✓ **Micro Critical Aseptic field:** sterilized caps and covers etc. including the inside of some equipment packaging
✓ **General Aseptic Field**: A disinfected plastic tray, suitable sized single-use cardboard tray. NB: General Aseptic Fields are not relied upon to maintain asepsis. They are used to promote asepsis whilst Key-Parts within them are protected by Micro Critical Aseptic Fields. (See above).

A pre-requisite to safe ANTT® is compliance with standard infection prevention and control precautions:

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

TRUST BOARD

TRUST WIDE POLICIES UPDATE

DATE OF MEETING	26 September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR NOTING
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Trust Board regarding the status of the Trust wide policies and to advise of those that have been approved during the period **August 2024 to September 2024.**
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the policies that have been approved during the period **August 2024 to September 2024.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	05/08/2024 and 29/08/2024
Quality, Safety and Performance Committee	12/09/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board **ENDORSED** the following policies:

- IPC 03 – Model Policy Aseptic Non-Touch Technique (ANTT)
- WF 30 – PADR Policy
- WF 18 – Alcohol, Drugs and Substance Misuse Policy
- WF 22 – Professional Registration Policy
- People Development Policy – New Policy
- PP02 – Security Policy
- QS02 – Management of Safety Alerts and Important Notifications Policy

The Quality, Safety and Performance Committee **APPROVED** the following policies:

- PP02 – Security Policy
- QS02 – Management of Safety Alerts and Important Notifications Policy

The Quality, Safety and Performance Committee **ENDORSED** the following polices for Trust Board Approval. These policies are on the main Trust Board agenda as item 7.1.6:

- People Development Policy – New Policy
- WF 30 – PADR Policy
- WF 18 – Alcohol, Drugs and Substance Misuse Policy
- WF 22 – Professional Registration Policy
- IPC 03 – Model Policy Aseptic Non-Touch Technique (ANTT)

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
Appendix 1	PP02 – Security Policy
Appendix 2	QS02 – Management of Safety Alerts and Important Notifications Policy

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy and Procedure for the Management of Trust wide Policies and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the Consent Agenda.

1.2 The purpose of this report is for the Trust Board to note the policies that have been through the Trust governance process and approved during the period **August 2024 – September 2024.**

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Since the last Trust Board, the Quality, Safety and Performance Committee **APPROVED** the policies below, which have been uploaded to the Trust Intranet and Internet site and circulated via the policy distribution list for immediate implementation.

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
PP02 – Security Policy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	12/09/2024	**2**
QS02 – Management of Safety Alerts and Important Notifications Policy	Executive Director of Nursing, AHPs and Health Scientists	Quality, Safety & Performance Committee	12/09/2024	**3**

3. IMPACT ASSESSMENT

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

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Non-compliance could result in significant costs due to legal challenges, fines and prosecutions against the Trust.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Each policy will be individually assessed to ensure compliance with EIA requirements.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not complying with Trust policy and procedure can result in legal challenges from staff at Employment Tribunal.

	Not complying with legislative requirements could result in fines and prosecutions against the Trust from respective government agencies.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**

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

Ref: PP 02

SECURITY POLICY

Executive Sponsor & Function:	Director of Strategic Transformation, Planning, Performance and Estates
Document Author:	Interim Assistant Director of Estates, Environment and Capital
Approved by:	Planning and Performance Committee
Approval Date:	12 September 2024
Date of Equality Impact Assessment:	17/05/2024
Equality Impact Assessment Outcome:	Approved
Review Date:	September 2027
Version:	2

Introduction

1. Policy Statement

1.1 The Velindre University NHS Trust Board recognises its exemplar role both as an employer and as a service provider. Velindre NHS University Trust (the 'Trust') is committed to creating, as far as reasonably practicable, a safe and secure environment for patients, donors, staff and visitors and also to protect people, property, equipment and assets against risk of injury, loss or damage whilst on Trust premises.

1.2 So far as is reasonably practicable, the Trust will ensure that security does not compromise safe means of escape in the event of fire or other emergency through assessment of risk.

1.3 The Trust is committed to working in partnership with staff, trade unions and outside agencies, such as the police, to achieve the aims of this policy.

2. Purpose

2.1 To ensure a safe and secure environment is provided for Trust service users, patients, donors, visitors and staff whilst on Trust premises or working on behalf of the Trust.

2.2 To provide a secure environment for property, equipment and assets of the Trust.

3. Scope

3.1 The Security Policy covers all areas within the Trust;

- patients, donors and visitors
- employees
- contractors
- property and equipment of the Trust
- personal property on Trust premises ("Trust premises" defined as "any premises either owned or leased by Velindre University NHS Trust, Divisions or Hosted bodies")
- volunteers

4. Aims and Objectives

4.1 The aim is to provide a safe and secure environment for patients, donors, staff and visitors within Trust premises and to provide a secure environment for property, equipment and assets of the Trust.

4.2 This Policy aims to be an overarching policy all Divisions and hosted organisations will implement procedures to support this policy. The policy is deemed to set the minimum requirements.

4.3 Objectives; to prevent/minimise the number of incidents relating to;

- Violence and Aggression (physical or verbal)
- Criminal Damage
- Theft (from Trust premises or of Trust property)
- Arson

4.4 To provide safe and secure working environments, taking into account the need for safe means of escape in the event of fire or other emergency.

4.5 To fulfil the Board's legal duty of care to all its employees, patients, donors and others to provide a safe working environment.

5. Roles and Responsibilities

5.1 Executive Lead

The Chief Executive has overall responsibility and is accountable to the Trust Board for the management of Security within the organisation.

The responsibility for policy implementation rests with the Director of Planning, Performance and Estates.

The Director of Strategic Transformation, Planning, Performance and Estates, through delegated powers, shall ensure that all employees, patients, donors and others are aware of the policy and of their role in its implementation and monitoring.

5.2 Trust Policy Review

The Assistant Director of Estates, Environment and Capital Development is the Trust lead for the review of this document.

5.3 Divisional Directors / Hosted Bodies

The Divisional Directors and Directors of Hosted bodies within the Trust are responsible for ensuring:

- policy is implemented within their Divisions.
- a responsible person is identified to manage security on a day to day basis and appropriate training given where necessary.

5.4 Departmental Managers

Departmental managers within the Trust will ensure:

- employees within their team will be aware of the Trust Security policy and any Divisional security procedures.
- assessments of security risks present within their areas of responsibility.
- relevant training responsibilities of staff are fulfilled.

- engage with the operational Teams and instigate (6 monthly) security audits and implement action plans derived from said audits.
- reasonable precautions, through risk assessment and taking appropriate action, to protect the Trust's staff, service users, patients, donors, visitors, contractors, property, equipment and assets.
- empower employees to raise any issues of security concerns or breaches of current security systems.

5.5 All Staff

- responsibility of all employees to adhere to this policy and the divisional operational procedures to which they refer to.
- responsibility to ensure security of the areas within which they work by closing windows and locking doors as necessary when the area is not in use.
- must take reasonable precautions to safeguard the Trust's staff, service users, donors, patients, visitors, contractors, property, equipment and assets.
- assist with any security investigation and engage and assist with any management security audits.
- aware of their own circumstances and report any security concerns to line managers.

6 Content for Divisional Procedures

The following areas will need to be addressed within all divisional procedures;

6.1 Site Security

6.1.1 Risk assessments completed to ensure that staff, patients, donors, visitors, property, equipment and assets of the Trust are not put at risk during the normal operational activities of the Trust's services.

6.1.2 Risk assessments completed to ensure that staff, patients, donors, visitors, property, equipment and assets of the Trust are not put at risk during exceptional circumstances of operational activities of the Trust's services.

6.1.3 All areas of the Trust should be risk assessed by a competent person/s in order to identify any security related risks. It is the responsibility of the service divisions to ensure security risks are assessed and review the appropriate and effectiveness of security in relation to security procedures.

6.1.4 When completing a risk assessment, the following risks should be considered. *(This is not an exhaustive list)*

- Points of ingress and egress
- Keypads /Key Locked / Access controlled doors
- Identification and visitor badges

- Security procedure and protocol for incidents / breaches
- Intruder alarms
- Intercom
- Security lighting
- Closed circuit television (CCTV)
- Sound maintenance practices
- Maintaining security during normal operational hours
- Securing the site/departments safely after operational department requirements have been completed.
- Security requirements specified by regulatory authorities e.g. NRW

6.1.5 Notices to deter criminal activity and dissuade persons from intimidating, threatening or violent behaviour are recommended. Signs concerning security measures must be prominently displayed in buildings and grounds, in particular reference to when CCTV is in operation, all signage produced should be bi-lingual.

6.1.6 No staff, unless trained to do so, should confront unauthorised persons on any premises. Personal safety is paramount.

If it is suspected that an intruder is on the premises or that a theft is being committed, staff should seek assistance or remove themselves to a safe area and inform the police immediately, contacting their manager where appropriate. Advice on any other or further action to be taken will be provided by the police.

6.1.7 Security of Unoccupied Offices/Departments - areas that are in use for only part of the day must have a visual check made that the building is secure before it is vacated and intruder systems correctly armed. The use of blinds and similar equipment will keep property out of obvious view to a prospective thief. Managers must encourage members of staff to use drawers and cupboards to place items out of site and temptation.

6.2 Security of possessions

6.2.1 Staff

The Trust cannot accept responsibility for the security of personal belongings on the premises. Staff are advised that personal belongings of a valuable nature should not be brought onto the trust premises.

All offices should be locked when not in use and all personal items should be removed from surfaces.

In some areas secure (locked) lockers will be available to staff to use and these will be managed locally by individual departments.

6.2.2 Patients / Donors

Patients (Velindre Cancer Centre), whose admission is planned must be told not to bring items of value into the hospital. If on arrival, patients are in possession of items of value they must be requested to ask a relative to take them home.

In the event that a patient / donor wish to deposit items of value with the Trust, a detailed record of the items must be completed and the items must be taken to a secure area as soon as possible. The Trust then accepts responsibility for this property unless the patient / donor are made aware otherwise.

6.3 Security of Equipment off Trust Premises

The Trust's property and equipment must only be removed from site for legitimate purposes e.g. for repair, transfer to another Trust premises or to facilitate fulfilment of the Trust's business.

Managers must ensure that any property or equipment removed from Trust facilities or being used on other sites, must be handled and transported with reasonable care and must be kept and stored in a secure environment. All members of staff must take reasonable security measures to prevent theft and or damage to Trust property, accidental or otherwise.

Departmental Managers should ensure staff understand the importance of securely transporting and storing Trust equipment while working remotely and always adhere to the Trust guidelines. To avoid thefts of IT Equipment and misuse staff must not leave equipment in unattended vehicles or in public spaces.

6.4 Storage

Division or departments that hold stores / stock must have procedures that effectively and actively manage the prevention of theft, damage or sabotage.

There must be regular stock audits, as defined by the manager responsible for the area or as dictated to by current departmental procedures, of stock, for high value or high-risk items.

6.5 Possession of Illegal substances

The Trust has a duty under the Misuse of Drugs Act 1977 (and subsequent Amendments) to ensure that its premises are not used for the illegal supply, use or possession of any controlled or illicit substance.

In relation to employees of the Trust please refer to the Trusts policy on Substance Misuse at Work.

6.6 Weapon Possession

There is no justification for any person on the Trust's premises to be in possession of a weapon. Safety is the first concern and no member of staff, unless trained to do so, should challenge or confront a person who is suspected of possessing a weapon.

Members of staff must remove themselves to a safe area and contact the police immediately.

6.7 Key Handling / Access Systems

Managers are to ensure robust, recorded and auditable systems are in place in relation to the management of existing and the provision of new key / access swipe cards.

Where digital or coded keypad door locks are fitted managers must ensure that the code entry is changed at regular risk assessed intervals.

6.8 Future Security Design

All new significant schemes shall be designed to comply with current Health Building Notes (HBN's) for Velindre Cancer Centre, and the principals of "*Secure by Design" and NRW requirements,* for non-hospital facilities.

6.9 Identity Badges

The policy requires that;

- identity badges must at a minimum contain a photograph of the member of staff, their name and be integrated into a managed computer data base system.
- badges are to be worn at all times and be clearly visible.
- refusal or consistent failure to display identification badges whilst in the work place may result in the instigation of the Trust's disciplinary code.
- lost badges must be reported immediately to the manager.
- when not being worn, identity badges must be stored securely and taken home after the end of the work shift
- all personnel are provided with a badge and that all new starters are immediately issued with an identity badge.
- It is crucial to implement the correct badge identification policy across Trust premises while always respecting the patient experience.
- Managers will ensure that staff leaving the Trust/Division will have their identity badge, swipe cards and keys returned.

- the use of visitor's books or temporary visitors' identification badges should be used where appropriate.
- contractors employed to work on Trust premises must undertake a full contractor's induction and wear appropriate identification badges in line with local procedures and returned upon completion of works (daily or otherwise stated).

6.10 **Arson –** *Further guidance provided in Fire Prevention and Arson Prevention protocol*

All cases of suspected arson must be reported immediately to;

- The Police and Fire Service who will investigate
- Divisional Director
- The Fire Safety Manager

6.11 **Assault**

Acts of physical or verbal assault on members of staff, patients, donors, visitors and any other persons on Trust premises will not be tolerated (Trust's Violence and Aggression Policy and the Domestic Abuse Policy). The Trust fully supports and endorses the involvement of the police.

Employees accused of the above will be subject to investigation under the Trusts Disciplinary code along with potential criminal investigations.

6.12 **Criminal Damage**

The Trust maintains the right to actively pursue those individuals that inflict criminal damage to their property or equipment where the offender can be identified.

6.13 **Out of Hours**

The Trust requires all sites to have out of hour's procedures in place, to deal with incidents relating to Trust premises, staff, equipment and key holding functionality to buildings.

7 Equality

7.1 The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

7.2 The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or

civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

7.3 The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

8 Training

8.1 Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Divisional Nurse, Departmental Manager, Head of Nursing and Head of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

8.2 Training must include equality and diversity training for managers, to highlight the risk of stereotyping in the workplace and service provision.

9 Resources

9.1 The implementation and management arrangements associated with this policy do not present any significant resource implications to the Trust.

10 Implementation

10.1 This policy will be maintained by the Planning, Performance and Estates Department.

10.2 Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

11 Audit and Monitoring

11.1 The Planning, Performance and Estates Department will review the operation of the policy as necessary and at least every 3 years.

12 Policy Conformance / Non-Compliance

12.1 If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

13 Distribution

13.1 The policy will be available via the Trust Intranet Site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

14 Review

14.1 The Assistant Director of Estates, Environment and Capital Development will review the operation of the policy as necessary and at least every 3 years.

15 Legislation

15.1 The major piece of legislation in terms of security is the Health & Safety at Work Act 1974.

The employer is criminally liable if they fail to protect employees whilst at work. As such the Division is required to provide 'reasonable' security arrangements for all staff.

16 Further Information

16.1This policy is supported by the following Trust Policies / protocols;

- Violence and Aggression Policy
- Health, Safety and Welfare Policy
- Business Continuity and Emergency Planning Policy
- Fire Safety Policy
- Reporting Incidents and Investigation Policy
- Data Protection and Confidentiality Policy
- Lone Working Policy
- Information Governance Policy
- Substance Misuse at work Policy and Procedure
- Domestic Abuse Policy
- Bomb Threats and Suspicious Packages protocol
- Fire Prevention and Arson Prevention protocol

16.2 Further information and support is available from the Assistant Director of Estates, Environment and Capital Development on 02920 316272**.**

17 References

17.1 HBN's – *Health Building Notes*

17.2 "*Secure by Design"* - Secured by Design has been cited as a key model in the Office of Deputy Prime Minister's guide *'Safer Places - The Planning System & Crime Prevention'* and in the Home Office's *'Crime Reduction Strategy 2008-11'*.

Canolfan Ganser Felindre
Velindre Cancer Centre

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Welsh Blood Service
Gwasanaeth Gwaed Cymru

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:	12 September 2024
Date of Equality Impact Assessment:	NA
Equality Impact Assessment Outcome:	NA
Review Date:	January 2025
Version:	2

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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 Executive 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
- Welsh Health Circulars
- 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. Velindre University NHS Trust Integrated Quality and Safety Group

The Trust Integrated Quality and Safety Group meet on a monthly basis and are responsible for overseeing the alerts and notification process, ensuring actions are implemented as per the appropriate action plans. Areas of non-compliance are reviewed and referred to an appropriate management group for further review and to determine mitigation actions. The Group, through its chair, will seek assurance that all alerts are appropriately managed in an effective and timely manner.

As well as managing externally created alerts, the Trust has developed its own system for sharing internal safety alerts to make staff aware of particular issues arising from concern and incidents learning outcomes.

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 / committee
Patient safety alerts	**Velindre Cancer Service** Head of Nursing Quality and Safety Manager / VCS Quality and Safety Manager	Quality and Safety Department	Trust Integrated Quality and Safety Group/Quality, Safety and Performance Committee
Patient safety notices	**Velindre Cancer Service** Head of Nursing Quality and Safety Manager / VCS Quality and Safety Manager	Quality and Safety Department	Trust Integrated Quality and Safety Group/Quality, Safety and Performance Committee
Ministerial Letters	Board Secretary	Governance Department	Executive Board & Quality, Safety and Performance Committee
Pharmaceutical Alerts	**Velindre Cancer Service** Head of Pharmacy / Responsible Pharmacy technicians **Welsh Blood Service** Health, Safety and Environmental Compliance Manager / Head of Nursing	Pharmacy Department	Trust Integrated Quality and Safety Group / Medicine Management Group
Product Recalls and Manufacturer/Field Safety Notices	**Velindre Cancer Service** Head of Estates **Welsh Blood Service** Health, Safety & Environment Manager	Estates Department / Health and Safety	Planning & Performance Committee/Trust Health & Safety Management Group/Integrated Quality and Safety Group
Estates and Facilities Alerts	**Velindre Cancer Service** Head of Estates **Welsh Blood Service** Health, Safety & Environment Manager	Estates Department /Health and Safety	Planning & Performance Committee/Trust Health & Safety Management Group/Integrated Quality and Safety Group

Medical Device Alerts	**Velindre Cancer Service** Medical Physics lead **Welsh Blood Service** Health, Safety & Environment Manager	Medical physics	Integrated Quality and Safety Group / Infection Prevention and Control Management Group/Trust Health and Safety Management Group
Welsh Health Circulars	**Velindre Cancer Service** Head of Nursing Quality and Safety Manager / VCS Quality and Safety Manager **Welsh Blood Service** Health, Safety & Environment Manager	Quality and Safety Department	Trust Integrated Quality and Safety Group/Quality, Safety and Performance Committee
Security Alerts	**Velindre Cancer Service** Head of Estates **Welsh Blood Service** Health, Safety and Environment Manager	Estates Department	Planning & Performance Committee/Trust Health & Safety Management Group
Healthcare Inspectorate Wales Reports	Head of Quality and Safety Department	Quality and Safety Department	Integrated Quality and Safety Group / Quality, Safety and Performance Committee
Regulatory agency reports e.g., Health and Safety Executive, Fire authority, Human Tissue authority	Head of Quality and Safety Department	Quality and Safety Department	Integrated Quality and Safety Group / Quality, Safety and Performance Committee
Accreditation visit reports	Head of Corporate Governance	Corporate Governance Department	Quality, Safety and Performance Committee
Internal Safety Notices (Health and Safety)	**Velindre Cancer Service** Head of Nursing Quality and Safety Manager / VCS Quality and Safety Manager **Welsh Blood Service** Health, Safety & Environment Manager	Health and Safety Department	Trust Health & Safety Management Group/Local Groups

Internal Safety Notices (Patient Safety)	**Velindre Cancer Service:** Head of Nursing Quality and Safety Manager **Welsh Blood Service** Health, Safety and Environment Manager	Quality and Safety Department	Quality, Safety and Performance Committee
Professional Regulatory Alerts	HR Officers Medical/Clinical Directors	Velindre Cancer Service/Welsh Blood Service/Divisions/Hosted Organisations	Workforce & Organisational Development Committee

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TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE PRIVATE REMUNERATION COMMITTEE

DATE OF MEETING	5 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Prof Donna Mead OBE, Velindre University NHS Trust Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Private Remuneration Committee on 05.09.2024.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There are no items for escalation to the Trust Board.
ADVISE	There are not items to advise to the Trust Board.
ASSURE	There are no items for assurance for the Trust Board.
INFORM	The Remuneration and Terms of Service Committee took the following actions: • **APPROVED** a change in pay band for the Chief Executive Officer post, following a review carried out by Welsh Government. • **APPROVED** the application of a consistent process, from 1st September, in respect of the back dating of re-evaluation outcomes for staff on the Executive and Senior Manager Pay scale to address inconsistency in the process. • **APPROVED** the appointment of the Interim Director of Corporate Governance. • **NOTED** the actions to be taken following a lessons learnt exercise in respect of a payment made.
APPENDICES	N/A.

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

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Velindre University NHS Trust

TRUST BOARD

CHARITABLE FUNDS COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
SACT	Systematic Anti Caner Therapy
BTS	Blood Transfusion Service
BBMDA	British Bone Marrow Donor Appeal

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Charitable Funds Committee at its Public meeting held on the 5th September 2024.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Charitable Funds Committee (CFC) held on the 5 September 2024:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**FUNDRAISING** **Director Update Report -** Terms and Conditions for Challenge Events being reviewed to ensure risks continue to be minimised. The Charitable Funds Committee were informed of the Fundraising progress to date and future events in the pipeline. The Charitable Funds Committee **APPROVED:** • The President Lunch. • The High Value Supporter Lunch / Dinner proposal subject to development of a governance framework and set of principles (to be approved by Charitable Funds Committee) on alignment of the Velindre Brand and businesses it chooses to enter a relationship with. • The change of numbers for the Summit to Sea Bike Ride proposal, resulting in a slightly higher cost but still resulting in a 2:1 return. **FINANCIAL POSITION** The Charitable Funds Committee **NOTED** the contents of the finance report and in particular: • The financial performance of the Charity for the period ending 31st July 2024. • The current position and performance of the Charity's investment portfolio as at 31st July 2024. The Charitable Funds Committee were informed of the large increase in funds which is mainly due to FAKTION monies, for which it was agreed an investment strategy will be produced. A paper is being taken to the September 2024 Charitable Funds Investment Performance Review Sub Committee on the Liquidity Review of future cashflows. The Charitable Funds Committee were advised of the three fund investment options below and that the Charity Investment Managers will advise on the three options at the Charitable Funds Investment Review Sub Committee that would make a recommendation to the Charitable Funds Committee: • Invest in the Charity portfolio - looking at 5 – 10 year time horizon.

- Bonds – potential for c5% returns on these.
- Liquidity Management fund – similar to a bank account where funds can be taken back within a day or two at a 5% return.

The Charity Reserves Policy is to be reviewed to assess if the current four month period should be extended given the significant increase in fund balances.

BUSINESS CASE AND EXPENDITURE PROPOSALS
The Charitable Funds Committee **REVIEWED** four Business Cases, three of which were **APPROVED**:

- **Innovation Small Grant Scheme Business Case**

The Charitable Funds Committee **APPROVED** the Innovation Small Grant Scheme Business Case on the basis that an annual evaluation be brought to the Committee, outlining savings available to refund the Charity investment, value for money, and lessons learnt where appropriate.

- **Clinical Scientist Post Business Case**

The Charitable Funds Committee **APPROVED** the Clinical Scientist Post Business case to be funded out of FAKTION monies.
A proposal to be produced for an investment strategy for the FAKTION Monies.

- **BTS BBMDA Class 2 Typing Business Case**

The Charitable Funds Committee agreed this would be good use of the funds and were supportive. The Committee **APPROVED** the BTS BBMDA Class 2 Typing Business Case to be funded out of Welsh Blood Service charitable funds.

- **SACT Patient Education: 2025-06 Business Case**

The Committee agreed there is a commitment to funding a patient education service pilot but did not think the proposal was sufficiently developed to approve and made recommendations to be reflected in the case.
The Charitable Funds Committee **AGREED** the updated Business Case could be brought back out of Committee as a Chair's Urgent Action.

BUSINESS CASE – FURTHER INFORMATION AND ACTIONS:
Arts in Health – Artist Induction
The Charitable Funds Committee **APPROVED** the Artist Induction Handbook on the basis it is evaluated in six months.

BUSINESS CASE SIX MONTH EVALUATION:
Velindre Cancer Centre – Patient Engagement Management and Support (Volunteers, Velindre Voices) - Six month report and evaluation of expenditure incurred.
The Charitable Funds Committee **APPROVED** the six months evaluation.

BUSINESS CASE ANNUAL EVALUATIONS:
Velindre Oncology Academy Annual Evaluation
The Charitable Funds Committee recognised the huge accomplishment so far

	establishing the Academy. The Committee agreed to give full approval of the annual evaluation once an addendum to the case is provided setting out the current forecast income generation and costs by financial years to give assurances that the approved business case financial plan remains achievable. The Committee needs clarity on how the Financial Plan has changed, given there was a six month delay in implementation and what the updated financial risks are.
ASSURE	**Charity Risk Register:** The Charitable Funds Committee **NOTED** the updates to the Charity Risk Register and agreement for the Director to review risk scoring and ensure DATIX is updated to reflect risks. Agreed the risk report would be for approval at future meetings.
INFORM	Due to time constraints, The Charitable Funds Committee **AGREED** any comments on the items below could be taken out of Committee. These would be brought to the next Committee if this is needed. • Charitable Funds Effectiveness Survey. • Advancing Radiotherapy Fund Board Highlight Report.

3. RECOMMENDATION

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

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Velindre University NHS Trust

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	17 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Sarah Morley, Executive Director of OD and Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	
LPF	Local Partnership Forum
SLT	Senior Leadership Team
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

DRAFT

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1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum held on 17.09.2024.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to escalate to Trust Board
ADVISE	Nothing to advise to Trust Board
ASSURE	Nothing to assure
INFORM	The Local Partnership took the following actions at the meeting: **Compassionate Leadership Pledge 2024** • **NOTED** and were in full support of the Compassionate Leadership Pledge 2024. **NHS Staff Survey Results 2023** • **NOTED** the cross referenced actions with work sitting under each of the 10 themes, against which scores and trends will be plotted. • LPF were informed that the next staff survey will be launched in October 2024, members were asked to encourage staff to complete the staff survey. **Anti-racist Wales Action Plan – Six-monthly Update** • **NOTED** the plan which sits within the Strategic Equality Plan. • The achievement of developing a Workforce Race Equality Standard (WRES) was acknowledged by the forum. • **NOTED** feedback that programmes of training are anticipated for across the workforce to support the anti-racist Wales actions. **Trust Values and Behaviour Framework** • **NOTED** the report detailing the development in the Trust Values and Behaviour Framework, including the embedding of Trust values throughout the organisation, following approval of the new values in

	January 2024, and the establishment of foundation documents to support this work. • Awareness and the use of values and behaviours will be supported as part of the Working Together Programme. • LPF were told that the values are embedded in the recruitment process and are increasingly integrated into the interview process. And that end to end inclusion of behaviours and values in the employment journey was the goal. **Employee Relations Report 2024** • **NOTED** The report, which detailed all of the activity undertaken thus far and ongoing in respect of Employee Relations, including; • Development of the work carried out with HEIW to reduce employee harm, for which positive feedback has been received. Further analysis of this work continues. • Assurance was provided that managers are being taken on the compassionate leadership journey, supported by Business Partners from the People and Relationship Team who are providing coaching in all areas. Data analysed so far shows improvement in management of issues, with an increase in cases dealt with informally and less escalation through management processes. • Fundamentals of Management training will be a core competency and mandatory training requirement for all staff with line management responsibilities going forward. **Velindre University NHS Trust Additional Volunteer Roles** • **DISCUSSED** and **NOTED** three new volunteer roles including two pharmacy specific roles. Discussion took place regarding the importance of ensuring clear boundaries were in place in respect of paid job roles and volunteer roles, for which the specific remit is to focus on patient experience. Assurance was provided that a full induction programme was being developed for volunteers taking on roles in pharmacy. Assurance was provided that care has been taken to ensure the volunteer roles do not blend into paid roles. • LPF were informed of ongoing work and discussions around individuals and businesses willing to offer gift in kind services, such as volunteering hours for reflexology, gardening or mentoring. There are ongoing discussions to manage skilled offers. **Radiotherapy Satellite Centre Update** • **NOTED** the report outlining the workforce issues around the radiotherapy satellite centre (SRU), which is due for completion in February 2025 with the first patient anticipated to be treated in April 2025. • Workforce for SRU will be both VUNHST and Aneurin Bevan University Health Board.

	• Recruitment is underway with some staff already commenced in post. • A considerable consultation process has taken place, closing at the end of August 2024. • One change is the need for staff to work on rotation at Velindre Cancer Centre and SRU for which support will be given to staff. **Organisational Change Processes** • An update was **NOTED** in respect of the organisational change processes going currently running in the Trust. **Sexual Safety** • **NOTED** the changes to Worker Protection (Amendment of the Equality Act 2010) Act 2023, and the emphasis of the Trust's commitment to taking reasonable steps to prevent sexual harassment and aligning current practices with the new legislation. • The Trust's current practices, such as respect and resolution training, are being reviewed and aligned with the new legislation to ensure continued support for staff against sexual harassment. **Attraction Resourcing Project** • **NOTED** the project aimed at enhancing the Trust's attraction and resourcing strategies, which aims to attract the best talent by aligning marketing campaigns with the Trust's values and behaviours. • The project will be developed in partnership with stakeholders, including trade union representatives, to ensure a collaborative approach to attracting the best talent. **Policies Update** • **ENDORSED** amendments to four policies, two of which are complete re-writes; PADR and People Development Policy. • There are minor changes to another two policies, Alcohol and Substance Misuse Policy and Professional Registration Policy, following feedback from Trade Union colleagues. **Escalation from WBS Divisional Partnership Forum** There were two items **DISCUSSED;** **Workplace related sickness being tracked on ESR** • The importance of differentiating workplace-related stress from other stress-related absences in ESR recordings, highlighting the need for targeted support and interventions based on the source of stress. • Information was provided that ESR allows for differentiation and encouraged managers to input accurate information to facilitate targeted interventions.

	Progress on non-pay elements of pay award • A query from a previous Divisional Partnership Forum meeting regarding the progress on non-pay elements of the pay award was discussed, suggesting the sharing of a tracker with the Divisional Partnership Forum for transparency and collaboration.
APPENDICES	None

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TRUST BOARD

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

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 23rd July 2024.

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

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

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2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
ADVISE	There were no items to advise to Trust Board.
ASSURE	**Programme Directors Report (including all project updates in scope)** The Delivery Confidence Assessment (DCA) for the overall programme is amber. <u>Project 5: Outreach</u> The Project Initiation Document (PID) for the Programme of work has been completed and shared with Health Board colleagues for approval. There are key elements of the project that are to be taken forward as part of the current work plan which are outlined within the report. <u>Cardiff Cancer Research Hub</u> Over the last six weeks the TCS Programme Team have been supporting the Cardiff Cancer Research Hub project which has been running for two years. Recently, it has been decided that Velindre will be the lead organisation for the centralised Project Management Office, a Heads of Terms have been signed and a high-level twelve-month plan has been developed. It has been proposed that the TCS Programme would be a suitable place to govern this collaborative project, and as such a new project request will be submitted for consideration once the wider programme scope is agreed. <u>Transforming Access to Medicines (TrAMS)</u> The project is actively progressing forward. Phase 1 of the project is SACT delivery which is required for Velindre Cancer Centre patients. This is on track to be completed in time for the nVCC. It was confirmed Radiopharmacy is separate piece of work. Within the private TCS Programme Scrutiny Sub-Committee there is a more detailed plan but due to commercially sensitive detail this cannot be included within the public Programme Directors Report. Further discussions to be held in the private section.

	The TCS Programme Scrutiny Sub-Committee **NOTED** the Programme Directors Report. **Radiotherapy Satellite Centre Project: Plan and Progress Update** An overview of the current position was provided to the TCS Programme Scrutiny Sub-Committee. Carl James took over as SRO following Cath O'Brien leaving the Trust. Carl James thanked Rachel Hennessy and the team for getting to this point. The risks of the Radiotherapy Satellite Centre are considered at Project Board and are scored appropriately. Project Board will be reviewing the risks, confirming if they are risks or issues. Following the Project Board these will be included within the Programme Directors Report. A clinical working group is being established from August 2024. The TCS Programme Scrutiny Sub-Committee **NOTED** the Radiotherapy Satellite Centre Project: Plan and Progress Update.
INFORM	**TCS Programme Finance Report** The overall forecast outturn for the Programme is an overspend of £6.866m for the financial year 2024-25 against a budget of £0.663m. No capital funding has been allocated yet for the nVCC Project for financial year 2024-25, resulting in the overspend. An interim funding request for the nVCC Project has been submitted to Welsh Government for c£2.632m and the Enabling Works project funding request will be part of the Enabling Works Full Business Case Addendum. The main financial risk to the TCS Programme at present is the lack of funding for the capital projects, which is being mitigated by the aforementioned funding request. To date, no funding has been provided by Welsh Government for the Whitchurch Hospital Site, however at present the risk to the Programme is low. The associated costs will be reimbursed by Welsh Government. A business justification case might be required to be submitted to Welsh Government. The TCS Programme Scrutiny Sub-Committee **NOTED** the TCS Programme Finance Paper.

	Communication and Engagement Report The Communication and Engagement Report was presented to the TCS Programme Scrutiny Sub-Committee. The following points were brought to the Committees attention: - There is a good working relationship between the Trust and Acorn. - Positive public communications. - Positive community engagement events. - Useful construction timeline illustration. The TCS Programme Scrutiny Sub-Committee **NOTED** the Communication and Engagement Report. **nVCC Project Board Terms of Reference** The Project Board Terms of Reference were delivered to the TCS Programme Scrutiny Sub-Committee. The Terms of Reference were endorsed at Extraordinary Project Board on 16th July 2024. It was confirmed the SRO will chair the nVCC Project Board once appointed. Currently the nVCC Project Board is chaired by Matt Bunce, Executive Director of Finance. It was requested to include a caveat that if it was decided that it was not appropriate for the meeting to be chaired by the SRO, it should be chaired by another senior officer. From September onwards the nVCC Project Board will include external parties including NWSSP, Welsh Government and Acorn. The TCS Programme Scrutiny Sub-Committee **ENDORSED** the nVCC Terms of Reference in principle.
APPENDICES	None.

JOINT COMMISSIONING COMMITTEE (JCC)
MEETING BRIEFING – 16 JULY 2024

The Joint Commissioning Committee (JCC) held its latest public meeting on 16 July 2024. 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 JCC.

The papers for the meeting can be accessed using the link below:
Meeting Dates and Papers - NHS Wales Joint Commissioning Committee.

1. Minutes of Previous Meetings
The minutes of the JCC meeting held on the 21 May 2024 were approved as a true and accurate record of the meeting.

2. Action log and matters arising
Members noted the progress on the actions outlined on the action log.

3. Patient Story
Members received the first patient story from Alan Owen who suffered a sudden cardiac arrest in 2022 and was transported to Cardiff via the Emergency Medical Retrieval Service (EMRTS) where he underwent emergency cardiac surgery and was fitted with two stents and an Implantable Cardioverter Defibrillator (ICD). CB explained that Alan has become a patient experience advocate and had written a book about his road to recovery to help others.

Alan provided members with a powerful story on experiencing a cardiac arrest whilst participating in a walking-football tournament at Caldicott leisure centre during 2022. He expressed his gratitude to all the NHS services and the public who saved his life and helped him overcome this traumatic event.

Members discussed the need to ensure that more people survive a sudden cardiac arrest and the importance of the community response, the timely arrival of specialist care on the scene via EMRTs and transfer to the specialist cardiac centre.

Members noted the patient story and thanked Alan for sharing his story.

4. Chairs Report
Members received the Chair's Report and noted updates on key meetings attended by the Chair as well as the following:

- JCC Development Programme – the Chair and lay members have continued to participate in induction sessions and two sessions took place on the 4th June 2024.
- Annual Attendance at Health Board Meetings – The Chair is keen to ensure open and transparent communication as the JCC exercises key commissioning responsibilities on behalf of the seven Health Boards (HBs). The JCC will report annually to each HB, whenever possible, in person and a letter has been issued to HB Chairs to request that this opportunity is built into HB forward plans.
- Lay Member Recruitment – WG is currently in the process of recruiting the final two Independent Lay Members, which will take the JCC to a full complement of six including the Chair. Interviews are scheduled for early September with a view that appointments will be made from 1 October 2024.

Members noted the report.

5. Interim Chief Commissioner's Report

Members received the Interim Chief Commissioner's Report and noted updates in relation to the following:

- Overarching assessment of delivery of Quarter 1 Transition Plan
- Establishing the JCC Sub-Committee Structure and work programme
- Public Health Input
- Infected Blood Inquiry
- Sexual Assault Referral Service (SARC) Update
- - Business Continuity for the upgrade works within Princess of Wales Hospital Maternal and Neonatal Unit
- North Wales Mother and Baby Unit (MBU)
- Extra Corporeal Membrane Oxygenation (ECMO).

Members noted the report.

6. Joint Commissioning Committee Risk Register

Members received a report presenting a transitional amalgamated risk register for the Joint Commissioning Committee (JCC) which encompasses risks scoring 15 and above taken from the commissioning teams and directorate risk registers across the former Emergency Ambulance Services (EASC), National Collaborative Commissioning Unit (NCCU) and the Welsh Health Specialised Services Committee (WHSSC).

Members noted that the amalgamated risk register was categorised as a transitional risk register whilst further work is undertaken to fully develop and implement the CTMUHB Risk Management Strategy for the JCC (in line with the hosting agreement) and until the JCC has an opportunity to consider its risk appetite as part of the JCC development programme.

Members noted that a significant amount of work had gone into developing the new risk register, and it was important to emphasise that it was a work in progress and there was still much more work to be undertaken to strengthen and develop it in conjunction with risk owners, commissioners and providers.

Members (1) Noted the report, (2) Noted the work undertaken to date to produce a transitional amalgamated risk register, (3) Noted the review work undertaken by the commissioning teams to produce a refreshed, updated version of the transitional amalgamated risk register to be presented to the JCC meeting on 16 July 2024, (4) Approved the JCC risk register as at 30 June 2024, (5) Noted the further work planned to fully develop the CTM Risk Management Strategy for the JCC, and the steps required to implement it; and (6) Noted that the CTMUHB Audit & Risk Committee (ARC) meeting for hosted bodies on 15 August 2024 will receive an update on the progress of the JCC risk register.

7. NHS 111 Wales Commissioning Arrangements

Members received a report providing an update on NHS 111 Wales Commissioning Arrangements.

Members noted that responsibility for the commissioning of NHS 111 Wales transferred to the NHS Wales Joint Commissioning Committee (NWJCC) on the 1 April 2024 and that Quarter 1 had seen transitional arrangements in place, with the previous programme team continuing to hold meetings of the Commissioning Board and Delivery Assurance Group (DAG).

Members noted that the transitional arrangement had ended, and the NWJCC Team would now assume full responsibility for the commissioning of the service. The JCC Team had submitted a request to WG for resources to support this function and it was noted that WG had confirmed that some funding would be available which would enable the commissioning function to be established.

Members (1) Noted the report, (2) Approved the adoption of the commissioning arrangements for NHS 111 Wales into the existing committee arrangements until such time as the formal sub-committee structure of the NWJCC is fully established, (3) Approved the proposed actions outlined for each of the risks of the previous programme and the development of specific risks required for the NWJCC to monitor in relation to their responsibilities in commissioning the service; and
(4) Noted the NWJCC team capacity to undertake the commissioning of the NHS 111 Wales service is limited without additional resource.

8. Emergency Medical Retrieval and Transfer Service (EMRTS) Review Update

Members received a report providing an update on the Emergency Medical Retrieval and Transfer Service (EMRTS) recommendation to develop a

bespoke road based enhanced critical care response for rural and remote areas and recommendation 4.

Members noted that:

- as part of the EMRTS Review a recommendation was agreed to develop a bespoke road-based enhanced/critical care response for rural and remote areas,
- Recommendation 4 was made in order to respond to the concerns raised by residents during the public engagement processes around the provision of emergency healthcare in rural and remote areas that would not fall into the remit of the EMRTS, this included 999 incidents for example such as falls, strokes and chest pain
- the Recommendation 4 Task and Finish Group had been established in line with the timescale agreed at the last NWJCC meeting. The group met on 28 June 2024 and as agreed, was chaired by the Interim Director of Commissioning – Ambulance and 111.
- the Task and Finish Group's project plan included a communications plan linked in with the national Communications and Engagement leads across NHS Wales, and that a Stakeholder Update had already been issued to the stakeholder distribution list summarising the current implementation position and that more detailed content was in development,
- the NWJCC continued to work closely with Wales Air Ambulance Charity Trust (WAACT) as its strategic partner in the delivery of pre-hospital critical care as we jointly implement the Review recommendations and future improvements to service delivery, and that the charity continued to actively engage with their stakeholders and the EMRTS on the implementation of the recommendations; and
- the EMRTS leadership team had welcomed the certainty the decision provided for them and the operational teams, that the leadership team continued to focus on the development of the operational implementation plan and that the team had met with staff at their bases and will continue to engage with colleagues across Wales through the changes required as part of this important service development.

Members (1) Noted the first meeting of the Recommendation 4 Task and Finish Group meeting held on 28 June 2024, (2) Approved the revised Terms of Reference for the Task and Finish Group, (3) Discussed and Approved the approach to communication and engagement relating to the additional bespoke road-based service (Recommendation 4),
(4) Noted the Wales Air Ambulance Charity Trust position in relation to the decision of the NWJCC, the engagement with their stakeholders, the work being undertaken to secure an appropriately located operational base and the work with EMRTS on the joint transition plan, (5) Noted the EMRTS Leadership team position in relation to the decision of the NWJCC, and that the team will continue to engage with colleagues across Wales,

(6) Noted the petition that will be considered by the Petitions Committee for debate, (7) Noted the commissioning approach, (8) Noted the work to update the previous legal advice following the decision made at the NWJCC in April 2024; and (9) Noted the receipt of the Letter Before Action in relation to a potential judicial review.

9. Implementation of Legacy Plans – Quarter 1
Members received a report providing an update for assurance against the Quarter 1 deliverables of the extant predecessor organisation legacy Plans.

Members noted that prior to the formation of the JCC, WHSSC and EASC produced plans in line with the Welsh Government NHS planning requirements, which were approved by the respective Joint Committees in March 2024. These plans remained extant in 2024/2025 as part of the legacy arrangements and the NWJCC has responsibility for assurance of their delivery.

Members Noted the assurance on delivery of the legacy Plans at the end of Quarter 1.

10. Development of Joint Commissioning Committee Integrated Medium Term Plan (IMTP) 2025-2028
Members received a report outlining the proposed process for the development of the inaugural JCC Integrated Medium Term Plan (IMTP) 2025-2028.

Members (1) Noted the feedback on legacy planning arrangements and plans that had been received from DOPs, DOFs and CEOs/Chairs,
(2) Noted that the JCC Standing Orders stated that the JCC will develop an Integrated Medium Term Plan (IMTP) for 2025-2028, (3) Agreed the approach laid out in section 3.4; and (4) Agreed the process and timeline for developing the 2025-2028 JCC IMTP.

11. Plastic Surgery South Wales – Revised Ministerial Key Performance Indicators (KPIs)
Members received a report outlining the options in relation to achieving the Welsh Government key performance indicators (KPIs) in 2024/2025 for the plastic surgery service for South Wales provided by SBUHB.

Members noted:

- that the waiting list and waiting times for plastic surgery had increased and that some patients were waiting in excess of the 104 weeks WG waiting time target,
- that the WHSSC Integrated Commissioning Plan (ICP) for 2024/25 did not include allocated funding above the SLA baselines to address long waits in plastics and achieve the 104 weeks target because choices were made on the balance of performance and finance in line with the difficult choices facing all HBs - the WHSSC Joint

Committee agreed not to accelerate improvement beyond a continued steady improvement towards the targets. However, following the approval of the ICP, WG published targets to achieve the 104 week waiting time target by March 2025. Members noted that this target was further revised through the NHS Wales CEO letter in May 2024 with revised Ministerial KPIs of no patients waiting over 104 weeks by the end of December 2024,

- that the NWJCC and SBUHB had worked collaboratively to consider the options for additional activity and cost to commissioners of achieving the WG KPIs for elective waiting times and members discussed these.

Following the detailed discussion around the affordability of the additional activity required and the other priorities HBs were needing to balance, members approved Option 2 subject to further urgent due diligence by the JCC Management Group.

Members (1) Noted the information presented within the report (2) Advised on the approach to the options in table; and (3) Approved Option 2 subject to additional due diligence by the Specialised Services Management Group.

12. Gender Identity Services for Children and Young People – Final Report of the Cass Review

Members received a report providing further information following the request made by the JCC on 21 May 2024 on the Cass Review recommendations. Members welcomed the additional work that had been undertaken and information that had been provided. It was agreed that the commissioning pathway for the service would continue, but recognised that it would be appropriate to review this in the future if further evidence became available.

Members (1) Noted the recommendations of the Cass Review and supported the continued alignment of the NHS Wales Joint JCC with the NHS England Implementation Plan; and (2) Endorsed the establishment of an 'Expert Clinical Advisory Group' to inform the review of the policy and specification for the adult gender identity service and associated terms of reference.

13. NWJCC Performance Report – April 2024

Members received a report providing an integrated overview of the performance of services commissioned by NWJCC up to the end of April 2024 for scrutiny and assurance.

Members (1) Noted the Performance Report for services commissioned by the NWJCC.

14. Financial Performance Report Month 2

Members received the month 2 and 3 financial positions.

Members noted that:

- the NWJCC financial position for 2024-2025 reported at Month 2 was a £1.6m overspend against the ICP financial plan to date, with a forecast year-end overspend of £655k at this point,
- the NWJCC financial position for 2024-2025 reported at Month 3 was a £2.8m overspend against the ICP financial plan to date, with a forecast year-end overspend of £2.5m,
- there had been a £1 million deterioration in position between the month 2 position and month 3 position with a £2 million deterioration in the year end forecast; and
- in relation to the savings target WG had requested a 2% savings target which amounted to a £10 million savings target. To date, only £802,000 savings were reported. Members noted that if this continued the NWJCC would be looking at a significant overspend at year end.

Members noted the month end financial position for Months 2 and 3 which was concerning and agreed the need for a recovery plan to ensure that the current rate of overspend was brought back in to balance. This would be brought to the JCC for consideration in September, having been worked up by the Director of Finance with commissioning teams and Health Board Directors of Finance

15. All Wales Molecular Radiotherapy (MRT) Programme

Members received a report setting out the context, challenges and opportunities for an All Wales Molecular Radiotherapy (MRT) service.

Members (1) Noted the report, (2) Noted the All-Wales MRT programme strategic report at for publication; and (3) Supported continuation of the programme as outlined in the All-Wales MRT programme strategic report subject to Welsh Government (WG) confirmation of continued funding to support a dedicated resources for the programme.

16. Corporate Governance Report

Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members noted the Annual Reports for the former EASC sub-committee and sub-groups as part of the legacy work of the JCC, and noted the results of the former WHSSC committee effectiveness survey for 2023-2024 and that the results will be used to inform the work of the JCC development programme.

Members (1) Noted the report, (2) Approved the Annual Reports for the former EASC sub-committee and sub-groups as part of the legacy work, (3) Noted the results of the former WHSSC committee effectiveness survey for 2023-2024; and (4) Received assurance that the Annual Committee effectiveness self-assessment for 2023-2024 was completed for the previous WHSSC Joint Committee.

17. Ambulance Services Performance – Update

Members received a presentation on emergency ambulance services performance.

Members noted:

- All Wales Daily EMS Performance Tracker,
- Verified Incidents, Conveyances, Emergency Department (ED) attendances and lost hours,
- Lost Hours and Total Arrivals per HB,
- The top 10 conveyed by nature of condition,
- Lost Hours by Age Profiles 2023,
- Monthly Indicators Dashboard,
- Performance Plan – Actions.

Members discussed the data, patient pathways and demand and capacity. Members welcomed the deep dive into the data and requested additional granular detail and agreed that further discussion was required to tackle the challenges would be included the JCC Development Session in August 2024.

Members noted the presentation.

18. Other Reports

Members also noted update reports from the following joint Sub-Committees/groups:

- Audit and Risk Committee (ARC) Assurance Report
- Management Group Briefings
- Individual Patient Funding Request (IPFR) Panel
- Welsh Kidney Network (WKN)
- Quality Patient Safety Committee (QPSC)
- South Wales Trauma Network Delivery Assurance Group (DAG)
- Neonatal Transport DAG
- Non-Emergency Patient Transport Service (NEPTS) DAG Minutes
- Emergency Medical Retrieval Transport Service (EMRTS) DAG Minutes

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ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Service Partnership Committee (SSPC)
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details	James Quance, Assistant Director of Corporate Services
Date of meeting	18 July 2024

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

Chair's Report

The Chair updated the Committee on her activities since the last meeting and forthcoming events. This included:

- The Welsh Risk Pool Committee (WRPC) had met twice since the May 2024 SSPC meeting and a report on Scheme of Delegation and functioning of the Committee was presented, in addition to a report on the WRPC as a Sub-Committee of the SSPC being received;
- There had been two Chairs' Peer Group meetings in May and June 2024, attended by Chair and Judith Paget;
- A collaboration meeting took place on 30 May 2024 with Police Commissioners, the Crown Prosecution Services, Welsh Government members and NHS organisations' representatives to refresh the Obligatory Reponses to Violence in Healthcare. This was attended by Chair and Managing Director highlights would be taken to the NHS Leadership Board in July 2024;
- The Chair met with the new Chair of the Joint Commissioning Committee;
- The SSPC autumn development workshop would be held on 11 October 2024. The Chair reminded Committee Members to diarise in advance to ensure good attendance and participation; and
- The Chair requested suggestions for areas the Committee would benefit from exploring as deep dive sessions in future meetings.

The Committee NOTED the update.

Ratification of Chair's Action

Chair requested the Committee ratify the Chair's Action taken between the May and July meetings, regarding the purchase of three isolators for RadioPharmacy to deliver the safe preparation of radioactive medicines in sterile conditions as set

out in the ratification paper.

The Committee RATIFIED the Chair's Action.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The financial position at the end of quarter 1 was a surplus of just over £1 million. There were challenges in the Covid allocation, which were currently being discussed with Welsh Government;
- There were no issues raised by Audit Wales in the audit of the NWSSP element of the Velindre University NHS Trust annual accounts;
- Around 80% of IMTP objectives were being met at present;
- The Radiopharmacy Business Justification Case was on the agenda for approval and the purchase of isolators was in progress, noting that it was likely that the selected supplier would be unable to deliver as anticipated and therefore discussions were ongoing regarding an alternative solution;
- Laundry Services continued to develop well and NWSSP continued to work with Health Boards on the transition of service;
- Regulations for the Death Certification Reforms were laid in parliament, including the introduction of a statutory Medical Examiner system on the 15 April 2024. The legislation would come into force on 9 September 2024, meaning independent scrutiny by a Medical Examiner would become a statutory requirement prior to the registration of all non-coronial deaths in England and Wales from this date;
- The new ESR system was being worked on with NHS England in a joint endeavour;
- Primary Care Services continued to work closely with Digital Health and Care Wales regarding the implementation of the new prescribing service;
- The National Health Application and Infrastructure Services (NHAIS) system decommissioning would take place and was being worked with Digital Health and Care Wales and colleagues in NHS England;
- Contingency plans for the Primary Care Workforce Intelligence Tool have been implemented to ensure resilience;
- Quantities of Personal Protective Equipment to be kept in storage and amounts to be purchased are being discussed with Welsh Government;
- Welsh Government outlined a new approach for the Flu Vaccination Program for the whole of Wales. NWSSP would acquire and store the vaccines to roll-out throughout Wales;
- An agreement regarding the new Medicine Buffer Stock had been finalised; and
- Reimbursement of medical negligence claims, circa of £6 million had been approved at the last Welsh Risk Pool meeting. Services had seen an increase in claims, such as maternity, radiology and cancer units.

The Committee NOTED the update.

Items Requiring SSPC Approval/Endorsement
Transforming Access to Medicines South-East Wales RadioPharmacy Business Justification Case NF presented the Business Justification case for the RadioPharmacy Service covering the South East of Wales. This service is part of the overall TrAMS programme and its urgency to be started is due to the forced closure of the C&VUHB RadioPharmacy unit. As a result the NWSSP RadioPharmacy unit will be established to provide a safe regulatory compliant facility to meet the future expected clinical demand of the South East. The preferred location is IP5 in Newport. The case recommends a capital investment of £9.2 million with no additional capital contribution required from health boards. £2.3 million funding from Welsh Government as base investment has already been approved by the Cabinet Secretary and has been received, which leaves a further £6.9 million of additional capital which will need to be agreed through Welsh Government. A new revenue model has been set out in the business case following in depth discussions with finance colleagues. The potential additional costs that would impact on the commissioner discussions with regard to Velindre's share of any revenue implications were noted in the business case. NWSSP has submitted a Planning Permission application to Newport Council covering the proposed area in IP5 where the new TRAMs unit is to be situated. Given the lead in times the purchase of radio pharmacy Isolators had been subject to the previously ratified Chair's Action and is in progress. The Committee APPROVED the Business Justification Case.
Annual Review 2023/24 The Annual Review was received as a positive reflection of staff going the extra mile during the previous financial year to fulfil the objectives set out in the Integrated Medium-Term Plan, showcasing best practice and achievements. Chair echoed the feedback of Committee Members, highlighting the importance of providing a balanced view of the positive impact of NWSSP across NHS Wales. It was recommended that the areas for improvement and lessons learned be included in the report, going forward. The Committee ENDORSED and NOTED the Report.
All Wales Overpayments Procedure The Procedure was revisited based on feedback received and places more emphasis on repayments, affordability and avoiding unnecessary hardship to staff, as well as providing for local flexibility for colleagues to address a dispute locally. Consultation had been sought through the Directors of Finance Peer group, including Trade Union and it was endorsed by all parties. It had also been to the Local Partnership Forum and through the NWSSP Equality Integrated

Impact Assessment process. Following approval, it would become operational from 1 October 2024, to allow time to translate all correspondence and to communicate the changes to all stakeholders. Members praised the focus on indicating accurately when the overpayment occurs, the reason for its occurrence, and the root cause, as to prevent reoccurrence. The Committee APPROVED the Procedure.
Procure to Pay Governance Update The All Wales Governance Group met on two occasions and seven priorities had been identified, to include the Procure to Pay (P2P) Policy, which required refreshing and updating. The Policy emphasised how payments should only be made against an approved purchase order that already exists in the system, subject to certain agreed exceptions. The revised Policy had been approved by the Deputy Directors of Finance in each organisation. Under the current governance arrangements, the Committee was asked to approve the revised Policy, for relaunch. The Group would share the Policy with suppliers and the Directors of Finance in each organisation to sign and distribute to staff internally. The Committee APPROVED the Policy.
Welsh Energy Group and Welsh Energy Operational Group Terms of Reference The Welsh Energy Group and the Welsh Energy Operational Group had a requirement to review their Terms of Reference annually and therefore met to carry out a review. Minor amendments were suggested and the Committee was content to approve the sub-groups' proposed revised Terms of Reference. The Committee APPROVED the updated Terms of Reference.
Items for Noting
2023/24 Annual Governance Statement The Statement provides assurance that NWSSP has a sound system of internal controls that supports the achievement of its policies, aims and objectives. Whilst strictly not a legal requirement for a non-statutory hosted organisation, it remains best practice to produce one. A particular highlight to note is the achievement of NWSSP's organisational Customer Service Excellence. Attention was drawn to the Limited Assurance review of Decarbonisation, but there were no further control issues reflected in the report. Members praised the assurances and transparency of the document and noted

that attendance at SSPC meetings could be improved, with some organisations not regularly being represented by a voting member. It was important that each organisation remains properly represented in the discussion and agreement of important issues, which support the work of NWSSP to benefit organisations.

The Committee NOTED the Report.

2023/24 Head of Internal Audit Opinion

The report was a vital source of assurance and the Opinion for the year was given as Reasonable Assurance overall. The report was presented to the Audit Committee, by the Head of Internal Audit on 25 July 2024. All reports from the 2023-24 Internal Audit Plan were almost complete with the exception of two, which were expected to be concluded shortly.

The Committee NOTED the Report.

Finance, Performance, People, Programme and Governance Updates

Finance – NWSSP reported a surplus of £1.153m at the end of month 3, made up of a reported surplus of £0.846m against core operational budgets and £0.307m against the Covid allocation, which was currently under review. Work was ongoing on the arrangements for the vaccination campaign as well as the PPE stockholding, logistics, distribution and storage. The Welsh Risk Pool (WRP) was on forecast at month 3 and WRP cost drivers for 2024 and 2025 were being reviewed and updated ready for reporting in September 2024. There had been a saving of £5.5 million on energy that had been communicated to NHS organisations for cascading.

People & OD Update – PADR compliance remained marginally below target at 83.6%. Reported sickness absence was consistent and within target and expectations. Turnover was being investigated in terms of accurately capturing the reasons people leave, with exception of Single Lead Employer, benchmarking turnover with the rest of Wales to understand performance. In terms of agency and bank staff, the numbers were expected to reduce in the next cycle. May 2024 figures show NWSSP has been non-compliant in several areas, while overall Time to Hire remained under target at 55 days (target 71 days). However, positive progress to improve these statistics had been made, internally and across the board.

Performance – Due to timing of the reporting cycle, there were no significant performance concerns to bring to the Committee's attention. The Procurement Team was working with Finance colleagues to identify savings within the organisation. Performance review meetings were completed with colleagues across NHS Wales to discuss further collaboration and areas of improvement. The Outcome Measures Report focussed on outcomes as per the IMTP. A workshop session was held with the SLG on 13 June 2024 and it was agreed that more work was needed on customer experience and benchmarking.

IMTP Quarter 1 Update Report – IMTP performance as at quarter 1 was on track and performance against divisional plans would be scrutinised in upcoming quarterly performance reviews.

Project Management Office Update – Current progress against projects was highlighted and confirmation received that controls were in place to ensure monitoring. Updates regarding higher risk projects would continue to be reported as a matter of course to the Committee. The Audit Committee also received further information on the TrAMS programme at its July 2024 meeting.

Corporate Risk Register – The refreshed and reframed version of the Register was presented following SLG consultation and would develop further through review and scrutiny. The decarbonisation risk had been split to show where NWSSP has a role both in delivering the organisation's targets and where it provides support across NHS Wales.

The Committee NOTED the above reports.

Papers for Information

The following items were provided for information only:

- NWSSP Annual Report on Conflict of Interests Declarations and Gifts, Hospitality & Sponsorship 2023-24;
- Annual Performance Review on Welsh Language 2023-24;
- Health and Safety Annual Report 2023-24;
- Counter Fraud Annual Report 2023-24;
- Annual Report on Information Governance 2023;
- Finance Monitoring Returns Month 3;
- PPE Dashboard Report; and
- SSPC Forward Plan 2024-25.

Members noted the importance of the assurance that each of the Annual Reports gives to the Committee and to Velindre University NHS Trust as NWSSP's hosting body. The hard work of the Teams involved in producing was recognised and appreciated.

The Committee NOTED the Information Reports.

Part B (Private Session)

Motion to exclude the public from the meeting in accordance with the provisions of section 1 (2) and (3) of the Public Bodies (Admissions to Meetings) Act 1960

Chair sought clarification that the Legal and Risk Case Management System procurement, as raised in the May 2024 meeting, had been approved by the Velindre University NHS Trust Board.

The Committee NOTED the following items discussed in Part B:

2.1 Wales Energy Operational Group Decision Outcome;
2.2 All Wales Costing System Commitment of Expenditure;

2.3 All Wales Junior Doctors E-Rota Monitoring Solutions; and 2.4 Welsh Risk Pool and Legal & Risk Services Annual Review 2023 – 2024.	
Any Other Business (AOB)	
No further items were raised for discussion.	
Matters requiring Board/Committee level consideration and/or approval	
• The Board is asked to NOTE the work of the Shared Services Partnership Committee.	
Matters referred to other Committees	
No further matters were referred to other Committees.	
Date of next meeting	19 September 2024

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TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE VELINDRE NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Carly Wilce, NWSSP Corporate Services Manager
PRESENTED BY	Gareth Jones, Chair of NWSSP Audit Committee
APPROVED BY	GARETH JONES, CHAIR OF NWSSP AUDIT COMMITTEE

EXECUTIVE SUMMARY	This paper has been prepared to provide the Trust Board with details of the key issues considered by the Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership, at its meeting on the 25th July 2024.

RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the contents of the report from the last meeting on 25 July 2024.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
NWSSP Senior Leadership Group	(29/08/2024)
Shared Services Partnership Committee	(19/09/2024)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	

1. SITUATION

This Highlight Report provides the Trust Board with details of the key issues considered by the Velindre NHS Trust Audit Committee for NHS Wales Shared Services Partnership, at its meeting on the 25th July 2024 for noting.

2. BACKGROUND

The Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership (Audit Committee) provides assurance to the Shared Services Partnership Committee (SSPC) on the issues delegated to them

through the Trust and NWSSP Standing Orders. A summary of the business matters discussed at the meeting held on 25 July 2024, is outlined below:

3. ASSESSMENT

Not Applicable

4. SUMMARY OF MATTERS FOR CONSIDERATION

ALERT / ESCALATE	There were no matters for **alert/escalation** to the Board.
ADVISE	There were no matters to **advise** to the Board.
ASSURE	**NWSSP Update** The Managing Director presented the Committee with an extensive update as to key developments within NWSSP. The main highlights discussed are as follows: • at the end of month 3, there was a cumulative surplus of £1.153m recorded, mainly due to ongoing turnover and delays in recruitment and £0.307m against the Covid-19 allocation; • there were no matters to raise in respect of NWSSP in the Audit Wales ISA260 report regarding the 2023-24 Annual Accounts; • 80% of IMTP objectives were on track for the year; • the Radiopharmacy business justification case had been approved by the Shared Services Partnership Committee at its meeting in July 2024; • positive progress had been made in terms of Laundry Services. A Memorandum of Terms of Occupation (MOTO) had been developed in conjunction with Hywel Dda in relation to the ongoing occupation at the Glangwili site, regarding its use as a Laundry hub; • Regulations for the Death Certification Reforms were laid in Parliament, including the introduction of a Statutory Medical Examiner system on the 15 April 2024. The

	Legislation would come into force on Monday 9 September 2024, meaning independent scrutiny by a Medical Examiner would become a Statutory requirement prior to the registration of all on-coronial deaths in England and Wales from this date; • The procurement phase of the enhancement to the ESR system was nearing completion and it was hoped that a contract would be awarded to the successful bidder by spring 2025 and costs would be known in the next few months; • the National Health Application and Infrastructure Services (NHAIS) system was being decommissioned; • NWSSP continue to work with Welsh Government in relation to Covid stock requirements for Personal Protective Equipment; • NWSSP continues to respond to requests for information from the Covid-19 Public Inquiry and are receiving disclosures as they are available as core participants for module 5 of the Covid-19 Inquiry; • Welsh Government approved the stock holding of medicines on 20 March 2024 to increase the resilience of Wales; • NWSSP received formal instruction from Welsh Government in June 2024 to make second interim compensation payments to beneficiaries of the Infected Blood Inquiry; • planning arrangements for the Shared Services Partnership Committee autumn development session was progressing. • the Senior Leadership Group would attend a service improvement workshop in August 2024 to further develop the approach and specific projects; and • there were no changes to Senior Management staffing to report.
ASSURE	**External Audit Position Statement** Audit Wales provided an update as to current and planned audit work. The audit and assurance work at NWSSP had been

	completed and conclusions had been shared with NHS audit teams in June 2024. Findings from the audit of IT systems hosted by NWSSP would be shared with the NWSSP Audit Committee in October 2024. There were no issues to report for NWSSP and the audit of 2023-24 Velindre Annual Accounts had been signed off in July 2024.
ASSURE	**Internal Audit Position Statement** The Head of Internal Audit presented the Position Statement together with an overview of other activity undertaken since the previous meeting. Key points to highlight were: • four Internal Audit reports from the 2023-24 annual plan had been finalised; and • progress had been made regarding the commencement of the 2024-25 Audit Plan.
ASSURE	**Internal Audit Reports** The following reports were presented to the Committee for consideration: **<u>Decarbonisation</u>** Due to the risk to achievement of National targets due to the lack of Capital funding, the review received an assurance opinion rating of Limited Assurance, with **three** recommendations for action, including a high priority recommendation for the development of a fully costed implementation plan. All recommendations were either implemented or in progress. **<u>Student Awards</u>** The audit achieved Reasonable Assurance with **three** medium priority recommendations for action. Implementation of the new GP UK system had improved automation, efficiency and sample testing identified no errors in the calculation of bursary awards. **<u>Single Lead Employer</u>**

	The review tested compliance with a range of Policies and Procedures, key aspects of risk and governance within the service. The audit achieved Reasonable Assurance, with **four** recommendations raised. **Procurement Services** The audit reviewed the adequacy of the systems and controls in place for procurement of contracts above OJEU thresholds. The allocated assurance rating was Reasonable Assurance, with **four** recommendations for action. **Head of Internal Audit Opinion & Annual Report 2023-24** The Head of Internal Audit presented the 2023-24 Audit Opinion and Annual Report to the Committee, which achieved an overall rating of Reasonable Assurance. The report was positive and demonstrated the significant amount of work performed throughout the year. Regular audit progress reports are submitted to each NWSSP Audit Committee throughout the 2023-24 reporting period. The report summarised key findings and outcomes of systems that NWSSP provided to NHS Wales.
ASSURE	**Counter Fraud Annual Report and Standard Return 2023-2024** The Counter Fraud Manager presented the 2023-24 Counter Fraud Annual Report to the Committee, which detailed the anti-fraud, bribery and corruption, measures implemented during the period. Key points to note were: • **206** days of Counter Fraud work had been completed against the agreed **210** days, as per the 2023-24 Counter Fraud Annual Work Plan; • the remaining **5** of the **206** days were provided to Llais; • **18** training sessions had been delivered to **432** staff and new starters are enrolled automatically; • the Counter Fraud Plan objectives fully align to the NHS Counter Fraud Authority requirements;

	• all **12** standards of the Annual Counter Fraud Functional Standards Return were rated green with one exception: the fraud, bribery and corruption risk assessment. • over £62k had been recovered/prevented from being lost in the year 2023-24; and • all Corporate and Finance staff would be encouraged to complete the Fraud Awareness training in ESR.

ASSURE	**Counter Fraud Position Statement, Q1 of 2024-25**
	
	The Q1 Counter Fraud Position Statement was presented to the Committee, with an overview of other activity. As of 30 June 2024, a total of **48.75** days of Counter Fraud work has been completed against the agreed full year **210** days, as detailed in the Counter Fraud Annual Work Plan for the 2024/25 financial year. The statement summarised the following activity in the last quarter:
	
	○ fraud awareness sessions for new starters commenced in November 2023 via Microsoft Teams with **108** staff attending up to 31st March 2024. A further **45** staff attended over **3** sessions during Q1 2024/25;
	○ **2** fraud awareness sessions were delivered in person to **27** staff;
	○ the NWSSP Local Counter Fraud Service intranet page continues to be updated;
	○ the LCFS Manager and NHS CFS Wales developed an All-Wales Counter Fraud Awareness E-learning module launched on 18/04/2023;
	○ **16** new fraud referrals have been made;
	○ there are **7** ongoing investigations, these are as follows -
	  ○ **3** relate to overpayment of salary;
	  ○ **2** relate to working on sick leave;
	  ○ **1** false representation on application for employment; and

	○ **1** allegation relating to overstating annual leave entitlement; and ○ no Fraud Prevention Notices (FPN) have been issued by the NHS Counter Fraud Authority during Q1 of 2024-25.
ASSURE	**Annual Governance Statement 2023-24** The Annual Governance Statement was presented to the Committee for final approval. It is not a formal requirement for NWSSP to produce the Statement. However, it is best practice to do so. The Statement is a positive assessment of the governance of NWSSP during the 2023-24 financial year and it had been presented to the Senior Leadership Group and the Shared Services Partnership Committee for endorsement. The Audit Committee approved the Annual Governance Statement.
ASSURE	**Governance Matters** The **Governance Matters** paper detailed the contracting activity for the last quarter. **26** contracts had been let for NWSSP and **40** further contracts for NHS Wales. There had been **2** further declarations made as to gifts, hospitality or sponsorship since the last meeting and no internal audits reports have received limited or no assurance. However, as noted above there would be **1** Limited Assurance Internal Audit Report relating to Decarbonisation to be reported to Welsh Government. Of **252** audit recommendations, **245** have been implemented, **5** are not yet due, **2** are overdue, but **1** is not in the control of NWSSP to fully implement and a revised deadline was brought to the Audit Committee for consideration and was approved. The **Corporate Risk Register** contains **4** red risks, **8** amber and no yellow or green risks.
INFORM	**Annual Report of Conflicts of Interest**

	The Committee received the Annual Conflicts of Interest Report. Overall compliance with recording declarations on ESR was generally good at nearly 80% of all staff, but it was noted that some areas do require some attention. These services are hard to reach areas, such as Laundry Services but it is acknowledged that the risk is lower. Compliance would continue to be managed and monitored and it was agreed that progress would be reported regularly to the Audit Committee.
INFORM	**Annual Report on Gifts, Hospitality & Sponsorship 2023-24** The Annual report for Gifts, Hospitality and Sponsorship for 2023-24 financial period was presented and provided a full list of all accepted and/or declined declarations offered to NWSSP staff during the financial period.
INFORM	**Audit Committee Annual Report 2023-24** The Audit Committee Chair presented the Annual Report for 2023-24 to the Committee for approval. In accordance with the Audit Committee Terms of Reference, an Annual Report is produced each year to inform the Shared Services Partnership Committee and the accountable officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of NWSSP's assurance arrangements.
INFORM	**Audit Committee Terms of Reference 2023-24** The Audit Committee received the Annual Terms of Reference Report, highlighting that a change of job title was the only change made, since its last review in July 2023 and the document remained fit for purpose.
INFORM	**Audit Committee Forward Plan for 2023-24**

	Members received the Audit Committee Forward Plan of business for the 2024-25 period, for information.
INFORM	**Items for Information** The following items were provided for information: • Welsh Language Annual Report 2023-24; and • Information Governance Annual Report 2023-24.
APPENDICES	N/A

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below Safe ☐ Timely ☐ Effective ☐

	Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. **Click or tap here to enter text**

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
	[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].

6. RISKS

None

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

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TRUST BOARD

2024/25 Approved Internal Audit Plan & Charter

DATE OF MEETING	26/09/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Emma Rees, Deputy Head of Internal Audit (NWSSP Audit & Assurance Services)
PRESENTED BY	Stephen Chaney, Head of Internal Audit (NWSSP Audit & Assurance Services)
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The 2024/25 Internal Audit Plan and Charter was approved by the Audit Committee in July 2024. The Plan is summarised in section 2 and attached (including the Charter) in Appendix 1.

RECOMMENDATION / ACTIONS	We ask the Board to • **NOTE** the approved 2024/25 Internal Audit Plan & Charter (Appendix 1); and • **NOTE** the 2024/25 mapping of assurance against the Trust Assurance Framework (appendix 2).

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board Run (for endorsement)	29/04/2024
Audit Committee (for approval)	10/07/2024
Executive Management Board Shape (for noting)	12/08/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

EMB Run endorsed the 2024/25 Draft Internal Audit Plan for approval by the Audit Committee subject to the following:

- Finalisation of the scopes for the VCC and WBS divisional reviews with the Divisional Directors;
- Removal of a proposed audit on BOFT governance and replacing this with an audit of the Performance Management Framework (EMB agreed the timing would not be right to audit BOFT during 2024/25); and
- Updating the DHCR audit scope to allow for the complexities of the DHCR implementation project and its link with the IRS Implementation.

These points were reflected in the Plan presented to Audit Committee for approval.

Audit Committee approved the 2024/25 Internal Audit Plan on 10/07/2024.

The approved 2024/25 Internal Audit Plan was taken to **EMB Shape** on 12/08/2024 for noting, with an action to EMB to ensure the plan is shared with divisional and service management teams and relevant operational staff to ensure awareness of upcoming audits.

7 LEVELS OF ASSURANCE	
N/a – not for assurance	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
1	2024/25 Draft Internal Audit Plan & Charter
2	2024/25 Internal Audit Assurance over Strategic Risks (TAF)

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1. SITUATION / BACKGROUND

The 2025/24 Internal Audit Plan (the Plan) was endorsed by EMB Run on 29 April 2024 and approved by the Audit Committee on 10 July 2024.

The Plan is based on the following annual planning work which took place during Spring 2024:

- meetings with the Trust's Directors and Independent members;
- reviewing key documents, including the TAF, TRR and the Trust strategies and priorities;
- considering previous reviews we have done and their outcomes;
- meeting with Audit Wales to understand its intended reviews to avoid duplication; and
- considering areas for potential all Wales reviews.

2. ASSESSMENT

2024/25 ANNUAL PLANNING

The approved 2024/25 Plan is summarised below. The full 2024/25 draft plan, including proposed outline scopes and our Internal Audit Charter, is detailed in Appendix 1.

2024/24 Planned Internal Audit Review		Link to:		Trust priority?
		TAF	TRR	
Financial Governance & Management				
4	Key Financial Controls	08		
5	Financial & Service Sustainability	08		✓
7	Procurement & Contract Management	08		
Information Governance & Security				
11	Digital Health & Care Record	05		✓
Workforce Management				
2	Medical Job Planning			
Operational Service & Functional Management				
8	WBS Futures Governance	06		✓
9	Acute Oncology Service			✓
Corporate Governance, Risk Management & Regulatory Compliance				
3	Board Assurance & Risk Management	06		✓
10	Follow up of prior year recommendations	06		
Strategic Planning, Performance Management & Reporting				
6	Performance Management Framework	06		✓
Quality & Safety				
1	Duties of Quality & Candour	06		✓

2024/24 Planned Internal Audit Review		Link to:		Trust priority?
		TAF	TRR	
Capital & Estates Management				
12	WBS Infrastructure	06		✓
13	IRS Implementation	-		✓
14	Estates Assurance – Energy Management	08		
Integrated Audit & Assurance Plan: new Velindre Cancer Centre (nVCC)				
15	nVCC Governance[1]	06 / 08	3227 / 3293	✓
16	nVCC Advisers[1]			✓
17	nVCC Contract Delivery[2]		3227	✓
18	TCS Digital Project[2]	05		✓

1. *Funded through the main 2024/25 Internal Audit Plan.*
2. *Funded through the nVCC draft Business Case provision for 2024/25.*

The graphs below analyse the profiling of the 2024/25 plan by Executive Lead, by planned quarter and by planning domain:

Note: reviews with timing TBC relate mainly to the nVCC IAAP. These reviews will be aligned with nVCC Project progress as appropriate.

Other areas considered in 2024/25 planning

The below table sets out other areas that were considered during our 2024/25 planning process. These were identified through our review of the TAF, TRR, Trust Priorities, Trust Strategy and IMTP, and in our meetings with Independent Members and Executive Directors.

These will be considered as priority areas for future plans and could be used as options for replacement reviews should any planned 2024/25 reviews be deferred or cancelled.

Governance	Strategic Planning & Performance Reporting
BOFT: Communication & Engagement (Trust priority) Charity Governance Freedom of Information BOFT: Leadership Development (Trust priority) Board Committee Effectiveness	BOFT (Trust priorities): • Clinical & Scientific Arrangements • Performance Management Framework • Ways of Working Programme WBS Futures individual programmes (Trust priorities): • Plasma for Medicines Programme • Welsh Bone Marrow Donor Registry Programme VCC Development Programmes (Trust priorities): • Transforming Access to Medicines Programme WBS Development Programmes (Trust priorities): • HEP B Testing • Advanced Welsh Medical Genetics Revenue-funded elements* of: • Velindre Futures programme (Trust priority) • WBS Futures programme (Trust priority) Radiotherapy Satellite Centre – Trust responsibilities (Trust priority) Outreach Services Project (Trust priority) ** For example, service redesign / transformation / modernisation, workforce planning, financial (revenue) planning, etc. Capital-funded elements will be subject to separate IAAPs.*
Quality & Safety	
Falls Management (VCC) Patient Engagement Strategy (VCC) Safe Staffing	
Workforce	
BOFT: Culture & Values (TAF 04, Trust priority) People Strategy (TAF 03) Equality Diversity & Inclusion Welsh Language Standards Staff Wellbeing (Trust priority) Response to NHS Wales Staff Survey	
Operational	**Digital**
Health & Safety WBS Wrexham Site Management Outpatients Service	Digitisation of Records

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3. SUMMARY OF MATTERS FOR CONSIDERATION

We ask the Audit Committee to:

- **NOTE** the 2024/25 Internal Audit Plan & Charter (appendix 1); and
- **NOTE** the 2024/25 mapping of assurance against the Trust Assurance Framework (appendix 2).

4. IMPACT ASSESSMENT

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

	Individual Internal Audit reports may provide assurance over the Quality Domains and Enablers. Internal Audit reports are linked to the Quality Domains and Enablers in the individual audit briefs and through the cover paper for each individual report, where applicable.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Not required for Internal Audit reports

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	Individual Internal Audit reports may provide assurance over the Wellbeing Goals.
	If more than one wellbeing goal applies please list below: Internal Audit reports will be linked to the Wellbeing Goals in the cover paper for each individual report, where applicable.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not required for Internal Audit reports
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Legal risks identified in our audits will be highlighted in the cover report for each individual report, where applicable.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Internal Audit reports are linked to the Trust Risk Register in the Annual Internal Audit Plan and through the cover paper for each individual report, where applicable.
WHAT IS THE CURRENT RISK SCORE	N/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/a
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/a
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

Internal Audit Assurance over Strategic Risks (TAF) - 2024/25 plan

TAF ref	Risk theme	Internal Audit assurance from			
		Previous audits *Audits undertaken from 2018/19 - 2023/24 (to Apr-24)*	2024/25 planned audits and 2023/24 audits not yet completed	Future potential audits (post 2024/25)	IAAPs
1	Service Capacity	23/24 Recruitment & Retention (reasonable)	24/25 Medical Job Planning (must do)		
2	Partnership Alignment			Communication & Engagement (should do)	Yes (must do)
3	Workforce Supply & Shape	23/24 Recruitment & Retention (reasonable)	24/25 Medical Job Planning (must do)	People Strategy (should do)	
		23/24 Education Strategy (reasonable)			
		20/21 Workforce Planning Follow Up (reasonable)			
		20/21 Workforce Planning (limited)			
4	Organisational Culture	23/24 Recruitment & Retention		Culture & Values (should do)	
		23/24 Education Strategy (reasonable)		People Strategy (should do)	
		22/23 Staff Wellbeing (advisory)		Equality, Diversity & Inclusion (should do)	
				Ways of Working (should do)	
				Communication & Engagement (should do)	
5	Digital Transformation	23/24 Digital Strategy & Transformation Programme (reasonable)	24/25 DHCR Implementation (should do)	BI Infrastructure (advisory) (long list)	Yes (must do)
		23/24 nVCC Digital Project (reasonable)	24/25 nVCC Digital Project (must do)		
		22/23 DHCR - Implementation (substantial)	23/24 IRS Procurement (draft report)		
		22/23 Cyber Security (substantial, draft report)			
		22/23 Information Governance (reasonable)			
		21/22 Use of Digital Technology - Fit for the Future (advisory)			
		21/22 DHCR (Canisc replacement) - Project Management (reasonable)			
		18/19 Cyber Security (reasonable)			
		18/19 GDPR (reasonable)			
6	Organisational & Clinical Governance				
	Organisational Governance	22/23 Trust Priorities (reasonable)	23/24 GAR (draft report)	Ways of Working (should do)	Yes (must do)
		22/23 Performance Management Framework (reasonable)	23/24 Follow Up (fieldwork)	Building Our Futures Together (must do)	
		21/22 Divisional Risk Management (reasonable)	24/25 Trust Assurance Framework / Trust Risk Register (must do)		
		22/23 Follow Up (reasonable)	24/25 Performance Management Framework (shouild do)		
		22/23 Estates Assurance - Decarbonisation (advisory)	24/25 Follow up (must do)		
		21/22 Board Committee Effectiveness (reasonable)	23/24 Decarbonisation (fieldwork)		
		21/22 Trust Assurance Framework (reasonable)	24/25 WBS Futures Governance (should do)		
		21/22 Follow Up (reasonable)			
		20/21 Covid-19 Governance Arrangements (advisory)			
		18/19 Performance Reporting (substantial)			
		18/19 Risk Management (reasonable)			
	Clinical Governance	22/23 Patient & Donor Experience (reasonable)	24/25 Duties of Quality & Candour (must do)	Quality & Safety Governance (must do)	
		22/23 Clinical audit (reasonable)	23/24 Medicines Management (fieldwork)		
		20/21 Health & Care Standards (substantial)			
		19 /20Health & Care Standards (reasonable)			
		18/19 Health & Care Standards (reasonable)			
7	Patient Outcomes	22/23 Patient & Donor Experience (reasonable)	24/25 Acute Oncology Service (should do)	Quality & Safety Governance (must do)	
		22/23 Clinical audit	24/24 Performance Management Framework (should do)	Patient Engagement Strategy (should do)	
				Clinical & Scientific Strategy - development / implementation (long list)	
8	Financial Sustainability & Long-Term Value	22/23 Trust Priorities (reasonable)	24/25 Finance & Service Sustainability: Financial Strategy, Medium-Term Financial Plan and Resourcing (should do)	Value Based Healthcare (should do)	
		22/23 Financial & Service Sustainability: Budget Control & Savings Plans (reasonable)	24/25 Key Financial Controls (should do)		
		21/22 Scrutiny of Expenditure over Chief Executive's Limit (reasonable)	24/25 Procurement & Contract Management		
		20/21 New Contracting Model (substantial)	23/24 Financial & Service Sustainability (fieldwork)		
		18/19 IMTP (substantial)			
		Key Financial Controls reviews (reasonable): 18/19-20/21			

Annual Internal Audit Plan 2024/25

Internal Audit Charter

July 2024

Velindre University NHS Trust

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Disclaimer notice - please note
This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared in accordance with the agreed audit brief and the Audit Charter, as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of Velindre University NHS Trust and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

1. Introduction

This document sets out the Internal Audit Plan for 2024/25 (the Plan) detailing the audits to be undertaken and an analysis of the corresponding resources. It also contains the Internal Audit Charter which defines the over-arching purpose, authority and responsibility of Internal Audit and the Key Performance Indicators for the service.

The Accountable Officer (the Trust Chief Executive) is required to certify, in the Annual Governance Statement, that they have reviewed the effectiveness of the organisation's governance arrangements, including the internal control systems, and provide confirmation that these arrangements have been effective, with any qualifications as necessary including required developments and improvement to address any issues identified.

The purpose of Internal Audit is to provide the Accountable Officer and the Board, through the Audit Committee, with an independent and objective annual opinion on the overall adequacy and effectiveness of the organisation's framework of governance, risk management, and control. The opinion should be used to inform the Annual Governance Statement.

Additionally, the findings and recommendations from internal audit reviews may be used by Trust management to improve governance, risk management, and control within their operational areas.

The Public Sector Internal Audit Standards (the Standards) require that 'The risk-based plan must take into account the requirement to produce an annual internal audit opinion and the assurance framework. It must incorporate or be linked to a strategic or high-level statement of how the internal audit service will be delivered in accordance with the internal audit charter and how it links to the organisational objectives and priorities.'

Accordingly, this document sets out the risk-based approach and the Plan for 2024/25. The Plan will be delivered in accordance with the Internal Audit Charter and the agreed KPIs which are monitored and reported to you. All internal audit activity will be provided by Audit & Assurance Services, a part of NHS Wales Shared Services Partnership (NWSSP).

1.1 National Assurance Audits

The proposed Plan includes assurance audits on some services that are provided by Digital Health and Care Wales (DHCW), NWSSP and the NHS Wales Joint Commissioning Committee (NWJCC) (the new Joint Committee for Welsh Health Specialised Services Committee (WHSSC), Emergency Ambulance Services Committee (EASC) and the National Collaborative Commissioning Unit (NCCU)) on behalf of NHS Wales. These audits will be included in Appendix A when agreed formally. These audits are part of the risk-based programme of work for DHCW, NWSSP and Cwm Taf Morgannwg UHB (for NWJCC) but the results, as in previous years, are reported to the relevant organisation and are used to inform the overall annual Internal Audit opinion for those organisations.

2. Developing the Internal Audit Plan

2.1 Link to the Public Sector Internal Audit Standards

The Plan has been developed in accordance with Standard 2010 – Planning, to enable the Head of Internal Audit to meet the following key objectives:

- the need to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals;
- provision to the Accountable Officer of an overall independent and objective annual opinion on the organisation's governance, risk management, and control, which will in turn support the preparation of the Annual Governance Statement;
- audits of the organisation's governance, risk management, and control arrangements which afford suitable priority to the organisation's objectives and risks;
- improvement of the organisation's governance, risk management, and control arrangements by providing line management with recommendations arising from audit work;
- confirmation of the audit resources required to deliver the Internal Audit Plan;
- effective co-operation with Audit Wales as external auditor and other review bodies functioning in the organisation; and
- provision of both assurance (opinion based) and consulting engagements by Internal Audit.

2.2 Risk based internal audit planning approach

Our risk-based planning approach recognises the need for the prioritisation of audit coverage to provide assurance on the management of key areas of risk, and our approach addresses this by considering:

- the organisation's risk assessment and maturity;
- the organisation's response to key areas of governance, risk management and control;
- the previous years' internal audit activities; and
- the audit resources required to provide a balanced and comprehensive view.

Our planning takes into account the NHS Wales Planning Framework and other NHS Wales priorities such as the Duties of Quality and Candour, and is mindful of significant national changes that are taking place. In addition, the plan aims to reflect any significant local changes occurring as identified through the Integrated Medium-Term Plan (IMTP) and other changes within the organisation, assurance needs, identified concerns from our discussions with management, and emerging risks.

We will ensure that the plan remains fit for purpose by recommending changes where appropriate and reacting to any emerging issues throughout the year. Any necessary updates will be reported to the Audit Committee in line with the Internal Audit Charter.

While some areas of governance, risk management and control will require annual consideration, our risk-based planning approach recognises that it is not possible to audit every area of an organisation's activities every year. Therefore, our approach identifies auditable areas (the audit universe). The risk associated with each auditable area is assessed and this determines the appropriate frequency for review.

In addition, we will, if requested, also agree a programme of work through both the Board Secretaries and Directors of Finance networks. These audits and reviews may be undertaken across all NHS bodies or a particular sub-set, for example at Health Boards only.

Therefore, our audit plan is made up of a number of key components:

1) Consideration of key governance and risk areas: We have identified a number of areas where an annual consideration supports the most efficient and effective delivery of an annual opinion. These cover Governance, Trust Assurance Framework, Risk Management, Clinical Governance and Quality, Financial Sustainability, Performance Monitoring & Management and an overall IM&T assessment. In each case we anticipate a short overview to establish the arrangements in place including any changes from the previous year with detailed testing or further work where required.

2) Organisation based audit work – this covers key risks and priorities from the Trust Assurance Framework and the Trust Risk Register together with other auditable areas identified and prioritised through our planning approach. This work combines elements of governance and risk management with the controls and processes put in place by management to effectively manage the areas under review.

3) Follow up: this is follow-up work on previous limited and no/unsatisfactory assurance reports as well as other high priority recommendations. Our work here also links to the organisation's recommendation tracker and considers the impact of their implementation on the systems of governance and control.

4) Work agreed with the Board Secretaries, Directors of Finance, other executive peer groups, or Audit Committee Chairs in response to common risks faced by a number of organisations. This may be advisory work in order to identify areas of best practice or shared learning.

5) The impact of audits undertaken at other NHS Wales bodies that impacts on the Trust, namely NWSSP, DHCW and NWJCC.

6) Where appropriate, Integrated Audit & Assurance Plans will be agreed for major capital and transformation schemes and charged for separately. Health bodies are able to add a provision for audit and assurance costs into the Final Business Case for major capital bids.

These components are designed to ensure that our internal audit programmes comply with all of the requirements of the Standards, supports the maximisation of the benefits of being an all-NHS Wales wide internal audit service, and allows us to respond in an agile way to requests for audit input at both an all-Wales and organisational level.

2.3 Link to the Trust's systems of assurance

The risk based internal audit planning approach integrates with the Trust's systems of assurance; therefore, we have considered the following:

- a review of the Board's vision, values and forward priorities as outlined in the Trust strategies, the Annual Plan and three year Integrated Medium Term Plan (IMTP);
- an assessment of the Trust's governance and assurance arrangements and the contents of the corporate risk register;
- risks identified in papers to the Board and its Committees (in particular the Audit Committee and the Quality, Safety and Performance Committee);
- key strategic and operational risks identified within the Trust Assurance Framework, Trust Risk Register and assurance processes;
- discussions with Executive Directors regarding risks and assurance needs in areas of corporate responsibility;
- cumulative internal audit knowledge of governance, risk management, and control arrangements (including a consideration of past internal audit opinions);
- new developments and service changes;
- legislative requirements to which the organisation is required to comply;
- planned audit coverage of systems and processes provided through NWSSP, DHCW and NWJCC;
- work undertaken by other supporting functions of the Audit Committee including Local Counter-Fraud Services (LCFS) and the Post-Payment Verification Team (PPV) where appropriate;
- work undertaken by other review bodies including Audit Wales and Healthcare Inspectorate Wales (HIW); and
- coverage necessary to provide assurance to the Accountable Officer in support of the Annual Governance Statement.

2.4 Audit planning meetings

In developing the Plan, in addition to consideration of the above, the Head of Internal Audit has met and spoken with a number of Trust Independent Members and Directors to discuss current areas of risk and related assurance needs.

The draft Plan has been provided to the Trust's Executive Management Board and Audit Committee Chair to ensure that Internal Audit's focus is best targeted to areas of risk.

3. Audit risk assessment

The prioritisation of audit coverage across the audit universe is based on both our and the organisation's assessment of risk and assurance requirements as defined in the Trust Assurance Framework and Trust Risk Register.

The maturity of these risk and assurance systems allows us to consider both inherent risk (impact and likelihood) and mitigation (adequacy and effectiveness of internal controls). Our assessment also takes into account corporate risk, materiality or significance, system complexity, previous audit findings, and potential for fraud.

4. Planned internal audit coverage

4.1 Internal Audit Plan 2024/25

The Plan is set out in Appendix A and identifies the audit assignments, lead executive officers, outline scopes, and proposed timings. It is structured under the six components referred to in section 2.2.

Where appropriate the Plan makes cross reference to key strategic and operational risks identified within the Trust Assurance Framework, Trust Risk Register and related systems of assurance together with the proposed audit response within the outline scope.

The scope, objectives and audit resource requirements and timing will be refined in each area when developing the audit scope in discussion with the responsible executive director(s) and operational management.

The scheduling takes account of the optimum timing for the performance of specific assignments in discussion with management, and Audit Wales requirements if appropriate.

The Audit Committee will be kept appraised of performance in delivery of the Plan, and any required changes, through routine progress reports to each Audit Committee meeting.

The majority of the audit work will be undertaken by our regionally based teams with support from our national Capital & Estates team, in terms of capital audit and estates assurance work, and from our IM&T team, in terms of Information Governance, IT security and Digital work.

4.2 Keeping the plan under review

Our risk assessment and resulting Plan is limited to matters emerging from the planning processes indicated above.

Audit & Assurance Services is committed to ensuring its service focuses on priority risk areas, business critical systems, and the provision of assurance to management across the medium term and in the operational year ahead. As in any given year, our Plan will be kept under review and may be subject to change to ensure it remains fit for purpose.

Consistent with previous years, and in accordance with best professional practice, an unallocated contingency provision has been retained in the Plan to enable Internal Audit to respond to emerging risks and priorities identified by the Executive Management Team and endorsed by the Audit Committee. Any changes to the Plan will be based upon consideration of risk and need and will be presented to the Audit Committee for approval.

Regular liaison with Audit Wales as your External Auditor will take place to coordinate planned coverage and ensure optimum benefit is derived from the total audit resource.

5. Resource needs assessment

The plan has been put together on the basis of the planning process described in this document. The plan includes sufficient audit work to be able to give an annual Head of Internal Audit Opinion in line with the requirements of Standard 2450 – Overall Opinions.

Audit & Assurance Services confirms that it has the necessary resources to deliver the agreed plan.

Provision has also been made for other essential audit work including planning, management, reporting and follow-up.

If additional work, support or further input is necessary to deliver the plan, we will look to deliver it from within our resources. It is possible, in exceptional cases, that an additional fee may be charged. Any change to the plan will be based upon consideration of risk and need and presented to the Audit Committee for approval.

The Standards enable Internal Audit to provide consulting services to management. The commissioning of these additional services by the Trust, unless already included in the plan, is discretionary. Accordingly, a separate fee may need to be agreed for any additional work.

In addition, project audits will be charged for separately on the basis of the agreed Integrated Audit & Assurance Plans (approved by Welsh Government within their respective business cases). For 2024/25, we have included a number of audits in relation to the new Velindre Cancer Centre. As the Business Case has yet to be finally approved, we have included some of those audits as part of the main plan with the remainder being funded from the draft Business Case provision. More details are included at Appendix A.

6. Action required

The Audit Committee is invited to consider the Internal Audit Plan for 2024/25 and:

- approve the Internal Audit Plan for 2024/25;
- approve the Internal Audit Charter; and
- note the associated Internal Audit resource requirements and Key Performance Indicators.

Simon Cookson

Director of Audit & Assurance and Head of Internal Audit (Velindre University NHS Trust)
Audit and Assurance Services
NHS Wales Shared Services Partnership

Appendix A: Internal Audit Plan 2024/2025

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Annual Governance Statement	-	TAF 06	To provide commentary on key aspects of Board Governance to underpin the completion of the statement.	Chief Executive / Director of Corporate Governance	Q4
Duties of Quality and Candour	01	TAF 06	To provide assurance that the Trust is implementing the requirements of the Duty of Quality and Duty of Candour	Director of Nursing, AHPs & Health Scientists	Q3
Medical Job Planning	02	-	To evaluate and determine the adequacy of the systems and controls in place for the management of medical job planning.	Medical Director	Q4
Board Assurance & Risk Management	03	TAF 06	To review the implementation and application of the Trust's board assurance and risk management processes.	Director of Corporate Governance	Q2
Key Financial Controls	04	TAF 08	To provide the Trust with assurance that core financial systems are operating effectively.	Director of Finance	Q1/2
Finance & Service Sustainability	05	TAF 08	To review the financial management arrangements in place to ensure sustainability of services. To focus on medium-loner term finance and resource planning to support the delivery of the Trust's Strategy (Destination 2033) and IMTP.	Director of Finance	Q3
Performance Management Framework	06	TAF 06	To provide the Trust with assurance over phases 2 and 3 of evolving the PMF, and over the effectiveness of the PMF in practice.	Director of Strategic Transformation, Planning & Digital	Q3
Procurement & Contract Management	07	TAF 08	To review the adequacy of procurement and contract management arrangements in place within the Trust, including interaction with NWSSP Procurement Services.	Director of Finance	Q3
WBS Futures Governance	08	TAF 06	To provide assurance over the governance mechanisms for the WBS Futures programme.	Chief Operating Officer	Q1/2

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Acute Oncology Service	09	-	To provide assurance that the Acute Oncology Service is operating in accordance with national requirements.	Chief Operating Officer	Q1/2
Follow Up of Previous Recommendations	10	TAF 06	To provide assurance that: • Internal Audit recommendations are implemented in a timely manner and have addressed identified risks; and • the Audit Action Tracker provides complete and accurate updates on progress against Internal Audit recommendations.	Director of Finance	Q3/4
Digital Health & Care Record	11	TAF 05	To provide assurance over the implementation of the DHCR, recognising the status of the project and interactions with the Integrated Radiotherapy Solution (IRS) implementation.	Chief Operating Officer	Q2/3
WBS – Infrastructure & Modernisation Programme	12	TAF 06	To consider the programme for the delivery of the WBS (Talbot Green) Infrastructure Project including timelines, governance, and risk management.	Chief Operating Officer	TBC
IRS (Implementation)	13	-	To provide assurance over the project governance for the IRS Implementation (TCS Project 3a), recognising the interactions with the DHCR implementation project.	Chief Operating Officer	Q2/3
Estates Assurance - Energy Management	14	TAF 08	Recognising the increase in utility costs and the associated financial risks, the audit will examine the arrangements in place to manage energy consumption, optimisation, conservation and efficiency. The audit will look to gain assurance the appropriate arrangements are in place to gather data, ensuring that the data is of suitable quality / reliability. The audit will also look at resulting strategies and/ or plans to address key risks.	Director of Strategic Transformation, Planning & Digital / Director of Finance	Q2/3

Planned output	Audit Ref	TAF / TRR Reference	Outline Scope	Executive Lead	Outline Timing
Integrated Audit & Assurance Plan: new Velindre Cancer Centre (nVCC)					
nVCC Governance Post Financial Close[1]	15	TAF 06, 08 TRR 3227, 3293	To determine whether appropriate governance arrangements are in place at the nVCC Project post financial close.	TCS Project Director	TBC
nVCC Appointment of Advisers[1]	16	-	To consider the adequacy of the arrangements to appoint and performance manage advisers at the nVCC Project	TCS Project Director	TBC
nVCC Contract Compliance[2]	17	TRR 3227	To consider whether appropriate contract delivery arrangements are in place at the nVCC Project.	TCS Project Director	TBC
nVCC Digital Project[2]	18	TAF 05	To provide assurance on the progress of planning and development of digital systems and solutions for the new Velindre Cancer Centre. This will include understanding how services will use the new hospital from a digital design perspective.	TCS Project Director	Q4
NHS Wales national audit work					
Collation of assurances from NHS Wales national audit work	-	-	To collate the assurances derived from the review of NHS Wales bodies that provide services to this organisation and contribute to its overall system of control. This will cover some of our work at Health Education & Improvement Wales, Public Health Wales, NHS Wales Shared Services Partnership, Digital Health and Care Wales and Emergency Ambulance Services Committee.	Director of Corporate Governance / Director of Finance	Q4

[1] This audit is funded through the main plan for 2024/25.
[2] This audit is funded from the draft Business Case provision for 2024/25.

Appendix B: Key performance indicators (KPI)

KPI	SLA required	Target 2024/25
Audit plan 2024/25 agreed/in draft by 30 April	✓	To deliver plan
Audit opinion 2024/25 delivered by 31 May	✓	To deliver opinion
Audits reported versus total planned audits, and in line with Audit Committee expectations	✓	varies
% of audit outputs in progress	No	varies
Report turnaround fieldwork to draft reporting [10 working days]	✓	95%
Report turnaround management response to draft report [15 working days maximum]	✓	80%
Report turnaround draft response to final reporting [10 working days]	✓	95%

Appendix C: Internal Audit Charter

1 Introduction

1.1 This Charter is produced and updated annually to comply with the Public Sector Internal Audit Standards. The Charter is complementary to the relevant provisions included in the organisation's own Standing Orders and Standing Financial Instructions.

1.2 The terms 'board' and 'senior management' are required to be defined under the Standards and therefore have the following meaning in this Charter:

- Board means the Board of Velindre University NHS Trust with responsibility to direct and oversee the activities and management of the organisation. The Board has delegated authority to the Audit Committee in terms of providing a reporting interface with internal audit activity; and
- Senior Management means the Chief Executive as being the designated Accountable Officer for Velindre University NHS Trust. The Chief Executive has made arrangements within this Charter for an operational interface with internal audit activity through the Board Secretary.

1.3 Internal Audit seeks to comply with all the appropriate requirements of the Welsh Language (Wales) Measure 2011. We are happy to correspond in both Welsh and English.

2 Purpose and responsibility

2.1 Internal audit is an independent, objective assurance and advisory function designed to add value and improve the operations of Velindre University NHS Trust. Internal audit helps the organisation accomplish its objectives by bringing a systematic and disciplined approach to evaluate and improve the effectiveness of governance, risk management and control processes. Its mission is to enhance and protect organisational value by providing risk-based and objective assurance, advice and insight.

2.2 Internal Audit is responsible for providing an independent and objective assurance opinion to the Accountable Officer, the Board and the Audit Committee on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. In addition, internal audit's findings and recommendations are beneficial to management in securing improvement in the audited areas.

2.3 The organisation's risk management, internal control and governance arrangements comprise:

- the policies, procedures and operations established by the organisation to ensure the achievement of objectives;
- the appropriate assessment and management of risk, and the related system of assurance;

- the arrangements to monitor performance and secure value for money in the use of resources;
- the reliability of internal and external reporting and accountability processes and the safeguarding of assets;
- compliance with applicable laws and regulations; and
- compliance with the behavioural and ethical standards set out for the organisation.

2.4 Internal audit also provides an independent and objective consulting service specifically to help management improve the organisations risk management, control and governance arrangements. The service applies the professional skills of internal audit through a systematic and disciplined evaluation of the policies, procedures and operations that management have put in place to ensure the achievement of the organisations objectives, and through recommendations for improvement. Such consulting work contributes to the opinion which internal audit provides on risk management control and governance.

3 Independence and Objectivity

3.1 Independence as described in the Public Sector Internal Audit Standards as the freedom from conditions that threaten the ability of the internal audit activity to carry out internal audit responsibilities in an unbiased manner. To achieve the degree of independence necessary to effectively carry out the responsibilities of the internal audit activity, the Head of Internal Audit will have direct and unrestricted access to the Board and Senior Management, in particular the Chair of the Audit Committee and Accountable Officer.

3.2 Organisational independence is effectively achieved when the auditor reports functionally to the Audit Committee on behalf of the Board. Such functional reporting includes the Audit Committee:

- approving the internal audit charter;
- approving the risk based internal audit plan;
- approving the internal audit resource plan;
- receiving outcomes of all internal audit work together with the assurance rating; and
- reporting on internal audit activity's performance relative to its plan.

3.3 While maintaining effective liaison and communication with the organisation, as provided in this Charter, all internal audit activities shall remain free of untoward influence by any element in the organisation, including matters of audit selection, scope, procedures, frequency, timing, or report content to permit maintenance of an independent and objective attitude necessary in rendering reports.

3.4 Internal Auditors shall have no executive or direct operational responsibility or authority over any of the activities they review. Accordingly, they shall not develop nor install systems or procedures, prepare records, or engage in any other activity which would normally be audited.

3.5 This Charter makes appropriate arrangements to secure the objectivity and independence of internal audit as required under the standards. In addition, the shared service model of provision in NHS Wales through NWSSP provides further organisational independence.

3.6 In terms of avoiding conflicts of interest in relation to non-audit activities, Audit & Assurance has produced a Consulting Protocol that includes all of the steps to be undertaken to ensure compliance with the relevant Standards that apply to non-audit activities.

4 Authority and Accountability

4.1 Internal Audit derives its authority from the Board, the Accountable Officer and Audit Committee. These authorities are established in Standing Orders and Standing Financial Instructions adopted by the Board.

4.2 The Minister for Health and Social Services has determined that internal audit will be provided to all health organisations by the NHS Wales Shared Services Partnership (NWSSP). The service provision will be in accordance with the Service Level Agreement agreed by the Shared Services Partnership Committee and in which the organisation has permanent membership.

4.3 The Director of Audit & Assurance leads the NWSSP Audit and Assurance Services and after due consultation will assign a named Head of Internal Audit to the organisation. For line management (e.g. individual performance) and professional quality purposes (e.g. compliance with the Public Sector Internal Audit Standards), the Head of Internal Audit reports to the Director of Audit & Assurance.

4.4 The Head of Internal Audit reports on a functional basis to the Accountable Officer and to the Audit Committee on behalf of the Board. Accordingly, the Head of Internal Audit has a direct right of access to the Accountable Officer, the Chair of the Audit Committee and the Chair of the organisation if deemed necessary.

4.5 The Audit Committee approves all Internal Audit plans and may review any aspect of its work. The Audit Committee also has regular private meetings with the Head of Internal Audit.

4.6 In order to facilitate its assessment of governance within the organisation, Internal Audit is granted access to attend any committee or sub-committee of the Board charged with aspects of governance.

5 Relationships

5.1 In terms of normal business the Accountable Officer has determined that the Board Secretary will be the nominated executive lead for internal audit. Accordingly, the Head of Internal Audit will maintain functional liaison with this officer.

5.2 In order to maximise its contribution to the Board's overall system of assurance, Internal Audit will work closely with the organisation's Board Secretary in planning its work programme.

5.3 Co-operative relationships with management enhance the ability of internal audit to achieve its objectives effectively. Audit work will be planned in conjunction with management, particularly in respect of the timing of audit work.

5.4 Internal Audit will meet regularly with the external auditor, Audit Wales, to consult on audit plans, discuss matters of mutual interest, discuss common understanding of audit techniques, method and terminology, and to seek opportunities for co-operation in the conduct of audit work. In particular, Internal Audit will make available their working files to the external auditor for them to place reliance upon the work of Internal Audit where appropriate.

5.5 The Head of Internal Audit will establish a means to gain an overview of other assurance providers' approaches and output as part of the establishment of an integrated assurance framework.

5.6 The Head of Internal Audit will take account of key systems being operated by organisation's outside of the remit of the Accountable Officer, or through a shared or joint arrangement, such as Health Education and Improvement Wales, Public Health Wales, Welsh Health Specialised Services Committee, Digital Health and Care Wales, NHS Wales Shared Services Partnership and Emergency Ambulance Services Committee.

5.7 Internal Audit strives to add value to the organisation's processes and help improve its systems and services. To support this Internal Audit will obtain an understanding of the organisation and its activities, encourage two-way communications between internal audit and operational staff, discuss the audit approach and seek feedback on work undertaken.

5.8 The Audit Committee may determine that another Committee of the organisation is a more appropriate forum to receive and action individual audit reports. However, the Audit Committee will remain the final reporting line for all our audit and consulting reports.

6 Standards, Ethics, and Performance

6.1 Internal Audit must comply with the Definition of Internal Auditing, the Core Principles, Public Sector Internal Audit Standards and the professional Code of Ethics, as published on the NHS Wales e-governance website.

6.2 Internal Audit will operate in accordance with the Service Level Agreement (updated 2024) and associated performance standards agreed with the Audit Committee and the Shared Services Partnership Committee. The Service Level Agreement includes a number of Key Performance Indicators, and we will agree with each Audit Committee which of these they want reported to them and how often.

7 Scope

7.1 The scope of Internal Audit encompasses the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management arrangements, system of internal control, and the quality of performance in carrying out assigned responsibilities to achieve the organisation's stated goals and objectives. It includes but is not limited to:

- reviewing the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information;
- reviewing the systems established to ensure compliance with those policies, plans, procedures, laws, and regulations which could have a significant impact on operations, and reports on whether the organisation is in compliance;
- reviewing the means of safeguarding assets and, as appropriate, verifying the existence of such assets;
- reviewing and appraising the economy and efficiency with which resources are employed, this may include benchmarking and sharing of best practice;
- reviewing operations or programmes to ascertain whether results are consistent with the organisation's objectives and goals and whether the operations or programmes are being carried out as planned;
- reviewing specific operations at the request of the Audit Committee or management, this may include areas of concern identified in the corporate risk register;
- monitoring and evaluating the effectiveness of the organisation's risk management arrangements and the overall system of assurance;
- ensuring effective co-ordination, as appropriate, with external auditors; and
- reviewing the Annual Governance Statement prepared by senior management.

7.2 Internal Audit will devote particular attention to any aspects of the risk management, internal control and governance arrangements affected by material changes to the organisation's risk environment.

7.3 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the Charter in any way limit the scope of internal audit or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they will advise the Accountable Officer and Board accordingly.

8 Approach

8.1 To ensure delivery of its scope and objectives in accordance with the Charter and Standards, Internal Audit has produced an Audit Manual (called the Quality Manual). The Quality Manual includes arrangements for planning the audit work. These audit planning arrangements are organised into a hierarchy as illustrated in Figure 1.

Figure 1: Audit planning hierarchy

NHS Wales Level	NWSSP overall audit strategy	Arrangements for provision of internal audit services across NHS Wales requirements of the Charter
Organisation Level	Entity strategic 3-year audit plan	Entity level medium term audit plan linked to organisational objectives priorities and risk assessment
	Entity annual internal audit plan	Annual internal audit plan detailing audit engagements to be completed in year ahead leading to the overall HIA opinion
Business Unit Level	Assignment plans	Assignment plans detail the scope and objectives for each audit engagement within the annual operational plan

8.2 NWSSP Audit & Assurance Services has developed an overall audit strategy which sets out the strategic approach to the delivery of audit services to all health organisations in NHS Wales. The strategy also includes arrangements for securing assurance on the national transaction processing systems including those operated by DHCW, NWSSP and NWJCC on behalf of NHS Wales.

8.3 The main purpose of the Strategic 3-year Audit Plan is to enable the Head of Internal Audit to plan over the medium term on how the assurance needs of the organisation will be met as required by the Standards and facilitate:

- the provision to the Accountable Officer and the Audit Committee of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Annual Governance Statement;
- audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks;
- improvement of the organisation's risk management, control and governance by providing management with constructive recommendations arising from audit work;
- an assessment of audit needs in terms of those audit resources which 'are appropriate, sufficient and effectively deployed to achieve the approved plan';
- effective co-operation with external auditors and other review bodies functioning in the organisation; and
- the allocation of resources between assurance and consulting work.

8.4 The Strategic 3-year Audit Plan will be largely based on the Trust Assurance Framework where it is sufficiently mature, together with the organisation-wide risk assessment.

8.5 An Annual Internal Audit Plan will be prepared each year drawn from the Strategic 3-year Audit Plan and other information and outlining the scope and timing of audit assignments to be completed during the year ahead.

8.6 The strategic 3-year and annual internal audit plans shall be prepared to support the audit opinion to the Accountable Officer on the risk management, internal control and governance arrangements within the organisation.

8.7 The annual internal audit plan will be developed in discussion with executive management and approved by the Audit Committee on behalf of the Board.

8.8 The NWSSP Audit Strategy is expanded in the form of a Quality Manual and a Consulting Protocol which together define the audit approach applied to the provision of internal audit and consulting services.

8.9 During the planning of audit assignments, an assignment brief will be prepared for discussion with the nominated operational manager. The brief will contain the proposed scope of the review along with the relevant objectives and risks to be covered. In order to ensure the scope of the review is appropriate it will require agreement by the relevant Executive Director or their nominated lead and will also be copied to the Board Secretary.

9 Reporting

9.1 Internal Audit will report formally to the Audit Committee through the following:

- An annual report will be presented to confirm completion of the audit plan and will include the Head of Internal Audit opinion provided for the Accountable Officer that will support the Annual Governance Statement.
- The Head of Internal Audit opinion will:
  a) State the overall adequacy and effectiveness of the organisation's risk management, control and governance processes;
  b) Disclose any qualification to that opinion, together with the reasons for the qualification;
  c) Present a summary of the audit work undertaken to formulate the opinion, including reliance placed on work by other assurance bodies;
  d) Draw attention to any issues Internal Audit judge as being particularly relevant to the preparation of the Annual Governance Statement;
  e) Compare work actually undertaken with the work which was planned and summarise performance of the internal audit function against its performance measurement criteria; and
  f) Provide a statement of conformity in terms of compliance with the Public Sector Internal Audit Standards and associated internal quality assurance arrangements.
- For each Audit Committee meeting a progress report will be presented to summarise progress against the plan. The progress report will highlight any slippage and changes in the programme. The findings arising from individual audit reviews will be reported in accordance with Audit Committee requirements; and
- The Audit Committee will be provided with copies of individual audit reports for each assignment undertaken unless the Head of Internal Audit is advised otherwise. The reports will include an action plan on any recommendations for improvement agreed with management including target dates for completion.

9.2 The process for audit reporting is summarised below:

- Following the closure of fieldwork and the resolution of any queries, Internal Audit will discuss findings with operational managers to confirm understanding and shape the reporting stage;
- Operational management will receive discussion draft reports which will include any proposed recommendations for improvement within 10 working days following the discussion of findings. A copy of the draft report will also be provided to the relevant Executive Director;
- The draft report will give an assurance opinion on the area reviewed in line with the criteria at Appendix B (unless it is a consulting review). The draft report will also indicate priority ratings for individual report findings and recommendations;

- Operational management will be required to respond to the draft report in consultation with the relevant Executive Director within 15 working days of issue, identifying actions, identifying staff with responsibility for implementation and the dates by which action will be taken;
- The Head of Internal Audit will seek to resolve any disagreement with management in the clearance of the draft report. However, where the management response is deemed inadequate or disagreement remains then the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where the management response is inadequate or where disagreement remains unresolved. The Head of Internal Audit may also escalate this directly to the Audit Committee Chair to ensure that the issues raised in the report are addressed appropriately;
- Reminder correspondence will be issued after the set response date where no management response has been received. Where no reply is received within 5 working days of the reminder, the matter will be escalated to the Board Secretary. The Head of Internal Audit may present the draft report to the Audit Committee where no management response is forthcoming;
- Internal Audit issues a Final report to Executive Director within 10 working days of receipt of complete management response. Within this timescale Internal Audit will quality assess the responses, and if necessary return the responses, requiring them to be strengthened.
- Responses to audit recommendations need to be SMART:
  - Specific
  - Measurable
  - Achievable
  - Relevant / Realistic
  - Timely.
- The relevant Executive Director, Board Secretary and the Chair of the Audit Committee will be copied into any correspondence.
- The final report will be copied to the Accountable Officer and Board Secretary and placed on the agenda for the next available Audit Committee.

9.3 Internal Audit will make provision to review the implementation of agreed action within the agreed timescales. However, where there are issues of particular concern provision maybe made for a follow-up review within the same financial year. Issue and clearance of follow up reports shall be as for other assignments referred to above.

9.4 Timescales are to be included in all initial scopes sent prior to commencing an audit.

10 Access and Confidentiality

10.1 Internal Audit shall have the authority to access all the organisation's information, documents, records, assets, personnel and premises that it considers necessary to

fulfil its role. This shall extend to the resources of the third parties that provide services on behalf of the organisation.

10.2 All information obtained during the course of a review will be regarded as strictly confidential to the organisation and shall not be divulged to any third party without the prior permission of the Accountable Officer. However, open access shall be granted to the organisation's external auditors.

10.3 Where there is a request to share information amongst the NHS bodies in Wales, for example to promote good practice and learning, then permission will be sought from the Accountable Officer before any information is shared.

11 Irregularities, Fraud & Corruption

11.1 It is the responsibility of management to maintain systems that ensure the organisation's resources are utilised in the manner and on activities intended. This includes the responsibility for the prevention and detection of fraud and other illegal acts.

11.2 Internal Audit shall not be relied upon to detect fraud or other irregularities. However, Internal Audit will give due regard to the possibility of fraud and other irregularities in work undertaken. Additionally, Internal Audit shall seek to identify weaknesses in control that could permit fraud or irregularity.

11.3 If Internal Audit discovers suspicion or evidence of fraud or irregularity, this will immediately be reported to the organisation's Local Counter Fraud Service (LCFS) in accordance with the organisation's Counter Fraud Policy & Fraud Response Plan and the agreed Internal Audit and Counter Fraud Protocol.

12 Quality Assurance

12.1 The work of internal audit is controlled at each level of operation to ensure that a continuously effective level of performance, compliant with the Public Sector Internal Audit Standards, is being achieved.

12.2 The Director of Audit & Assurance will establish a quality assurance and improvement programme designed to give assurance through internal and external review that the work of Internal Audit is compliant with the Public Sector Internal Audit Standards and to achieve its objectives. A commentary on compliance against the Standards will be provided in the Annual Audit Report to the Audit Committee.

12.3 The Director of Audit & Assurance will monitor the performance of the internal audit provision in terms of meeting the service performance standards set out in the NWSSP Service Level Agreement. The Head of Internal Audit will periodically report service performance to the Audit Committee through the reporting mechanisms outlined in Section 9.

13 Resolving Concerns

13.1 NWSSP Audit & Assurance was established for the collective benefit of NHS Wales and as such needs to meet the expectations of client partners. Any questions or concerns about the audit service should be raised initially with the Head of Internal Audit assigned to the organisation. In addition, any matter may be escalated to the

Director of Audit & Assurance. NWSSP Audit & Assurance will seek to resolve any issues and find a way forward.

13.2 Any formal complaints will be handled in accordance with the NWSSP complaint handling procedure. Where any concerns relate to the conduct of the Director of Audit & Assurance, the NHS organisation will have access to the Managing Director of Shared Services.

14 Review of the Internal Audit Charter

14.1 This Internal Audit Charter shall be reviewed annually and approved by the Board, taking account of advice from the Audit Committee.

Simon Cookson
Director of Audit & Assurance
NHS Wales Shared Services Partnership
August 2024

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
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Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

LLAIS

Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

Llais Cardiff & Vale of Glamorgan Region

Visit Report

(Announced)

Clinical Trials Unit, Velindre Cancer Centre, Cardiff.

Friday 16th February 2024

Accessible formats

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

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About Llais

Llais is the independent Citizen Voice Body for health and social care in Wales. We seek to hear and enable members of the public to be actively involved in decisions affecting the design, development and delivery of health and social care services for their families and local communities.

Llais seeks to work with the NHS and social care providers, reflecting what people have told us is important in relation to their health and social care services. Llais routinely shares this information with inspection and regulatory bodies to provide the crucial link between those who use these services, with those who plan and deliver health and social care services in Wales, and importantly those who inspect and regulate them.

Llais maintains a continuous dialogue with the public through a wide range of community networks, direct contact with patients, service users, and families and carers. This is mainly achieved through enquires, our Complaints Advocacy Service, visiting activities, engagement events and through public and patient surveys, with Llais being the “Citizens’ Voice for Health & Social Care” within Cardiff and the Vale of Glamorgan.

Visit Overview

Two volunteers of Llais visited the Clinical Research Trials Unit (CRTU) at Velindre Cancer Centre, Cardiff on Friday 16th February 2024 at 10:00am.

The purpose of the announced visit was for the visiting team to hear what matters most to the public by engaging and listening to patients, carers, and others regarding their experiences of receiving care within the area being visited. Llais volunteers listen and gather the views and experiences of the patients, carers, and visitors whilst on site.

As part of the visit, the Llais visiting team were able to speak with the following staff:

- Head of Patient Engagement
- Nurse
- Lead Nurse
- Complaints and Patient Experience Manager

Setting The Scene

Operating Information

The unit is located at the Velindre Cancer Centre (VCC) and has a dedicated entrance situated to the right of the main entrance. There is a push button on the outside. The CRTU is situated straight ahead and is signposted.

The unit operates Monday to Friday, 8:00am – 16:00pm.

The unit does not operate protected mealtimes.

The unit contains 4 beds and 6 chairs.

Patient Cohort

The unit is a mixed gender ward.

The average length of stay for patients on the unit is up to 7 hours depending on their treatment regime.

Patient Facilities

The following facilities are provided for patients during their stay.

- The Dining Room at VCC is open to the public. It provides hot and cold beverages and food.
- There is a hot drinks machine within the unit and tokens are given to patients to receive a free hot drink.
- A member of the catering team attends the unit to offer snakes and sandwiches.
- Patients can be accompanied if required.
- There are dedicated toilet facilities on the unit.

There are no formal activities for patients within the unit.

Patients will bring their own iPad, kindles etc.

Information on expected waits and appointment times is available via leaflets and the VCC webpages. This provides advice on what things a patient may wish to bring with them which includes devices, reading materials etc.

There is the opportunity for patients to socialise with others, away from their beds whilst on this unit. The beds are spaced apart to meet COVID regulations, but the bays are open spaces which allow privacy and the opportunity for socialisation if the patient wishes to interact with others.

VCC are commencing the reintegration of volunteers with a social and recruitment meeting planned for November 2023. Previously there were no dedicated volunteers in this area.

Patient Engagement

The Llais visiting team spoke with several patients, all of whom were willing to speak with the team about their experiences.

Patient one said that “the Nurses are brilliant, spot on” and that the unit was “so nice and happy "and it cheered them up. This patient had travelled from West Wales, which they found difficult when having to return for appointments for blood tests etc. on different days from their Chemotherapy days, and felt that it would be better if the unit could combine appointments to cut down on expensive travel. They added “it’s very expensive but what can I do, it’s my life.”

The second patient spoken with was very complimentary about the unit saying that it is “a lovely place, so bright and cheerful.” They commented that the “staff are so lovely; they explain everything so well and answer all my question, even when I ask again.” The patient stated that parking on site has been a problem.

The third patient praised the staff describing them as “very good” and said that they always felt happy, adding that it was “mad when they are giving me painful treatments”. He had been expecting to have blood taken but staff were unaware of this, they did however organise for this to take place.

Patient 4 and their spouse described the service as “excellent”. The patient was diagnosed in July 2023 and was admitted to the cancer centre four weeks later. Following treatments and surgery their consultant suggested a trial which has now resulted in the patient having cancer free blood cells. High praise for the staff saying that “everyone’s been amazing”. There was a delay with administering an injection that staff were unaware of, but this was dealt with by one of the Nurses

who apologised and carried out the task. The patient commented that the staff “do their best”.

The last patient the team spoke with was also complimentary about the staff saying that the “Nurses are so kind” and that the unit was a “lovely place”. This patient had used the available transport for previous visits and had found this tiring and uncomfortable. They commented that they “felt rough” and as the bus had to carry out a number of stops so it took a long time. They praised the staff at the unit saying that “they've been so good to me”. The patient expressed concerns regarding a lack of support on return home, telling the Llais visiting team “I’m worried about who is keeping an eye on me once finished here and I’m home alone?”.

Observations

The entrance to the unit was noted to be bright and airy with pleasant garden areas to the front.

The main door to the unit is locked and accessible by a call bell; volunteers noted that this is situated on the wall approximately 4ft from the ground with a handmade A4 sign pointing to the button. As the door and surrounding area has a lot of posters affixed to it, the button sign is not easy to detect.

Decoration of the unit was thought to be reasonable overall, being clean and tidy and although a little worn in places, it felt pleasant, safe and cheerful. Four chairs and a coffee table were present in an area near the entrance door, but volunteers noted these to be of poor quality and not suitable for long waits.

The treatment room had six bays each with a chair. One of the bays had two maintenance personnel working on the ceiling while a patient was receiving treatment in the adjacent bay.

The self-service tea and coffee machines were not working. Staff made refreshments in the unit's kitchen.

Volunteers noted that the water dispenser 'push' button was difficult to use and needed a hard push.

It was observed that the signs for the toilets were being repaired therefore leaving no signage.

Staff Feedback

The volunteering team were warmly welcomed with all staff greeting them and happy to engage. A Nurse gave the team a tour of the unit.

The team observed that the lead Nurse in the team had a motivational effect on the staff and patients.

There were positive and caring interactions between staff and patients. It was observed that the Nursing team appeared professional and dedicated, carrying out their duties with genuine care and respect for the patients and each other. The volunteers reported that it was an “absolute joy” to witness the relationships between staff, patients and their family members.

Staff explained that the team required another Health Care Assistant and that if two members of staff are absent, the service cannot function and has to close. Demand for the service is present but not the capacity; more staff and equipment are needed.

A member of the Patient Experience Service spoke with our volunteers and commented that the staff were “amazing”. They highlighted the need for a larger space as the services have outgrown the current building. Waiting times are dependent on referrals. They added that emergency patients arrive via the A&E department which is not always ideal but there are hopes for an Acute Oncology Service. A 24-hour helpline is also in existence.

Our volunteering team also spoke with a member of the Patient Engagement Team who stated that the Covid Pandemic had impacted on demand across the Velindre Cancer Centre, with patients' symptoms becoming more severe.

Staff explained how that the unit is funded by research and cancer charities, Welsh Government grants and local/national funding. This is not secure funding, but staff did not express concern at this time, however, with growing demand and success rates improving, secure funding is required.

Staff also spoke of the validity of volunteers support to the patients at the unit. This was stopped during the pandemic and is in the process of recommencing. The staff feel that volunteers play a key role when supporting patients.

With regards to access to the clinical trials, the staff member commented that more awareness is required nationally as only 20% of patients are currently referred to the service, they added that this is discussion with Health Wales. They also felt that patients may not be fully aware of the free Welsh Ambulance Service Trust transport.

Staff are aware of the travel issues that impact some patients and had listened to their comments. WAST staff were praised as “good” and “helpful” but waiting to be collected, and numerous drop-offs when patients feel poorly is a struggle for them.

Summary of Visit

Positive Findings

1. Volunteers were satisfied that the overall look of the unit was pleasant in appearance.

2. Patient satisfaction with staff and the service was extremely high.

3. Volunteers praised the welcoming reception from staff.

4. Staff offered hot beverages to patients despite coffee/tea machine being out of order.

Negative Findings

1. Maintenance personnel carrying out a task while a patient was receiving treatment in the next bay.

2. Visiting the unit for tests is costly and time consuming for patients.

3. Waiting room chairs are uncomfortable.

4. Water dispenser is difficult to operate.

5. Tea/coffee machine broken requiring staff to provide beverages from kitchen, taking them away from clinical duties.

6. External sign for the access button is not easily recognisable and low to ground level.

7. Limited parking availability.

8. WAST transport was said to be unsuitable for patients attending from out of area, following treatment.

Feedback for Improvement and Good Practice

1. Llais requests that the Velindre Health Trust share the extremely complimentary patient feedback received by volunteers, to unit staff.

2. Llais request that the Trust pass on our volunteer thanks to unit staff for their warm welcome and informative visit.

3. The Trust should endeavour to reduce the number of individual appointments each patient is required to attend, by combining required tests etc. where clinically appropriate.

4. The Trust should ensure that any maintenance work carried out does not negatively impact on patients receiving treatment.

5. The Trust should ensure that the water dispenser provided is fully functional and easily operated by patients undergoing treatment.

6. The Trust should endeavour to repair or replace the hot drinks machine in order to free staff from the task of making drinks for patients.

7. The Trust should ensure the call bell sign on the external door is clearly visible and easily accessible.

8. The Trust should review waiting room seating to ensure it is suitable and comfortable for patients receiving treatment.

9. Llais request that the Trust liaise with WAST to consider improving the current journey lengths for patients attending from out of area.

10. Llais request that the Trust review parking provision for patients at the Clinical Trials Unit.

11. Llais would be pleased to offer our assistance in sharing any information the Trust would like us to share on the trials and free transport throughout social media channels, newsletter and volunteer networks.

The visiting team would like to thank the patients, family members and carers who gave their time to speak with them during the visit. Thank you also to the staff for their time and assistance on an interesting and informative visit.

TRUST BOARD

TRUST SEAL REPORT: 22ND MAY 2024 – 25TH SEPTEMBER 2024

DATE OF MEETING	26 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	FOR NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Kyle Page, Business Support Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(23 May 2024 to 25 September 2024)**.

RECOMMENDATION / ACTIONS	The Trust Board is requested to **NOTE** the contents of the Trust Board Seal Register included below as **Appendix 1.**

GOVERNANCE ROUTE	
N/A	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS **N/A**	

7 LEVELS OF ASSURANCE – N/A

APPENDICES
Appendix 1 – Seal Register

1. SITUATION/ BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal Request **(23rd May 2024 to 25th September 2024)**.

1.2 Board Members are asked to view the content of the report. Further information or queries should be directed to the Interim Director of Corporate Governance.

2.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis: Please refer to the Seal Register at **Appendix 1**.

3 IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒

	Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	A record that the Trust Board Seal Register has been approved by the Chair and the CEO of the Trust at every Seal request.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

Appendix 1 – Seal Register

Date	Document Details	Signed
31st July 2024	Lease relating to 4a and 4b Dupont Building, Mamhilad Park Estate, Pontypool, Torfaen, between Johnsey Estates UK Limited and Velindre University NHS Trust.	Prof Donna Mead OBE, Chair Carl James, Interim CEO

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	26/09/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Vicky Morris, Quality, Safety & Performance Committee chair and Independent Member
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

REPORT PURPOSE	FOR DISCUSSION

1. PURPOSE

This paper is to provide the Trust Board with details of the key issues and risks considered by the Quality, Safety & Performance Committee at its meeting held on the 12th September 2024.

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 March 2024, the Committee continues to mature, actively seeking opportunities for continuous improvement, together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHTS FROM THE MEETING HELD ON 12TH SEPTEMBER 2024

3.1 Triangulated themes

The following triangulated themes were identified:

- The ***workforce Supply impact on core service delivery*** – action agreed in respect of Trust recruitment promotional approach and support and the impact of staff sickness levels.
- ***Organisational and workforce culture*** – action agreed of specific work to enhance organisational culture and the working experiences of our staff. This includes specific Board training on setting organisational culture.
- ***Requirement to strengthen organisational governance and business intelligence*** to ensure that core requirements and delivery is robustly achieved. To include enhancing outcomes based reporting, ensuring all actions are SMART, and enhanced integrated risk management.
- ***Quality and Safety Reporting:*** Presentation of the first fully integrated Trust Quality and Safety Report, focusing on positive outcomes and ongoing efforts to develop a quality dashboard for better data analysis and reporting.
- ***Performance Management Framework (PMF) Development:*** Discussion on the development of the PMF, including the implementation of improvements and the focus on creating a single source of truth for data.
- ***Cancer Service Capacity:*** Efforts to improve cancer service capacity, including the commissioning of new equipment and the exploration of new service models, in response to growing demand.

3.2 Further Information

Board members who are not members of the Committee and would like further detail of the Quality, Safety and Performance (QSP) committee are able to access the agenda and papers for the September 2024 QSP Committee meeting at:

https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-2024/public-quality-safety-performance-committee-12092024/

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	There are no matters for Alert / Escalation.
ADVISE	**Trust Performance Management Framework Report and Supporting Analysis for July 2024** The areas of discussion in respect of the July 2024 Performance Management Framework were: • Further assurance sought in respect of any harm that may have occurred to the 3% of patients that did not received their scheduled radiotherapy within the required 28 day target deadline. The Committee were advised that all patients had been clinically prioritised and reviewed and no harm had been identified. • Increase in long term staff sickness levels was discussed with a focus on staff wellbeing and support that staff received. The Committee was advised of all the support that is provided and how

	the themes are being monitored through the Healthy and Engaged Steering Group. • Manual Handling Training provision which is impacting on compliance and increasing staff and patient risk. The Committee were advised that to address this it is being brought in-house.
ASSURE	**SACT Gold Report** The Committee received, discussed and noted the Systemic Anti-Cancer Treatment (SACT) Gold Command Report that provided an overview of the position within SACT. The Committee noted that there were clear recovery plans in place that included revised pharmacy and nursing workforce plans that were being enacted and were advised that the compliance with 21day non-emergency treatment during the summer months was around 80% and that no patient harm had been identified due to any treatment delays. **Trust Values and Behaviour Framework** The Committee considered the draft Behaviour Framework. It was identified that further engagement, particularly at Board level was required to strengthen the Framework as a standalone document. Through discussion it was identified that the appropriate assurance rating was currently a level 2, with a view to progressing to a level 3 with a robust action plan to underpin the work required. **Finance Report for the Period Ended 31st July 2024 (month 4)** The Committee received the month 4 Financial Report which outlined the financial position and performance for the period to the end of July 2024. It was highlighted that although the financial forecast is challenging the Trust is on track to deliver against its key financial targets and there is a high level of assurance in respect of this. **2024-2025 Quarter 1 Trust Quality and Safety Report** The Committee welcomed and commended the first combined Trust Quality and Safety report that brings together the work of the three Quality Hubs: Trust wide; Welsh Blood Service and Velindre Cancer Services incorporating what would previously have been contained in 6 separate reports. The Committee considered the report which provided concise data driven analysis of key outcomes, activity, learning and improvement during the quarter. However, concerns were raised regarding the need for support from the Business Intelligence Team to progress the Quality Dashboard and the further development of the Quality Metrics / Quality Outcome Framework. The ongoing delays are impacting on the 'Always on Reporting' as a legislative requirement of the Duty of Quality. **Trust Risk Register** The Committee discussed in detail the Trust Risk Register and the following points were highlighted:

	• SACT Escalation risks require review to ensure alignment and to remove any duplication. • Risks 3338 & 3366 - the inherent risk scores were lower than the current risk rating. These risks will be reviewed prior to Trust Board. **Trust Assurance Framework** The Trust Assurance Framework was discussed. The Committee noted that it had not been updated in full and, were advised that enhanced governance mechanisms were required in respect of this and the newly appointed Risk and Assurance Manager will be prioritising this.
INFORM	**Velindre Cancer Services – Patient Story** A letter was shared with the Committee from the wife of a Velindre Cancer Service patient who has sadly passed away. The letter was a powerful reflection of the empathy, respect and exemplary care that had been provided by the staff to not only the patient but to his family and visitors during his stay at the Cancer Centre. The letter demonstrated how valued staff are and has had a significant impact on the First- Floor ward staff. It was highlighted that the Trust has a 'Wall of Thanks' on the staff intranet which allows the opportunity to acknowledge these positive messages. The Committee concluded that the sharing of and focussing on the positive feedback received from patients and families is extremely important. Whilst the 'Wall of Thanks' is a valuable mechanism for sharing this type of feedback, a co-ordinated approach and the more formal capturing of messages of thanks will be explored. **Trust-wide Policies and Procedures** The Committee received the Trust Policy and Procedure compliance report which identified that 32.38% of Trust policies had passed their review date. The Committee requested enhanced assurance reporting in respect of this going forward including reasons for a delay in review, risks and timelines. The Committee approved the revised Trust Security Policy and Safety Alerts Policy. The Committee endorsed the following Policies for submission to the Trust Board for approval: • People Development Policy (new policy) • PADR Policy (WF 30) • Alcohol, Drugs and Substance Misuse Policy (WF 18) • Professional Registration Policy (WF 22) • Model Policy Aseptic Non-Touch Technique (ANTT) (IPC 03)

	2023-2024 Annual Reports The Committee approved the **Digital Services Annual Report** and noted **Wales Infected Blood Support Scheme (WIBSS) Annual Report,** The Committee endorsed the **Communications and Engagement Annual Report 2023-24** for submission to the Trust Board for approval. The Committee endorsed the **2023/2024 Nurse Staffing Levels Wales Annual Report**, and the **2021/2024 Nurse Staffing Levels Wales 3-year** report for submission to the Trust Board for approval prior to submission to the Welsh Government.
APPENDICES	N/A

4. RECOMMENDATION

The Trust Board is asked to **DISCUSS** and **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on 12th September 2024.