Public Trust Board

Tue 26 March 2024, 10:00 - 14:00

Trust Headquarters, Nantgarw / Zoom

Chaired by Stephen Harries, Vice Chair

Agenda

10:00 - 10:15
15 min

1. STANDARD BUSINESS

Stephen Harries, Vice Chair

1.1. Welcome and Apologies

Stephen Harries, Vice Chair

1.2. In Attendance

Stephen Harries, Vice Chair

1.3. Declarations of Interest

Stephen Harries, Vice Chair

1.4. Draft minutes from previous Public Trust Board meetings

Stephen Harries, Vice Chair

- Public Trust Board meeting held on 30.01.2024
- Extraordinary Public Trust Board meeting held on 07.02.2024

1.4.0a FINAL Public Trust Board Minutes 30.01.2024(DM).pdf (14 pages)
1.4.0b FINAL PUBLIC Extraordinary Trust Board_07.02.24(DM).pdf (4 pages)

1.5. Action Log

Stephen Harries, Vice Chair

1.5.0 PUBLIC ACTION LOG.pdf (1 pages)

1.6. Matters Arising

Stephen Harries, Vice Chair

10:15 - 10:35
20 min

2. KEY REPORTS

2.1.

Chair's Report

Prof. Donna Mead OBE, Chair

2.1.0 Chair's update Trust Board 26.03.202- Final.pdf (7 pages)

2.2.
Vice Chair's Report

Stephen Harries, Vice Chair

2.2.0 202403_Vice Chair Report.pdf (5 pages)

2.3.
Chief Executive's Report

Led by Steve Ham, CEO

2.3.0 Chief Executive's Report 26 March.pdf (6 pages)

2.4.
Board Champions Report

Gareth Jones, Independent Member and Board Champion for Patient Information, Welsh Language

***DEFERRED UNTIL MAY TRUST BOARD MEETING*

10:35 - 10:55
20 min

3.
INTEGRATED GOVERNANCE

3.1.
Audit Wales Annual Audit Report

Steve Wyndham, Audit Manager and Katrina Febry, Audit Lead, Audit Wales

3.1.0 VUNHST Annual Audit Report 2023.pdf (20 pages)

10:55 - 11:05
10 min

BREAK 10:55-11:05

11:05 - 12:05
60 min

4.
QUALITY, SAFETY & PERFORMANCE

4.1.
VUNHST Risk Register

Lauren Fear, Director of Corporate Governance & Chief of Staff

4.1.0 TRR Paper - Trust Board - Mar 24.pdf (14 pages)
4.1.0a RISK REPORT - March reporting-update 2.pdf (5 pages)

4.2.
Trust Assurance Framework

Lauren Fear, Director of Corporate Governance & Chief of Staff

4.2.0 TAF Paper - Trust Board - Mar 24.pdf (7 pages)
4.2.0a V46 - TAF DASHBOARD - 22.03.2024.pdf (17 pages)

4.3.

Performance Management Framework (January 2024)

Alan Prosser, Director of Welsh Blood Service and Rachel Hennessy, Acting Director of Velindre Cancer Service

4.3.0 Trust Board 26.03.24 JAN PMF Performance Report FINAL version 010.pdf (67 pages)

4.4.
Financial Report (January 2024)

Matthew Bunce, Executive Director of Finance

4.4.0 Month 10 Finance Report Cover Paper Trust Board.pdf (11 pages)
4.4.0a Appendix 1 -M10 VELINDRE NHS TRUST FINANCIAL POSITION TO JANUARY 2024 Trust Board March 24.pdf (27 pages)

12:05 - 12:45
40 min

LUNCH 12:05-12:45

12:45 - 13:25
40 min

5.
PLANNING AND STRATEGIC DEVELOPMENT

5.1.
Integrated Medium Term Plan (IMTP) 2024-2025 - 2026-2027

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

5.1.0 Trust Board - 26th March 2024 - IMTP Cover Paper.pdf (8 pages)
5.1.0a Appendix 1- VUNHST IMTP 2024-2027 - Trust Board 26th March 2024.pdf (147 pages)
5.1.0b App2a - Quality Impact Assessment - nVCC FBC.pdf (18 pages)
5.1.0c App2b - Quality Impact Assessment WBS - NEQAS .pdf (8 pages)
5.1.0d App2c - Quality Impact Assessment WBS - West Nile Virus .pdf (7 pages)
5.1.0e App2d - Quality Impact Assessment WBS - Nucleic Acid Testing .pdf (8 pages)

5.2.
Accountability Conditions

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

5.2.0 Trust Board 26.03.24 Accountability Conditions Progress version 003.pdf (5 pages)
5.2.0a Appendix 1 - 2023-10-02 VELINDRE- Judith Paget - IMTP Accountability Letter 2023.24.pdf (3 pages)
5.2.0b Appendix 2 IMTP Accountability Letter 2.10.23 Quarterly Monitoring version 017.pdf (9 pages)

5.3.
Integrated Medium Term Plan (IMTP) 2023-2024 Quarter 3 Update

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

5.3.0 Trust Board 26.03.24 IMTP 2023.24 Quarter 3 Update version 011a.pdf (47 pages)

13:25 - 14:00
35 min

6.
CONSENT ITEMS

6.1.
CONSENT FOR APPROVAL

Stephen Harries, Vice Chair

6.1.1.
Commitment of Expenditure exceeding Chief Executive's Limit

Matthew Bunce, Executive Director of Finance

- 6.1.1 PUBLIC Trust Board_Commitment of Expenditure_March 2024 v2.pdf (4 pages)
- 6.1.1a APPENDIX 1 NWSSP Companies House & Charnwood Court to Cefn Coed.pdf (7 pages)

6.1.2.
Chair's Urgent Actions Report

Prof. Donna Mead OBE, Chair

- 6.1.2 PUBLIC Chairs Urgent Action Report MARCH 2024.pdf (5 pages)

6.1.3.
Strategic Equality Plan 2024-2028

Sarah Morley, Executive Director of Organisational Development & Workforce

- 6.1.3 Strategic Equality Plan 2024-28 Trust Board 26.3.24.pdf (10 pages)
- 6.1.3a Strategic Equality Plan 2024- 2028 Appendix 1 7.3.24.pdf (5 pages)

6.1.4.
Charitable Funds Committee Terms of Reference

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.1.4 Charitable Funds Committee Terms of Reference - Trust Board March 2024 Cover Paper.pdf (6 pages)
- 6.1.4a Appendix 1 Feb 2024 Review of CFC Terms of Reference - with track changes.pdf (9 pages)
- 6.1.4b Appendix 2 Feb 2024 Review of CFC Terms of Reference - Clean version.pdf (9 pages)

6.1.5.
Velindre University NHS Trust Food Mission

Matthew Bunce, Executive Director of Finance

- 6.1.5a Velindre University NHS Trust Food Mission_March 2024.pdf (12 pages)
- 6.1.5 Velindre Food Mission_Trust Board_Mar 2024.pdf (13 pages)

6.1.6.
Surrender of Lease Part Ground Floor Matrix House Swansea

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

- 6.1.6 Sterling Lease Surrender.pdf (6 pages)
- 6.1.6a Sterling Lease Surrender Heads of Terms 2024.pdf (2 pages)

6.1.7.
Deed of Rectification with Toast (Mail Order) Limited

Matthew Bunce, Executive Director of Finance and Lauren Fear, Director of Corporate Governance & Chief of StaffBC

- 6.1.7 Toast Deed of Rectification.pdf (6 pages)
- 6.1.7a Deed of rectification.pdf (8 pages)
- 6.1.7b Matrix House Car Park, Swansea_01S-PDF A3 NTS.pdf (1 pages)

6.1.8.
Tenancy at Will Agreement for the Du Pont Building

Matthew Bunce, Executive Director of Finance and Lauren Fear, Director of Corporate Governance & Chief of StaffTBC

- 6.1.8 DuPont Tenancy at Will.pdf (6 pages)
- 6.1.8a DOC150324-15032024134858.pdf (8 pages)

6.1.9.
NWSSP Companies House & Charnwood Court to Cefn Coed, Nantgarw proposed relocation

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

6.1.9 Trust Board Paper NG2 V2.pdf (7 pages)
6.1.9a Heads of Terms - NHS.pdf (6 pages)

6.2.
CONSENT FOR NOTING

Stephen Harries, Vice Chair

6.2.1.
Trust-wide Policies Update

Lauren Fear, Director of Corporate Governance & Chief of Staff

6.2.1 TRUST WIDE POLICIES UPDATE March 2024.pdf (5 pages)
6.2.1a Appendix 1 IPC00.pdf (33 pages)
6.2.1b Appendix 2 IPC11.pdf (28 pages)
6.2.1c Appendix 3 PP10.pdf (29 pages)
6.2.1d Appendix 4 PP11.pdf (15 pages)
6.2.1e Appendix 5 PP12.pdf (8 pages)
6.2.1f Appendix 6 PP13.pdf (10 pages)
6.2.1g Appendix 7 PP14.pdf (10 pages)

6.2.2.
Public Quality, Safety & Performance Committee Highlight Report (14/03/2024)

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

6.2.2 Public QSP Highlight Report 14th March 2024-VM amended- Final version.pdf (11 pages)

6.2.3.
Public Audit Committee Highlight Report (12/03/2024)

Gareth Jones, Independent Member and Acting Chair of Audit Committee

**Paper not received.*

6.2.4.
Public Charitable Funds Committee Highlight Report (20/02/2024)

Prof. Donna Mead OBE, Chair of the Charitable Funds Committee

**Paper not received.*

6.2.5.
Remuneration Committee Highlight Report (14/03/2024)

Prof. Donna Mead OBE, Chair of the Remuneration Committee

6.2.5 Highlight Report REMCOM 14.03.2024-V02.pdf (3 pages)

6.2.6.
Local Partnership Forum Highlight Report (08/03/2024)

Sarah Morley, Executive Director of Organisational Development & Workforce

6.2.6 08.03.2024 - LPF Highlight Report V02.pdf (4 pages)

6.2.7.
Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Report (25/01/2024)

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

6.2.7 Trust Board Highlight Report Public 25.01.2024.pdf (2 pages)

6.2.8.

Public Welsh Health Specialised Services (WHSSC) Committee Briefing (30/01/2024, 27/02/2024, 19/03/2024)

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.8a JC Briefing (Public) 30 January 2024.pdf (5 pages)
- 6.2.8b JC Briefing (Public) 27 February 2024.pdf (1 pages)
- 6.2.8c JC Briefing (Public) 19 March 2024.pdf (4 pages)

6.2.9.
Emergency Ambulance Services Joint Committee (EASC) Briefing (30/01/2024)

Lauren Fear, Director of Corporate Governance & Chief of Staff

- 6.2.9 Chair's EASC Summary from 30 January 2024.pdf (12 pages)

6.2.10.
NHS Wales Shared Services Partnership Committee Assurance Report (18/01/2024)

Lauren Fear, Director of Corporate Governance and Chief of Staff

- 6.2.10 SSPC Assurance Report 18 January 2024.pdf (5 pages)

6.2.11.
Trust Seal Approval Report – (31st January 2024 – 25th March 2024)

Lauren Fear, Director of Corporate Governance and Chief of Staff

- 6.2.11 Trust Seal Report 31.01.24-25.03.24.pdf (4 pages)

14:00 - 14:00
0 min

7.
ANY OTHER BUSINESS

Stephen Harries, Vice Chair

14:00 - 14:00
0 min

8.
DATE OF NEXT MEETING

Stephen Harries, Vice Chair

Tuesday, 23rd May 2024

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

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

1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies noted:** • Dr Jacinta Abraham, Executive Medical Director • Cath O'Brien, Chief Operating Officer • David Cogan, Patient Representative • Steve Ham, Chief Executive Officer • Martin Veale, Independent Member – *The Chair advised that an update on Martin Veale's absence would be provided within the Chair's Report at the March Trust Board meeting.*	
1.2.0	**In Attendance** The Chair extended a warm welcome to the following additional attendees: • Dr Edwin Massey, Medical Director Welsh Blood Service - deputising for Dr Jacinta Abraham today *(attending remotely)* • Katrina Febry, Audit Lead, Audit Wales *(to support item 3.1.0)* • Rachel Hennessy, Acting Director of Velindre Cancer Service *(attending remotely)* • Alan Prosser, Director of Welsh Blood Service *(in part)* • Stephen Allen, Regional Director, Llais Cymru *(in part)* – **The Chair acknowledged that this would be Stephen Allen's final Trust Board meeting, thanking him for his contribution and support to the Trust, and wished him the very best on his retirement on behalf of the Board** • Steffan Wiliam, Simultaneous Welsh Translation Service	

1.3.0	**Declarations of Interest** There were no declarations of interest to **note** in respect of today's agenda.	
1.4.0	**Minutes from the Public Trust Board meeting held on 30th November 2023** The Trust Board confirmed that the minutes of the meeting held on the 30th November 2023 were an accurate and true reflection of proceedings.	
1.5.0	**Action Log** The Trust Board reviewed the status of open actions (3.2.0 from the 28th September 2023 and 4.5.0 from 30th November 2023) ***3.2.0 – Confirm approach to approval of Trust Assurance Framework (TAF) via Chair's Urgent Action or via discussion Board meeting discussion*** – it was agreed that this action would be closed following receipt of the paper on today's agenda. ***4.5.0 – Reword measure in relation to patient surveys within Performance Management Framework (PMF)*** – Nicola Williams confirmed that this had been undertaken and that the national standards contained in the PMF has been amended to include 8, 9 and 10 as opposed to 9 and 10 only. It was agreed that this action could now be closed. The Board was content that remaining actions noted as closed was an accurate reflection.	**Secretariat** **Secretariat**
1.6.0	**Matters Arising** The Chair re-iterated that Vicky Morris had previously requested a discussion in relation to aligning the TAF risks with the Trust's Strategic Objectives at a future Board Development Session. It was advised that this would be addressed at the Board Development Session on February 27th 2024.	
2.0.0	**KEY REPORTS**	
2.1.0	**Chair's Report** The report provided an overview of the Chair's activity since the last meeting of the Trust Board. The Chair noted another busy period, including: • Attendance at a Youth Engagement nVCC Workshop, to hear from children across a number of schools regarding helping design family rooms and children's spaces at the new Velindre Cancer Centre. • The Welsh Blood Service spotlight improvement event, which the Chair attended alongside members of the Executive Team and Independent Members, had been of great interest, highlighting the outstanding quality improvement work undertaken to improve services. The Chair advised that this would also be presented at the next Board Development Session. Vicky Morris applauded the approach taken by the Welsh Blood Service to service improvements, suggesting that this could be replicated within the Velindre Cancer Service. • A meeting with Board Chairs in the public sector held on 16th January 2024 had discussed the intention for the future process of public appointments, in addition to a 'job shadowing' system for appointments	

	of Independent Members to improve diversity and inclusion. Stephen Harries had kindly agreed to facilitate mentorship on behalf of the Trust. • The Chair also acknowledged that the number of donors attending the Abergavenny WBS Donor Awards on 17th January 2023 had provided enough blood and blood products to save approximately 10,725 lives of patients. • In addition, the report detailed numerous matters addressed during the Board Development Session which took place on 14th December 2023 and acknowledged a significant donation to the Trust's Charity during the period. The Trust Board **NOTED** the content of the Chair's Update Report.	
2.2.0	**Vice Chair's Report** The report provided an overview of the Vice Chair's activity since the last meeting of the Trust Board. Stephen Harries highlighted the following: • Attendance at a number meetings and discussions with the Executive Director of Organisational Development & Workforce in his role as the Trust's "Wellbeing Board Independent Member Champion", to agree the Annual Report to the Board in this role. • Acceptance of a recent invite to assume the role as "Speaking up Safely Board Independent Member Champion"; further meetings will take place to address the function and responsibilities of the role, particularly how this will work in practice in relation to staff engagement. The Chair thanked Stephen Harries for assuming this role, noting this is a Welsh Government requirement. The Trust Board **NOTED** the content of the Vice Chair's Update Report.	
2.3.0	**Chief Executive's Report** The Chief Executive's report was not discussed in detail and Carl James (Acting Chief Executive) expressed thanks to staff for their commitment and professionalism during the period of Industrial Action (15th-18th January 2024) which had ensured the continued safe care of patients throughout. The significant amount of preparation that had been undertaken, including engagement with all staff groups and communication to patients prior to the Industrial Action was also commended. The Board added their appreciation of how staff had worked cohesively to ensure this, demonstrating the importance of detailed planning prior to Industrial Action. Sarah Morley acknowledged that in addition to input from the Workforce Team, credit should also go to the Acting Director of Velindre Cancer Service for her leadership. . No questions were raised and the Trust Board **NOTED** the content of the Chief Executive's Update Report.	
2.4.0	**Board Champion Report – Health and Wellbeing**	

	The Health and Wellbeing Board Champion Report highlighted a number of key matters. Stephen Harries highlighted the following: • The introduction of the role of Health and Wellbeing Champion to the Trust in 2023, the purpose of which is to gain a deeper level of insight and knowledge around key wellbeing areas and issues, to enable the Champion and whole Board to fulfil this role. • Arrangements within the Trust for Health and Wellbeing and associated coordination via quarterly meetings of the Healthy and Engaged Steering Group (represented by all divisions within the Trust). The group is responsible for the development and monitoring of impact of wellbeing interventions that are implemented as appropriate. • Key activities undertaken over the past 12 months and the importance of learning and benefit to the Trust resulting from the activity undertaken. It was advised that the annual work plan will be reviewed and built upon, in addition to exploring a number of key themes for the coming year. • In terms of practical delivery, further evaluation will be undertaken in the coming period to enable development of a positive and healthy working environment for the Trust. Hilary Jones noted that the national NHS staff survey referred to on a number of occasions in the paper made no reference to an anticipated date that the results would be received. Sarah Morley advised that the results had not been included due to the retrospective nature of the report. However, it was confirmed that the Trust receives regular updates from Health Education Improvement Wales (HEIW) in relation to survey results and receipt of the report at Trust level is anticipated next month, followed by a breakdown by service area and staff group across the organisation. Sarah Morley also indicated that the Trust's response rate had historically remained higher in comparison to the rest of the NHS Wales average. It was advised that data was awaited from the survey which had closed in November 2023 and that a further survey would be issued towards the end of 2024; therefore facilitating a more useful dataset as an annual cycle of analysis is developed over the next three years. The Trust Board **NOTED** the content of the Board Champion report and subsequent discussion.	
3.0.0	**INTEGRATED GOVERNANCE**	
3.1.0	**Audit Wales Structured Assessment Report 2023** The report outlined the findings from the Auditor General's 2023 structured assessment work at the Trust. Katrina Febry advised that the report was generally positive, indicating a small number of recommendations which the Trust had duly considered and responded to, detail of which was also included in the report. Overall, the Trust continues to be generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance and effective arrangements for managing its finances. A small number of further opportunities for improvement (and associated low priority recommendations) were identified, including further enhancement of public transparency of Board business, strengthening of strategic risk management and ensuring that corporate plans and strategies contain clear objectives and actions for all Trust functions. It was however, noted that progress had been made since the drafting of the report.	

	Gareth Jones informed the Board that the report had been discussed in detail at Audit Committee, noting that a number of emerging themes were those which had previously been raised by Independent Members. While this was positive, one theme concerned the publishing of unconfirmed meeting minutes on the Trust website ahead of Trust Board meetings to allow for public perusal prior to the forthcoming meeting. The Chair advised that Trust Board minutes are robustly scrutinised and verified ahead of publishing, with formal agreement of the minutes taking place at the following meeting, allowing any Board member present at the previous meeting to request amendments. However, as it is now deemed good practice to publish unconfirmed minutes on the Trust website within 22 days of the meeting, it was agreed that as much assurance as possible should be worked into the process (such as input from Independent Members). This would allow the public to peruse the minutes prior to the next meeting. It was noted that the practicalities of doing so still require work through and Stephen Allen suggested that UNCONFIRMED should be clearly noted on the minutes, noting that a final copy will be uploaded on to the website following any amendments. It was acknowledged that amendments / updates are clearly noted in the minutes of the next meeting. Hilary Jones noted that four of last year's recommendations were still marked as open in the report, querying how it can be ensured these would not be missed due to a lack of target date. Lauren Fear advised that all recommendations (both internal and external) are tracked via the Audit Committee tracker. The Chair suggested that regular sight of the Audit tracker would be beneficial for Board members who do not attend Audit Committee. The Trust Board **NOTED** the content of the Audit Wales Structured Assessment Report.	**LF/MB**
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, in addition to changes since the December 2023 reporting period. Lauren Fear highlighted the following: • The new format of the cover paper sets out the steps from a governance perspective for each risk (from Executive Management Board, following recommendations from the Senior Leadership Team / specific comments from Quality, Safety & Performance Committee / Audit Committee). • The paper now also outlines development activity more clearly and the Quality, Safety & Performance Committee had agreed with the progress as noted, in addition to three ongoing actions. **Risk 3125** *(Clinical instruction or information may not be received or acted on by primary or secondary care medical colleagues for patient management due to clinical correspondence not being signed off via the Document Management System (DMS))* – Lauren Fear advised that following comments received during both Quality, Safety & Performance Committee and Audit Committee, assurance regarding compliance would be brought back through Executive Management Board for discussion, with	

	a view to recommend closure of the risk on the basis of receiving this assurance. Vicky Morris commended the additional supporting information relating to closure of risks. However, Vicky Morris noted that while the narrative for **Risk 2187** *(Risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks)* outlined that the risk had reduced and subsequently increased, the accompanying visual (graph) did not align to this and was not an accurate reflection of the timescale. **Risk 2515** *(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)* – The Chair noted that the narrative for this risk required updating (references still being made to April, May, July 2023). Lauren Fear advised that information included in the report from Datix can be included / deleted as required dependent on Board requirements. Gareth Jones noted that the ongoing risk rating of 15 for this risk suggests that steps taken to date may have not been sufficient to reduce this. Rachel Hennessy advised that this was due to the fragile workforce within Brachytherapy and a number of senior vacancies remaining within the service group. It was noted that further review of the risk would take place at the February 2024 Executive Management Board. Nicola Williams advised that significant work had been undertaken with the intention to implement a more resilient service and while many sub risks had been addressed, the service remains fragile due to its highly specialised nature and challenges with retention of specialist staff. There are plans to align the workforce with the wider IRS work and the team is exploring opportunities to create a different, more resilient workforce, avoiding reliance on one or two specialists. The Chair thanked Nicola Williams for this assurance, noting that this is not represented in the report presented to Board and therefore not visible to the public. It was suggested that actions undertaken to date to prevent the risk from increasing should be included in the narrative, as well as actions resulting in the successful reduction of the risk. The Trust Board: • **NOTED** the risks level 15, as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTED** the on-going developments of the Trust's risk framework. It was noted that minor anomalies within the paper (such as dates and wording of recommendations and further narrative) would be updated / included as appropriate in next version of the paper.	**LF**
4.2.0	**Trust Assurance Framework (TAF)** Following collaboration with the divisional Senior Leadership / Management Teams, Committee members, Executives and Independent Members, a review of the Trust Assurance Framework (TAF) and Strategic Risks had been undertaken. Lauren Fear advised that the refreshed Strategic Risks had been reviewed by the Strategic Development Committee and Quality, Safety & Performance Committee during this reporting cycle and a final draft	

	of 8 Strategic Risks had been collated, to be managed and utilised to drive a variety of discussions across the Trust. Vicky Morris acknowledged the notable amount of work undertaken on the TAF, in particular informing Board members of the immediate lines of controls and assurances in place. Additionally, alignment of this with the Integrated Medium Term Plan (IMTP) actions will enable the Board to understand the current and emerging risks against delivery of these strategic objectives. Nicola Williams advised that TAF07 *(Patient Outcomes)* was a new addition and following initial discussion at January's Quality, Safety & Performance Committee, further work / refinement would be undertaken and the risk rating would reduce as a result. It was not expected that the title of the risk would change. The Chair requested an update on **Risk 2465** *(Risk to patient safety cause by excessive use of email for the processing of clinical purposes)* and whether a system had been implemented to capture and monitor such emails separately, following the audit undertaken. Rachel Hennessy advised that following receipt of the audit report by the Senior Leadership Team during December 2023, a task and finish group had been established to take forward resulting recommendations. Additionally, a number of key actions had commenced in the interim such as the move to centralised email inboxes for clinical issues (it had not been deemed feasible for all emails to be directed to a single mailbox as a solution). It is also the intention to circulate an email etiquette document across the Trust once completed and approved. It was recognised that a number of solutions will be required to resolve this risk, requiring engagement with a number of professional groups over a period of time. Following further discussion in relation to the recommendation for today's Board, it was recognised that the Board was today being requested to approve the baseline document and risks and that due to the live nature of the document, further development would be expected. It was noted that the range of risks align with the expectations of the Board and that work relevant to each risk is currently in train. The Trust Board **APPROVED** the Trust Assurance Framework and associated risks attached ***(as at today's position, setting out the key risks and mitigating actions, with further changes and additions anticipated)***. The Trust Board also noted the alignment of the TAF with IMTP actions.	
4.3.0	**Performance Management Framework (November 2023)** The paper provided an update on the performance of the Trust for the month of November 2023, against a number of national targets. Alan Prosser reported the following in relation to Welsh Blood Service performance: • A challenging month due to a significant reduction in collections due to clinic cancellations. A Blue Alert was issued and although clinical demand was met, mutual aid had been necessary during December 2023 to cover the Christmas period. The situation and stock position has since recovered, however January continues to look challenging due to sickness absence and staff turnover within collections teams. A Task & Finish Group has been established to identify where constraints can be unlocked in terms of service delivery.	

- All Quality & Safety markers remain within tolerance, with activity encouraged in terms of stem cell collection and a new tactical approach to bone marrow volunteer targeting (to be discussed at a future Board Development session).
- Satisfaction remains high within the service, despite challenging circumstances.

Hilary Jones suggested including that reliance on mutual aid should not be considered negatively, as the arrangement is in place for good reason. The Chair agreed, requesting further clarification of the mutual aid process. Alan Prosser advised that the mutual aid agreement was signed up to on a bi-annual basis (with the other 3 UK countries) to ensure effective business contingencies are in place. In addition to blood supply shortage, the agreement also covers issues within the wide range of unique testing services run by the service and facilitates effective laboratory networks. Additionally, shared learning opportunities are provided for example via workshops, should the service excel in a particular area.

Rachel Hennessy reported the following in relation to the Velindre Cancer Service performance:

- Continued improvement evidenced within Radiotherapy and sustained due to significant work undertaken by teams to review and revise pathways (specifically clinical training) and the introduction of a new digital care path system (rollout of which has now been completed across all treatment sites).
- Lower than anticipated demand for Radiotherapy Treatment during the month, reflected across the south east region as a whole.
- A challenging period within Systemic Anti-Cancer Therapy (SACT), due to a significant increase in demand for the service (with the referral rate currently showing 6.8% above the forecast growth of 8%). However, the Trust continues to treat clinical trials and emergency patients within the stipulated timeframe.
- Non-emergency (21 day) SACT treatment currently remains challenging for the service, in particular due to Workforce and capacity issues within Pharmacy. It is the intention that Transforming Access to Medicines (TrAMS) will form part of the solution, however a task and finish group has been established in the interim to explore options to increase capacity.
- Successful management of patients during the Christmas period and period of Industrial Action during January 2024.

Andrew Westwell queried the progress of the Task & Finish group in relation to capital funding and workforce due to the delayed 'go live' date for TrAMS. Rachel Hennessy advised that Capital Funding is linked to reconfiguration of the service to support a septic dispensing capacity, completion of which is anticipated by March 31st 2024, to be supported by:

- Recruitment of technical posts.
- Considering increasing the amount of product purchased by the Trust.
- Discussions with Tenovus mobile unit to explore expanding the current contract to provide treatment to appropriate cohorts of patients.
- Discussions with Health Board colleagues to secure Pharmacy support to increase the Trust's dispending capacity.

Nicola Williams advised that enhanced arrangements are in place to enable close monitoring of the above and to support the Cancer Service in areas requiring escalation. It will also be necessary to ensure that Chemotherapy

	treatment is prioritised appropriately and that the harm review process is in place in the event that it is required. Stephen Harries queried how the 14.8% increase in referral rate for SACT had been calculated, as this was not reflected as such within the associated Key Performance Indicator. Following further discussion, Rachel Hennessy agreed to provide further clarification. Vicky Morris commended the significant range of actions outlined by Rachel Hennessy to enable this demand to be met, also noting the paper does not detail the impact of the actions and resulting improvements. It would be of benefit (particularly for Quality, Safety & Performance Committee) if this could be included in future reporting. Gareth Jones queried that as the information contained in the report is almost 2 months old, how the Trust receives information to provide foresight of issues of escalation (such as Blue Alert over the Christmas period). Carl James advised that due to the cycle of Corporate Committees and Trust Board meetings, the report to Board remains retrospective due to collation and analysis of the data and that numerous options to reduce the time that the information becomes available to the Board. However, daily / weekly Management information received at Executive Management Board allows immediate escalation and addressing of issues requiring such. It was recognised that Business Intelligence insight into data would enable forward planning and projections, however this is yet to be explored by the Trust. Sarah Morley suggested that it would be more beneficial to identify a means of alerting Independent Members of emerging issues as opposed to re-mapping the meeting cycle. Nicola Williams also noted that matters to be escalated following the end of the data reporting period could be included in a designated section in the report, in addition to any related outcomes which would follow via the next cycle. The Trust Board **NOTED:** • The contents of this report and the detailed performance analysis provided in the PMF Scorecards and supporting Data Analysis Templates in Appendices 1 to 3. • The new style PMF Performance reports continue to be developed by the PMF Project Group, with a number of potential new measures currently under consideration. *It was agreed at the meeting that urgent performance matters escalated between Board meetings would be brought to future Board meetings as "addendum of matters that had been escalated."*	**RH** **RH**
4.4.0	**Financial Report (November 2023)** In presenting the report outlining the financial position for the period ended (month 8) November 2023, Matthew Bunce highlighted the following: • The option to offer unused reserves (if not fully required during the remainder of this financial year) to support the current NHS Wales deficit. • Key Financial Targets – it is anticipated that all 3 key targets will be achieved by the end of the financial year, subject to approval of capital funding from Welsh Government for Project Management; Matthew Bunce had received assurance from the Capital Funding Finance Lead	

	in Welsh Government that it is expected that the funding letter would be issued this week. • Finalisation of a December (month 9) report, to be presented at Executive Management Board. • LTA Income & Covid Recovery / Planned Care Capacity – although it had previously been assumed that growth in activity levels would not adequately cover the costs of investment made in the additional capacity, reporting of activity between April and November 2023 had indicated that the additional capacity will be covered. • The Trust has delivered a further £2m savings for the whole of NHS Wales and an Audit Wales review of NHS Wales financial pressures would be undertaken. Gareth Jones queried whether the Trust would be required to return the Public Dividend Capital from Welsh Government which had been drawn down to support cash flow pressure during October 2023. Matthew Bunce advised that this had been an advance rather than a loan (for the cash support of wage awards); therefore no payback will be required. The Board will be kept fully informed of the process and an extraordinary Board meeting would be scheduled if deemed appropriate. The Trust Board: • **NOTED** the content of the November 2023 financial report and in particular the expectation that the Trust will deliver against its 3 statutory financial targets at year end, subject to Welsh Government capital funding being approved; • **APPROVED** the option that any reserves not required to deliver the Trust revenue breakeven position may be offered to support the NHS Wales position on a non-recurrent basis. The Chair commended the significant work undertaken across the Trust to achieve this position.	
5.0.0	**PLANNING AND STRATEGIC DEVELOPMENT**	
5.1.0	**Trust Values** Following a significant amount of engagement with staff members, patients and donors across the Trust and feedback received, a refreshed set of Trust Values had been developed via an 18 month process. The paper outlined the decision making that had enabled the Trust to arrive at the current Trust Values. Sarah Morley advised that this had also been discussed at Board Development on 14th December 2023 and received at Strategic Development Committee on January 18th 2024. This had been an important step for the Organisation and will form the basis of the development of the behaviours framework. Hilary Jones questioned the embedding process to when staff would be living these values. Sarah Morley indicated that while these values have been launched, the full embedding rollout plan is being finalised. Sarah Morley confirmed that the Board would be kept up to date. It is the intention to progress the behaviours framework through the governance cycle (including staff survey input), to ensure that Trust-wide understanding of the meaning of the values, prior to implementation of metrics to monitor these. The Trust Board **APPROVED** the proposed values for the Trust.	

6.0.0	**CONSENT ITEMS**	
6.1.0	**CONSENT FOR APPROVAL** Gareth Jones requested confirmation that all items within the **CONSENT FOR APPROVAL** section had been considered at the relevant Committee before being presented to Board for approval, as it was not clear from the papers. Lauren Fear advised that it is not a requirement for all consent items to have been sighted by a Committee, however this is noted on the cover paper in the case of a paper being presented to a Committee. No concerns was raised to the Chair in relation to the appropriateness of the items remaining in the **CONSENT FOR APPROVAL** section.	
6.1.1	**Commitment of Expenditure exceeding Chief Executive's Limit** The Trust Board **AUTHORISED** the Chief Executive to **APPROVE** the award of contracts summarised within this paper and supporting appendices **and AUTHORISED** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement, subject to the note above.	
6.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chair's Urgent Actions taken between 22/11/2023 and 23/02/2024.	
6.1.3	**Trust Policies for Approval** The Trust Board **APPROVED** the following policies, which had been **ENDORSED** at the relevant Committees for Trust Board approval: • Policy on the Use of Small Animals in Research • All Wales NHS Dress Code • Annual Leave Policy (Agenda for Change) • Redundancy and Security of Employment Policy • Recruitment and Selection Policy	
6.1.4	**NHS Wales Shared Services Partnership – Renewal of Lease** Hilary Jones requested for the removal of this item from consent to allow for further discussion. The following was raised: • The Trust Board had not received a copy of the Lease for comment before signoff and whether this was regular protocol. It was agreed that the Lease should be received by Board members and that this would be circulated for finalisation outside of the meeting. • The payment for the lease as detailed in the cover paper is not inclusive of VAT and that this should be amended to reflect the information presented in the associated Appendix 5 under the Commitment of Expenditure Exceeding Chief Executive's Limit. • The current lease expired on the 7th October 2023. Gareth Jones queried a) the delay in the signing of the new lease and b) the cover paper states that the new lease will be backdated to the 8th October 2023. Lauren Fear agreed to revert to NHS Wales Shared Services Partnership to obtain a clearer explanation as to why this is the case. Following receipt of this and the addition of amendments as stated in point 2 above, it was	**LF** **LF**

	agreed that the Lease would then be circulated to Board members for out of Board approval. The renewal of the lease for the Counter Fraud Wales Services offices, Mamhilad House, **was not approved** by the Trust Board. Additionally it was noted that it is not a requirement for this to be presented to a Committee prior to Board.	
6.2.0	**CONSENT FOR NOTING**	
6.2.1	**Trust-wide Approved Policies Update** The Trust Board **NOTED** the content of the report.	
6.2.2	**Public Quality, Safety & Performance Committee Highlight Report (16/01/2024)** Led by Vicky Morris, Independent Member and Chair of Quality, Safety & Performance Committee The Trust Board **NOTED** the content of the report.	
6.2.3	**Public Audit Committee Highlight Report (19/12/2023)** Led by Gareth Jones, Independent Member and Acting Chair of Audit Committee The Trust Board **NOTED** the content of the report.	
6.2.4	**Public Strategic Development Committee Highlight Report (18/01/2024)** The Trust Board **NOTED** the content of the report.	
6.2.5	**Public Charitable Funds Committee Highlight Report (12/12/2023)** The Trust Board **NOTED** the content of the report.	
6.2.6	**Public Transforming Cancer Services Programme Scrutiny Sub Committee Highlight Reports (23/11/2023)** The Trust Board **NOTED** the content of the report.	
6.2.7	**Local Partnership Forum Highlight Report (19/12/2023)** The Trust Board **NOTED** the content of the report.	
6.2.8	**Public Welsh Health Specialised Services (WHSSC) Committee Briefing (21/11/2023)** The Trust Board **NOTED** the content of the report.	
6.2.9	**Emergency Ambulance Services Joint Committee (EASC) Briefing (21/11/2023 & 21/12/2023)** The Trust Board **NOTED** the content of the reports.	
6.2.10	**NHS Wales Shared Services Partnership Committee Assurance Report (23/11/2023)**	

	The Trust Board **NOTED** the content of the report.	
6.2.11	**Trust Seal Approval Report – (23rd November 2023 – 30th January 2024)** The Trust Board **NOTED** the content of the report.	
6.2.12	**Nurse Staffing Level (Wales) Act Update (6 month report)** Led by Nicola Williams, Executive Director or Nursing, Allied Health Professionals and Health Science The Chair removed this item from consent to allow for further discussion. Nicola Williams confirmed that while there is sufficient nursing establishment (with headroom) on First Floor Ward, to care for 'regular' patients up to the allocated patient numbers, difficulties resulting from absences have identified insufficient resource within the SACT (Systemic Anti-Cancer Therapy) team, which has been mitigated via the support of a number of First Floor Ward staff, trained to provide SACT treatment. Significant work has been undertaken to increase the nursing establishment within SACT (for example via international recruitment), however there is an 18.5% maternity leave rate within the service; therefore headroom will not adequately address this. The Trust has, however, over-recruited to ensure this issue within SACT will be addressed. Drawing on First Floor Ward staff resource had not resulted in any issues under the Act and patient care on the Ward had not been adversely affected due to the release of staff, however doing so had resulted in morale issues. Vicky Morris indicated that the three 25A areas where insufficient establishment had been identified (SACT, Assessment Unit and Clinical Nurse Specialist Team), further discussion at the Quality, Safety & Performance Committee had prompted a review of the establishment for these areas and it was anticipated that this would be provided. Nicola Williams advised that the Board would be provided a brief update on the three areas at the March meeting of the Trust Board. The Trust Board **NOTED** the content of the report.	**NW**
6.2.13	**Integrated Medium Term Plan (IMTP) (oral update)** Carl James advised that due to a shorter January 2024 Strategic Development Committee resulting from Industrial Action planning, the IMTP had not been presented at the Committee; therefore an oral update would be provided to the Board. The Trust remains on track to develop this year's plan, based on the existing approved plan. This has progressed through a number of workshops, Committees and Board Development and the planning guidance and Welsh Government financial allocation have been received. The Quality Impact Assessments (QIAs) are currently being worked through; therefore the final plan presented to the Board for discussion will include the QIAs, to enable the Board to make informed choices on the priorities for next and the forthcoming years. This will be presented at a Board Development Session on the 6th February 2024 with a clear plan towards Board approval.	

	Carl James was confident that this would be achievable in time for submission to Welsh Government on the 29th March 2024. The Trust Board **NOTED** the update.	
7.0.0	**ANY OTHER BUSINESS** The Chair had not received prior notice of any other business and the meeting was closed.	
8.0.0	**DATE of the next meeting** The next meeting of the Public Trust Board will take place on Tuesday 26th March 2024. An extraordinary Public Trust Board is scheduled to take place on Wednesday, February 7th 2024.	
9.0.0	**CLOSE**	

MINUTES OF EXTRAORDINARY PUBLIC TRUST BOARD MEETING
VELINDRE UNIVERSITY NHS TRUST
7th FEBRUARY 2024 (13:00-14:00)
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
Prof. Andrew Westwell	Independent Member
Vicky Morris	Independent Member
Carl James	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
ATTENDEES	
Lauren Fear	Director of Corporate Governance & Chief of Staff
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, the purpose of which was to approve the Strategic Business Case, a key component of the Full Business Case for the new Velindre Cancer Centre. The Chair expressed thanks to those involved for enabling the Trust to arrive at the current position. Carl James, Acting CEO, agreed to convey this to those not present. The following apologies had been received: • Jacinta Abraham, Executive Medical Director • Cath O'Brien, Chief Operating Officer • Steve Ham, Chief Executive Officer • Gareth Jones, Independent Member	
1.2.0	**In Attendance:** Led by Prof Donna Mead OBE, Chair The Chair extended a warm welcome to the following additional attendees: • Katrina Febry, Audit Lead, Audit Wales • Stephen Allen, Regional Director, Llais Cymru • David Cogan, Patient Representative • David Powell, Project Director nVCC *(for item 2.1.0)* • Mark Ash, Assistant Project Director nVCC *(for item 2.1.0)*	
1.3.0	**Declarations of Interest**	

	Led by Prof Donna Mead, Chair There were no declarations of interest pertinent to the items on today's agenda to note.	
2.0.0	**MATTERS ARISING**	
2.1.0	**Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee Chair's Scrutiny Assurance Report to the Board** Led by Stephen Harries, Vice Chair and Chair of TCS Programme Scrutiny Sub-Committee In recognition of the understandably high level of public interest, Stephen Harries wished to assure the public audience of the robust governance, assurance processes and scrutiny activities undertaken by the TCS Scrutiny Sub-Committee in relation to the new Velindre Cancer Centre to date. Stephen Harries provided the following background information: • The Transforming Cancer Services (TCS) Programme was established by the Trust in 2015, which is the overarching programme for transforming cancer service delivery across the south east Wales region and wider cancer network. To achieve this, 7 high value, high impact, complex projects were established, one of which is the construction of a new Velindre Cancer Centre. • In recognition of the level of scrutiny and consideration required, the Trust Board formally established a TCS Scrutiny Sub-Committee in 2018, with membership drawn solely from the Board's Independent Members. It was noted that the Sub-Committee stands independently from the Trust Board and reports to Trust Board in addition subsequently to reporting to the Quality, Safety & Performance Committee also. • Terms of Reference for the Sub-Committee were agreed by the Trust Board Membership currently comprises Stephen Harries (Vice Chair and Chair of the Sub-Committee), Hilary Jones (Independent Member - Estates) and Gareth Jones (Independent Member - Legal). The Trust's Chair has also attended as many Sub-Committee meetings as possible, in addition to the Chief Executive, Executive Team members, Senior Officers and other professional staff as appropriate to each meeting's agenda. • The complexity of the projects has required the appointment of senior Project Directors, in addition to other subject matter experts both internally and across the cancer network. A range of external professional advisors has also been appointed who attend TCS Scrutiny Sub-Committee meetings as appropriate. • Each meeting follows an agenda agreed in advance of the meeting by the Chair, with additional private / extraordinary meetings held as required. Stephen Harries shared the following assurance opinion in respect of the scrutiny activities undertaken, for consideration by the Board in this meeting: • The frequency of meetings of the Sub-Committee has increased as this point has approached, with rigorous scrutiny of the papers being considered at today's public Board meeting (and today's subsequent private Board meeting). Recent meetings of the Sub-Committee were held on the 1st, 5th and 6th February 2024, totalling approximately 10 hours of consideration. In reviewing the papers, particular attention was paid to the scrutiny of key assumptions, risks, funding, value for money, procurement, commercial arrangements and professional assurances. • In doing so, the Sub-Committee identified a minimal number of (non-material) amendments for further clarification and assurance purposes. The Sub-	

	Committee also formally endorsed for Board approval all matters requiring endorsement, subject to inclusion of the amendments in the final submission to Welsh Government. In conclusion, Stephen Harries confirmed to the Board that he was content in his role as Chair of the TCS Scrutiny Sub-Committee that the Sub-Committee had discharged its responsibilities required for the papers being brought to today's Board meeting and had sought and received sufficient in depth detailed information to achieve this. Stephen Harries expressed thanks to Hilary Jones and Gareth Jones for their robust scrutiny and challenging of every aspect at all stages of the process. The Chair welcomed the report and the Board **NOTED** the opinion and assurances provided by the Chair of the Sub-Committee.	
2.2.0	**New Velindre Cancer Centre FBC Strategic Case** Led by David Powell, Project Director nVCC Lauren Fear informed the Board that the Strategic Case would be considered at today's public meeting, whilst the remaining 4 cases would be received at the private meeting at this stage, due to ongoing commercial sensitivities until Financial Close. It was advised that all 5 cases would be published on the Trust website upon finalisation. The paper introduced the Strategic Case and its structure in accordance with the Treasury Green Book Guidance. The purpose of the Strategic Case is to make the case for change and to demonstrate how it provides strategic fit. The paper also included a summary of governance arrangements, assurance of the Full Business Case's compliance with the Treasury Green Book and items raised by the TCS Scrutiny Sub-Committee (which have been addressed and included in this version). Following comment by Stephen Allen regarding the significant number of acronyms included in the paper, it was agreed that an accompanying glossary of acronyms would be published on the Trust website alongside the paper. Stephen Allen also requested further clarity regarding the meaning of Extant Programme EQIA (Equality Impact Assessment) and whether an overarching EQIA for the programme exists (or whether multiple EQIAs existed dependent on the area of the programme). Lauren Fear advised that while there is an overall programme EQIA, the Full Business Case itself has an additional schedule which addresses the Equality Impacts of the new Velindre Cancer Centre scope within this case. It was agreed that improved signposting within the documentation is required. David Powell introduced the Strategic case, advising the following: • Introduction (section 1) - The current Strategic Business Case is a follow on from the Outline Business Case approved by Welsh Government in March 2021. The purpose of the case is to review the assumptions made at the time of signing off the Outline Business Case, in addition to the current position and any required updates or changes. • Section 2 outlines the structure of the Strategic Case, in addition to the associated Equipment Strategy, Digital Strategies and Environmental and Sustainability Strategies which are progressing in parallel. • Section 3 reviews the existing situation, which broadly remains as originally described in the Outline Business Case.	

	• Section 4 establishes the case for change for the development of the new Velindre Cancer Centre, including the opportunity for complete compliance with Health Building Notes (HBNs) and enabling of more appropriate spaces for patient care. • Section 5 sets out the two key areas of business needs, such as the suitability of the existing accommodation / environment, anticipated increases in activity and predictions for growth. Growth lines predicted during 2021 remain on the trajectory anticipated at the time. • The Case also explores financial, non-financial and societal benefits which can be drawn from the scheme and how these can be achieved. Vicky Morris noted that the report states that planning assumptions for cancer incidence had been supported a range of evidence (including figures for inpatient and outpatient facilities), querying whether this evidence had been considered at wider regional meetings. Carl James advised that the Business Case and planning assumptions had been sighted at the (formerly) South Wales Cancer Collaborative Leadership Group; the Trust's focus is how incidence of cancer may impact tertiary services provided by the Cancer Centre such as Systemic Anti-Cancer Therapy (SACT) / Radiotherapy, due to the Trust's 'end of pathway' position. Additionally, as the new Cancer Centre will be of finite capacity, which can only be maximised by the provision of additional hours or days of services, opportunities to provide as much care, where appropriate, at home or in the community (supported by technology) has been explored, so that patients will be required travel to the hospital for highly specialised treatment only, therefore servicing the demand in a different way. There were no other observations and the Trust Board **APPROVED** the new Velindre Cancer Centre Strategic Case <u>as it will appear in the Full Business Case.</u>	
3.0.0	**Any other Business** Led by Prof Donna Mead OBE, Chair No other business was raised.	
4.0.0	**CLOSE** The Chair closed the meeting.	

VUNHST PUBLIC TRUST BOARD MEETING 30th JANUARY 2024 – ACTION LOG

No.	Action	Owner	Target Date	Progress to date	Status (Open / Closed)
ACTIONS ARISING FROM 30/01/2024					
3.1.0	All Board members to receive regular sight of Audit Tracker.	Executive Director of Finance / Director of Corporate Governance & Chief of Staff	**26/03/2024**	Audit Tracker circulated to all Board members in line with publishing for each Audit Committee meeting	**CLOSED**
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.	Executive Team (where applicable)	**26/03/2024**	To be discussed in Executive Management Board 4th April and Executive Leads will then action with the respective Committee Chairs.	**OPEN**
4.1.0	Minor amendments to be made to Trust Risk Register in relation to dates, recommendation and inclusion of further narrative in relation to actions undertaken to date.	Director of Corporate Governance & Chief of Staff	**26/03/2024**	Addressed in **March** paper	**CLOSED**
4.3.0	Include detail of significant action taken (and resulting improvement) to increase capacity within Pharmacy and non-emergency SACT treatment in Performance Management Framework.	Acting Director of Velindre Cancer Service	**26/03/2024**	Detailed plan developed and being monitored on a weekly basis in conjunction with Executive leads	**OPEN**
4.3.0	Clarify % increase in SACT referral rate noted in Performance Management Framework.	Acting Director of Velindre Cancer Service	**26/03/2024**		**OPEN**
5.1.0	Board to be kept up to date regarding rollout of plan to embed of Trust Values (plan currently being finalised).	Executive Director of Organisational Development & Workforce	**26/03/2024**		**OPEN**
6.1.4	Obtain clarity from NHS Wales Shared Services Partnership re backdating of Lease for the Counter Fraud Wales Services Offices in relation to backdating of Lease to 8th October 2023.	Director of Corporate Governance & Chief of Staff	**26/03/2024**	Addressed and dealt with in Urgent Chair Action	**CLOSED**
6.2.12	Update to be provided to Board Members in relation to the 3 25A areas of the Nurse Staffing Level (Wales) Act following a review of the establishment for these areas.	Executive Director of Nursing, Allied Health Professionals and Health Sciences	**25/05/2024**		**OPEN**

TRUST BOARD

CHAIR'S UPDATE REPORT

DATE OF MEETING	26th March 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	Lauren Fear, Director of Corporate Governance & 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
- Thank you to Martin Veale (Independent Member)
- Independent Members – Extension of Tenure
- Wear Red for Wales (and Velindre)
- WBS Donor Awards – 28th / 29th February 2024
- International Women's Day
- Blood Health National Oversight Group (BHNOG) Annual Conference 2024
- A night with Rugby Legends - Pugh's Garden Centre, Wenvoe

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Board Development Sessions

Two Board Development Session were held on the 6th February 2024 and the 27th February 2024. Topics discussed were:

- **6th February 2024 (Integrated Medium Term Plan only)**:

The session provided a recap of our requirements and agreed strategies in addition to a progress update in relation to the development of the Integrated Medium Term Plan. Key priorities, risks and challenges to the delivery of the Trust's service plans were noted.

- **27th February 2024:**

The session discussed the following key matters:

- ***Research & Innovation at Velindre*** – how we deliver for our patients and donors.
- ***Maggie's*** – the impact of the centre on those who use it, work with teams across Velindre and plans for 2024, including plans for north Wales and proposed new centre for Cardiff.
- ***Welsh Blood Service Improvement Spotlight Event*** – showcasing how the Quality Assurance Team has supported staff in making changes to their day to day work.
- ***Integrated Medium Term Plan (IMTP) 2024/25–2026/27*** – providing an update in relation to the development of the IMTP and developments since the last Board Development Session.
- ***Clinical & Scientific Strategy Development*** – presenting a draft vision and strategic aims based on priority themes.
- ***Strategic Risks and Strategic Goals*** – to ensure that the IMTP reflects the strategic objectives that the Trust Board would expect in order to effectively address the strategic risks within the Trust Assurance Framework (TAF).
- ***Development of Governance, Assurance & Risk Programme*** – to recap on the current position of the Governance, Assurance and Risk Programme of Works.

3.2 Thank you to Martin Veale, Independent Member

The Chair would like to thank Martin Veale, on behalf of the whole Board, for the contribution he has made as Independent Member of the Board over the past seven years.

Martin has been as Chair of Audit Committee, NWSSP Audit Committee and Charitable Funds Investment Sub-Committee, in addition to membership of many other of our Committees. In addition, Martin has been a member also at wider NHS Wales fora, including: NHS Wales Audit Chairs Group, Welsh Risk Pool Committee and Counter Fraud Steering Group. Martin has also been consistent champion for governance and risk development in the organisation and also on our role in respect to hosted organisations.

3.3 Independent Members – Extension of Tenure

The Chair is pleased to report that Gareth Jones (Legal) and Hilary Jones (Estates) have both been offered and accepted a second four year term of office by the Minister for Health and Social Care.

The Trust is pleased to be participating in the Job shadowing initiative led by the public Appointments unit and will be welcoming the first participant shortly. The Chair is grateful to Stephen Harries for agreeing to act as Mentor for the initiative.

Arrangements for the appointment for two independent members are progressing. One is the additional independent member resulting from the requirements set out in the Health and Social Care (Quality and Engagement) (Wales) Act and the second is for an Independent Member (Finance).

3.4 Wear Red for Wales (and Velindre)

Staff at Velindre turned the Cancer Centre red as the Charity's flagship campaign returned for another year, encouraging everyone to wear something red in support of Wales' rugby teams on the eve of the Six Nations, while raising vital funds for the Cancer Centre.

Activities on the day included a special delivery of pies from Peter's (the campaign's principal sponsor), an appearance from former Love Island winner Liam Reardon (pictured) and a number of other events.

3.5 WBS Donor Awards (Swansea area) 28th – 29th February 2024

On the 28th and 29th February 2024, the Trust welcomed 119 milestone donors to the February Donor Award ceremonies, held at the Village Hotel Swansea over two nights, to celebrate their commitment to the Welsh Blood Service.

The evenings showcased local blood donors being celebrated for their 50, 75 and 100 blood donation milestones, in addition to a number of 50, 100 and 200 platelet donors and 8 bone marrow donors.

The donations made by donors across both ceremonies had potentially saved the lives of over 20,000 patients in need.

3.6 International Women's Day

In celebration of International Women's Day, the Chair attended a lunch at the Angel Hotel, Cardiff.

This year the Trust hosted a table of incredible women from across the organisation including patients, consultants and relatives. The Chair welcomed the guests by sharing information on the charity, where funds will be spent and to thank everyone for their donations.

3.7 Blood Health National Oversight Group (BHNOG) Annual Conference 2024

The Chair attended this year's Blood Health National Oversight Group (BHNOG) annual conference 'The Blood Health Plan: Making it work for you' was held virtually on Monday 11th March. Opened by Sir Frank Atherton, the conference showcased the work used to deliver the Blood Health Plan's strategic aims. An outstanding array of poster presentations were displayed from health care professionals across Wales.

Also in February the Trust welcomed Staff Sergeant Andrew Ferguson to the Welsh Blood Centre. Staff Sereant Ferguson is a biomedical Scientist, and he shared his experience of biomedical science from a military perspective and also insights into walking Blood banks. (emergency Donor Panel)

3.9 A night with Rugby Legends - Pugh's Garden Centre, Wenvoe

This event was held by Pugh's Garden Centre, Wenvoe in aid of Velindre Charity and hosted by Rugby Legends Shane Williams, James Hook and Lee Byrne with broadcaster Hugh LLewllyn Davies acting as MC and auctioneer. The event was filled with food, rugby stories, a raffle and an auction and was another opportunity for us to give back to our charity supporters. The Chair shared her experience of her daughter-in-law Clare and the Lion teddies provided by the charity. The Chair's speech had a huge impact on everyone in the room and touched many of the guests. The Trust and the Charity are most grateful to all those who donated food and gifts for the raffle.

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

3 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

VICE CHAIR'S UPDATE REPORT

DATE OF MEETING	26th March 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	Lauren Fear, Director of Corporate Governance & Chief of Staff

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 Meetings
- Board Development/Briefing Sessions
- Trust Committee Meetings
- Attendance at Internal / External 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: *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

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

APPENDIX 1

Vice Chair's Update to Trust Board March 2024

This Report provides an update from the Vice Chair.

Trust Board & Committees

At the time of writing, during the period, I have attended the following Board Meetings/Sessions:

- Extraordinary Private Trust Board – 7 Feb 2024
- Extraordinary Private Trust Board – 7 Mar 2024
- Board Briefing Session – 13 Mar 2024
- Extraordinary Private Trust Board – 18 Mar 2024

I have Chaired the following Committee and Sub-committee meetings:

- Extraordinary Private TCS Scrutiny Sub-Committee – 1 Feb 2024
- Extraordinary Private TCS Scrutiny Sub-Committee – 5 Feb 2024
- Extraordinary Private TCS Scrutiny Sub-Committee – 6 Feb 2024
- Extraordinary Private TCS Scrutiny Sub-Committee – 5 Mar 2024
- Strategic Development Committee, Public and Private Meetings – 21 March 2024

I have attended the following Committee meetings:

- QSP Committee, Public and Private Meetings – 14 March 2024
- Remuneration Committee – 14 March 2024

External Meetings

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

On 18 March 2024 I attended a Meeting of Vice-Chairs of Health Boards and Trusts with the Health Minister.

Internal Meetings

I have had 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.

On 4 March 2024 I met with the Director of Finance and Deputy Director of Finance to discuss progress and proposals in respect of the "Food Mission" initiative.

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 as necessary 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 been invited by the Chair to take on an 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". I have had an initial meeting with the successful candidate ahead to the Board meeting and will be arranging regular engagement sessions to support the aims of the Programme and the individual.

Stephen Harries

Vice Chair

TRUST BOARD

CHIEF EXECUTIVE'S UPDATE REPORT

DATE OF MEETING	26th March 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	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Steve Ham, Chief Executive
APPROVED BY	Steve Ham, Chief Executive

EXECUTIVE SUMMARY	This report provides information to the Board regarding a number of matters and activity the since the previous meeting of the Trust Board.
RECOMMENDATION / ACTIONS	To **NOTE** the content of the Chief Executive'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/BACKGROUND

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

Matters addressed in this report cover the following:

- Industrial Action
- nVCC Financial Close
- COO departure and recruitment
- COVID-19 visit to Wales

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Industrial Action

Following the first period of industrial action by Junior Doctors in January 2024, a second round of action took place between 21st and 24th February 2024.

The Trust once again stood up its incident management command structure to prepare for and manage the period, in line with the Trust's response in January.

Significant preparation work was undertaken, including one to one meetings with medical staff, wider communications and engagement of all staff groups, communication to patients where required.

The service continued to operate during the strike with no significant escalations required. There was clearly an impact on wider workload, particularly on the consultant workforce. The Executive Team has conveyed its thanks to everyone involved in the planning and delivery of services during this period and also for the professional manner/partnership working with our trade union partners.

Further action has since been confirmed by Junior Doctors from the 25th – 29th March 2024, with planning arrangements once again being robust to support services and colleagues during this time.

In addition, the results of a ballot held with Consultants and with SAS Doctors have been confirmed and the first period of action by these staff groups has been confirmed from **16th – 18th April 2024.** Work is underway to plan for this action with the Trust actively participating in local and national arrangements in preparation for this action.

2.2 nVCC Financial Close

The Trust continues to work to complete the procurement process with the Consortia who are designing, building and maintaining the new Velindre Cancer Centre. This continues to be expected to conclude shortly. The new cancer centre will deliver vital world-class care and treatment for patients today and for future generations as more of us are diagnosed with cancer.

2.3 COO Departure and recruitment

The Chief Executive would like to publically share the organisation's thanks to Cath O'Brien who left the Trust earlier this month to take on a new role as Chief Pharmacy Information Officer at Digital Health and Care Wales.

Cath joined the Welsh Blood Service in 2013 and led the organisation through several major change programmes. Cath also led the development of the Advanced Therapies Statement of Intent on behalf of Welsh Government, a contribution recognised by the award of an MBE (Member of the Order of the British Empire) in 2019 for services to the Welsh Blood Service and the adoption of Cell and Gene Therapy in Wales. In recent years, Cath took on the new role of Trust Chief Operating Officer and has worked to embed a programme of service improvement and innovation.

Thank you Cath.

The process is currently underway to recruit to the post.

2.5 COVID-19 visit to Wales

The Trust continues to support the work of the Covid-19 Inquiry.

Module 2 “Core UK decision making and political governance” is reviewing the core political and administrative governance and decision-making for the UK. It includes the initial response, central government decision making, political and civil service performance as well as the effectiveness of relationships with governments in the devolved administrations and local and voluntary sectors. Module 2 also assesses decision-making about non-pharmaceutical measures and the factors that contributed to their implementation. Module 2B assesses the strategic and overarching issues from the perspective of Wales. The public hearings for Module 2B have been taking place from end February to mid-March 2024. There were not any specific matters relating to the Trust.

The Trust, as part of the Group of Welsh NHS Bodies, is a Core Participant in Module 3, “Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK.” The next preliminary hearing will be held on 19th April. Public hearings are expected later in the year.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

Archwilio Cymru
Audit Wales

Annual Audit Report 2023 – Velindre University NHS Trust

Audit year: 2022-23

Date issued: January 2023

Document reference: TBC

Purpose of this document

This document is a draft supplied in confidence solely for the purpose of verifying the accuracy and completeness of the information contained in it and to obtain views on the conclusions reached.

Handling prior to publication

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and Audit Wales are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to Audit Wales at infoofficer@audit.wales.

We welcome correspondence and telephone calls in Welsh and English. Corresponding in Welsh will not lead to delay. Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg. Ni fydd gohebu yn Gymraeg yn arwain at oedi.

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

Contents

Summary report

About this report

1 This report summarises the findings from my 2023 audit work at Velindre University NHS Trust (the Trust) undertaken to fulfil my responsibilities under the Public Audit (Wales) Act 2004. That Act requires me to:

- examine and certify the accounts submitted to me by the Trust, and to lay them before the Senedd;
- satisfy myself that expenditure and income have been applied to the purposes intended and are in accordance with authorities; and
- satisfy myself that the Trust has made proper arrangements for securing economy, efficiency, and effectiveness in its use of resources.

2 I report my overall findings under the following headings:

- audit of accounts; and
- arrangements for securing economy, efficiency, and effectiveness in the use of resources.

3 This year's audit work took place at a time when NHS bodies were still responding to the legacy of the COVID-19 pandemic as they look to recover and transform services and respond to the additional demand in the system that has built up during the pandemic. Furthermore, health bodies were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate. My work programme, therefore, was designed to best assure the people of Wales that public funds are well managed.

4 I aimed to ensure my work did not hamper public bodies in tackling the post-pandemic challenges they face, whilst ensuring it continued to support both scrutiny and learning. We largely continued to work and engage remotely where possible through the use of technology, but some on-site audit work resumed where it was safe and appropriate to do so. This inevitably had an impact on how we deliver audit work but has also helped to embed positive changes in our ways of working.

5 The delivery of my audit of accounts work has continued mostly remotely. Auditing standards were updated for 2022-23 audits which resulted in some significant changes in our approach. The specific changes were discussed in detail in my 2023 Audit Plan. The audited accounts submission deadline was extended to 31 July 2023. The financial statements were certified on 31 July 2023, meaning the deadline was met. This reflects a great collective effort by both my staff and the Trust's officers.

6 I also adjusted the focus and approach of my performance audit work to ensure its relevance in the context of the post-pandemic challenges facing the NHS in Wales. I have commented on how NHS Wales is tackling the backlog of patients waiting for orthopaedic treatments. I have also published an NHS Workforce Data Briefing

that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally. The data briefing complements my assessments of how the workforce planning arrangements of individual NHS bodies are helping them to effectively address current and future workforce challenges. My local audit teams have commented on the governance arrangements of individual bodies, as well as how they are responding to specific local challenges and risks. My performance audit work is conducted in line with INTOSAI auditing standards[1].

7 This report is a summary of the issues presented in more detailed reports to the Trust this year (see **Appendix 1)**. I also include a summary of the status of work still underway, but not yet completed.

8 **Appendix 2** presents the latest estimate of the audit fee that I will need to charge to cover the costs of undertaking my work, compared to the original fee set out in the 2023 Audit Plan.

9 **Appendix 3** sets out the audit of accounts risks set out in my 2023 Audit Plan and how they were addressed through the audit.

10 The Chief Executive, the Executive Director of Finance and the Director of Corporate Governance and Chief of Staff have agreed the factual accuracy of this report. We presented it to the Audit Committee on 12 March 2024. The Board will receive the report at a later Board meeting and every member will receive a copy. We strongly encourage the Trust to arrange its wider publication. We will make the report available to the public on the Audit Wales website after the Board have considered it.

11 I would like to thank the Trust's staff and members for their help and co-operation throughout my audit.

Key messages

Audit of accounts

12 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however I brought some issues to the attention of officers and the Audit Committee for improvement.

13 I identified no material financial transactions within the Trust's 2022-23 accounts that were not in accordance with authorities or not used for the purpose intended,

[1] INTOSAI (International Organisation of Supreme Audit Institutions) is a global umbrella organisation for the performance audit community. It is a non-governmental organisation with special consultative status with the Economic and Social Council (ECOSOC) of the United Nations.

and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2022-23 accounts.

14 I placed no substantive report alongside my opinion this year as there were no issues to report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

15 My programme of Performance Audit work has led me to draw the following conclusions:

- Across Wales, despite an increasing NHS workforce, there remain vacancies in key areas, high sickness and staff turnover resulting in over-reliance on agency staffing. More positively, NHS Wales is becoming a more flexible and equal employer.
- The Trust is strengthening its strategic workforce planning supported by improving workforce intelligence. However, it lacks sufficient oversight on the impact of its workforce initiatives and needs to ensure it has the capacity and capability to deliver longer term workforce priorities.
- Overall, the Trust continues to be generally well led and governed, with a clear strategic vision and priorities, improving systems of assurance, and effective arrangements for managing its finances. However, opportunities remain to further enhance public transparency of Board business, strengthen strategic risk management arrangements, and ensure corporate plans and strategies contain clear objectives and actions for all Trust functions.

16 These findings are considered further in the following sections.

Detailed report

Audit of accounts

17 Preparing annual accounts is an essential part of demonstrating the stewardship of public money. The accounts show the organisation's financial performance and set out its net assets, net operating costs, gains and losses, and cash flows. My annual audit of those accounts provides an opinion on both their accuracy and the proper use ('regularity') of public monies.

18 My 2023 Audit Plan set out the key risks for audit of the accounts for 2022-23 and these are detailed along with how they were addressed in **Appendix 3 Exhibit 4**.

19 My responsibilities in auditing the accounts are described in my Statement of Responsibilities publications, which are available on the Audit Wales website.

Accuracy and preparation of the 2022-23 accounts

20 I concluded that the Trust's accounts were properly prepared and materially accurate and issued an unqualified audit opinion on them. My work did not identify any material weaknesses in internal controls (as relevant to my audit) however I brought some issues to the attention of officers and the Audit Committee for improvement.

21 The Trust submitted their draft accounts within the required deadline. The accounts, and supporting working papers, were of good quality. We did experience some difficulties in obtaining timely responses to some of our audit queries which delayed the completion of our audit. A major issue impacting on this was the staffing capacity within the Trust's finance team to support the audit process.

22 I must report issues arising from my work to those charged with governance (the Audit Committee) for consideration before I issue my audit opinion on the accounts. My financial audit team reported these issues on 26 July 2023. **Exhibit 1** summarises the key issues set out in that report.

Exhibit 1: issues reported to the Audit Committee

Issue	Auditors' comments
Uncorrected misstatements	There were no uncorrected misstatements.
Corrected misstatements	As a result of our audit there were a number of adjustments to the financial statements.

Issue	Auditors' comments
Other significant issues	We reported the difficulties we experienced in obtaining timely responses to clear some audit queries and that this delayed the completion of our audit. A major issue impacting on this was the staffing capacity within the Trust's finance team to support the audit process. A planned secondment and unforeseen sickness absence had a significant contribution to this.

23 I also undertook a review of the Whole of Government Accounts return. I concluded that the counterparty consolidation information was consistent with the Trust's financial position on 31 March 2023 and the return was prepared in accordance with the Treasury's instructions.

24 My audit of the Trust's charitable funds accounts commenced during November 2023. Whilst our audit fieldwork is substantially complete, we will not be able to certify the accounts until March 2024 due to a delay in the receipt of the independent assurances upon the activities of the fund's investment management company, Brewin Dolphin. Given the material nature of these activities it is essential that we receive these assurances prior to our audit certification.

Regularity of financial transactions

25 The Trust's financial transactions must be in accordance with the authorities that govern them. It must have the powers to receive income and incur expenditure. Our work reviews these powers and tests that there are no material elements of income or expenditure which the Trust does not have the powers to receive or incur.

26 I identified no material financial transactions within the Trust's 2022-23 accounts that were not in accordance with authorities or not used for the purpose intended, and so I have issued an unqualified opinion on the regularity of the financial transactions within the Trust's 2022-23 accounts.

27 I placed no substantive report on the accounts alongside my opinion this year as there were no issues to report.

28 I have the power to place a substantive report on the Trust's accounts alongside my opinions where I want to highlight issues. Where the Trust fails one of its financial duties - to break-even over a three-year period and to have an approved three-year plan in place - or my opinion is qualified, I will issue a substantive report.

29 The Trust met its financial duties for 2022-23, reporting a small surplus of £76,000 at the end of the financial year. The Trust also achieved its statutory financial duty

to achieve break-even over a three-year rolling period 2020-23, reporting an overall three-year surplus of £155,000. As a result, my opinions were unqualified, so I did not issue a such a report.

Arrangements for securing efficiency, effectiveness, and economy in the use of resources

30 I have a statutory requirement to satisfy myself that the Trust has proper arrangements in place to secure efficiency, effectiveness, and economy in the use of resources. I have undertaken a range of performance audit work at the Trust over the last 12 months to help me discharge that responsibility. This work has involved:

- Publishing an NHS Workforce Data Briefing that brings together a range of metrics and trends to help illustrate the challenges that need to be gripped locally and nationally.
- Reviewing the effectiveness of the Trust's workforce planning arrangements.
- Undertaking a structured assessment of the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically.

31 My conclusions based on this work are set out below.

NHS workforce data briefing

32 In September 2023, I published a data briefing which set out key workforce data for NHS Wales. My briefing highlighted continued growth of NHS Wales, and reflected that in some instances, the growth in staff levels, particularly in nursing and some medical specialties hasn't kept up with increasing demand.

33 The pandemic clearly had an impact on staff and the workforce remains under significant pressure. The recent key trends show increased staff turnover, sickness absence and vacancies. This has resulted in greater reliance on external agency staffing and notably increased agency costs to £325 million in 2022-23. Wales is growing its own workforce, with increased nurses and doctors in training.

34 Despite this, there is still a heavy reliance on medical staff from outside of Wales, demonstrating a need to both ensure that education commissioning is aligned to demand, but also that health bodies are able to recruit sufficient graduates, once they have completed their training. My report also highlights some positive trends that show that the NHS is becoming a more flexible and equal employer.

Workforce planning arrangements

35 My review examined whether the Trust has effective arrangements to support workforce planning. It focussed on the strategic and operational workforce planning, how it uses workforce information and how it works with its stakeholders to develop solutions. The work also considered the organisation's capacity and capability to identify and address key short and long-term workforce challenges and how it monitors whether its approach is making a difference.

36 My work found that the Trust is strengthening its strategic workforce planning supported by improving workforce intelligence. However, it lacks sufficient oversight on the impact of its workforce initiatives and needs to ensure it has the capacity and capability to deliver longer term workforce priorities.

37 The key workforce issues at the Trust relate to filling vacancies for professions in areas with longstanding national challenges. Vacancy levels are higher than average across Wales, with some notable gaps including consultant radiologists, acute oncology consultants and medical physicists and some nursing roles. The Trust is still dealing with the effect of the pandemic with high sickness levels experienced in some service areas. Spending on agency staff increased considerably in 2020-2021 to £2.7 million but fell to £1.3 million in 2022-23.

38 The Trust has a clear strategic vision for its workforce; however, to effectively deliver it, it needs to develop its strategic workforce planning approaches and develop an underpinning implementation plan. The Trust has a reasonable understanding of current service demands, based on current service models. It is working well with internal and external stakeholders to find shared solutions to workforce challenges. However, there is scope for the Trust to strengthen its analysis of anticipated future demand to shape future workforce requirements and inform workforce modelling. At the time of reporting, the Trust was working to finalise its Supply and Shape Framework.

39 The Trust has clear intent to improve workforce planning capacity and capability. However, limited corporate capacity and operational pressures meant that service leads do not have sufficient time to develop workforce planning solutions to help address operational challenges. The Trust understands high-level workforce risks associated with delivering its People Strategy, but actions to mitigate these risks have achieved minimal effect to date. The development of the Supply and Shape Framework should help to identify workforce gaps and inform future corporate risk assessment. The Trust is taking steps to help it respond to current workforce challenges through a range of recruitment and retention activities.

40 Whilst the Trust's Board and its committees maintain reasonable oversight of workforce challenges, there needs to be stronger focus on the extent that actions are having an impact on reducing short and medium-term workforce risks. Whilst the Quality, Safety and Performance Committee receive timely workforce performance reports, the Trust needs to strengthen how it reports on the impact of the People Strategy's delivery to demonstrate what difference it is making. Where possible the Trust benchmarks its workforce performance with other health bodies in Wales and networks with comparing organisations across the UK.

Structured assessment

41 My 2023 structured assessment work took place at a time when NHS bodies were continuing to deal with the legacy of the COVID-19 pandemic in terms of recovering and transforming services and responding to the additional demand in the system that built up during the pandemic. Furthermore, they were also dealing with a broader set of challenges associated with the cost-of-living crisis, the climate emergency, inflationary pressures on public finances, workforce shortages, and an ageing estate.

42 My team focussed on the Trust's corporate arrangements for ensuring that resources are used efficiently, effectively, and economically, with a specific focus on: Board transparency, effectiveness, and cohesion; corporate systems of assurance; corporate approach to planning; and corporate approach to managing financial resources. Auditors also paid attention to progress made to address previous recommendations.

Board transparency, effectiveness, and cohesion

43 My work considered whether the Trust's Board conducts its business appropriately, effectively, and transparently. I paid particular attention to:

- Public transparency of Board business;
- Arrangements to support the conduct of Board business;
- Board and committee structure, business, meetings, and flows of assurance;
- Board commitment to hearing from staff, users, other stakeholders; and
- Board skills, experiences, cohesiveness, and commitment to improvement.

44 My work found that the Board and its committees generally operate well, with an ongoing commitment to public transparency, continuous improvement and to hear from patients and donors. However, opportunities remain to further enhance certain arrangements further.

45 The Board remains committed to conducting its business transparently. Board meetings are live-streamed, and papers made available in advance of meetings. However, opportunities remain to further enhance transparency of Board business. This includes promoting Board meetings via social media, publishing committee agenda papers in advance of meetings, giving the public a brief summary of decisions made in private sessions, and publishing unconfirmed Board and committee minutes shortly after meetings.

46 There are effective arrangements to support the conduct of Board business. Board and committee meetings are well managed, with good scrutiny, challenge, and debate. However, some committees are finding it difficult to run meetings to time. Board and Committee papers often contain too much detail and do not provide enough assurance on the impact of initiatives or actions taken.

47 The Board promotes and demonstrates a commitment to hear from patients and donors and is stepping up activities to enable Board members to hear from service

users. The Board is stable and continues to demonstrate a positive commitment to continuous improvement. However, the Trust will need to ensure that appropriate arrangements are in place to ensure continued stability once it has successfully recruited a replacement independent member.

Corporate systems of assurance

48 My work considered whether the Trust has a sound corporate approach to managing risks, performance, and the quality and safety of services. I paid particular attention to the organisation's arrangements for:

- Overseeing strategic and corporate risks;
- Overseeing organisational performance;
- Overseeing the quality and safety of services; and
- Tracking recommendations.

49 My work found that positive improvements have been made to key corporate systems of assurance, particularly in relation to managing performance, tracking recommendations, and responding to the new duties of quality and candour. However, progress in refreshing strategic risks has been slow, limiting the Board's ability to maintain effective oversight of them.

50 The Trust has continued to develop its Board Assurance Framework, but progress to refresh strategic risks has been slow. Consequently, the Board Assurance Framework was not reviewed by the Board for more than six months. However, the new template was populated with the revised risks and associated controls and assurance by the end of 2023. In January 2024, both the Quality, Safety, and Performance Committee and the Strategic Development Committee received the new Board Assurance Framework and endorsed the new strategic risks for Board approval later in the month. Improvements to information included in the Corporate Risk Register are providing better clarity about operational risks. This has drawn attention to the long-standing nature of many of the risks, and the Board wants to give more attention to the longest open risks over the coming months.

51 The Trust is strengthening its corporate approach to reporting, overseeing, and scrutinising organisational performance. It is looking to develop a Business Intelligence solution to help automate the collection and reporting of performance measures. The Trust has taken appropriate steps to review its compliance with the new duties of quality and candour. There are good arrangements to oversee and scrutinise progress to address audit and review recommendations.

Corporate approach to planning

52 My work considered whether the Trust has a sound corporate approach to planning. I paid particular attention to the organisation's arrangements for:

- Producing and overseeing the development of strategies and corporate plans, including the Integrated Medium-Term Plan; and
- Overseeing the delivery of corporate strategies and plans.

53 My work found that the Trust has set out a clear vision in its long-term strategy and its supporting enabling strategies. The Trust has effective corporate planning arrangements but needs to ensure that when it develops priorities for future Integrated Medium-Term Plans (IMTP), it considers the collective resources required to deliver them all rather than on an individual basis. There was good Board-level engagement throughout the development of the 2023-26 IMTP.

54 The 2023-26 IMTP contains clear objectives and actions, supported by timescales for delivery and intended measurable outcomes for blood and cancer services. However, the objectives for cross-cutting corporate functions are not underpinned by specific actions, and nor are they time-bound or measurable. Progress reporting against the 2023-26 IMTP has been limited to blood and cancer services only, and progress reports have not been received by the full Board. Going forward, the Trust recognises that IMTP progress reports need to provide better narrative to explain the resulting impact of both delivered and non-delivered actions on service quality and performance.

Corporate approach to managing financial resources

55 My work considered whether the Trust has a sound corporate approach to managing its financial resources. I paid particular attention to the organisation's arrangements for:

- Achieving its financial objectives;
- Overseeing financial planning;
- Overseeing financial management; and
- Overseeing financial performance.

56 My work found that the Trust continues to have good arrangements for financial planning and managing and monitoring its financial position.

57 The Trust met its financial duties for 2022-2023 and is forecasting to break-even in 2023-24. The Trust has a clear process for financial planning, with good involvement from the Board, although the development and the identification of recurrent savings plan has been a challenge. Its arrangements for controlling, overseeing, and scrutinising financial management are robust.

Appendix 1

Reports issued since my last annual audit report

Exhibit 2: reports issued since my last annual audit report

The following table lists the reports issued to the Trust in 2023.

Report	Date
Financial audit reports	
Audit of Financial Statements Report	July 2023
Opinion on the Financial Statements	July 2023
Audit of Accounts report	October 2023
Performance audit reports	
Review of Workforce Planning Arrangements	August 2023
NHS Workforce Data Briefing	September 2023
Structured Assessment 2023	November 2023
Other	
2023 Detailed Audit Plan	July 2023

My wider programme of national value for money studies in 2023 included reviews that focused on the NHS and pan-public-sector topics. These studies are typically funded through the Welsh Consolidated Fund and are presented to the Public Accounts

Committee to support its scrutiny of public expenditure. Reports are available on the Audit Wales website.

Exhibit 3: performance audit work still underway

There are several performance audits that are still underway at the Trust. These are shown in the following table, with the estimated dates for completion of the work.

Report	Estimated completion date
Review of Financial Efficiencies	March 2024
Operational Governance	May 2024
Follow-up of quality governance review	May 2024
Examination of the setting of well-being objectives	May 2024

Appendix 2

Audit fee

The 2023 Audit Plan set out the proposed audit fee of £243,111 (excluding VAT). The actual fee for the year was £252,111. Additional audit fee was charged owing to the additional audit required to complete the audit of the Trust's 2022-23 financial statements. [In addition to the fee set out above, the audit work undertaken on the shared services provided to the Trust by the NHS Wales Shared Services Partnership cost £2,779.

Appendix 3

Audit of accounts risks

Exhibit 4: audit of accounts risks

My 2023 Audit Plan set out the risks of material misstatement and/or irregularity for the audit of the Trust's 2022-23 accounts. The table below lists these risks and sets out how they were addressed as part of the audit.

Audit risk	Proposed audit response	Work done and outcome
Significant risks		
Management Override The risk of management override of controls is present in all entities. Due to the unpredictable way in which such override could occur, it is viewed as a significant risk [ISA 240.32-33].	The audit team will: • test the appropriateness of journal entries and other adjustments made in preparing the financial statements; • review accounting estimates for bias; and • evaluate the rationale for any significant transactions outside the normal course of business.	Planned audit work completed and no issues arising.
Other areas of audit focus		
IFRS16 – Leases A new accounting standard, IFRS16 Leases, has been adopted by the FReM for 2022-23. IFRS16 will significantly change how most leased assets are accounted for, as leased assets will need to be recognised as assets	My audit team will: • consider the completeness of the lease portfolios identified by the health board/trust/authority needing to be included in IFRS16 calculations; • review a sample of calculated asset and liability values and ensure that these have been accounted for and	Planned audit work completed and no issues arising.

Audit risk	Proposed audit response	Work done and outcome
and liabilities in the Statement of Financial Position. There are also significant additional disclosure requirements specific to leased assets that will need to be reflected in the financial statements.	disclosed in accordance with the Manual for Accounts; and • ensure that all material disclosures have been made.	
Asset Valuations The quinquennial valuation of the NHS estate took place as at 1 April 2022. There is a risk that assets are not valued on appropriate bases and that movements in the carrying values of assets are not appropriately accounted for and disclosed. Given the current economic climate, there is a further risk that the carrying values of assets have changed during 2022-23 and that 1 April 2022 valuations are materially misstated at the balance sheet date.	My audit team will: • consider the appropriateness of the work of the Valuation Office as a management expert; • test the appropriateness of asset valuation bases; • review a sample of movements in carrying values to ensure that movements have been accounted for and disclosed in accordance with the Manual for Accounts; and • consider whether the carrying value of assets at 1 April 2022 remains materially appropriate or whether additional in-year adjustments are required due to the impact of current economic conditions.	Planned audit work completed and there was one significant audit adjustment to asset valuations as a result of the correction of a validation error raised by the Welsh Government. This resulted in a £7.090m increase in the closing Net Book Value of the Trust's property plant and equipment.
Inventory Whilst decreasing, the inventory balance within the Trust's annual accounts remains material. In	We will undertake audit procedures to obtain assurance upon the accuracy and completeness of the write-downs undertaken during the	All audit work completed as planned and there were no issues arising.

Audit risk	Proposed audit response	Work done and outcome
addition there have been material write-downs of some stock values during the financial year. There is a risk that these write-downs are not founded on correct assumptions, accurately calculated or complete.	financial year to help inform whether the inventory balance within the financial statements is materially correct.	
Welsh Risk Pool The Trust hosts the Welsh Risk Pool Services on behalf of NHS Wales bodies in respect of costs associated settling clinical negligence claims, including structured settlement cases. As a result of the typically high value of these claims the aggregate value within the Trust's accounts far exceeds our materiality level. As a result, there is an inherent risk that any errors in presenting and disclosing these liabilities within the annual accounts could be material.	We will undertake audit testing and seek assurances from the work undertaken by other NHS Wales auditors in order to obtain assurance that the liabilities are materially correct.	An audit adjustment was made of £4.587m to reduce the Welsh Risk Pool Provision and corresponding debtor due from the Welsh Government due to the duplication of a case that became a Structured Settlement case in the year.

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	26th March 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	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the Committees to have effective oversight and assurance of the way in which risks are currently being managed across the Trust. • Note the on-going development activity and status of these actions.
RECOMMENDATION / ACTIONS	The Committees are asked to: • **NOTE** the risks of 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. • **NOTE** the on-going developments of the Trust's risk framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board - Out of Committee	19TH MARCH
Quality, Safety & Performance & Audit Extraordinary Committees	20TH MARCH

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Quality, Safety & Performance & Audit Extraordinary Committee:

- It was discussed that although the action to review underlying risk related to administration systems and processes had previously closed in January reporting given no further risks proposed by SLT following consideration, the Committee on 20th March, requested that this is considered again given the on-going issues evident as a result of this risk root cause. (re-opened as action in table in section 4)
- The Committee provided feedback that the format of the attached risk register has become difficult to read given the level of detail – and this will be addressed in the next cycle and tested with Committee members to ensure it works well for all. (Included in table in section 4)
- The timing of the cycle of risk review and oversight between the Divisional Senior Leadership Teams, Executive Management Board, Committees and Trust Board. The various options will be outlined and shared with Committee members prior to the next cycle to ensure there is a consensus on the optimum approach. (Included in table in section 4)
- Where actions relate to recruitment, there to be clearer detail on this going forwards so that there can be more effective assurance of the impact.

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

	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0

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

APPENDICES	
1	Current risk register data.

1. SITUATION

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

2. BACKGROUND

The risks currently held on Datix, and above the Trust Board approved Risk Appetite level of reporting, are to be considered.

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 9 risks to report in line with the Trust's risk appetite during this reporting period. This includes 5 risks with a current score over 15 and 4 risks with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

Changes since January reporting:

3.2 Reduction in risk scores

There have been two risks which have reduced in score during the reporting period:

- ***2187*** *– "There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks."*

  This risk has been reviewed by the Head of Service during February and reassessed to a score of 12 from 15 based on the progress in recruiting additional posts. Further detail on the progress with recruitment will be provided in the Trust Board meeting and included in the Datix record going forwards. It is a "safety" category of risk and therefore is still included in the risk reporting at Board level according to the Trust's risk appetite thresholds.

  Executive Management Board support this reduction.

- ***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."*

  This risk has been reviewed by the Head of Service during February and reassessed to a score of 12 by reducing the impact assessment from 5 to 4. It is a "Performance and service sustainability" category of risk and therefore it would now not be included in the risk reporting at Board level according to the Trust's risk appetite thresholds.

  Executive Management require further rationale to support this reduction and this is to be brought to Executive Management Board in the April meeting.

3.3 New risks opened

There have been four new risks opened during the reporting period:

- ***3338*** *– "There is a risk that Velindre Cancer Services are unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in-patient treatment" (score 20)*

- ***3337*** *– "There is a risk that patients are missed as a result of multiple lists being used to manage booking leading to clinical harm." (score 16)*

- ***3293*** *– "There is a risk to Quality, Performance and Service as a result of the timing of 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." (score 16)*

- ***3277*** *– "There is a risk to Performance, Quality and Safety as a result of the Consultant Therapeutic Radiographer for Head & Neck Cancer retiring leading to reduced capability to provide an adequate on-treatment review service for patients with head and neck cancer, resulting in a poorer patient experience and increase in workload for on-treatment review radiographers and consultant clinical oncologists for head and neck." (score 20)*

- ***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." (score 15)*

- ***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" (score 15)*

Risk 3338 has been discussed during the Gold Command meetings on SACT performance.

Executive Management Board require further discussion on 3337, 3293 and 3277 this is to be brought to Executive Management Board in the April meeting.

3.3. Risks score consistent during reporting period

- **3001 – Risk score remains at 12, as a result of action being taken and external environment continuing to be challenging**

  "There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Trust

sickness absence figures show mental health issues and stress to be the highest cause of absence from work."

Executive Management Board confirm that it still agrees appropriate for risk score to remain at 12.

- **3230 – Risk score remains at 12**

  "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"

  There has been good progress made on the action plan, including: recruitment of additional clinic co-ordinators to manage all activities associated with outpatient appointments (booking, processing, cancellation, clinic amendments/blocking and telephone queries); implementation of an interim electronic solution in April to deliver a standardised new patient referral template for submission in to a centralised, managed e-mail account which is to be piloted in Lung in conjunction with CAVUHB.

  The longer term solution, which is to implement new patient e-referral solution (hospital2Hospital solution) in conjunction with DHCW workplan, does not currently have any timescales agreed. Executive Management Board will therefore review the target risk score and action plan in the April meeting.

- **2465 – Good progress made and risk score will start to reduce as actions implemented during 2024**

  "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."

  An audit was completed and received at Senior Leadership Team in December - Operational services will now oversee Divisional wide working group to develop plan to develop recommendations and support implementation. Included in draft Integrated Medium Term Plan 2026-27.

  Executive Management Board confirmed that it still agrees appropriate for risk score to remain at 12 until new actions implemented during 2024 begin to have an impact on risk score and this will be considered each reporting period in line with progress.

- **3227 – Risk expected to decrease in line with progress to Financial Close**

  "new Velindre Cancer Centre - 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."

  Executive Management Board confirm that it still agrees appropriate for risk score to remain at 16 until Financial Close process has concluded.

4. KEY MATTERS - Summary of Actions Taken/ In Plan from Recent Governance Cycle or Matters raised by Trust Risk Group

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe/ Update	Status to report in January reporting cycle
1	Risk scores and target risk scores	Following Executive Management Board review and Divisional Leadership Team work, a number of scores were challenged and are being reassessed through the December-January cycle	December- January reporting cycle	**Closed** – updated in December Audit Committee and in this paper for January reporting cycle
2	Digital Risks	Separate paper to be brought back on the enterprise digital risk landscape to the next Committee meeting.	January Quality, Safety & Performance Committee	**Closed** – On January Quality, Safety & Performance Committee agenda

3	Administration systems and processes	This will be considered by the Divisional leadership teams and appropriate risk(s) articulated and scored	May reporting cycle	Although previously closed in January reporting given no further risks proposed by SLT following consideration. In Quality, Safety & Performance & Audit Extraordinary Committee on 20th March, it was requested that this is considered again given the on-going issues evident as a result of this risk root cause.
4	15 level risks are related to workforce issues in Velindre Cancer Services – triangulated to TAF 03	Workforce Risk 03 will include this in next review	December- January reporting cycle	**Closed** – addressed in TAF 03
5	Formatting of report to be clear on active risk management in the period	New updates from Datix are included in this cover paper as well as in a separate column in the Risk Register appendix	Addressed in this paper	**Closed** – cover paper style re-vamped and positive feedback in December Audit Committee
6	Datix information for risk 2515 required updating	Updated since November Quality, Safety & Performance Committee	Addressed in this paper	**Closed**
7a	Assurance level considerations by Audit Committee	Active risk management has resulted in a number of scores	December- January reporting cycle	**Closed** – Audit Committee confirmed that due to progress

		being reduced however not yet evidence of impact of actions on remaining risks – This will be further addressed and challenged in next period and explicit comment from the Executive Management Board (EMB) will be included for the next report – to demonstrate why EMB is comfortable with the current risk score or if not, what action is being taken.		made in December reporting cycle that Assurance Level could remain at 2
7b	Assurance level considerations by Audit Committee	In addition, any decrease in scores which result is no longer being currently reported at Trust Board level will be summarised for the next report in a separate table in the cover paper also.	Current risks have been reviewed against the previous report. There are no risks which have reduced to a level below that reportable to Trust Board.	**Closed** – now included in re-vamped style of cover paper
8	Review of risk domains – particular concern with respect to Clinical safety being clearly part of Quality domain on Datix	Review of Policy by Trust Risk Team, including this. Data pull for Quality and Safety domains during December – (to report on in January) – to review categorisation	May (for Trust Board approval) May reporting cycle	Deep dive work underway for May cycle reporting.

9	When risks first loaded onto Datix, inherent risks reported above risk appetite levels – for assurance on effectiveness of controls	To action for March reporting cycle	May reporting cycle	Process discussed with Risk Group to be implemented for May Board cycle reporting
10	Risk report to track overall number of risks at different scores in Datix	To action for March reporting cycle	May reporting cycle	
11	Risk Register format	The format of the attached risk register has become difficult to read given the level of detail	May reporting cycle	
12	Timing of the cycle of risk review	Review timing of the cycle of risk review and oversight between the Divisional Senior Leadership Teams, Executive Management Board, Committees and Trust Board.	May reporting cycle	

5. IMPACT ASSESSMENT

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

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

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

	Click or tap here to enter text.

6. RISKS

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

APPENDIX 1

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

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

ID	Risk Title - New	Risk (in brief)	RR - Current Controls	Division	Service	Area	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Due date	Description
3227	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.	changes during the design development process lead to a design which costs more overall, increasing project costs.	1.Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial bootcamp is scheduled for w/c 09/10/23 to try to finalise commercial position on various issues Ongoing 2. See comments against Action 1. Ongoing	Transforming Cancer Services	Transforming Cancer Services	Velindre Hospital	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	31/10/2023	14/12/2023	Increasing Costs
3277	There is a risk to Performance, Quality and Safety as a result of the Consultant Therapeutic Radiographer for Head & Neck Cancer retiring leading reduced capability to provide an adequate on-treatment review service for patients with head and neck cancer, resulting in a poorer patient experience and increase in workload for on-treatment review radiographers and consultant clinical oncologists for head and neck.	Situation - Consultant Therapeutic Radiographer for Head & Neck Cancer is retiring. Background - The role of Consultant Therapeutic Radiographer for Head & Neck Cancer is a highly specialised role, developed over a number of years in response to the needs of head and neck patients undergoing and recovering from radiotherapy. This role has developed to include aspects of patient care traditionally covered by a Consultant Clinical Oncologist (CCO), such as weekly on-treatment review and side-effect assessment and management, post treatment review and side-effect assessment and management, prescribing of chemotherapy and completing end of treatment letters for all head and neck patients receiving radiotherapy. As a senior member of the radiotherapy team, they are also responsible for a number of roles to support the function of the radiotherapy department such as, department lead for non-medical prescribing and PGD's (Patient Group Directive) prescribing and staff training in assessing and managing side-effects from radiotherapy and chemo-radiotherapy.	When Consultant Therapeutic Radiographer for Head & Neck Cancer is on leave, on-treatment review radiographer informs CCO if patient ok or not after weekly review so chemotherapy can be prescribed.	Velindre Cancer Centre	Radiotherapy Services	Radiotherapy	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Possible - May occur/reoccur at some time / occasionally.	2 - Minor	6	22/03/2024		
3293	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.	Current provisions for Radiotherapy Services at VCC are based on the clinical service model of having 10 clinical linear accelerators, 3 CT simulators, orthovolage and Brachytherapy across the new Cancer Centre (nVCC) and associated Satellite Radiotherapy Unit (SRU). There is an assumption that the new Velindre Cancer Centre will be operational in 2027. Delays on this project will impact negatively on the Radiotherapy Department at VCC.	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 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.	Velindre Cancer Centre	Radiotherapy Services	Radiotherapy	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	21/06/2024		
3337	there is a risk that patients are missed as a result of multiple lists being used to manage booking leading to clinical harm	review of booking systems within SACT services has indicated that the booking team are using multiple lists to manage patient. there is a risk that a patients name may be missed due to the need to coordinate these list when booking patient appointments	daily escalation meetings take place to ensure that patients are identified and managed appropriately	Velindre Cancer Centre	SACT	Chemotherapy Administration (inc Bookings)	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8	29/03/2024		
3338	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	Demand for SACT delivery (oral and parenteral) has exceeded forecast demand for 2023/2024. There is insufficient Pharmacy capacity at VCC to meet this increased demand at present.	daily escalation meetings outsourcing more product to suppport capacity within pharmacy	Velindre Cancer Centre	SACT	Chemotherapy Day Unit (CDU)	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	15/04/2024		

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.	There is a risk to PERFORMANCE & SUSTAINABILITY as a result of a failure to secure sufficient funding for the delivery of a new BECS contract and software platform, leading to a degradation of critical WBS (NHS Wales) blood supply chain activities. Failure to secure sufficient funding for the delivery of a new BECS contract and software platform.	Full costs to be confirmed via procurement.	Welsh Blood Service	Whole Service	Affecting whole service	Probable - Will probably occur/reoccur but will not be a persistent issue.	5	20	Possible - May occur/reoccur at some time / occasionally.	5	15	Rare - Would only occur/reoccur in very exceptional circumstances; considered a v	5	5		11/04/2024	Review update
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	Ability to maintain compliance to Blood Safety Quality Regulations (BSQR) whilst proceeding with implementation of BECS. Ability to maintain current BECS to comply to Blood Safety Quality Regulations (BSQR) if supported through configuration changes.	Ability to deliver configuration changes with current resources, implementation of software changes may not be possible without implementing a version change to the software FE - 11/03/24 - MAK support crucial to this activity. Discussions underway - No change "	Welsh Blood Service	Whole Service	Affecting whole service	Possible - may occire/reoc	5	15	Possible - May occur/reoccur at some time / occasionally.	5	15	Rare - Would only occur/reoccur in very exceptional circumstances; considered a vi	5	5	11/04/2023		Review update

ID	Risk Title - New	RR - Current Controls	Risk (in brief)	Risk Type	Opened	Division	Service	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Risk Decision	Controls in place	Adequacy of Controls	RR - Direction of Travel	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Due date	Description
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Due to the wide range of factors that cause stress, within work and outside of work, no single action will address the issue. Moreover, progress towards stress reduction will take time as new ways of working come into effect. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	Safety	09/12/2022	Corporate Services	Whole Service	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	Treat - actions agreed to reduce the level of risk which will be implemented		Adequate	Stable/No Movement	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	31/03/2024	31/03/2024	Divisions/Departments should have proactive stress risk assessments Formal arrangements not in place for the Healthy and Engaged Steering Group to evaluate wellbeing interventions Steering Group to This risk needs a SMART action plan Systemic factors that impact on levels of workforce stress to be described and associated actions plans developed Develop management training in managing stress
3230	REFERRAL PROCESS - 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 caused by the 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	Monitoring the receipt of paper and electronic communications specific to new patient referrals to ensure timely actions to be taken.	Multiple methods for the communication of new patient referrals to Velindre Cancer Centre	Safety	19/10/2023	Velindre Cancer Centre	Health Records	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented	Monitoring of paper and electronic communication sent to Velindre Cancer Centre to enable the prioritisation and management of patient referrals.	Inadequate	Stable/No Movement	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	4 - Major	4	31/05/2024	26/10/2023	An Action Plan needs to be established Short term central management of new patient referrals Electronic Solution (Long Term) Escalation to the Chief Operating Officer and Chief New Patient Waiting List Referral Discussion with Health Board Colleagues Establish Workstream - Referrals and Referral Process
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks. Inadequate staffing may result in: - Patient treatment delay and breaches - Key projects not keeping to time with an impact on radiotherapy capacity e.g. commissioning and implementation of IRS systems, system upgrades of essential radiotherapy software and hardware - Suboptimal patient treatment - either due to lack of planning time or lack of developmental time - Radiotherapy treatment errors; individual patient errors or errors affecting multiple patients due to	Safety	14/09/2020	Velindre Cancer Centre	ical Physics (previously Radiotherapy Physics)	- Will occur/reoccur and likely to be frequent.	5 - Critical	25	lay occur/reoccur at some time / occasionally.	4 - Major	12	ce the level of risk which will be implemented			Risk Increasing	to occur/reoccur but there is some possibility.	4 - Major	8	31/05/2024	31/01/2023	Recruitment Action Plan

		complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. The risk rating did reduce to 10 following recruitment of surge posts but has since increased to 15 as the number of Physics posts required for the implementation of the IRS is significantly greater than the posts recruited to, with the resource gap being filled by staff within the service. IRS staffing plan approved and recruitment now underway.	errors or errors affecting multiple patients due to insufficient developmental, commissioning or training time, or too few staff with the specialist skills required. This staff group comprises highly trained, specialist scientific and technical staff key to ensuring quality and safety of radiotherapy treatments. The Engineering Section in particular is identified as an area of risk to the radiotherapy service, with 2 recent retirements and an additional 4 engineers due to retire within the next 4 years. Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. RTDS data submissions v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at				Med	Expected			Possible - M			Treat - actions agreed to redu				Unlikely - Not expected t					5 year workforce plan Readvertise post that did not recruit Prioritise business critical tasks and ensure detailed project and resource plans are kept up to date Log when IRS implementation put on hold to meet clinical demand
2465	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	There is a lack of current controls that enable the mitigation of this risk. As a result a formal internal audit of the underlying causes of this risk is underway. Reporting to VCC SLT is required on a regular basis in order to provide assurance that the issue is being addressed.	There is a risk of severe harm due to the excessive use of email both internally and externally to the Trust. This is because processes and procedures are not carried out in a manner that is appropriate. in particular, emails containing time critical clinical information is being sent to and received by individuals who may not be in work. The impact is severe harm, which may result in National reportable incidents.	Safety	05/11/2021	Velindre Cancer Centre	Medics	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate	Stable/No Movement	Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	29/02/2024	30/06/2023	work progressed as a part of SACT management which includes co-location of SACT scheduling team with outpatient booking and location within outpatient setting which will minimise delays and unnecessary email traffic. training of medical teams on utilisation of outcome function on WPAS taken place in March, which should improve information available for booking whereby reducing email traffic

																							Implementation of an interim electronic solution to deliver a standardised new patient referral template for submission in to a centralised, managed e-mail account – to be piloted in Lung in conjunction with CAVUHB

TRUST BOARD

Trust Assurance Framework

DATE OF MEETING	26th March 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	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	A review of the Trust Assurance Framework, including a refresh of the Strategic Risks has been undertaken and the refreshed framework was approved by the Trust Board in January 2024.
RECOMMENDATION / ACTIONS	The Trust Board are asked to **DISCUSS AND NOTE** the Trust Assurance Framework.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board - Out of Committee	19TH MARCH
Quality, Safety & Performance & Audit Extraordinary Committees	20TH MARCH

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Quality, Safety & Performance & Audit Extraordinary Committee:

- Various risks were reviewed to confirmed that update dates were reflective of recent review where relevant.
- There is to be a review of the related workforce risks in the next iteration.
- From the next reporting cycle, the 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. (Documented in table in section 2)

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

APPENDICES	
1	Trust Assurance Framework

1. SITUATION

An updated set of Strategic Risks were approved by the Trust Board in January 2024.

The work to transition onto a new system has been delayed due to resource issues. This was due for March reporting but will be completed when resource in place.

2. ASSESSMENT

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

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe
1	Populate refreshed TAF on Power BI template	Work completed in background on Power BI and refreshed information to be populated from March reporting cycle.	To be confirmed
2	Finalise template for remaining two newest TAF risks – TAF 07 and 08	Work continued to progress well since Quality, Safety & Performance Committee with Executive leads.	**Closed** – Included in this paper
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Progress made since Quality, Safety & Performance Committee – with the Risk & Assurance lead working with the Planning team to map and then populate with Executive leads at next review.	May reporting cycle – following approval of IMTP
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.	May reporting cycle
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional Leadership and senior management as a valuable management tool	December- April, in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

		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.	May reporting cycle

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*	**Choose an item** All Strategic Risks are related.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). All domains are relevant to this work, as the strategic risks span all areas of the Trust business and are imperative to quality and safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated

	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below

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

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

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

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE		CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN

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

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	Steve Ham	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

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual SLA meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. 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 plan please in time for Board.	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 EPRR for Health, Local Resilience Forum - SCG. 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 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, JPAC, SaBTO Regular liaison with Blood Policy and Tissue, Cells and Organs team in Welsh Government. NICE Guidelines re Cancer drugs	Not Assessed	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	Not Assessed	QSP, SDC	Not Assessed
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
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 CAV in light of new supplier for All Wales LIMS soplution.	22.3.24	No current funding route idetified within LIMS and may be identified as a core recommendation through Infected Blood Inquiry (IBI).	
A1.1	Working with DCHW to support the Blood Transfution Model of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	**IA**		Discussions ongoing about funding solutions	22.3.25		
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	22.3.26	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 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness:	**RATING**	**PE**	**Overall Trend in Assurance**	THIS WILL HAVE 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		
1.3	Performance data and measures to clearly track progress				X	PE
2.1	Blood - core blood services commissioning arrangements			X		E
3.1	Local Partnership Forum		X	X		E
4.1	South Wales Collaborative Cancer Leadership Group system			X		PE
5.1	Partnership Board arrangements with partner Health Boards			X		E
5.2	Partnerhsip with other stakeholders e.g. WAST, HEIW and University partnerships.		X			E

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Linked through performance framework	IA	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
Commissioning contracting reporting in	PA	Strategic Development	PA	Regulatory scope re MHRA tbc; clear	E
Feedback from LPF; proven to be effective	PA	Strategic Development	PA	Wales Audit Office	E
Agreed to model for next phase	IA	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
Agreed to model for each organisation	PA	Strategic Development	PA	Wales Audit Office/Welsh Government	E
Good working relationships with regular communication	E	HIW	E	QSP	E

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	First line and second lines of defence assurance are in place to a certain extent	

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	Development of Phase 2 of PMF with additionalperfromance measures/quality metrics	Carl James	Mar-24	Design stage commenced		Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
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	22.3.24	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)	tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc)	target date Feb 2024 (tbc by CEOs	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 / accountabilioty 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	22.3.24	Unknonw 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)	Carl James	tbc subject to the programme dates	Chief Executive/Executive Director of Transformation/Executive Medical Director attended regional workshop to discuss shape of programme/strategic aligment on 6th December 2023	22-Dec-23	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

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 / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE						
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			E	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
C3	Workforce planning - skills development	Susan Thomas	X			PE	Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE	Evaluation sheets	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE	Staff Meeting to feedback on implementation plan	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	IA
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	IA
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE	Performance reports monthly to operational managers with improvemnt plans/actions set out.	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports - Education Strategy Audit	IA
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	E	Agile Project and Programme Board - see comments below - programme now closed - updates on any future work progammes via EMB	PA	Policies and proceedures to be imbedded with Hybrid Working Principles	PA	Internal Audit	PA
C9	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	X	X	E	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	External Audit Reports - Managing Attendance at Work, Recruitment and Retention and Edication Strategy Audit (ongoing)	PA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed	
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	IA	Mar-24	The annual workplan has been reviewed at the Healthy and Engaged Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff. The next meeting is on 28.03.24 where the worklplan will be approved. Task and Finish group has been set up to embed the Values and Behaviour Framework into the recruitment process.	20.03.2024	Plan is moniitoted via Health and Engaged Steering group	
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	
1.5	Development of a Strategic workforce plan	Susan Thomas	IA	Sep-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy. Workforce models will be developed inline with the Clinical and Scientific Strategy	20.03.2024		
1.6	Development of a Trust Retention Plan	Susan Thomas	IA	Apr-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly. The implementation of the Nurse Retention plan is complete. The model will be used to roll out a Trustwide Retention Plan	20.03.204		
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 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

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E
C2	Developed Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE
C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE
C4	Values to be reviewed and Behaviour framework to be considered	Susan Thomas	X			PE
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycles of business	PA	To be completed as per compliance/ reg tracker updates	PA
Education and training steering group	IA	Trust Board reporting on strategy and controls via cycles of business	IA	To be completed as per compliance/ reg tracker updates	IA
Education and training steering group	PA	Highlight Report to EMB from Education and Training Steering Group on a quarterly basis	PA	Internal Audit Reports	IA
Healthy and Engaged Steering Group and Education and Training Steering Group	PA	Reported through EMB Shape to Strategic Development Committee	IA	Internal Audit Reports	IA
Healthy and Engaged Steering Group	IA	Reported through EMB to QSP	IA	Internal Audit Reports	IA
Health and Wellbeing Steering Group	PA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
Workforce and OD steering groups and internal governance	PA	Steering Groups' highlight reports to Executive Management Board	PA	Internal Audit Reports	IA
PMF Workling Group	PA	Exucutive Management Board	PA	Internal Audit Reports	IA
SLT Meetings	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
SLT Meetings and Educationa and Training Steering Group	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defence assurance to be completed	
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND
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
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		May-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A summary of the themes and proposed actions will be presented to EMB in April 2024. This paper also proposes that the conversations continue as routine in person and virtually.	20.03.2024		
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey have begun to be distilled to further develop our work programme	20.03.2024		
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley		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	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. A page on the Trust intranet site has been established to ensure staff understand the Trust intent re: Speaking up Safely and they know how to act if there are issues. An initial exercise on Employee Voice is being undertaken to gain a baseline on speaking up safely which will link with the ongoing listening exercise within the Trust. An Independent Member Champion in this work has been identified to ensure effective scrutiny and oversight. The full implementation of the framework is expected by March 2024. Updates will be reported via EMB Run.	07.02.2024	A programme of work is in train with three work streams, leads attached.	

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: **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	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	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP	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 inclusiion in wider community	Chief Digital Officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales	Not Assessed
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	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/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		PE	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	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
Agreed Digital Inclusion plan - C4,C7	Assurance Arrangements for Digital Architecture will need to be established -	
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Data and Insight prioritisation as this becomes part of the Digital Services team	
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
3222	There is a risk to performance & service sustainability as a result of the failure to recruit to the Cyber Security Manager role, leading to the delayed implementation of the services and processes needed to ensure the cyber security posture of VUNHST.	15	Cyber Security Manager has been recruited and has started at the Trust - risk will be closed post induction.
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
R022 (EPMA)	There is a risk that there will not be a resource available from the Pharmacy team to both lead and support the evaluation panel activities (before and during) from a clinical perspective, caused by staff shortages, resulting in slippage of timescales in publishing and awarding the supplier	16	Lead Digital Pharmacist has now been recruited with the expectation that the risk will trend down to target
R008 (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	20	Commercial agreement on BECS contract established with Trust Board - Business case underdevelopment - Risk will remain high until funding is secured.
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	Ownder	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer	PA	Nov-22	Digital Programme has now been established from Oct '23 Now meets on a bi-monthly basis	Dec-23	As the Programme continues to develop the overall level of risk should reduce by reducing the likelihood scores	The level of asurance should increase.
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	IA	Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The	Dec-23	Terms of reference for the Digital Programme include the creation of Digital Design Authority which is in the process of being stood up in Q4 23/24	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	Feb-24	Non-Recurrent Revenue has been made avallanble to support the creation of the plan	Dec-23	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	Mar-24	Head of Cyber Security has been appointed from Dec	Dec-23	Dedicated post now in place to lead on cyber - will still be a single point of failure	C13 to move to Effective
1.5	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer	IA	Apr-24	Assistant Director of Data and Insight starts in post on 3rd Jan 24. Future model for Data and Insight to be established	Dec-23	Will contribute to reduction in likelihood of risk	C9 would move to Effective
1.6	Identify external benchmark / standards for the Digital Services (e.g. ISO27001 ./ ITIL)	Chief Digital Officer	IA	Apr-24	Will start with identification of standards for Digital Service (through new ITSM tool) and Cyber Security	Dec-23	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
1.7	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer	IA	Mar-24	To be reviewed at March EMB	Jan-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice

SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS | **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)	Lauren Fear		X		E						
C2	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Audit Committee Trust Board	6	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Audit Review	4	Audit Committee Trust Board	4	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	4
C4	Board Development Programme	Lauren Fear	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	Lauren Fear	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	Lauren Fear	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.	Lauren Fear	4	Apr-24	Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work progressing well through 2023/24, final analysis of progress to be confirmed and agreed in February 2024 Board Development session	22.3.34	Impact to be asseessed when programme delviered	
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	22.3.34	Requirement for C7 to be put in place	
3.0	Revised reporting mechanism to be developed	Lauren Fear	4	Apr-24	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 further embedding required with Senior Leadership Teams.	22.3.34	Impact to be asseessed when delviered	
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	22.3.34	Requirement for C7 to be put in place	
5.0	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Lauren Fear	4	Apr-24	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	22.3.34	Impact to be asseessed when programme delviered	
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	1	Apr-24	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	22.3.34	Impact to be asseessed when delviered	

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)

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

SECTION 3

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

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
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	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C4	Quality and safety monitoring (Via PMF)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nurisng, AHP & HCS			X	NE	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	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	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Interim Director VCS / Exec Director Nursing, AHP & HCS			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		NE	VOA Implementation Group	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	NE	VCS Quality & Safety Group / VCS SLT	NA	Integrated Quality & Saefty Group / Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA

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	Transofrmation, planning, performance and digital	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 & external company PCS	22.3.24	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 being drafted based on benchmarking outcomes and review of national standards	22.3.24	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	Director / Exec Director Nursing, AHP & HCS	2	Aug-24	Clinical & Scientific Board established. Terms of Reference endorsed by EMB.	22.3.24	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	Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed by March 2024, followed by consultation period. .	22.3.24	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	22.3.24	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	

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	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
3227	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. [Note added here outside of Datix that this relates to nVCC]	16	Risk Increasing

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, including WBS Pre-Operative Anaemia project; Value Intelligence Centre and Food Mission	22.3.24	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.	22.3.24	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	22.3.24	Strengthened control procedures will support risk mitigation	tbc
F4	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Sep-24	Criteria have been drafted and Board Reporting Template updated to reflect types of initiatives and sources of funding available for investments	22.3.24	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	Mar-24	Cardiff Cancer Research Hub market engagement exercise to identify potential sources of external funding to support development Strengthening private patient cash collection and pricing	22.3.24	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	Jun-24	Scheme of Delegation and Governance Framework was approved in June-23 by the Trust Board. The first major programme this has been applied to is the IRS programme. A Scheme of Delegation and Governance Framework needs to be developed for nVCC	22.3.24	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	tbc

Trust Board

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

Date of meeting	**26/03/24**
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. Rachel Hennessy, Acting Director of Velindre Cancer Services, Sarah Richards, Head of Planning and Performance Services**
PRESENTED BY	**Rachel Hennessy, Acting Director VCS, Alan Prosser, Director WBS, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance**
APPROVED BY	**Carl James, Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**THE PERFORMANCE HIGHLIGHTS FOR THE PERIOD TO JANUARY 2023/24 ARE:** **Velindre Cancer Service** **SACT Services:** • SACT non-emergency performance dropped to 65% compliance, from previous performance ranging between 90 and 95% over the last 12 months, against our target of 98%. This is due to constrained pharmacy capacity against an increase in demand during January 2024. In response to this business continuity plans have been initiated. A weekly VCS SACT demand planning group established that has developed plans to increase capacity across the service. It is anticipated that these plans will positively affect performance by July 2024. • A demand forecast for SACT services, up to 2028/2029, has been completed. The outcome of this exercise is an assumption that SACT demand will increase by 8%-12% over the next five years. A demand focus response programme for 2024/25 has been established and the associated recovery plans will ensure that this anticipated level of demand can be met in line with requirements. • A weekly Gold command group has also been established to ensure Executive oversight and support in respect of SACT performance. A Gold Command addendum is attached. **Radiotherapy Services:** • Radiotherapy performance for January was reported as 79% in relation to patient treated within 21 days. This was due to an increase of treatments due to commence in January 2024 following the Christmas period. However, recovery to required delivery levels has been achieved in February 2024 (Note: not this current reporting period). **Welsh Blood Service:** • Despite being another challenging month, all clinical demand was met. The blue alert, issued in December 2023 to support increasing the stock position, was lifted on the 25th January. This has been assisted in part by the establishment of a Task & Finish Group that is examining workforce related pressures in the collection clinic model. **Financial Performance:** • The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the revised planned savings targets are achieved, and that any new financial risks that may emerge before the end of the financial year are mitigated for in 2023-24.

RECOMMENDATION / ACTIONS	**The Trust Board is asked to:** • **NOTE and DISCUSS the January 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 February 2024**
VCS SLT / Performance Review	**20 February 2024**
Executive Management Board – Run	**29 February 2024**
Quality Safety and Performance Committee	**14 March 2024**
Summary and outcome of previous governance discussions **The report has been considered and endorsed at the VCS and WBS Performance Review meetings, EMB and QSP Committee and is presented to the Trust Board for information and noting.**	

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

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

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

1. SITUATION AND BACKGROUND

VELINDRE NHST PERFORMANCE REPORT FOR JANUARY 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 January 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.

1.1 Cancer Centre Services Overview

Radiotherapy

79% of patients referred for scheduled radiotherapy treatments began treatment within 21-days of the decision to treat in January, a drop in performance from 87% in December 2023 against a target of 100%. It is, however, expected that February performance will recover to the average compliance being reported towards the end of last calendar year. Plans are in development to compensate the planned spring bank holidays and the linac replacement programme, but this is expected to be challenging for the service.

Compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy treatment improved from 88% in December 2023 to 95% in January 2024 against a target of 100%.

95% of patients requiring emergency radiotherapy treatment began treatment within required timescale (target 100%). One patient breached, due to a compliance issue with the referral processes. The process has now been reviewed and safeguards put in place to prevent any further breaches occurring of this nature.

SACT
All patients (100%) received emergency SACT within the required timescales.

160 patients did not receive their non-emergency SACT within the required 21 days (65% compliance). This is due to constrained pharmacy capacity against an increase in demand during January 2024. In response to this business continuity plans have been initiated. A weekly VCS SACT demand planning group has been established that has developed plans to increase capacity across the service. It is anticipated that these plans will positively impact performance by July 2024. A demand forecast analysis for SACT up to 2028/2029 has been completed. This has identified a forecast increase in demand between 8%-12% over this period. In response a demand focus plan for 2024/25 has been initiated and the recovery plans will ensure that this anticipated demand can be met. Weekly Gold command meetings have also been established to ensure Executive oversight and support in respect of SACT performance. A Gold Command addendum is attached

The greatest area of risk to achieving our required level of performance relates to SACT Pharmacy provision. However, we have identified a number of mitigating actions. These include buying in pre-prepared SACT, additional third party support and increasing VCC pharmacy capacity to manufacture and dispense treatment agents. This is all anticipated to have a positive impact on performance by July 2024.

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

Falls
There was an increase in the number of falls during January 2024. There were 8 patients who fell against an average of 4 falls per month. However, no patient experienced any harm from their fall. Each patient fall has been investigated and reviewed by the falls scrutiny panel. From these investigations it was deemed that each fall was unavoidable.

Welsh Blood Service Overview

Despite being another challenging month, all clinical demand was met. The blue alert, issued in December 2023 to support increasing the stock position, was lifted on the 25th January. This has been assisted in part by the establishment of a Task & Finish Group that is examining workforce related pressures in the collection clinic model.

There is an increase in Quality incident investigations closed within 30 days, which remains above target (90%) once again at 93% in January. This performance reflects the improvement in timely closure of Datix reports in the past month. No adverse event reports were

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

Donor satisfaction continues to perform strongly in January and was above target at 96% (95% target). 7,906 donors were registered at donation clinics and 9 informal concerns was raised (0.11% of all donors registered). All the concerns were managed as early resolutions and responded to, to the donor's satisfaction within 48 hours. No formal concerns were raised in January 2024.

All clinical demand for platelets was met representing a strong performance against this metric. At 9%, platelet wastage met target (10%) again for January. There has been significantly improved performance against the platelet wastage target since April 2023.

The total cell provision for the service in January 2024 was 7 (7 stem cell collections from Welsh donors and 1 cell product imported for Welsh patients). The service is seeing a gradual increase in activity for this year with a current projected outturn of 45-50 at year end. The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is in development and will be informed by the assessment of the Recovery Plan for Bone Marrow Volunteer recruitment and will be managed under WBS Futures. Bespoke swab only recruitment sessions were introduced towards the end of January and an increase in new bone marrow volunteers is expected from February onwards.

1.2 Workforce and Wellbeing

Sickness

Overall sickness remains high with the current rolling absence of 5.35% to January 2024, above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%.

PDAR'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 86% (target 85%) and has been consecutively on target for the whole year to date.

1.3 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys. In January performance against 'Would you recommend us?' was 89% and 'Your Velindre experience?' was 98% both set against the 85% target.

The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 96% for January which continues to meet the target (95%).

1.4 Digital Services

Performance largely stable – largely unchanged from December 2024.

Planning for implementation of a new IT Service Management tool has commenced, with work to deploy anticipated to start in late-February 2024. Deployment should improve performance across a range of service areas, as well as improve various regulatory and administrative activities – e.g. asset management.

Rolling 12-month position for the number of significant IT business continuity incidents continues to steadily improve, down slightly again in January 2024 to 10 incidents in the last 12 months. Significant improvement in performance anticipated from February 2024, due to overall improvement in stability through 2023. Work remains ongoing to remove / replace legacy IT infrastructure and improve the resilience across both the WBS and VCC sites. There was on significant incident in January 2024 – a telephony failure that affected external (inbound and outbound) call across all Trust sites for approx. 2 hours on the evening of 30th January 2024. The root cause has already been identified and remediated to prevent risk of re-occurrence.

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

- Digital Cyber Security % of employees clicking on internal phishing campaigns/exercises – campaigns to be re-started following recruitment into the Cyber Security Manager role, this role has now been filled – new starter due to commence in post early December 2023.
- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Delivery of routine reporting has been delayed due to competing priorities within the team.

A number of new metrics have been drafted, to demonstrate Trust performance against the various objectives set out in the recently-published Digital Strategy. Internal discussions on their inclusion on the PMF are ongoing; however, the aim is to commence reporting of these indicators from February 2024. The 5 measures are as follows:

- % of outpatient consultations performed virtually
- % of donors booking online

- % compliance with cyber security statutory & mandatory training
- % of Trust expenditure in digital
- Hours saved through digitisation / automation of paper-based manual processes

1.5 Estates Infrastructure and Sustainability

The period through to January has seen consolidation of levels of compliance for Planned Preventive Maintenance (PPM) and reactive tasks which are currently listed as green for the North Wales' sites and Trust HQ. VCC is slightly under benchmark standard of 95% benchmark due to newly appointed staff obtaining site familiarity and training courses attended by technicians. There has also been a number of staff off sick during this period. Recruitment completed within the Estates Team. Successfully appointed VUNHST Trust Health and Safety manger with a planned start date 11th March.

The Trust have appointed a bureau (Team Sigma) to manage the validation of utility bills which will improve the management position. Recent events have hindered the availability of utility data which is largely due to the introduction of Energy Bill Relief Scheme (EBRS) which continues to be an issue with reporting data. This is becoming a month-on-month issue. There have been some teething issues with the new NHS Wales gas & electricity suppliers. These are being worked through by the Trust and some of the utilities graphs contained in this document may be subject to change as a result of this.

Fire Safety and Health & Safety KPIs are at acceptable levels with the exception of training, which is a constant challenge. New initiatives have been rolled out working closely with Education and Development Colleagues which is having a positive impact on performance, there is now sufficient training capacity to meet the needs of the organisation. Fire Safety Manager has continued to work with departments to improve training compliance through bespoke in person scheduling to suit departmental requirements.
Module C training (Violence and Aggression) is currently listed as red, due to this being new course which is currently being rolled out to relevant areas. It is anticipated that this figure will rise with availability of training moving forward.

1.6 Finance

The overall position against the profiled revenue budget to the end of January 2024 is underspent by £0.015m and is currently expecting to achieve an outturn forecast of **Breakeven.**

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

The latest approved Capital Expenditure Limit (CEL) as of January 2024 is **£26.407m**. This represents all Wales Capital funding of **£24.724m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to January'24 of £22.987m and is currently forecast to remain within the overall CEL. The Trust has now received the funding award letter towards the nVCC project costs and once signed and returned will officially form part of the CEL.

During January ’24 the Trust (core) achieved a compliance level of **97.8%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 10, and a Trust position (including hosted) of **97.7%** compared to the target of 95%.

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

As previously disclosed the originally planned underlying surplus to be carried into 2024-25 had reduced from £0.391m to £0.086m as underlying recurrent cost pressures are forecast to exceed recurrent savings schemes. Further assessment of savings and cost pressures has meant that there is now no underlying surplus to carry forward to 2024-25.

In response to the letter received from the Health Minister which detailed the financial pressures that was being faced by NHS Wales, the Trust identified costs savings proposals to the sum of c£2m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit. In addition, the reserves position continues to be under review with the option that if the emergency reserve is not fully required during the remainder of 2023-24 then it will be offered to support the NHS Wales position on a non-recurrent basis.

2. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION
VELINDRE NHST PERFORMANCE SCORECARDS FOR JANUARY 2024

2.1 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.

2.2 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.

Quality Safety & Performance (QSP) Committee Scorecard as at January (Month 10) 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 10 (January 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%	86%	✓	↑	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	0	✓	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	99%	✓	→	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
	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

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 10 (January 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	
Effectiveness	Number of Pathway of Care Delays	National	Monthly	1	0	3	✗	🡻	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	109%	✓	🡹	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0.01%	✓	🡺	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	115%	✓	🡻	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	9%	✓	🡹	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	7	✓	🡹	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.35%	✗	🡹	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	74%	✗	🡹🡻	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	89% 98%	✓	🡺	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	96%	✓	🡹	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	🡺	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	N/A	✓	🡺	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	18% 79%	✗	🡻	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	8% 95%	✗	🡺	KPV.15
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	95% 95%	✗	🡻	KPV.16

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 10 (January 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	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	National	Monthly	27% 32%	80% 100%	85% 89%	✗	🡻	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days	National	Monthly	98%	98%	65%	✗	🡻	KPV.20
	% Patients Beginning Emergency SACT within 5 days	National	Monthly	100%	98%	100%	✓	🡒	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	97%	✓	🡹	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	100%	✓	🡹	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.015 m	✓	🡒	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£22.987m	£22.9872	✓	🡒	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.543 m	£0.890 m	✗	🡻	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.456 m	£1.456 m	✓	🡒	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	🡒	FIN.60
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	TBA	TBA	✓	🡒	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	TBA	5.62%	✓	🡒	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	TBA	5.33%	✓	🡒	WOD.80
	% of Workforce not declared Welsh Language Listening/Speaking capability	National	Quarterly	11.63%	0%	9.41%	✓	🡒	WOD.81

Symbols Key: In Month = Compliant ✓ Non-compliant ✖ Cumulative data trend (15 months) = Improving 🡹 stable 🡒 fluctuating 🡹🡻 deteriorating 🡻

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 considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

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

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

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

4. RISKS

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

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

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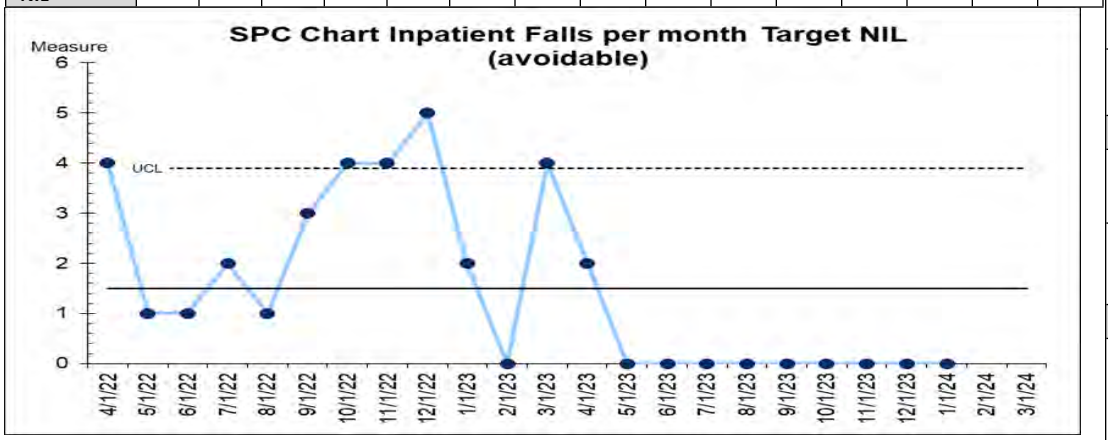
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual Number	4	5	2	0	4	2	0	3	5	5	3	5	3	6	8
Avoidable Falls	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

Performance

No avoidable falls in January 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 KPV.01

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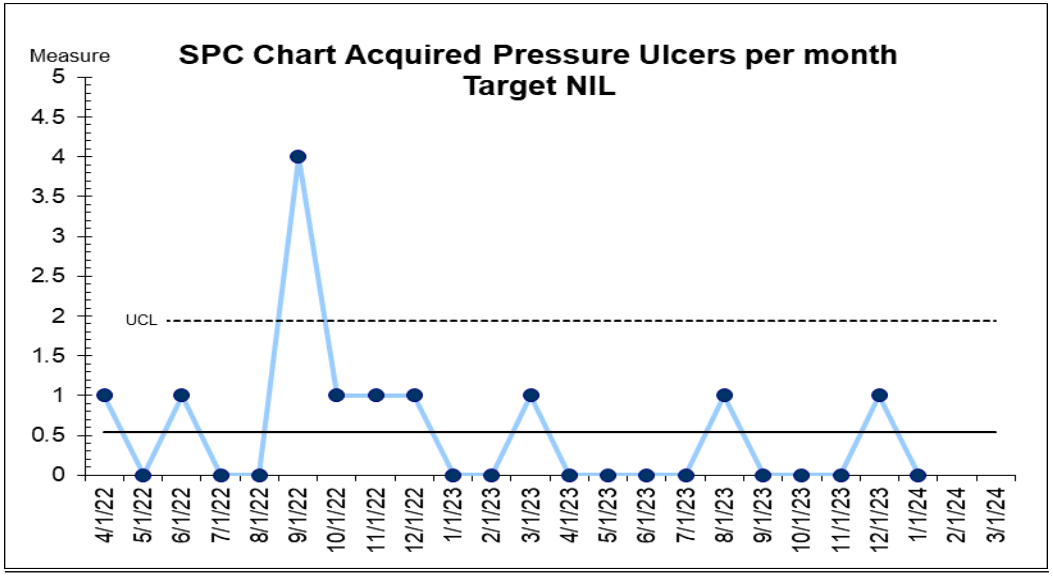
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual Number	1	1	0	0	1	0	0	0	2	2	3	0	2	2	1
Avoidable Ulcers	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

Performance

There was 1 unavoidable pressure ulcer in January 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

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 WOD.19

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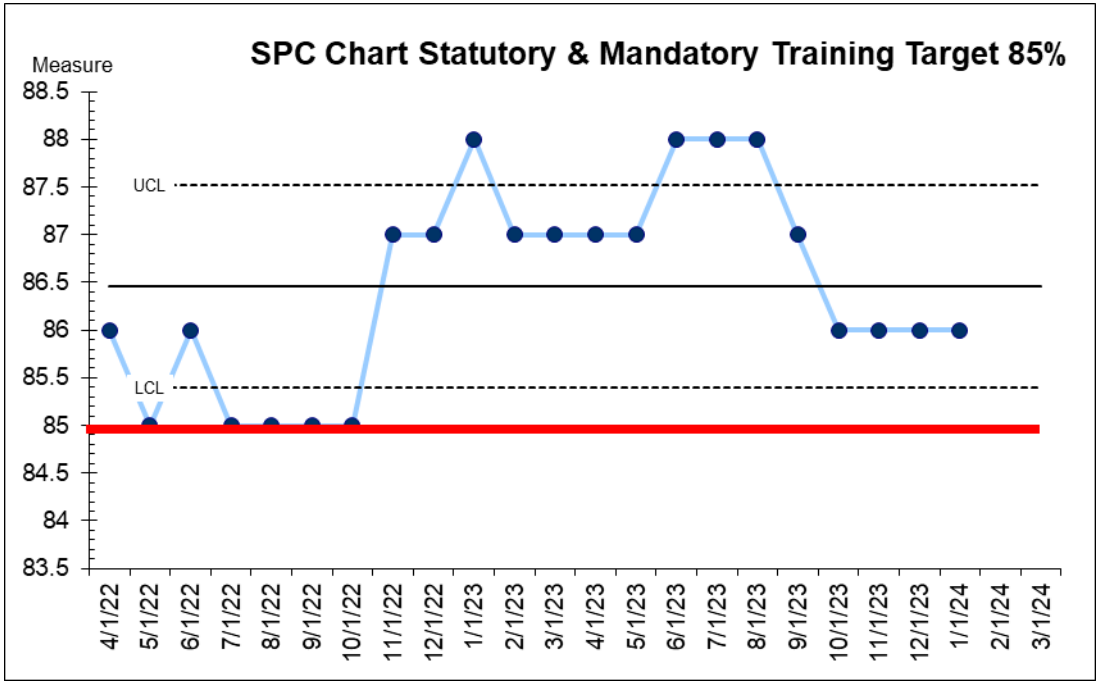
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	87	87	88	87	87	87	87	88	88	88	87	86	86	86	86
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

- Compliance target is being met

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

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

Risks to future performance

Set out risks which could affect future performance

- Future predicated 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

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

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Hospital Acquired Thromboses	0	0	0	0	2	1	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

Performance

Assessment of current performance, set out key points:

On target for the month

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.04

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Healthcare Acquired Infections (Inpatients)

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Incidence of Healthcare Acquired Infections for the period Oct 2022 to Dec 2023

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
C.diff	0	1	1	0	0	1	0	0	0	0	0	1	0	1	0
MRSA bacteraemia	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
MSSA bacteraemia	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
E.coli bacteraemia	0	1	3	1	0	1	0	1	1	0	1	0	0	0	0
Klebsiella bacteraemia	0	0	1	0	0	1	1	0	1	1	0	0	0	0	0
Pseudo Aerugi bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg bacteraemia	0	1	4	1	0	3	1	1	3	1	1	1	0	0	0

Performance

Assessment of current performance, set out key points:

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.08

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

Target: 100%

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
VCS Hand Hygiene								100 %	100 %	99%	99.6 %	100 %	99%	100 %	97.5 %
WBS Hand Hygiene								100 %	99.2 %	99%					99.8 %
Trust Hand Hygiene								100 %	100 %	99%					98.6 %
IPC Validation								100 %	100 %	100 %	99.4 %	100 %	96%		100 %
Target l00%	0	0	0	0	0	0	0	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

Performance

Assessment of current performance, set out key points:

- Performance is on target

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

KPI Indicator KPV.60

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Number of National 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

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual NRI Recorded															
% NRI over VCS Activity															
Target NRI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target % NRI														TBA	TBA

[Currently under development]

Performance

Assessment of current performance, set out key points:

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

KPI Indicator KPI.30

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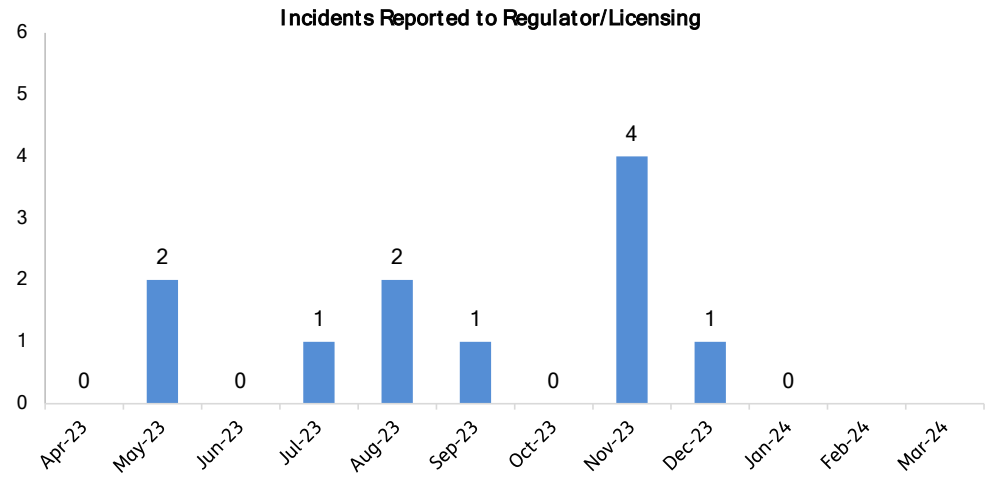
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual	0	2	0	2	0	0	2	0	1	2	1	0	4	1	0
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Performance

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

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), in respect of SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub. Operational Managers are exploring opportunities to share learning through formal staff engagement sessions, to promote discussion	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

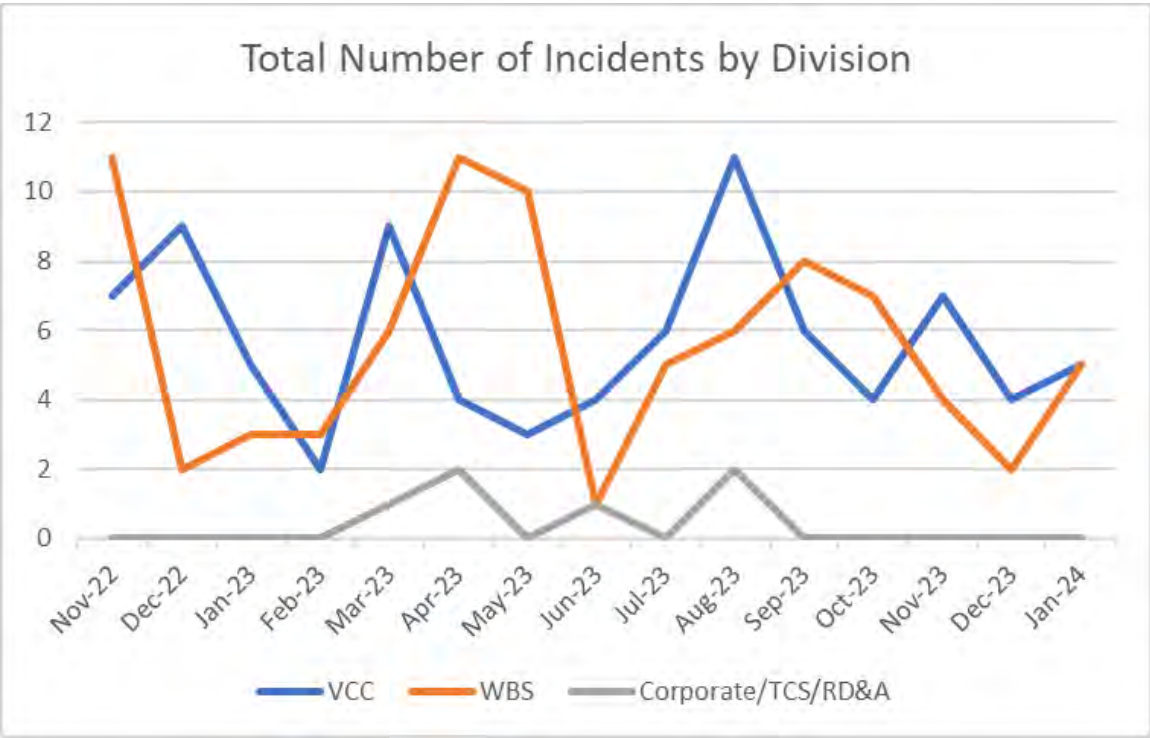
Target: 0

SLT Lead: Carl James

Current Performance against Target or Standard - Level

Performance - remains stable

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
VCC	7	9	5	2	9	4	3	4	6	9	6	4	7	4	5
WBS	11	2	3	3	6	2	10	1	9	6	8	7	4	2	5
Corporate	0	0	0	0	0	2	0	1	0	2	0	0	0	0	0



Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain

Improved identification root causes VCC & Corporate

Improved data quality in incident records

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale:**

Expected Performance gain

Risks to future performance

Incomplete incident investigation – ongoing monitoring

KPI Indicator EST.06

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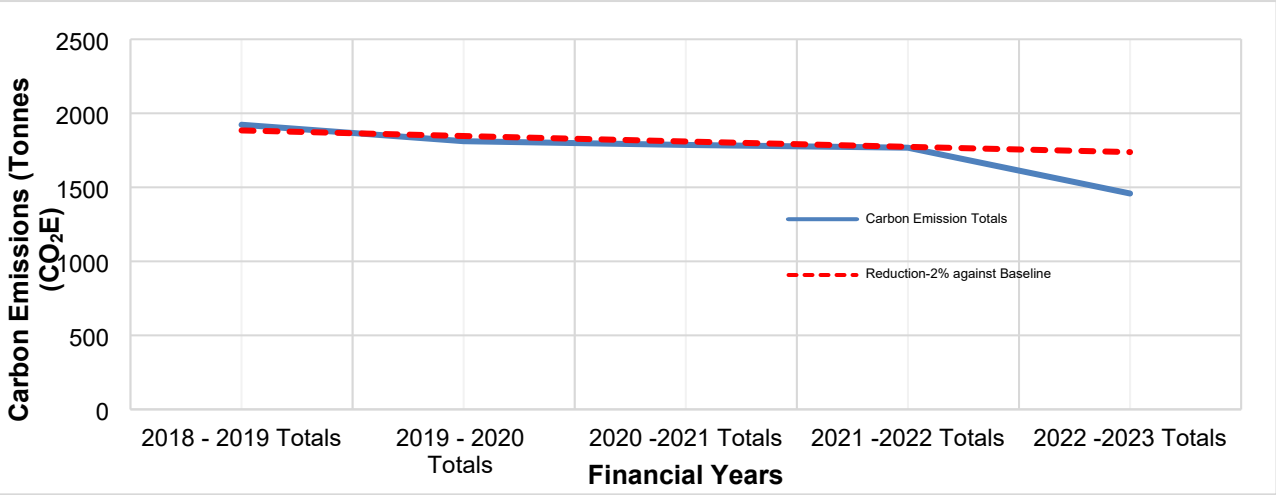
% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline

Target: -16% by 2025

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual Number	172.82	155.55	212.01	179.31	187.06	130.20	111.83	86.13	85.33	86.37	85.36	105.00	117.56	137.40	
Target (-3% from previous yeare missions)	190.288	201.7611	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858	95.86	102.66	132.22	187.67	205.74	



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

Performance

Assessment of current performance, set out key points:

- Carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.
- 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 • Site Based Sustainability Implementation Plan	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – immediate

Ongoing communication and engagement with staff to reduce consumption.

Amendments to the BMS across all sites for better controls.

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 • Improvement to monitoring energy through the BMS	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Reduced carbon footprint

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

Risks to future performance

Set out risks which could affect future performance

-

EFFECTIVENESS

KPI Indicator KPV.05

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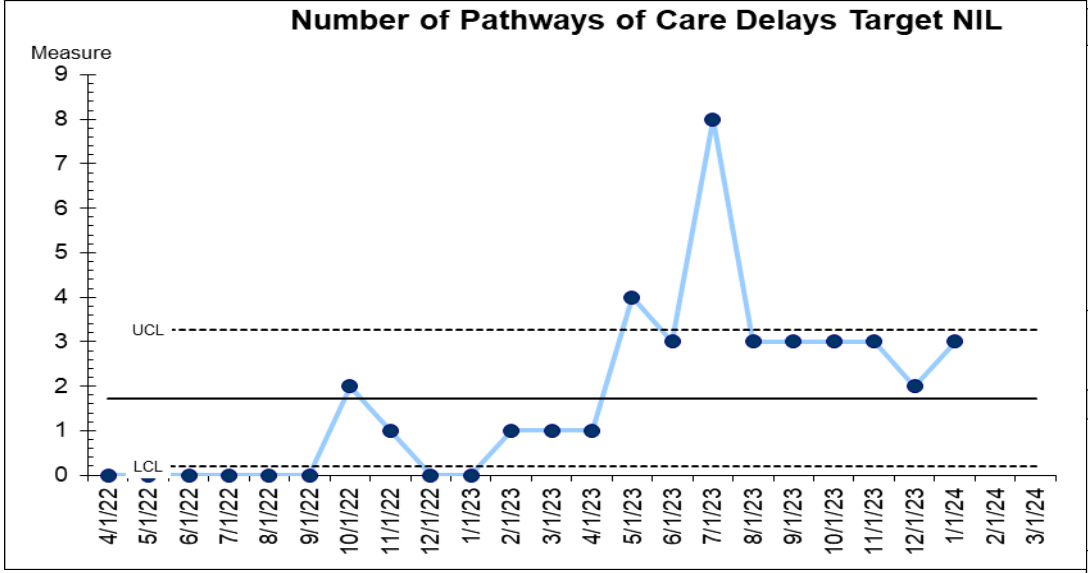
Number of Pathway of Care Delays

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual PoCDs Number	1	0	0	1	1	1	4	3	8	3	3	3	3	2	3
Days Delayed									32	19	43	73		5	
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

There were 2 Pathway of Care delays reported in January 2024

Patient 1: Delayed Transfer of Care with a delay of 4 days due to lack of capacity within HB.

Patient 2: Delayed Transfer of Care with a delay of 3 days due to lack of capacity within HB.

There was 1 Repatriation delay reported in January 2024

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.04

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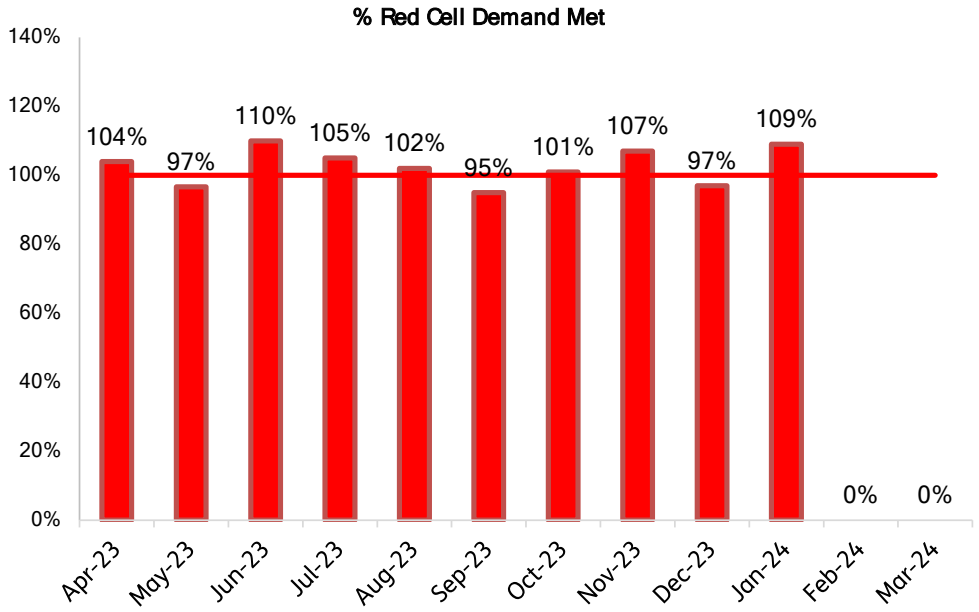
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	115	94	106	103	104	104	97	110	105	102	95	101	107	97	109
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

Performance on this metric has met target in January.

The average weekly demand in January was 1398 compared to December at an average of 1350 units per week.

Overall, the stock position improved throughout January, with the Blue alert removed on 25th January.

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

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

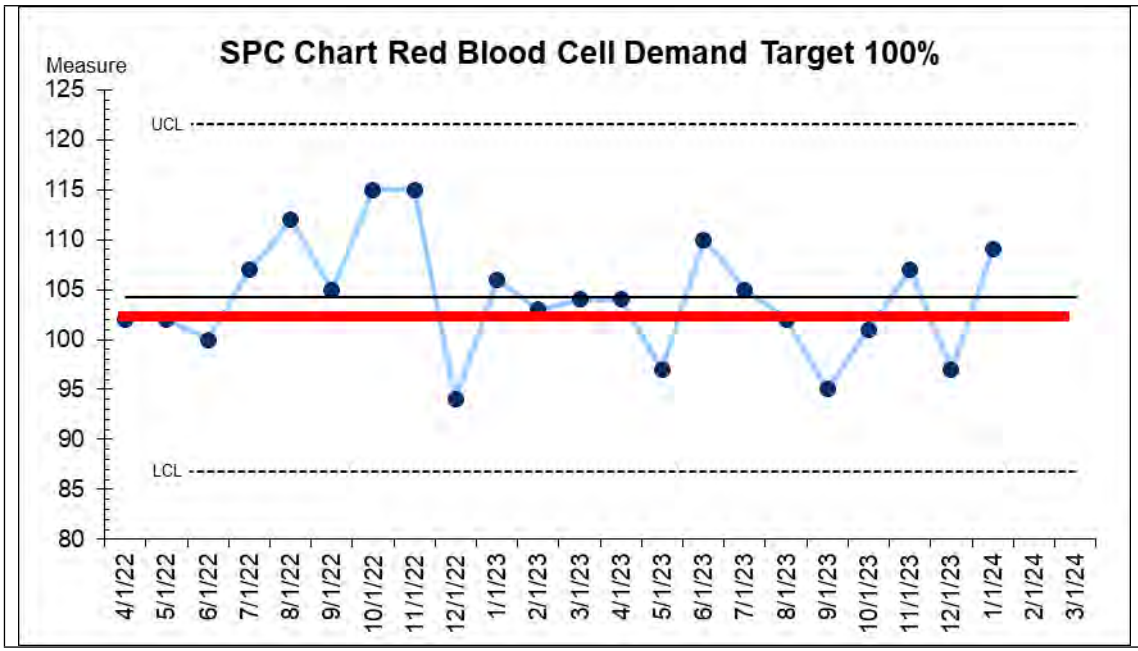
Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
T&F group set up to review capacity to collect whole blood and identify actions to increase it in the short and longer term.	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 15-month period. Performance continues to fluctuate. However, the overall trend shows performance exceeding target.

KPI Indicator KPI.26

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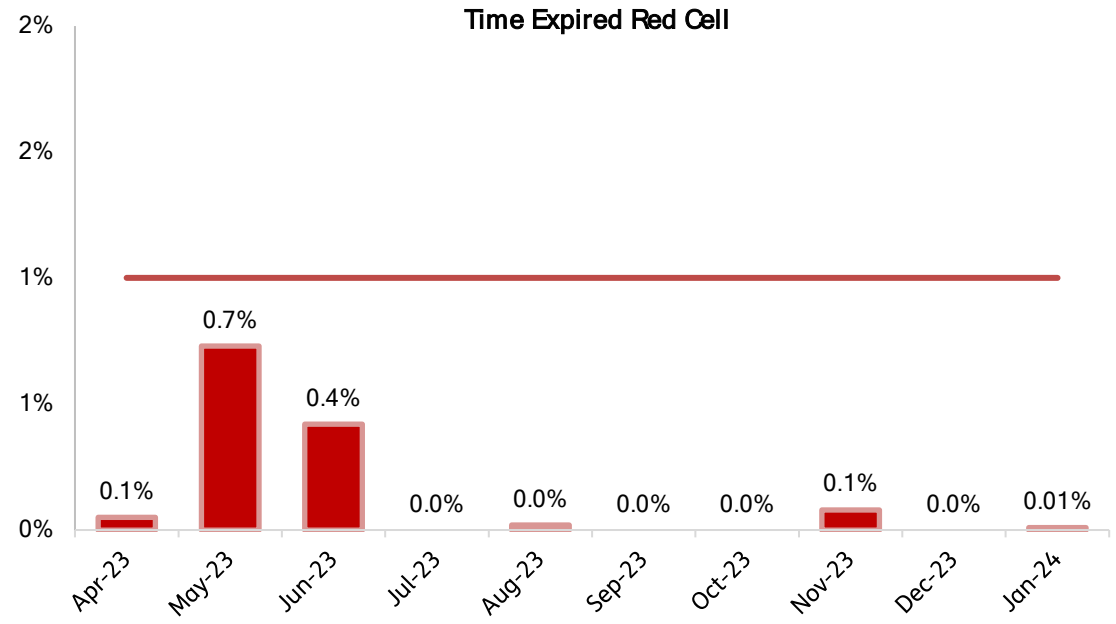
Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags

Target: Maximum Wastage 1%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	0.33	0.36	0.21	0.05	0.02	0.05	0.7	0.42	0	0.02	0	0	0	0	0.01
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance

Assessment of current performance, set out key points:
Performance of this metric has met target in January 2024, with minimal Red Cell expiry recorded.

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale	Lead:
Balanced stocks for each blood group are managed through the daily Resilience meetings where priorities are set as needed. This supports the recovery of specific blood groups when they are at lower level but also minimises excess collections to minimise wastage. Robust stocks management system in place.	Daily (BAU)	Georgia Stephens

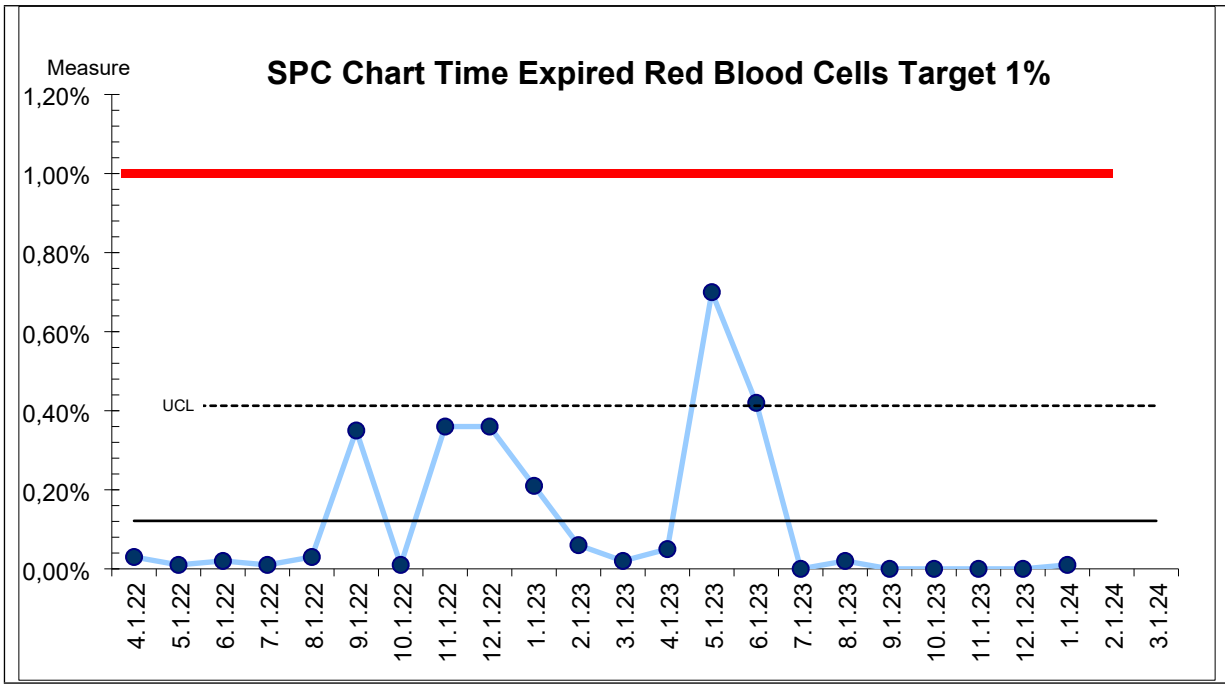
Expected Performance gain - immediate.
Continued effective management of blood stocks to minimise the number of wasted units.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

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



SPC Chart Analysis

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

KPI Indicator KPI.05

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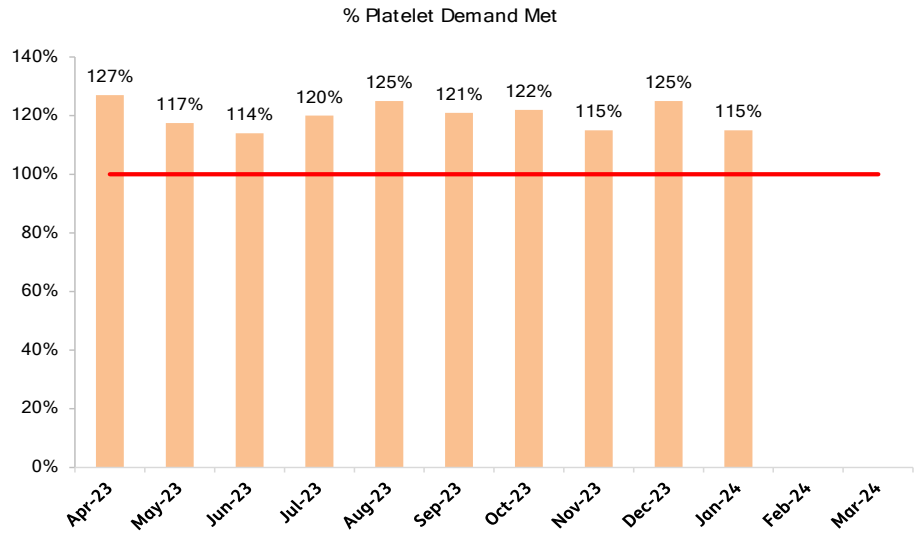
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	139	145	141	168	133	127	117	114	120	125	121	122	115	125	115
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



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

Performance

Assessment of current performance, set out key points:

All clinical demand for platelets was met in January, representing a 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

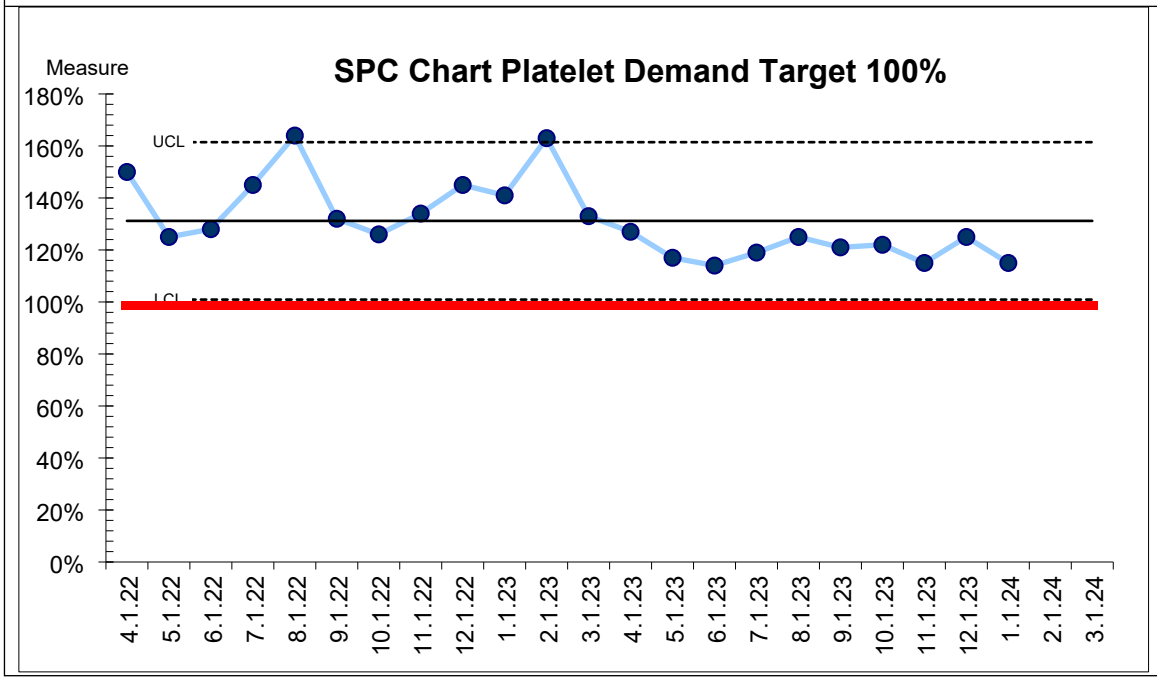
Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs.
Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve A work stream 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 work stream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q1 2024/25	**Timescale:** Q1 2024/25 **Lead:** Georgia Stephens

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 15-month period. The average performance of 135% consistently exceeding the 100% target.

KPI Indicator KPI.25

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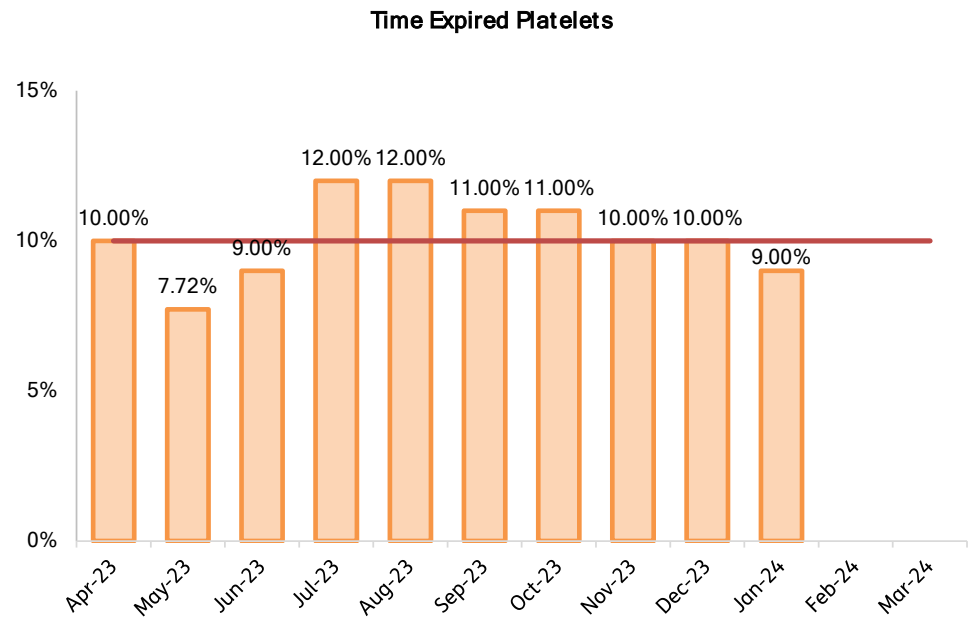
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	15	27	23	25	20	10	8	9	12	12	11	11	10	10	9
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



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

Performance

Assessment of current performance, set out key points:

At 9%, performance met target for January.

An overall improved performance has been sustained since April 2023 (as demonstrated by SPC chart).

Service Improvement Actions – Immediate (0 to 3 months)

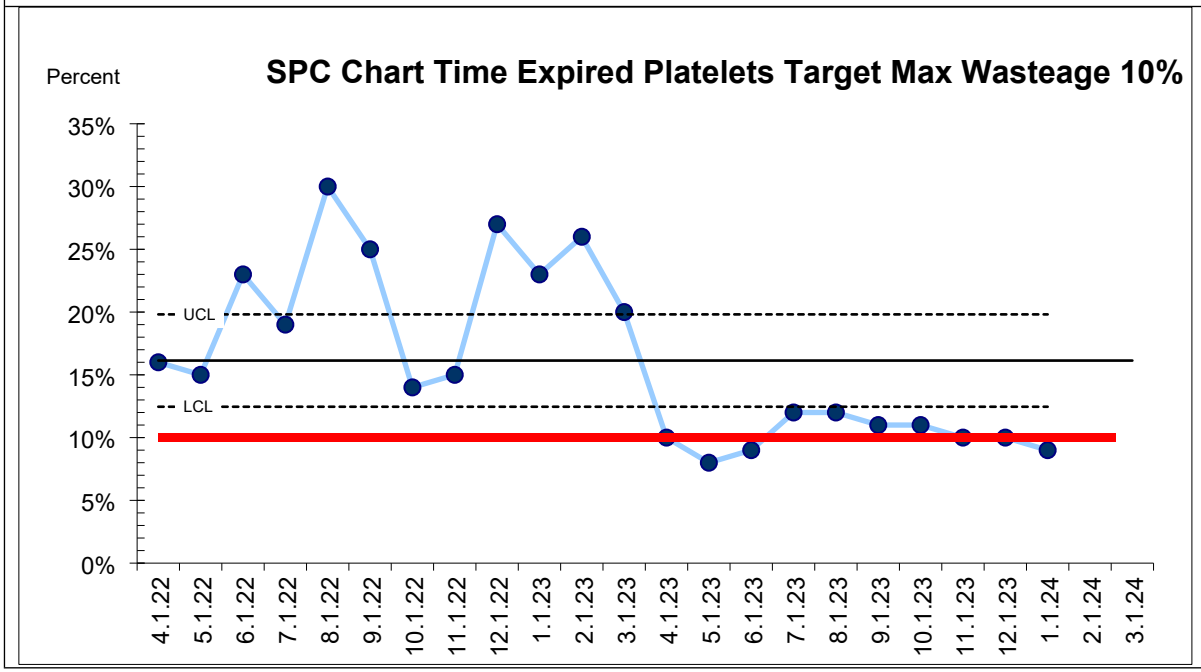
Actions: what we are doing to improve	Lead:
a. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings. b. A Platelet Strategy is being developed. This will sit under WBS Futures under the Lab Services Modernisation Programme. c. Develop a forecasting tool to inform decisions around 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 improve	Timescale:
A work stream 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 work stream meetings have been initiated, work is underway on the scope and prioritisation	Q1 2024/25 **Lead:** Jayne Davey/ Georgia Stephens

	of work with the revised platelet strategy expected to be delivered in Q1 2024/25
	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 a significantly improved performance, sustained since Apr. 2023.

KPI Indicator KPI.13

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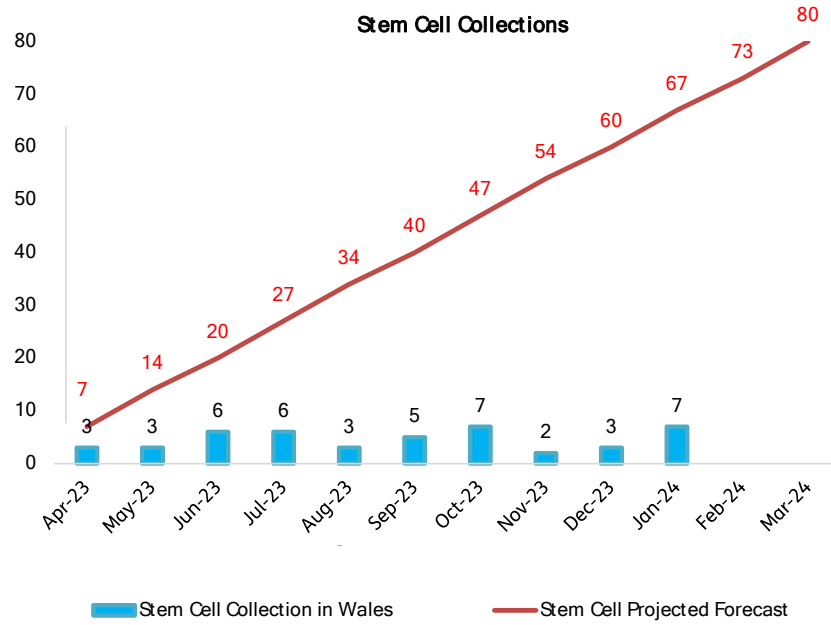
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Deborah Pritchard

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Cumulative Actual	15	19	23	26	32	3	6	12	18	21	26	33	35	38	44
Cumulative Target p/a	56	63	70	77	84	7	14	21	28	35	42	49	56	63	70



Performance

At 7 total stem cell provision for January the service met target. January performance compiled of 6 Peripheral Blood Stem Cell (PBSC) collections and 1 import for a Welsh patient.

The Service continues to experience a cancellation rate of approx. 25%-35% on average compared to 15% -20% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

The service is seeing a gradual increase in activity for this year with a current projected outturn of 45-50 at year end (against a target of 80).

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

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	
The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being developed to support the ongoing development of the WBMDR. This is part of WBS Futures programme. A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collections see KPI.20	**Timescale:** Q4 **Lead:** Deborah Pritchard

Expected Performance gain - immediate. As above

Service Improvement Actions – tactical (12 months +)

Implementation of the five-year strategy.	**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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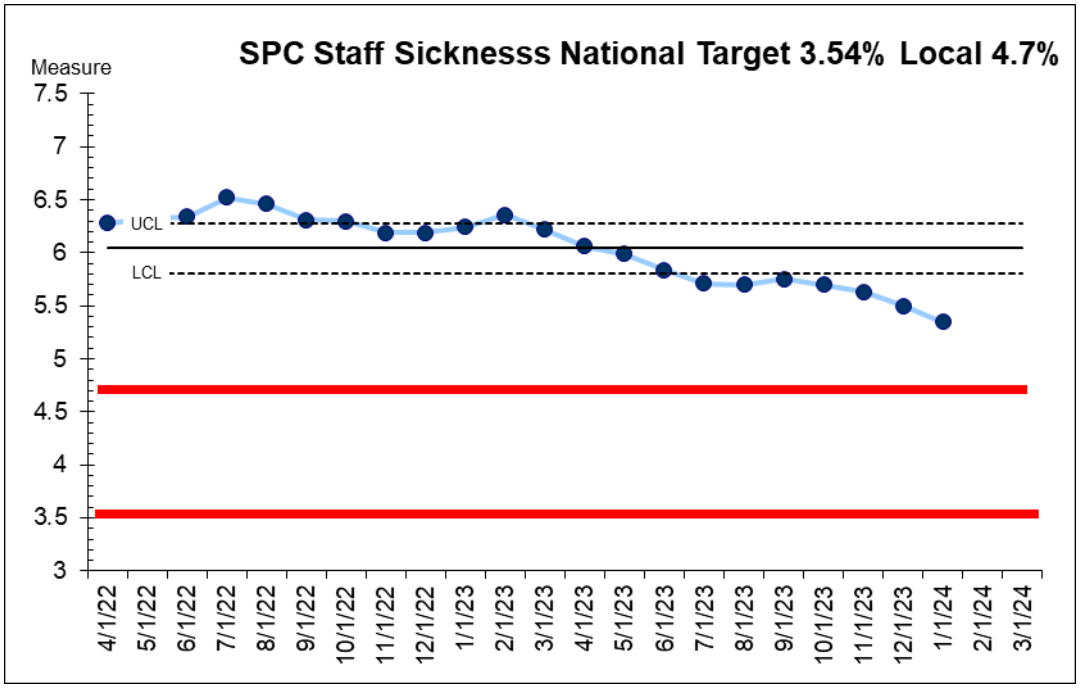
Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	6.19	6.19	6.24	6.36	6.22	6.06	5.99	5.84	5.71	5.70	5.75	5.70	5.63	5.50	5.35
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
National Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



SPC Chart Analysis

Performance

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.

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)	Ongoing	Head of Workforce
Detailed analysis of anxiety/stress/depression and other psychiatric illness to be undertaken		Head of Workforce

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engagement sessions in Autumn 2022 the following actions are being taken over the coming 12 months • Staff wellbeing support survey • Developing a Menopause friendly culture • Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan	30/04/2024 Ongoing	Head of OD Head of OD and Trust Board

The SPC chart shows an improving trend over the last 7 months. However, the overall average 6.2% sickness level remains higher than the 3.54% target	Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation		
	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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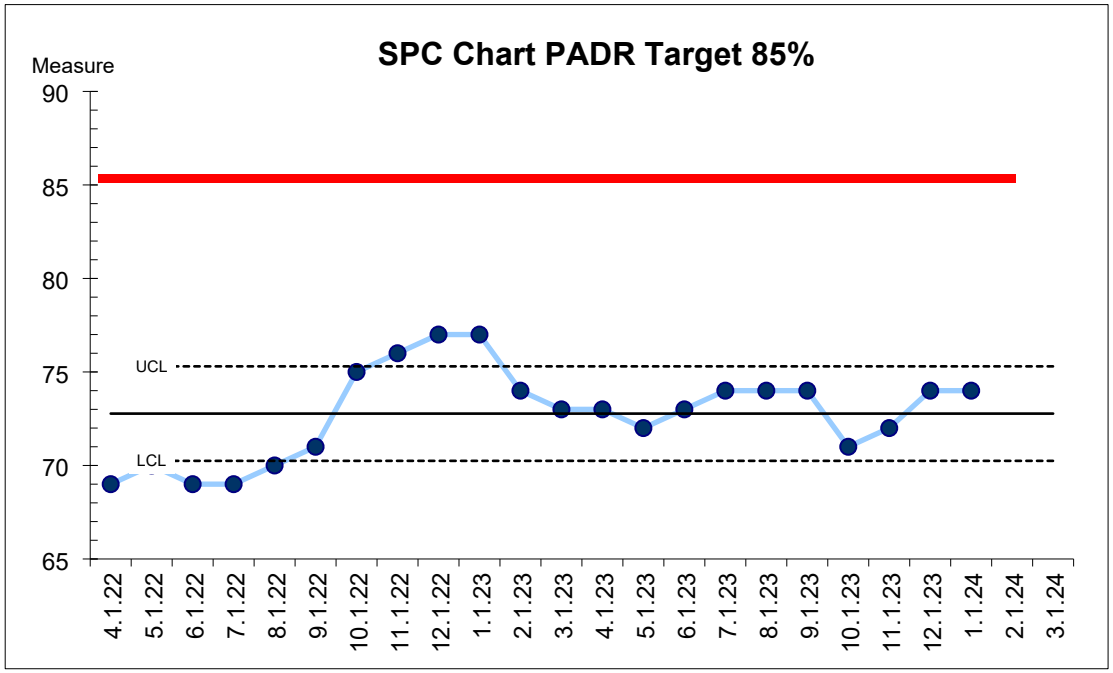
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	76	77	77	74	73	73	72	73	74	74	74	71	72	74	74
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

Since the implementation of the Pay Progression Policy over a year ago there has been no noticeable improvement in the progress towards achieving the target for PADR's. 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.

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 People and Development Trainers POD Senior Business Partners
PADR training for managers who undertake the process.	Quarterly	
SLT at all divisions are regularly reported to on compliance against targets, with action plans drawn up for hotspot areas	Monthly	

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The People and OD Team plan to launch a PADR review programme this year, considering the policy, procedure and current best practice in relation to annual reviews and performance management.	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 hopefully unlock the issues in relation to completing regular performance reviews and developing robust policies for performance management 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

Performance

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Would you recommend us? %	nda	nda	93	96	95	95	98	96	97	97	95	95	94	95	89
Your Velindre Experience? %	nda	nda	84	86	82	82	68	71	91	94	63	83	87	95	98
Target CIVICA 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 78.57% = Good 10.71% = 89.28%

Your Velindre Experience target = good or above (good + very good +excellent)

Excellent (10/10) 82.76 + Very good (9/10) 8.62% + Good (8/10) 6.9% = 98.28 %

Reset Target to CIVICA 85%

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	66	78.57%
Good	9	10.71%
Neither good nor poor	2	2.38%
Poor	5	5.95%
Very poor	2	2.38%
Don't know	0	0.00%
Total	84	100%

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

Survey: Your Velindre Experience

Create new action

Available Answers	Responses	Score (%)
10	48	82.76%
9	5	8.62%
8	4	6.90%
7	0	0.00%
6	0	0.00%
5	0	0.00%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	1	1.72%
0	0	0.00%
Total	58	100%

	Service Improvement Actions – Immediate (0 to 3 months)		
	Actions: what we are doing to improve Outcomes from CIVICA are reviewed monthly and form part of SLT Q&S highlight report and the QSP report Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback Directorates to develop plans to increase response rate. Q+S team to work with each directorate to provide further analysis on responses CIVICA working group established with attendees from each directorate Q+S team to review the difference in positive percentages for both surveys	**Timescale:** Ongoing Ongoing Ongoing	**Lead:** Head of Nursing/SLT SLT/Directorate Managers SLT/Directorate Managers Q+S manager
	Expected Performance gain – immediate 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 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.	**Timescale:** December 2023	**Lead:** Head of Patient Engagement
	Expected Performance gain – longer-term		
	Risks to future performance		
	Set out risks which could affect future performance • insert text		

KPI Indicator KPI.09

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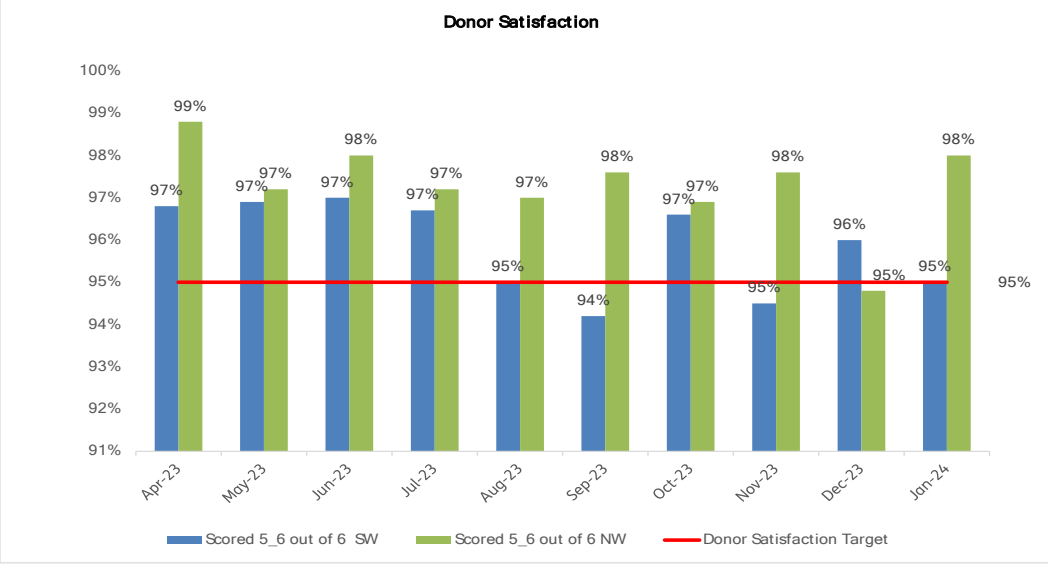
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	96	95	97	97	95	97	97	97	97	96	94.9	96.7	95.1	95.6	96.3
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95



Performance

Assessment of current performance, set out key points:
At 96.3%, donor satisfaction is above target for January. In total there were 1,341 respondents to the donor survey, 281 from North Wales (scoring satisfaction at 97.7%), and 831 from South or West Wales (scoring satisfaction at 95.0%).

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 +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

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

KPI Indicator KPV.12

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

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:

- Target deadline has consistently been achieved

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.03

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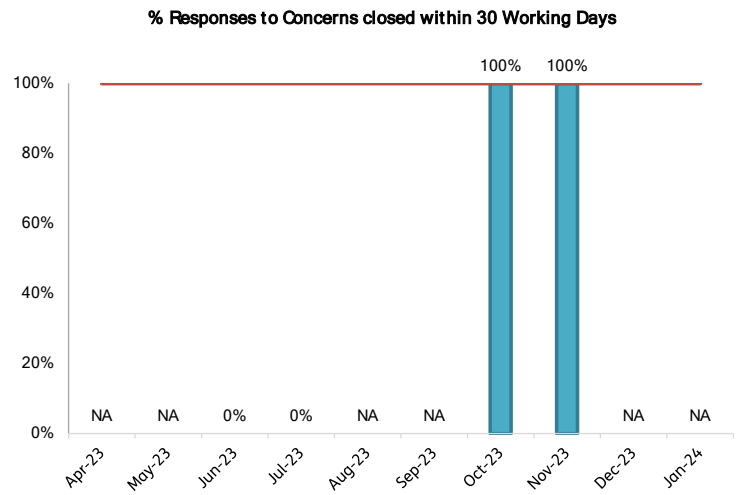
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

WBS	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	100	N/A	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	N/a
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



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

Performance

Assessment of current performance, set out key points:
No formal concerns were due to be reported in January 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance.

TIMELINESS

KPI Indicator KPV.14

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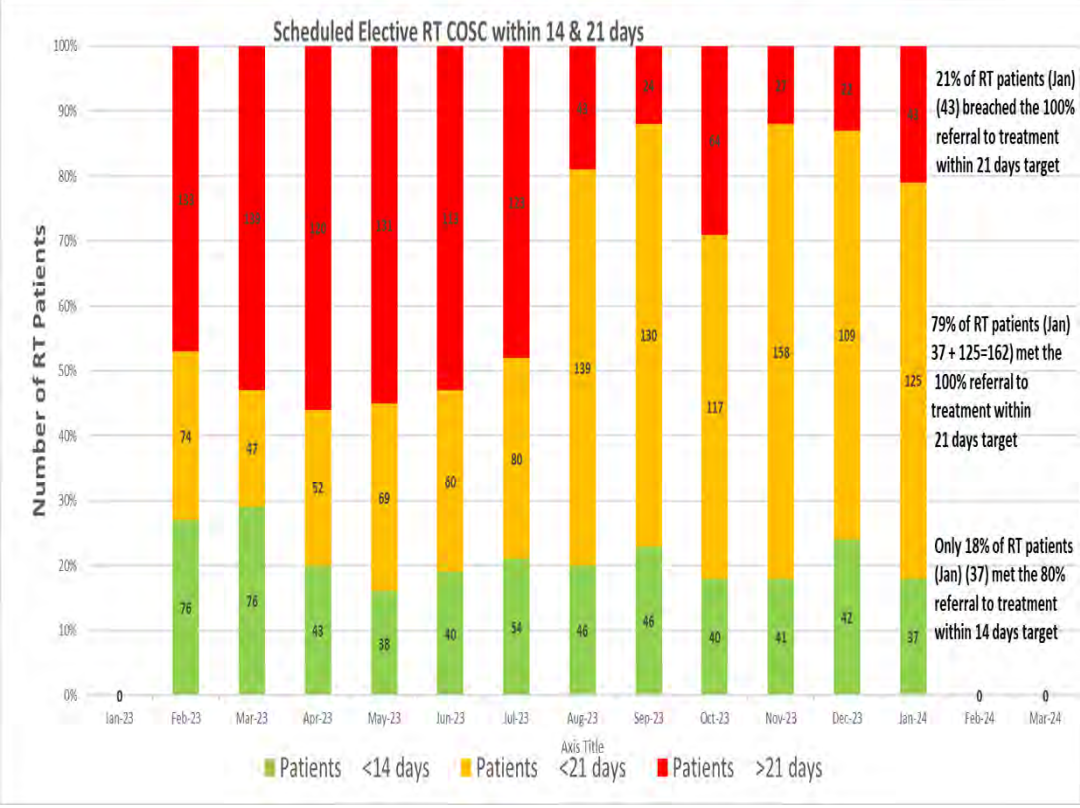
Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days

Target: 80% within 14 Days and 100% within 21 Days

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

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

Number of referrals	205	
treated within 14 days of referral (80% target)	36	18%
treated within 21 days of referral (100% target)	162	79%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain – immediate

Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Changes to patient pathway in line with time to radiotherapy timings

Risks to future performance

Set out risks which could affect future performance

Linac replacement programme which has commenced

Sickness absence levels in radiotherapy workforce

KPI Indicator KPV.15

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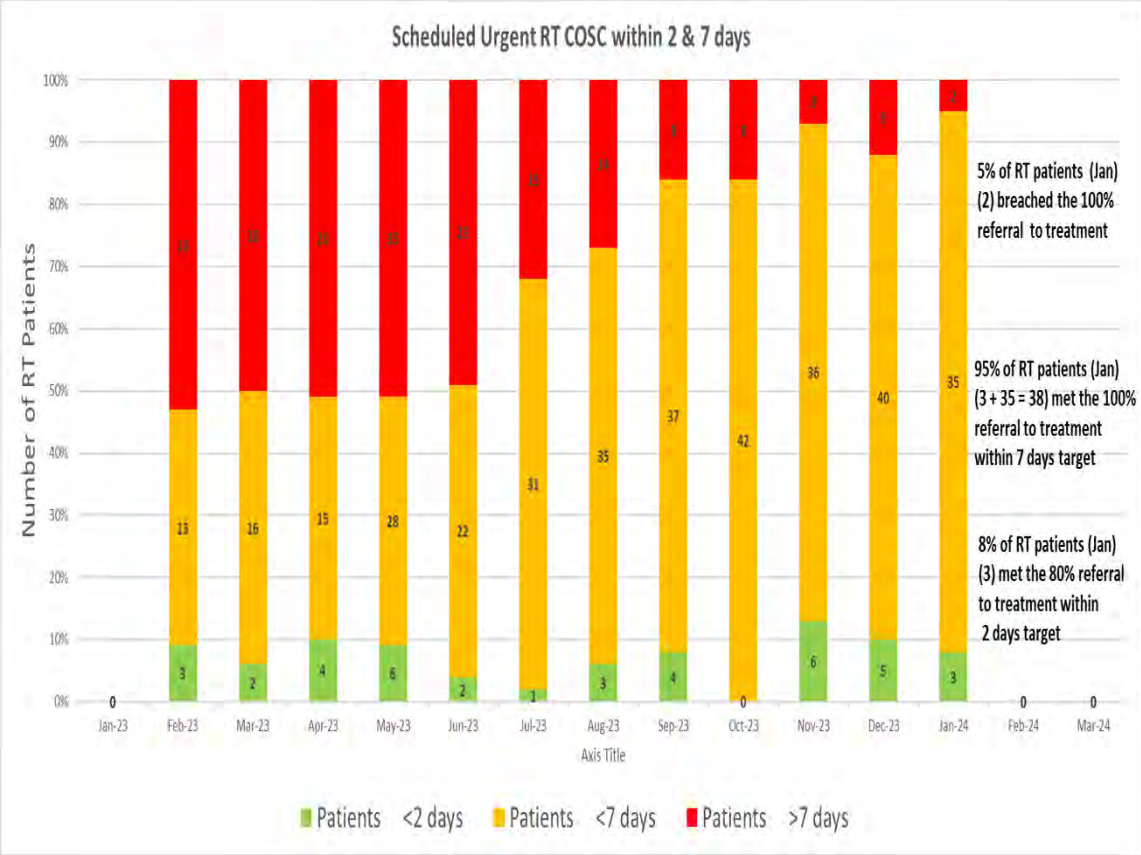
Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days

Target: 80% within 2 Days and 100% within 7 days

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	40	
treated within 2 days of referral (80% target)	3	8%
treated within 7 days of referral (100% target)	38	95%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve Implementation of revised Urgent Symptom Control definition	Helen Payne/ Thomas Rackley	April 2024

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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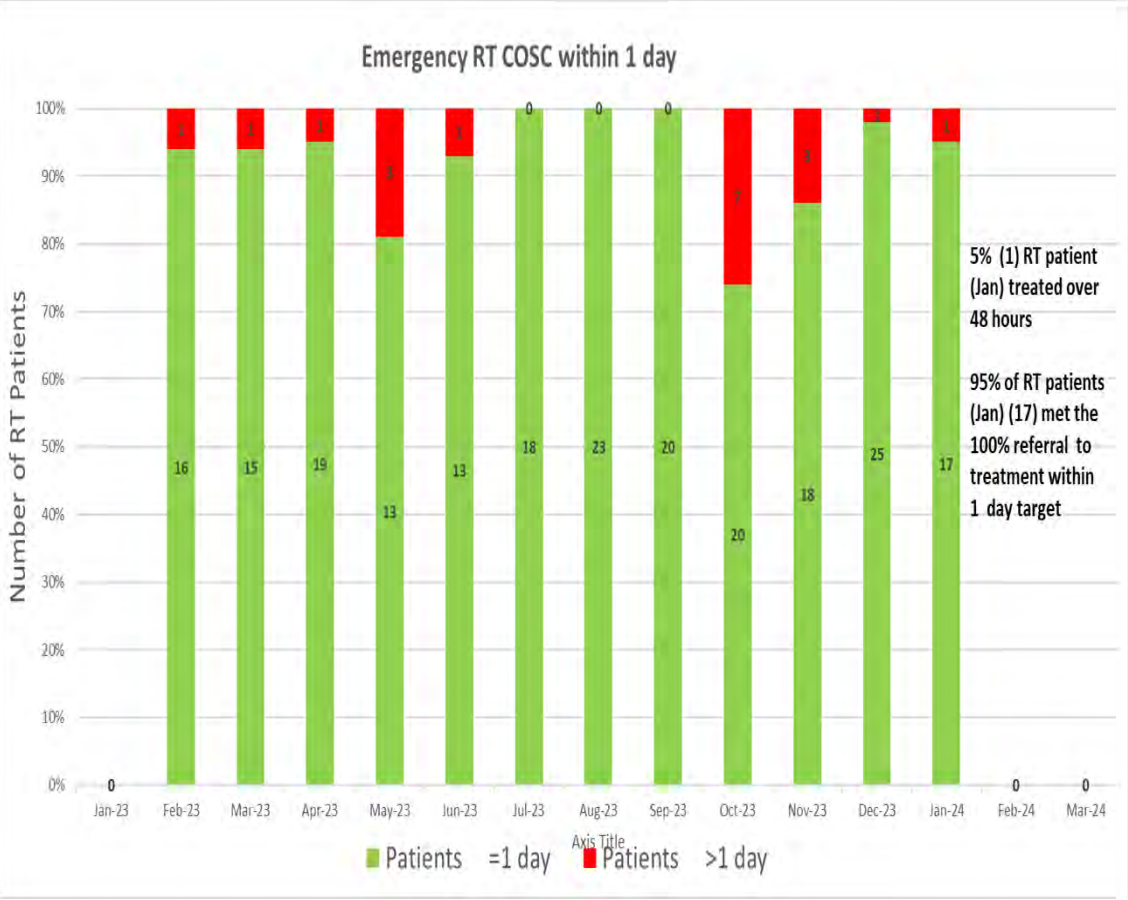
Emergency Radiotherapy Patients Treated Within 1 Day

Target: 80% within 1 Day and 100% within 2 Days

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

Target Achieved

Number of referrals	18	
80% treated within 1 day of referral	17	95%
100% treated within 2 days of referral	17	95%

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

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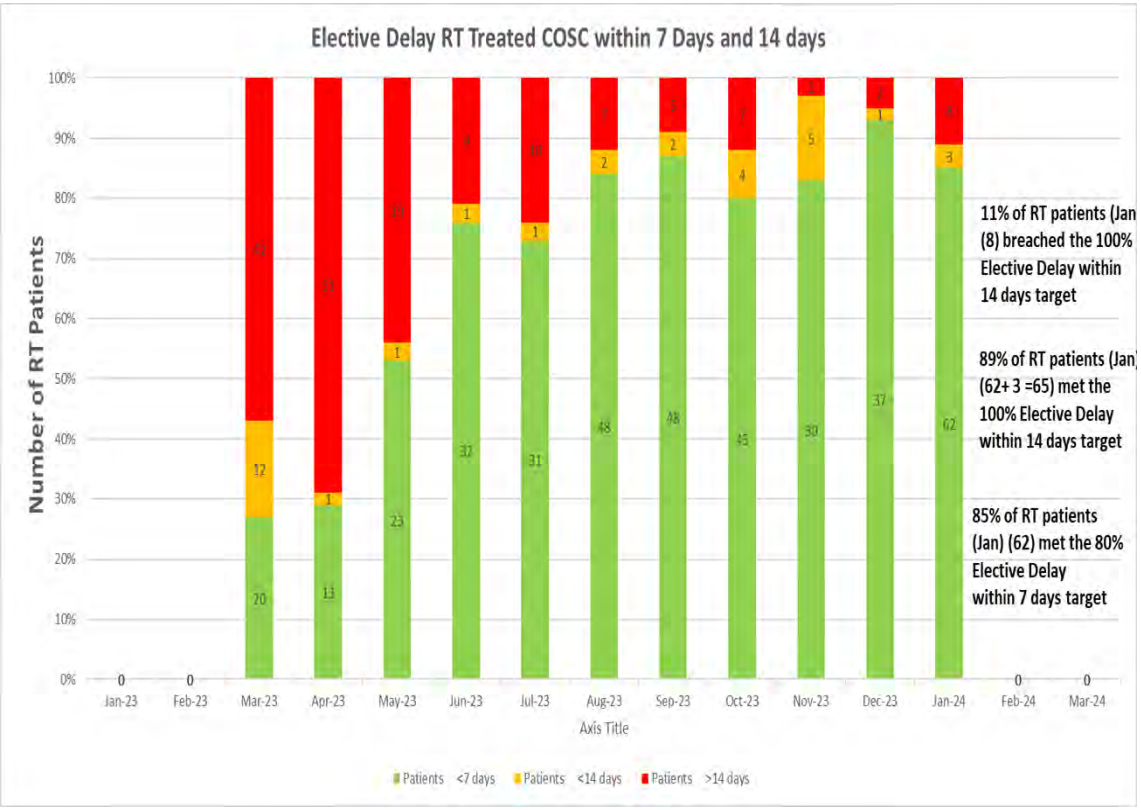
Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days

Target: 80%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard

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



SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	73	
treated within 7 days of referral (80% target)	62	85%
treated within 14 days of referral (100% target)	65	89%

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

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	98	96	97	98	98	93	90	90	94	92	90	98	85	90	65
Target 98%	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**	**98**
More than 21 days	**6**	**12**	**9**	**9**	**8**	**26**	**40**	**40**	**25**	**32**	**35**	**10**	**57**	**29**	**160**
Within 21 days	**354**	**322**	**336**	**388**	**409**	**343**	**354**	**378**	**370**	**380**	**323**	**414**	**329**	**251**	**283**

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	2,811	2,414	2661		

Performance

January 24:

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	65	33	30	32

The longest wait was 56 days.
Demand continues in excess of predicted levels.
Pharmacy capacity remains the main challenge to delivering required activity levels to meet demand.

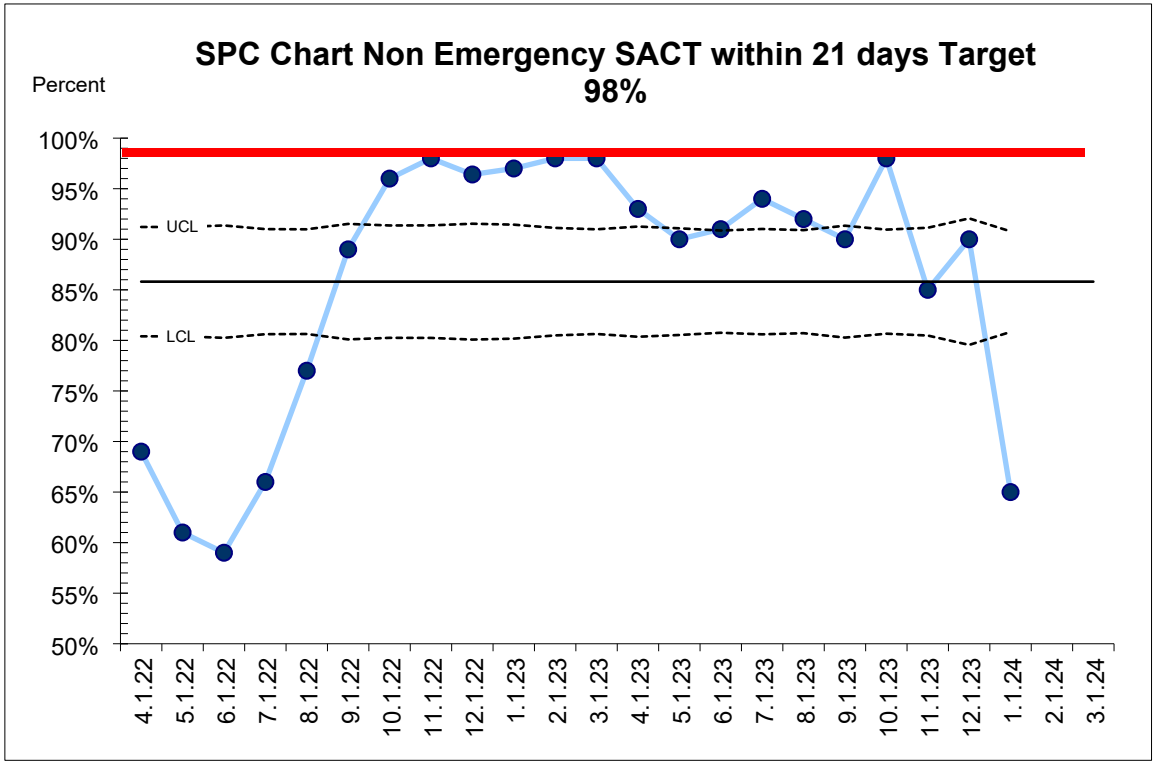
All patients within a Trial are booked within Trial timeframes.

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 June/July 2024.	31/06/2024	BT
2) Agreed increase on mobile unit from 14 to 20 patients daily x 2 days weekly.	31/06/2024	BT
3) provide cleaning provision from operations to allow for potential release pharmacy staff on weekends to produce additional regimens	31/06/2024	MD/MRM

Expected Performance gain – immediate

Not until June 2024



SPC Chart Analysis

The SPC chart shows a reduced performance in January 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	BT
• Realign working patterns at outpatient clinics to maximise daily throughput.	01/05/24	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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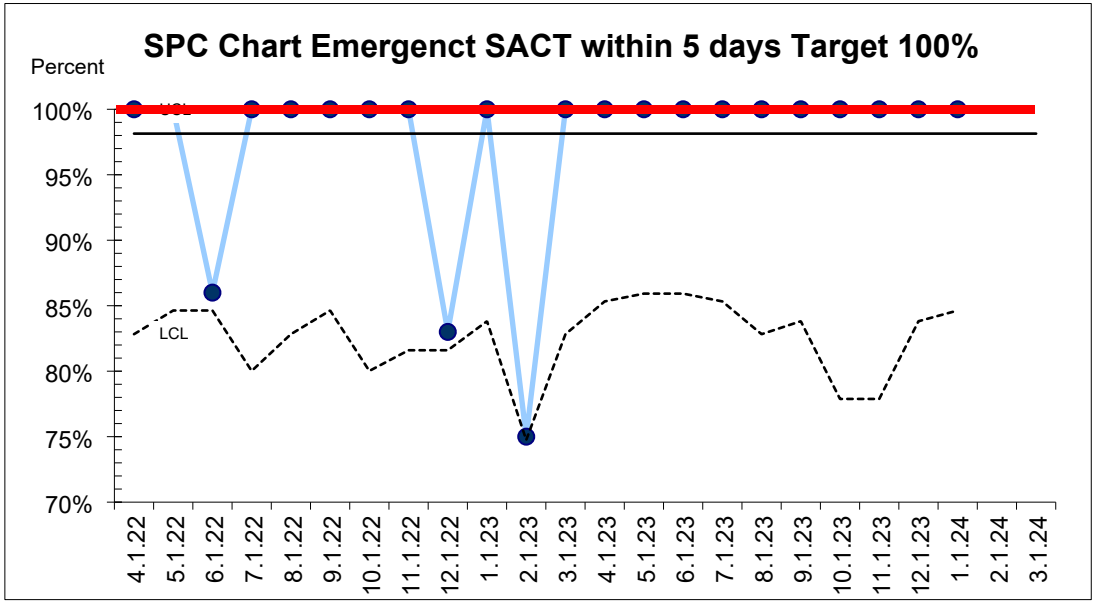
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	100	83	100	75	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	1	0	1	0	0	0	0	0	2	0	0		1	0
Within 5 days	6	5	8	3		5	0	12	10	5	8	4		7	9



SPC Chart Analysis

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

Performance

Target achieved

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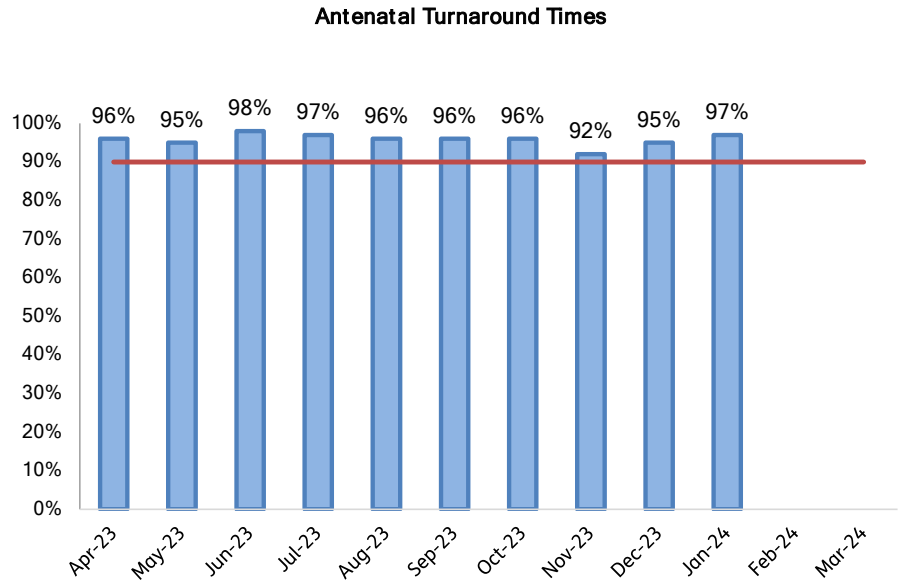
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	96	87	97	96	96	96	95	98	97	96	96	96	92	95	97
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Assessment of current performance, set out key points:
At 97% the turnaround time performance for routine Antenatal tests continued to exceed target in January 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.

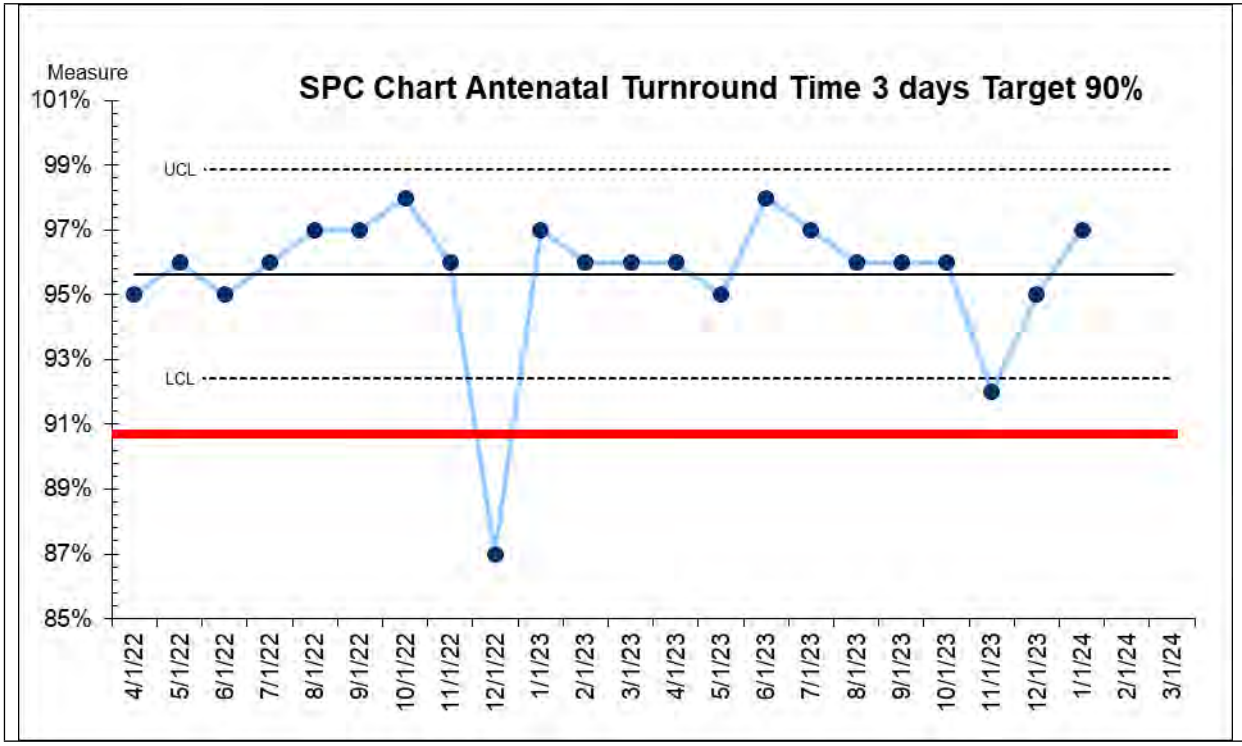
Service Improvement Actions – tactical (12 months +)

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 15-month period. However, whilst the performance decreased in November it remained above target, the average performance continued to exceed the 90% target and improved further in January.

KPI Indicator KPI.17

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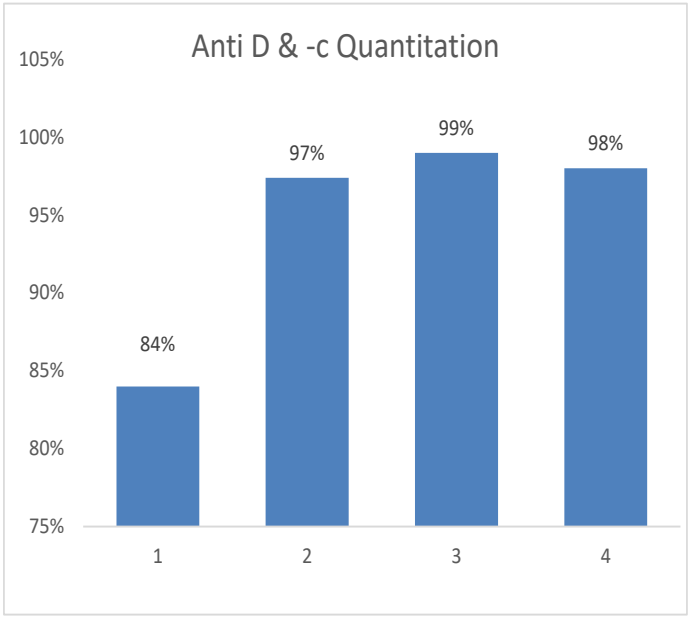
% Antenatal -D & -c quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	96	97	96	60	92	97	98	97	98	99	100	99	100	98	100
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

There was excellent performance during Quarter 3 for Antenatal -D & -c quantitation Turnaround Times within 5 working days. At 100% in January 2024 & performance averaged 99% in quarter 3, meeting target and showing consistent high performance.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate.

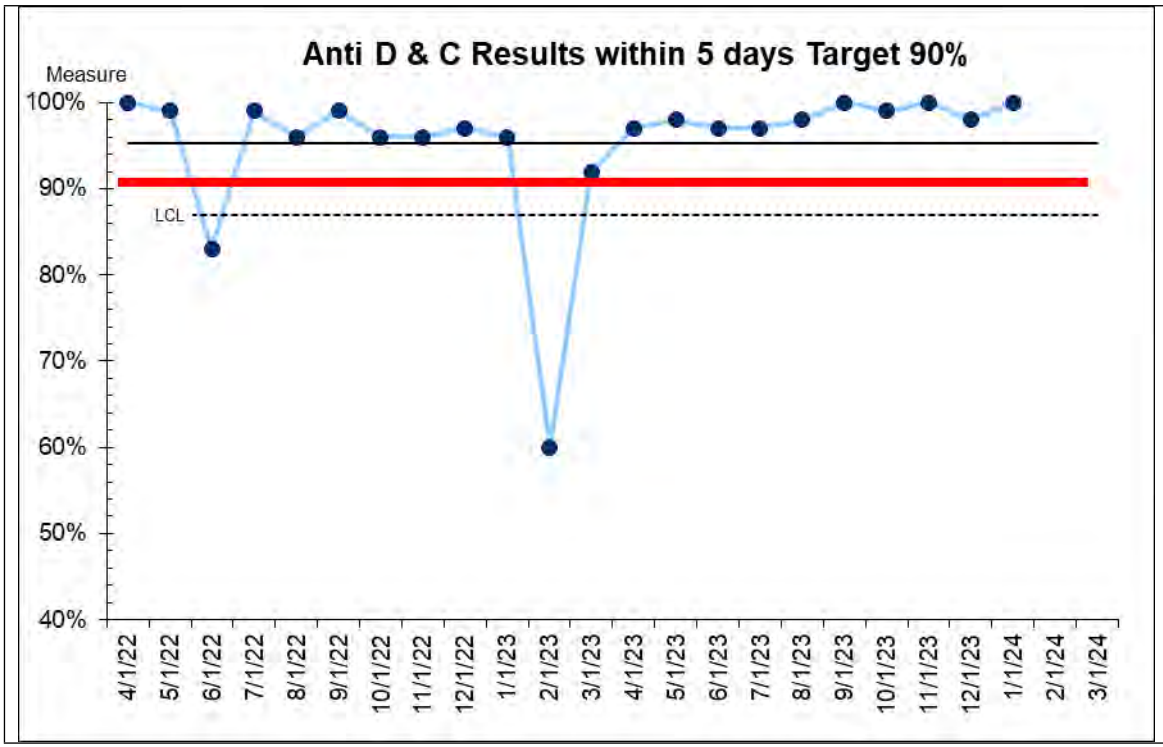
Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.



SPC Chart Analysis

The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter four 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)	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual £k	64	1	4	2	4	5	7	7	17	9	15		
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at January 24

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(34.733)	(34.733)	(0.000)	(41.347)	(41.347)	(0.000)
RD&I	(0.281)	(0.280)	0.001	0.091	0.091	0.000
WBS	(18.356)	(18.354)	0.001	(21.703)	(21.703)	0.000
Sub-Total Divisions	**(53.369)**	**(53.367)**	**0.000**	**(62.959)**	**(62.959)**	**(0.000)**
Corporate Services Directorates	(11.052)	(11.050)	0.002	(13.204)	(13.203)	0.000
Delegated Budget Position	**(64.422)**	**(64.417)**	**0.005**	**(76.163)**	**(76.163)**	**0.000**
TCS	(0.605)	(0.594)	0.010	(0.744)	(0.744)	0.000
Health Technology Wales	(0.109)	(0.109)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	65.136	65.136	0.000	77.024	77.024	0.000
Trust Position	0.000	0.015	0.015	(0.000)	0.000	(0.000)

Performance

The overall position against the profiled revenue budget to the end of January 2024 is underspent by £0.015m and is currently expecting to achieve an outturn forecast of Breakeven.

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

On the 31st July the NHS Wales Chief Executive Judith Paget wrote to all NHS organisations, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services to reduce the forecast NHS Wales's financial deficit in 2023-24. In response to the financial pressures faced by the system, the Trust was asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the options were considered to contribute c£2m cost reduction to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

Service Improvement Actions – Immediate (0 to 3 months)

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

NHS Wales Financial Pressures Contribution

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.569	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 10 there is a reduction of c£0.569m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.069	

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator FIN.73

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Financial Balance – Capital Expenditure Position	
Target: Expenditure in line with Capital Forecast	**SLT Lead: Finance Director**
Current Performance against Target or Standard	**Performance**

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual(Cum)	27.8	1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m	20.672m	22.987m		
Target £26.4075 CEL		1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m	20.672m	22.987m		

Capital Position as at December 2024

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M10 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	9.579	0.000	1.317	10.896	0.000
nVCC - Project costs	0.000	2.818	0.000	(2.818)	3.243	(3.243)
nVCC - Advanced Design Works	3.882	3.863	0.000	0.019	3.882	0.000
nVCC - Advanced Works	0.898	0.898	0.000	0.000	0.898	0.000
nVCC - Whitchurch Hospital Site	0.000	0.014	0.000	(0.014)	0.014	(0.014)
Integrated Radiotherapy Solutions (IRS)	7.826	5.211	0.000	2.615	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.073	0.000	0.074	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Digital DPIF -RISP	0.168	0.113	0.000	0.055	0.168	0.000
Digital Cyber Security	0.051	0.000	0.000	0.051	0.051	0.000
Digital Cyber Security (2)	0.085	0.000	0.000	0.085	0.085	0.000
Digital DPIF - EPMA	0.100	0.000	0.000	0.100	0.100	0.000
Digital WHAIS	0.250	0.000	0.000	0.250	0.250	0.000
Capital Year End Spend	0.257	0.000	0.000	0.257	0.257	0.000
Total All Wales Capital Programme	24.724	22.569	0.000	2.155	27.981	(3.257)
Discretionary Capital	1.683	0.418	0.000	1.265	1.683	0.000
Total	26.407	22.987	0.000	3.420	29.664	(3.257)

The approved Capital Expenditure Limit (CEL) as at January 2024 is **£26.407m**. This represents all Wales Capital funding of **£24.724m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.882m in respect of advanced design works in nVCC.

During December the Trust was awarded £0.898m towards nVCC advanced works, £0.168m from the DFIF fund for RISP, and £0.051m for cyber security.

In January the Trust was awarded a further £0.085m for cyber security, £0.100m for EPMA, £0.250m for WHAIS (previously ring-fenced from discretionary) and £0.257m towards the year end prioritised Capital Scheme list which was submitted to WG on 12th January. The allocation has provided funding to support the following prioritised schemes.

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

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

The allocation of the discretionary programme for 2023/24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m had been ring fenced to support the nVCC enabling works and project costs. Following slippage in expenditure against the enabling works budget this funding has now been re-provided to the discretionary programme and will be re-allocated based on Divisional priorities. In addition, a further £0.250m was ring-fenced to support WHAIS with the Trust only receiving confirmation of funding from WG on the

	14th February. The £0.250m will now be released and considered for redistribution against prioritised schemes at the next Capital planning group meeting. **NHS – All Wales Capital Prioritization** The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have agreed a framework for investment decision making that will provide a common basis for prioritisation of capital schemes. The review and prioritisation for 2023/24 is required due to the challenging financial climate, an oversubscribed capital backlog and need to ensure alignment with the Duty of Quality which came into force in April 2023. Consequently, the Trust needs to complete a prioritisation form by 31st March 2024 which coincides with the IMTP submission. The prioritisation from must be completed for all unapproved business cases irrelevant of status, where Full Business Case / Business Justification approval has not been received. The forms will be presented to EMB Shape on the 18th March before being submitted to WG. **Performance to date** The actual expenditure to January 2024 on the All-Wales Capital Programme schemes was £22.569m, this is broken down between spend on the nVCC enabling works £9.579m, nVCC Project Costs £2.5818, nVCC Advanced design works £3.863m, nVCC Advanced works £0.898m Whitchurch Hospital Site £0.014m, IRS £5.211m, IRS RSC £0.073m and Digital RISP £0.113m. Spend to date on Discretionary Capital is currently £0.418m. **Year-end Forecast Spend** The Trust has now received the funding award letter to support the nVCC projects costs and the costs associated with the Whitchurch Hospital site. Once signed and returned the funding will officially form part of the overall Trust CEL. All schemes including the discretionary programme are at this stage expected to deliver to budget for 2023/24. *The CEL was fixed by WG at the end of October (for all capital programmes apart from the nVCC Project as highlighted above), after this point the Trust is expected to internally manage any slippage or overspends on the Capital programme.*

	Service Improvement Actions – Immediate (0 to 3 months)		
	Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
	Expected Performance gain - immediate		
	Service Improvement Actions – tactical (12 months +)		
	Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
	Expected Performance gain – longer-term		
	Risks to future performance		

KPI Indicator FIN.72

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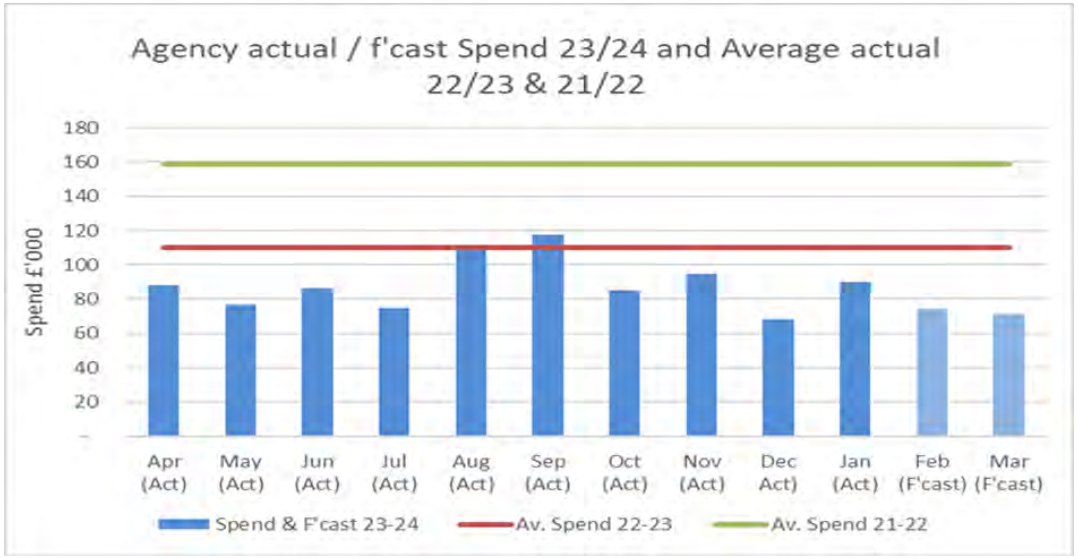
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.323	88	77	86	**75**	109	117	83	95	68	90		
Target (per IMTP) £0.543M Forecast	**543**	115	115	115	58	50	50	16	16	8	0	0	0



Performance

The spend on agency for Jan'24 was **£0.090m** (Dec £0.068m), which gives a cumulative year to date spend of £0.890m and a current forecast outturn spend of circa **£1.035m** (£1.323m 2022/23).

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator FIN.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP

SLT Lead: Finance Director

Current Performance against Target or Standard

Performance

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.300	0.084m	0.108m	0.087m	**0.132m**	0.137m	0.137m	0.254m	0.167m	0.167m	0.172m		
Target £1.8M Forecast		0.084M	0.084m	0.084m	0.172m	0.172m	0.172m	0.172m	0.1727m	0.172m	0.172m	0.1772m	1.8M

Overall VUNHST Cost Improvement Programme £1.8M

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

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

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

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has removed the £0.391m of underlying surplus which had been carried forward from 2022/23.

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

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	22/23	Apr 23	My 23.	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Capital & Revenue Invoices	95	98	98	99	98	96	98	97	98	98	98		
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

During January '24 the Trust (core) achieved a compliance level of **97.8%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 10, and a Trust position (including hosted) of **97.7%** compared to the target of 95%.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
Ensured compliance

Risks to future performance

Set out risks which could affect future performance

EQUITABLE

KPI Indicator WOD.81

Return to Top

% of Workforce not declared Welsh Language Listening/Speaking capability

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	-	-	-	-	11.63	-	-	10.30	-	-	9.81	-		9.41	
Target %	-	-	-	-	0%	-	-	0%	-	-	0%	-			

Trust

Welsh Language (Listening/Speaking)

31st Dec 2023

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1077	1689	63.77%
1 - Entry/ Mynediad	236	1689	13.97%
2 - Foundation / Sylfaen	64	1689	3.79%
3 - Intermediate / Canolradd	41	1689	2.43%
4 - Higher / Uwch	50	1689	2.96%
5 - Proficiency / Hyfedredd	62	1689	3.67%
Not Stated	159	1689	9.41%
Grand Total	**1689**	**1689**	**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	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	-	-	-	-	13.45	-	-	-	-	-	-	-			
Target TBA%	-	-	-	-	TBA	-	-	-	-	-	-	-			

Trust
Gender Pay Gap

31st Mar 2023

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£22.25	£17.94
Female	£19.26	£16.84
Difference	£2.99	£1.09
Pay Gap %	13.45%	6.10%

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	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	-	-	-	-	5.18	-	-	4.56	-	-	5.45	-		5.62	
Target TBA%	-	-		-	TBA	-	-	TBA	-	-	TBA	-			

Trust

Ethnic Origin

31st Dec 2023

Ethnic Origin	Headcount	%	BAME %
Asian	52	3.08%	**5.62%**
Black	17	1.01%	
Chinese	11	0.65%	
Mixed	15	0.89%	
Not Stated or Unspecified	86	5.09%	
Other	10	0.59%	
White	1498	88.69%	
Grand Total	**1689**	**100%**	

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

Return to Top

Diversity of Workforce – % People with a Disability within workforce

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	Ma 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual %	-	-	-	-	4.63	-	-	4.9	-	-	4.9	-		5.33	
Target TBA%	-	-	-	-	TBA	-	-	TBA	-	-	TBA	-			

Trust

Disability

31st Dec 2023

Disability	Headcount	%
No	1396	82.65%
Not Declared	48	2.84%
Prefer Not To Answer	12	0.71%
Unspecified	143	8.47%
Yes	90	5.33%
Grand Total	**1689**	**100%**

Performance

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 BOARD

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

DATE OF MEETING	26/03/2024
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 January 2024. The three main issues are highlighted below: **1. 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 to meet the PSPP target of paying

	95% of Non-NHS invoices within 30 days for 2023-24. • At this stage the Trust is expecting to achieve the Capital CEL, a funding letter has now been provided by WG for the nVCC projects costs, and so this risk has been removed. **2. LTA Income & Covid Recovery / Planned Care Capacity** • The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to cover the costs of the investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Dec'23 is that income will cover the cost of the additional capacity. **3. NHS Wales Financial Pressures** • In response to the letter received from the Health Minister which detailed the financial pressures that was being faced by NHS Wales, the Trust identified costs savings proposals to the sum of c£2m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit. • In addition, the reserves position continues to be under review with the option that if the emergency reserve us not fully required during the remainder of 2023-24 then it could be offered to support the NHS Wales position on a non-recurrent basis.

RECOMMENDATION / ACTIONS	**Trust Board** is asked to: **NOTE** the contents of the January 2024 financial report and in particular the expectation that the Trust will

	deliver against its 3 statutory Financial Targets at year end.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board (EMB)	29/02/2024
Quality, Safety and Performance Committee (QSP)	14/03/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The report was received and noted at the EMB on the 29th February 2024 and QSP on 14th March 2024.	

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

APPENDICES	
Appendix 1	Trust Finance Report – January 2024
Appendix 2	TCS Finance Report – January 2024
Appendix 3	Velindre Monthly Monitoring Return Commentary

1. SITUATION/ BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of January 2024 and forecast year end performance.

1.2 The key financial targets information included within this report relates to the Core Trust (Including Health Technology Wales (HTW)). The financial position reported does not include NHS Wales Shared Services Partnership (NWSSP) as it is directly accountable to Welsh Government (WG) for its financial performance. The Balance Sheet / Statement of Financial Position (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 £000	Year to date £000	Year End Forecast £000
Revenue	Variance	6	15	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2,315	22,987	29,664
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.8%	97.8%	95.0%

2.2 Revenue Budget

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

The overall position against the profiled revenue budget to the end of January'24 is an underspend of **£0.015m**, with an outturn forecast of **Breakeven** expected.

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

Long Term Agreement (LTA) Contract Performance

Velindre Cancer Service (VCS) Contract income has recovered to a level that sufficiently funds the capacity investments made to date. However, there remains a small risk that the income growth for the remaining months of the year may not transpire at the projected levels.

NHS Wales Financial Pressures

On the 31st July the NHS Wales Chief Executive Judith Paget wrote to all NHS organisations, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services to reduce the forecast NHS Wales financial deficit in 2023-24. In response to the financial pressures faced by the system, the Trust was asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the following options were considered to contribute c£2m cost reduction to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.569	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 10 there is a reduction of c£0.569m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.069	

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

2.3 Savings

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

Enacting service re-design and supportive structures continues to be a challenge due to both the high level of activity growth and sickness levels limiting the capacity of service leads to implement changes.

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

2.4 PSPP Performance

PSPP performance for the whole Trust is currently 97.7% against a target of 95%, with the performance against the Core Trust excluding NWSSP currently achieving a target of 97.8% as at the end of Janaury'24.

2.5 Covid Expenditure

Covid Programme Costs

In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast for 2023-24 reduced to £0.053m.

Covid Recovery and Planned Care Capacity

Funding for Covid recovery and planned care capacity investment flows through the LTA marginal contract income from commissioners. The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to recover the costs of investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Dec'23 which has been shared with commissioners is that income will cover the cost of the additional capacity.

The activity levels and Commissioner demand for services will continue be closely monitored over the remaining months of the year.

2.6 Reserves

The financial strategy for 2023-24 enabled the establishment of recurrent and non-recurrent reserve to support the Trust 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. These assumptions have largely held, apart from the non-delivery of £305k of planned recurrent savings which have been replaced by non-recurrent schemes and removal of the planned c/fwd of a recurrent surplus into 2024-25. In addition, the Trust holds an emergency reserve of £0.522m which has been unused.

Work to review the third year of investment commitments in corporate infrastructure to support delivery of front-line services has been completed. This has not identified any significant funding release that can contribute to the All Wales position. It is important that the Trust keeps its reserve for emergency costs which may arise over the remainder of the year, however, given that none of the emergency reserve has thus far been utilised it is expected that the Trust should be in a position later in the year to release this funding on a non-recurrent basis to contribute to the All Wales position.

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 2023-24, however following actions taken by the Trust the risks the majority of these risk have been managed or mitigated for 2023/24.

A new risk had emerged in terms of the Trust receiving full funding for the 2023/24 pay award. Indicative figures suggested that the gap could have been up to c£0.300m, however latest intelligence suggests that this could be a lot less or even removed completely.

There are still several risks that may impact from 2024/25 with the material risks being uncertainty around the Whitchurch site security costs and operational cost pressures as highlighted within the main finance report which are being considered as part of the IMTP.

2.8 Capital

All Wales Programme

Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) Projects the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG in September, with the caveat that the funding will be re-provided in future years.

The Trust has now received the funding award letter to support the nVCC projects costs and the costs associated with the Whitchurch Hospital site. Once signed and returned the funding will officially form part of the overall Trust CEL.

The all Wales schemes are at this stage expected to deliver to budget for 2023/24.

Other Major Schemes in development that are detailed in the main finance report will be considered as a part of the IMTP process in conjunction with WG.

Discretionary Programme

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

The allocation of the discretionary programme for 2023-24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB in August.

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

The Capital Expenditure Limit (CEL) was fixed by WG at the end of October, after this point the Trust is expected to internally manage any slippage or overspends on the Capital programme.

2.9 Cash

In order to support a cash flow pressure during October the Trust drew down £8.881m of Public Dividend Capital (PDC) from WG.

The Trust has also received an interim payment of c£10m from WG to support the cash position whilst the final pay award settlement figure is agreed.

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:	Choose an item

For more information: *https://www.gov.wales/socio-economic-duty-overview*	N/A. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of **£0.015m** for January'24 which is in line with the IMTP financial plan. The capital position is forecast overspend as the Trust is awaiting for the nVCC Project cost to officially form part of the CEL.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

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

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

Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31 JANUARY 2024

TRUST BOARD
26/03/2024

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 2023-24.

2. Background / Context

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

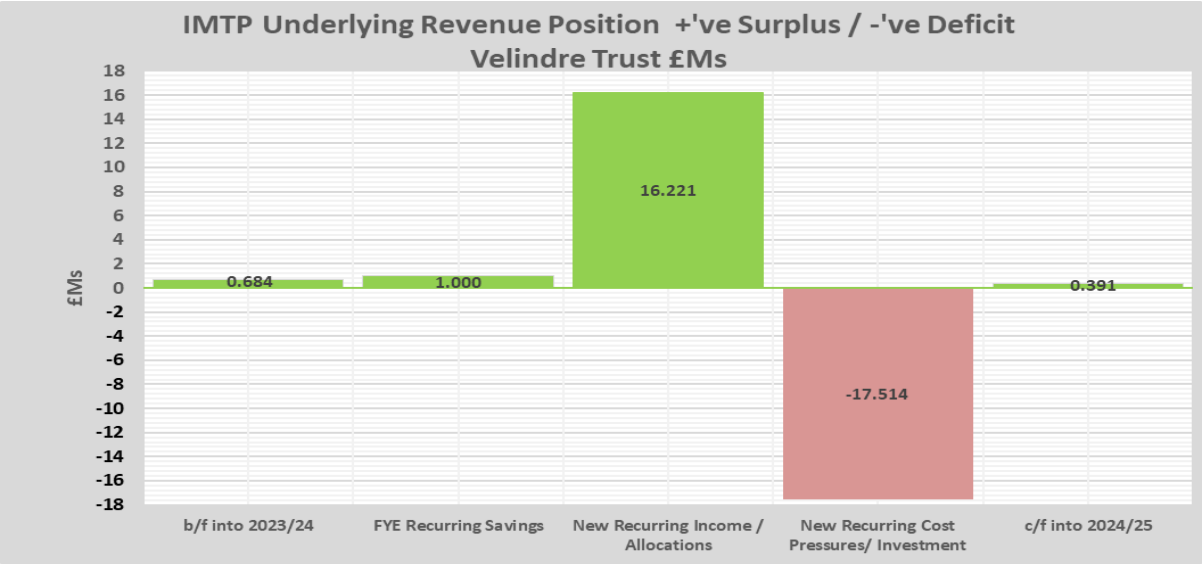
- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

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

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

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

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



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

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	6	15	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	2,315	22,987	29,664
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.8%	97.8%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	0.000	0.000	0.000

Revenue

The Trust has reported a **£0.006m** underspend on the in-month position for January '24, which gives a year to date cumulative underspend of **£0.015m** and an outturn forecast of **Breakeven**.

Capital

The latest approved Capital Expenditure Limit (CEL) as of January 2024 is **£26.407m**. This represents all Wales Capital funding of **£24.724m**, and Discretionary funding of **£1.683m.** The Trust reported Capital spend to January'24 of £22.987m and is currently forecast to remain within the overall CEL. The Trust has now received the funding award letter towards the nVCC project costs and once signed and returned will officially form part of the CEL.

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

	£m Opening	£m Movement	£m Current
Discretionary Capital	**1.683**	**-**	**1.683**
All Wales Capital:			
nVCC - Enabling Works	10.896	-	10.896
nVCC - Advanced Design Works		3.882	3.882
IRS	10.326	(2.500)	7.826
Digital Priority Investment	0.164	-	0.164
RSC Satellite Centre	1.347	(1.200)	0.147
Digital DPIF Cyber Security		0.051	0.051
nVCC - Advanced Works		0.898	0.898
Digital DPIF RISP		0.168	0.168
Digital DPIF Cyber Security (2)		0.085	0.085
Digital DPIF EPMA		0.100	0.100
Digital WHAIS		0.250	0.250
Priority Year end Spend		0.257	0.257
Total All Wales Capital	**22.733**	**1.991**	**24.724**
Total CEL	**24.416**		**26.407**

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

During September the Trust was awarded £3.882m in respect of advanced design works in nVCC.

Further funding has since been awarded to the following schemes £0.898m towards nVCC advanced works, £0.168m from the DFIF fund for RISP and £0.051m & £0.085m for cyber security, £0.100m for EPMA, £0.250m for WHAIS, and £0.257m towards the year end prioritised Capital Scheme list.

PSPP

During January ’24 the Trust (core) achieved a compliance level of **97.8%** of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **97.8%** as at the end of month 10, and a Trust position (including hosted) of **97.7%** compared to the target of 95%.

Efficiency / Savings

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

Revenue Position

Cumulative				Forecast		
£0.015m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(162.885)	(165.184)	2.299	(200.004)	(202.272)	2.268
Pay	71.457	70.936	0.522	85.767	85.249	0.518
Non Pay	91.428	94.234	(2.806)	114.238	117.023	(2.785)
Total	**(0.000)**	**(0.015)**	**0.015**	**0.000**	**(0.000)**	**0.000**

The overall position against the profiled revenue budget to the end of January 2024 is an underspend of **£0.015m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

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

4.1 Revenue Position Highlights / Key Issues

NHS Wales Financial Pressures

On the 31st July the NHS Wales Chief Executive Judith Paget wrote to all NHS organisations, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services to reduce the forecast NHS Wales financial deficit in 2023-24. In response to the financial pressures faced by the system, the Trust was asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

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

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust will work with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This would reduce the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs.
Energy	0.569	The latest energy forecast position for 2023-24 from NWSSP suggests that as at month 10 there is a reduction of c£0.569m from the forecast presented at the IMTP planning stage. The range of savings that will be available will be depended on forecast wholesale prices which are provided by the supplier and led by NWSSP as part of the all Wales Energy Group, however expectation is that an opportunity will arise that can be released to support the NHS deficit.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	TBC	Review of third year of investment strategy for corporate infrastructure to support the delivery of front line services.
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.069	

Underlying Position

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

The expected underlying surplus to be carried into 2024-25 had reduced from £0.391m to £0.086m following the inability to enact several savings schemes, which resulted in the underlying recurrent cost pressures forecast exceeding the recurrent savings schemes. Further recent assessment of savings and cost pressures has meant that there is now no underlying surplus to carry forward into 2024-25

Income Highlights / Key Issues

Other Income

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

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

VCS Long Term Agreement (LTA) Contract Performance

The Trust's Medium-Term Financial Plan assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24, however there was a risk that activity levels may have been high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The latest position (Dec'23 M9) is that the contract performance has recovered to a level that sufficiently funds the capacity investments made to date.

The tables below set out the projected year-end LTA Income performance based on data to December '23 by Commissioner and main service delivery areas:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Hywel Dda (7A2)	0.283	-0.025	0.258	-9%
Swansea Bay (7A3)	0.294	-0.001	0.293	0%
Cardiff & Vale (7A4)	15.036	1.256	16.292	8%
Cwm Taf Morgannwg (7A5)	13.221	0.918	14.140	7%
Aneurin Bevan (7A6)	17.344	1.191	18.535	7%
Powys (7A7)	0.758	0.154	0.912	20%
WHSSC	2.633	0.255	2.888	10%
Total	**49.569**	**3.748**	**53.317**	**8%**

Financial Performance Per Contract Currency	Base Contract Value £m	Projected Outturn Variance £m	Projected Outturn £m	Projected Variance (%)
Radiotherapy	17.929	-0.294	17.634	-2%
Nuclear Medicine	0.923	-0.049	0.874	-5%
Radiology Imaging	2.840	0.536	3.376	19%
Preparation for Systemic Anti-Cancer Therapy	2.594	0.161	2.755	6%
Delivery of Systemic Anti-Cancer Therapy	5.935	0.969	6.904	16%
Ambulatory Care Services	1.235	0.246	1.482	20%
Outpatient Services		2.255	11.484	24%
Inpatient Admitted Care	9.229	-0.076	8.808	-1%
Total	**49.569**	**3.748**	**53.317**	**8%**

VCS Contract income has recovered to a level that sufficiently funds the capacity investments made to date (£3.5m).

Pay Highlights / Key Issue

At this stage the Trust is still expecting to receive full funding from WG for the recurrent impact of the 1.5% (c£1.2m), 5% (c£3.5m) AFC consolidated pay award which was processed in July and the Medical Pay award which was processed in October (c£0.7m). WG have now made an interim payment which equates to 90% of the pay award and are aiming to resolve the final pay allocation as soon as possible. Indicative figures suggested that the gap in pay award funding against actual costs could be c£0.300m, however recent correspondence suggests that the gap could now be a lot less or removed completely. If the Trust does not receive the full funding, then the shortfall can be managed on a non-recurrent basis during 2023-24, however could lead to a recurrent shortfall being carried into next financial year. Pay award budget has been allocated to Divisions on assumption of WG matched funding.

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

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work is continuing in VCS and with Health Board partners through the operational groups 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 (£0.600m), WBS (£0.450m) and Corporate (£0.150m) hold a vacancy factor target, which will need to be achieved each year in order to balance the overall Trust financial position.

Non-Pay Key Issues

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

As part of the IMTP the Trust included £1.191m for the anticipated increase in energy prices during 2023-24. Latest projection from NWSSP suggests that the stepped increase will be c£0.622m. As noted above this potentially releases c£0.569m (£0.661m m9) back into the system to support the NHS Wales Financial Pressures.

The Trust emergency reserve remains uncommitted at this stage and should it not be required may be released to support the overall NHS Wales Position. The budget for the reserves is held in month 12 and is released into the position to match agreed spend as it occurs throughout the year.

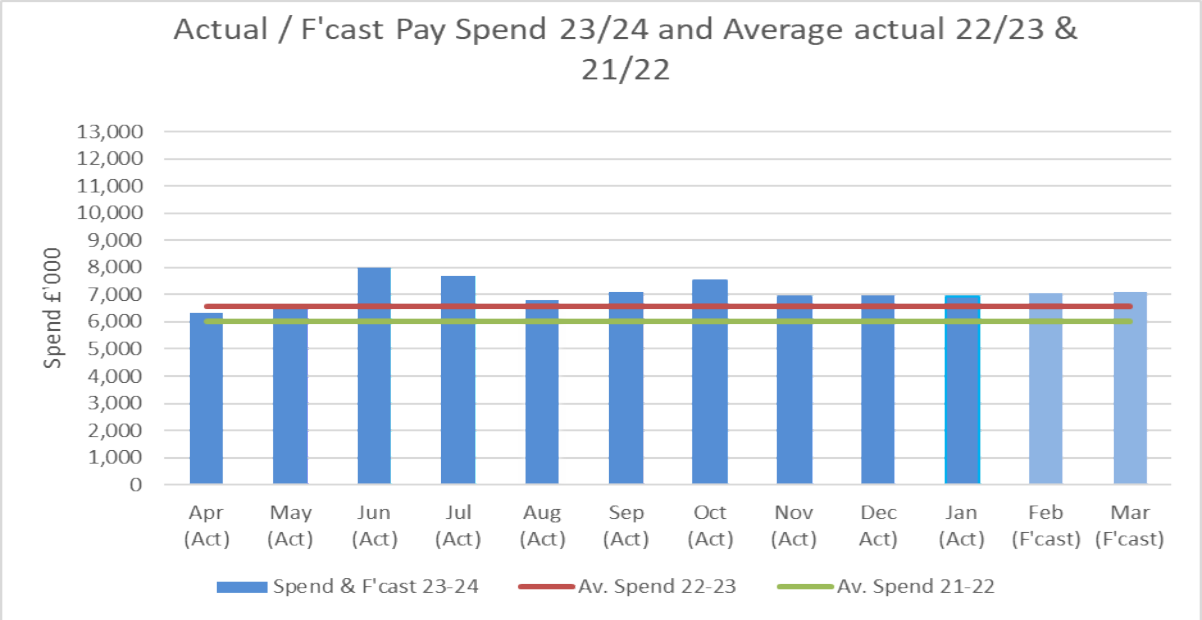
4.2 Pay Spend Trends (Run Rate)

As of January 2024, the current staff in post is 1,560 WTE. The number of vacancies is 79 WTE, which represents a vacancy rate of 4.82% (5.2% December) against the budget of 1639 WTE. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting each Divisional vacancy factor savings target.

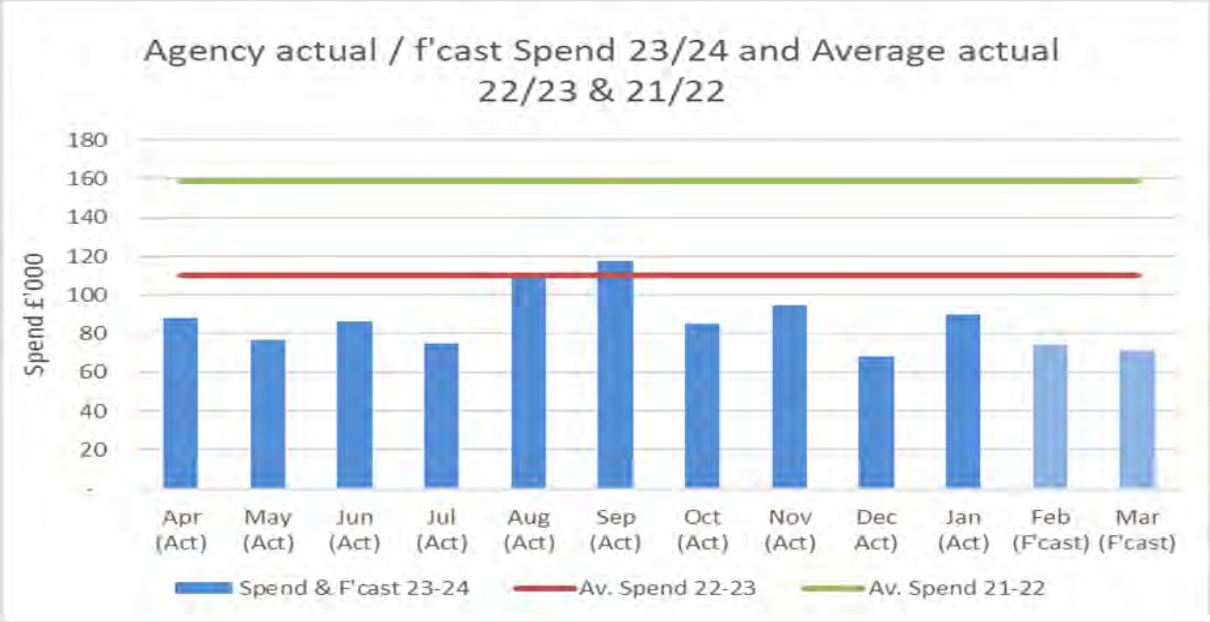
Vacancies throughout continues to reduce, however remains relatively high particularly in Nursing, last year significant improvement was made through targeted recruitment interventions in SACT (in VCC and outreach), reducing the Nursing and HCSW vacancies. Ongoing recruitment interventions are being assessed for SACT nursing with the Trust utlising the international recuritment scheme, with 17wte posts expected to be recruited in Quarter 4 of 2023/24. During October'23 VCS filled 10 vacancies across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy. The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to January 2024:

The total Trust vacancies as of January 2024 is 79wte (December 84wte), VCC (47wte), WBS (17wte), Corporate (6wte), R&D (5wte), TCS (2wte) and HTW (2wte).

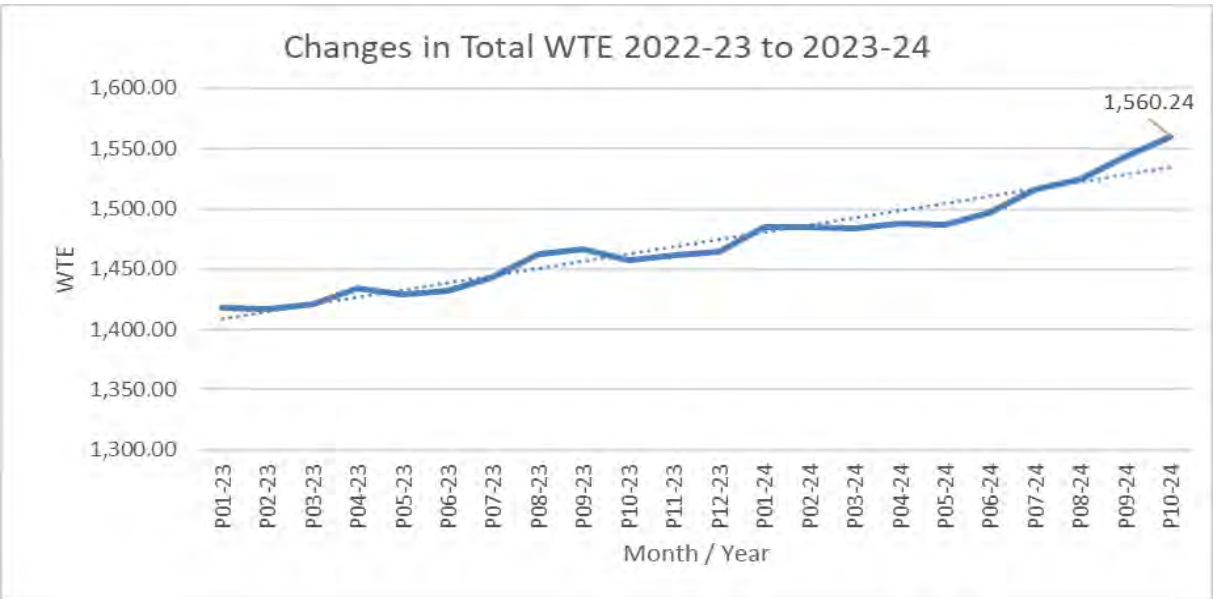
Per the IMTP the Trust is still aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions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

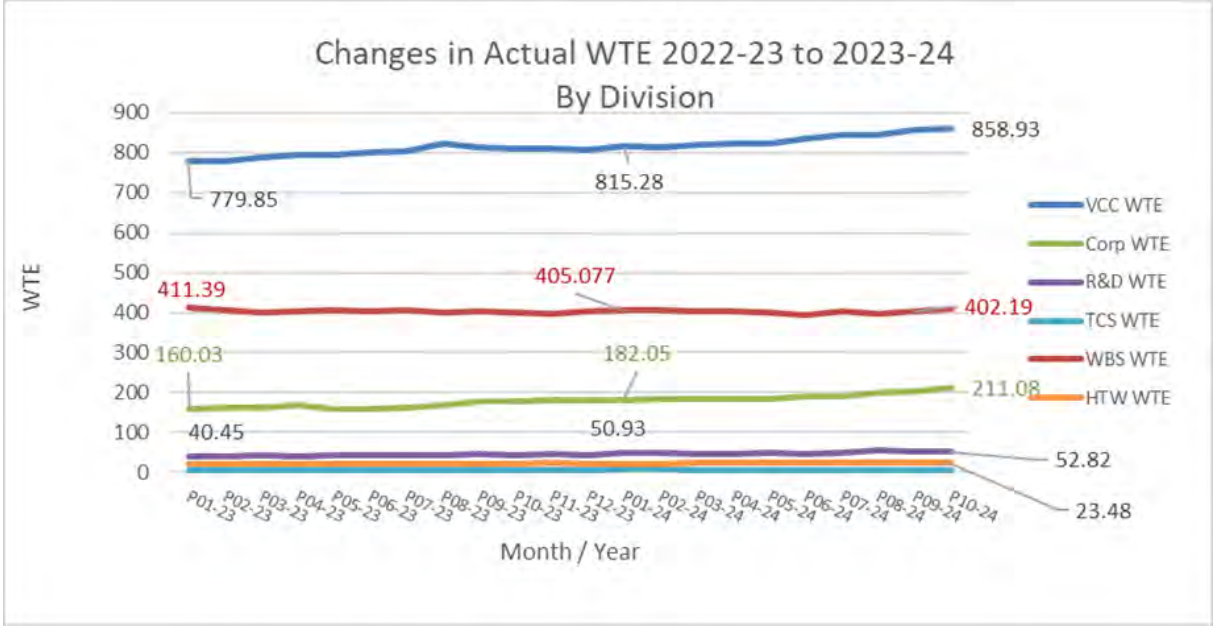


*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% AFC consolidated pay award backdated to April 2023.
*The Spike in pay during October relates to the 5% Medical consolidated pay award backdated to April 2023.



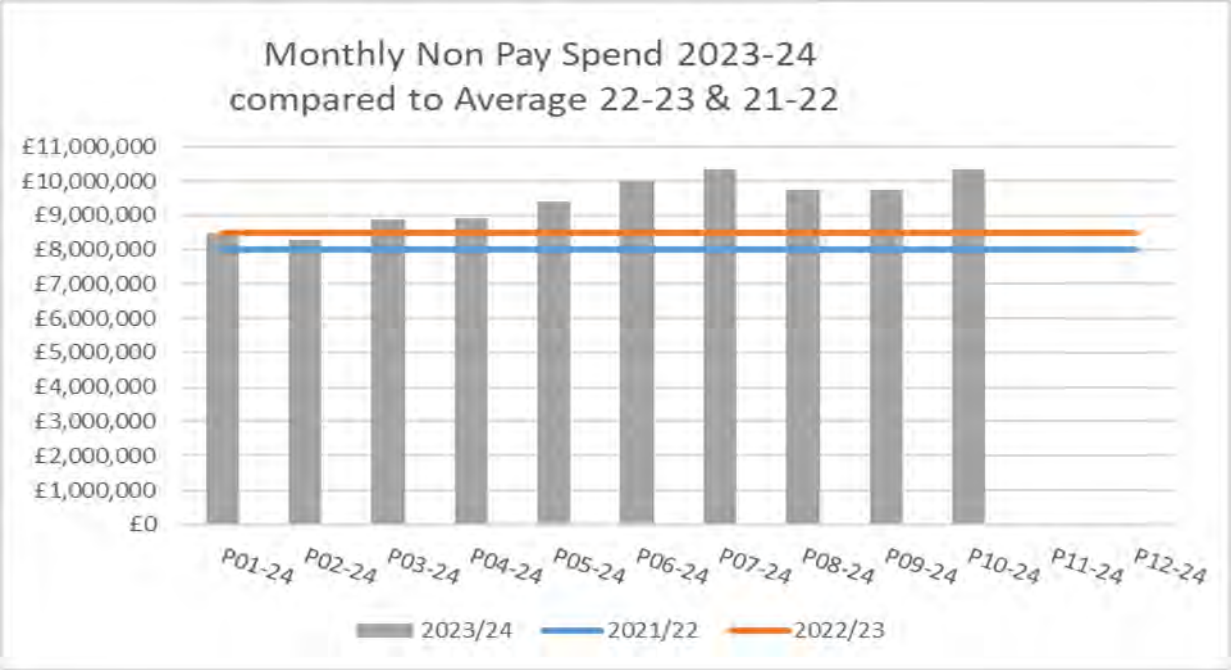
The spend on agency for Jan'24 was **£0.090m** (Dec £0.068m), which gives a cumulative year to date spend of £0.890m and a current forecast outturn spend of circa **£1.035m** (£1.323m 2022/23).





4.3 Non-Pay

The average monthly spend for 2022-23 was £8.5m which was £0.5m higher than the reported monthly average spend for 2021-22. Most of the monthly average increase related to the WBS wholesaling costs, along with the growth in energy costs and general inflation. Average non-pay spend so far for 2023/24 is £9.3m per month which is a £0.7m increase from the previous whole year average. Largest movement is in drug spend which has increased by £8m ytd, or £0.8m average per month when compared with the previous year's spend for the same period.



4.4 Covid-19

Covid Programme Costs

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

At present the Trust is only expecting to draw funding from WG towards PPE costs with the forecast requirement for 2023/24 as at January 23 being £0.053m, which is a reduction of £0.187m from the £0.240m requested as part of the IMTP. However, whilst unlikely if the Trust is required to support the HBs with the vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Covid Recovery and Planned Care Capacity

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

It is assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners. The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to recover the costs of investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Nov '23 is that income will cover the cost of the additional capacity.

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

The activity levels and Commissioner demand for services will continue be closely monitored over the remaining months of the year.

4. Savings

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

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

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

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has removed the underlying surplus of £0.391m position that had been carried forward from 2022-23.

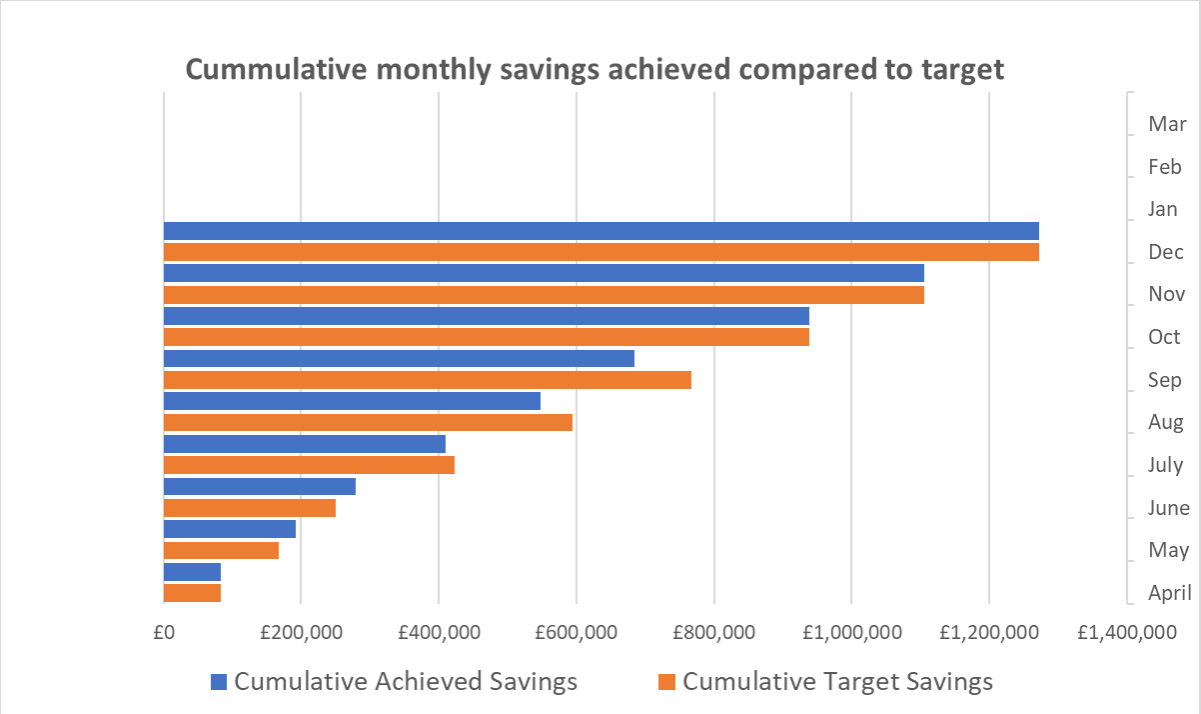
Service redesign and support service structures continue to be a key area for the Trust where it is focusing on to find efficiencies in the ways we are working, ensuring the appropriate staff are undertaking each activity. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of activity growth and sickness limiting the capacity of service leads to implement changes.

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

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented, or mitigations put in place to ensure that the Savings target is met each year.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**950**	**765**	**765**	**0**	**950**	**0**
			100%		**100%**	
WBS TOTAL SAVINGS	**700**	**565**	**565**	**0**	**700**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**150**	**125**	**125**	**0**	**150**	**0**
			100%		**100%**	
TRUST TOTAL SAVINGS IDENTIFIED	**1,800**	**1,456**	**1,456**	**0**	**1,800**	**0**
			100%		**100%**	

Scheme Type	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes						
Establishment Control (N/R) (Corporate)	75	63	63	0	75	0
Procurement Supply Chain (R) (WBS)	100	78	0	(78)	0	(100)
Collection Team Costs Reduction (R) (WBS)	10	8	8	0	10	0
Collection Team Costs Reduction (NR) (WBS)	8	7	7	0	8	0
Establishment Control (R) (WBS)	60	50	50	0	60	0
Reduced use of Nitrogen (R) (WBS)	55	43	0	(43)	0	(55)
Reduced Research Investment (R) (WBS)	25	21	8	(13)	25	0
Stock Management (NR) (WBS)	125	104	125	21	125	0
Reduced Transport Maintenance (NR) (WBS)	30	23	18	(5)	30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	137	107	91	(15)	137	0
Service Workforce Re-design (R) (VCS)	50	39	0	(39)	0	(50)
Establishment Control (NR) (VCS)	175	136	136	0	175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	150	117	117	0	150	0
Reduction in use of Agency - Radiation Services (R) (V	125	104	104	0	125	0
Reduction in use of Agency - Radiation Services (NR) (	50	42	42	0	50	0
Procurement Supply Chain (R) (VCS)	100	78	0	(78)	0	(100)
Total Saving Schemes	**1,275**	1,018	769	(249)	970	(305)
Income Generation						
Bank Interest (R) (Corporate)	75	63	63	0	75	0
Sale of Plasma (R) (WBS)	150	125	125	0	150	0
Expand SACT Delivery (R) (VCS)	200	167	167	0	200	0
Private Patient Income (R) (VCS)	50	42	42	0	50	0
Private Patient Income (N/R) (VCS)	50	42	42	0	50	0
NEW Medicines at Home (N/R) (VCS)		0	117	117	150	150
NEW Sale of Plasma (NR) (WBS)		0	132	132	155	155
Total Income Generation	**525**	438	686	249	830	305
TRUST TOTAL SAVINGS	**1,800**	**1,456**	**1,456**	**0**	**1,800**	**0**
			100%		**100%**	



5. Reserves

The financial strategy for 2023-24 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust 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. These assumptions have largely held, apart from the non-delivery of £305k of planned recurrent savings which have been replaced by non-recurrent schemes and removal of the planned c/fwd of a recurrent surplus into 2024-25.

As well as the planned reserves further, un-planned non-recurrent reserves have arisen during the year as financial pressures built into the IMTP financial plan have reduced (e.g. energy costs) or been mitigated and income levels improved above the plan, including Bank Interest, cancer services activity recovery above plan, balance sheet provisions not required, Plasma Sale income (commercial) and Private Patient Income (Commercial) above plan.

In addition to the above reserves, the Trust holds an emergency reserve of £0.522m which it has not had to utilise to date.

Work to review the third year of investment commitments in corporate infrastructure to support delivery of front-line services has been completed. This has not identified any significant funding release that can contribute to the All Wales position. It is important that the Trust keeps its reserve for emergency costs which may arise over the remainder of the year, however, given that none of the emergency reserve has thus far been utilised it is expected that the Trust should be in a position later in the year to release this funding on a non-recurrent basis to contribute to the All Wales position.

6. End of Year Forecast / Risk & Opportunities Assessment

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

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

Risks

2023/24 Pay Award – c£0.300m

At this stage the Trust is still expecting to receive full funding from WG for the recurrent impact of the 1.5% (c£1.2m), 5% (c£3.5m) AFC consolidated pay award which was processed in July and the Medical Pay award which was processed in October (c£0.7m). WG have now made an interim payment which equates to 90% of the pay award and are aiming to resolve the final pay allocation as soon as possible. Indicative figures suggested that the gap in pay award funding against actual costs could be c£0.300m, however recent correspondence suggests that the gap could now be a lot less or removed completely. If the Trust does not receive the full funding, then the shortfall can be managed on a non-recurrent basis during 2023-24, however could lead to a recurrent shortfall being carried into next financial year. Pay award budget has been allocated to Divisions on assumption of WG matched funding.

Trust wide - Management of Operational Cost Pressures – *Risk mitigated for 2023/24 / Risk 2024/25.*

Whilst there are several cost pressures that are already within the service divisions, expectation is that these will be managed from within normal budgetary control procedures or through utilisation of the Trust reserve during 2023/24. The recurrent impact of these cost pressures for future years will be considered as part of the IMTP process.

VCS - NEW RISK - Whitchurch Site Security – *Risk mitigated for 2023/24 / Risk 2024/25.*

The annual cost of maintaining security on the Whitchurch hospital site based on information provided by C&VUHB is expected to be £0.600m.The Trust does not currently have any identified agreed funding route for these costs, but its expectation, based on discussions between Trust Officers and WG Officials, is that WG will funds these costs, The costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer will be dependent on completion of all due diligence work regarding the land and the Whitchurch Hospital building and the WG formal process for transfer which is currently anticipated to take place towards the end of the financial year, however this could be delayed into 2024-25. Once the land is transferred to the Trust, the cost pressure would remain on a recurrent basis, if WG does not fund, until the residual Whitchurch estate can be disposed of. This £0.600m cost pressure together with other revenue cost pressures relating to the nVCC over the next 4 years could lead to the Trust failing to meet its Financial breakeven requirement.

7. CAPITAL EXPENDITURE

Administrative Target

- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *And to ensure the Trust does not exceed its External Financing Limit*

	Approved CEL £m	YTD Spend £m	Committed Orders Outstanding £m	Budget Remaining @ M10 £m	Full Year Forecast Spend £m	Forecast Year End Variance £m
All Wales Capital Programme						
nVCC - Enabling Works	10.896	9.579	0.000	1.317	10.896	0.000
nVCC - Project costs	0.000	2.818	0.000	(2.818)	3.243	(3.243)
nVCC - Advanced Design Works	3.882	3.863	0.000	0.019	3.882	0.000
nVCC - Advanced Works	0.898	0.898	0.000	0.000	0.898	0.000
nVCC - Whitchurch Hospital Site	0.000	0.014	0.000	(0.014)	0.014	(0.014)
Integrated Radiotherapy Solutions (IRS)	7.826	5.211	0.000	2.615	7.826	0.000
IRS Satellite Centre (RSC)	0.147	0.073	0.000	0.074	0.147	0.000
Digital Priorities Investment Fund	0.164	0.000	0.000	0.164	0.164	0.000
Digital DPIF -RISP	0.168	0.113	0.000	0.055	0.168	0.000
Digital Cyber Security	0.051	0.000	0.000	0.051	0.051	0.000
Digital Cyber Security (2)	0.085	0.000	0.000	0.085	0.085	0.000
Digital DPIF - EPMA	0.100	0.000	0.000	0.100	0.100	0.000
Digital WHAIS	0.250	0.000	0.000	0.250	0.250	0.000
Capital Year End Spend	0.257	0.000	0.000	0.257	0.257	0.000
Total All Wales Capital Programme	24.724	22.569	0.000	2.155	27.981	(3.257)
Discretionary Capital	1.683	0.418	0.000	1.265	1.683	0.000
Total	26.407	22.987	0.000	3.420	29.664	(3.257)

The approved Capital Expenditure Limit (CEL) as at January 2024 is **£26.407m**. This represents all Wales Capital funding of **£24.724m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.882m in respect of advanced design works in nVCC.

During December the Trust was awarded £0.898m towards nVCC advanced works, £0.168m from the DFIF fund for RISP, and £0.051m for cyber security.

In January the Trust was awarded a further £0.085m for cyber security, £0.100m for EPMA, £0.250m for WHAIS (previously ringfenced from discretionary) and £0.257m towards the year end prioritised Capital Scheme list which was submitted to WG on 12th January. The allocation has provided funding to support the following prioritised schemes.

Scheme	Amount £'000s
Abdominal Compression	35
Centrifuge Sorvall	7
Hand and Foot Monitor	25
Microplate Reader	6
Phase Contrast Material for Transport of Frozen Products	40
PRRT	35
QPCR Machine (PC-DCR Machine)	75
Radiological Equipment Test Instrument	16
Replacement Blood Gas Analyser	18
Total	**257**

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

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

The allocation of the discretionary programme for 2023/24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m had been ring fenced to support the nVCC enabling works and project costs. Following slippage in expenditure against the enabling works budget this funding has now been re-provided to the discretionary programme and will be re-allocated based on Divisional priorities. In addition, a further £0.250m was ringfenced to support WHAIS with the Trust only receiving confirmation of funding from WG on the 14th February. The £0.250m will now be released and considered for redistribution against prioritised schemes at the next Capital planning group meeting.

NHS – All Wales Capital Prioritisation

The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have agreed a framework for investment decision making that will provide a common basis for prioritisation of capital schemes. The review and prioritisation for 2023/24 is required due to the challenging financial climate, an oversubscribed capital backlog and need to ensure alignment with the Duty of Quality which came into force in April 2023. Consequently, the Trust needs to complete a prioritisation form by 31st March 2024 which coincides with the IMTP submission. The prioritisation from must be completed for all unapproved business cases irrelevant of status, where Full Business Case / Business Justification approval has not been received. The forms will be presented to EMB Shape on the 18th March before being submitted to WG.

Performance to date

The actual expenditure to January 2024 on the All-Wales Capital Programme schemes was £22.569m, this is broken down between spend on the nVCC enabling works £9.579m, nVCC Project Costs £2.5818, nVCC Advanced design works £3.863m, nVCC Advanced works £0.898m Whitchurch Hospital Site £0.014m, IRS £5.211m, IRS RSC £0.073m and Digital RISP £0.113m.

Spend to date on Discretionary Capital is currently £0.418m.

Year-end Forecast Spend

The Trust has now received the funding award letter to support the nVCC projects costs and the costs associated with the Whitchurch Hospital site. Once signed and returned the funding will officially form part of the overall Trust CEL.

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

The CEL was fixed by WG at the end of October (for all capital programmes apart from the nVCC Project as highlighted above), after this point the Trust is expected to internally manage any slippage or overspends on the Capital programme.

Major Schemes in Development

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

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund.

The latest draft position of schemes that will be 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	7.653	6.952	52.429	1.801		68.835
TCS nVCC Enabling works	2.900		0.600			3.500
Digital - IT Infrastructure	1.060	0.583	0.586	0.500		2.729
WHAIS	0.494	0.092				0.586
WBS Electrical Resilience	0.320					0.320
Liquid Nitrogen Vessel	0.500					0.500
Welsh Plasma - Medicine	2.253	0.050	0.050	0.159		2.512
Talbot Green - Infrastructure	0.369	1.346	10.633	10.640	19.708	42.696
WBS Fleet Replacement		0.330	1.205	1.225		2.760
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
Total Unapproved Capital Schemes	**16.269**	**10.047**	**65.774**	**14.325**	**21.268**	**127.683**
Total All Wales Capital Plans	**32.698**	**13.634**	**81.574**	**15.164**	**21.268**	**164.338**

8. BALANCE SHEET / Statement of Financial Position (Including Hosted Organisations)

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

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

	Opening Balance Beginning of Apr 23	Closing Balance End of Jan-24	Movement from 1st April Jan-24	Forecast Closing Balance End of Mar 24
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	170.418	186.662	16.244	186.662
Intangible assets	11.194	9.335	(1.859)	9.335
Trade and other receivables	1,107.047	1,111.853	4.806	1,111.853
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,288.659	1,307.850	19.191	1,307.850
Current Assets				
Inventories	34.070	31.769	(2.301)	31.769
Trade and other receivables	565.742	548.019	(17.723)	578.107
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	31.136	40.488	9.352	10.400
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	630.948	620.276	(10.672)	620.276
TOTAL ASSETS	1,919.607	1,928.126	8.519	1,928.126
Current Liabilities				
Trade and other payables	(226.254)	(230.258)	(4.004)	(230.258)
Borrowings	(1.123)	0.00	1.123	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(392.525)	(430.662)	(38.137)	(430.662)
Current Liabilities sub total	(619.902)	(660.920)	(41.018)	(660.920)
NET ASSETS LESS CURRENT LIABILITIES	1,299.705	1,267.206	(32.499)	1,267.206
Non-Current Liabilities				
Trade and other payables	(3.092)	(3.092)	0.000	(3.092)
Borrowings	(2.421)	0.00	2.421	0.00
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,108.919)	(1,069.028)	39.891	(1,069.028)
Non-Current Liabilities sub total	(1,114.432)	(1,072.120)	42.31	(1,072.120)
TOTAL ASSETS EMPLOYED	185.273	195.086	9.813	195.086
FINANCED BY: **Taxpayers' Equity**				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	34.708	36.039	1.33	36.039
PDC	131.461	139.928	8.467	139.928
Retained earnings	19.104	19.119	0.015	19.119
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	185.273	195.086	9.813	195.086

9. CASH FLOW (Includes Hosted Organisations)

The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

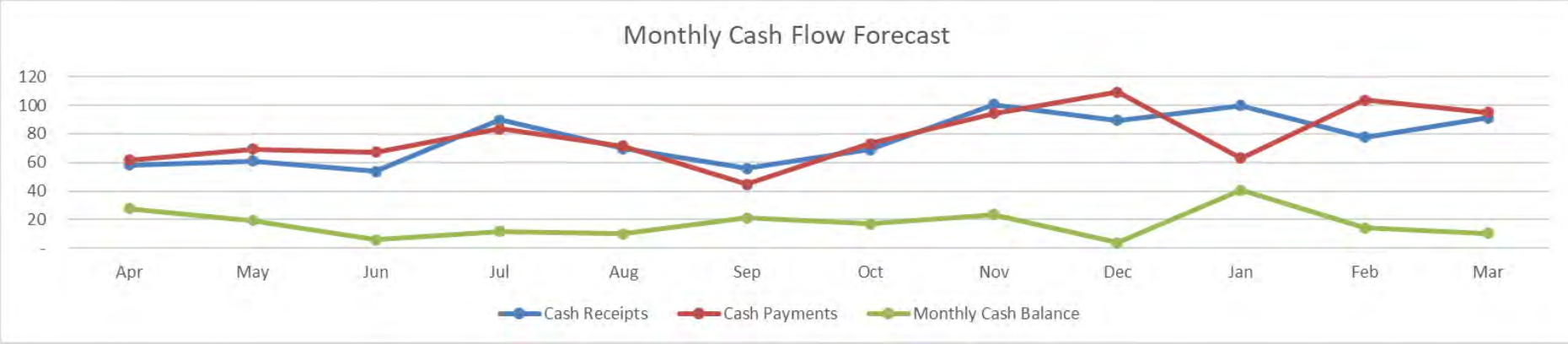
As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the ongoing uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however have now issued the additional stock and the £4.5m was repaid to WG during February '23.

In order to support cash flow pressures during October the Trust drew down £8.881m of Public Dividend Capital (PDC) from WG. In addition, whilst the Trust is yet to receive confirmation of the 2023-24 Pay award allocation, WG have provided an interim payment of c£10m which equates to 90% of the pay award for the whole Trust whilst the final allocation is agreed and settled.

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

		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	Income from other Welsh NHS	37.581	38.378	41.097	40.905	41.581	41.028	45.508	50.729	40.780	49.819	44.217	45.167	516.790
2	WG Income	14.460	18.799	9.707	42.966	22.143	2.138	9.901	40.339	38.269	45.454	26.944	26.144	297.263
3	Short Term Loans													0.000
4	PDC							8.881					13.145	22.026
5	Interest Receivable	0.149	0.162	0.143	0.126	0.106	0.117	0.140	0.107	0.147	0.124	0.100	0.100	1.521
6	Sale of Assets													0.000
7	Other	6.156	3.753	2.953	5.651	5.886	12.689	4.605	9.557	10.364	4.299	6.250	6.525	78.687
8	TOTAL RECEIPTS	**58.346**	**61.092**	**53.900**	**89.648**	**69.716**	**55.971**	**69.035**	**100.732**	**89.560**	**99.696**	**77.510**	**91.080**	**916.287**
	PAYMENTS													
9	Salaries and Wages	31.801	34.720	38.993	34.802	34.922	34.500	37.556	39.292	35.915	35.533	35.911	35.971	429.917
10	Non pay items	28.883	34.362	26.186	46.813	35.820	9.253	33.404	49.863	71.353	25.586	64.746	50.502	476.772
11	Short Term Loan Repayment											0.000		0.000
12	PDC Repayment		0.000											0.000
14	Capital Payment	1.122	0.394	2.160	1.949	0.824	1.094	2.297	5.077	1.955	1.915	3.071	8.476	30.334
15	Other items													0.000
16	TOTAL PAYMENTS	**61.807**	**69.477**	**67.339**	**83.564**	**71.566**	**44.847**	**73.257**	**94.232**	**109.223**	**63.034**	**103.728**	**94.949**	**937.022**
17	Net cash inflow/outflow	(3.461)	(8.385)	(13.438)	6.085	(1.850)	11.124	(4.222)	6.500	(19.663)	36.662	(26.218)	(3.869)	
18	Balance b/f	31.136	27.675	19.290	5.851	11.936	10.086	21.210	16.988	23.488	3.826	40.488	14.270	
19	Balance c/f	27.675	19.290	5.851	11.936	10.086	21.210	16.988	23.488	3.826	40.488	14.270	10.400	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(34.733)	(34.733)	(0.000)	(41.347)	(41.347)	(0.000)
RD&I	(0.281)	(0.280)	0.001	0.091	0.091	0.000
WBS	(18.356)	(18.354)	0.001	(21.703)	(21.703)	0.000
Sub-Total Divisions	**(53.369)**	**(53.367)**	**0.000**	**(62.959)**	**(62.959)**	**(0.000)**
Corporate Services Directorates	(11.052)	(11.050)	0.002	(13.204)	(13.203)	0.000
Delegated Budget Position	**(64.422)**	**(64.417)**	**0.005**	**(76.163)**	**(76.163)**	**0.000**
TCS	(0.605)	(0.594)	0.010	(0.744)	(0.744)	0.000
Health Technology Wales	(0.109)	(0.109)	(0.000)	(0.117)	(0.117)	0.000
Trust Income / Reserves	65.136	65.136	0.000	77.024	77.024	0.000
Trust Position	0.000	0.015	0.015	(0.000)	0.000	(0.000)

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**62.110**	**63.379**	**1.269**	**76.174**	**77.443**	**1.269**
Expenditure						
Staff	41.420	41.498	(0.079)	49.729	49.808	(0.079)
Non Staff	55.423	56.614	(1.191)	67.792	68.983	(1.191)
Sub Total	**96.843**	**98.112**	**(1.269)**	**117.522**	**118.791**	**(1.269)**
Total	**(34.733)**	**(34.733)**	0.000	**(41.347)**	**(41.347)**	**(0.000)**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of January 2024 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 10 represents a surplus of **£1.005m**. Considerable overachievement on Private Patients drugs due to both activity and the VAT savings from delivery of SACT homecare. This is offsetting and providing a significant surplus above the divisional management savings target. Other income overachievements are in areas such as Catering and project income which are offset with non-pay costs.

VCS have reported a year to date overspend of **£(0.79)m** against staff. Vacancies with the division continue to reduce with VCS filing 10 vacancies in October across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy.

Vacancies levels do however remain high in Nursing budgets, this along with recruitment challenges, is largely offsetting both the vacancy savings target and the requirement to support posts appointed into without funding agreement i.e. Advanced recruitment and Capacity investments. The international recruitment scheme has been used to help fill current vacancies in Nursing with 17wte expected to be recruited during Quarter 4.

Non-Staff Expenditure at Month 10 was **£(0.191)m** overspent which is a result of the divisional management savings target, along with increased activity pressures which can be linked to activity contract performance in areas such as PICC and SACT following treatment returning to Nevill Hall.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**23.783**	**24.306**	**0.523**	**28.957**	**29.480**	**0.523**
Expenditure						
Staff	15.239	15.224	0.015	18.442	18.428	0.015
Non Staff	26.899	27.436	(0.537)	32.218	32.755	(0.538)
Sub Total	**42.138**	**42.660**	**(0.522)**	**50.660**	**51.183**	**(0.523)**
Total	**(18.356)**	**(18.354)**	0.001	**(21.703)**	**(21.703)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of January 2024 was a small **£0.001m underspend** with an outturn forecast position of **Breakeven**.

Income overachievement of **£0.523m** to month 10. Targeted income generation on plasma sales through increased activity which is exceeding planned expectations and creating opportunities to support divisional investment. Plasma sale income is being partly offset by lower than planned Bone Marrow activity.

There has been a lack of growth in the bone marrow registry which was largely impacted during the pandemic and is still yet to see signs of recovery. WBS are continuing 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, however the year to date target continues to underachieve by c39% as at the end of January.

Staff reported a **£0.015m** underspend to January. Vacancies are helping to offset the overspend from posts supported without identified funding source. This includes advanced recruitment and service developments which have been incurred as a divisional cost pressure particularly in relation to Component development where no WHSSC funding has been secured.

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

Non-Staff reported an overspend of **£(0.537)m** to January. YTD energy price rises have been funded centrally by the Trust as agreed at the IMTP planning stage along with venue hire costs

pressures c£10-£15k per month previously funded by WHSSC, are being partly offset by reduced spend from lower activity releasing non-recurrent benefits linked to reduced production volumes. Trust and Divisional savings plans are phased into the position and contributing to the overspend.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**2.497**	**2.948**	**0.451**	**2.963**	**3.415**	**0.451**
Expenditure						
Staff	10.521	9.968	0.553	12.601	12.048	0.553
Non Staff	3.028	4.030	(1.002)	3.566	4.570	(1.004)
Sub Total	**13.549**	**13.998**	**(0.449)**	**16.167**	**16.618**	**(0.451)**
Total	**(11.052)**	**(11.050)**	0.002	**(13.204)**	**(13.203)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of January 2024 was a small underspend of **£0.002m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

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

For staff several vacancies have been carried throughout the year across the division particularly within finance which is offsetting the cost of agency and the divisional savings target within non pay and reflecting and underspend of £0.553m as at month 10.

Non pay overspend largely relates to the divisional savings target and the increased running costs associated with the ageing hospital estate.

RD&I

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**2.329**	**2.353**	**0.024**	**3.384**	**3.408**	**0.024**
Expenditure						
Staff	2.426	2.398	0.028	3.006	2.978	0.028
Non Staff	0.184	0.235	(0.051)	0.287	0.339	(0.052)
Sub Total	**2.610**	**2.633**	**(0.023)**	**3.292**	**3.316**	**(0.024)**
Total	**(0.281)**	**(0.280)**	0.001	**0.091**	**0.091**	**(0.000)**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of January 2024 was a **£0.001m** underspend with a current forecast outturn position of **breakeven**.

Trials Income fluctuations expected throughout the year.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.000**	**0.032**	**0.032**	**0.000**	**0.000**	**0.000**
Expenditure						
Staff	**0.523**	**0.523**	**(0.000)**	**0.693**	**0.693**	**0.000**
Non Staff	**0.011**	**0.043**	**(0.032)**	**0.051**	**0.051**	**0.000**
Sub Total	**0.534**	**0.566**	**(0.032)**	**0.744**	**0.744**	**0.000**
Total	**(0.534)**	**(0.534)**	(0.000)	**(0.744)**	**(0.744)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of January 2024 is **Breakeven** overspent with a forecasted outturn position of **Breakeven.**

Revenue funding of £0.041m will be provided to the nVCC Project for Project Delivery and Judicial Review cost from interest incurred from the Escrow Account.

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	**1.154**	**1.151**	**(0.004)**	**1.677**	**1.677**	**0.000**
Expenditure						
Staff	**1.151**	**1.146**	**0.004**	**1.545**	**1.545**	**0.000**
Non Staff	**0.107**	**0.107**	**0.000**	**0.248**	**0.248**	**0.000**
Sub Total	**1.257**	**1.253**	**0.004**	**1.794**	**1.794**	**0.000**
Total	**(0.103)**	**(0.103)**	(0.000)	**(0.117)**	**(0.117)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of January 2024 was **breakeven,** with a forecasted outturn position of **breakeven.**

HTW programme costs are funded directly by WG.

TRUST BOARD

INTEGRATED MEDIUM TERM PLAN – 2024 / 25 – 2026 / 27

DATE OF MEETING	26th March 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?	NO
PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Phil Hodson, Deputy Director of Planning and Performance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	The Trust is required to submit a Trust Board approved Integrated Medium Term Plan (2024 / 25 – 2026 / 27) to the Welsh Government by 28th March 2024.
RECOMMENDATION / ACTIONS	The Trust Board is asked to approve the Velindre University NHS Trust Integrated Medium Term Plan (IMTP) for 2024 / 25 – 2026 / 27. The IMTP includes the following: • Service plans for the Welsh Blood Service and for the Velindre Cancer Service

	• The Trust Financial Plan • Plans for our enabling functions e.g. digital services

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Velindre University NHST Trust Board (Development Session)	14/12/2023
Velindre University NHS Trust Executive Management Board	22/01/2024
Velindre University NHST Trust Board (Development Session)	06/02/2024
Velindre University NHS Trust Executive Management Board	19/02/2024
Velindre University NHST Trust Board (Development Session)	27/02/2024
Velindre University NHS Trust Executive Management Board	29/02/2024
Velindre University NHS Trust Executive Management Board	18/03/2024
Velindre University NHS Trust Strategic Development Committee	21/03/2024
Please Note: In addition the service plans have been approved by the: • Velindre Cancer Service Leadership Team • Welsh Blood Service Leadership Team	

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Velindre University NHS Trust IMTP has been endorsed by:

- Velindre University NHS Trust Executive Management Board (18/02/2024)
- Velindre University NHS Trust Strategic Devlopment Committee (21/03/2024)

Assuming endorsement of the IMTP by the Velindre University NHS Trust Board it will then be submitted to the Welsh Government on 28th March 2024.

7 LEVELS OF ASSURANCE – NOT APPLICABLE

APPENDICES	
1	Velindre University NHS Trust Integrated Medium Term Plan (2024 / 25 – 2026 / 27)
2 (a-d)	Quality Impact Assessments for service changes / developments: 2a - Velindre Cancer Service - New Velindre Cancer Centre 2b – Welsh Blood Service - National External Quality Assessment Service 2c – Welsh Blood Service – West Nile Virus Testing 2d – Welsh Blood Service - Nucleic Acid Testing

1. SITUATION

1.1 The Trust, on 22nd July 2023, received confirmation from the Welsh Government that it's IMTP for 2023 /24 – 2025 / 26 had been approved in accordance with the requirements of the NHS Wales Planning Framework and the duties set out by section 175 of the National Health Service (Wales) Act 2006. However, there is a requirement to update and refine our approved plan for the period covering 2024 / 25 – 2026 / 27.

2. BACKGROUND

2.1 Prior to submission to the Welsh Government the IMTP must be endorsed / approved by the following:

- Velindre University NHS Trust Executive Management Board – 18th March 2024 (endorsed)
- Velindre University NHS Trust Strategic Development Committee – 21st March 2024 (endorsed)
- Velindre University NHS Trust Board – 26th March 2024

3. ASSESSMENT

The Requirement:

3.1 Velindre University NHS Trust is required to submit a financially balanced and Trust Board approved IMTP to the Welsh Government by **28th March 2024**.

Velindre University NHS Trust IMTP (2024 / 25 – 2026 / 27) – Core Principle(s):

3.2 The core principle in developing our IMTP is our commitment to quality and safety. Our plan will ensure that we put our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving.

3.3 Our strategic priorities will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve.

3.4 These include:

- Implementing our legislative requirements
- Implementation of the Cancer Standards (those which are applicable)
- Delivering services that meet the national clinical quality and safety standards and requirements which ensure that patients and donors receive an excellent experience
- Treating patients as quickly as possible
- Delivering services which are efficient, effective and productive – Value Based Healthcare
- Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales
- Supporting the health and well-being of our staff
- Workforce and Organisational Development

3.5 In addition we have identified a number of important strategic areas of work. These include:

- Improving population outcomes and reducing inequalities
- Regional working, partnerships and collaboration to improve outcomes

- Delivery of our Transformation Programmes
- Delivery of our Organisational Development Programmes
- Delivery of our research, development and innovation Programmes
- Delivery of our decarbonisation strategy

3.6 The IMTP sets out our plans across the following:

1. Our strategic ambition and our strategic goals
2. Our commitment to delivering high quality, safe services which provide an excellent experience
3. Our priorities related to the implementation of enhanced models of care and services for blood and cancer services
4. Our support functions / enabling plans which will help to ensure that WBS / VCS are able to deliver against their key service priorities
5. Our financial plan which:
   - Provides assurance that we will achieve a financially balanced revenue position
   - Outlines our capital requirements for the next three years
   - Outlines how we will target investment where it will have the greatest impact (*Value Based Healthcare*)
   - Clearly articulates the investment required from our commissioners and of the Welsh Government
   - Details our robust cost improvement / savings plans

Service Plans and Key Areas of Work:

3.7 Service plans have been developed and previously endorsed by the Executive Management Board. The primary aim of these plans is to ensure that both VCC and WBS are able to meet forecast demand for cancer services and for blood and blood products respectively.

3.8 These plans also outline key service developments which support the continued improvement of performance and patient / donor quality and safety across both services and which align with the strategic ambition of the organisation.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Velindre University NHS Trust Board is asked to approve the Velindre University NHS Trust Integrated Medium Term Plan (IMTP) for 2024 / 25 – 2026 / 27.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	The IMTP has been developed to ensure that actions will help to mitigate risks identified within the Trust Assurance Framework.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Not Applicable
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the approach outlined within the attached presentation.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	The guiding principle in developing our IMTP has The Well-Being of Future Generations Act

	(2015) and to our contribution to the seven goals identified within the Act: • A Prosperous Wales • A Resilient Wales • A More Equal Wales • A Heathier Wales • A Wales of Cohesive Communities • A Wales of Vibrant Culture and Welsh Language • A Globally Responsible Wales The IMTP has also been developed to align with our Trust Well Being Objectives.
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 IMTP covers: • Decisions / actions already approved by the Trust Board • Strategic developments which have been endorsed by the Trust Board, but, the preferred option(s) for implementation is yet to be agreed • Clinical developments which have been proposed but have not yet been approved by the Trust Board Each proposal, prior to implementation, will need an Equality Impact Assessment (and a Quality Impact Assessment) to be completed prior to implementation.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust

Integrated Medium Term Plan 2024/25 - 2026/27 (1st April 2024 to 31st March 2027)

CONTENTS

Introduction

We are proud to present the Velindre University NHS Trust Integrated Medium Term Plan (IMTP) for 2024 / 25 – 2026 / 27. Our plan builds upon our recently approved plan for 2023 / 24 – 2025 / 26 and is an output of the excellent work undertaken by our teams from across the Trust and our continued engagement with our many stakeholders. We have set ourselves a set of ambitious priorities, which build upon our strengths, and which will result in the people who use our services receiving excellent and person-centred care. Our IMTP sets out our plans across the following areas.

Firstly, the plan sets out our commitment to ensuring that we have firm foundations to support the delivery of high quality, safe and effective services which provide an excellent experience to all of our service users.

We then provide an overview of the Trust's strategic intent. This not only covers the scope of our core services but also identifies wider opportunities where we believe we can contribute across the health and social care system so that we can further support our partners in achieving outcomes and benefits for the populations we serve. It outlines our key strategic priorities and objectives and describes the programmes of work we have established to ensure that these will be delivered.

Thirdly, the plan identifies our priorities related to the implementation of enhanced models and integrated pathways of care and services for blood and cancer services. This will see donors and patients being able to access services as close to home as possible, being able to receive a wider range of information services digitally, and having access to clinical trials and other services. To support this ambition we are also actively progressing a number of key infrastructure programmes. These infrastructure improvements, together with our clinical and sustainability plans, will provide us with the opportunity to deliver a carbon net-zero organisation and a range of wider benefits to support the development services across Wales.

Finally, we have included a detailed financial plan which sets out how we will deliver our key actions whilst remaining within our assumed financial allocation, both for revenue and capital.

The plan we have set out demonstrates the challenging, but exciting times, ahead for the Trust. We look forward to working with our commissioners, staff, patients, donors and partners to deliver the changes set out within the plan and continue our transformation into the future.

Part 1

Organisation Overview

An overview of Velindre University NHS Trust and the services we provide

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

Overview of Our Services

Velindre Cancer Services

We are a specialist treatment, teaching, research and development centre for non-surgical tertiary oncology services to patients from across South-East Wales serving a population of 1.7million.

Blood and Transplant Services

We provide a range of essential and specialised services including the collection and production of blood and blood components to treat patients; and supporting the transplant programmes through the Welsh Transplantation and Immunogenetics Laboratory services. This is a national service supporting the 3.3million population of Wales.

Hosted Services

Our Trust is responsible for hosting the following organisations on behalf of the Welsh Government and NHS Wales:

- **NHS Wales Shared Services Partnership (NWSSP):** who provide a wide range of support services to NHS Wales including procurement, recruitment and wider back office services.

- **Health Technology Wales (HTW):** a national body working to improve the quality of care in Wales. It collaborates with partners across health, social care and the technology sectors to identify, appraise and advise on the adoption of technology or models of care to ensure an all-Wales approach.

Part 2

Our Operating Environment

Making sense of our environment, our commitment to quality and to reducing inequalities

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Velindre University NHS Trust

Our Commitment to Quality and Safety

Our Trust strategy sets out our commitment to quality and safety:

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: An international renowned provider of exceptional clinical services that always meet, and routinely, exceed expectations

Quality and safety is at the heart of everything we do. We will ensure we will continue to put our patients and donors at the centre of everything we do, working towards optimum quality, safety and experience and continual learning and improving.

Our strategic goals will be achieved by ensuring that we meet in full the requirements of the Duty of Quality (Health and Social Care Quality and Engagement (Wales) Act 2020) and by ensuring that quality improvement is driving all strategic decision making. We will also ensure that our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to continually learn and improve.

We will continue to actively engage and participate with Improvement Cymru, the Safe Care Collaborative and national improvement work Programmes. Our quality Improvement Goals are being progressed through the collaborative.

Whilst we are proud of what we have achieved to date, we recognise that considerable more work is required to have robust quality and safety foundations in place. This IMTP has been developed with quality, safety and experience at its centre and we will work with all partners to secure the best possible outcomes over the next three years.

Our Plan for 2024/25 – 2026/27 and Beyond:

Our Quality and Safety Framework provides the framework and mechanism through which the Trust will meet its Quality and Safety responsibilities as outlined in the Health and Social Care (Quality and Engagement) Wales Act 2020 and the NHS Wales Quality and Safety Framework – Learning and Improving (2021). The framework has been developed in line with Quality standards (Duty of Quality): safe, effective, person-centred, timely, efficient and equitable and sets the structure for embedding quality and safety, outcomes, experiences and learning from service level to Board across all areas of the Trust.

Our Quality and Safety Vision:
All Velindre University NHS Trust staff put quality, patient / donor safety and experience firmly at the heart of everything they do, and all decisions made, that enables the active involvement of both the people who receive care / services and those who provide it, and a relentless focus on learning and improvement.

Our Quality and Safety Framework – Key Aims:

Our framework is developed to support us in delivering our vision for quality and our strategic objectives. This will include meeting our responsibilities in relation to the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and the NHS Wales Quality and Safety Framework: Learning and Improving (Welsh Government 2021). In order to achieve this, the framework will:

- Articulate the expectations of the Board in relation to quality and patient / donor safety
- Improve the provision of safe care through clear lines of communication and reporting from service level to Board and Board to service level
- Provide clarity of roles, responsibilities and lines of reporting in respect of Quality, Safety and Experience
- Develop a Quality Management System and a robust automated business intelligence infrastructure
- Provide a structure within which Corporate Services, Divisions, Departments and teams can:
  - Engage and actively listen to donors, patients, their families, staff and other key stakeholders to improve experience, outcomes and therefore efficiency
  - Empower everyone to put quality and patient safety at the heart of everything they do, ensuring quality drives delivery of care to improve experience and outcomes
  - Promote a quality and patient / donor safety focused culture in all aspects of care delivery they are responsible for and beyond
  - Clearly articulate a common understanding and ownership in relation to their individual and collective role, responsibility and accountability related to quality and patient / donor safety
  - Be sufficiently aware of potential risks to quality in delivery of safe and effective care
  - Demonstrate effective processes for escalating, investigating, managing and reporting on concerns about quality and patient / donor safety
  - Use triangulated data to drive quality improvement, ensuring issues of equity are also identified and where appropriate addressed

Our Quality Hubs across Velindre University NHS Trust
Three Quality hubs have been established to support the delivery of this framework and the Duty of Quality legislative requirements:

- **The Corporate Quality Hub** will have a central co-ordinating role pulling together all elements of Quality and Safety, will interface significantly with national work and bodies, as well as professionally supporting the Divisional Quality Hubs.

- **Welsh Blood Service (WBS) Quality Hub and Velindre Cancer Service (VCS) Quality Hub**: These are led by nominated divisional senior leaders and support the Divisional Senior Management Teams in executing their Quality, Safety, regulatory and assurance responsibilities by ensuring effective oversight, co-ordination, learning, assurance and triangulation of 'the whole' and effective functioning of Divisional Quality and Safety Group.

Quality Impact Assessment – Helping to Improve Quality, Safety and Outcomes:

Overview:

We are committed to supporting the use of the Quality Impact Assessment (QIA) methodology when considering any key service developments which could impact our staff, patients and donors. In doing so we consider:

- Will the service development impact 'patient / staff safety', 'clinical effectiveness' and 'patient / staff experience'; and
- How any risks or negative impacts can be mitigated.

The undertaking of Quality Impact Assessments is a continuous process and has been carried out on all our key IMTP developments to ensure quality and patient safety are always at the forefront when delivering our services throughout the development, implementation and review of any project or development.

The QIA focuses on Three Main Areas:

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.

Velindre University NHS Trust Quality Priorities 2024 – 2025

Quality Priority:	What these goals mean in practice/ Baseline Position	To achieve this, we will:	What we expect to see:	Evidence of this will be measured by:	Division
1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.	During 2022 to 2023 a number of themes emerged from concerns, patient feedback, and incidents (including Duty of Candour and Nationally Reportable Incidents) in relation to patient communication and administrative processes. These were: 1. Patient referral processes 2. SACT Booking 3. General Booking Processes	A strategic improvement plan has been developed. By December 2024 the planned programme of work in relation to: • Single electronic referral mechanism into the Cancer Service • Appointments process for SACT • General appointments (OPD/ medical records) • Patient letters (including appointment letters, and clinic outcome letters) • Access into the Cancer Service – telephony Will be completed by December 2024.	• A reduction in patient concerns/incidents related to administration of communication issues. • An improvement in patient experience. • An improved referral processes.	• Quality and Safety reporting and thematic analysis. • Improvements reported through governance structures. • Outcomes of audits.	VCS

	4. GP / patient letters post appointment. 5. Response to patient telephone calls into Velindre Cancer Service				
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.	Currently there is not a consistent process for deaths within 30 days of SACT and 30/90 days of radiotherapy reviews at the Velindre Centre Service.	By September 2024, a process will be established to ensure that there is an objective review within all site-Specific teams. • A multidisciplinary infrastructure will be developed. • Accurate reporting data will be generated and reported through governance structures.	• 100% compliance with the VCS agreed process in line with best practice guidance. • Increased opportunity for early detection learning that can be rapidly share.	• Clinical audit compliance. • Reporting of accurate data.	VCS
3. To Integrate Clinical Audit within VCS Quality and Safety function	Currently within Velindre Centre Service, audit does not form part of the Quality and Safety Hub.	By September 2024 the VCS Quality Management Framework will be reviewed and updated to include the integration of the Clinical Audit team within Quality and Safety Hub, to ensure the clinical audit plan	• An audit plan that reflects themes and trends identified from concerns/incidents.	• Clinical audit report and findings.	VCS

		reflects the quality and safety themes and learning identified through incident and concern reporting.			
4. Development of robust Site-Specific Quality Metrics	There is a requirement to develop a suite of quality measures with the site-specific teams.	By December 2024, SSTs will develop quality metrics and strengthen the link between the medical directorate and the quality and safety hub - identify medical lead for quality and safety at VCC.	• Publish the Quality Matrix. • Medical Lead identified	• Quality and Safety reporting and thematic analysis. • Improvements reported through governance structures.	VCS
5. To improve incident and risk management.	The Trust does not currently have a patient safety incident framework. Some incidents remain open longer that 30 days.	By September 2024 we will improve the management and compliance of Datix Incidents and Risks to ensure timely management, and identify themes, trends and learning through governance structures.	• Improved quality of incident investigation. • Proportionate investigations depending on incident grade. • Improved compliance with incidents closed with 30 days.	• Audit findings. • Datix dashboards. • Quality and Safety reporting and thematic analysis.	TRUST
6. Continue to review and update the WBS Quality Management Framework, including the deployment of a	The current quality management system requires expansion to meet the regulatory requirements and ensure integration of the Trust system.	• Align with the broader VUNHST Quality management framework, • Adapt to new ISO standards and medical devices legislation as they are introduced,	• A Trust wide quality management system. • A management system that is compliant with current ISO standards and medical devices legislation.	• The operation of the quality management system. • ISO accreditation.	WBS

new electronic Quality Management System		• Maintain all mandatory registrations and current national/international accreditations throughout the 2024 inspection cycle.	• A repository of all registration and current accreditation.		
7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service.	Currently due to the unavailability of West Nile Testing donors a deferred due to international travel, this impacts on viable blood donations. We know that donors hate being told they cannot donate especially after they have travelled to a donation session. This is a particular challenge during the summer holiday season. To reduce the number of times this happens we will introduce additional testing for donors who have travelled	• Screening tests to be introduced for high-risk donors by the start of June 2024 to minimise deferrals during the summer travel season.	• Availability of WNV testing for high-risk donors.	• Reduced donation deferrals. • Increase in blood stocks. • Data of tests performed.	WBS

	to areas where West Nile Virus is a risk instead of deferring their donation.				
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.	Whole blood donations in Wales produce more plasma than is needed clinically so to reduce waste and to ensure all viable donations are effectively utilised we will work with the pharmaceutical industry and introduce additional processing to make life-saving medicines from blood plasma. These medicines will be returned to Wales for patients who need them.	• 1) Switch to the use of new collection packs by end September 2024 to allow for plasma to be stored in quarantine. • 2) All stored plasma to be tested for Parvo B-19 and Hepatitis A by the end of February 2025 to enable plasma to be released from Quarantine. • 3) First plasma to be shipped to the fractionator by end April 2025	Introduction of: • Leucodepletion filters • Hepatitis A testing • Parvovirus testing	• Service provision • Evidence of tests being performed.	WBS
9. Review and improvement of donor selection	The safety of patients treated with blood products	• Gap analysis WBS vs rest of UK complete by start of Q1 2024	• Revised UK screening guidance	• Incident reporting	WBS

and screening processes	relies on careful screening of donors for any infection risks. This can be complex, and mistakes can sometimes occur which means that donated blood is wasted. We will work with the other UK services to review and improve the screening process, taking advantage of digital technology where possible, to reduce the risk of errors and wasted donations.	• Proposal for revised sequence of screening questions submitted to Standing Advisory Committee on Care and Selection of Donors Q2 2024 • Adoption of new Questionnaire Q3 2024	• Development and implementation of revised donor screening processes and procedures. • Reduced safety incidents relating to errors in donor screening practices.	• Clinical and regulatory audit •	
10. Introduction of all Wales foetal D Screening for RhD negative pregnant women.	Currently all RhD negative women in Wales receive anti - D injections when pregnant to prevent health issues. From 2024 we will offer a simple screening test to predict your	• Test platform validated and live by end of May 2024 • First samples processed by and of June (subject to demand)	• Testing platforms operationalised. • Foetal RHD screening undertaken	• Service provision • Evidence of tests being performed	WBS

	baby's blood type – called foetal RhD screening. If a RhD negative woman's unborn baby is predicted to be RhD negative, then no further treatment or tests are needed. This avoids unnecessary anti-D injections without this or future babies being at risk.				
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.	The Welsh Blood Service shares tissue typing information with the national organ donation and transplant (ODT) service. This is currently a slow manual process and errors can happen. By digitally linking our test systems with ODT we can remove the	• software update deployed and validated by end June 2024 • Service go-live by end of September 2024	• System operationalised. • Reduced errors in transcription	• System reporting • Incident reporting	WBS

	risk of errors and speed up the process of matching donors with patients across the UK.				
11. Achieve JACIE accreditation for the WBMDR	The Welsh Bone Marrow Donor Registry provides donated stem cell and bone marrow to patients across the world. We are seeking accreditation by the Foundation for the Accreditation of Cellular Therapies (FACT) and the Joint Accreditation Committee ISCT-Europe & EBMT (JACIE). This globally recognised award confirms that an organisation meets the highest international standards for donated material.	• All documents submitted to JACIE, only awaiting accreditation audit. 1) Audit expected to occur no later than September 2024 but TBC by JACIE. Close out of audit findings and accreditation confirmed within 30 working days of audit date.	JACIE Accreditation in place	• Accreditation documentation • Regulatory audits and inspections	WBS

12. Commencing rollout of live connectivity of the BECS at community-based donation clinics,	The Welsh Blood service travels nationally to locations near the donor, but this means that donor clinics are not connected to our digital systems in real time and donation clinic records have to manually upload at the end of each day. As with any manual process, errors can occur. We will take advantage of the latest generation of mobile networking technology to connect our mobile donation clinics to head office systems. This will reduce the risk of data errors, delays in processing donated blood and wasted donations.	1) A live digital connectivity pilot to be completed with the West Collections team by end Q4 2023/24 2) Pilot Review to be completed by end April 2024. 3) Rollout plan to be published by end Q1 2024/25	• Live connectivity is operationalised. • Reduced transcription errors • Improved donor experience	• Audit • Incident reporting • Donor Experience Surveys	

13. Enablement of DATIX, QPULSE connectivity on community-based clinics for incident, risk and concerns recording at point of contact.	Enablement of DATIX, QPULSE connectivity on community-based clinics for incident, risk and concerns recording at point of contact. This will improve the speed of reporting for concerns, incidents and risks and support timely monitoring of actions.	• A live connectivity pilot to be completed with the West Collections team by end Q4 2023/24 • Pilot Review to be completed by end April 2024. • Rollout plan to be published by end Q1 2024/25	• Live connectivity is operationalised. • Improved incident and concern response times • Improved standard of donor care follow up.	• Audit of incident and concerns reporting processes	WBS
14. Increase in staff psychological safety (target TBC) scores within VUNHST Staff Survey results.	The Trust is committed to ensuring that staff and teams feel empowered to speak up with ideas, questions, concerns, or mistakes to enable a robust and effective safety culture based upon learning and continuous improvement.	• Introduce the speaking up safely framework. • Development and implementation of incident and learning frameworks. • Engagement with staff via the building our futures together programme. • Review of Trust Values • Annual Staff Survey. • Development of triangulated metrics to measure psychological	• Increased staff concerns being raised. • Increased staff suggestions for improvement • Improved staff survey results. • Increased staff innovations.	• Concerns audits and reporting • Number of improvement projects • Staff Survey results	Trust

	Current staff survey responses are low, and results to provide a baseline are currently unavailable.	safety in the organisation. • Develop a mechanism to record and theme staff feedback.			

Equality Impact Assessment:

The requirement to undertake an Equality Impact Assessment (EQIA) forms an integral part of our approach to ensure that our services address the needs of vulnerable groups.

The EQIA complements the overall QIA, focusing as it does, on the way our current services, and any development programmes, are designed and delivered in a way that no patient, donor or member of staff is unintentionally disadvantaged. This means that we have a duty to consider the diverse needs of the individuals they serve, minimising disadvantage and ensuring the inclusion of under-represented groups. Undertaking EQIAs, where appropriate, is a vital step in our planning process for all our key service developments**.**

Developing our Plan – Our Response:

In developing our plan we have ensure that we have considered:

- The Human Rights Act 1998
- The Mental Capacity Act 2005
- Social Services and Wellbeing (Wales) Act 2014
- Well-being of Future Generations (Wales) Act (2015) T
- The Equality Act 2010

Developing our Plan: The Nine Protected Characteristics:

In developing our plan we have considered the impact of our choices on the nine protected characteristics:

Age	Disability	Gender Reassignment
Marriage and Civil Partnership	Pregnancy and Maternity	Race
Religion or Belief	Sex	Sexual Orientation

Delivering Equitable Services to our Patients and Donors:

The Trust has established a range of protocols and procedures to support patients, donors and staff who have extra challenges, as defined by the nine protected characteristics, and to identify areas where we want to improve.

The Trust-wide Vulnerable Groups Forum, chaired by the Head of Safeguarding and Vulnerable Persons, meets quarterly and has developed a Vulnerable Persons Work Plan that includes improvements to the care and support of vulnerable groups of

patients and donors, including those with dementia and learning disabilities. The group links with national work streams including Improvement Cymru.

We re-enforce our understanding of the needs and priorities of vulnerable persons in our community by reaching out and engaging with groups that represent the interests of people with the nine protected characteristics, as defined by the Equality Act 2010 where we have duty to be 'proactive in eliminating unlawful discrimination, advancing equality of opportunity and fostering good relations'.

How our EQIA Approach Supports the Delivery of Equitable Services:

The IMTP gives us the opportunity to promote the approach we will take over the next three years and is outlined below:

- We have undertaken an EQIA to support the development of our IMTP
- We have also used the EQIA methodology to help 'baseline' where we are as a Trust in supporting our patients, donors and staff who may have a range of challenges as defined by the 'nine protected characteristics', and to identify any potential improvements that can be added to the Vulnerable Persons Work Plan
- In addition, we have undertaken research into the demographics of our patient (S.E. Wales) and donor (All Wales) populations, using ONS Census and other sources, to further enhance our appreciation of the proportion of people with protected characteristics plus tapping into some CIVICA data on cancer referrals

Our Strategic Equality Plan – Key Areas of Focus:

The 2010 Equality Act, under our Public Sector Equality Duty, means that we are required to publish a Strategic Equality Plan (SEP) which sets out and justifies equality plan objectives and explains how we will achieve them.

There are 3 overall aims of the Public Sector Equality Duty (PSED), namely to:

1) Eliminate unlawful discrimination, harassment and victimisation (and other conduct prohibited by the Act)
2) Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
3) Foster good relations between people who share a protected characteristic and those who do not.

Our Strategic Equality Objectives:

We have consulted and engaged with patients, staff, partners, equality organisations and other stakeholders in partnership with Wales' Public Body Equality Partnership, and asked them what they thought the equality priorities should be for the Trust.

We have identified what research and information was already available to help in the development of the objectives, and also surveyed patients, staff, partners, equality and third sector organisations and other representative groups to develop the following key objectives.

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

Our action plan to support the delivery of these objectives is available upon request.

Our Vulnerable Persons Work Plan 2024/25 to 2026/27 – Key Areas:

There is a further priority within our plan which focusses on identifying and prioritising a range of actions to ensure that we continue to deliver appropriate support to patients and donors with particular challenges in accessing our cancer and blood services.

In many cases, this will be about putting in place further engagement mechanisms (with representative service user groups) to find out exactly what measures and changes will have the greatest impact.

In Summary we Plan to Focus on the Following Planning Priorities:

1. **Baselining** – Understanding where are against the nine protected characteristics
2. **Demographics** – Reviewing the SE Wales (cancer) and All Wales (blood) population demographics using ONS population statistics and referral patterns
3. **Identify Improvements** – To prioritise areas in the most need of improvement and to develop actions for delivery and improvement
4. **Matching Capacity** – Ensuring that we have sufficient service capacity to deliver our improvement plans from 2025/26 to 2026/27

Part 3

Our Strategic Intent

In this chapter we set out the main strategic priorities for 2024/25 - 2026/27. These include our key programmes of work which we are taking forwards with our service partners and our major infrastructure programmes.

Destination 2033: Developing our Strategy:

Over the last twelve months we have worked closely with our workforce, patients, donors and other key stakeholders to develop our revised Trust strategy. In developing this strategy we considered the following in relation to the services which we deliver as well as the wider requirements across the health and care system.

We serve a growing and ageing population, with a range of local challenges relating to health, ill-health and inequalities, requiring us to better coordinate and join up care.
People's expectations are changing with the reasonable expectation that our services will be personalised to their needs. Our buildings, facilities and green spaces are a vital part of patient, donor and staff experience, are pivotal in improving mental health and well-being and will play an important role in developing thriving and resilient communities.
A Healthier Wales sets out a clear path to move from ill-health to well-being. Reducing the environmental and health impact of our estate is a priority for NHS Wales.
Technology, the Fourth Industrial Revolution, provides healthcare with the opportunity to transform the way we deliver services, increasing the value for patients, donors and our partners in a more sustainable way.
We need to reduce carbon emissions, drive energy efficiency, reduce plastics and waste, improve air quality and use resources more efficiently to move from ill-health to well-being.
The climate emergency and need to develop a sustainable approach to living on the planet; a global challenge we need to respond to.

Our Guiding Principles: The Well-Being of Future Generations Act (2015):

Everything we do will make a contribution to developing:

A Prosperous Wales

A Resilient Wales

A More Equal Wales

A Heathier Wales

A Wales of Cohesive Communities

A Wales of Vibrant Culture and Welsh Language

A Globally Responsible Wales

How we will Work:

Long-term

Integration

Involvement

Collaboration

Partnership

Destination 2033: Our View of the Future:

Our Purpose: To Improve Lives

Our Vision: Excellent Care, Inspirational Learning, Healthier People

Our Trust Values

Our Strategic Goals:

1 – Outstanding for quality, safety and experience

2 – An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

3 – A beacon for research, development and innovation in our stated areas of priority

4 – An established University Trust which provides highly valued knowledge and training for all

5 – A sustainable organisation that plays its part in creating a better future for people

Trust Values

During 2023 / 2024 we have engaged extensively in relation to our Trust values. The outcome of this engagement process has been a refresh of our previous Trust values. Our new Trust values are listed below. These will underpin how we plan all service developments across the Trust.

Caring	Respectful	Accountable
We are always kind, supportive, approachable and show compassion to all.	We seek to understand other people's perspectives. We are always open and transparent.	We always take personal responsibility for what we do and how we do it.

Trust Strategic Objectives

Our Trust strategy identifies a number of objectives which will support us in achieving our strategic goals.

Strategic Goal 1: Outstanding for quality, safety and experience

Our objectives are to:

- Provide harm free care, the best outcomes and a great patient and donor experience
- Listen to, and learn from, patients and donors experiences of our care to drive continuous improvement
- Be an organisation which consistently demonstrates Compassionate Leadership in everything we do
- Be recognised as 'outstanding' by Health Inspectorate Wales, the Medicines and Healthcare Products Regulatory Authority and by UK and international peers for the services we provide

We will achieve these by:

- Implementing the requirements within the Health and Social Care Quality and Engagement Act
- Implementing a quality and safety management framework which will drive every action we take and decision we make
- Delivering the national programme for Compassionate Leadership across the organisation.
- Continuing the development of a quality led culture which drives the highest standards of care and safety and ensures all staff live the ethos that 'the standard you walk past is the standard we set'.

- Getting the basics right by improving access and transport to our services; reducing the need for journeys for care and improving car parking and public transport if you have to visit us
- Continuing to develop an open, transparent, just and learning culture which allows excellence to flourish
- Developing a value based healthcare programme which supports us in reducing unwarranted clinical variation and inefficiencies, using best practice as our benchmark.
- Providing staff with education, training and support to develop improvement skills and knowledge which drive quality and safety standards
- Developing our performance management framework to report our performance on quality, safety and experience in an uncomplicated way to ensure everyone can easily see how we are doing
- Benchmarking the quality, safety and experience of our services nationally and internationally to identify learning and improvement

Strategic Goal 2: A leading provider of clinical services that always meet, and routinely exceed, expectations

Our objectives are to:

- Achieve national and internationally recognised standards of care which keep pace with emerging evidence
- Be a trusted and influential partner across Wales to deliver great local health services which meet need
- Become a 'centre for excellence' and leading provider across the UK for the highly specialist services we deliver
- Become a system leader in our areas of expertise nationally and internationally
- Identify a range of new services that the Trust could deliver to improve quality, experience and outcomes across Wales

We will achieve these by:

- Delivering services which comply with all statutory and professional standards
- Implementing the National Clinical Framework to continuously improve the quality, experience and outcomes of the services we provide
- Implementing our patient/donor/citizen engagement strategy to continuously hear what people need and value from our services
- Co-designing models of care in partnership with people from all parts of the communities with the aim improving access to our services and providing care at home or close to home wherever appropriate and desired
- Working with the community and our partners to reduce inequalities in healthcare
- Rapidly adopting evidence-based research outcomes which improve patient and donors quality, safety and experience of care
- Developing and implementing our clinical and scientific strategies which will set out what services we will deliver over the next ten years; focusing our offer on delivering services that we believe we can truly become leading experts in

- Agreeing with our Local Health Board partners and the Welsh Government the system leadership roles we will undertake to maximise the value we can add for our patients, donors and partners
- Working with the Welsh Government and other partners to plan, fund and deliver world class buildings, facilities and technology for patients, donors and staff
- Benchmarking our performance nationally and internationally to see how we perform against our peers and to identify learning and improvement

Strategic Goal 3: A beacon for research, development and innovation in our stated areas of priority

Our objectives are to:

- Deliver world class research, development and innovation to improve tomorrow's care
- Accelerate the implementation of research and new discoveries to improve our patient's and donors experience and outcomes
- Prioritise research, development and innovation that is clinically relevant and patient and donor centred
- Build a sustainable culture of multi-professional research, development and innovation involving the whole organisation
- Publish and promote research of the highest quality which achieves UK and international recognition

We will achieve these by:

- Implementing the our research, development and innovation strategy across which sets outs a prioritised programme of work in cancer, blood and transplant services
- Giving every donor, patient and carer access to the latest research
- Advancing new treatments, interventions and care by increasing new studies locally, widening access to early phase/solid tumour advanced therapies and integrating novel research into clinical studies
- Building a culture of curiosity where research, development and innovation is an 'Always Event' involving all 1500 employees in the Trust, staff challenge the status quo and make it better
- Increasing the number of lead investigators and clinical academics within the Trust
- Recruiting honorary entrepreneurs and academics whilst also developing entrepreneurs, with a flow of staff between our partner organisations on exchanges to attract and retain world class talent
- Creating a cadre of blended professionals, to promote knowledge exchange with impact on improvements of patient outcomes
- Establishing exciting work programmes with our local health and academic partners at Cardiff University, Cardiff Metropolitan University, Swansea University, University of South Wales and Trinity St. David's University.
- Increasing our research, development and innovation infrastructure to keeps pace with our ambition. This will include:

- Establishing the research hub with Cardiff and Vale University Health Board and Cardiff University
- Providing world class facilities via the Welsh Blood Service Infrastructure Programme; the new Velindre Cancer Centre; Velindre@ research hubs at University Health Board partners; and the Collaborative Centre for Learning and Innovation
- Developing the Library Service into a sustainable Trust wide Evidence Centre

- Generating reinvestment income through partnerships with industry for commercial research, development and innovation

Strategic Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all

Our objectives are to:

- To deliver inspirational teaching which is enhanced and informed by world-class research and professional practice
- Create a supportive and enriching learning environment for all of our learners
- Provide a learning experience that learners rate as excellent
- Be rated as a high quality provider of education and learning nationally and internationally in a number of priority areas
- Raise the profile of the University Trust on a UK and international stage

We will achieve these by:

- Developing a highly quality education and training programme which is aligned to the needs of our local, national and international partners
- Appointing visiting professors and Professors of Practice to the Trust and aligning their work with priority areas of industry and business partners
- Attracting academics with national/international reputations and foster partnerships with leading organisations from around the world in our stated areas of priority
- Equipping all learners to make the best use of physical and digital learning resources and utilise Cardiff as a living classroom
- Increasing our investment in a range of funded strategic initiatives to ensure staff have the time and environment to undertake learning. We will invest additional funds in:
  - Supporting our workforce to undertake MSCs and PhDs
  - Supporting our workforce to take up Fellowships
  - Supporting our workforce to obtain professional, technical and role specific qualifications and accreditations
  - Providing research and learning opportunities for students from our university partners, industry and other sectors
- Developing unique learning opportunities in specialist areas including the Velindre School of Oncology and Welsh Blood Service Modernising Scientific careers programme

- Developing a marketing and communications strategy which attracts learners to our programmes and raises the profile of the Trust
- Identifying a range of partners and collaborators to enhance our offer and brand across the globe

Strategic Goal 5: A sustainable organisation which contributes to a better world for future generations across the globe

Our objectives are to:

- Be recognised as a leading NHS Trust for sustainability nationally
- Be a carbon 'Net Zero' NHS organisation by 2030
- Become an anchor organisation in the communities we serve which enhances their economic, social, environmental and cultural well-being
- Support the transformation from ill-health to well-being across Wales

We will achieve these by:

- Developing clinical service models which support sustainability e.g. more care at home
- Implementing our sustainability strategy
- Applying the principles of the circular economy into our business processes through design, procurement, re-use and lifecycle.
- Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day')
- Implementation of our carbon reduction plan which will see us achieve Net Zero and transition to renewable energy for our services and facilities.
- Investing in a range of refurbishments and new buildings which will support our carbon reduction and healthier buildings and healthier people approach. These include:
  - Major refurbishment of the Welsh Blood Service
  - Construction of a Radiotherapy Satellite Centre at Nevill Hall
  - Construction of a new Velindre Cancer Centre
- Implementing an attractive approach to agile working for our staff which reduces avoidable travel, improves well-being and offers the potential to support money going into local communities
- Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport
- Using our procurement activities and NHS Wales Shared Services capability to drive a sustainable approach and achieve wider ethical and social value in areas including local employment and prosperity; carbon reduction; anti-slavery and unethical practices.
- Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and

apprenticeships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Governments Foundational economy

Delivering our strategy will support us in:

- Delivering excellence in our core clinical services
- Placing quality and safety at the centre of everything we do
- Developing our clinical, scientific and healthcare professional leadership
- Becoming world leaders in specific areas of research, development and innovation
- Expanding our culture of learning across staff, students and the communities we work with
- Delivering carbon net zero operations and wider benefits and social value for our communities
- Moving towards a future which will see us becoming a valued partner in the prevention, public health and wider social policy areas; helping to find solutions to deep-seated problems in Wales such as poverty and deprivation

To support the delivery of our strategic goals also have Trust Board approved strategies for both the Welsh Blood Service Strategy the Velindre Cancer Service.

These are supported by a range of other services (see part 6 for of our plan for additional information) who have also developed 5 year strategies:

- Research Development and Innovation
- Digital
- Workforce and Organisational Development
- Estates and Sustainability

Our strategic plans provides the Trust with a clear line of sight and the ‘golden thread’ between our Purpose, Vision, Strategic Goals and the priorities contained within our Integrated Medium Term Plan. This has enabled us to effectively prioritise our activities and resources over the coming years as summarised below.

Our service and enabling plans outlined within this IMTP outline the specific actions we will take to deliver these organisational priorities.

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 primary health partners are set out below:

Organisation	Relationship
Aneurin Bevan University Health Board	Commissioner
Betsi Cadwaladr University Health Board	Commissioner
Cardiff and Vale University Health Board	Commissioner
Cwm Taf Morgannwg University Health Board	Commissioner
Hywel Dda University Health Board	Commissioner
Powys University Health Board	Commissioner
Swansea Bay University Health Board	Commissioner
Welsh Ambulance Service NHS Trust	Provider
Public Health Wales NHS Trust	Provider
Health Education and Improvement Wales	Provider
NHS Wales Shared Services Partnership	Provider of services
Digital Healthcare Wales (DHCW)	Provider of services
Welsh Health Specialist Services Committee	Specialist Commissioner

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our Local Health Board partners to ensure that our key strategies are aligned, that there are a clear set of shared priorities and to ensure that we can provide sufficient capacity and capability to deliver commissioned services of the highest quality.

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.

Our focus during this period will be on:

Delivering the Fundamental Cornerstones of Healthcare Provision:

These include:

- Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework and the National Clinical Framework to provide services of the highest possible quality
- Delivering services that meet the national clinical quality and safety standards and provide an excellent experience
- Treating patients as quickly as possible
- Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales
- Developing agile and flexible capacity plans which allow us to respond quickly to changes in demand for our services
- Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past three years
- Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working

Improving Population Outcomes and Reducing Inequalities:

We will continue to work with our Local Health Board and wider partners to identify opportunities where we can support the improvement of public health and population outcomes through primary and primary and secondary prevention. This will focus on a number of areas:

- Improving access to our services to increase uptake and reduce inequalities and ill-health
- Strengthening our decision-making 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

Regional Working, Partnerships and Collaboration to Improve Outcomes

We will:

- 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

Delivery of Transformation Programmes

Non-surgical Tertiary Oncology Services:

We will progress a number of key areas of work:

- 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

Development of the infrastructure to support regional cancer services including:

- 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:

We will progress a number of key areas of work within blood and transplant services including:

- Laboratory Modernisation programme:
  - Refurbishment of the Talbot Green facility by 2027
- Plasma for Fractionation: developing the case for change and delivery of the Programme

Part 4

Translating our priorities into high quality services

We summarise our service delivery framework for Strategic Trust Programmes

Our Strategic Delivery Framework

Our strategic delivery framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation.

Trust Purpose and Vision

Trust Strategic Goals in line with:

- Our agreed strategic priorities
- Our key organisational strategic risks
- Our statutory requirements

Velindre Cancer Service Strategy: Objectives and Priorities

Welsh Blood Service Strategy: Objectives and Priorities

Service Plans for the Welsh Blood Service and the Velindre Cancer Service

Support Functions Strategies and Plans e.g. Digital Services

Velindre University NHS Trust IMTP: 2024 - 2027

Business and Usual and Transformation Programmes used as Delivery Mechanisms:

Velindre Cancer Service:
Velindre Futures Programme

Welsh Blood and Transplant Service:
Welsh Blood Service Futures Programme

Improved Outcomes and Benefits

Building our Future Together

To support the implementation of our Trust Strategy ('*Destination 2033'*) we have developed an organisational development approach which is designed to identify and develop the leadership, culture, behaviours, processes and systems that we want to be.

The driver being a consideration of the type of organisation we need to be to deliver our purpose and our vision and how we listen and respond to what our own staff and leadership teams have been saying through survey and other engagement mechanisms over the last two years.

To enable us to move forward within the current context, deliver our ambitions and take account of what our people say about working in our Trust we recognise that we need to make changes across our systems in a way that takes account of how people work and interact with each other.

To achieve this we must continue to take a considered and planned approach to effect change across a number of inter-related elements and therefore an organisational development approach will be applied.

Our response has been the development of our *'Building our Future Together'* Programme.

Aims and Objectives

- Ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as its golden thread
- Provide a way of working and shape to the organisation which enables us to maintain focus
- Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future
- Draw together our organisational developments with a common sense of purpose
- Improve our effectiveness, efficiency and value based approach
- Develop the mechanisms which enable us to prioritise where and when we focus our efforts
- Provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition
- Support realistic, authentic and compassionate leadership

These aims will be realised under the following inter-related areas of work which will re-assessed in 24/25 to ensure that together they provide the mechanisms that 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

Part 5

Our Service Delivery Plans

Our Velindre Cancer Centre and Welsh Blood and Transplant Service delivery plans for 2024 to 2027

Our clinical services

Cancer Services Non-Surgical Tertiary Oncology

A key focus for us from 2024/25 – 2026/27 will be the implementation of our enhanced regional clinical model and the successful delivery of our new infrastructure programmes. We want to ensure that, in all areas, we are consistently working in ways which result in the best possible outcomes for our patients. We will do this by continuing to empower our teams to design the best possible processes and pathways and to lead change. The input of our patients, their families and our partners across south-east Wales will be key to this process.

The ambitious programme of change we are taking forward includes major undertakings such as work to support the new Velindre Cancer Centre (nVCC) development and the delivery of the Integrated Radiotherapy Solution (IRS) programme. We are committed to delivering initiatives which will improve the support provided to our patients across the entirety of their care pathways. This will include significant proactive change in service provision in outpatients, SACT, and radiotherapy as well as plans to further develop our active engagement and support to primary care, palliative care and therapies. This list is not exhaustive.

All of this will happen against a background of growing demand for cancer services and in an environment characterised by ever increasing complexity. New systemic therapies are presenting new treatment options and changing the way in which patient experience cancer treatment. Such advances are undeniably positive but, they do present the healthcare system with certain challenges. We need to optimise our horizon scanning and to cooperate with partners in a proactive way to ensure that we are able to anticipate, to manage and to maximise the impact of these exciting developments. In responding to demand, we have always sought to innovate. Changes such as the introduction of virtual consultation methods, the extension of SACT delivery with additional service through the mobile unit with Tenovus, and the expansion of the SACT homecare service are all adaptations which will need to be maintained and optimised in the medium term. The expansion of outreach services to service the requirements of patients across south-east Wales, ahead of our transition to a new Velindre Cancer Centre, is an important part of our service plan and will help us manage the impacts of growing demand.

The leadership and co-ordination of this work through the *Velindre Futures* programme will continue. The delivery of the Velindre Cancer Service contribution to key regional programmes e.g. the Acute Oncology Service, the continued delivery of the Nuffield Recommendations and the implementation of outreach service improvements are all activities which will form part of the *Velindre Futures* agenda. These arrangements will

promote a truly coherent approach and ensure that all the initiatives we are progressing are properly linked to wider service modernisation and transformation projects.

We have also entered the implementation phase of the Integrated Radiotherapy Solution (IRS). This constitutes a further key work programme which underpins the ongoing delivery of sustainable radiotherapy services as well as enabling the new Radiotherapy Satellite Centre at Nevill Hall Hospital.

Together these changes constitute an agenda of unprecedented change for Velindre Cancer Services. This agenda will be progressed alongside plans to repatriate services back to local heath boards, where appropriate, following a period when centralised delivery at the Velindre Cancer Centre in response to the COVID-19 pandemic was operationally necessary.

The delivery of our plan for 2024/25 – 2026/27 will depend on effective partnership working with our local health board partners.

Our Priorities for 2024/25-2026/27

The Velindre Cancer Services Strategy '*Shaping our Future Together*' sets out our strategic priorities.

Strategic Priority 1:	**Equitable and consistent care, no matter where; meeting increasing demand.**
Strategic Priority 2:	**Access to state-of-the-art, world-class, evidence-based treatments**
Strategic Priority 3:	**Improving care and support for patients to live well through and beyond cancer**
Strategic Priority 4:	**To be an international leader in research, development, innovation and education**
Strategic Priority 5:	**To work in partnership with stakeholders to improve prevention and early detection of cancer.**

Alongside the range of major service transformation initiatives we plan to deliver, the sustainable delivery of patient services and the provision of sufficient capacity continues to be our primary focus. Our capacity challenge will not only be in the delivery of treatment by SACT and radiotherapy but, also in the case of other services which support patient care including radiology, therapies, pharmacy and palliative care.

Responding to these challenges will require the delivery of outpatient and SACT services at local hospital sites in collaboration with health boards as well as expanding capacity across our full range of services at the cancer centre. This will allow us to plan to meet expected levels of demand and ensure equitable access to our services for patients living right across south-east Wales.

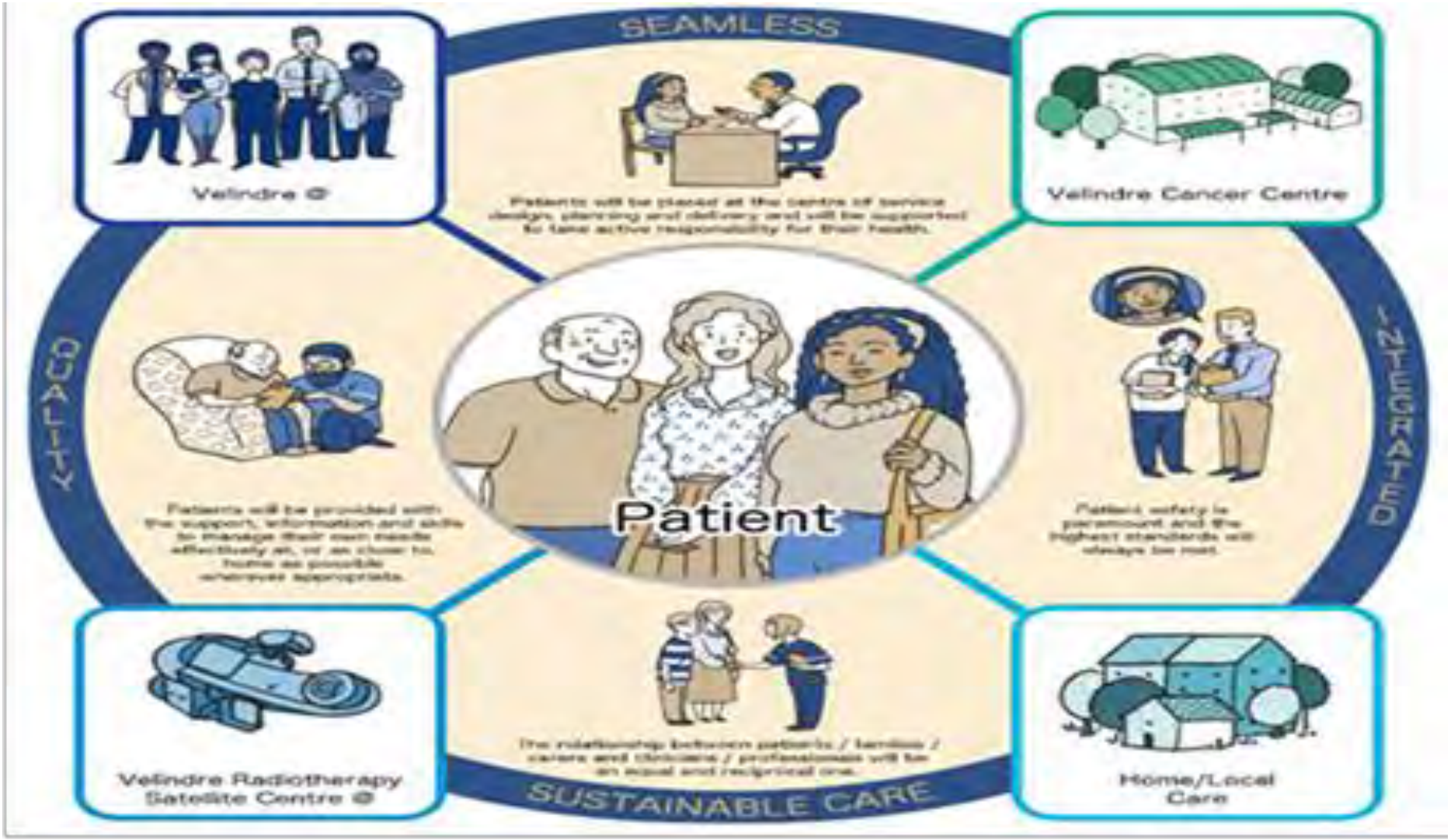
Velindre Futures is the vehicle which will deliver the changes we need to realise in order to successfully meet our ambitions including the VCS element of the regional work and the implementation phases of the TCS programme. Established in 2020, Velindre Futures is a clinically led initiative that directs the development of the clinical model and future service configuration, working in partnership and collaboration with staff, patients and carers and the public. It will ensure that the Cancer Centre systems and processes remain fit for purpose and patient centred, now and in the future. It will also enable the VCS aspects of regional collaborative working.

Through 2024 and beyond, the *Velindre Futures* work programme will ensure the delivery of the key recommendations identified alongside the existing service changes planned.

This is an ambitious programme of work that will be prioritised and delivered through 2024/25 – 2026/27 as we continue to focus on increasing capacity to manage demand increases.

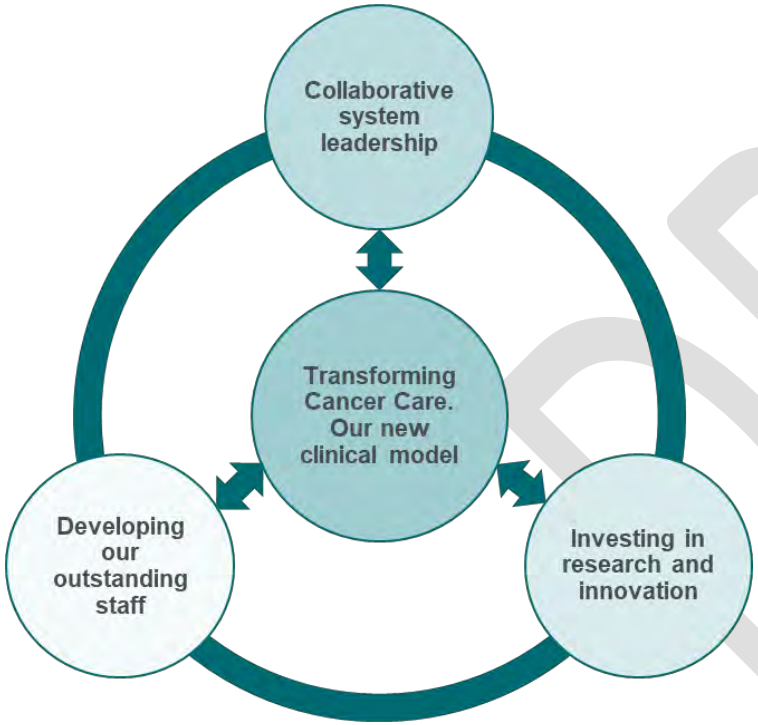
Core to service change is ensuring that the voice of the patient, their carers, families and the public are involved in shaping what we do. To enable this, a new framework for engaging with patients and the public will be developed to draw on best practice and set our expectations and ideas**.**

Our Clinical Model



Our Approach

The four areas of focus within our *Velindre Futures* and Transforming Cancer Services programme will allow us to realise our vision. These are deliverable within an overall environment of maintaining our excellent quality, operational and financial performance, which also encourages us to be enterprising.



Responding to more people living longer with cancer: an improved model of care:

- An improved model of care: at home or local where possible, centralised where necessary, and based around delivering equitable access to high quality care and research.
- A new state-of-the-art cancer centre in Cardiff networked across South Wales delivering acute oncology services and research centres of excellence.
- A Radiotherapy Satellite Centre in Nevill Hall and chemotherapy in a variety of outreach locations across south-east Wales.
- Delivery of outreach services in V@ facilities in Local Health Boards.
- Complete digital transformation through our 'connecting for the future' programme.

Collaborative System Leadership:

- Play a lead role in the development of a system wide approach to cancer services in the region through the Cancer Collaborative Leadership Group.
- Continue to lead and contribute to key areas of care and research, including through embedding our new clinical model, both nationally and internationally.
- Support the development of the diagnostic network and single cancer pathway as key enablers of service transformation.
- Support the development of integrated health and social care and research models across south Wales/Wales.

Investing in research and innovation:

- Increase participation in clinical trials, Velindre sponsored studies, and become renowned for qualitative research.
- Developing a research network across south-east Wales with our LHB and University partners.
- Lead the research and innovation agenda through taking an active leadership role in partnership with universities, commercial partners and the Research Network.
- Increase our opportunities to be at the forefront of innovation.

Developing our outstanding staff:

- Developing our clinical, scientific, nursing and allied health professional leadership capability
- A consistent approach to quality improvement through the Quality and Safety Framework.
- Developing a comprehensive approach to Education and Training.
- A focus on engaging and empowering staff.
- New workforce skills and leadership development to meet our workforce challenges.

Velindre Cancer Centre: How we will Meet Our Challenges

The Challenge…	We will meet this by…
Cancer Incidence is Increasing	✓ Expanding our role in the early diagnosis of cancer ✓ Promoting effective public health messages – making every contact count
There Continues to be Variation in Outcomes Throughout Wales	✓ Delivering more services of consistent quality in outreach settings closer to patients' homes ✓ Delivering a Radiotherapy satellite centre, in collaboration with Aneurin Bevan University Health Board ✓ Leading on the standardisation of Acute Oncology Services across and the development of a Cancer of the Unknown Primary service across SE Wales
There is a Gap Between Forecast Demand and Supply Which We Need to Close	✓ Continuing to implement techniques which are resource neutral or that deliver efficiencies elsewhere in the process ✓ Developing a robust, flexible, highly skilled and responsive workforce ✓ Rationalising treatment pathways and identifying efficiencies
Treatments are Becoming More Complex and New Advances are Continuously Emerging	✓ Ensuring, in collaboration with health board partners, that sufficient linear accelerator capacity is available to accommodate new techniques ✓ Effective horizon scanning
More People are Living With and Beyond Cancer	✓ Ensuring timely access to robust, high quality Clinical Psychology and Therapies services

Our priorities for 2024/25 – 2026/27
We have identified a range of key deliverables:

Strategic Priority 1: To meet increasing demand

- Reduce patient backlog and waiting times
- Support improved compliance with the Suspected Cancer Pathway
- Delivery of clinical audit programme
- Deliver quality improvements in brachytherapy service
- Delivery of quality and safety requirements and Healthcare Associated Infections/Infection Prevention Control Requirements
- Delivery of next phase of Velindre Futures / TCS Programme:
    - Implementation of unscheduled care pathways
    - Implementation of regional acute oncology service model
    - Implementation of V@UHW Research hub
    - Agreement of V@ CTM and AB service model and phased implementation
- Development of sustainable workforce model and agreement for funding with LHB to support transition to improved clinical model and stepped change in capacity

Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments

- Identify and secure additional capacity to deliver radiotherapy and SACT requirements
- Deliver infrastructure phase of TCS Programme:
    - Support the opening of the radiotherapy satellite centre in Nevill Hall
    - Make a second new linear accelerator available for clinical use at Velindre Cancer Centre.
    - Identification of outreach requirements in LHB models/facilities

Strategic Priority 3: Improving care and support for patients to live well through and beyond cancer

- Enhance our assessment unit to improve access and support for patients with acute needs
- Increase the range of holistic therapies available to patients during/following their treatment
- Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners
- Patient self-management programmes
- End of life/palliative care

Strategic Priority 4: To be an international leader in research, development, innovation and education

- Implementation of Research and Development strategy
- Implementation of V@UHW Research hub
- Progress a range of strategic partnerships to take innovation to market

Strategic Priority 5: To work in partnership with stakeholders to improve prevention and early detection of cancer

- Deliver our secondary prevention programme to support patients in improving their health and well-being
- Deliver our Macmillan primary care programme to support improved detection and diagnosis of cancer

Forecasting Demand and Capacity to Deliver Services

Demand for cancer services is driven by the need to deliver care for patients newly diagnosed with cancer but, also by the requirement to make available new cycles of treatment to existing patients, e.g. patients with metastatic disease who are prescribed further cycles of therapy. Demand is also influenced by the availability of new treatment regimens, i.e. newly approved treatment agents, such as certain immunotherapies and targeted treatments, which are presenting entirely new treatment options or are influencing dramatic changes to treatment pathways.

Demand for non-surgical cancer services at VCS has been increasing steadily in recent years. The demand forecast for 2024/25 is informed by data derived from a major exercise we have led in conjunction with our health board partners, the Wales Cancer Network, Improvement Cymru and the NHS Executive's Delivery Unit.

The demand modelling initially focused on historic flows of patients from primary care to diagnosis and on to treatment. This approach was used to develop a predictive model which could forecast external demand driven by new patient referrals. We have used this model to quantify capacity requirements for 2024/25 and beyond. We will continue to use this model to review demand in the future.

The table below provides a summary of the planning assumptions that underpin the capacity and delivery plan for 2024/25:

Forecast Growth in Demand for our Services in 2024/25

Service	2024/25
Radiotherapy	6%
Nuclear Medicine	2%
Radiology Imaging	10%
Preparation and Delivery for Systematic Anti-Cancer Therapy	10%
Ambulatory Care Services	2%
Outpatient Services	10%
Inpatient Admitted Care	2%

To accommodate the forecast increases in demand for anticipated in 2024/25 will require changes to clinical practice and service delivery. The increased utilisation of virtual outpatient attendances, the mix of oral and IV infusion SACT delivery, the expanded use of hypofractionation in administering radiotherapy treatments to certain patient groups and the delivery of patient care in outreach settings will all need to be explored. This work is ongoing alongside activity to identify efficiencies and developments across all treatment pathways.

Systemic Anti-Cancer Therapy (SACT)

Demand for SACT is driven not only by new patient referrals but, by the requirement to offer on-going treatments to patients undergoing subsequent cycles of care. This is increasingly prevalent because there more treatment options, patients are living longer and receiving intermittent SACT regimens and because of the increasing use of 'maintenance' regimens.

There is a direct impact of the increasing demand on SACT which is seen in Out-patients and by the Ambulatory Support Unit where treatment related toxicities are assessed and managed.

External Beam Radiotherapy

The development and improvement of radiotherapy treatment pathways to meet revised treatment start targets will continue. This activity represents a key constituent of the pathway improvement programme included in our plan for 2024/25 – 2026/27.

Outpatient Services

The forecast increase in demand for Outpatient services presents a significant challenge. We have therefore developed plans from 2024/25 – 2026/27 to transform and improve our patient pathways. This will ensure that we have sufficient capacity to meet demand.

Key Programmes of Work 2024 – 2025

The initiatives listed below include a wide range of projects which will help us deliver our over-arching ambition. However, alongside these, there is also an extensive programme of ongoing "business as usual" measures which includes the planned replacement of equipment and digital system upgrades.

Meeting Demand

Sustaining and building capacity in all areas of the service to meet the anticipated demand and to enable us to consult with and treat people in a timely manner and in accordance with the appropriate professional standards of care.

Velindre Futures

- Continue to deliver service change in each of the directorate service areas; Medical, SACT and Medicines Management, Radiation Services, Integrated Care, Operational Services including Outpatients.
- Primary Care Oncology – exploring where we can provide additional support for primary care and work in partnership with primary care colleagues to strengthen patient pathways and Care Closer to Home.
- Working to meet the Suspected Cancer Pathway and improved compliance with the new time-to-treatment Quality Performance Indicators (QPIs) in radiotherapy.
- Palliative care – reviewing the service requirements and ongoing service developments aligned with the End of Life Care Board programme, ensuring the ability to meet the internal demand for specialist palliative care services, implementing and embedding Advance Care Planning at the Cancer Centre. For instance, embed electronic Advance and Future Care Planning patient records into healthcare records in patients with palliative care needs.
- Supporting delivery of the pharmacy Transforming Access to Medicines (TrAMS) programme.
- Patient support services development which includes the realisation of improvements to the SACT treatment patient helpline.
- Increase the range of therapies available to patients during/following their treatment – including pre-habilitation.
- Outpatient transformation programme – working to modernise the outpatient model of care delivery, including implementing 'supported self-management' for cancer patients with a Values Based Health Care approach (rather than the traditional outpatient model of '*follow up*').
- Supporting specific treatment developments identified by SSTs as priorities. These will be delivered through external negotiations e.g. commissioning, and internal programmes of work to tackle gaps in service, access to trials, pathway reviews, etc.

Specific Major Projects

- Preparing for a paperless environment – defining the wider project structure and embedding and optimising the Welsh Patient Administration System (WPAS) and the Welsh Clinical Portal (WCP) in all service areas.
- The joint delivery, with Aneurin Bevin University Health Board, of a Radiotherapy Satellite Centre at Nevill Hall Hospital. This includes implementation of the operating model for the Centre and the commissioning of new Radiotherapy equipment.
- The implementation of the Integrated Radiotherapy Solution (IRS). This includes the commissioning of new linear accelerators at the Velindre Cancer Centre and the commissioning of linear accelerators and other equipment at the Radiotherapy Satellite Centre.
- The delivery and transition to a new Velindre Cancer Centre.

Supporting Projects

- Digital enablement of all *Velindre Future* projects.
- Patient Engagement: establishing the new ways of working to enable delivery of the aspirations in the new patient framework.
- Workforce for the Future: further modernise our workforce model to ensure we have all staff operating at the top of their licence and make the most of advanced practice and consultant roles.
- Working with HEIW and the Wales Cancer Network to ensure that Velindre has a workforce which is '*fit for the future*' with new roles, succession planning and the upskilling of staff through development programmes.
- The Value Intelligence Centre will lead the procurement of a digital PROMs platform in 2024/25 and support the design, development and delivery of Patient Reported Outcome Measures (PROMs) across 2-3 Site Specific Teams (SSTs) with the intention to roll out more broadly over the 3 year plan.

Velindre Cancer Service Plan 2024/25 – 2026/27

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)**	• 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.	• Project close and Radiotherapy Satellite Unit to 'go-live'.		% Patients beginning scheduled radiotherapy within 21 days (Target 100%) % Patients beginning urgent unscheduled radiotherapy within 7 days (Target 100%) Patient satisfaction (PREMS) Patient Outcomes (PROMS)
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Integrated Radiotherapy Solution**	• Improved patient outcomes	• Second new linear accelerator commissioned	•Implementation of InSightive radiotherapy analytics tool.	• Third new linear accelerator and associated		• Progress phase 3 objectives.	• Project close.	Improved patient outcomes on a PROMS

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
	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	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.	• 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.				dashboard by Q4 2024/25 as a result of reduced downtime, improved efficiency, increased in throughput and increased flexibility by which to manage tumour specific cases
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Outreach Programme by 2025-26**	• Increase care close to home. • Improved access. • Improved equity.	• Engage with health boards, agree intention and principles.	• Define model for delivery of care on outreach contexts.		• Develop workforce model.	• Project complete.		% of Patients treated by local health boards

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Improved patient experience. • Reduction in carbon emissions.	• Establish programme board.						% of Patients treated at VCS. Average patient travel time. Patient satisfaction (PREMS). Patient outcomes (PROMS).
Trust Strategic Goals 1, 2, 4 and 5	**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 radiopharmacy delivery model. • Review governance structure in the context of interim requirements and contingency planning	• 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.		• Develop contingency plan to address scenario in which national implementation of the TrAMs model is delayed beyond the opening of nVCC.		Alignment with national quality metrics

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
			pending delivery of TrAMs model. • Secure interim support pending delivery of TrAMs. • Identify resource to support clinical and scientific infrastructure for national programme.						
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. • Improved patient experience. • Reduction in carbon footprint.	• Regional service co-ordinator recruited and in post. • Project board re-established and revised governance structure defined. • Undertake benchmarking exercise to facilitate assessment of	• Develop proposal for OS network structure and implementation.	• Develop work plan to enable delivery of remaining project objectives aligned to Wales Cancer Network service specification. • AOS network board and supporting infrastructure in place.	• Undertake review of data requirements. • Undertake review of existing policies and standard operating procedures (SOPs). Develop shared policies and SOPs, where appropriate.			Avoidable inpatient admissions Patient satisfaction (PREMS) Patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
			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.		• Data sharing agreements and memoranda of understanding (MOUs) in place.				
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).	• Procure system following approval of Full Business Case (FBC) by Welsh Government. • Undertake recruitment to	• Commence system implementation following approval of FBC and subsequent award of contract.	• Continue implementation of system.		• Project close following successful implementation.		Alignment with national quality metrics.

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Improved levels of efficiency and productivity. • Reduction in carbon emissions.	externally funded posts required to support implementation.						
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 maximise with new system.	• Full implementation of electronic test requesting.		• Project close following successful implementation.		Patient satisfaction (PREMS) Patient outcomes (PROMS) Improved compliance with time-to-treatment targets across all treatment modalities

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Improved patient satisfaction.							
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 solution and call centre.	• Develop plans to support the transition to the nVCC site and for dual-site running for all clinical and operational services.			• Develop plan to facilitate transition of brachytherapy service to nVCC. • Develop interim business case for radiotherapy as part of contingency planning to address potential delays to wider infrastructure project to include commissioning a fourth linear accelerator, outsourcing,	• Deploy workforce plan for operational and facilities services. Draw down identified funding from FBC to enable recruitment to necessary posts.	Patient satisfaction (PREMS) Patient outcomes (PROMS) % Staff satisfaction % Staff sickness (Note: a comprehensive list of benefits and KPIs are included within the Full Business Case)

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
							7-day working, etc..		
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.					Patient satisfaction (PREMS) Patient outcomes (PROMS) Reduction in inappropriate inpatient admissions
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.			• Full programme implemented. • Undertake post-implementation programme review.		Patient satisfaction (PREMS) Patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
			service development.						
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25**	• Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety. • Improved productivity and efficiency levels. • Reduction in avoidable admissions. • Improved patient satisfaction.	• Identify and secure consistent funding to support service delivery. • Develop business case.						Reduction in inappropriate inpatient admissions Patient satisfaction (PREMS) Patient outcomes (PROMS)
Trust Strategic Goals 1 and 2	**Implement Changes to the Nursing Workforce Which Ensure Compliance with Regulatory Requirements and Supports Delivery of**	• Improved patient outcomes. • Improved quality of care. • Improved patient safety. • Improved patient satisfaction.	• Develop business cases to secure funding to support nursing workforce innovations and developments.	•Implementation of recommendations of Cancer Nurse Specialist (CNS) review. • Undertake evaluation of	• Develop Practice Educator role to facilitate person centred care. • Define and implement Model for Clinical	• Evaluate requirement for nursing support in radiotherapy.			Improved patient satisfaction (PREMS) Improved patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
	Clinical and Scientific Strategy	• Reduction in avoidable admissions.		the CNS Navigator role and implement recommendations. • Introduce Advanced Clinical Practitioner Framework.	Supervision (CNO Mandate).				Improved workforce satisfaction and staff retention levels.
	Ensure the Viability of the Neuro-Oncology Service	• Improved patient outcomes. • Improved quality of care. • Improved patient safety. • Improved patient satisfaction. • Reduction in avoidable admissions.	• Develop business case and secure funding to maintain service.						Improved patient outcomes (PROMS) Improved patient satisfaction (PREMS)
Trust Strategic Goals 1, 2, 4 and 5	**Undertake Evaluation of SACT Service (to Include SACT Nursing, SACT Bookings and**	• Improved quality. • Improved patient safety. • Reduced waiting times.	• Service delivery manager recruited and in post.	• Baseline assessment complete of SACT service. Service delivery plan developed.	• Alignment of SACT booking processes with wider booking processes.				% Patients Beginning Non-Emergency SACT within 21 days

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
	SACT Prepping). Define Recommendations, Develop and Deliver Improvement Plan	• Improved levels of efficiency and productivity. • Reduced costs. • Improved patient experience.		• Undertake review of booking processes and identify nature and level of Business Intelligence support required to minimise clinical risk.	• Complete SACT demand profiling exercise.				% Patients Beginning Emergency SACT within 5 days
Trust Strategic Goals 1 and 2	**Implement Recommendations from Peer Review of SACT Treatment Helpline**	• Improved quality. • Improved patient safety. • Improved access. • Improved clinical outcomes. • Reduced waiting times. • Improved patient experience.	• Receive and prepare response to peer review and determine plan for implementation (further details to be developed following the receipt of the review).						Patient satisfaction (PREMS) Improved patient outcomes (PROMS)
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.	• Development of costed business case to support service expansion.	• 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			% Face-to-face outpatient appointments % Virtual appointments

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Increased patient experience / satisfaction.	• Identify appropriate funding stream to support provision in the longer term.			delivery model.			Patient satisfaction (PREMS)
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. • Enhanced organisational reputation for quality of service.	• Progress the phased implementation of new Peptide Receptor Radionuclide Therapy (PRRT) service from quarter 1 (dependent upon WHSSC undertaking to commission service and availability of discretionary capital to facilitate procurement of equipment). • Undertake recruitment of additional workforce to support full implementation	• 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.		• Determine resource implications of the introduction of new Molecular Radiotherapy treatments at VCS in anticipation of NICE approval. • Actively engage with commissioners.		Improved patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
			of new PRRT service.						
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 Innovative Diagnostic and Therapeutic Clinical Services with Ionising Radiation Sources**	• 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.			Maintained compliance with established Service Level Agreements (SLAs).
	Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	• Develop and deploy operational delivery plan for pharmacy which responds to previously	• Complete development of new strategy for the pharmacy service.					% Patients Beginning Non-Emergency SACT within 21 days

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
	Transformation Programme		undertaken external service reviews.						% Patients Beginning Emergency SACT within 5 days
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.	• Complete operational implementation of upgrade.				% Patients Beginning Non-Emergency SACT within 21 days % Patients Beginning Emergency SACT within 5 days
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	• Implementation of clinical decision-making framework to support wider service delivery. • Embed clinical and scientific strategy.	• Site-Specific Team (SST) activity and performance dashboard.				Improved patient satisfaction (PREMS) Improved patient outcomes (PROMS) Improved workforce satisfaction and staff

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
			new deputy Clinical Director.						retention levels.
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.				Patient satisfaction (PREMS) Reduction in Did Not Attend (DNAs) % Emergency Radiotherapy Patients Treated within 1 and 2 days.
Trust Strategic Goals 1, 2 and 4	**Implement Pathway Improvement Programme**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes.	• Develop and deploy plan to improve capacity and flow in the Outpatients department. • Develop implementation plan for replacement video consultation solution.	• Identify services which might be repatriated to local health board contexts. • Introduce interim process for managing electronic referrals. • Introduce revised appointment	• 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.	• Undertake evaluation of new models.		% Elective Radiotherapy Patients treated within 14 and 21 Days % Urgent Scheduled Radiotherapy Patients treated within 2 and 7 Days

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Improved patient experience.	• Actively engage in video consultation solution design dialogue facilitated by Tech Cymru.	booking Standard Operating Procedures (SOPs). • Introduce revised telephone standards (to include appropriate consideration of the Welsh 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					% Emergency Radiotherapy Patients treated within 1 Day Patient outcomes (PROMS) % Face-to-face outpatient appointments % Virtual appointments Reduced wait for 1st outpatient appointment to ensure earlier access to treatment and improved outcomes. Ratio of face-to-face to

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
				replacement video consultation solution.					virtual appointments
Trust Strategic Goals 1, 2 and 5	**Undertake Digitisation of Medical Records**	• Improved patient safety • Improved access to information (for sharing / decision-making) • Improved levels of efficiency/productivity • Reduced carbon emissions					• Establish project group. • Identify service improvements / opportunities for change. • Identify additional resource requirements. • Undertake options appraisal. • Develop supporting business case(s). • Initiate phased delivery of the project.	• Undertake post-project evaluation	Patient outcomes (PROMS)

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
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.				Develop solutions for, develop service model for delivery of, identify resource implications and develop business cases to secure funding, where appropriate, to facilitate: • Implementation of new Internal Mammary Node (IMN) service, axillary radiotherapy service and partial breast radiotherapy service		Patient outcomes (PROMS) Patient outcomes (PREMS) % Scheduled Radiotherapy Patients treated within 14 and 21 Days % Urgent Scheduled Radiotherapy Patients treated within 2 and 7 Days % Emergency Radiotherapy Patients treated within 1 Day

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
							• Implementation no new extreme hypofractionation for prostate / SABR prostate service. • Implement SABR treatments for new indications. • Expansion of stereotactic radiosurgery (SRS) service. • Palliative radiotherapy service.		
Trust Strategic Goals 1 and 2	**Implement DHCR Phase 2 by 2024/25**	• Improved quality. • Improved patient safety.	• Review learning from phase 1 to support implementation	• Clarify scope and service delivery requirements.	• Develop work plan to support implementation.				DHCR phase 2 implemented

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Increased levels of efficiency and productivity.	of further phases. • Establish revised governance, reporting and delivery structure for VCS agreed scope and prioritisation of VCS-specific elements for phase 2.						
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.						Improved compliance with national and / or industry standards
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 recommendations of CCTV audit.						Improved compliance with national and / or industry standards

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
			• Develop and deploy remedial action plan to address recommendations of e-mail audit. • Develop and deploy remedial action plan to address recommendations 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.					• Phased implementation work to commence (initial proposals aligned to nVCC Full Business Case agreed).		Patient outcomes (PROMS) % Utilisation of Facility Number of attendees ton education and training programmes

IMTP Strategic Priorities Velindre Cancer Services 2024 to 2027									
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Actions and 2024/27 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Physical space to support innovation and development working across the region/Wales/wider.							

Blood and Transplant Services

The Welsh Blood Service (WBS) is an operating division of Velindre University NHS Trust collecting voluntary, non-remunerated whole blood and blood component donations from the general public and providing advice and guidance regarding appropriate blood component use in Health Boards throughout Wales. Donations are processed and tested at the laboratories based in WBS headquarters in Talbot Green, Llantrisant, before distribution to 17 customer hospitals throughout Wales. We have a Stock Holding Unit (SHU) and staff base in Wrexham, north Wales and also have staff based in Bangor, north Wales and Dafen, west Wales. The WBS laboratory services also include antenatal patient testing and a reference centre for complex immuno-haematology investigations.

We support the solid organ and stem cell transplant programmes that run out of Cardiff and Vale University Health Board and manage the Welsh Bone Marrow Donor Registry, which provides stem cell products nationally and internationally. We also provide the UK National External Quality Assurance Scheme for Histocompatibility and Immuno-genetics (NEQAS) an international quality assessment service.

In addition, we hold a wholesaling dealers licence to supply medicinal blood products to our customer hospitals.

The service models are supported by strong Research, Development and Innovation derived from within WBS and working closely with other Blood Services across the home nations and globally. Investing our time in supporting and facilitating Research, Development and Innovation is fundamental in ensuring we remain a leading service within the fields of blood component, transplant, and transfusion services.

We are committed to ensuring the services we provide meet the high expectations required by patients, donors, staff and partner organisations across health, academia and industry. Our services must be high quality, clinically safe, effective and underpinned by a strong evidence-base.

Strong clinical and scientific leadership and governance helps to ensure that the quality of our service remains at the forefront of our decision-making. This assurance is maintained through our commitment to ensuring the services we provide meet the high standards of our regulators and auditors, such as the Medicines and Healthcare Regulatory Agency (MHRA), Human Tissue Authority (HTA), UK Accreditation Services (UKAS) and the Health and Safety Executive (HSE).

The delivery of our blood, transfusion and transplantation services requires us to work in partnership and collaboration with colleagues within our corporate and support functions:

- The modernisation of our digital services is fundamental to the provision of modern services that minimise unnecessary work, maximise efficiency and support clinical safety.
- Data from our Data & Insight Service is used to support planning of our service delivery and development and provides a means of monitoring performance and measuring our success.
- Strong corporate governance and project structures, provided by our Innovation and Improvement Hub and business support team, are important in ensuring successful delivery and continuous improvement are embedded throughout the service.
- Maintaining a safe, sustainable and efficient estates infrastructure from which to run our services and look after our staff, is an essential requirement of WBS and is managed in partnership between our corporate estates team and local facilities team.
- Working with our People and Organisational Development team helps ensure that the well-being of our staff remains an important part of service.
- Strong financial and procurement support helps to ensure services are delivered within our agreed financial envelope and we meet our Standing Financial Instructions (SFIs) obligations.

Continuous Improvement

A long-term, integrated whole-system approach is being implemented to ensure sustained improvements across the WBS. This incorporates leadership and governance and the improvement culture, behaviours and skills at every level.

The action plan incorporates a tailored approach to coach and support the organisation to embed a culture of service improvement (SI) across WBS. It aims to maximise the resource we have available to us and focus effort where it's needed most.

The whole system approach focusses on three themes:

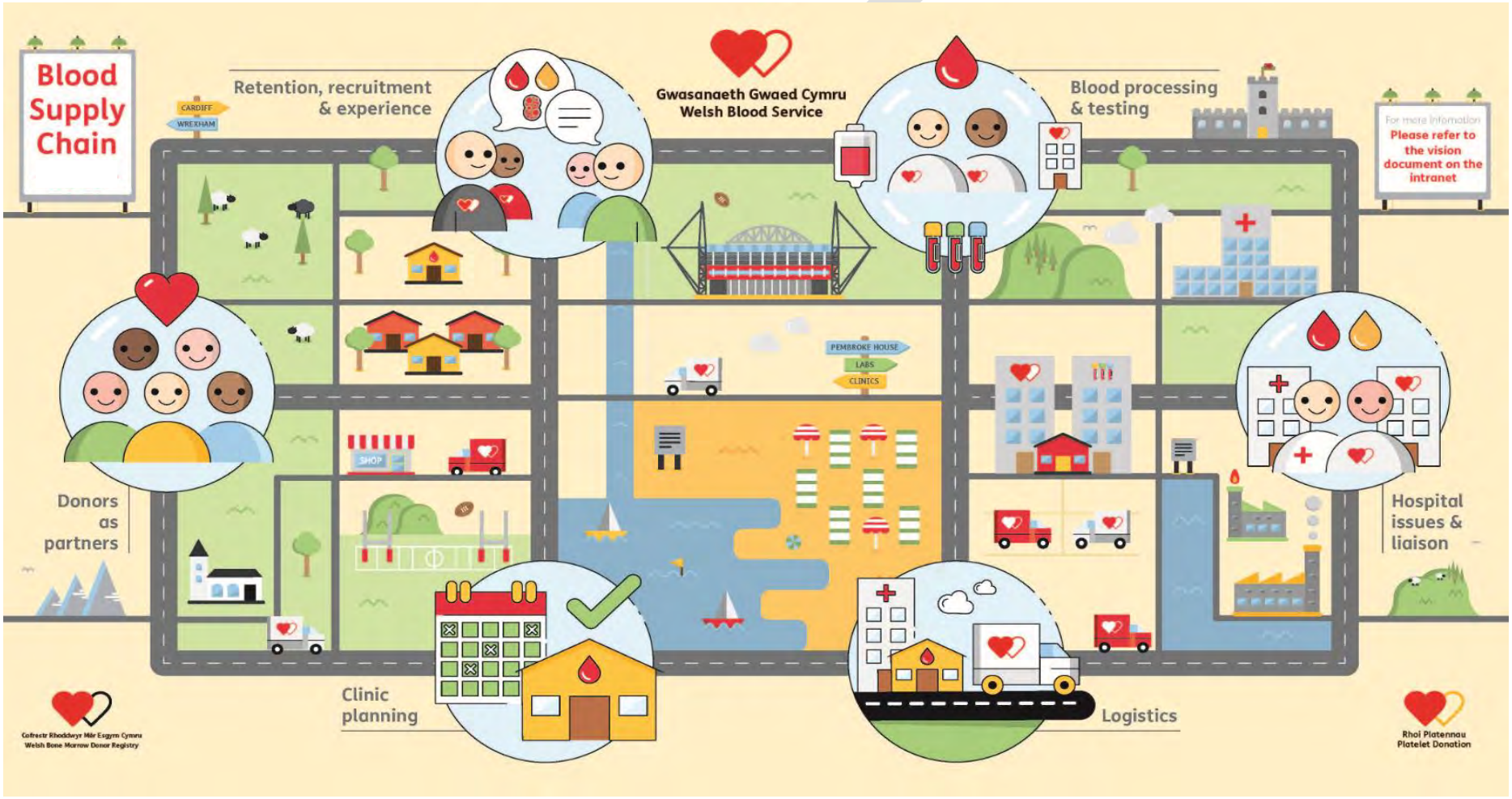
Culture – create a culture that generates interest and involvement to drive SI.

Knowledge – develop the relevant skills to underpin SI activity and culture.

Activity – identify areas for improvement and empower staff to make changes.

Service Improvement is at the core of each of the seven strategic themes of the 5 year strategy. It exists to build upon our existing services and capabilities to improve what we do currently.

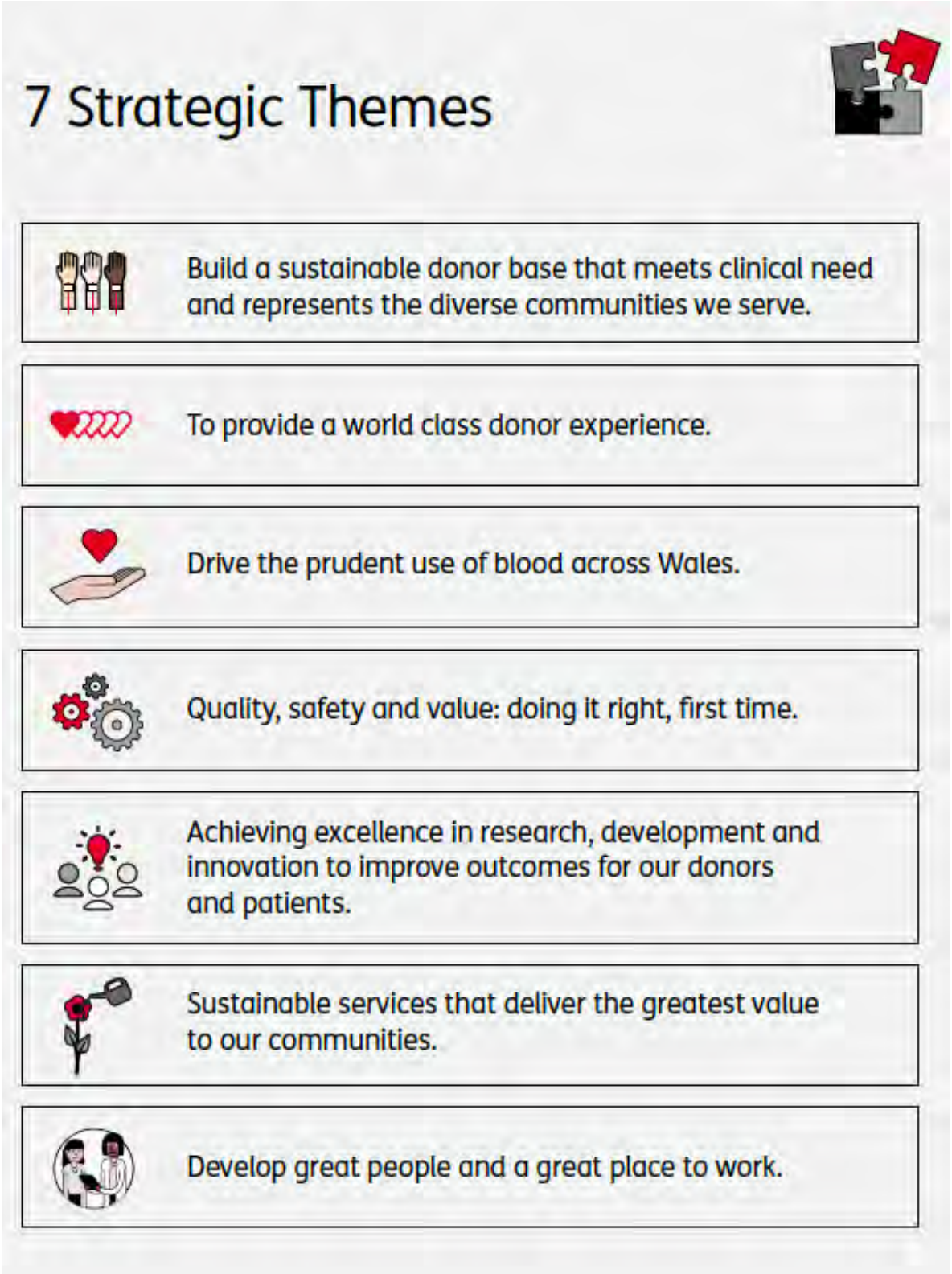
Our Blood Supply Chain Model



Our Strategic Priorities

Vision

To be recognised by the people of Wales and our peers as a leader in transplant and transfusion services.



Forecasting Demand for Blood Components

Meeting Demand - Planning assumptions

The following assumptions have been made when forecasting the demand for blood components:

We expect demand for 2024/25 to remain in line with 2023/24. However, we know from our analysis that there is natural variation in relation to demand; therefore, our collection model builds in sufficient capacity to account for this.

We will continue to review red cell demand and will adjust collections capacity accordingly where required for the upcoming quarter.

Figures are subject to external changes which may have a significant impact on blood component usage by hospitals (our customers) throughout the year.

We will continue to monitor actual issuing against forecasted issuing and will adjust the planned whole blood and apheresis platelet collection and the corresponding product manufacturing accordingly, to meet demand.

The Blood Health Team will continue to work with hospitals on appropriate and prudent blood component use and minimise hospital waste.

Meeting Demand for Red Blood Cells

The Clinic Planning department will aim to schedule donation clinics to collect enough whole blood to meet the estimated demand, flexing the collection plan in accordance with changes to demand.

Based upon our planning assumptions, we have modelled how much whole blood we will need to collect from our donors compared to red blood cell issuing to Health Boards, in order to support safe and effective patient care. There is always a challenge in the interpretation of Health Board activity planning and the impact on red blood cell demand due to the myriad of factors that influence usage.

Meeting demand for Platelets

Based upon our planning assumptions, we have modelled how many platelets we expect to manufacture, both from whole blood and apheresis, compared to issuing to Health Boards, in order to support safe and effective patient care.

Platelet demand will be met through a combination of apheresis derived and the pooling of whole blood platelets.

We will flex our production of pooled platelets appropriately to ensure supply chain integrity. However, it is important to note that platelet demand can be volatile due to the nature of the component, the short shelf life (7 days), the blood group complexities

and the requirement for special bleeds, as well as the two different manufacturing methods (apheresis and pooled), which in turn can lead to higher wastage levels.

Based upon the above assumptions the plan for 2024/2025 will ensure that we meet demand for all blood components.

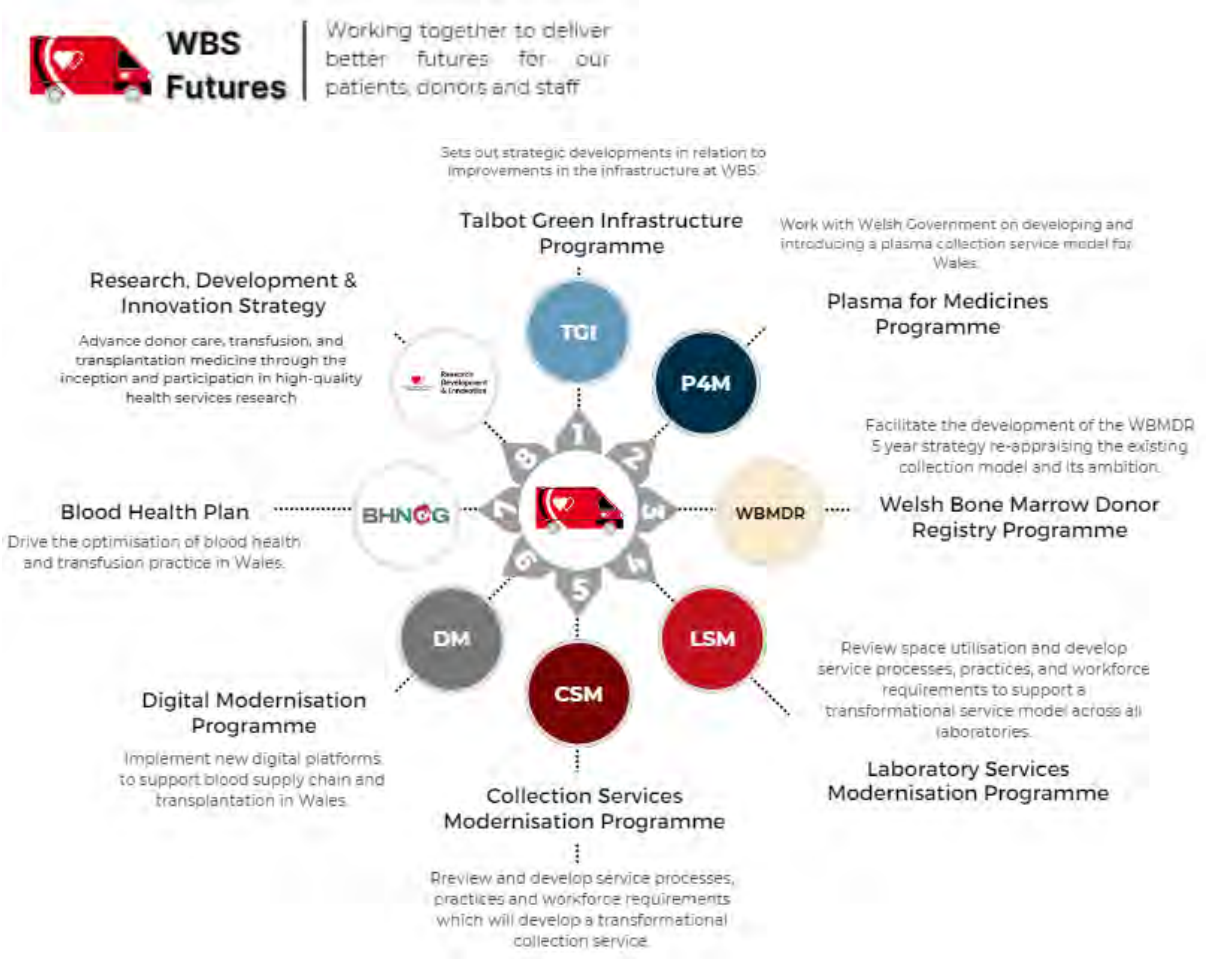
Contingency Planning

Work is ongoing through the Blood Health Team and Collections Team to align the collection profile with demand for specific blood groups. We are continuing to work closely with the hospital blood banks and service leads for blood transfusion to understand and help manage appropriate demand and meet the required capacity. To further support the effective and prudent use of stock, the Blood Health National Oversight Group will continue to provide scrutiny and leadership across Wales.

For business continuity purposes, and if required to support blood supply to the patients of Wales, the WBS can call on mutual aid support from the other UK Blood Services or in extreme circumstances the service can instigate the National Blood or Platelet Shortage Plan which provides a structured approach to addressing any shortfalls in supply.

Key Programmes of Work during 2024 – 2027

WBS Futures has been established to be the vehicle to deliver the WBS 5 Year Strategy and our ambitious IMTP. It consists of 6 programmes and 2 associated work programmes outlined below.



Other Key Areas of Work for 2024 – 2027:

Work Programme	Deliverable
Occult Hepatitis B Infection in UK Blood Donors	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.
Service Development and Regulation	Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology.
Safe Care Collaborative	Two projects under the Safe Care Collaborative initiative: • Donor Adverse Event Reporting Project

	• Haemochromatosis Patients Project
Workforce	Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning.
Infected Blood Inquiry (IBI)	The final report will be published on 20th May 2024. The WBS, along with other UK Blood Services and Welsh Government, will respond to and, where appropriate, implement any recommendations.
Pre-Operative Anaemia Pathway Programme	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25.

Welsh Blood Service Plan 2024 – 2027

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2033 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2026/27. WBS Futures	• 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.	Complete introduction of a donor experience hub. Complete implementation of a Customer Relationship Management (CRM) System. Implement omni-channel software.	Implement tailored pathways for donors and advocates. New donor app implementation and create content.	% Donor Satisfaction.
	Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model and its ambition by 2026/27.	• Sustained growth and retention of the stem cell donor panel. • Increase in stem cells supply. • Increased diversity in the donor panel.	Introduce Self - Administration of G-CSF as part of the modernisation of Clinical services. Develop model for bone marrow	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 for stem cell	Implement identified and developed strategies for maintaining growth of the registry such as collecting 3rd party	Implement recommended strategies for maintaining growth of the registry such as collecting 3rd	Continue to implement recommended strategies for the expansion of stem cell	Number of stem cell collections.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
	WBS Futures	• Improved resilience in stem cell supplies. • Improved clinical outcomes nationally / internationally. • Increased income levels.	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.	donor medicals. Produce and process tender to replace current WBMDR software.	cellular products or ATMP starting materials. Follow tender process to replace current WBMDR software.	party cellular products or ATMP starting materials. Continue to progress with the WBMDR replacement software project.	collection services. Implement new WBMDR software.	
SP2: To provide a world class donor experience	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.	Re-submit new donor and advocate strategy for approval.	Begin to develop recommendation paper for systems, processes and people	Complete recommendation paper for systems, processes and people required to		Begin to implement new strategy.		% Red Blood Cell Demand met for Hospitals.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)		• Improved levels of 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.		required to deliver the strategy.	deliver the strategy				
SP3: Drive the prudent use of blood across Wales **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 4 and 5)**	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 demand for blood). • Increased equity of care and outcomes. • Reduction in clinical complications associated with receiving blood products.	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.			Full programme implementation by 2024/25.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Compliance with the NICE guidance. • Improved efficiency. • Cost efficiencies.							
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 4 and 5)**	Revised blood collection clinic portfolio by 2025/26. WBS Futures	• Increased /Sustainable collection model. • Improved access for service users. • Improved collection efficiency. • Reduction in costs. • Improved access to donors for recruitment to the Welsh Bone Marrow Donor Registry.	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 venue/s. Continue review of existing blood donation venues.	Continue to develop options for introduction of a new fixed donation venue/s. Continue review of existing blood donation venues.	Complete development of options for introduction of a new fixed donation venue/s. Complete review of existing blood donation venues.		Implementation of revised model by 2025/26.
	Introduce clinically led collection team model by 2024/25. WBS Futures	• Improved leadership capability. • Standardisation of terms and conditions across collection teams. • Improved quality.	Continue to undertake a workforce review, to include roles and responsibilities.	Continue to undertake a workforce review, to include roles and	Begin to implement workforce review in line with	Continue to implement workforce review in line with Organisational			Whole Blood Collection Efficiency per Full

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• Improved safety. • Reduction in staff turnover. • Improved collection efficiency.		responsibilities. Develop new job descriptions.	Organisational Change Policy (OCP).	Change Policy (OCP).			Time Staff.
	Develop and implement a platelet strategy by 2025/26. WBS Futures	• 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). Research and development of new components.	Continue development and Implementation of the Validated Demand and Capacity tool. Continue with implementation 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 Optimise 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 Optimise the clinical efficacy of platelet supply including substitutions. Research and development of new components.	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		% Platelet Supply meeting Demand to Hospitals.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
							all platelet types: Including expanding donor panel. Research and development of new components.		
	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. WBS Futures	• Modernise 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.	Commence deployment	Complete deployment (Q1)		Full implementation of WLIMS 2.0 by 2025/26.
	Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics	• Improved availability of information. • Increased efficiency / productivity. • Improved patient experience. • Reduced turnaround times.	Completion of Discovery Phase. Commence Implementation.	Commence Environments set-up.	Complete implementation. Complete Environments set-up.		Complete Data Migration (Q1). Training (Q1).		Implementation of WHAIS LIMS by 2025/26.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
	Service (WHAIS) by 2025/26. WBS Futures	• Reduction in avoidable waste.	Commence Data Migration.				Go-Live (end of Q1).		
	Procure new Blood Establishment Computer System (BECS) contract. WBS Futures	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	New contract procurement commences – Competitive Dialogue. Recruitment of SMEs. Analyse Semester patch feasibility. Analyse and test Maintenance patch. Virtualisation of existing infrastructure.	New Contract Procurement. Business Analysis – ways of working/service mapping. Implement Maintenance patch. Continue analysis of Semester patch. Continue virtualisation of existing infrastructure.	New Contract Procurement. Business Analysis – ways of working/service mapping. Analysis of Semester patch if required. Prepare new hardware. Plan and prepare Delta Release.	New Contract Procurement ends. Continue analysis and testing of Semester patch. Implement Delta Release.	New Contract Award (Q1). New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECS solution.	BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28). Continue supporting existing BECS solution.	Procurement of new BECS Solution by 2027/28.
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs	• Reduction in risk of HepB virus transmission to recipients of blood	Submit data required for review by SaBTO.	Review updated recommendations from SaBTO and	Implement any changes in practice recommended by SaBTO.	Implement any changes in practice recommended by SaBTO.	Part of standard activity post implementation.	Part of standard activity post implementation.	Assessment and implementation complete

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
	(SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25.	components in Wales. • Compliance with SaBTO recommendations.		agree an organisational response.					by 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.	Implement Medical Devices Regulations (MDR) / In Vitro Diagnostic Devices (IVDDR) strategy (Qtr 1). Substances of Human Origin (SoHo) Regulations – develop strategy for WBS.	Substances of Human Origin (SoHo) Regulations – WBS Strategy to be in place.	Numbers of critical non-conformances through external audits or inspection. Reduction in paper usage.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
	Implementation of Foetal DNA typing by 2024/25. WBS Futures	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women. • Improved safety. • Improved patient experience. • Reduction in avoidable waste/costs.	Undertake digital developments to support reporting of results. Complete validation and implementation of new test.	Implement all Wales service for Cell Free Foetal DNA screening.	Embed service.		Scope expansion of service.		Implementation of Foetal D typing by 2024/25.
	Implement new digital solution for National External Quality Assessment Service (NEQAS). 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 change the service. • 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.	Go live with new NEQAS system. Close project.			Implementation by 2024/25.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		• 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 Testing (NAT). WBS Futures	• Robust Service Provision • Enable income generation. • Service Development.	Develop User Requirement Specification. Identify preferred service model. Procurement process.	Continue procurement of new NAT analysers.	Continue procurement of new NAT analysers.	Commence validation and implementation of NAT testing platform.	Implement new NAT strategy.		Full implementation by 2025/26.
	Introduction of West Nile Virus (WNV) Testing. WBS Futures Quality Priority	• 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	eProgesa development work to create test codes and trigger requirement for WNV testing. Develop clinical algorithm.						Full implementation by 2024/25.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
		products to meet demand	Validate Roche platform for WNV testing. Implement WNV testing.						
	Assess and implement the recommendations of the Infected Blood Inquiry (IBI).	• Learning from the findings of the inquiry and optimising the safety of blood components as recommended. • Maintained compliance.	Attend the launch of the report, review the recommendations and draft an action plan	Commence implementation of the action plan and populate the predicted timescales for actions for the IMTP 2024-27.					Implementation of the action plan.
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales. WBS Futures *(Quality Priority: Introduce leucodepletion filters,*	• 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.	Commence supply of frozen recovered plasma for fractionation from Q1. Receipt of first fractionated product from Q3.	Source Plasma TBC depending on policy decision and business case support.	Service model developed and implemented.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
 **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	*Hepatitis A and Parvo B19 testing)*								
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. 	• Improved donor satisfaction. • Improved staff well-being. • Increased service resilience. • Reduction in energy consumption and utilisation. • Reduction in carbon emissions. • Compliance with statutory requirements. • Improved efficiency, reduction in waste and carbon emissions.	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.	Develop Full Business Case (FBC).	Construction commences - three-year programme.	OBC submitted to Welsh Government by 2024/25.

IMTP Strategic Priorities Welsh Blood Services Service Delivery Framework 2024 to 2027									
Strategic Priorities 2024/25 – 2026/27	**Objectives**	**Expected Benefits**	**Key Specific Actions and 2024 - 2027 Timescales**						**Primary KPIs**
			2024/25				**2025/26**	**2026/27**	
			Q1	**Q2**	**Q3**	**Q4**			
SP7 Develop great people and a great place to work  **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.	• Enhanced workforce capacity & capability to meet need. • Enhanced Leadership capacity & capability. • Improved staff satisfaction. • Improved staff well-being. • Improved service quality, safety and donor satisfaction.	Support Collection Teams workforce review. Commence review of workforce planning across WBS. Plan and deliver training / team development sessions with new Senior Leadership Team (SLT).	Support Collections Teams workforce review. Continue review of workforce planning across WBS.	Support implementation of Collections Team workforce review in line with Organisational Change Policy (OCP). Continue review of workforce planning across WBS.	Support implementation of Collections Team workforce review in line with Organisational Change Policy (OCP). Continue review of workforce planning across WBS.	Implement recommendations of review of workforce planning across WBS.	TBC	Collections Team workforce model completed by 2024/25.

Part 6

Our Trust-wide Enabling Services

We set out how our Trust-wide services are vital to the delivery of our Plan

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

Research, Development and Innovation:

We will continue to drive our research, development and innovation ambition for our patients and donors and focus on

- Joint delivery, with Cardiff & Vale UHB and Cardiff University, of the Cardiff Cancer Research Hub
- Implementing our Cancer Research and Development Strategy (2021-2031)
- Building upon and enhancing our Welsh Blood Service Research and Development Strategy
- Developing our national and international Research, Development and Innovation Partnerships
- Building and embedding our **innovation infrastructure** through our key innovation themes to support the delivery of our Trust overarching strategic goals:

    - **Developing a collaborative innovation ecosystem:** Our vision includes building a collaborative innovation ecosystem where staff, healthcare providers, researchers, academia, industry, patients, donors and community partners work seamlessly together to drive innovation, address healthcare disparities, and create healthier communities. We are building an ecosystem that supports and strengthens the capability and capacity for the Trust to innovate. This includes the internal and external infrastructure and specifically the development of a **Collaborative Centre for Learning and Innovation** (CCLI). The CCLI aims to improve whole system cancer care through collaboratively accelerating cancer research, innovation education and involvement. Providing a virtual and physical space to encourage creativity, collaboration, and knowledge exchange with practical and positive impact on cancer care for all those involved.
    - **Developing a culture of innovation:** We are dedicated to fostering a culture where every member of our organisation is empowered, informed, and supported to innovate, experiment, and embrace change, making innovation a way of life rather than an isolated event.
    - **Clear communications and recognition:** We are committed to delivering clear communications to support the capability and capacity building for research and Innovation of the Trust. Recognising the efforts of our staff, patients, donors, community, funders partners and stakeholders; and reinforcing our Trust culture of innovation.
    - **Patient and Donor Centred Excellence**: aspiring to redefine patient and donor centred care, placing patients and donors at the heart of every decision, ensuring their voices are heard, and tailoring healthcare experiences to their unique needs and preference.
    - **Leadership and role modelling:** As a University Designated Organisation – Senior Leadership are committed to sponsoring key

initiatives and novel projects and ensuring that Research, Development, Learning and Education opportunities are enabled and reflected in job roles and responsibilities.

- **Advancing Technology Integration:** Our approach is to harness the power of cutting-edge technologies, including artificial intelligence, telemedicine, wearable devices and data analytics, to optimise treatment, inform diagnostics and preventative care, with the aim of making services more accessible and efficient.
- **Data Driven Insights:** Leveraging data as a strategic asset, using it to inform our innovation activities and efforts.
- **Health equity and Inclusion:** Our commitment extends to achieving health equity and inclusion for all with a focus on disparities in healthcare access and outcomes. Our innovations will strive to remove barriers to care and promote health equity.
- **Empowerment and Autonomy:** Empowering employees by giving them autonomy to propose and implement innovative ideas within their areas of expertise.
- **Training and Development:** Innovation training is key to building the capability and capacity of the innovation infrastructure for the Trust. It will equip staff with the knowledge, skills and mind-set necessary to drive innovation, improve patient and donor care, and adapt our delivery approaches to the changing innovation landscape. It helps create a culture where innovation is not just encouraged but also effectively implemented for the benefit of our patients and donors.

Strategic Priority 3: The Trust will implement the Velindre Innovation Plan

In partnership with the Welsh Government Health and Care Innovation Team and the Velindre Charity, we continue to develop our Innovation infrastructure, encompassing our commitments as a 'university designated' organisation. We are committed to taking our innovation activity beyond the training and research and development activity undertaken within the organisation, and drawing in good practice and research approaches and evidence from elsewhere, applying this knowledge in order to drive up the quality of care and improve health and well-being outcomes.

Over the course of our plan we will have agreed innovation priorities and themes that will include emerging technology, commercialisation, workforce, engagement, arts and creativity, new hospital design, Collaborative Centre for Learning and Innovation, sustainability and future generations and social innovation with community benefit. At the Velindre Cancer Service, these will also include patient outcomes and patient experience, diagnostics, advanced cancer treatments and therapies, supportive care and palliative care. At the Welsh Blood Service these will include, plasma fractionation,

donor engagement, experience and care, components and products, stem cell and transplant, along with advanced blood-based therapies and innovative logistics.

We continue to improve our processes for triaging and accelerating innovation and strengthening the infrastructure for delivering innovation building capability and capacity. We will continue to be flexible and responsive in undertaking innovation funding approaches, developing materials, toolkits, and training platforms and innovation portals. Furthermore, in increasing our capability and capacity we will continue to build strong collaborations with a diverse range of partners. We will continue to undertake targeted promotion, develop publications and deliver value through our innovation themes aligned to our strategic goals, the Welsh Government's Innovation Strategy and supporting delivery programmes.

Strategic Goal 3: A beacon for research, development, and innovation in our stated areas of priority.

Our objectives are to:

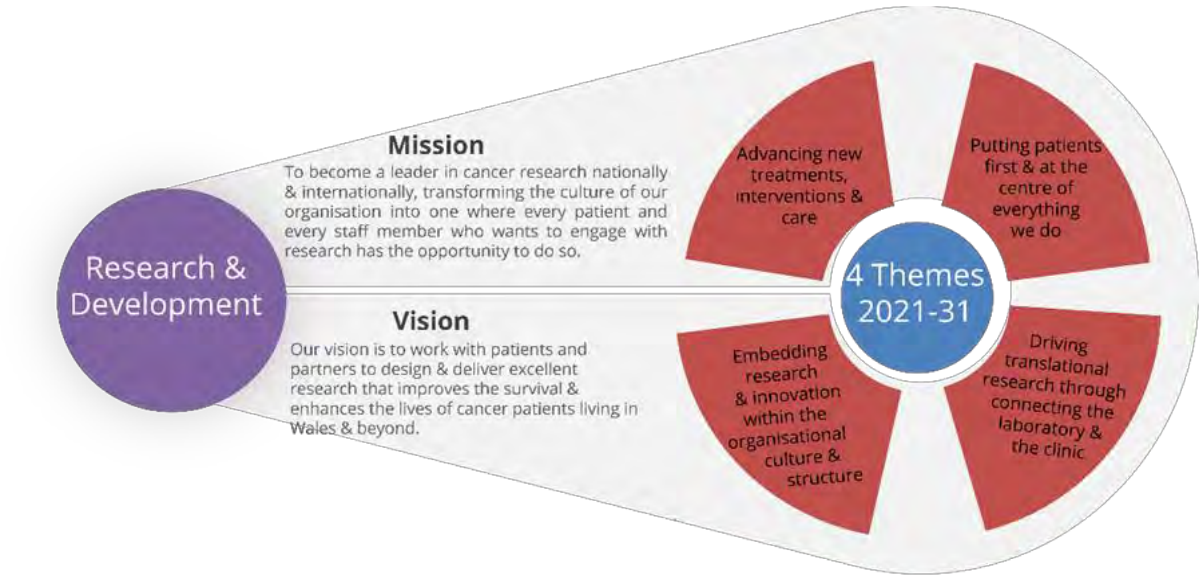
- Deliver world class research, development, and innovation to improve tomorrow's care.
- Accelerate the implementation of research and new discoveries to improve our patients and donor's experience and outcomes.
- Prioritise research, development and innovation that is clinically relevant, and patient and donor centred.
- Build a sustainable culture of multi-professional research, development and innovation involving the whole organisation.
- Publish and promote research of the highest quality achieving UK and international recognition.

We will achieve these by:

- Implementing our research, development, and innovation strategy that sets outs a prioritised programme of work in cancer, blood, and transplant services.
- Giving every donor, patient, and carer access to the latest research.
- Advancing new treatments, interventions, and care by increasing new studies locally, widening access to early phase/solid tumour advanced therapies and integrating novel research into clinical studies.
- Building a culture of curiosity where research, development, and innovation is an 'Always Event' involving all 1500 employees in the Trust, where staff challenge the status quo and make it better.
- Increasing the number of lead investigators and clinical academics within the Trust.
- Recruiting honorary entrepreneurs and academics whilst also developing entrepreneurs, with a flow of staff between our partner organisations on exchanges to attract and retain world class talent.
- Creating a cadre of blended professionals, to promote knowledge exchange with impact on improvements of patient outcomes.
- Establishing exciting work programmes with our local health and academic partners at Cardiff University, Cardiff Metropolitan University, Swansea

University, University of South Wales, and University of Wales Trinity Saint David.

- Increasing our research, development, and innovation infrastructure to keep pace with our ambitions. This will include:
  - Establishing the research hub with Cardiff & Vale University Health Board and Cardiff University.
  - Providing world class facilities via the Welsh Blood Service Infrastructure Programme; the new Velindre Cancer Centre; Velindre@ research hubs at University Health Board partners; and the Collaborative Centre for Learning, Technology, and Innovation.
  - Developing the Library Service into a sustainable Trust-wide Evidence Centre.
- Generating reinvestment income through partnerships with industry for commercial research, development, and innovation.



Research, Development, and Innovation:

Our Aims are to:

- Enhance patient experience and care.
- Improve patient outcomes and reduce variation.
- Accelerate the implementation of new discoveries into the clinic.
- Demonstrate the impact of our research on patients and the NHS.
- Build research capacity and capability at Velindre and across SE Wales.

In line with the Trust's Strategic goal to be ***"A beacon for research, development and innovation,"*** we are committed to building on our excellent national and international reputation, based on successful delivery and management of a wide portfolio of research, development, and innovation; and a firm commitment to partnership working. Our prioritisation of research and innovation is clear and embedded within the two divisions, both being focused on their approach and have developed robust research strategies and plans for innovation. Patients and donors remain at the centre of this activity and through the four key priorities identified below, we seek to radically improve access to research and innovation whilst building a sustainable and capable clinical and scientific workforce for the future.

The Velindre Cancer Service plays a key role in South-East Wales's (SEWs) cancer research network. It provides an important link between the region's three University Health Boards for collaborative clinical cancer research, offering opportunities for patients to access clinical trials and a range of other research studies, either at Velindre Cancer Centre (VCC) itself or in outreach facilities. Velindre Cancer Service is also in a prime position to provide crucial connections between laboratory cancer researchers and patients, enabling research to '*bridge the translational gap*' bringing new discoveries from the laboratory to the clinic for patient benefit. The new Velindre Cancer Centre development in Whitchurch, Cardiff brings opportunities for both clinical and non-clinical research and innovation, these are being explored and will contribute to this new build's design and facilities.

The Welsh Blood Service is a unique organisation within the Welsh healthcare system, with the capacity to perform research and to implement and disseminate evidence-based innovations and new technologies on an all-Wales basis, to advance donor care and our reputation for transfusion and transplantation medicine.

Our Priorities:

Strategic Priority 1: We will Drive Forward the Implementation of our Cancer Research and Development Ambitions

We have set out our Cancer Research and Development Ambitions up to 2031. Cancer Centre multidisciplinary research leads, University partners, and Patient and Public representatives developed these.

These describe our vision, mission and aims for future Cancer Research at Velindre that we will be deliver through research in four interconnected strategic themes.

Our Research Themes:

- **Putting patients First and at the Centre of Everything We Do:** Patients will help set the research agenda and we aim to increase opportunities for patients and their families to take part in research, so that within 10 years most of our patients are offered research and innovation opportunities at some point in their cancer journey.
- **Advancing New Treatments, Interventions and Care:** We will lead and take part in well-designed Clinical Trials and research studies, providing the evidence base required to bring new, improved treatments and interventions to clinic enhancing patient care. Wales-led research will be prioritised and new research delivery infrastructure will be developed, including a Cardiff Cancer Research Hub delivering Early Phase and Translational research on the University Hospital of Wales (UHW) site and a firm research footprint at the new Velindre Cancer Centre, particularly to enable cutting-edge radiotherapy research.
- **Driving Translational Research through connecting the laboratory and clinic:** We will work with our academic (university) partners to enable translational ('*bench to bedside*') research, bringing new discoveries (novel drugs, imaging techniques and/or technological advances) through from the laboratory to the clinic to benefit patients. We will enable reverse translation ('*bedside to bench*') research taking patient samples/scans and/or data back to the laboratory to generate new knowledge. Developing Clinical Academic posts that link across clinical-academic boundaries will be key to success in this theme.
- **Embedding Research and Innovation within the Organisational Culture:** We will drive an organisational culture valuing research and builds capacity and capability in the multi-disciplinary workforce, providing staff who wish to engage in research with dedicated ring-fenced time and training opportunities. The Velindre Professor of Nursing and Interdisciplinary Research is important in supporting this endeavour.

Our research will be facilitated by a governance and enabling infrastructure, supported by a communication, engagement and funding strategy, and delivered by an agile research workforce. Close collaboration with our regional NHS and Academic partners and engagement across different sectors will be key to success (see Strategic Priority 4).

Strategic Priority 2: The Trust will Maximise the Research and Development Ambitions of the Welsh Blood Service

The Welsh Blood Service has an established Research and Development strategy, developed in collaboration with our staff, scientists, clinicians, academia, and other UK blood services. Our aims are to drive improvement, increase our research activity, be open to collaboration and build our reputation for research and development, in order to improve donor and patient health.

We will continue to develop our 4 Welsh Blood Service Research and Development themes which are:

- **Transplantation:** including solid organ and stem cell transplants

- **Donor Care and Public Health:** including donor recruitment and retention strategies, aiming to enhance their experience and continued engagement.
- **Products:** including blood components, immuno-haematology, manufacturing, and quality management.
- **Therapies:** including preparation of cellular and blood therapies for research.

We will also honour the expectation of our staff that Research and Development is an embedded function that is part of an evidence based, first class service, delivered with pride. We will also maximise opportunities to improve and expand the services at WBS, through feasible and evidence-based Research and Development.

The Welsh Blood Service Research and Development team will continue to grow commercial Research and Development opportunities and the significant potential of our Component Development Lab. We will continue to actively seek strong academic and professional Research and Development partners, nationally and internationally. These will include high quality networks such as the international BEST Collaborative and the European Blood Alliance. We will leverage these partnerships to further explore the potential of Advanced Therapies aligned to our unique Service. Finally, we will continue to build the capacity and capability of our workforce and to embed a positive culture around Research and Development activity.

Strategic Priority 3: The Trust will Implement the Velindre Innovation Plan
In partnership with the Welsh Government Health and Care Innovation Team and the Velindre Charity, a Velindre Innovation infrastructure has been established to deliver a step change improvement in the quality and quantity of multi-disciplinary and multi-partner innovation to achieve our purpose to improve lives.

Over the course of our plan we will have agreed innovation priorities and themes that will include emerging technology and informatics, commercialisation, workforce, engagement, arts and creativity, new hospital design, sustainability and future generations and social innovation with community benefit. At the Velindre Cancer Service, these will also include patient outcomes and patient experience, primary and community oncology care, diagnostics, advanced cancer treatments and therapies, supportive care, and palliative care. At the Welsh Blood Service these will include, plasma fractionation, donor engagement, experience and care, components and products, stem cell and transplant, along with advanced blood-based therapies and innovative logistics.
We will have a clear process for triaging and accelerating innovation. We will have a strong platform for delivering innovation that will include the right people and culture, flexible and responsive innovation funding, toolkits, and a responsive IP protection procedure. To increase our capability and capacity we will have strong partnerships that with both the public and private sector. We will build an innovation premium through awards, targeted promotion, publication and delivering value through a Performance framework, aligned to the Welsh Government's Innovation Strategy and Programme.

Strategic Priority 4: The Trust will Maximise Collaborative Opportunities Locally, Nationally, and Internationally

We will work with our Health Board colleagues to maximise research opportunities for our patients and donors. This includes the Velindre@ Programme which aims to evolve the South-East Wales infrastructure, enabling local access to clinical research. Our partnership with Cardiff & Vale University Health Board and Cardiff University to develop the Cardiff Cancer Research Hub will provide a safe environment to treat patients with cutting edge and complex advanced therapies, and enable translational research collaborating with Haematology and University partners, and Advanced Therapies Wales.

We will work with scientists in Cardiff and beyond, bringing new therapies to clinic for the first time and generating reverse translation opportunities in both systemic therapy and radiotherapy. Moreover, we will increase the number of Velindre Chief Investigators collaborating with Cardiff University's Centre for Trials Research (CTR). Through our Cardiff Experimental Cancer Research Centre (ECMC), the Wales Cancer Research Centre (WCRC), and Health and Care Research Wales (HCRW) interactions, we will maximise opportunities across all cancer research fields including early diagnosis, interventional therapies, and palliative and supportive care.

In addition, with the All-Wales Medical Genomics Service, we will become the only UK hub offering a 500 gene panel to all new metastatic cancer diagnoses, providing outstanding potential for precision medicine research opportunities with all our patients.

At a national level we will continue to work with our UK cancer research colleagues. We will further enhance our healthy relationships with the third sector, industry partners and contract research organisations (CROs) to deliver commercial research, and to collaborate in designing and delivering Trust sponsored clinical trials.

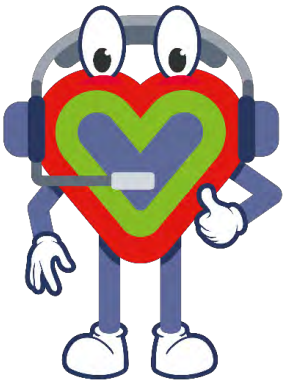
Working with multiple Welsh HEI partners we will strengthen our Academic Partnership Board to help shape our Trust University Status and develop the Velindre Oncology Academy ensuring multi-professional development of research and innovation remains central to this agenda.

Lastly, and most importantly, we will work with patients and the public to ensure that the research we develop, and offer is relevant to their needs.

Digital Services:

Over several years, the Trust has undertaken a number of significant developments in Digital Services which have made a difference to the quality, safety and experience for the users of the services that we provide. Alongside this the Digital team has been developing its capabilities and structures to support the future plans for the Trust. This has been articulated in the Trust's Digital Strategy, "Digital Excellence: Our Strategy 2023-2033". We continue to change the way that Digital Services operate in the Trust in support of the strategy and to enable the service plans for the Velindre Cancer Service (VCS), the Welsh Blood Service (WBS), and the new Velindre Cancer Centre (nVCC) as set out in their respective IMTPs. The achievements over the last 5 years have put strong foundations, skills and capabilities in place to support the next stage of digital transformation across the Trust.

Trust Digital Plan for 2024 / 2025 – 2026 / 2027



These are exciting times when you consider the opportunities ahead for Blood and Cancer Services in Wales. By taking full advantage of digital to support our transformation we have an opportunity to accelerate progress toward our ambitious long-term strategic goals.

One of the most important components of our future success will be how well we embrace the challenge of digital. Our refreshed ten-year Digital Strategy describes our approach to digital in response to the Trust purpose to *'Improve Lives'"*, and its vision to deliver *'Excellent Care, Inspirational Learning, Healthier People'*.

Our Digital Vision: To Ensure Patient, Donor and Staff Experience of Digital Services is the same as our Care…… Outstanding

The Welsh Government have also refreshed their Health and Care Digital Strategy, which can be found at https://www.gov.wales/digital-and-data-strategy-health-and-social-care-wales-html , and the Trust Digital Strategy aligns well with this.

To deliver our vision, we have set out several themes which will support us in delivering a connected, people focused, personalised and sustainable future.

Figure 1: Digital Strategy Themes

Theme 1: Ensuring our Foundations
We will empower our staff to have access to the high quality information, equipment and technology they require 24 hours a day, 7 days a week to deliver high quality and safe services.

Theme 2: Digital Inclusion
We will support people to become more digitally confident, included and connected.

Theme 3: Insight Driven
We will optimise the use of data and knowledge to help us make informed and insight driven decisions within the organisation and in collaboration with partners across organisational boundaries.

Theme 4: Safe and Secure Systems
We will secure our data and information through an effective approach to cyber security, working in collaboration with the Cyber Resilience Unit and the National Cyber Security Centre.

Theme 5: A Digital Organisation
We will work with patients, donors, staff and partners to create a service culture that embraces the use of digital technology to get the best quality services from it.

Theme 6: Working in Partnership
We will work to build a network of partners and capabilities which enable us to maximise the benefits from research, development and innovation and become an exemplar within NHS Wales for digital innovation and services.

Our Digital Objectives

Our objectives are to:

- Provide resilient digital services which support excellent care
- Seamlessly digitally connect patients, donors, staff and partners with our services and equally value non-digital channels
- Become a data driven, insight led organisation where staff take care of and have the right information, at the right time, all of the time
- Secure our data, information and services through an effective approach to Cyber Security
- Create a digital culture across the Trust of innovation and knowledge sharing that supports the delivery of world class services

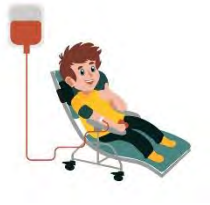
We will achieve these by:

- Implementing our digital strategy
- Constantly evolving our IT infrastructure and Cyber Security arrangements to meet good practice with a hybrid of cloud and on premise deployment
- Implementing a digital transformation programme to drive benefits and create digital services that our patients, donors and staff value and can be accessed close to home
- Increasing the speed of development through new service design approaches, deployment and functioning of new technologies to increase our productivity
- Working in partnership to implement a range of national systems, to support a once for Wales approach
- Working with the public and Centre for Digital Public Services and Digital Communities Wales to champion and accelerate digital inclusion
- Developing our partnership role with Health Education and Improvement Wales to increase the digital literacy, skills and knowledge of our staff
- Identifying opportunities to join digital accelerator programmes and initiatives
- Improve the quality of our data by driving data standards; identifying data champions; and improving data sharing protocols
- Transforming our data and insight capability to provide data, information and knowledge to the right person at the right time and introduce new analytical capabilities
- Building digital partnerships with partner organisations, academia and digital providers to create value in health, wealth and well-being

The Difference this will make to our Donors, Patients, Staff and our Partners

Digital technology and services provide the opportunity to make a real shift in the relationship between health and care professionals, the people they serve, and the healthcare services we provide. Designing services in partnership with patients and donors will allow us to re-imagine services and provide a more personal experience; enabled by digital technology.

Our Welsh Blood Service Donors will be able to:



- Manage their donation appointments on the move
- View their donation history and track how it has been used
- Update their personal details when circumstances change
- Identify donation sessions close to their current location
- Identify other public services which they may find useful
- View the difference that their donation is making

Our Velindre Cancer Patients will be able to:

- Access information about their health
- Make more informed decisions over what they need from the services we provide
- Have more choice about where and how they access services
- Identify other public services which they may find useful

Our Staff and other Healthcare Partners will be able to:

- Work in more efficient ways so that they can focus on their most important tasks
- Connect digitally with their team, organisation and other health partners
- Work flexibility in terms of how and where they work
- Access the right information at the right time
- Share information across our regional partners to improve care

Trust Digital Priorities for 2024/25-2026/27

The Trust's Digital Strategy sets out our strategic themes and in the next sections we have used these to show coverage across the Digital IMTP. This highlights that we have a balanced plan in support of our vision.

Theme 1:	**Ensuring our Foundations**
Theme 2:	**Digital Inclusion**
Theme 3:	**Insight Driven**
Theme 4:	**Safe and Secure Systems**
Theme 5:	**A Digital Organisation**
Theme 6:	**Working in Partnership**

The digital priorities need to enable the service transformation as set out in the service IMTPs and we plan to achieve the majority of this work through enablement of the Welsh Blood Service and Velindre Futures programmes.

As set out in the service IMTPs:

- *Velindre Futures Programme: Established in 2020, Velindre Futures is a clinically led initiative that directs the development of the clinical model and future service configuration, working in partnership and collaboration with staff, patients, regional partners and carers and the public. It will ensure that the Cancer Centre systems and processes remain fit for purpose and patient centred, now and in the future.*
- *Welsh Blood Service Futures Programme: WBS Futures has been established to be the vehicle to deliver the WBS 5 Year Strategy and our ambitious IMTP. It consists of 6 programmes and 2 associated work programmes. "Digital Modernisation" is one of the 6 programmes and contains three projects.*

In addition to enablement of the Futures programmes for 24-27, a Trust digital priority will be the design, implementation, transition and go-live for the digital workstream for the new Velindre Cancer Centre. This includes a comprehensive new digital infrastructure for the Trust and new digital systems focussed on the patient experience of services at nVCC.

To successfully deliver the Digital IMTP through 24-27 we have established a Digital Programme, which will co-ordinate the digital transformation. The rationale for bringing this work together into a programme is to recognise the importance that Digital plays in supporting the services of the Trust, the interconnected nature of Digital services and to better focus our Digital resources on patients, donors and staff. This will allow

us to be more efficient with our resource, increase staff confidence and capability with Digital, and better manage our Digital risk. The components of the Digital Programme are shown in Figure 2 below.

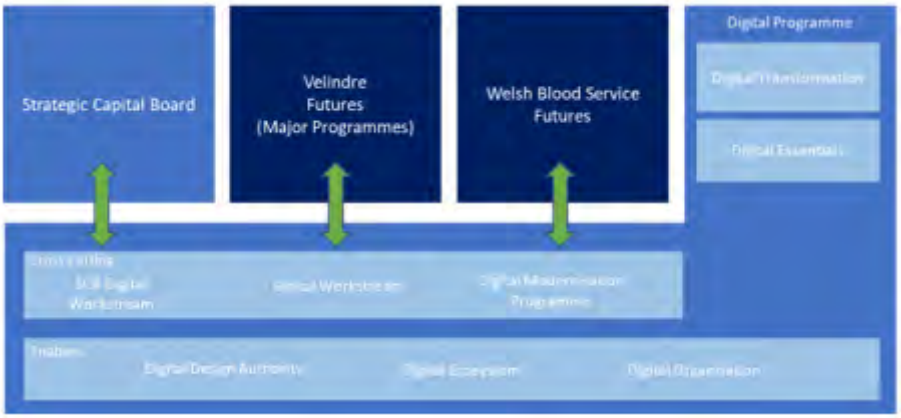


Figure 2: Digital Programme Scope

The cross-cutting workstreams provide Digital solutions into the services through the "Futures" programmes and nVCC through the SCB Digital workstream.

There are a set of enablers that are required to support the success of the IMTP and in line with good practice these are included within the Digital Programme for ownership and alignment. These include the Digital Organisation, Digital Ecosystem and a Digital Design Authority to set the standards and principles against which solutions are built.

The Digital Essentials workstream will be responsible for an Integrated Platform including managing capacity and demand, managing technical debt, plans for transition to a cloud first approach, dealing with National infrastructure programmes (e.g. All Wales Infrastructure Programme), and Cyber Security.

The Digital Transformation workstream will cover new Digital services for patients & donors and staff and the transformation of how we deliver digital services in line with modern service design standards.

Key Programmes of Work 2024 / 2025

The initiatives listed below, set out against our digital themes, include a wide range of digital projects which will help us enable the service visions for VCS, WBS and prepare for nVCC. In addition, the table includes essential digital projects and Trust wide initiatives. The initiatives sit alongside the "business as usual" digital services which includes the planned ongoing replacement of digital equipment, minor digital system upgrades (e.g. BECS Delta releases for WBS) to local and national systems, and data and insight improvements.

Theme 1: Ensuring our Foundations

- VCS: Implementation of National Radiology Informatics System (RISP)
- VCS: Deployment of Integrated Radiotherapy Solution Programme by 2026-27
- VCS: Renewal of SACT e-Prescribing
- Trust: Implementation of Call Centre telephony underpinning service plans
- VCS: Phase 2 of WPAS/WCP National systems
- WBS: Procurement for new Blood Establishment Computer System
- WBS: Implementation of National LIMS 2.0 system
- WBS: Migrate Prometheus donor matching from Digital Healthcare Wales
- Digital: implement new IT Service Management tool – Halo
- Digital: implementation and transition to new Managed Print service

Theme 2: Digital Inclusion

- VCS: extending use of Video Consultation platforms
- Trust: implementation of Digital Inclusion Plan
- VCS: PSA Tracker Phase 2
- VCS: RITA virtual assistant further development
- WBS: implement new appointment system for Donors

Theme 3: Insight Driven

- Trust: digitally enable Value Based Healthcare (VBHC) initiatives
- Trust: implement new digital system for Patient Reported Outcome Measures (PROMS) for VBHC
- Trust: implement performance management framework (including quality measures) dashboards
- Data and Insight: go-live on VXRails data warehouse platform and transition VCS/WBS
- Data and Insight: pilot and scale National Data Resource roadmap
- Data and Insight: create prioritised Data and Insight roadmaps for WBC/VCS
- Data and Insight: define Trust wide Data and Insight plan and transition to the new service model

Theme 4: Safe and Secure Systems

- WBS: digital enablement for Foetal D testing
- Trust: Design a new Trust-Wide network and implement for Radiotherapy Satellite Centre and plan for nVCC and Talbot Green Infrastructure programmes
- Digital: continue to implement strategic cyber security plan
- Digital: server refresh/virtualisation and refresh backup/storage
- Digital: pilot and scale migration from Windows 10 to Windows 11 and common user/device experience
- Digital: pilot (through ePMA) and scale single sign-on

Theme 5: A Digital Organisation

- VCS: Implementation of Electronic prescribing (EPMA)
- VCS/nVCC: Scoping for digitisation of Medical Records
- WBS: implementation of new digital system for WHAIS
- WBS: implementation of new digital system for the Welsh Bone Marrow Donor Registry
- WBS: implement digital services in support of the Plasma for Medicines programme
- WBS: enable live connectivity for collections teams
- Digital: pilot agile delivery squads in line with service design principles
- Digital: pilot and scale Robotic Process Automation (RPA)

• Digital: go-live with Digital Training Platform • Digital: Scope donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre.
Theme 6: Working in Partnership • VCS: Implementation of digital services at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) 2025. • VCS: Digital implementation of Regional Acute Oncology Service (AoS) • WBS: implementation of new digital system for NEQAS external quality assessment service • nVCC: collaborate on nVCC digital plans with Acorn consortium

Please Note: Our action plan to support the delivery of our digital objectives is available upon request.

Workforce and Organisational Development

Trust Values

During 2023 / 2024 we have engaged extensively in relation to our Trust values. The outcome of this engagement process has been a refresh of our previous Trust values. Our new Trust values are listed below. These will underpin how we plan all service developments across the Trust.

Caring	Respectful	Accountable
We are always kind, supportive, approachable and show compassion to all.	We seek to understand other people's perspectives. We are always open and transparent.	We always take personal responsibility for what we do and how we do it.

Velindre is committed to being an employer of choice, offering an excellent working and development environment, with staff dedicated to providing outstanding care every time for our patient and donors and recognising that the key quality and strategic objectives can only be achieved through a combination of a well led, engaged and efficient people. We strive to behave in line with our values which we are always continuing to review.

The Trust is dedicated to providing opportunities for staff to engage and develop. We strive to provide opportunities for staff to learn and has strong relationships with academia through the Trust Academic Board. There is a range of health and wellbeing initiatives that are being made available to staff across our sites and on-line health and wellbeing resources that can be accessed at any time.

Models of care and service delivery need however to be constantly replaced and updated to support a changing NHS landscape and to meet the requirements of NHS Wales's service delivery strategy. We are modernising in response to new healthcare options, the national Workforce Strategy, changing social expectation and expectations of patients and donors, rapid advances in technology and economic pressures. Additionally, the expectation that people have of their working lives and career pathways are evolving. The development of our people is key to transformation.

Our Plan for 2024/25 – 2026/27 and Beyond

Our people and the needs of our patients and donors are changing and so is the way in which we deliver care. Shortages of clinical staff nationally, an ageing workforce and changes to education pathways means that the workforce profile is evolving.

We value our staff and recognise that they are a key priority to the successful delivery of high quality services. Our aims, therefore, are to continue to develop our workforce by:

- Supporting career pathways
- Developing the leadership skills of our staff
- Providing our staff with the knowledge and skills that they need now and in the future
- Supporting the well-being of our staff
- Recognising and valuing the diversity of our staff as part of a bi-lingual culture and ensuring all staff are able to be themselves and work in an environment that supports and values difference.

Our strategic ambitions build upon our strong foundation as a good employer and is essential to the delivery of our service plans for VCS and WBS.

Our Workforce Vision: To Become an Employer of Choice:

Skilled and Developed People: an employer of choice for staff already employed by us, starting their career in the NHS or looking for a role that will fulfil their professional ambitions and meet their personal aspirations.

Planned and Sustained People: having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing.

Healthy and Engaged People: within a culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and cultural identity.

Our workforce plan will help ensure that we can continue to deliver world class services for our donors, patients and carers. This will only be possible if we have the right workforce in the right place with the right sills at the right time.

Our Workforce Response

To deliver our vision we have set out a number of themes which will support us in attracting, developing and retaining a workforce fit-for-now and fit-for-the future.

Theme 1: Wellbeing and Engagement
We will ensure our staff feel valued and supported

Theme 2: Supply and Shape
We will have the right people with the right skills in the right place at the right time

Theme 3: Skilled and Developed People
We will continually develop our staff to support them to achieve excellence in everything they do

Theme 4: Leadership and Succession Planning
We will develop compassionate leaders and managers which sustain our future requirements

Theme 5: Digital Ready People
We will create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology

Theme 6: Attracting and Retaining the Best Talent
We will seek to identify the best talent locally and across the globe to work in our organisation.

Delivering our Workforce Objectives – We will achieve these by:

- Implementing a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement.
- Working towards a psychologically safe culture that allows our people to speak up safely.
- 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-Racist Action Plan and other aligned anti-discriminatory practices
- Developing our talent management process that supports career pathways
- Developing our data, information and insight to support the embedding our workforce planning process to support new ways of working for our staff
- Implement our welsh culture plan 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
- Working with partnerships both in academia and nationally to ensure the best leadership and management offers are provided for staff including coaching, mentoring and provision of masterclasses

With the successful implementation of the core themes we will be able to facilitate the transition of people across all of our key deliverable areas. This will help us create and sustain a Health and Engaged, Skilled and Developed and a Planned and Sustained Workforce.

Our Key Workforce Changes

- Clinical agreed short and long-term Multi-Disciplinary workforce plans
- Improved alignment of our education and training functions to the needs of our services
- Services delivered at a location and time which best suits our patients and donors
- All staff to be proud to, and able to, promote our core values and behaviours
- Improved health and well-being of our workforce.

Please Note: Our action plan to support the delivery of our workforce objectives is available upon request

Our Estates Plan

Our Estate

Headquarters:

The headquarters building, located in Nantgarw, Cardiff, houses the executive and corporate function of the organisation.

Cancer Services

We deliver these services from a number of locations.

Velindre Cancer Centre:
The Velindre Cancer Centre is based in Cardiff. The Centre was constructed in 1966 and has been subject to various extensions through each decade since opening. The hospital occupies a footprint of approximately 16,000m2.

Velindre@ facilities:
We provide services across South East Wales from buildings and facilities across our partner Health Board sites.

Blood and Transplantation Services

We have access to a number of locations.

Talbot Green, Llantrisant:
Constructed in 2003/4 and was extended in 2017-2019 to provide a Clinical Services and Hospital Lab Area. The building occupies a footprint of approximately 7,000m2.

Dafen:
Situated in Llanelli and is the primary base for our collection teams in West Wales. The building occupies a footprint of approximately 400m2, and houses all consumables required to support collections.

Bangor:
This is the primary base for our collection teams in North Wales. The building occupies a footprint of approximately 500m2, and houses all consumables required to support collections.

Wrexham (Pembroke House):
Pembroke House occupies a floor area of approximately 500m2. The main purpose of this building is to act as a stock holding unit providing north wales hospitals with blood products together with the main base of operations for the collections team in the North-east region of Wales.

Our Plan for 2024/25 – 2026/27 and Beyond

The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in. The estate is an important component of our future success and it is vital that we embrace the opportunities that the estate, sustainability and wider opportunities offer to create social value in the communities we serve.

'*Estates Excellence*' sets out our strategy for the next ten years and will help us maximise the opportunities which exist. It sets out what estate we require now, and in the future, and how we will work with our patients, donors, staff and communities to ensure they have a safe and enjoyable experience which helps to improve their overall health and well-being. It also sets out how we can use our estate and facilities to make a wider contribution to communities and society.

Our Estates Vision: A Sustainable Estate which Provides a Great Experience for all

We have developed four themes to support the development of our estate.

Theme 1: A safe and high quality estate which provides a great experience

Theme 2: Healthy buildings and healthier people

Theme 3: Minimising our impact to the environment

Theme 4: Using our estate to deliver the maximum benefit and social value to the community we serve

Our Estate Objectives

Our objectives are to:

- Provide an estate which enables the delivery of high quality clinical services
- Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience

- Provide healthy buildings which support and enhance individual well-being
- Minimise the impact of our estate on the environment
- Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve

We will achieve these by:

- Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs
- Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces
- Investing additional resources in the maintenance of the existing estate to maintain a Category B
- Implementing our estates, digital, workforce and sustainability strategies
- Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles
- Identifying innovative ways to adopt renewable energy sources to service our requirements
- Identifying facilities we can share the use of with other public bodies and wider partners
- Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets
- Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services
- Delivering a number of transformative capital programmes which have sustainability at their centre of design:
  - Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025
  - Refurbishment / development of new outreach facilities by 2024/2025
  - Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024
  - Opening of the new Velindre Cancer Centre by 2025

Our plan is supported by an ambitious infrastructure programme which includes:

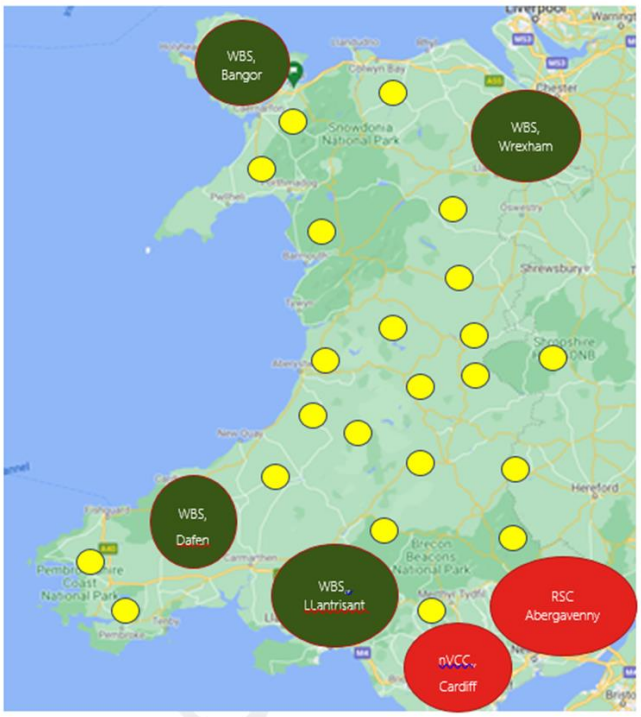
- **Development of a New Velindre Cancer Centre in Whitchurch, Cardiff:** the replacement of the existing VCS has been identified as a key commitment within the Welsh Government's '*Programme for Government*'. The new Velindre Cancer Centre will provide improved services for our patients, families and staff; will contribute to our sustainability strategic ambition of becoming a carbon net zero organisation and will deliver numerous community benefits for the population we serve.
- **Development of a Velindre Radiotherapy Satellite Centre at Nevill Hall Hospital:** the provision of a Radiotherapy Satellite Centre (RSC) has been identified as a key regional development to facilitate the delivery of timely and effective Radiotherapy services to the South-east Wales population. The ambition

is to deliver a world-class facility that will provide specialist care for cancer patients from that locality.

- **Programme to re-develop the Welsh Blood and Transplantation Services Facility:** this Programme sets out a number of strategic developments which will support the provision of high quality, safe, sustainable, efficient services and support the decarbonisation of our estate. It will also provide the foundation for the Laboratory Modernisation programme which will look at a range of new services to support NHS Wales.
- **Maintenance and Upkeep of the Estates:** the Trust recognises the importance of maintaining suitable environments in lieu of delivering major capital programmes so are committed to ensure there is sufficient investment in key areas to ensure environments continue to be suitable for patients and staff.

Our Transformed Estate in 2026/27

Our services are based on a hub and spoke model and we will continue to provide services from various buildings across Wales, some which we own / lease and some which are provided by our partners.



Key:

●	Illustration of the multiple venues across Wales we will collect blood and blood products from

Please Note: Our action plan to support the delivery of our estate and infrastructure objectives is available upon request.

Sustainable Services

We recognise the responsibility vested in us by the people we serve to make the country a better place to live, work and enjoy. We fully recognise the impact we have on the environment, the communities we operate in, the people we provide services for, and the staff who work for us.

We have a clear ambition over the next three years to deliver high quality, sustainable health care services which reduce our impact on the environment and provides wider value to our communities. The delivery of our plan provides us with an exciting challenge which will require us to continue to pursue excellence in our clinical services whilst also making a contribution to the wealth, health and prosperity across Wales.

As an anchor organisation, we are committed to embedding sustainability within our own organisation and becoming an exemplar in Wales. Our plan provides a roadmap to achieving a sustainable future which will enable us delivering high-quality clinical services whilst reducing our impact on the planet and providing a wider range of benefits for the communities we work and live in.

Our Plan for 2024/25 – 2026/27 and Beyond:

The pioneering 2015 Well-being of Future Generations Act (the "Act") and the Environment (Wales) Act 2016 provides Wales with an exciting opportunity to lead the way internationally and this strategy outlines our sustainability aims and enables real action to create positive and significant change.

We are passionate about sustainability and we know the communities we serve and our workforce are too. We have an uncomplicated goal; to become a sustainable organisation that plays a part in creating a better future for people across the globe.

Over the past year we have delivered a wide range of initiatives including establishing, alongside our Therapies Department, a new walking aid recycling initiative at Velindre Cancer Centre. This initiative aims to reduce waste, save costs and avoid carbon emissions whilst supporting service users and delivering a more sustainable service.

In addition, during financial year 2023, the Trust was successfully reaccredited with the ISO14001 Environmental Management Standard during which the Auditor was complimentary of the work of the Trust to promote sustainability and effective environmental management.

The Trust is also in the process of finalising its Decarbonisation Action Plan and Site-based Sustainability Implementation Plans which have been developed alongside the Trust's recently refreshed Sustainability Strategy – 'Sustainability Excellence'.

Our Vision for Sustainable Services: A Sustainable Organisation which Contributes to a Better World for Future Generations Locally and Across the Globe

Our vision will be supported by the following aims:

- To deliver sustainable services which add wider social value for our community
- To be recognised as an exemplar organisation of delivering the Well-Being of Future Generations Act
- To deliver a biodiversity net gain and enjoyment of our green spaces to improve health and well-being
- To become a carbon '*Net Zero*' organisation
- To use our resources effectively and efficiently: zero waste to landfill by 2025 and reduced consumption of energy and water

Theme 1: Creating Wider Value
To embed sustainability within our organisation and create more value for the people we work for and the communities we work within.
Theme 2: Sustainable Care Models
To deliver the highest quality of care which minimises our impact and supports our journey to a sustainable planet
Theme 3: Carbon Net Zero
To become a carbon Net Zero organisation by 2025
Theme 4: Sustainable Infrastructure
To provide buildings which improve the well-being of our patients, donors and staff to reduce our environmental impact
Theme 5: Transiton to a Renewable Future
To reduce our overall energy requirements and transition to renewable sources
Theme 6: Sustainable Use of Resources
To reduce, re-use and recycle resources annually and adopt a circular economy approach as the '*way we do things around here*'
Theme 7: Connecting with Nature
To maximise the quality and benefits of our green space, buildings, facilities and resources to enhance nature, biodiversity and well-being
Theme 8: Greening our Travel and Transport
To reduce the health impacts associated with our business and support a transformation in the way we travel
Theme 9: Adapting to Climate Change
To ensure our organisation is well prepared to manage the impacts of climate change
Theme 10: Our people as Agents for Change
To develop a workforce which places sustainability at the heart of everything we do

Our Sustainability Objectives

Our Objectives are to:

- Be recognised as a leading NHS Trust for sustainability nationally
- Be a carbon 'Net Zero' NHS organisation by 2030.
- Become an anchor organisation in the communities we serve which enhances their economic, social, environmental and cultural well-being
- Support the transformation from ill-health to well-being across Wales

We will achieve these by:

- Developing clinical service models which support sustainability
- Implementing our sustainability strategy
- Applying the principles of the circular economy into our business processes through design, procurement, re-use and lifecycle.
- Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day')

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

Please Note: Our action plan to support the delivery of our sustainability objectives is available upon request.

Value Based Healthcare Programme

Our vision is to enable clinical and operational teams to deliver exceptional services, using linked datasets to identify and deliver continuous improvements that maximise the value, quality, safety, and efficiency of the service our donors and care our patients receive.

In 2023 the Trust received an allocation from the Welsh Government VBHC (Value Based Health and Care) fund to implement 2 programmes, Pre-op Anaemia and the Value Intelligence Centre. In addition to these, the Trust is developing a Food Mission.

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).

The evidenced benefits across NHS Wales are as follows:

- Prudent use of donated blood and reduced demand for blood
- Improved clinical outcomes post operatively, especially after major surgery, such as cardiac surgery
- Reduced length of stay post-surgery which will support the NHS Wales Planned Care Recovery programme
- Ensuring equity of care and outcomes across Wales in pre-operative anaemia management
- Providing evidence for a potential further roll out of the All-Wales Anaemia Pathway to benefit others, in particular pregnant people.

Recurrent funding has been allocated to each Health Board to recruit clinical staff to support Blood Health Management, with the non-recurrent funding covering the programme team within WBS (Welsh Blood Service).

A proposal has been drafted to secure the sustainability of the achievements to date and to extend the scope of this programme to include more surgical procedures, Cancer Pathways, Primary care, Obstetrics and Paediatrics. Funding the programme recurrently will improve the management of anaemia more widely across the health system.

Value Intelligence Centre:
Work to establish the trust Value Based Healthcare Programme started in April 2023, which included the creation of a Value Intelligence Centre in September.

Funded by the Welsh Government, the Value Intelligence Centre works across the organisation to enable the optimisation of care through Value Based Healthcare (VBH).

The Centre will help to modernise and replace traditional retrospective audits of disease-related outcomes, and blood product usage. This will free up clinicians and

scientists from using manual data gathering and analytical processes, to spend more time delivering improvements to services.
The team comprises of data, finance and business analysts who are focusing on implementing enablers of VBH (e.g. Patient Reported Outcome Measures (PROMS) and Information Dashboards) as well as conducting analysis to identify and track interventions that increase the value of the delivery of care.

We will achieve our vision through the following enabling workstreams:

- **Training, Engagement and Communication:** Creating, sharing and delivering developmental content to staff at all levels to build confidence and understanding of the principles of VBHC. This includes generating case studies of value in action projects within VUNHST (Velindre University NHS Trust) across both the Welsh Blood Service and the Velindre Cancer Service. Through close collaboration with the Welsh Value in Health Centre we will pursue opportunities for shared learning and spread of improvements in practice.
- **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 and to incorporate future data feeds, for example blood transfusion data and patient reported outcome measures (PROMS).
- **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 issues. It includes working with our population to achieve accurate contact details to ensure that messages sent by text are received by as high a proportion of our donors and patients as possible.
- **Data Driven Sense Making and Action Planning** This takes all the above information and applies financial, workforce and data analytical capabilities to provide actionable information for services to apply through the Value Intelligence Cycle. By applying analytics prior to, and after changes to services are made, the impact of interventions can be assessed enabling further refinement to processes and services provided. Areas of intervention include identifying and reducing unwarranted variation in the provision of care.

- **Digital PROMs Platform:** To enable the systematic collection of patient reported outcome measures (PROMs) to capture and understand the quality of life and symptom burden that our patients experience. For most patients, this will take the form of a structured questionnaire sent periodically to their mobile phones. The responses to the questions will be stored on the patient's electronic health record and form part of their medical history to support with the management of their care. This PROMs system will be part of a suite of patient facing apps within the Digital Services' portfolio. Roll out will include work to support patients that are not familiar with using their phones in this way, and use of alternative methods for completion for those who do not have this technology to hand.
- **Patient Outcomes:** To achieve **shared decision making**, our patients need meaningful information on the outcomes that they should expect from different treatment options. To understand the outcomes of treatment for our patients, we need to agree the questions to be asked. This ensures consistency across pathways and the ability to analyse aggregated data 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 different types of cancer and when to send them on a national basis. These will be used to inform the consultations of the patients completing the form as well as, in aggregate being used to help future patients understand typical outcomes from different treatments using real-life locally gathered data.

The additional information that patient reported outcomes brings to clinical practice represents a seismic shift in our ability to support shared decision making. The Value Intelligence Centre will work to ensure that the enabling structures are in place to support services with this transition.

This programme seeks to ensure that the patient's voice is captured throughout and beyond their care with Velindre, as such we will communicate developments and involve our community to ask for feedback at stages of patient-facing projects.

Over the next 3 years, clinical and operational teams will see a step change improvement in capability to evaluate patient reported outcomes alongside cost of treatment and be supported to change and refine practice as a result.

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.

The outcomes that we want to achieve through this mission are:

- Healthier people with access to healthy, affordable food

- Shorter, more resilient food supply chain which minimises environmental impact and delivers values for money
- More spaces to enjoy and learn about food across the Trust
- Reduced food waste and ecological footprint
- Vibrant local food economy and communities through partnership

Areas of focus include menu redesign, enabling access to healthy food, developing knowledge and skills of staff on this subject, working with Procurement to achieve both value and values for money through shorter supply chains and helping to deliver the Social Partnerships and Public Procurement (Wales) Act 2023.

Part 7

Our Financial Plan

We set out our 3 Year Financial Plan for 2024 / 25 to 2026 /27

Overview of our Financial Plan – 2024/25 – 2026/27

The Trust has had an approved Integrated Medium Term Plan (IMTP) since their introduction by Welsh Government (WG) in 2014/15. Central to IMTP approval has been the Trust's ability to consistently achieve a balanced out-turn position annually, whilst maintaining or improving the quality of our services, meeting the rising demand and delivering agreed performance measures.

This section sets out our Medium Term Financial Plan from 1st April 2024 to 31st March 2027. During this period, the Financial Strategy aims to enable the Trust to meet the anticipated growing demand for services whilst dealing with significant financial challenges due to a number of major strategic developments as part of the Trust's transformation programme. In addition, there are other significant cost and service pressures as well as the cost of implementing additional capacity to deal with rising demand. There remain system wide cost pressures in relation to Digital and Welsh Risk Pool as well as relatively high levels of inflation especially over the last year, which will need to be met by the Trust in 2024/25.

As outlined in the Health Board Allocations 2024-25 document issued by Welsh Government, the Trust understands that a 3.67% uplift to Recurrent Discretionary Allocations has been provided in 2024-25. In line with Welsh Government policy, and further guidelines received from the NHS Executive Financial Planning and Delivery directorate, we recognise that the funding settlement is intended to support sustainability, unavoidable demand and core cost inflationary pressures. Further, the Trust recognises Welsh Government's expectation that an equivalent 3.67% allocation will be passed through to Provider organisations by Commissioners.
The Trust financial plan assumes that its Commissioners pass the 3.67% uplift to the Trust via its LTA's, which together with a 3.14% savings target, is a fundamental assumption in enabling the Trust to develop a balanced financial plan in 2024/25.

The financial plan for 2024/25 consists of three distinct parts:

Core Plan: Balanced

Balanced Brought Forward Position:

- The Trust brought forward an underlying surplus of £0.684m into 2023/24, however due to the financial challenges from underlying recurrent cost pressures, investment decisions, and non-achievement of recurrent savings this underling surplus was eliminated during the period and has resulted in the Trust bringing a balanced position into 2024/25.

- During 2023-24 LTA activity performance recovered to a level above the 2019/20 baseline that was sufficient to provide marginal income to fund the amount of investment made in capacity.
- WG will provide recurrent funding towards the increase in energy costs during 2024-25, eliminating the underlying cost pressure.

Growth Pressures:

- The 3.67% core discretionary uplift (sustainability) funding will be required to fund the significant underling cost pressures, investment in capacity beyond marginal cost, the revenue investment decisions in relation to the Trusts major infrastructure and equipment projects.
- Divisional cost pressures above those recognised in the IMTP Financial Plan at this stage will either need to be mitigated, funded from existing budgets in service divisions or require additional savings above the £2.6m (3.1%) target already identified.

Savings Plans:

- The following table summarises the level of savings the Trust is planning to deliver during 2024-25 which will be required to support the level of investment decisions and cost pressures within the system.

Savings Plan	2024-25 £000
CIP Planned Savings	1,179
Income Generation	1,427
Total Savings / Income Generation	**2,606**
CIP % (of Core LTA values)	**3.1%**

Financial Plan

The plan aims to provide services with sufficient capacity to meet demand in support of recovery from the Covid pandemic, whilst targeting improved levels of efficiency and productivity alongside sustained delivery against national targets and / or professional performance standards. In terms of efficiency the Trust has set a 3.1% savings target of £2.6m in 2024-25.

In addition to this internal savings target and the associated savings schemes the Trust is leading on a number of all Wales service developments that are currently leading to or will lead to capacity release, cost avoidance and cost reduction in Health Boards.

Whilst the Trust is submitting a balanced financial plan there is significant financial risk and challenges to deliver this plan due to the uncertainties around the income it will receive to cover the committed investment in Velindre Cancer Services.

The proposed financial plan has been developed using the latest assumptions regarding the Trust's expected income from Commissioners and Welsh Government, the likely cost pressures facing the Trust, both pay and non-pay inflation, and realistic, but challenging view of the cost saving potential of services.

These assumptions have been discussed and agreed with Commissioners and Trust Board through the IMTP engagement process.

The formal agreement of the Trust income planning assumptions will be summarised within respective Commissioner Long Term Agreements for 2024-25 which must be signed by the 28th June 2024, but the Trust is working with its Commissioners to sign LTAs by the end of March. A summary financial plan reflecting the marginal revenue and cost impact for period 2024-25 to 2026-27 is presented in the following table:

	2024/25		2025/26		2026/27	
Summary of Financial Plan 2024-27	**In Year Effect £000**	**FYE of Rec £000**	**In Year Effect £000**	**FYE of Rec £000**	**In Year Effect £000**	**FYE of Rec £000**
Underlying Core Position b/f	0	0	0	0	0	0
Unallocated reserves b/f	0	0	0	0	0	0
b/fwd. underlying deficit	**0**	**0**	**(208)**	**(208)**	**0**	**0**
Revenue						
WG Velindre Pay Commissioner Pay Award Matrix & Real Living Wage 24/25	81	71	71	71	71	71
LTA Core Uplift (3.6% 24/25 assumed 1% for 25/26 & 26/27)	2,864	2,864	1,222	1,222	1,234	1,234
Exceptional National Cost Pressures (Energy)	563	563	0	0	0	0
Assumed LTA Income Growth for NICE drug growth & WBS Blood derived medicines growth	11,418	11,418	11,977	11,977	12,618	12,618
LTA Service Growth Investment	2,455	2,455	2,315	2,315	6,542	6,542
VCS LTA Marginal cost income from activity growth	1,300	1,300	1,000	1,000	1,000	1,000
AME & Non Cash Depreciation / Special Payments	18,954	0	13,820		14,079	
Total Revenue	**37,635**	**18,671**	**30405**	**16,585**	**35,544**	**21,465**
LTA Service Growth Investment to LTA Service Costs for IRS, AO, RSU, nVCC, SACT Infrastructure, RT devpts	(2,455)	(2,455)	(2,315)	(2,315)	(6,542)	(6,542)
VCS NICE Drug Growth	(7,701)	(7,701)	(7,701)	(7,701)	(7,701)	(7,701)

Summary of Financial Plan 2024-27	2024/25 In Year Effect £000	2024/25 FYE of Rec £000	2025/26 In Year Effect £000	2025/26 FYE of Rec £000	2026/27 In Year Effect £000	2026/27 FYE of Rec £000
WBS Contract Price/ Inflation	(3,717)	(3,717)	(4,276)	(4,276)	(4,917)	(4,917)
Exceptional National Cost Pressures (Energy)	(563)	(563)	0	0	0	0
National / General Cost Pressures	(1,499)	(1,489)	(786)	(786)	(808)	(808)
Local Cost & Service Pressures	(4,052)	(2,748)	(2,558)	(1,758)	(2,547)	(1,747)
VCS LTA Marignal Income for Service Capacity Investment	(1,300)	(1,300)	(750)	(750)	(750)	(750)
AME & Non Cash Depreciation / Special Payments	(18,954)		(13,820)		(14,079)	
Total In Year Changes to Cost Base	**(40,241)**	**(19,973)**	**(32,206)**	**(17,586)**	**(37,344)**	**(22,465)**
Net Opening Balance before Savings	**(2,606)**	**(1,302)**	**(1,800)**	**(1,000)**	**(1,800)**	**(1,000)**
Savings Plan (3.1%)	2,606	1,302	1,800	1,000	1,800	1,000
Net Income Generation	0	0	0	0	0	0
Net Opening Balance	**0**	**0**	**0**	**0)**	**0**	**0**

Income Assumptions

Income Assumptions and Extent of Alignment with Commissioner and WG Plans:

The following are the income growth assumptions the Trust has made to meet the unavoidable inflationary, demand and growth pressures forecast during 2024-25:

- Commissioners will uplift LTA values by 3.67% which amounts to £2.864m core uplift in 2024-25. For planning purpose. The Trust is assuming a 1.5% uplift to LTA values for 2025-26 and 2026/27. Commissioners have developed an options paper that includes proposals of reduced uplift of 1.2% or 1.67%. However, the Trust expectation is the uplift is 3.67% as the expectation set out in the Health Board Allocation Letter.
- Energy funding of £0.563m recurrently has been recognised for the Trust in Health Board Allocation Letter to cover the exceptional energy cost pressure.
- Commissioners will pass through as additional income to the LTA the 2023-24 Agenda for Change (AfC) and Doctor & Dentist Review Body (DDRB) costs as per the WG Pay award matrix.

- The 2024-25 Pay Inflation not currently agreed but is expected to be funded directly by WG over the 3 years of the IMTP (any shortfall will need be met by discretionary uplift, additional savings or absorbed by Divisions).
- **In line with WG guidance any planning assumption for the 2024-25 pay award is excluded from the IMTP financial plan.**
- Funding for the Real Living Wage (the impact of the policy on Social Care) will be dealt with as a non-recurrent allocation, addressed in year.
- The cost increase in employer's pension contributions from 14.3% to 20.6% will continue to be paid by WG. (**Per WG guidance excluded from the plan**)
- Allocations for accelerated depreciation, AME depreciation for donated assets, relevant IFRS 16, and DEL and AME impairments will be issued as direct funding from WG. This will also apply to any increases in depreciation related to approved schemes with confirmed strategic support.
- Activity demand modelling forecasts £1.300m additional LTA marginal cost income above the 2023-24 projected outturn.
- The Trust will receive pass through income from commissioners to cover the cost of NICE / High-Cost drugs VCS uses in delivering cancer care. The forecast annual cost growth has been estimated using historic trends and the latest horizon scanning, this amounts to a £7.701m increase in 2024-25.
- The Trust will receive pass through income from LHBs through their SLAs to cover the cost of wholesale blood derived products WBS supplies to them. The forecast annual cost growth for 2024-25 has been calculated based an estimated 15% volume growth and general price inflation totalling £3.717m.
- In 2022-23 the Trust secured funding from WG from the Value Based Healthcare (VBHC) fund. Funding will be held by WG and invoiced based on actual costs.
- WG and / or WHSSC will fund the WBS Plasma for Medicines (Fractionation) business case costs should WG decide to progress with this service development.
- The Trust is expecting as confirmed by WG when the bid was submitted that the SDEC service development funding of £0.935m available in 2023-24 is recurrent, however funding has only been confirmed non-recurrently for 2024-25. Unless funding is secured recurrently this becomes a significant risk for the Trust during 2025-26 and beyond. The Trust recognises that a 7% saving reduction has been applied to the funding.
- At this stage the Trust is expecting that WG will provide funding to cover the costs relating to the Whitchurch site that will be transferred to the Trust from C&VUHB. These include revenue costs of c£0.600m p.a. for security and other costs delating to due diligence work (land searches, structural survey's etc.) which are currently being assessed. A paper setting out these costs will be submitted to Health Service Board for consideration.
- It is assumed that the Trust will receive additional income from commissioners to cover any new service developments or additional capacity they agree to commission. Should funding not be agreed, developments and infrastructure will not be implemented, and any costs already committed to will need to be mitigated

or removed. Funding for the key service infrastructure, quality improvement, activity growth and cost pressures included in the table below have previously been shared and agreed with Commissioners:

	2024/25				Incremental Income			
LTA Service Growth Investment	LHB £000	WHSCC £000	TOTAL £000	IMTP Total 2024/25 £000	IMTP Total 2025/26 £000	IMTP Total 2026/27 £000	IMTP Total 2027/28 £000	IMTP Total 2028/29 £000
TCS Acute Oncology Services	726		726	726	0	0	0	0
TCS Integrated Radiotherapy Solution Planned Requirement	591		591	591	621	(50)	18	43
TCS Radiotherapy Satellite Centre - Transition Cost	565		565	565	0	0	0	0
TCS Radiotherapy Satellite Centre - Fixed Fee Share	112		112	112	1,233	0	0	0
TCS nVCC FBC Planned Recurrent Funding Requirement			0	0	0	4,080	0	0
TCS nVCC FBC Planned Transition Funding Requirement			0	0	0	2,412	0	0
TCS Outreach Programme			TBC	TBC	TBC	TBC	TBC	TBC
SACT Medicine Infrastructure Financial impacts (MIFs)	100		100	100	100	100	100	100
Radiotherapy Service Implementation	361		361	361	361	0	0	0
Total Service Improvement & Growth	**2,455**		**2,455**	**2,455**	**2,315**	**6,542**	**118**	**143**

- The current financial plan assumes no additional internal investments in major programmes and projects beyond resources agreed within approved business cases. Any additional funding requirements will either need to be met through a reallocation of existing resources or additional savings above the £2.7m target.

Pay Related Cost Assumptions:

- Expectation that Pay Inflation funding received will cover the cost growth. (Any shortfall will need be met by discretionary uplift, additional savings or absorbed by service Divisions.
- The Trust holds a £1m vacancy factor target, which will need to be achieved on an ongoing basis in order to balance the overall financial position.

- In line with the guidance the 2024-25 pay inflation and employer's pension contributions from 14.3% to 20.6% has been excluded from the financial plan.

Non-Pay Related Cost Assumptions:

- Latest forecast modelling of forecast energy prices suggests that the incremental cost above baseline to the Trust could be c£0.563m, which will be funded by WG per the allocation letter.
- The national / general cost pressures have currently been estimated at £1.209m for 2024-25. General Non-Pay inflation is forecast to be 3.2% (£0.673m), WRP (£0.331m) and the expected increase in digital costs via the DHCW SLA for services such as Microsoft 365 and national IT system projects.
- Non-pay Inflationary uplifts on Welsh NHS SLAs of 3.67% (£0.120m) have been assumed for 2024-25 on the basis of a 3.67% core funding uplift to LTA values is passed through to the Trust.

Local Core Service Growth and Cost Pressures:

- The Trust has undertaken a review of its local core service growth and cost pressures, which has resulted in a number being mitigated, removed or costs reduced.
- The cost pressures in the table below are included in the financial plan as needed to meet demand, quality & safety statutory requirements and essential Trust wide digital infrastructure so unavoidable for 2024-25.

Local Cost Pressures	Division	Recurrent/ Non-Recurrent	2024/25 £000
Service investment above marginal cost to maintain capacity	VCS	Rec	2,154
Acute Medical On-Site Clinical Model	VCS	Rec	150
Palliative Care - Additional Posts to maintain service	VCS	Rec	62
Enhancements to Service Delivery model	VCS	Rec	390
Collections Model	WBS	Rec	120
Loss of income due to change in service Model	VCS	Rec	36
Increased costs of running VCC Hospital Estate	VCS	Non-Rec	250
RCI Volume Increase - Discussions with WHSSC for Rec Support (Band 6 plus Non Pay)	WBS	Rec	120
Pathology SLA	VCS	Rec	250
HEIW reduction in funding support	VCS / WBS	Rec	20
WBMDR – Reduced contribution on present activity trajectory	WBS	Non-Rec	300

Local Cost Pressures	Division	Recurrent/ Non-Recurrent	2024/25 £000
Velindre Futures Programme Office	VCS	Rec	450
Advanced Recruitment, Plasma for Medicines, WTAIL LIMS/LINC	WBS	Rec	200
Total Local Cost Pressures			**4,502**

- The current financial plan assumes that these cost & growth pressures that have been identified as unavoidable for 2024-25 will at this stage be funded either through additional marginal cost VCS LTA income from activity growth, LTA core uplift funding or further savings within service Divisions.

National / General Cost Pressures:

The national cost pressures are funded in part by the 3.67% LTA core uplift (sustainability & capacity) funding and in part from savings delivery:

National / General Cost Pressures	Recurrent/ Non-Recurrent	2024/25 £000	2025/26 £000	2026/27 £000
NHS SLA Increase 3.67% 24/25, (1% 25/26 & 26/27)	Rec	120	33	33
Non-Pay Inflation (3.2% 24/25 - 2% 25/26 & 26/27)	Rec	673	394	402
Real Living Wage	Non Rec	10	0	0
Digital (DHCW SLA)	Rec	65	TBC	TBC
NWSSP SLA	Rec	12	12	12
WRP 24/25	Rec	331	347	361
WRP 23/24 (N/R funded during 23/24)	Rec	288	x	x
Total National Cost Pressures		**1,499**	**786**	**808**

Other Assumptions:

- Prioritised service developments will be submitted to commissioners as business cases for funding consideration.
- Plan assumes no additional investment in major programme / project resources beyond those agreed in capital business cases.
- The plan assumes Divisions will mitigate or manage other local cost pressures not recognised in the financial plan.
- Expectation is other new cost pressures that may materialise over the period are either avoided/mitigated as far as possible. Where costs are unavoidable additional savings will be required to fund them.

- Investment in organisational staff capacity and capability to deliver major change Programmes is required to, progress regional work to deliver improved cancer services, establish clinical leadership and to meet statutory duties around quality & safety and duty of candor.
- Without funding support for major change capacity and capability the Trust is considering what decisions are required with regards to reallocation of existing resources or delivery of additional savings and efficiencies, but this is proving difficult given competing priorities and will only enable a small element of the staff capacity and capability to be implemented with consequential impact on delivery of major change.

Planned Savings

The following table summarises the level of savings the Trust is planning to deliver in 2023-24.

Savings Plan	2024-25 £000
CIP Planned Savings	1,179
Income Generation	1,427
Total Savings / Income Generation	**2,606**
CIP % (of Core LTA value)	**3.1%**

The Trust has Identified schemes against full savings target of £2.606m, (£1.600m RAG Green, £0.150m RAG Amber & 0.934m RAG Red).

Savings Plan by Division	Target £000	Schemes Identified £000	Savings Target Gap £000
Welsh Blood Service	650	515	(135)
Velindre Cancer Centre	939	414	(525)
Corporate Services	787	787	0
RD&I	230	230	0
Total	**2,606**	**1,946**	**(660)**

Contracting Model & National Funds Flow Framework:

LTA Contract Rebasing for Velindre Cancer Services:

- The Trust is completing the LTA Contract Rebasing exercise ahead of the 2024/25 financial year.

- This will finalise the transfer of responsibility for commissioning a number of services from WHSSC to LHBs directly. Further, it will conclude the move towards cost recharges being made based on actual activity and utilisation of resources by Commissioners (LHBs and WHSSC) through the new contracting framework developed.

Financial Risks and Opportunities:

There are several financial risks that could impact on the successful delivery of the plan. The Trust recognises these and is taking appropriate actions as set out below, to ensure risks are appropriately managed and mitigated against. All areas of delivery are risk assessed and any identified risks are included within the Trust Assurance Framework and Trust wide Risk Register.

Key Financial Risks	Worst Case £'000	Best Case £'000	Risk Mitigation
Non-delivery of amber / red saving schemes	(660)	0	Service to urgently review savings schemes that are classified as amber with a view to turn green or find replacement schemes
Management of operational Pressures	(500)	0	Operational cost pressures to be mitigated at divisional level. Increased risk due to high level of vacancy factor, with increased savings target and recruitment push
Whitchurch Site Security	(600)	0	Secure funding from WG
Energy Costs Increase	(200)	0	Energy Costs increase above WG funding support
Commissioners not passing through the full recurrent discretionary allocation	(1,560)	0	Per the allocation the letter it is assumed that the full 3.67% will flow from commissioners via the usual mechanism of LTA uplift. Commissioner options paper for funding uplift to providers includes a 2% saving reduction to the 3.67%, reducing the allocation to 1.67% or funding for non-pay inflation only estimated at 1.2%
Total Risks	**(3,520)**	**0**	

Key Financial Opportunities	Worst Case £'000	Best Case £'000	Opportunity application and action
Further vacancy turnover savings above the vacancy factor held in divisions	0	200	Used to provide non-rec savings against savings schemes that are amber
Emergency Reserve	0	500	Reserve held for emergency expenditure but could be released to support position if no unforeseen costs materialise.
Energy Cost Decrease	0	200	Energy Costs are less than WG funding support
Bank interest	0	200	N/R benefit from the recent rise in interest rates. Predicted outlook for 2024/25 is that interest rates will start decreasing now that inflation has been controlled
Total Opportunities	**0**	**1,100**	
Net Financial Risk	**(3,820)**	**1,100**	

Value & Sustainability

In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures.

The purpose of the Finance and Investment Enhanced Monitoring agenda item is to strengthen the control environment by ensuring accountability at an Executive level in relation to:

1. Savings delivery
2. Cost control
3. Choices and Options which could contribute towards wider system financial pressures
4. Impacts of spending decisions considering quality, safety, experience and value

This process will also help to address the strategic risk theme of Financial Sustainability and Long-Term Value for the Trust.

It will provide an additional level of assurance before reporting to external monitoring bodies including:

- Monthly Value and Sustainability Board
- WG / NHS Exec Quarterly Review

Five focus areas were outlined by the Value and Sustainability Board including (1) Workforce; (2) Medicines Management; (3) CHC/FNC; (4) Non-pay and Procurement; (5) Clinical Variation/Service Configuration.

The Value and Sustainability agenda will develop in 2024/25 with the Minister issuing guidance on the following areas of focus:

- Continued progress in reducing the reliance on high-cost agency staff.
- Ensuring strengthened 'Once for Wales' arrangements to key workforce enablers such as recruitment, and digital.
- Maximising opportunities for regional working.
- Redistributing resources to community and primary care where appropriate and maximising the opportunities offered by key policies such as Further Faster.
- Reducing unwarranted variation and low value interventions.
- Increasing administrative efficiency, to enable a reduction in administrative and management costs as a proportion of the spend base.

2024/25 Plans:

- 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.
- Opportunities being explored include the following:
- Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit.
- VBH Pre-operative anaemia pathway work with Health Boards will releasebed 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.

Capital Plans for the Trust

The focus of the capital investment Programme is to maintain a high-quality environment in which to collect, transport, process and supply blood, treat cancer patients and provide modern treatment equipment.

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund. These include:

All Wales Approved and Unapproved Capital Schemes	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 (indicative)	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
Total Unapproved Capital Schemes	**23.084**	**14.257**	**50.322**	**14.269**	**21.267**	**123.199**
Total All Wales Capital Plans	**39.513**	**17.844**	**66.122**	**15.108**	**21.267**	**159.854**

Trust Discretionary Capital Funding:
The Trust discretionary allocation of £1.911m for 2024-25 is an increase of £0.228m from the £1.683 allocated during 2023-24.

Depreciation & Impairment Funding:

The Trust will require additional WG funding estimated at £37.4m over the three years of the IMTP 2023-24 to 2025-26 for accelerated depreciation in relation to the existing cancer centre building and equipment. These costs are set out in the table below and included in the n VCC FBC:

Cost Category	2024-25 £'000	2025-26 £'000	2026-27 £'000	2027-28 £'000	Total £'000
VCS Buildings	9,832	10,016	10,142	5,138	35,128
VCS Equipment	574	607	740	380	2,301
Total	**10,406**	**10,623**	**10,882**	**5,518**	**37,429**

The Trust will require WG impairment funding in 2024-25 of c£5.9m in relation to the capital costs incurred on the ASDA Enabling Works access road for the nVCC. This is currently an asset under construction and will be reflected as such in the Trust Balance Sheet in 2023-24. However, once construction is completed in 2024-25 the asset value will need to be fully impaired as the Trust does not have legal ownership of the asset, but a right to use the asset by way of a license.

Part 8

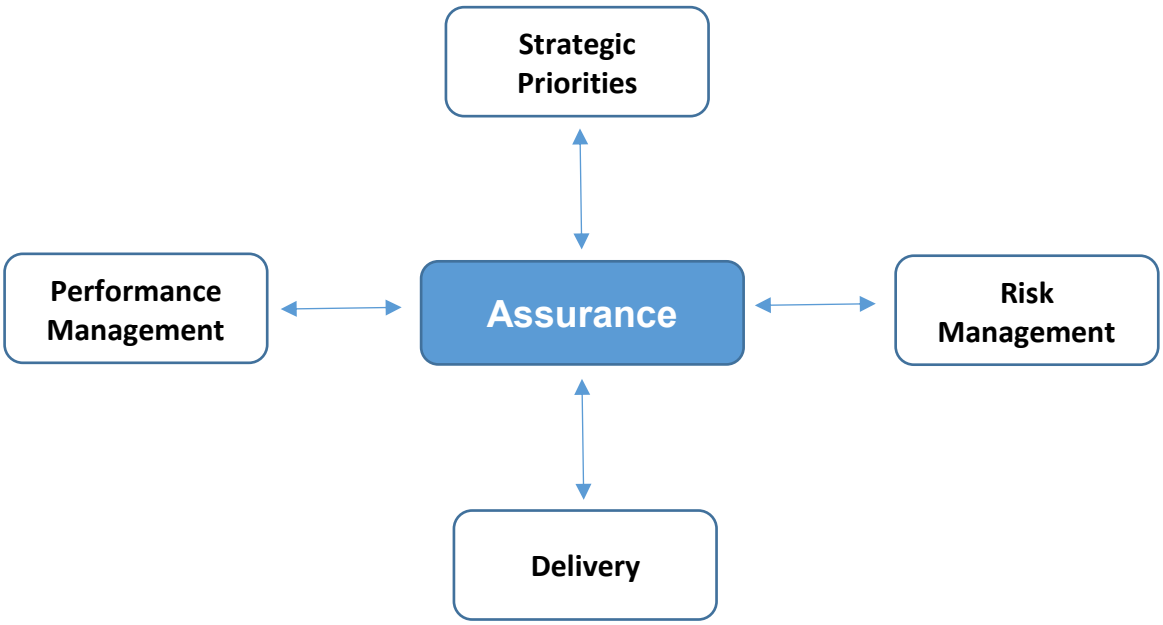
Our Performance Management Framework

We set out how we will manage the delivery of our plan and monitor progress in delivering the changes we wish to see.

Managing the Delivery of our Plan

We utilise an Integrated Framework to manage the delivery of service and strategic plans. This ensures that there is a '*golden thread'* that links all organisational plans and priorities, risk, delivery and measurement into an overall system of assurance.

Integrated Performance, Risk and Assurance Framework



Plans and priorities - Our strategic aims and priorities are set out within our strategies and translated into specific objectives and actions within this plan.

Delivery - The focus of delivery are the divisional service plans which set out the actions we will take to deliver the identified priorities and objectives.

Performance Measures - We use a range of quantitative and qualitative information to allow us to monitor our progress. These are a combination of Welsh Government statutory targets and self-imposed stretch targets.

Risk Management - We assess the risk of achievement against each of our strategic aims, priorities and objectives as part of the planning process. We keep these under regular review throughout the year using our Trust Assurance Framework.

Performance Management Framework

We use a robust framework to support our staff in achieving the improvements required and in delivering our plan. The system is based upon four main elements:

- A clear set of aims, objectives, plans and supporting actions to improve quality
- A range of performance measures
- A regular process of monitoring and review
- A process of escalation/action if we are not on track to achieve our aims.

However, and despite the robust existing arrangements, we continue to enhance our Performance Management Framework (PMF) by introducing a wider range of outcome based measures. A key priority during 2024 -25 is the introduction of greater automation in the production of our monthly performance monitoring reports.

Governance Arrangements
The Board is accountable for governance and internal control of those services directly managed and for services delivered via hosting arrangements. The Board discharges its responsibilities through its Committees and scheme of delegation.

Delivering our Plan
Our plan sets out a clear set of milestones and trajectories that are owned by the Board who will receive a regular assessment of progress against the plan. Responsibility for delivering the plan is discharged to the divisional Senior Management teams who manage the detailed progress of service objectives and their associated performance and risks. Regular meetings between the divisions and the Executive Directors will take a more strategic overview of progress.

Whilst the plan objectives and related performance will be scrutinised by the most appropriate committee, the Quality Safety and Performance Committee will assume overall responsibility for challenging plan progress and providing assurance.

Commissioning Arrangements
Health Boards are responsible for commissioning cancer and blood services from the Trust. However, there is a common view that the current arrangements are not sufficient to meet the future needs of the Trust in delivering services on behalf of our commissioners and the patients and donors who use them. We are therefore committed to working with our Health Board partners and the Welsh Government to develop a planning, commissioning and funding framework that provides us with the greatest opportunity to achieve our ambitions and achieve the levels of excellence that people can be proud of.

Implementation: How will we measure success?
We will track implementation of our plan through a small number of key metrics and strategic markers, which will be underpinned by more detailed reporting. The following metrics will be used to monitor and track implementation as they:

- **Provide a headline picture against our strategies and plans as a whole.** Identifying a small number of headline metrics allows for a simple mechanism to track progress and report to our patients, donors, staff and partners.
- **Includes a mixture of process, output and outcome measures.** This allows us to track specific actions in the short-term (process and output measures) and ensure they are translating into real change in the longer-term (outcomes and benefits).

Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	New Velindre Cancer Centre (nVCC) Full Business Case (FBC)
QIA completed by / on date	David Powell, nVCC Project Director 30/01/2024 (Updated 05.03.24)
QIA agreed by / on date	David Powell, nVCC Project Director Nicola Williams, Executive Director Nursing, AHPs and Healthcare Scientists (as Executive Lead for Quality)

Part 2a: Clinical review and sign off of QIA

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

QIA clinically agreed by / on date	 Prof. Tom Crosby OBE Consultant Oncologist Clinical Lead, Transforming Cancer Service Programme National Cancer Clinical Director for Wales 06/03/24

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

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

Clinical Executive 1 sign off / date	 Dr Jacinta Abraham Executive Medical Director 06/03/24
Clinical Executive 2 sign off / date	 Nicola Williams Executive Director Nursing, AHPs and Healthcare Scientists 06/03/24
Clinical Executive 3 sign off / date	N/A

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
It is proposed that the existing Velindre Cancer Centre is replaced with a new Velindre Cancer Centre (nVCC) that will deliver the majority of tertiary non-surgical oncology services for the population of south-east Wales, contributing to the regional Clinical Operating Model for cancer services. This will include the provision of new equipment where it is not possible or economically viable to transfer from the existing Velindre Cancer Centre. Approval is being sought for the Full Business Case (FBC) which outlines the investment requirements via the Welsh government Mutual Investment Model (MiM) which is described in detail in the Full Business Case.
2. Why is the proposal / decision needed?
There are significant limitations relating to the fabric and functionality of the existing main building of VCC, which was built in 1956. These include: i) The existing VCC has insufficient space and if built on a 'like for like' basis, and in line with current Health Building Notes (HBNs), it would have a footprint of circa 28,000m2 compared to the existing building footprint of 17,777m2.

ii) There is very limited expansion space on the existing VCC site. It is also unlikely that any future expansion proposals would be granted planning permission on the current site because of its location within the heart of a residential area. This severely limits the Velindre Cancer Services' ability to expand its footprint to meet the increasing demand for its cancer services across a range of specialities / departments.

iii) A high proportion of accommodation at the existing VCC site is non-compliant with statutory requirements and creates challenges in maintaining important levels of patient safety and confidentiality.

iv) The existing patient environment at the VCC is sub-optimal in promoting patient dignity, experience and well-being.

v) The existing VCC has limitations in its ability to provide the most up-to-date treatments for patients to support improved outcomes and quality of life.

vi) There is insufficient car parking at the existing VCC.

Therefore, it is clear that the existing VCC is significantly inhibiting VUNHST's ability to both maintain and progress its clinical services. Conversely, the nVCC project is critical to the successful delivery of the Velindre Cancer Centre's Long-Term Cancer Strategy and the delivery of the benefits set out within VUNHST's Transforming Cancer Services in south-east Wales Programme (TCS).

Further detail on the case for the investment is set out in depth in the Strategic Case of the Full Business Case.

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)

VUNHST and its University Health Board partners / Commissioners are committed to providing safe, efficient, and effective care to all our patients. To achieve this, it is essential that a nVCC is implemented. The key drivers supporting the case for investment are:

(i) The Welsh Government's health and cancer policies (A Healthier Wales: Long Term Plan for Health and Social Care; the Quality Statement for Cancer and A Cancer Improvement Plan for NHS Wales 2023 – 2026), to improve the quality of cancer treatment and care, particularly the experience of care, and patient outcomes

(ii) Continuing growth in the incidence of cancer and the demand for cancer services across Wales; with overall incidences for all malignancies, except non-melanoma skin cancer, expected to grow at approximately 13.4% in Wales according to Public Health Wales (Wales-only) over the period 2024-2039.

(iii) The role of Velindre Cancer Services in the south-east Wales region as being the sole provider of highly specialist non-surgical tertiary oncology for the patient population

(iv) The need to keep pace with the advances in treatments and technology which support the provision of modern cancer care that achieves the required clinical standards and expected outcomes.

4. Who is directly affected by this proposal / decision?
Please also consider people who may be indirectly affected

- **Velindre patients and their families** who currently attend the Cancer Centre for their treatment and ongoing cancer care (or may in the future) will benefit from a new, purpose-built Centre, located in an improved location in terms of its accessibility (transport links, parking provision etc) and a therapeutic environment (a 'green' space situated in nature).

- **Velindre staff** who currently work at the Cancer Centre (or may in the future) will benefit from a new, purpose-built Centre, located in an improved location in terms of its accessibility (transport links, parking provision etc) and a 'green' space situated in nature, which has been designed with extensive input from staff to ensure it fully meets all requirements.

- **Neighbours of the existing Cancer Centre** and local community will benefit from a reduction in traffic and disruption associated with the current Cancer Centre, particularly in relation to the availability of parking in the vicinity.

- **Commissioning Health Boards** will be able to access the improved nVCC facility for their resident populations and staff. The ongoing revenue consequences have been addressed fully in the Full Business Case.

5. How have you engaged with the people affected?
If you have not yet engaged, what are your plans?

There has been a comprehensive consultation process with patients, their families, staff, local residents and Commissioners over several years which is described in detail in the Full Business Case. Key highlights are detailed below:

With regards to the designs and layouts of the hospital, input has been secured throughout the development process with presentations, working group sessions and surveys. This has been led by a small team of Velindre staff.

This work has culminated in 'sign-offs' for all department designs by Department Leads, together with commentary from staff teams and patient representatives.

The project has also developed an engagement programme with a specific focus on local residents and groups impacted by the change to complement the implementation of the works. In the main, this programme has focused on creating formal and informal

opportunities to ask questions and better understand the purpose and plans for the project.

Building on this, and working with our consortium partner ACORN, we have developed an enhanced programme that combines ACORN's community benefits activities with the Trust's added value programme under the banner *'Hefyd'.*

Hefyd is our community initiative that will invest in, and develop, a series of programmes which include arts, green social prescribing, sustainability, engagement; and children and young people complementing the construction programme but built for the long-term.

Working relationships with local organisations have been further enhanced by collaboration with key public, third sector and social enterprises in Wales. Central to the success of the programme is ensuring a voice for patients and their families who currently have, or have previously had, a connection with Velindre.

Based on the empowerment of all our stakeholders and meaningful collaboration, we want Hefyd to have a lasting legacy that will be managed by the Trust on an ongoing basis following completion of the new Cancer Centre.

6. What are the main benefits of this proposal / decision?

The principal benefit of this proposal is a 'fit for purpose' environment built for patients, families and staff contributing to improved cancer outcomes and survival. However, there are a series of sub-benefits, including carbon reduction and a reduction in energy consumption and costs, which are outlined in detail in the Economic Case of the Full Business Case (monetisable and other benefits).

The benefits assessment demonstrates that investing in the nVCC Project will deliver significant benefits by:

(i) Improving access to services to contribute to more patients receiving the right care in the right place, resulting in an increased take up of treatment and services.
(ii) Complying with modern healthcare building standards to provide a comfortable and safe environment for patients, visitors and staff.
(iii) Improving clinical and departmental adjacencies to provide facilities that are easier for patients and visitors to navigate and enable more efficient ways of working for staff.
(iv) Creating a Collaborative Centre for Learning and Innovation to better facilitate education and knowledge sharing.
(v) Creating a dedicated radiotherapy research bunker, which will contribute to improved patient outcomes and increase access to clinical trials.

(vi) Improving car parking facilities and public transport links to reduce travel and parking time.
(vii) Investing in a building design which creates therapeutic spaces, located in a quiet site which is close to nature.
(viii) Investing in a flexible and adaptable design to ensure a future-proofed facility.
(ix) Generating local investment which will deliver wider community benefits by creating increased employment, education, and training opportunities.

The main benefits which will be realised as a result of the nVCC are further categorised below:

Patients	Clinical Quality	Staff
• Improved patient, carer, and family experience. • Improved treatments and services. • Improved clinical adjacencies. • Access to information about treatments to make better informed decisions. • Increased access to clinical trials. • Easier to park. • Better public transport links.	• Improved clinical outcomes that result in better survival rates and better quality of life. • Improved quality of care. • Increased opportunities to share and drive best practice through better partnership working. • Reputation as a world class leader in cancer care and research. • Increased opportunities to drive innovation.	• Increased ability to recruit and retain appropriately skilled and high calibre staff. • Reduced expenditure on variable staff costs. • Enhanced training and development. • More RD&I opportunities. • More car parking and better public transport links. • Improved staff morale.
Estates	**Velindre NHS Trust**	**Wider Society**
• Improved clinical adjacencies. • More flexible and adaptable facilities. • Modern care facilities that are safe, offer privacy and dignity, and support best practice. • Well-designed therapeutic environment to reduce stress and aid patient recovery. • Greener energy usage. • Lower risk of regulatory enforcement related to ageing estate.	• Improved productivity. • Supports delivery of clinical model contributing to Programme benefits in terms of reduced avoidable admissions and reduced length of stay. • Better utilisation of resources. • Improved staff recruitment and retention. • Increased income generation opportunities. • Enhanced reputation.	• Economic benefits of better survival rates. • Training and employment opportunities for local people. • Investment in local and wider economy. • Environmental benefits. • Increased opportunities to support local and national strategy. • Benefits to the wider NHS Wales of training highly skilled researchers and innovators.

In addition to the Economic Case, the non-monetised benefits (NMB) associated with the nVCC are also extensively described in **Appendix FBC/MC17** of the FBC Management Case.

7. i) What are the main risks of implementing this proposal / decision?
ii) What are the main risks of not implementing it?

There are a series of project risks outlined in the Management Case associated with undertaking the nVCC (in relation to time, cost and quality) which can be found at **Appendix FBC/MC18** of the Management Case.

These are, however, largely process risks as opposed to the risk of 'doing nothing', which include statutory breach and safety issues, associated with continuing to operate from the current VCC site.

The risk associated with remaining at current VCC site (known as the 'Business as Usual' option) are mirrored in Section 2 above which describe why the proposal is needed. These risks are:

(i) The existing patient environment at the Velindre Cancer Centre is suboptimal and does not promote patient recovery, and patient or carer wellbeing

(ii) A high proportion of accommodation at the existing Velindre Cancer Centre is non-compliant with statutory requirements and creates challenges in maintaining high levels of patient safety

(iii) The existing Velindre Cancer Centre, built on a 'like for like' basis and in line with Health Building Notes, would have a footprint of circa 28,000m2 compared to the existing building footprint of 17,777m2

(iv) There is extremely limited expansion space on the existing Velindre Cancer Centre. This prevents VUNHST's ability to expand its footprint to meet the increasing demand for its clinical services across a range of specialities / departments

(v) There is insufficient patient and family car parking at the existing Velindre Cancer Centre

(vi) And all the while growth assumptions suggest that cancer prevalence is increasing and demand for cancer services will grow.

8. How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?

VUNHST's strategic approach and plans in support of the Full Business Case for a nVCC are fully aligned with the Welsh Government's Programme for Government 2021-26 and all related policies and strategies. Specifically, its commitment to prioritise cancer treatment and the need to address COVID-19 backlog and waiting times. It is also fully integrated and aligned with the south-east Wales regional cancer strategies.

As part of the Full Business Case development, and in addition to the Nuffield Trust advice, VUNHST has described its alignment with the Welsh Government's strategic health and cancer policies, such as:

- A Healthier Wales;
- The Quality Statement for Cancer (2021);
- A Cancer Improvement Plan for NHS Wales 2023 – 2026
- Well-being of Future Generations Act 2015,
- NHS Wales Decarbonisation Strategic Delivery Plan,

- Socio-economic Duty 2023 The nVCC Project is also critical to the successful delivery of Velindre Cancer Centre's Long-Term Cancer Strategy and delivery of the benefits set out within VUNHST's Transforming Cancer Services (TCS) in south-east Wales Programme.
9. Is the proposal / decision planned to be temporary or permanent?
The nVCC is a permanent solution.

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	The nVCC proposal provides a solution to the current unfit environment for patients, their families and staff alike. As described above, a high proportion of accommodation at the existing VCC site is non-compliant with statutory requirements and creates challenges in maintaining important levels of patient safety and confidentiality. The current site does not fully comply with modern healthcare building standards making it difficult to provide a comfortable and safe environment at all times. The proposed facility offers a purpose-built environment with modern equipment, designed with extensive input from staff and patients, which meets all current safety standards. The building design and construction materials have been developed with clinical functionality and safety in mind, particularly in relation to creating beneficial adjacencies between departments and the suitability of materials in respect of infection prevention and control. Compliance with the latest technical healthcare buildings guidance and other standards will ensure a comfortable and safe environment for patients, carers, and staff. Patient	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**
	safety will increase as a result of improved infection control and fewer accidents such as slips, trips and falls. A well-designed building with dedicated spaces for patients and support facilities for families and carers will ensure privacy and dignity standards for patients can be met and improve the patient experience overall. Continuing with the status quo puts the Trust at risk of failing to meet the relevant safety standards. To ensure the nVCC is built in accordance with the highest standard, the Trust will: i) Develop a comprehensive set of Authority Construction Requirements (ACRs) linked to Welsh Health Technical Memoranda, Firecode, British Standards etc.; ii) Maintain tightly controlled list of derogations against the above ACRs to ensure all obligations are met by the ACORN consortium throughout construction; iii) Ensure the document hierarchy in the contract prioritises these requirements over and above any design solutions included in the contract. There are (as at 7th March 2024) a number of clinical caveats in respect of the safety clinical and professional sign off of the design. Assurance has been provided that these will all be appropriately addressed during phase 4 to the safety satisfaction of the clinical, specialist and professional leads.	
Timely	The nVCC will help ensure timely access to care for cancer patients by providing a facility with sufficient capacity to meet the current and future service demand.	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**
	A detailed demand and capacity analysis was undertaken as part of the FBC Strategic Case which sets out the capacity required for Day 1 opening and Year 5 post-opening. It is clear from this exercise, that the nVCC is 'right sized' to meet the needs of patients and carers on Day 1 and up to five years post-opening. In addition, the design of the nVCC has been built around a flexibility strategy that allows for the future expansion of core services without the need to increase the footprint of the building. To ensure the facility is 'future proofed' as treatment modalities change, the Project has ensured: • Additional capacity is built into treatment areas including radiotherapy. • There is a flexible template design to permit change. • Potentially foreseeable changes (e.g. the potential inclusion of a PET scanner) have been pre-designed to respond to future requirements	
Effective	The nVCC design focuses on key pathways and treatments including radiotherapy, SACT delivery, acute assessment and ambulatory care. The most effective clinical adjacencies have been considered throughout the design process. Improved adjacencies will make it easier for patients to find their way around the hospital, reducing anxiety levels and provide a better patient experience. Staff will be able to work in more effective ways, releasing inefficient time that could be better spent with patients and enabling more effective collaboration with colleagues. This is likely to increase job satisfaction and improve staff morale.	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**
	The design and location of the new building will contribute to the effectiveness of the care provided by the Cancer Centre. There is evidence to show that good design of therapeutic environments can reduce stress, aid patient recovery, and support the retention of staff. The flexible design of the nVCC will future proof the building, enabling it to adapt to the changing needs of patients and to incorporate technological advances in treatment and practices and ensure its effectiveness. It creates the infrastructure to meet increases in service demand over and above forecast levels. There is a risk however that given the pace of change with cancer research and discoveries , there may be new advances in cancer technology or treatments that are unknown or benefits yet to be discovered, which may affect future equipment or facilities needed impacting on the clinical model .This will need to be robustly managed as they arise, through an appropriate governance structure with Executive Clinical oversight.	
Efficient	Improved adjacencies within the new building will result in better productivity and more efficient ways of working specifically for clinical, portering, catering and domestic staff. It is estimated that there will be a c. 2% productivity gain as a result of improved adjacencies and flow. The compact design centred around the 'Lolfa' minimises corridor space and travel distances. It is centrally located under-build car park that allows simple routes for	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**
	patients and families from entrance to department. The design has a 1.70 ratio direct area to gross area which is very efficient compared to new hospital average of 1.80. There are a number of environmental efficiency benefits as a result of the 'greener' building design of the nVCC. Overall energy usage is expected to increase because the nVCC will have a greater floor area than the existing VCC. However, given the design of more modern energy efficient facilities, the nVCC will enable a change in fuel type, shifting from a combination of electricity and gas usage to all energy being generated from Standard Grid (Green Electricity). This will result in a reduction in energy usage per m² in the new facility.	
Equitable	The new hospital is designed on equity of access principles, including meeting all equality provisions within design standards. Travel times for staff and patients in the Velindre Cancer Centre catchment population have been analysed in relation to the location of the nVCC and its accessibility. This demonstrated that the proposed new site offers improved accessibility via the Coryton M4 interchange and offers a beneficial solution for equitable access for patients across the south-east Wales catchment area.	Positive
Person-centred	Consultation with staff, patients and their families throughout the design phase has helped shape a person-centred approach to the nVCC design. A series of Patient and Carer Panels have been held to inform the design, as well as a programme of thematic staff session to explore key topics ('Un Peth Bach' / 'One Small Thing' series). Themes emerging from patient and carer panels included easy navigating around the site ('wayfinding'), car parking, access to wi-fi, a welcoming environment, provision for	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**
	patients with children, discreet exits, the appearance of clinical areas, café deign and more. Feedback from our staff and Patient & Carer Liaison Group in particular highlighted areas where we could improve our person-centred approach. For example, adding a quiet room in the Outpatient area for breaking bad news, as well as a discreet exit from the building to avoid having to walk back through busy spaces, were suggestions raised and incorporated into the design. Staff also highlighted the need for a private adult feeding space which was also incorporated following discussions around the specific needs of head and neck cancer patients to ensure privacy and dignity. Facilities throughout have been designed providing privacy and personalised environments for patients, families and staff including a range of single rooms; which meet all acoustic standards within clinical areas, and providing multi-faith facilities for patients, families and staff.	
Leadership	The new Velindre Cancer Centre aims to show through innovative design how to lead the way in providing safe, efficient, patient-centred and community orientated hospital environments. The design has already been recognised at the prestigious European Healthcare Design Awards (2023) in the Future Healthcare Design category for excellence in the design and is demonstrating how sustainable design, exemplary standards of clinical functionality and appealing aesthetics can co-exist.	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**
	The nVCC has a key role in developing a collaborative way of working across partner health organisations within the region and with other core cancer stakeholders The Collaborative Centre for Learning and Innovation will provide an opportunity for the nVCC to play a pivotal regional leadership and coordination role, and act as a resource to support the improvement of the whole regional cancer pathway.	
Workforce	The design includes a series of design features to support the workforce including: • Dedicated staff rest facilities (a key theme of staff feedback), • Staff travel support including a cycle centre, parking under the hospital and ease of access to train and bus facilities; • Plentiful staff change and welfare facilities; • A centre for collaborative learning and innovation It is anticipated that the new facility will have positive impact on staff recruitment and retention as the new clinical model will enable more efficient ways of working and improve VCC's ability to recruit to vacancies. This will result in a reduced need for bank, agency, and overtime usage, as well as lower travel expenses. It is anticipated that this will result in a 10% to 50% reduction in current variable pay costs associated with bank, agency and overtime (further details are also available in the Economic Case of the FBC).	Positive
Culture	The design has focussed on opportunities to foster interaction between staff teams including the use of the central 'Lolfa' that (apart from offering opportunity for informal	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**
	interaction) provides a route to facilities such as the centre for learning and the dining facilities. The collaborative design process has also sought to engage staff, patients and carer throughout with the aim of fostering high levels on ownership and connection with the nVCC. The original evaluation criteria for selecting the successful consortium to develop the scheme also placed an emphasis on the design reflect the existing culture of Velindre described as 'the Velindre Way'.	
Information	The new hospital has digital infrastructure that has been built to house the new suite of Velindre digital applications (including digital wayfinding). The Centre for Collaborative Learning and Innovation has a key role in facilitating information and knowledge sharing. As described above, the Centre will engage with and support patients, families, and carers to make more informed decisions and to participate in the management of their own care confidently and effectively. It will also bring clinicians, academics and entrepreneurs together to provide opportunities for innovation and collaboration.	Positive
Learning, improvement and research	As described above, the new hospital includes the Centre for Collaborative Learning and Innovation (CCLI)that quadruples the space dedicated to learning and research over the existing Cancer Centre. The design of the new hospital will accommodate an expansion of early and late phase trial activity. The creation of a dedicated radiotherapy	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**
	research bunker at the nVCC will also increase patient access to clinical trials. This will increase the number of treatment options and improve patients' confidence in their care. Advances in treatments that result from clinical trials lead to improved clinical outcomes and a better quality of life for patients. The Velindre Oncology Academy which is establishing formal mutliprofessional oncology educational pathways with accreditation will be housed in the CCLI	
Whole systems approach	The new hospital has been designed to facilitate interaction between elements of the cancer pathway including a major expansion in digital consulting/clinical facilities and is a central feature of the regional Transforming Cancer Services (TCS) Programme and Clinical Operating Model. In addition to the outcomes outlined above, the investment will contribute to delivery of the overarching TCS Programme. This includes ensuring patients receive the right care in the right place in the healthcare system and enabling a new clinical model that provides services in a range of locations. Patients will have more choice about where and when they receive treatment, improving the patient experience. The new model also improves workforce utilisation and makes more efficient use of resources more generally. It will contribute to a higher take-up of treatments meaning more patients will receive treatment appropriate to their needs, leading to better clinical outcomes. Patients will benefit from better symptom control	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**
	and pain management, which will reduce anxiety not only for patients but also for families and carers. Job satisfaction for clinicians will increase because they will be able to see more patients and improve outcomes. The Economic Case of the FBC described these benefits and how they are calculated in greater depth.	

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?
The principal message is that the old environment presents untenable risk for patient safety and treatment. The new hospital has been built around compliance with the relevant Health Building Notes (HBNs) and all other regulatory requirements and meets the current and future needs of patients, their families and staff as demonstrated in the FBC.
What are the proposed monitoring arrangements and frequency of QIA Review?
Annual review of the QIA during the construction and commissioning phases of the project.

Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	Welsh Blood Service – National External Quality Assessment Service
QIA completed by / on date	Sarah Richards / Phil Hodson – March 2024
QIA agreed by / on date	Executive Management Board – 18th March 2024

Part 2a: Clinical review and sign off of QIA

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

QIA clinically agreed by / on date	**Not applicable –** The UK National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics was digitalised in 2018/19 following Trust Board approval. Due to the specialist nature of the Welsh Blood Service a bespoke IT solution was required to be created as there was not a 'of the shelf' suitable commercial software product available. An External Quality Assessment IT System (EQAITS) was subsequently created and procured from a third part provider. However, the contract with this supplier expires in 2025. We are therefore required to re-tender for a new digital solution which will enable the continuation of this service. This Quality Impact Assessment therefore relates to the procurement of this digital solution.

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

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

Clinical Executive 1 sign off / date	N/A
Clinical Executive 2 sign off / date	N/A
Clinical Executive 3 sign off / date	N/A

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
The Trust is currently in the process of refreshing and updating its three year Integrated Medium Term Plan (IMTP). As part of this process there is a requirement to consider, in relation to any new service developments not previously agreed and / or approved, the impact, to undertake a quality impact assessment (QIA). This QIA is in relation to the proposal covering the re-procurement of a digital solution to support the National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics.
2. Why is the proposal / decision needed?
The UK National External Quality Assessment Service for Histocompatibility and Immunogenetics is a business that provide an external quality assessment service for clinical laboratories supporting organ transplantation. The External Quality Assessment Service monitors laboratory performance using '*blind*' samples analysed as if they were patient samples to ensure testing is comparable, safe and clinically useful to a patient no matter where the testing is performed to facilitate optimal patient care. There are currently over 320 participants laboratories based in more than 50 countries across the world. The External Quality Assessment IT System controls all aspects of service provision by the Welsh Blood Service. It allows our customers to register for our schemes, to submit test results and to view their results. It then provides a summary report via an on-line entry system. The system also allows the National External Quality Assessment Service

to manage participant information, schemes and the distribution of samples, assess and report results as well as manage annual registration and fees / invoicing.

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)

The UK National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics was digitalised in 2018/19 following Trust Board approval.

However, the contract with this supplier expires in 2025. We are therefore required to re-tender for a new digital solution.

4. Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected

The following will be affected by this proposal:

- Welsh Blood Service Donors and their families
- Welsh Blood Service staff

5. How have you engaged with the people affected? If you have not yet engaged, what are your plans?

There is regular engagement with our donors and we respond to their feedback. In addition this proposal has been discussed and agreed with the Welsh Blood Service Leadership Team and with the Trust Executive Management Board, Trust Quality, Safety and Performance Committee and with the Trust Board. The Welsh Blood Service are also represented at National forums and working groups.

6. What are the main benefits of this proposal / decision?

The main benefits of this proposal are summarised below:

- Improved donor and patient safety
- Assurance that clinical laboratory results are accurate, reliable and comparable to facilitate optimal patient care
- The long-term future proofing of the digital solution to support the National External Quality Assessment Service
- Continued provision of the National External Quality Assessment Service for Histocompatibility and Immunogenetics. This service includes the provision of material, results analysis, performance criteria and, if required, professional support for our laboratories.

7. What are the main risks of implementing this proposal / decision?

The main risks of not implementing this proposal are summarised below:

- Reduced donor and patient safety

- The potential removal of support for the existing digital solution to support the National External Quality Assessment Service
- Reduced assurance that clinical laboratory results are accurate, reliable and comparable
- Potential loss of the digital National External Quality Assessment Service for Histocompatibility and Immunogenetics

8. How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?

The proposal is in alignment with the Trust Vision and Purpose:

- **Our Vision:** Excellent Care, Inspirational Learning, Healthier People
- **Our Purpose:** To Improve Lives

The proposal is also aligned with the following Trust strategic goals:

- Outstanding for quality, safety and experience
- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

9. Is the proposal / decision planned to be temporary or permanent?

It is anticipated that the service will be permanent unless there is an alternative / enhanced testing service solution available in the future.

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	• The National External Quality Assessment Service supports improved donor and patient safety • The National External Quality Assessment Service provides assurance that clinical laboratory results are accurate, reliable and comparable to facilitate optimal patient care	Positive
Timely	• The UK National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics was digitalised in 2018/19 following Trust Board approval. Due to the specialist nature of the Welsh Blood Service a bespoke IT solution was required to be created as there was not a 'of the shelf' suitable commercial software product available. An External Quality Assessment IT System (EQAITS) was subsequently created and procured from a third part provider. However, the contract with this supplier expires in 2025. We are therefore required to re-tender for a new digital solution which will enable the continuation of this service. This proposal supports this requirement.	Positive
Effective	• The re-procurement of a digital solution to support the National External Quality Assessment Service will support the effective and efficient delivery of services	Positive
Efficient		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**
Equitable	• The Welsh Blood Service is a National service and therefore the National External Quality Assessment Service is equitable across Wales	Positive
Person-centred	• The Welsh Blood Service is committed to ensuring that their services are centred on their donors and their workforce. The proposed service development will assure the continued delivery of safe and donor centred services.	Positive
Leadership	• The Welsh Blood Service plays a vital role in the delivery of a national service. In addition the Welsh Blood Service plays a key role in the future development of Blood services across the United Kingdom. • In relation to this proposal the Welsh Blood Service have endorsed the recommendation	Positive
Workforce	• Welsh Blood Service Workforce Plans are aligned to this proposal	Positive
Culture	• This proposal supports the Trusts strategic goals in relation to: o Outstanding for quality, safety and experience o An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Positive
Information	• Not applicable.	Neutral

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**
Learning, improvement and research	• The Welsh Blood Service embraces learning, improvement and research and will continue to respond to feedback if, and when, it can enhance National External Quality Assessment Service	Positive
Whole systems approach	• The requirement for a digital solution to support the National External Quality Assessment Service is aligned with the rest of the United Kingdom	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?
The requirement, and benefits, of a digital solution to support the National External Quality Assessment Service have previously been approved by the Trust Board. This proposal relates to the re-procurement of this digital solution. The main benefits are summarised below: • Improved donor and patient safety • Assurance that clinical laboratory results are accurate, reliable and comparable to facilitate optimal patient care • The long-term future proofing of the digital solution to support the National External Quality Assessment Service

- Continued provision of the National External Quality Assessment Service for Histocompatibility and Immunogenetics. This service includes the provision of material, results analysis, performance criteria and, if required, professional support for our laboratories.

The main risks of not implementing this proposal are summarised below:

- Reduced donor and patient safety
- The potential removal of support for the existing digital solution to support the National External Quality Assessment Service
- Reduced assurance that clinical laboratory results are accurate, reliable and comparable
- Potential loss of the digital National External Quality Assessment Service for Histocompatibility and Immunogenetics
-

What are the proposed monitoring arrangements and frequency of QIA Review?

The Welsh Blood Service will utilise the Trust approved Programme and Performance Management processes to oversee the delivery of the proposed service development. This will include close liaison with NHS Wales procurement services.

It is proposed that Quality Impact Assessment Reviews are completed on an annual basis.

Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	Welsh Blood Service – West Nile Virus Testing
QIA completed by / on date	Sarah Richards / Phil Hodson – March 2024
QIA agreed by / on date	Executive Management Board – 18th March 2024

Part 2a: Clinical review and sign off of QIA

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

QIA clinically agreed by / on date	**Not applicable –** The requirement, and benefits, of West Nile Virus (WNV) Testing have previously been approved by the Trust Board following a joint recommendation made by the Clinical Services, Automated Testing, and Donor Engagement departments. This proposal relates a '*bring forward*' of the implementation date from 2025 to 2024.

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

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

Clinical Executive 1 sign off / date	N/A
Clinical Executive 2 sign off / date	N/A
Clinical Executive 3 sign off / date	N/A

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
The Trust is currently in the process of refreshing and updating its three year Integrated Medium Term Plan (IMTP). As part of this process there is a requirement to consider, in relation to any new service developments not previously agreed and / or approved, the impact, to undertake a quality impact assessment (QIA). This QIA is in relation to the proposal to '*bring forward*' the implementation date from 2025 to 2024.
2. Why is the proposal / decision needed?
West Nile Virus Testing is an arthropod-borne flavivirus, widely distributed in Africa, Western Asia, Europe, and Australia. Current national guidelines state, travel to a West Nile Virus risk area provokes a 28-day deferral if the donor is not symptomatic or six months if the donor has any suggestive symptoms at or upon arrival to the UK. Other UK blood services (NHSBT and SNBTS) do Nucleic Acid Amplification (NAT) test on these donors. A negative test result allows the donor to continue donating.
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)
WBS currently complies with the JPAC recommended donor deferral period but does not test donors. This results in the loss of some potential donations during the summer and the autumn. The Trust formally agreed to implement West Nile Virus Testing in mid-2025 following a joint recommendation made by the Clinical Services, Automated Testing, and Donor Engagement departments. However, the recent evidence of accelerated spread of West Nile Virus indicates that the Trust may face additional pressure in maintaining the blood supply during 2024. This has led the Trust to re-evaluate this decision and to recommend that West Nile Virus Testing is introduced, utilising existing equipment and systems, from 1st May 2024. This would help mitigate potential donor losses and related blood supply shortages. The West Nile Virus Testing assay (M/N 09171142190) will be available to the Welsh Blood Service from 1st May 2024 to support the commencement of testing from that time. West Nile Virus Testing will then be undertaken on all donors who have previously been deferred due to West Nile Virus risk factors (travel). This testing is already carried out in NHSBT and SNBTS.
4. Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected
The following will be affected by this proposal:

- Welsh Blood Service Donors and their families
- Welsh Blood Service staff

5. How have you engaged with the people affected? If you have not yet engaged, what are your plans?

There is regular engagement with our donors and we respond to their feedback. In addition this proposal has been discussed and agreed with the Welsh Blood Service Leadership Team and with the Trust Executive Management Board, Trust Quality, Safety and Performance Committee and with the Trust Board. The Welsh Blood Service are also represented at National forums and working groups. Finally, the Welsh Blood Service is subject to external audits and investigations and again all strategic decisions are informed by any recommendations from these external reviews.

6. What are the main benefits of this proposal / decision?

The main benefits of this proposal are summarised below:

- Improved donor and patient safety
- Reduces the risk of transfusion transmitted infections (TTIs) for blood donors in the recipients thus providing an additional layer of blood safety
- Mitigates potential donor losses and related blood supply shortages

7. What are the main risks of implementing this proposal / decision?

The main risks of not implementing this proposal are summarised below:

- Reduced donor and patient safety
- Increased risk of transfusion transmitted infections (TTIs) for blood donors in the recipients
- Potential donor losses and related blood supply shortages

8. How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?

The proposal is in alignment with the Trust Vision and Purpose:

- **Our Vision:** Excellent Care, Inspirational Learning, Healthier People
- **Our Purpose:** To Improve Lives

The proposal is also aligned with the following Trust strategic goals:

- Outstanding for quality, safety and experience
- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

9. Is the proposal / decision planned to be temporary or permanent?
It is anticipated that the service will be permanent unless there is an alternative / enhanced testing service solution available in the future.

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	• Improved donor and patient safety • Reduces the risk of transfusion transmitted infections (TTIs) for blood donors in the recipients thus providing an additional layer of blood safety	Positive
Timely	• Will support the implementation of West Nile Virus Testing from May 2024	Positive
Effective	• The implementation of West Nile Virus Testing from May 2024 will support the effective and efficient delivery of services	Positive
Efficient		Positive
Equitable	• The Welsh Blood Service is a National service and all donors will be subject to the same level of testing. This will also mean that all recipients from across Wales will have the same level of assurance regarding their transfusion.	Positive
Person-centred	• The Welsh Blood Service is committed to ensuring that their services are centred on their donors and their workforce. The proposed service development will assure the continued delivery of safe and donor centred services.	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**
Leadership	• The Welsh Blood Service plays a vital role in the delivery of a national service. In addition the Welsh Blood Service plays a key role in the future development of Blood services across the United Kingdom. • In relation to this proposal the Welsh Blood Service have endorsed the recommendation	Positive
Workforce	• Welsh Blood Service Workforce Plans are aligned to this proposal	Positive
Culture	• This proposal supports the Trusts strategic goals in relation to: o Outstanding for quality, safety and experience o An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Positive
Information	• Not applicable.	Neutral
Learning, improvement and research	• The Welsh Blood Service embraces learning, improvement and research and will continue to respond to feedback if, and when, it can enhance its West Nile Virus Testing Programme	Positive
Whole systems approach	• The requirement for West Nile Virus testing is aligned with: o United Kingdom Blood Service testing processes	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?
The requirement, and benefits, of West Nile Virus Testing have previously been approved by the Trust Board following a joint recommendation made by the Clinical Services, Automated Testing, and Donor Engagement departments. This proposal relates a '*bring forward*' of the implementation date from 2025 to 2024. The main benefits of West Nile Virus Testing are summarised below: • Improved donor and patient safety • Reduces the risk of transfusion transmitted infections (TTIs) for blood donors in the recipients thus providing an additional layer of blood safety • Mitigates potential donor losses and related blood supply shortages The main risks of not implementing West Nile Virus Testing are summarised below: • Reduced donor and patient safety • Increased risk of transfusion transmitted infections (TTIs) for blood donors in the recipients • Potential donor losses and related blood supply shortages
What are the proposed monitoring arrangements and frequency of QIA Review?
The Welsh Blood Service will utilise the Trust approved Programme and Performance Management processes to oversee the delivery of the proposed service development. It is proposed that Quality Impact Assessment Reviews are completed on an annual basis.

Quality-driven decision-making

Quality Impact Assessment

Part 1: Developing the QIA

Proposal / decision being assessed	Welsh Blood Service - Nucleic Acid Testing
QIA completed by / on date	Sarah Richards / Phil Hodson – March 2024
QIA agreed by / on date	Executive Management Board – 18th March 2024

Part 2a: Clinical review and sign off of QIA

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

QIA clinically agreed by / on date	**Not applicable –** The requirement, and benefits, of Nucleic Acid Testing have previously been clinically recommended by the Welsh Blood Service and approved by the Velindre University NHS Trust Board. Nucleic Acid Testing is also mandated by Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC). This proposal relates to the procurement of a new solution ion to support the safe and timely Nucleic Acid Testing for Welsh Blood Service Donors.

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

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

Clinical Executive 1 sign off / date	N/A
Clinical Executive 2 sign off / date	N/A
Clinical Executive 3 sign off / date	N/A

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**
The Trust is currently in the process of refreshing and updating its three year Integrated Medium Term Plan (IMTP). As part of this process there is a requirement to consider, in relation to any new service developments not previously agreed and / or approved, the impact, to undertake a quality impact assessment (QIA). This QIA is in relation to the re-procurement and implementation of Nucleic Acid Testing for the Welsh Blood Service.
2. Why is the proposal / decision needed?
Nucleic Acid Testing is a molecular technique for screening blood donations with the benefit of reducing the risk of transfusion transmitted infections.
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)
Nucleic Acid Testing is required to ensure the safety of the blood supply chain, this must be delivered according to JPAC guidelines. Welsh Blood Service Nucleic Acid Testing is currently provided by two suppliers. These contracts have been extended and are aligned to end in October 2025. There is, however, the potential for these contracts to be terminated earlier as there is a 6 months termination notice built into the contracts. The notice period may be invoked to enable WBS to provide HAV/B19 testing to enable the production of recovered Plasma for Medicine. In terms of delivery the Programme will be split into two discrete phases: The main output of phase 1 will be the re-procurement of a Nucleic Acid Testing solution from a single supplier. This will require subject matter experts to develop the User Requirement Specification (URS). The main output of phase 2 will be the implementation of the preferred solution once this is known and approved by the Trust.
4. Who is directly affected by this proposal / decision? Please also consider people who may be indirectly affected
The following will be affected by this proposal: • Welsh Blood Service Donors and their families • Welsh Blood Service staff

5. How have you engaged with the people affected? If you have not yet engaged, what are your plans?

There is regular engagement with our donors and we respond to their feedback. In addition this proposal has been discussed and agreed with the Welsh Blood Service Leadership Team and with the Trust Executive Management Board, Trust Quality, Safety and Performance Committee and with the Trust Board. The Welsh Blood Service are also represented at National forums and working groups. Finally, the Welsh Blood Service is subject to external audits and investigations and again all strategic decisions are informed by any recommendations from these external reviews.

6. What are the main benefits of this proposal / decision?

The main benefits Nucleic Acid Testing are summarised below:

- Improved donor and patient safety - All donations are checked for infections to help check that each donation is as safe as possible to transfuse to patients
- Reduces the risk of transfusion transmitted infections (TTIs) for blood donors in the recipients thus providing an additional layer of blood safety

7. What are the main risks of implementing this proposal / decision?

The main risks of not continuing to deliver Nucleic Acid Testing are summarised below:

- Reduced donor and patient safety - Donations will not be checked for infections and, therefore, donations that are infected would be transfused to patients
- Increased risk of transfusion transmitted infections (TTIs) for blood donors in the recipients

8. How does the proposal / decision impact on delivery of the organisation's strategic objectives or ministerial priorities?

The proposal is in alignment with the Trust Vision and Purpose:

- **Our Vision:** Excellent Care, Inspirational Learning, Healthier People
- **Our Purpose:** To Improve Lives

The proposal is also aligned with the following Trust strategic goals:

- Outstanding for quality, safety and experience
- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

9. Is the proposal / decision planned to be temporary or permanent?

The proposal will be subject to the length of the contract awarded. However, it is anticipated that the service will be permanent unless there is an alternative / enhanced testing service solution available in the future.

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	• Improved donor and patient safety - All donations are checked for infections to help check that each donation is as safe as possible to transfuse to patients • Reduces the risk of transfusion transmitted infections (TTIs) for blood donors in the recipients thus providing an additional layer of blood safety	Positive
Timely	• Will support the timely delivery of Nucleic Acid Testing for Welsh Blood Service donors to ensure that recipients of blood donations receive received their donation when required	Positive
Effective	• The transition to a single applier for Nucleic Acid Testing will be more effective	Positive
Efficient	• The transition to a single applier for Nucleic Acid Testing will be more efficient	Positive
Equitable	• The Welsh Blood Service is a National service and all donors from across Wales will be subject to the same level of testing. This will also mean that all recipients from across Wales will have the same level of assurance regarding their transfusion.	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**
Person-centred	• The Welsh Blood Service is committed to ensuring that their services are centred on their donors and their workforce. The proposed service development will assure the continued delivery of safe and donor centred services.	Positive
Leadership	• The Welsh Blood Service plays a vital role in the delivery of a national service. In addition the Welsh Blood Service plays a key role in the future development of Blood services across the United Kingdom. • In relation to this proposal the Welsh Blood Service have endorsed the recommendation	Positive
Workforce	• Welsh Blood Service Workforce Plans are aligned to this proposal	Positive
Culture	• This proposal supports the Trusts strategic goals in relation to: o Outstanding for quality, safety and experience o An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations	Positive
Information	• Not applicable.	Neutral
Learning, improvement and research	• The Welsh Blood Service embraces learning, improvement and research and will continue to respond to feedback if, and when, it can enhance its Nucleic Acid Testing processes	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**
Whole systems approach	• The requirement for Nucleic Acid Testing is aligned with: o United Kingdom Nucleic Acid Testing requirements o Welsh Nucleic Acid Testing requirements	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?
The requirement, and benefits, of Nucleic Acid Testing has previously been clinically agreed and is mandated by Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) guidelines. This proposal relates to the procurement of a new solution ion to support the safe and timely Nucleic Acid Testing for Welsh Blood Service Donors. In terms of delivery the Programme will be split into two discrete phases: • The main output of phase 1 will be the re-procurement of a Nucleic Acid Testing solution from a single supplier. This will require subject matter experts to develop the User Requirement Specification (URS). • The main output of phase 2 will be the implementation of the preferred solution once this is known and approved by the Trust

The main benefits of Nucleic Acid Testing are summarised below:

- Improved donor and patient safety - All donations are checked for infections to help check that each donation is as safe as possible to transfuse to patients
- Reduces the risk of transfusion transmitted infections (TTIs) for blood donors in the recipients thus providing an additional layer of blood safety

The main risks of not continuing to deliver Nucleic Acid Testing are summarised below:

- Reduced donor and patient safety - Donations will not be checked for infections and, therefore, donations that are infected would be transfused to patients
- Increased risk of transfusion transmitted infections (TTIs) for blood donors in the recipients

What are the proposed monitoring arrangements and frequency of QIA Review?

In terms of delivery the Programme will be split into two discrete phases:

- Phase 1 will be the re-procurement of a Nucleic Acid Testing solution from a single supplier. This will require subject matter experts to develop the User Requirement Specification (URS)
- Phase 2 will be the implementation of the preferred solution once this is known and approved by the Trust

The Welsh Blood Service will utilise the Trust approved Programme and Performance Management processes to oversee the delivery of the proposed service development.

It is proposed that Quality Impact Assessment Reviews are completed on an annual basis.

TRUST BOARD

INTEGRATED MEDIUM TERM PLAN – ACCOUNTABILTY CONDITIONS.

DATE OF MEETING	26th March 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	Peter Gorin, Head of Strategic Planning and Performance
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital.
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	Following the approval of the IMTP 2023/24 to 2025/26 the Trust received an Accountability Conditions letter, on 2nd October 2023, from the NHS Wales Chief Executive, **see Appendix 1**. A stated requirement within the Accountability Conditions letter was for the Trust to report progress against the conditions on a quarterly basis from quarter 3 (2023/24).

RECOMMENDATION / ACTIONS	The Trust Board is asked to: • Note the progress update against the Welsh Government accountabilities conditions in **Appendix 1 and 2**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Run	**30/10/23**
Executive Management Board – Run	**1/02/24**
Quality Safety and Performance Committee	**14/03/24**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The approach for reporting against the accountability conditions was approved by the Executive Management Board and QSP Committee	

7 LEVELS OF ASSURANCE – NOT APPLICABLE

APPENDICES	
1	Velindre University NHS Trust IMTP Accountability Conditions Letter from the Welsh Government
2	Accountability Conditions Progress Quarter 3 Update

1. SITUATION

1.1 The Trust, on 14th September 2023, received confirmation from the Welsh Government that it's IMTP for 2023/24 to 2025/26 had been approved.

1.2 Following the approval of the IMTP, the Trust received an Accountability Conditions letter dated 2nd October 2023, from the NHS Wales Chief Executive **(see Appendix 1)** which laid down the following key accountabilities:

a) Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risk.

b) Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.

c) Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.

d) Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.

2. BACKGROUND

2.1 The Welsh Government Accountability Conditions letter stated there was an expectation that:
"*The Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year*".

3. ASSESSMENT

3.1 To ensure robust delivery of IMTP objectives and actions, and to discharge the Welsh Government IMTP accountability conditions, the November QSP Committee recommended that quarterly progress reports are submitted to:

- The Executive Management Board (Run)
- The Quality, Safety and Performance Committee
- The Velindre University NHS Trust Board

Note: we currently report progress against the actions included within the Trust IMTP on a quarterly basis. This proposal is specific to the four Welsh Government accountability conditions.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Trust Board is asked to:

- Note the progress made against the Welsh Government accountability Conditions for 2023/24 a) to d) in **Appendix 2**

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Not applicable
	Not Applicable
	The purpose of this paper is to outline the approach for reporting against the Welsh Government IMTP accountability conditions.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	There are no socio-economic impacts linked directly to the approach outlined within the paper or attached appendices.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A - There are no Trust Well-Being goal implications or impact linked directly to the approach outlined within the paper.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	The purpose of this paper is to initiate a discussion in relation reporting requirements against the Trust IMTP accountability conditions. However, there will be a requirement to undertake an IMTP Equality Impact Assessment I support of the development of the Trust IMTP for 2024/25 – 2026/27.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

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

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

Llywodraeth Cymru
Welsh Government

Mr Steve Ham
Chief Executive
Velindre University NHS Trust
Trust Headquarters
Unit 2, Charnwood Court
Parc Nantgarw
Cardiff
CF15 7QZ
Steve.Ham2@wales.nhs.uk

2 October 2023

Dear Steve

Integrated Medium-Term Plan 2023-2026

I am pleased to confirm that the Minister for Health and Social Services has approved the Trust's Integrated Medium-Term Plan (IMTP) which you submitted on the 31 March 2023, together with Ministerial priority templates. This approval recognises the development of integrated planning within Velindre, whilst recognising the current challenges and management of risks**.**

Whilst the financial position is extremely challenging for the system, I expect organisations to deliver the commitments set out within their plans, particularly in relation to the Ministerial priorities. You will be aware of parallel discussions with NHS Trusts to proactively explore if there are opportunities to deliver financial improvement beyond the current forecast.

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. The organisation will need to:

a) Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risks.

b) Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.

c) Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.

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Caerdydd • Cardiff
CF10 3NQ

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

Gwefan • website: www.gov.wales

d) Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.

This will be monitored by the NHS Executive, Financial Planning and Delivery Team on a quarterly basis.

There is an ongoing expectation that the organisation will continue preparing robust financial plans for future years, that considers all choices and options to meet the requirements of the Finance Wales Act 2014.

I expect the Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year, in particular against the Ministerial priority templates you submitted. A copy of your Board reports should be forwarded on a quarterly basis to HSS-PlanningTeam@gov.wales. Organisations should refresh their Minimum Data Set (MDS) on a quarterly basis for as part of their internal review of plans. Please submit your quarter two MDS returns to HSS-PlanningTeam@gov.wales by 27th October 2023.

The Minister is clear that progress in delivering key priorities will form part of the ongoing discussions with Chairs. The delivery of plans will also form the agenda for our Joint Executive Team (JET) meetings going forward. The Welsh Government Planning team will continue to engage and support local planning teams and track progress. 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.

Risks or challenges that develop during the year will need to be discussed and agreed at your Board and communicated to Welsh Government via the governance arrangements (e.g. IPQD meetings). 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.

As articulated in the Ministerial letter, approval of the Integrated Medium-Term Plan does not equate to agreement to the detailed service changes, business case proposals or capital assumptions indicated within it. Nor does the plan approval confirm any validity in funding assumptions around additional revenue or capital funding other than that specified below. All service change and business case proposals will still be subject to:

- compliance with extant requirements set out in guidance or in legislation, and
- business cases and bids being subject to the normal business case approval process, including capital, and Invest to Save bid approval processes.

You will be aware that I wrote to you separately on 11th September confirming there will be no change in your escalation status, which remains at "routine arrangements".

The organisation has not requested financial flexibility as part of the IMTP, and none has been granted. 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

Judith Paget CBE

cc: Nick Wood, Deputy Chief Executive NHS Wales
Samia Edmonds, Planning Director
Jeremy Griffiths, Director of Operations
Hywel Jones, Director of Finance

APPENDIX 2

Integrated Medium Term Plan 2023/24 – 2025/26 Accountability Letter 2 October 2023

Quarterly Actions Monitoring Document 2023/24 – New Conditions 2023/24

Accountability Conditions (Judith Paget Letter dated 2/10/23)	Quarterly Actions Progress to comply with IMTP Accountability Conditions			
	Q1	Q2	Q3	Q4
a) Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risks.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	**Savings** The Trust is currently planning to fully achieve the revised savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status. Enacting service re-design and supportive structures continues to be a challenge due to both the high level of activity growth and sickness levels limiting the capacity of service	

			leads to implement changes. The procurement supply chain saving schemes have again been affected by procurement team personnel changes and capacity constraints and current market conditions during 2023-24.	
b) Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	The Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures in response to national financial pressures. As set out to EMB Shape in September, the purpose of the Finance and Investment Enhanced Monitoring agenda item is to strengthen the control environment by	

			ensuring accountability at an Executive level in relation to: 1. Savings delivery 2. Cost control 3. Choices and Options which could contribute towards wider system financial pressures 4. Impacts of spending decisions considering quality, safety, experience and value This process will also help to address the strategic risk theme of Financial Sustainability and Long-Term Value for the Trust. In response to the financial pressures faced by NHS Wales, the Trust identified costs savings	

			proposals to the sum of c£2m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit. Additionally, the non-recurrent reserves position continues to be monitored against financial risks. If it is not required, it can be utilised to support the NHS Wales position on a non-recurrent basis.	
c) Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	**Covid Programme Costs** In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast	

			for 2023-24 reduced to £0.053m. **Covid Recovery and Planned Care Capacity** Funding for Covid recovery and planned care capacity investment flows through the LTA marginal contract income from commissioners. The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to recover the costs of investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Nov '23 is that income will cover the cost of the additional capacity.	

			The activity levels and Commissioner demand for services will continue be closely monitored over the remaining months of the year.	
d) Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	**Value Based Healthcare Programme** The scope of the Value Based Healthcare programme at Velindre includes the Value Intelligence Centre, Preoperative Anaemia Pathway Project and the Velindre Food Mission. The Value Based Healthcare Programme received funding from Welsh Government to progress two key Value Based Healthcare initiatives across the Trust as follows:	

			• Preoperative Anaemia Pathway Project with the Welsh Blood Service (WBS) • Value Intelligence Centre across the Trust A VBH Programme update and governance proposal was provided to EMB Shape in October 2023. The governance, terms of reference and implementation plan was approved. **Pre-op Anaemia Pathway (WBS)** This project addresses the variation in the diagnosis and management of patients prior to major surgery. It is funded as a 2 year project to implement an All-	

			Wales Pre-operative Anaemia Pathway (up to December 2024). **Value Intelligence Centre** A detailed programme plan was approved by the VBH Steering group in November 2023 and is set out in the table below. This includes specific, prioritised work packages and resource requirements taking into account the following interdependencies: • other Velindre programmes (e.g. Data and Insights Data Warehouse, Workforce changes, Quality and Safety, Digital etc.)	

			• National PROMs procurement • Organisational dashboard development workplan • Varian's Noona implementation (as part of the Integrated Radiotherapy Solution) **Food Mission** This workstream focuses on improving the health and wellbeing of patients, donors and staff whilst contributing to the local economy and environmental sustainability of food production through increasing access to healthy food across the Trust.	

Trust Board

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2023 / 2024 (QUARTER 3).

Date of meeting	26/03/24

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	**Carl James, Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**1. VELINDRE NHST IMTP PROGRESS 2023/24** 1.1 This report provides an update (position as of 25th December 2023) of progress against the actions (October – December 2023) which were included within the IMTP for 2023/24 as at Quarter 3. 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 3.

RECOMMENDATION / ACTIONS	**The Trust Board is asked to:** • **NOTE the progress made in the delivery of the agreed IMTP (2023 – 2026) actions as at Quarter 3 for both the Velindre Cancer Service, the Welsh Blood Service and Trust-wide initiatives.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SLT / Performance Review	**19 December 2023**
VCS SLT / Performance Review	**20 December 2023**
Executive Management Board	**29 February 2024**
Quality Safety and Performance Committee	**14 March 2024**
Summary and outcome of previous governance discussions: **The report has been considered and endorsed at the VCS and WBS Performance Review, EMB Run and QSP meetings and is presented to the Trust Board for information and noting.**	

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

APPENDICES	
1	**Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/12/2023.**
2	**Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 2 as at 25/12/2023.**
3	**Trust-wide Initiatives - IMTP Quarterly Progress Report 2023/24 for Quarter 3 as at 25/12/2023.**

ACRONYMS	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

2. SITUATION/BACKGROUND

2.1 The Integrated Medium Term Plan (IMTP) 2023/24-2025/26 was submitted to the Welsh Government on 31st March 2023. Integral to the successful delivery of our IMTP were a number of actions to support the delivery of the Trust's Strategic Aims, across both cancer services and blood and transplant services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The timing of the end of Quarter 3 (October to December 2023), has given only a short time for a detailed assessment of progress against IMTP actions during early January for EMB consideration.

3.2 The table below gives a high-level overview of progress made in the delivery of actions at Q3 for WBS, VCS and Trust-wide.

BRAG Rating	Progress Categories Definitions	Welsh Blood Services IMTP 2023/24 Actions	Velindre Cancer Services IMTP 2023/24 Actions	Trust-wide Initiatives IMTP 2023/24 Actions
BLUE	Action successfully completed with benefits being realized			
GREEN	Satisfactory progress being made against action in line with agreed timescale	**10 Q actions**	**10 Q actions**	**6 Q actions**
YELLOW	Issues with delivery identified and being resolved with remedial actions in place	**5 Q actions**	**10 Q actions**	**6 Q actions**
AMBER	Delays in implementation / action paused due to external issues beyond our control		**2 Q actions**	
RED	Challenges causing problems requiring recovery actions to be identified			
Total IMTP 2023/23 Quarterly Actions		**15 Q actions**	**22 Q actions**	**32 Full Year Actions**

3.3 WBS are making satisfactory progress, categorised as '*green or yellow*', against all 15 of their actions as at Q3.

3.4 VCS are making satisfactory progress, categorised as '*green or yellow*', against 20 of their 22 actions.

3.5 However, two actions that remain assessed as 'amber'. This is defined as *'Delays in implementation / action paused due to external issues beyond our control*'. These two actions are:

- Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Service (pg.22)
- Implementation of the approved Full Business case for the development of the new Velindre Cancer Centre (nVCC) by 2025/26 (December 2025) (pg. 30)

3.6 There are 32 Trust-wide actions or 'themes' (Digital 6; workforce 6; Estates 4; Sustainability 10 and finance 6), see Appendix 3. Whilst good progress is being made against these actions as at Q3, it is our intention to provide more detail against individual actions in future reports.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organization that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance

QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarized here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

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

	Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

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

APPENDIX 1

Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 3 as at 15/01/2024.

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2032 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2025/26.	• Personalised donor experience • Wider communication choice for donors • Increased donor retention • Improved information (for sharing/decision -making) • Increased levels of efficiency/ productivity	Prepare donor data recovery map for incorrect donor details.	Begin implementation of donor data recovery plan.	Finalise implementation of donor data recovery plan. Re-platform appointment system portal for booking blood donations.	Scope requirements of integrated communication platform for Donor Contact Centre.	Donor Data Recovery Plan - semi-automated process introduced. Appointment system portal launch planned for Summer 2024. Scoping completed for an integrated communication platform for Donor Contact Centre.	
	Develop and implement strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2023/24.	• Increased stem cell donor panel • Increase in stem cells supply. • Improved resilience in stem cell supplies	Develop strategy. Engagement with key stakeholders.	Formal sign off of strategy. Communication plan developed and approved. Develop implementation plan.	Launch and implement strategy.	Post implementation review.	Development of Strategy has been transferred to WBS Futures portfolio and work is underway. Timelines are being reappraised.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Improved clinical outcomes in Wales/globally • Increased income levels						
SP2: To provide a world class donor experience **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Implement our new donor strategy by 2025/26.	• Right size/shape donor panel • Increased resilience for supply of blood/products across Wales • Improved levels of efficiency/productivity Reduced importation and costs • Increased brand awareness and reach • Wider population/donor education • Development of rich data to	Sign off strategy.	Review existing systems and processes in line with strategy.	Identify opportunities for further improvement.	Commence implementation. Review and Identify opportunities. Review current establishment.	Final draft strategy developed, awaiting sign off prior to initiating a review of systems and processes. Implementation will form part of the WBS Futures portfolio.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		improved insights and focus efforts in right areas						
SP3: Drive the prudent use of blood across Wales **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)**	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25.	• Improved clinical outcomes for patients post operatively • Reduced length of stay post-surgery • Prudent use of (reduced demand for blood). • Increased equity of care and outcomes • Reduction in clinical complications associated with receiving blood products. • Compliance with the NICE guidance.	Advertise and recruit Anaemia Team Review baseline Digital Health Care Wales (DHCW) data.	Develop bespoke Health Board Anaemia Plan with key stakeholders.	Develop bespoke Health Board Anaemia Plan with key stakeholders.	Implement relevant plan as agreed. Recruit Health Board nurses to manage Anaemia clinics. Raise profile with primary care leads, and the internal review of the Pathway with users (January 2024).	Stakeholder engagement underway. Resource Toolkit for patients and healthcare professionals developed. Stakeholder and nursing data dashboard training sessions staged in October and December 2023. A pilot of patient related experience survey (PREMS) is taking place with BCUHB and ABUHB.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Improved efficiency • Cost efficiencies.						
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)**	Revised blood collection clinic portfolio by 2024/25.	• Increased /Sustainable collection model • Improved access for service users • Improved collection efficiency • Reduction in costs. • Improved access to donors for recruitment to the Welsh Bone Marrow Donor Registry	Continue reintroduction of Mobile Donation Collections.	Introduce 'tours' to remote areas of North West Wales.	Establish project group to progress identified fixed site options.	Continue to progress fixed site model.	Tours for North Wales have been scoped and stakeholder engagement commenced. Continued exploration of potential fixed venues/sites is underway.	

	Introduce clinically led collection team model by 2023/24.	• Improved leadership capability. • Standardisation of terms and conditions across collection teams. • Improved quality • Improved safety • Reduction in staff turnover. • Improved collection efficiency.	Continue phased implementation of OCP (2019) outcomes. Complete new job descriptions.	Continue phased implementation of OCP (2019) outcomes. Complete review of existing service model.	Complete implementation of OCP (2019) outcomes. Develop workforce plan. Provide and promote leadership learning opportunities.	Prepare OCP 2 process in relation to clinically led service model. Complete OCP 2 consultation. Implement new clinically led collection team model.	Work continues with the Organisational Change Process (OCP) to review the impact on north and west Wales collection teams. Work continues in preparation for go live of OCP recommendations in South Wales in January 2024. OCP2 will form part of the WBS Futures portfolio.	
	Develop and implement a platelet strategy by 2024/25.	• Improved levels of efficiency • Improved alignment between capacity and demand • Reduction in avoidable waste • Reduce wastage.	Establish a platelet strategy group under the Laboratory Modernisation Programme to coordinate the work. Complete development of platelet planning tool.	Planning tool developed and in routine use. Review the clinic collection plan for Apheresis to ensure the clinic times are optimised.	Clinical and Scientific roadmap established to predict future trends e.g., cold platelets. Begin development of platelet strategy.	Continue development of the platelet strategy.	The Platelet Strategy development has been transferred to WBS Futures portfolio and work is underway. First workshop took place in October 2023 and second planned for January 2024 to finalise scope and prioritisation of work. Timelines are being reappraised.	
	Implement a new Laboratory Information Management	• Improved availability of information	Secure funding from Welsh Government.	Commence procurement process.	Complete procurement process.	Develop implementation plan.	Procurement has been completed and supplier identified.	

	System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.	• Increased efficiency /productivity through Improved patient experience • Reduced turnaround times. • Reduction in avoidable waste					Implementation commenced January 2024 after contract award. Implementation will form part of the WBS Futures portfolio.	
	Procure new Blood Establishment Computer System (BECS) contract.	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	Commence Supplier engagement for new BECS contract.	Supplier Engagement.	Contract award.	Confirm supplier & commence implementation	Schedule for procurement approved. User Requirements Specification is approximately 90% complete. Consultants supporting Outline Business case. Funding position remains unconfirmed.	
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales • Compliance with SaBTO	Implemented testing strategy in 2022/23. Ongoing look back exercises as required.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	The project is running to plan, in compliance with SaBTO recommendations. Data is being collated as our contribution to the SaBTO review.	

	donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25.	recommendations.	Input data into SaBTO review.				SaBTO have not confirmed a report date for this review.	
	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 2023/24.	• Maintain compliance with regulatory standards • Improved quality • Improved safety • Improved donor experience.	Complete reconfiguration of the Regulatory Assurance and Governance Group to create the Divisional Quality Hub. Launch the pilot of electronic signatures. Commence formal procurement of an electronic quality Management system (eQMS). Review feedback from Change Management workshops and	Validation and deployment of eQMS. Review document hierarchy structure. Adapt change management process to support Continuous Improvement culture.	6 month review of Quality Hub delivery. Implementation of eQMS. Review amended Change Management process.	Review pilot of electronic signatures and implement learnings. Review eQMS Implementation and functionality.	Divisional Quality Hub meets monthly and is delivering on its objectives. The e-Quality Management System procurement (eQMS) has concluded. A Project group established to validate the new system. A continuous improvement approach to review changes and identify further improvements to the change management system has been adopted.	

			update processes.					
	Implementation of Foetal DNA typing by 2023/24.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women • Improved safety • Improved patient experience • Reduction in avoidable waste/costs	Procure commercial kit	Undertake digital developments to support new test. Validate test.	Complete validation and implementation of new test.	Implement all-Wales service for cell free Foetal DNA testing.	Procurement of commercial kit completed November 2023. Validation of test and development of software in progress. The 'Go live' date has been agreed by Programme Board as 13th May 2024.	
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales.	• Secure the supply chain for Immunoglobulins in Wales • Reduces need for importation. • Cost avoidance/reduction • Avoids patient rationing.	Develop project plan for supply of recovered plasma for fractionation (estimated start date April 2025). Develop high level business case for investment to support the plasma programme.	Renegotiate / renew supply contracts for diagnostic plasma to align with fractionation plan and maximise income. Develop detailed business case for plasma programme	Commence validation of leucocyte filtration (NQT) blood packs. Commence validation of Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG pathway and governance arrangements are clear. Consider options for BC preparation for Welsh Government for source and	A business case for Welsh Government (WG) has been drafted. Financial modeling is under review and endorsed by Strategic Development Committee (January 24). If approved by Trust Board this will be circulated to WG and WHSCC in February 2024. A MOU has been signed allowing WBS and WG	

				(subject to WG policy decision).		recovered plasma.	to join the UK Plasma Board and participate in the national program. WG advice on program governance at Wales level to be agreed.	
SP6 Sustainable services that deliver the greatest value to our communities **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2 and 5)**	Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model	• Improved donor satisfaction • Improved staff well-being • Increased service resilience • Reduction in energy consumption and utilisation • Reduction in carbon emissions • Compliance with statutory requirements • Improved efficiency, reduction in waste and carbon emissions.	Refresh of Programme Business Case (PBC). Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation.	Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation (following outcome of Feasibility Study).	Internal scrutiny of Outline Business Case (OBC).	Submission to Welsh Government.	Decision to integrate phase 1 (sustainability elements) & phase 2 (laboratory space utilisation) into one OBC. Funding secured to update OBC. Project re-baselined. Anticipated submission Qtr 2 2024.	
SP7 Develop great people and a	Develop a sustainable workforce model	• Enhanced workforce capacity &	Consult on new Senior Leadership	Permanently recruit to remaining SLT	Permanently recruit to remaining SLT	Review of newly implemented	WBS Senior Leadership Team (SLT) recruitment complete.	

great place to work **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	which provides 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.	Team (SLT) workforce model and recruit to roles where there are substantive job holders.	roles where there are currently only seconded post holders. Scope out new WBS workforce model for Clinical Services. Laboratory Services Modernisation Programme determine requirements for future workforce in Laboratory Services.	roles where there are currently only seconded post holders. Plan and deliver training / team development sessions with new SLT. Phased implementation of new (Clinical Services workforce model. Scope out new WBS workforce model for Laboratory Services.	SLT workforce model. Phased implementation of new Clinical Services workforce model. Phased implementation of new Laboratory Services workforce model.	The Clinical Services delivery model scoping has concluded with a new model recommended. Existing roles are being reviewed/introduced via a phased approach as opposed to an OCP. The Laboratory Services Modernisation Programme is on schedule to be delivered via the WBS Futures portfolio.	

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

APPENDIX 2

Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 3 as at 25/12/2023

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patient satisfaction	Complete recruitment to any additional posts identified in workforce plan. Review SLAs. Review operational model	Undertake staff training. Deploy communications plan. Review SLAs	Development of a transition and implementation plan to support the move to the Satellite Centre in 2024/25 Installation of 2 standard linear accelerators and a CT Sim at the centre.	Complete recruitment to any additional posts identified in workforce plan Develop stakeholder communication plan .	• Working group established in conjunction with ABUHB to design service specification and SLA.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Integrated Radiotherapy Solution Programme by 2026/27**	• Improved patient outcomes • Improved quality of care	Clinical commissioning of first replacement linear accelerator at the existing VCS	Realise initial pathway improvements. Initiate digital implementation and develop	Decommissioning and removal of second linear accelerator. Bunker refurbishment commenced in	Installation and commissioning of second replacement linear accelerator at VCS	• All aspects of phase 1 (year 1) delivered on-time and on-budget.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	First patient treatment (June 2023)	benefits realisation plan.	advance of installation of second replacement linear accelerator.		• Planning for phase 1 (year 2) in development.	
Trust Strategic Goals 1 and 2	**Implementation of findings of Clatterbridge peer review within brachytherapy services by Q1 2024/25**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Brachy therapy service improvement group. Identify actions requiring divisional/Trust support.	Optional appraisal to be completed to identify and agree service model required to address capacity gap.	Business case to be completed (if required) to address additional resource requirement.	Continue to implement local actions.	• Work on the peer review action plan has been paused following the resignation of a Brachytherapy MPE. Now single handed MPE focused	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Improved productivity and efficiency levels • Improved patient satisfaction	Gather and review baseline data set for theatre utilisation and determine capacity gap Work with Cardiff and Vale University Health Board to review anaesthetic provision and associated SLA	Continue to implement local actions. In conjunction with CAV review processes and flows aligned to Brachy theatre utilisation	Continue to implement local actions		activity on Clinical Commissioning and training additional MPE to maintain operational service.	
Trust Strategic Goals 1, 2 3 and 4	**Implement Radiology Informatics System (RISP) and participate in RISP - Radiology Informatics System Procurement.**	• Improved diagnostics information • Better information sharing and enhanced clinical decision-making	Continue to engage with DHCW facilitated project board		Development of a local implementation plan to support National implementation	Development of a local implementation plan to support National implementation	• Local deployment order approved by Executive Management Board and the Trust Board (September 2023).	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction					• Full implementation plan in development.	
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		Complete phase 2 of SDEC programme Develop business case to secure ongoing funding			• Year 3 work plan to be completed during quarter 4. • All year 2 objectives to be completed during quarter 4.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Reduction in avoidable admissions • Improved patient satisfaction						
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Quality Management System (Hub) within Velindre Cancer Services by Q2 2023/24**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Task and Finish group. Agree scope of Quality Management System.	Identify resource within VCS to support delivery of functions of QMS Develop and implement revised governance structure	Fully implement QMS	Establish patient engagement hub	• Hub at VCS to be fully implemented by end of quarter 4.	
Trust Strategic Goals 1 and 2	**Implementation of Cancer Nurse Specialist Review by Q3 2023/24**	• Improved patient outcomes • Improved quality of care • Improved patient safety	Identify possible funding requirements and develop business case to support change of service model / finance	Align work to wider scope/review of CNS as part of charity funding expectations	Engage with commissioners on matter of funding of CNS posts Completion of review	Review and evaluate impact of implementation	• CNS competency framework formally approved. • Capacity and demand review	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Improved patient • Satisfaction • Reduction in avoidable admissions					complete in the case of all tumour sites. • Feedback to CNS teams and wider SSTs complete.	
Trust Strategic Goals 1, 2, 4 and 5	**Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Services**	• Increased service resilience • Increased workforce resilience • Increased levels of efficiency and productivity • Reduced costs • Improved access to medicines in a timely manner	Progress Pilot 3 - BOPA Centralised (Separated) Clinical Verification Process	Clinical and technical elements of Clinical Verification separated Undertake local compounding of materials	Define local financial impact of model. Further review / Development of SACT processes to ensure service sustainability	Confirm Pay Tech Service resource that must remain @nVCC	• Agreed model for VCC dispensary. • Secured capital funding to support expansion of VCC dispensary capacity. • Continued engagement with national programme.	
Trust Strategic Goals 1, 2 and 5	**Expansion of VAP services by Q4 2023/24**	• Provision of care at home/close to home		Develop service model for expansion of service (to	Develop workforce plan. Develop	Realise service expansion subject to any	• Business case to support VAP expansion completed and	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Reduced patient needs to travel • Increased patient experience / satisfaction		include opportunities for service transformation).	financial plan and supporting business case.	resource requirement being secured. Evaluation of service change.	submitted to VCS Senior Leadership Team for scrutiny and approval.	
Trust Strategic Goals 1, 2 and 5	**E-prescribing implementation of phases 1 and 2 for E-prescribing for general medicines in line with national timeframes**	• Improved quality • Improved patient safety • Improved information (access to and sharing of) • Improved levels of efficiency and productivity • Reduction in carbon emissions	Establish engagement with ePMA suppliers, arrange demonstrations and identify preferred supplier Map business processes and consider the effects ePMA will have on ways of working	Develop local procurement specification Identify resource required for implementation team Develop business case to support recruitment of implementation team Develop project plan for implementation	Recruit VCS system implementation team	Recruit to VCS System Implementation Team (if staff additional to Pre-implementation Team required)	• Engagement with health board partners focused on identifying potential collaboration opportunities.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
Trust Strategic Goals 1, 2, 4 and 5	**Implementation of SACT improvement programme by Q1 2024/25**	• Improved quality • Improved patient safety • Reduced waiting times • Improved levels of efficiency and productivity • Reduced costs • Improved patient experience	Commence implementation of changes in response to findings of capacity reviews in nursing, treatment booking and pharmacy Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs.	Implementation of findings from capacity reviews in nursing and booking NHH interim service model in place Best practice service model in place ready to transition to nVCC	Progress continues: • Nursing – 5 outstanding recommendations. Anticipated that all will be complete by the end of quarter 4. • Bookings – 4 of 6 recommendations complete. • Pharmacy - 4 outstanding recommendations. Anticipated that all will be complete by the end of quarter 4.	
Trust Strategic Goals 1 and 2	**Enhance the Velindre Cancer Services SACT telephone**	• Improved quality • Improved patient safety	Establish working group as part of the Safe Care Collaborative	Develop guidelines for audit.	SACT treatment helpline fully implemented	Respond to audit findings Ensure the SACT triage	• Improvements to processes implemented supported by	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
	helpline to provide 24hr advice, triage service and achieve required standards by Q3 2023/24	• Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Technical capability to record all telephone calls is in place Digitalise UKONS tool and upload to clinical system Revise guidelines for escalation of calls.	Conduct audit process		line is achieving agreed VCS standards in accordance with the VCS Generic Patient Enquiry implementation action plan	the Safe Care Collaborative. • Further digital telephony improvement work identified.	
Trust Strategic Goals 1, 2 and 4	**Implementation of pathway programme to support optimisation of cancer pathway and transition to nVCC by Q4 2024/25**	• Improved quality • Improved patient safety • Reduced waiting times • Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Establish governance structure, develop work plan and define timelines (programme to encompass a number of work streams which will include a focus on supporting improved system-wide Suspected	Establish work streams to support the delivery of the pathway programme to include RRTT Develop action plan in response to support work with Improvement Cymru and Toyota to address area for	Develop supporting business case(s) where required to support new delivery models, identifying funding stream. Implementation of pathway improvements where possible Review ways of	Develop and implement revised processes / pathways. Implementation of service delivery model for Attend Anywhere Continued engagement in Safe Care Collaborative	• Scoping work on development of interim process to rationalize referral processes ahead of introduction of Hospital 2 Hospital referral solution undertaken.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
			Cancer Pathway compliance. Improving compliance against new radiotherapy time-to-treatment (previously COSC) targets and improved flow and performance in Outpatients) Identify two tumour sites to commence pathway work. Set up workshop to map sessions and agree key processes and treatment specific pathways for focus Identify service	improvement Establish project teams to take forward Safe care Collaborative project and ensure clear scope of work Develop and Implement new service and delivery model for Attend Anywhere.	working and identify opportunities for workforce reconfiguration Continued engagement in Safe Care Collaborative programme, including review of existing pathways for MSSC and SACT telephone helpline Implementation of services delivery model for Attend Anywhere	Programme Identify new ways of working and opportunities for workforce reconfiguration	• Safe Care Collaborative project teams have identified and implemented various pathway improvements and areas for further focused improvement work.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
			improvements / opportunities for change aligned to best practice / national standards Gather and review baseline data sets Establish Task and Finish Group to identify service improvement opportunities within outpatients department and medical records/medical secretaries Initiate service improvement projects in conjunction with the Safe Care					

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
			Collaborative within MSSC pathway and SACT telephone helpline Review lessons learned/benefits from previous Attend Anywhere pilot, identify tumour site group to initiate work, secure approval to proceed Establish project group					
Trust Strategic Goals 1, 2 and 5	**Digitisation of Medical Records programme by Q4 2024/25**	• Improved patient safety • Improved access to information (for sharing /	Establish Project group	Identify service improvements / opportunities for change	Identify additional resource requirements Undertake options appraisal	Develop supporting business case(s) Initiate phased delivery of the Project	• Project group yet to be established.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		decision-making) • Improved levels of efficiency/productivity • Reduced carbon emissions			Explore off-site storage options as part of a phased transition			
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of national prehabilitation to rehabilitation deliverables by 2025/26**	• Improved quality • Improved patient safety • Reduction in cancelled treatments • Improved patient health and well-being • Improved clinical outcomes • Improved patient experience	Continue engagement with Prehab to Rehab south-east Wales collaborative and WCN national prehabilitation group Establish local governance structure, develop work plan and define timelines Review funding streams and commissioning models to	Establish task and finish group to develop prehabilitation website for VCS patients	Introduce prehabilitation (self-management) website for VCS patients Introduce physical activity prehabilitation group sessions.	Introduce virtual physical activity programme Develop local service improvement plan	• Working group now meeting on a monthly basis. • Continued engagement with national prehabilitation meetings. • Staff engagement and awareness survey in development. • First project communication	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
			facilitate prehabilitation service development.				newsletter in development.	
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025)**	• Improved quality • Improved patient safety • Improved patient dignity and experience • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being • Reduction in carbon emissions • Reduced staff sickness	Secure FBC approval from the Welsh Government Secure full planning permission Complete clinical design Ground clearance works Continued engagement between nVCC project team and VCS.	Achieve financial close Ground clearance works Continued engagement between nVCC project team and VCS.	Commence nVCC construction Continued engagement between nVCC project team and VCS.	nVCC construction Revise/refine delivery plans Develop plans to support the transition of services from VCS to the nVCC Finalise clinical models to be implemented to support nVCC.	• Full Business Case remains under development and awaits Welsh Government approval.	
Link to Trust Destination	**Implementation of Outreach**	• Increase care close to home	Project board re-established in	Service model developed and agreed in	Identify and agree additional workforce	Service model developed and agreed with	• Strategic planning assumptions	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Programme by 2025/26**	• Improved access • Improved equity • Improved patient experience • Reduction in carbon emissions	conjunction with HBs	partnership with ABUHB Development of service model in partnership with CTMUHB	requirements and funding streams Development of service model in partnership with CTMUHB Development of service model in partnership with CTMUHB Ongoing discussions with CTMUHB to determine model and next steps.	both CTMUHB and C&VUHB	and baseline data reviewed. • Engagement with Aneurin Bevan UHB, in the first instance, on delivery model scheduled to take place in January 2024.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Phase 1 of the regional Acute Oncology Service by 2023/24**	• Improved quality • Improved patient safety • Improved clinical outcomes	Establish an acute care programme board Agree scope and develop a statement of intent	Undertake review of service model at VCS and identification of required next steps	Develop communication strategy Develop AOS framework for VCS and service model	Undertake engagement on service model for nVCC	• New operational manager recruited to support regional work.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Reduction in avoidable admissions • Improved patient experience • Reduction in carbon footprint					• Velindre specific acute oncology project progressing with particular focus on pathways, processes and patient transport issues.	
Trust Strategic Goals 1, 2 and 4	**Implementation of national programme for palliative care and end of life in line with national timeframes**	• Improved quality of care • Reduction in avoidable admissions • Improved patient experience	Review baseline data and outcome from pilot work to date. Identify scope of palliative radiotherapy within VCS and as part of a regional model.	Develop agreed costed model for palliative radiotherapy Identify opportunities for workforce redesign and develop associated workforce plan Identify possible funding options	Collaborate with Cardiff and Vale University Health Board to explore options for regionalised chronic pain service Review and develop agreed costed model for palliative radiotherapy Identify opportunities for workforce	Develop business case to support palliative radiotherapy model if required	• Meetings to focus on the development of an agreed, sustainable model for palliative radiotherapy scheduled for early 2024.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
					redesign and develop associated workforce plan			
Trust Strategic Goals 1, 2, and 4	**Implementation of new services / delivery models by 2025/26.**	• Improved quality • Improved patient safety • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being • Enhanced organisational reputation for quality of service	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service developments Establish working group to develop service model to support delivery of internal mammary lymph node (IMN) radiotherapy for eligible patients	Finalise the priority of implementation of key treatments where external funding is required and agree timescales Determine requirement for additional funding and where appropriate commence business case developments for agreed treatments in phased approach according to priority and	Identify preferred service model and any additional resource requirement. To support delivery of partial breast and axillary radiotherapy for eligible patients with breast cancer Develop strategy and service model to support adoption of motion management	Identify additional resource required to implement partial breast and axillary radiotherapy and develop business case for consideration by commissioners Expand SRS service to support the routine treatment of patients with more than 3 metastases Identify additional	• Working group established to plan introduction of IMN and other novel breast cancer treatments. Group will identify treatment solution and any resource implications which will inform the development of a business case to support introduction of new techniques.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
			with breast cancer Continue to engage with WHSSC service appraisal process in relation to proposed PRRT service Develop service model to support implementation of PRRT service for eligible patients with neuroendocrine tumours Identify additional resource required to expand HDR brachytherapy boost treatments for eligible patients	timetable agreed Identify additional resource required to implement IMN and develop business case if required for consideration by commissioners. Develop service models to support delivery of extreme hypofractionated radiotherapy for eligible patients with prostate cancer if required Identify additional resource required to implement extreme hypofractionated		resource required to support the expansion of the SRS service and develop business case, if required	• Working group established to plan implementation of hypofraction for the treatment of eligible prostate cancer patients (aka SABR for prostate).	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
			with prostate cancer. Develop business case for WHSSC to support expansion of HDR brachytherapy boost service Develop service model and associated pathways to support delivery of new indications for Stereotactic Ablative Radiotherapy (SABR)	radiotherapy for eligible patients with prostate cancer and develop business case for consideration by commissioners Develop business case to support implementation of PRRT service to WHSSC and funding stream for additional revenue resource if required Train Medical Physics Expert to support implementation of PRRT service				

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
Trust Strategic Goals 1, 2 and 5	**Implement DHCR phase 2 by 2024/25**		Review learning from phase 1 to support implementation of further phases continue implementation of training plan Identify super users/champions for each service group to continue to support implementation Establish revised governance, reporting and delivery structure for VCS agreed scope and prioritisation of phase 1b (VCS specific) agree scope and prioritisation of phase 2	Review learning from phase 1 Establish revised governance structure	Clarify scope and service delivery requirements	Develop work plan to support implementation.	• Phase 1 closure report and benefits realisation review developed. Lessons learned exercise undertaken.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q3**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Centre for Collaborative Learning and Innovation by Q4 2024/25**	• Creation and sharing of knowledge across Wales/wider to improved cancer care • Development of network of partners to tackle key issues • Creation of knowledge economy and innovation across Wales • Physical space to support innovation and development working across the region/Wales/wider	Workshop to be held to scope CFCL and ways of working Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway delivery between and with primary and community care and Velindre	Workshop to be held to scope CfCL and ways of working	Review potential projects aligned to CfCL, e.g. school for oncology, ARC, etc.	Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway delivery between and with primary and community care and Velindre	• CCfLI collaborative workshop undertaken and next steps agreed.	

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

APPENDIX 3

Trust-wide Initiatives - IMTP Progress Report 2023/24 for Quarter 3 as at 25/12/2023.

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
Digital Initiatives	**Theme 1: Ensuring our Foundations** **Theme 2: Digital Inclusion** **Theme 3: Insight Driven** **Theme 4: Safe and Secure Systems** **Theme 5: A Digital Organization** **Theme 6: Working in Partnership**	• Provide resilient digital services which support excellent care • Seamlessly digitally connect patients, donors, staff and partners with our services and equally value non-digital channels • Become a data driven, insight led organisation where staff take care of and have the right information, at the right time, all of the time • Secure our data, information and services through an effective approach to Cyber Security • Create a digital culture across the Trust of innovation and knowledge sharing that supports the delivery of world class services	• Implementing our digital strategy • Constantly evolving our IT infrastructure and Cyber Security arrangements to meet good practice with a hybrid of cloud and on premise deployment • Implementing a digital transformation programme to drive benefits and create digital services that our patients, donors and staff value and can be accessed close to home • Increasing the speed of development, deployment and functioning of new technologies to increase our productivity • Working in partnership to implement a range of national systems, to support a once for Wales approach • Working with the public and Centre for Digital Public Services and Digital Communities Wales to champion and accelerate digital inclusion • Developing our partnership role with the Digital Intensive Learning Academy and Health Education and Improvement Wales to increase the digital literacy, skills and knowledge of our staff • Identifying opportunities to join digital accelerator programmes and initiatives	• Digital Strategy Published • Digital Programme established – group met for first time in Q3 2023/24. Digital Design Authority to be established in Q4. • Cyber Security Manager in post – implementation activities against Cyber Security Strategic Plan re-commenced. • Ongoing progress in respect of major digital change programmes – i.e. BECS, WHAIS, RISP, ePMA. • Further development of	

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
			• Improve the quality of our data by driving data standards; identifying data champions; and improving data sharing protocols • Transforming our information capability to provide data, information and knowledge to the right person at the right time and introduce new analytical capabilities • Building digital partnerships with partner organisations, academia and digital providers to create value in health, wealth and well-being	relationships with Academia – e.g. Digital Degree Apprenticeships Roadshow planned for Q4 2023/24. • Digital Infrastructure Strategy and Supplier Management Framework drafted – for approval in Q4 2024/25. • New Assistant Director of Data & Insight due to commence in post January 2024. Piloting of 'Agile' delivery model for digital transformation activities due to commence in Q4 2024/25.	

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
Workforce and Organizational Development	**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-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	• Clinical agreed short and long-term MDT workforce plans • Improved alignment of our education and training functions to the needs of our services • Services delivered at a location and time which best suits our patients and donors • All staff to be proud to, and able to, promote our core values and principles • Improved health and well-being of our workforce.	A Health and Wellbeing Plan has been in place for 22/23 overseen by the Healthy and Engages Steering Group. A highlight report is sent to EMB quarterly A training plan is in place for 22/23 overseen by the Education and Training Steering group. A highlight report is sent to EMB quarterly A Strategic Equality plan has been agreed. An implementation plan for 22/23 is being delivered An Agile working Programme has been delivered to support hybrid working across the Trust A Programme to increase Welsh Essential roles is ongoing in the Trust. A Programme of welsh	

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
		• Growing the Trust Inspire Leadership and Management Programme		education is also in place The Trust has undertaken Staff Awards in 2023 and has a programme of Long Service Awards in place The Trust Inspire Management and Leadership programme is in its 4th Cohort, intermediate evaluation is in train	

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
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**	• Provide an estate which enables the delivery of high quality clinical services • Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience • Provide healthy buildings which support and enhance individual well-being • Minimise the impact of our estate on the environment • Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve	• 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:		

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
			o Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025 o Refurbishment / development of new outreach facilities by 2024/2025 o Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024 o Opening of the new Velindre Cancer Centre by 2025		
Sustainability	**Theme 1: Creating Wider Value** **Theme 2: Sustainable Care Models** **Theme 3: Carbon Net Zero** **Theme 4: Sustainable Infrastructure** **Theme 5: Transition to a Renewable Future** **Theme 6: Sustainable Use of Resources** **Theme 7: Connecting with Nature**	• Be recognised as a leading NHS Trust for sustainability nationally • Be a carbon 'Net Zero' NHS organisation by 2030. • Become an anchor organisation in the communities we serve which enhances their economic, social, environmental and cultural well-being • Support the transformation from ill-health to well-being across Wales •	• 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		

	Theme 8: Greening our Travel and Transport **Theme 9: Adapting to Climate Change** **Theme 10: Our people as Agents for Change**		reduction and healthier buildings and healthier people approach. These include: o Major refurbishment of the Welsh Blood Service, Llantrisant site, by 2025 o Construction of a Radiotherapy Satellite Centre at Neville Hall by 2024 o 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		

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q3**	**Progress Rating**
The Financial Plan	We have had an approved Integrated Medium Term Plan (IMTP) since their introduction by Welsh Government (WG) in 2014-15. Central to IMTP approval has been the Trust's ability to consistently achieve a balanced year-end out-turn position annually, whilst maintaining or improving the quality of our services and delivering agreed performance measures.	Our Integrated Medium Term Plan (IMTP) for 2023-2026 sets out our Financial Strategy from 1st April 2023 to 31st March 2026. During this period, the Financial Strategy aims to enable the Trust to meet the anticipated demand for services whilst still in recovery, ensuring that we return to pre-pandemic activity levels and address the backlog. Recovery from the pandemic continues to be further compounded by significant financial challenges due to the system wide exceptional cost pressures, which include energy & fuel cost increases and extraordinary levels of cost inflation, each of which will need to be met by the Trust in 2023-24.	The financial plan for 2023-24 consists of a number of distinct parts: 1. Core Revenue Plan: Balanced 2. COVID-19 Recovery 3. Financial Plan – demand & capacity 4. Income & Cost Assumptions 5. Planned Savings 6. Capital Plans Financial reports and returns		

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

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 30 January 2024 to 19 March 2024

DATE OF MEETING	26 March 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?	NO
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	**Appendix 1** Andy Butler, NWSSP Director of Finance & Corporate Services
EXECUTIVE SUMMARY	This report details the Trust Board decisions required for Commitment of Expenditure exceeding the Chief Executive's Limit (£100k), for the period **30/01/2024 – 26/03/2024.** There is one (1) item of expenditure are required for the Trust Board Approval during this period: • **APPENDIX 1** – NWSSP Companies House & Charnwood Court to Cefn Coed, Nantgarw proposed relocation.

RECOMMENDATION / ACTIONS	The Trust Board is requested to: • **AUTHORISE** the Chief Executive to **APPROVE** the award of contract summarised within this report and supporting appendix. • **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
• **Appendix 1 –** NWSSP/NHS Wales Shared Services Partnership Committee	21/03/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS **APPENDIX 1 –** The NWSSP/NHS Wales Shared Services Partnership Committee is expected to **APPROVE** the NWSSP Companies House & Charnwood Court to Cefn Coed, Nantgarw proposed relocation.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES
Appendix 1 – NWSSP Companies House & Charnwood Court to Cefn Coed, Nantgarw proposed relocation.

1. SITUATION/ BACKGROUND

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

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

1.3 The decisions expected during the period **30/01/2024 – 26/03/2024** are highlighted in this report.

1.4 In line with the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are received by the Executive Management Board to ensure

Executive oversight and scrutiny, to provide the Board with supporting recommendations and additional assurance.

2.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendix 1** for the detailed appraisal undertaken of the expenditure proposal that the Trust Board is asked to **APPROVE**.

2.2 The table below provides a summary of the decisions sought from the March 2024 meeting of the VUNHST Board:

Appendix No.	**Division**	**Scheme / Contract Agreement Title**	**Period of Contract**	**Total Expected Maximum Value of Contract £**
Appendix 1	NWSSP	NWSSP Companies House & Charnwood Court to Cefn Coed, Nantgarw proposed relocation ***This expenditure links to the separate Trust Board agenda item 6.1.5***	Start: 01/11/2024 (estimated) End: 31/03/2035	£3,657,000 (inc VAT)

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*	03 - Workforce Planning

QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Further details are provided in Appendix 1 of this report
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required, undertaken on a case by case basis, as part of the procurement process.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	If applicable, as identified in each case as part of the service design/procurement process.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

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

SCHEME TITLE	NWSSP Companies House & Charnwood Court to Cefn Coed, Nantgarw proposed relocation
DIVISION / HOST ORGANISATION	NWSSP
DATE PREPARED	29TH February 2024
PREPARED BY	Mark Roscrow, Programme Director
SCHEME SPONSOR	Andrew Butler Director of Finance

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The lease covering two floors of the Companies House building in Cardiff is shortly due to expire and we have been informed that we need to move out of the building. Prior to the pandemic we had approximately 600 staff attending the building daily but post-pandemic the average attendance is between 60 and 70.

The original plan was to relocate Companies House staff to the Welsh Government building in Cathays Park but increases in cost and restrictions on parking and access necessitated consideration of further options. At the same time the lease for the current Nantgarw HQ was due for renewal. Again prior to the pandemic average attendance would have been approximately 120 staff but this figure has now dropped to around 40.

The decision was therefore taken to widen the scope of the search to find a building that could accommodate staff from both locations.

Searches within the Cardiff area identified no suitable options, but an alternative option was identified at Cefn Coed, Nantgarw, in a building that was previously occupied by public sector tenants, but which has been empty for several years. This option has been considered by the NWSSP Senior Leadership team and has now emerged as the preferred option supported by a small satellite hub in Cardiff.

The Rent reserved in the lease will be £292,530 per annum. The Rent is exclusive of business rates, service charges, insurance, VAT, and all other outgoings. The Rent will be payable quarterly in advance. NWSSP will also be granted an 18-month rent free

period from lease commencement or date of occupation, whichever is the earlier. This value amounts to £439K and this sum will be used to cover any additional expenditure that might be required to bring the building up to the standard required. This will be over and above those "fit outs" which the landlord has already agreed to fund and undertake in the first instance The lease will contain an upward only rent review at the end of the 5th year, based on the market rent at the review date. The tenant will be responsible for any Estate Service Charge attributable to the property.

Approval will also be sought from the Shared Services Partnership Committee at its meeting on 21st March 2024.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	(est) 01/11/2024
Expected End Date of Contract	31/03/2035
Contract Extension Options **(E.g. maximum term in months)**	

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

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

Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☐
If not, please explain the reason for this in the space provided.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES

This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.

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

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

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

Click **here** for more information

Prevention	☐	Long Term	☐	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

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

3.1 Please state alternative options considered and reasons for declining
Due to ongoing accommodation requirement albeit on a reduced volume of desks the " Do Nothing " was not an option. Our Estates Property team undertook a detailed survey of what was available with a very limited outcome. The current proposal represents the best option.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
The preferred option will allow NWSSP and its staff to deploy its agile working strategy and with this the flexibility that staff have enjoyed over the past few years. It also provides a financial benefit to the organisation and a lower operating cost for NWSSP which is reflected in the services the organisation provides across NHS Wales as well as any ongoing financial benefit.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
The organisation would struggle to deliver a number of key services without this facility. This would have an adverse impact on all NHS bodies in Wales as well as Welsh Government.	The property search did not identify any other suitable location within the catchment area and therefore it is critical the scheme goes ahead.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐

Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy

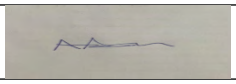
This is not a procurement but rather the agreement of a building lease. Specialist Estates experts have been used to undertake a search for a suitable building option and to agree the rent including the negotiation of an 18-month rent-free period to pay for specific refurbishment that may be required by NWSSP, and which is over and above that already agreed by the Landlord.

6.3 What is the approximate timeline for procurement?

Refurbishment work is to be undertaken by the Landlord in the coming months with an expected occupation date of 1st November 2024.

6.4 PROCUREMENT ROUTE APPROVAL

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

Head of Procurement Name:	Andrew Nash
Signature:	
Date:	28/02/2024

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£3,047**	**Including VAT (£k)** **£3,657**
The nature of spend	**Capital** ☒	**Revenue**

How is the scheme to be funded? Please mark with a (x) as relevant.	
Existing budgets	☒
Additional Welsh Government funding	☐
Other	☐
If you have selected 'Other' – please provide further details below:	

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1* (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Rent	0	0	268	2,340	2,608	3,130
Refurbishment	439	0	0	0	439	527
Overall Total	439	0	268	2340	3,047	3,657

*Year one is the period from Nov 1 2024 to 31 March 2025

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	There is full PMO support to this project.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

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

Signature:	
Service Area:	Director of Finance and Corporate Services
Date:	29/02/2024

10. APPROVALS RECEIVED

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

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

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	21 March 2024
HTW – Senior Management Team	

TRUST BOARD

CHAIR'S URGENT ACTION MATTER REPORT

DATE OF MEETING	26 March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	**CONSIDER** and **ENDORSE**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	This report details Chair's Urgent Action taken between the **23/01/2024 – 19/03/2024**. There was one (1) urgent item of business for the Trust Board that were considered via Chairs Urgent Action during this period: 1. Renewal of NHS Wales Shared Services Partnership (NWSSP) Mamhilad Lease. No objections to approval were received in respect of the items of business considered.

	A number of queries were raised and subsequently addressed; these are detailed in the report.

RECOMMENDATION / ACTIONS	To **CONSIDER** and **ENDORSE** the Chairs Urgent Action taken between the **23/01/2024 – 19/03/2024.**

GOVERNANCE ROUTE	
Trust Board Members – Via Email	**27/03/2024**: Renewal of NHS Wales Shared Services Partnership (NWSSP) Mamhilad Lease.
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Trust Board **APPROVED** this item of business considered via Chairs Urgent Action.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES – N/A

1. SITUATION

This paper provides the Trust Board with an overview of key decisions and outcomes considered via Chairs Urgent Action between the **23/01/2024 – 19/03/2024.**

2. BACKGROUND

2.1 In accordance with the Trust Standing Orders, there may occasionally, be circumstances where decisions, which would normally be made by the Board, need to be taken between scheduled meetings and it is not practicable to call a meeting of the Board. In these circumstances, the Chair and Chief Executive, supported by the Director of Corporate Governance & Chief of Staff, as appropriate, may deal with the matter on behalf of the Board – after first consulting with at least two other Independent Members. The Director of Corporate Governance & Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Board for consideration and ratification. Where issues are included in the Schedule of 'Expected Urgent Decisions' and prior approval is sought from the Board, these issues will not be reported here.

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

3.0 ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following is a summary of the key outcomes from the items of business considered by the Trust Board via Chairs Urgent Action since the last formal meeting of the Trust Board at the end of January 2024:

3.1 At the Trust Board on 30th January 2024, the **Renewal of NWSSP Mamhilad Lease** was discussed and a number of points were raised that needed to be resolved prior to the Trust Board approving the renewal of the lease. The points to address were:

- The Trust Board had not received a copy of the Lease for comment before sign off and whether this was regular protocol. It was agreed that the Lease should be received by Board members and that this would be circulated for finalisation outside of the meeting.
- The payment for the lease as detailed in the cover paper is not inclusive of VAT and that this should be amended to reflect the information presented in the associated Appendix 5 under the Commitment of Expenditure Exceeding Chief Executive's Limit.
- The current lease expired on the 7th October 2023. Gareth Jones queried a) the delay in the signing of the new lease and b) the cover paper states that the new lease will be backdated to the 8th October 2023.

The following response has been received from Peter Stephenson, NWSSP:

I have attached a copy of the draft lease which is still being finalised. We however need to get the Board approval in advance of the lease being signed so that it does not delay completion. Obviously if anything material changed post Board approval; we would bring this to your attention prior to asking the Trust to sign the lease.

For a new lease we would normally provide the Heads of Terms document as supporting detail but this one related to a renewal of an existing lease with the only significant changes being the rent and lease term which was documented in the paper that we submitted. Additionally, we have included a Service Charge cap which is to our benefit. The lease has been subject to specialist estates and legal input, but if you do need these submitted in future please let me know.

I have added in the VAT inclusive figures to the approval paper and resubmit this together with the Commitment of Expenditure paper.

We did start the process for renewal of the lease prior to its expiry. It is common for the negotiation of the lease renewal to extend beyond the lease expiry date and for it therefore to be backdated. We understand that Johnseys have bigger strategic priorities at present and are therefore quite relaxed about getting the lease finalised and signed.

I hope that this answers your queries and helps to ensure that the situation doesn't reoccur. This particular lease is not time-critical, but we are planning to bring similar papers (supported by the Heads of Terms documentation) to the March Trust Board for the new HQ and it will be vital that we get this approved.

The Trust Board were sent an email and Chair's Urgent Action Report on the **27 February 2024** in relation to the **Renewal Of NWSSP Mamhilad Lease** that required urgent approval and asked to:

- **APPROVE** the renewal of the lease for the Counter Fraud Wales Service offices covering part of the 1st Floor, Block B South, Mamhilad House and the corresponding Commitment of Expenditure exceeding the Chief Executive's Limit/Business Justification for the **Renewal of NWSSP Mamhilad Lease** and the commitment to spend a total of **£259,000 (including VAT).**

The following approvals were received:

Recommendation Approved by:

- Donna Mead, Chair
- Steve Ham, CEO
- Stephen Harries, Vice Chair
- Vicky Morris, Independent Member

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	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Financial impact was captured within the documentation considered by the Board.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Legal impact was captured within the documentation considered by the Board.

4 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

TRUST BOARD

Strategic Equality Plan 2024 - 2028

DATE OF MEETING	26 March 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	Michelle Fowler, Equality, Diversity and Inclusion 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	As part of our specific duties under the Equalities Act 2010 and Regulations in Wales, Velindre University NHS Trust is required to develop and publish a Strategic Equality Plan (SEP) and its strategic equality objectives every four years. Velindre Trust has worked in partnership with 11

	other public bodies to develop a shared set of SEP Objectives for the 2024 to 2028 period. The partnership have agreed to broadly keep the same list of objectives as in the previous four years, merging the first two of them into one, to make a set of four objectives. Following our own SEP consultation; we found people largely agreed with the chosen objectives, however some issues were raised about the specific language used in them. Specifically, several respondents were unhappy with the word 'needs' and so we are recommending a slight change to the wording for a couple of the objectives in order that they feel more neutral.

RECOMMENDATION / ACTIONS	**To ENDORSE the Strategic Equality Plan and Objectives for Board Approval.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/2/24
Strategic Development Committee	21/3/24
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Endorsed by EMB with minor additions to the Strategic Equality Plan. Noted that the delivery of the Strategic Equality Plan rests on the actions being embedded in service delivery plans across the Trust.	

7 LEVELS OF ASSURANCE

Not for assurance	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
1	Strategic Equality Plan 2024 – 2028:

1. SITUATION

1.1 As part of our specific duties under the Equality Act 2010 and Regulations in Wales, Velindre University NHS Trust is required to develop and publish a Strategic Equality Plan and its strategic equality objectives every four years. These objectives set out the strategic priorities of the organisation, focusing on how the Trust can contribute to a fairer society, advancing equality and good relations. The objectives should be specific and focus on one issue at a time.

1.2 An engagement exercise was conducted towards the end of 2023 to inform the Equality Impact Assessment and gather feedback on the proposed objectives. This feedback has been aligned with the strategic and organisational context of the Trust into the attached Strategic Equality Plan, 2024 to 2028.

2. BACKGROUND

2.1 Four years ago, Velindre collaborated with 11 other public bodies in developing a Strategic Equality Plan and a shared set of Strategic Equality Objectives for the period 2020 to 2024. Five objectives were agreed which all 11 bodies adopted within their own organisational plans, with the exception of Objective 4 below, which was chosen by Velindre University NHS Trust in place of an objective relating to procurement. These objectives were:

1. Increase workforce diversity and inclusion
2. Eliminate pay gaps
3. Engage with the community

4. Communicate with people in ways that meet their needs
5. Ensure service delivery reflects individual need.

2.2 These objectives have shaped the equalities activities during the last four years and have been reported on through the Annual Equality Report. Key developments have been:

- In 2021 Executive Board Members took up roles as Equalities Ambassadors, focussing on each of the protected characteristics. This gives a platform for progressing diversity and inclusion both internally and with the public through Board presentations.
- A refreshed approach to conducting Equality Impact Assessments, including a Toolkit, was introduced at the end of March 2023. This has opened up discussions around the differential impact of policies and decisions and has led to the EQIA becoming more than a tick box exercise.
- A renewed focus has been given to producing the Gender Pay Gap report, bring the analysis forward in the year. This highlights issues where employment may be skewed to one gender over another, which is the underpinning cause of gender pay disparity.
- In May 2023 the Trust launched Velindre Voices a means for anyone to engage with us, influence our work and have their voices heard in a way that suits them.
- Welsh Blood Service has a well-developed Donor Engagement Panel who can support and advise on service improvement and development.

2.3 During the second half of 2023-24, a programme of engagement was planned and delivered to secure a wide range of feedback on the proposed objectives and issues of importance to people. The methods utilised are summarised below.

Stakeholder Group	**Questions**
Meeting with the Executive Management Board on 18.9.23 to start a discussion on what the Trust wants to achieve through the next iteration of the Strategic Equality Plan.	Questions: • What does the Trust want to accomplish? • What is not working? • How can things improve?

Meeting with the Public Sector Equality Partnership on 6.11.23 to review existing objectives and re-confirm commitment to working in collaboration.	Questions: • How well will the current objectives serve us for the next four years?
Survey issued to internal and external stakeholders.	Questions: • Do you agree with the four objectives which are proposed? • What actions can we take to achieve these objectives over the next four years?
Open invitation to send feedback, sent out with PowerPoint slides.	Questions: • What actions can we take to achieve these objectives over the next four years? • What else is important to you in terms of our Strategic Equality Plan?

2.4 The findings from this consultation have been fed into the Equality Impact Assessment for the Strategic Equality Plan and from there have informed the Actions within the attached plan.

3. ASSESSMENT

3.1 Strategic Context

The Strategic Equality Plan will support and be delivered through a number of other Trust strategies, for example:

- The Trust's equalities aspirations fit within our goals under the Wellbeing of Future Generations Act's goals of A More Equal Wales and 'A Healthier Wales'.

- The Trust Strategy, Destination 2033 sets out the purpose and vision:

Our Purpose: To improve lives.
Our Vision: Excellent care, inspirational learning, healthier people.

- The Trust's values of Caring, Respectful and Accountable shape everything we do and are fundamental in achieving equality.

- The People Strategy sets an ambition of having: "Healthy and Engaged Workforce within a culture of true inclusivity, fairness, and equity across the workforce. A workforce which is reflective of the Welsh population's diversity, Welsh language and cultural unity.

- Our Anti-Racist Action Plan aims to create an organisational culture in which all members of staff are able to enjoy working free from discrimination and where ethnic background is a source of strength, not a barrier.

3.2 The Executive Management Board identified some priorities for the next Strategic Equality Plan, as below.

Communication
This is a varied topic with a variety of needs. Communication involves languages and how to adapt to those with other linguistic requirements. Communication also includes how Velindre communicates with patients, staff, and stakeholders.

Values
The Trust has recently reviewed what is important to staff and service users and this has created a refreshed set of organisational values: Caring, Respectful and Accountable. These underpin everything within the Strategic Equality Plan.

Equality Impact Assessment
Making our EQIA process meaningful and effective.

Governance
Clarity of process and complying with all legal frameworks.

3.3 The Public Sector Equality Collaborative re-convened to review their shared objectives agreed in 2020. There was agreement that the existing objectives were

as relevant now as four years previously and these were endorsed by that group as a guide for the next planning period. Velindre maintained its own Objective 4 concerning Communication in place of an objective relating to Procurement. The one change was that the first two objectives were merged, thus leaving four objectives.

3.4 The full findings from the consultation exercise were analysed through the Equality Impact Assessment following which the actions were designed.

Feedback from the consultation gave a wide range of views and insights that we have been able to capture within the attached Strategic Equality Plan.

- There was a high level of support for the four objectives proposed by the Public Body Equality Collaborative, as amended by the Trust.
- Respondents were keen to see a workforce that more accurately reflects our local community which would also allow more 'normalisation' of diversity.
- Staff wanted to see improved collaboration between teams and departments to reduce siloed working and avoid duplication of effort.
- Communication, particularly in the case of Deaf, BSL-users was highlighted as a barrier. This was only highlighted in this instance due to specifically engaging with the Deaf community via BSL.
- Staff were keen to have more opportunities to use Welsh while at work.
- There was some desire for additional training for staff in terms of disability and LGBTQ+ issues to help boost their confidence in how best to engage with patients.
- The importance of disability and age on how people can interact with the organisation, as an employee, patient or donor was brought out clearly.
- Several responses pointed out that the use of the word 'needs' may not be in line with the Social Model of Disability and had connotations of people being 'needy'.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 In view of the strategic direction of the Trust and in light of feedback from the consultation exercise a Strategic Equality Plan 2024-2028 is attached at Appendix 1.

4.2 The implementation plan will be monitored and reviewed through the Healthy and Engaged Steering Group.

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 Strategic Equality Plan guides our work with our staff and those we serve. The relevance and impact of the objectives that we choose will be shaped by the quality of feedback that we access from our stakeholder community. At the same time, the objectives also need to encompass our legislative and policy obligations.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	Click or tap here to enter text. Completed as part of the EQIA. No specific issues arose during consultation.
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
	Funding requirements will be identified as part of individual actions
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
	The feedback has directly influenced the actions outlined in the attached plan.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	S149 of the Equalities Act 2010 sets out the Public Sector Equality Duty. This was supplemented in Wales in 2012 with a regulation requiring the publication of Strategic Equality Objectives.

3. 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	

Velindre University NHS Trust

Strategic Equality Plan 2024 - 2028

Introduction

As a public body we are required to publish a Strategic Equality Plan which sets out our equality objectives and explains how we will achieve these objectives. We are guided by the Equality Act 2010 and the Public Sector Equality Duty, which call on us to think ahead so we can better meet the needs of the people we work with. The Trust publishes an annual report with information about our progress, together with equality information about our workforce each Spring.

There are three overall aims of the Public Sector Equality Duty:

1. Eliminate unlawful discrimination, harassment and victimisation (and other conduct prohibited by the Act).
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

Under the Equality Act, there are **9 protected characteristics**, they are:

Age	Disability	Gender Reassignment
Religion & Belief	Sex (Gender)	Race
Sexual Orientation	Pregnancy & Maternity	Marriage / Civil Partnership

Developing our Objectives for 2024 – 2028

We consulted and engaged with patients, staff, partners, equality organisations and other stakeholders in partnership with Wales Public Body Equality Partnership. We asked these stakeholders what they thought the equality priorities should be for the Trust and what they thought should be done to improve equality. We also identified what research and information was already available to help in the development of the objectives. We surveyed patients, staff, partners, equality and third sector organisations and other people as to whether our previously set objectives should be kept as they are, changed or whether we needed to add new ones.

In light of the understanding of our legal obligations, our strategic intentions and stakeholder feedback, we have established our Vision for Equality and four Strategic Equality Objectives for 2024 – 2028. We have also described the broad areas of work that will enable us to achieve our vision.

Our Vision for Equality

Our vision for equality is that our values of Caring, Respectful and Accountable are evident in **everything** we do, thereby improving the lives of all our stakeholders, irrespective of their background. We will use this Strategic Equality Plan to put patients, donors and staff at the heart of everything we do. The lens of equality will allow us to challenge the status quo and ask questions so that we can design our organisation and systems around people, taking heed of individuals' views, requirements and aspirations.

Our overarching ambition is to ensure that there is enhanced collaboration between the members of the Leadership and management teams and the people we employ. There will be an improved relationship between staff and patients and we will strive to eliminate barriers to care. Teams throughout Velindre Cancer Service, the Welsh Blood Service and Trustwide Services will reduce working in silos and will have an improved knowledge of other departments' working strategies and aims. There will be increased engagement throughout the Trust which will in turn develop relationships and knowledge sharing. Patients and Donors will be invited to networks to listen to their feedback which will then improve services delivered in Cancer and Blood services and we will develop strategies to reduce barriers to care and service delivery. A positive working environment will be fostered with clear channels of staff feedback, tackling each equality issue raised.

Bringing the objectives to life

We have four clear objectives and have outlined the key areas of work over the next four years that will enable us to achieve our vision for equality.

1 **Increase workforce diversity and inclusion and eliminate Pay Gaps**
We would like the workforce to better reflect the diverse nature of the communities that we serve and also to ensure that there is no systemic pay disparity between people of different genders, races or disability.

Actions

- Check that our approaches to recruitment and selection are open and fair.
- Acknowledge that our workforce profile is changing and our teams need to develop to meet this change, for example our teams are becoming more diverse as a result of successful recruitment of Doctors and Nurses from India and Hong Kong.
- Build on our links with schools, colleges and the community to introduce people from across the whole community into roles and careers in healthcare.
- Support women to thrive in STEM professions.
- Create a positive working environment in all areas so that the Trust is regarded as an employer of choice where people want to stay.

- Utilise reasonable adjustments from first contact with applicants throughout their employment with the Trust.
- Prioritise professional development for all.
- Embed staff engagement and diversity forums in day-to-day life, including consideration of the impact of intersectionality.
- Implement the Trust Anti-racist Action Plan and the Workforce Race Equality Standard.
- Build on our status as a Disability Confident employer, achieving Leader Level.
- Develop our reporting of pay gaps and feed the recommendations into annual work plans.

2 **Engage with the community**

In order to ensure that we are providing services that our patients and donors want and need, it is important that we understand them and ask them about what things they want from us and how we might be able to do to that in better ways.

Actions

- Create opportunities for staff, patients and donors to engage with communities, for example Pride, Sign Language Week, Disability Equality Week, Black History Month to allow everyone to learn, experience and connect with different communities and cultures.
- Establish a regular system of capturing feedback from stakeholders to understand how people feel about our services and organisation.
- Further develop our stakeholder engagement for Cancer and Blood services by engaging with diverse groups and communities.

3. **Communicate with people in ways that meet their requirements.**

We have a variety of ways that we stay in contact with the people of Wales; letters, phone calls, social media; it is important that we are doing this in way that people can easily understand and in their first, or preferred, language.

Actions

- To continue to improve collection of language information and communicate effectively with patients, donors, their carers and families, in the language of their choice.
- Improve access to our services for BSL users to allow Deaf people to be able to communicate with, access, engage and provide feedback/ concerns to the system in a way that fully meets their needs.
- Truly implement the Active Offer for Welsh speakers and comply with the Welsh Language Standards Framework

4. **Ensure service delivery reflects individual requirements.**

We provide specialist cancer services to the population of south east Wales at a time when people are particularly vulnerable. We are also indebted to our donors who volunteer to give blood or tissue for the benefit of others. We

want all these individuals to be able to access what they require as simply as possible.

Actions

- Apply the Equality Impact Assessment methodology to any projects on redesigning patient pathways, including a consideration of the impact of age.
- Improve the accessibility of our services by innovating, in light of patient and donor feedback, including a regular review of disability or adjustments.
- Improve the recording and transfer of patient data so that patients identified by other services as being disadvantaged receive the appropriate support when they come to us.
- Support the development of a single, unified approach towards Equality Impact Assessments across all NHS Wales.
- Support managers in undertaking Equality Impact Assessments to create positive change
- Educate staff on the needs of other people across all protected characteristics.

Checking our progress

Progress with the Strategic Equality Plan will be monitored within the Healthy and Engaged Steering Group. A full progress report is presented with the Annual Equality Report, in line with the Trust's reporting cycle.

The measures that demonstrate progress will be:

1. Workforce data showing a broadening of the employee profile over time, both in relation to year-on-year change and in relation to comparison with the 2021 Census figures.

2. Improved scores shown in the NHS Staff Survey for equality and diversity measures.

3. Improved scores shown in the Workforce Race Equality Standard report.

4. Increase in numbers of staff involved in engagement events, training and Diversity Forums.

5. Increase in numbers of patients and donors offering feedback and participating in engagement events.

6. Comprehensive use of Equality Impact Assessments where required and improvements in the quality of recommendations and actions resulting from the analysis.

TRUST BOARD

CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE

DATE OF MEETING	26/03/2024
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	Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	In accordance with the Charitable Funds Committee Cycle of Business, the latest version of the Charitable Funds Committee Terms of Reference have been brought to the Trust Board for review and approval.
RECOMMENDATION / ACTIONS	The Trust Board is asked **APPROVE** the Charitable Funds Committee Terms of Reference.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Velindre Charity Senior Leadership Group	**02/02/2024**
Charitable Funds Committee	**20/02/2024**
The Velindre Charity Senior Leadership Group reviewed the Charitable Funds Committee Terms of Reference in readiness to be Endorsed for Approval at the Charitable Funds Committee. The Charitable Funds Committee reviewed the Charitable Funds Committee Terms of Reference and Endorsed for Approval at Trust Board.	

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

APPENDICES	
Appendix 1	Charitable Funds Terms of Reference – with track changes
Appendix 2	Charitable Funds Committee Terms of Reference – Clean version

1. SITUATION

In accordance with the Charitable Funds Committee Cycle of Business, the latest version of the Charitable Funds Committee Terms of Reference have been brought to the Trust Board for review and approval.

2. BACKGROUND

3. ASSESSMENT

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Charitable Funds Committee Terms of Reference have updated as appropriate since the previous version but today is opened to the Trust Board members for any comments or recommended changes.

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*	Choose an item
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 ☒
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, enduing 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*	**Choose an item**
	Click or tap here to enter text. Not applicable
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.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected:

	Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required *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

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

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*

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

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2024
Approved:	
Next Review due:	March 2025

Deleted: 3

Deleted: 4

1. INTRODUCTION

1.1 The Trust's Standing Orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In accordance with standing orders (and the Trust's Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. CONSTITUTION

2.1 The Velindre University NHS Trust Board was appointed as corporate trustee of the charitable funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and that its Board serves as its agent in the administration of the charitable funds held by the Trust.

2.2 The purpose of the Committee is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

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3. SCOPE AND DUTIES

3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the Charitable Funds in accordance with their respective governing documents.

3.2 To ensure that the Trust policies and procedures for Charitable Funds investments are followed. To make decisions involving the sound investment of Charitable Funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The terms outlined in the Velindre University NHS Trust Charity's Governing Documents

3.3 At least twice a year, receive highlight reports from the Executive Director of Finance in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.

3.4 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.5 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

4. DELEGATED POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR OF FINANCE

4.1 The Executive Director of Finance has prime responsibility for the Trust's Charitable Funds as defined in the Trust's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Executive Director of Finance are:

- Administration of all existing Charitable Funds.
- To identify any new charity that may be created (of which the Trust would also be Trustee). Ensuring that all legal requirements are followed in the creation of any new charity in order to formalise the governing arrangements.
- Provide guidelines with response to donations, legacies and bequests, fundraising and trading income.
- Responsibility for the management of investment of funds held on trust.
- Ensure appropriate banking services are available to the Trust.
- Prepare reports to the Trust Board including the Annual Accounts and Annual Report.

5. AUTHORITY

5.1 The Committee is empowered with the responsibility for:

- Overseeing the day to day management of the investments of the Charitable Funds in accordance with the investment strategy set down from time to time by the Trustees and the requirements of the Trust's Standing Financial Instructions.
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power the Committee must ensure that:

  a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
  b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
  c) The performance of the person or persons exercising the delegated power is regularly reviewed.
  d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2021.

Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

- Ensuring that the banking arrangements for the Charitable Funds are kept entirely distinct from the Trust's NHS funds.

- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.

- Obtaining appropriate professional advice to support its investment activities.

- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

5.3 Approve policies relevant to the business of the Committee as delegated by the Board.

5.4 **Sub Committees**

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the ***'Charitable Funds Investment Performance Review Sub Committee'***, to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

The Charitable Funds Committee is also supported by the **Velindre Charity Senior Leadership Group**, whose purpose on behalf of the Trust Board as Corporate Trustee is to support the development of the strategic direction and take forward strategic delivery of

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the Velindre University NHS Trust Charity and operational management of all Charitable Funds held within the Trust.

In addition, the Trust **Research, Development & Innovation Sub-Committee** has been established to act as the 'front door' for all RD&I business at Board level. The RD&I Sub Committee will feed into the Charitable Funds Committee for alignment with strategy and funding.

The **Advancing Radiotherapy Fund (ARF) Programme Board** has also been established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the Charitable Funds Committee, and whilst is not a formal Sub-Committee of the Charitable Funds Committee, it is directly accountable to the Committee for its performance in exercising the functions set out in its Terms of Reference as part of good governance arrangements, which are approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the Charitable Funds Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board will be supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

Advancing Radiotherapy Cymru (ARC) Academy has been established as an all-Wales programme with ambitions to drive innovation in radiotherapy treatment, expedite the adoption of novel service developments and widen access to state-of-the-art equipment, accelerating improvements in radiotherapy treatment across Wales. ARC will also drive initiatives to support the training of the multi-disciplinary radiotherapy workforce and fund clinically focused radiotherapy research projects.

The ARC fund will be overseen by a multidisciplinary Programme Board as outlined in the ARC Terms of Reference. This includes representation from all three cancer centres in NHS Wales. VCC will be acting as the host organisation for the award made by The Moondance Foundation, combined with matched funding from the Velindre Trust Charity. The ARC Programme Board has been established by the Charitable Funds Committee in order to govern and manage the fund, that will be used to improve outcomes for cancer

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patients in Wales, reducing variation and inequalities in provision. The ARC Academy will place Wales at the very forefront of UK radiotherapy training and development and will facilitate recruitment and retention of the highest quality staff to work in Wales. In addition, ARC will fund research for the benefit of patients receiving radiotherapy in Wales.

ARC will prioritise, but not limit its activity to, the following key areas:

- Expanding patient access to the SABR service
- Expanding the stereotactic radiosurgery service
- Training the multi-disciplinary radiotherapy workforce across Wales, supporting innovation and service developments within the radiotherapy treatment pathway across Wales.
- Supporting clinically focused radiotherapy research projects.

The ARC Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the Charitable Funds Committee, and whilst is not a formal Sub-Committee of the Charitable Funds Committee, it is directly accountable to the Committee for its performance in exercising the functions set out in its Terms of Reference as part of good governance arrangements, which were approved by the Charitable Funds Committee on 13th November 2023.

The ARC Programme Board will provide assurance to the Charitable Funds Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee on 8th June 2023.

The ARC Programme Board will be supported by the ARC Advisory Group, whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARC Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The Advisory Group is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARC Programme Board.

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6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

- Chair, Independent member of the Board (Non-Executive Director)
- Independent Member of the Board (Non-Executive Director)
- The Trust's Chief Executive and Executive Director of Finance (one of which at any one meeting may be represented by a Nominated Representative in their absence)

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Attendees

6.2 In attendance The Committee may require the attendance for advice, support and information routinely at meetings from:

- Charity Director
- Chief Operating Officer
- Executive Director of Nursing, AHPs & Health Science
- Director Velindre Cancer Service (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Senior Finance Business Partner
- Deputy Director of Finance
- Head of Financial Planning & Reporting
- Head of Fundraising
- Head of Corporate Governance (Charity Governance Lead)
- Head of Communications

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By invitation, The Committee Chair may invite:

- any other Trust officials; and/or
- any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

6.3 Secretary As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

6.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

6.5 Applicable to Independent Members only. Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

6.6 In order to demonstrate that there is a visible independence in the consideration of decisions and management of charitable funds from the Trust's core functions, the Board should consider extending invitations to the Charitable Funds Committee to individuals outside of the Board. One option might be to seek representation from the Patient Liaison Group.

Support to Committee Members

6.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure and co-ordinate the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Organisational

Development & Workforce.

7. COMMITTEE MEETINGS

Quorum

7.1 At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member and one must be the Executive Director of Finance or Nominated Representative.

Frequency of meetings

7.2 Meetings shall be held every three months and otherwise as the Committee Chair deems necessary - consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

7.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 The Committee will only consider Research, Development and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation Sub-Committee. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

8.3 The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and appropriate sharing of information in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in its capacity as corporate Trustee. This may include, where appropriate, a separate meeting with the Board.

9.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year.

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9.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross referenced with the Trust Standing Orders.

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

12. CHAIR'S ACTION ON URGENT MATTERS

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

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

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2024
Approved:	
Next Review due:	March 2025

1. INTRODUCTION

1.1 The Trust's Standing Orders provide that "*The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by committees*".

1.2 In accordance with standing orders (and the Trust's Scheme of Delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. CONSTITUTION

2.1 The Velindre University NHS Trust Board was appointed as corporate trustee of the charitable funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and that its Board serves as its agent in the administration of the charitable funds held by the Trust.

2.2 The purpose of the Committee is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

3. SCOPE AND DUTIES

3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the Charitable Funds in accordance with their respective governing documents.

3.2 To ensure that the Trust policies and procedures for Charitable Funds investments are followed. To make decisions involving the sound investment of Charitable Funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:

- Trustee Act 2000
- The terms outlined in the Velindre University NHS Trust Charity's Governing Documents

3.3 At least twice a year, receive highlight reports from the Executive Director of Finance in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.

3.4 To oversee and monitor the functions performed by the Executive Director of Finance as defined in Standing Financial Instructions.

3.5 To respond to, and monitor the level of donations and legacies received, including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.

3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

4. DELEGATED POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR OF FINANCE

4.1 The Executive Director of Finance has prime responsibility for the Trust's Charitable Funds as defined in the Trust's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Executive Director of Finance are:

- Administration of all existing Charitable Funds.
- To identify any new charity that may be created (of which the Trust would also be Trustee). Ensuring that all legal requirements are followed in the creation of any new charity in order to formalise the governing arrangements.
- Provide guidelines with response to donations, legacies and bequests, fundraising and trading income.
- Responsibility for the management of investment of funds held on trust.
- Ensure appropriate banking services are available to the Trust.
- Prepare reports to the Trust Board including the Annual Accounts and Annual Report.

5. AUTHORITY

5.1 The Committee is empowered with the responsibility for:

- Overseeing the day to day management of the investments of the Charitable Funds in accordance with the investment strategy set down from time to time by the Trustees and the requirements of the Trust's Standing Financial Instructions.
- The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power the Committee must ensure that:

    a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.
    b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
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    d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2021.

Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance.

- Ensuring that the banking arrangements for the Charitable Funds are kept entirely distinct from the Trust's NHS funds.

- Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.

- The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.

- The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.

- Obtaining appropriate professional advice to support its investment activities.

- Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;

- Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

5.3 Approve policies relevant to the business of the Committee as delegated by the Board.

5.4 **Sub Committees**

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the *'**Charitable Funds Investment Performance Review Sub Committee'***, to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

The Charitable Funds Committee is also supported by the **Velindre Charity Senior Leadership Group**, whose purpose on behalf of the Trust Board as Corporate Trustee is to support the development of the strategic direction and take forward strategic delivery of

the Velindre University NHS Trust Charity and operational management of all Charitable Funds held within the Trust.

In addition, the Trust **Research, Development & Innovation Sub-Committee** has been established to act as the 'front door' for all RD&I business at Board level. The RD&I Sub Committee will feed into the Charitable Funds Committee for alignment with strategy and funding.

The **Advancing Radiotherapy Fund (ARF) Programme Board** has also been established by the Charitable Funds Committee in order to govern and manage a grant fund received and subsequently matched by the Charity, that will allow the Velindre Cancer Service to develop a programme of activity which will enable the development of stereotactic and other radiotherapy technology for the benefit of patients across Wales.

The ARF Programme Board will assure, advice and scrutinise all aspects of programme activity and expenditure on behalf of the Charitable Funds Committee, and whilst is not a formal Sub-Committee of the Charitable Funds Committee, it is directly accountable to the Committee for its performance in exercising the functions set out in its Terms of Reference as part of good governance arrangements, which are approved by the Charitable Funds Committee.

The ARF Programme Board will provide assurance to the Charitable Funds Committee that the allocation of funds have been dealt with in a robust and transparent way and in accordance with the objectives set out in the business case approved by the Charitable Funds Committee in 2015.

The ARF Programme Board will be supported by the **Advancing Radiotherapy Fund Advisory Group,** whose main purpose will be to quality assure and scrutinise any bids proposed for submission to the ARF Programme Board who then have delegated authority to approve bids, ensuring they have been developed through the appropriate routes and due process has been followed e.g. review by the Research, Development and Innovation Sub-Committee where appropriate. The **Advisory Group** is comprised of experts in the field that ensure due diligence is applied to each bid ensuring that these are assessed for science, ethics, funding, and quality; before making recommendations to the ARF Programme Board.

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6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

- Chair, Independent member of the Board (Non-Executive Director)
- Independent Member of the Board (Non-Executive Director)
- The Trust's Chief Executive and Executive Director of Finance (one of which at any one meeting may be represented by a Nominated Representative in their absence)

Attendees

6.2 In attendance The Committee may require the attendance for advice, support and information routinely at meetings from:

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- Chief Operating Officer
- Executive Director of Nursing, AHPs & Health Science
- Director Velindre Cancer Service (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Senior Finance Business Partner
- Deputy Director of Finance
- Head of Financial Planning & Reporting
- Head of Fundraising
- Head of Corporate Governance (Charity Governance Lead)
- Head of Communications

By invitation, The Committee Chair may invite:

- any other Trust officials; and/or
- any others from within or outside the organisation to attend all or part of a meeting to assist it with its discussions on any particular matter.

Secretariat

6.3 Secretary — As determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

6.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair - taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government.

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Support to Committee Members

6.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure and co-ordinate the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Organisational

Development & Workforce.

7. COMMITTEE MEETINGS

Quorum

7.1 At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member and one must be the Executive Director of Finance or Nominated Representative.

Frequency of meetings

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Withdrawal of individuals in attendance

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8. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

8.1 The Committee will only consider Research, Development and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation Sub-Committee. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.

8.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

8.3 The Committee, through its Chair and members, shall work closely with the Board and, [*where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and appropriate sharing of information in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance arrangements.

8.4 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

9. REPORTING AND ASSURANCE ARRANGEMENTS

9.1 The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in its capacity as corporate Trustee. This may include, where appropriate, a separate meeting with the Board.

9.2 The Committee Chair shall report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity and the submission of written highlight reports throughout the year.

9.3 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

10.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross referenced with the Trust Standing Orders.

11. REVIEW

11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

12. CHAIR'S ACTION ON URGENT MATTERS

12.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

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

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

Velindre's Food Mission: Enabling a FutureGen-ready food system in Wales

Value Based Healthcare Programme

Velindre University NHS Trust

Contents

1. Background and Context: The challenges facing the Welsh Food System

The food system, as presently configured in Wales and the United Kingdom has created major challenges for the entire nation:

- **Climate** - agriculture in Wales is responsible for around 14% of GHG emissions (1)
- **Nature** - food production is the major driver of nature loss, including biodiversity, soil health, air pollution, and river health
- **Health** - diet-related disease is on an upward trajectory and putting pressure on NHS services. Around Two thirds of the £500m Diabetes spend in Wales is on Type II diabetes. Added to this is the spend on diet-related diseases such as cancers, cardiac and vascular diseases, strokes and joint management.
- **Rural economy** - decades of agriculture intensification have left communities poorer and less stable with wellbeing impacts on farming communities (2)
- **Food security/sovereignty** - the very ability of the nation to feed itself is under threat with food poverty and inequality rising because of reliance on an increasingly fragile global food system.

Velindre, and more broadly NHS Wales, is a direct participant in the food system as a buyer but also as an institution responding to the negative consequences of today's food system. NHS Wales spends around £22m on food, just under a quarter of the £97m the Welsh public sector spends on food for schools, hospitals and social care.

1. Background and Context: The need for change to deliver on the Wellbeing Goals

The Welsh public sector, including NHS Wales and Velindre, needs to help transform the food system to achieve the Wellbeing Goals

- NHS Wales's food spend is not big enough to drive a shift in the working of the food system. However, it could play a leadership role in driving public sector food sourcing, and wider food systems, in an environmentally and socially responsible direction, which in turn can drive better health and wellbeing outcomes.
- Only Wales has the Wellbeing of Future Generations Act, which both challenges the public sector to consider wholistic approaches to these issues, while also providing a legislative basis for making progress.
- A food mission that targets increases in the supply of local, healthy, good quality and environmentally sustainable food would improve the wellbeing of patients, staff and their families. Further, it would contribute to Velindre's Value Based Healthcare, Innovation, Decarbonisation, Workforce and Sustainability Strategies, as well as the Wellbeing of Future Generations goals, and contribute towards the ambition to reach Net Zero by 2030.
- It will also integrate the various actions relating to food that are already being carried out within Velindre, plus it will help drive leadership actions in the rest of the Welsh public sector's engagement with the food system. This will help the Trust to deliver its Socially Responsible Public Procurement (3) duties and aligns with WG's 'Buying Food Fit for the Future' initiative (4).

Taking action to transform the food system and deliver the Wellbeing Goals:
Food is a focus area in the Future Generations Commissioner's 2023-2030 strategy Cymru Can

2. Velindre's Food Mission: Enabling a FutureGen-ready food system in Wales

By taking a mission-based innovation approach, Velindre can act to help transform the food system in Wales by working within the Trust, across the public sector and, more broadly, through engagement with the wider food system. The suggested mission for Velindre is as follows:

Velindre's Food Mission: Enabling a FutureGen-ready food system in Wales:

By 2035 at least 70% of food sourced by Velindre University NHS Trust will be Welsh, environmentally friendly or globally responsible. Our people have access to affordable, healthy food.

The outcomes that we want to achieve through this mission are:

1. Healthier people with access to healthy, affordable food
2. Shorter, more resilient food supply chain which minimises environmental impact and delivers values for money
3. More spaces to enjoy and learn about food across the Trust
4. Reduced food waste and ecological footprint
5. Vibrant local food economy and communities through partnership

The mission statement is designed to recognise that it may not be possible to source 70% of food within Wales, but that wherever food is being sourced from it is important to consider the impact of how that food was produced, in line with Welsh legislation.

3. Food Mission Objectives: To achieve the mission, we will take action in the following areas…

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Velindre University NHS Trust

Based on learnings from case studies and engagement with staff, the food mission in Velindre will aim to deliver the following objectives:

- **Enable access to healthy, affordable food:** We will make food a wellbeing priority and a key consideration for patients, donors and staff across the Trust. The workshops identified a lack of healthy food options during work for some staff, dependent on where they were based. Following the example of the 'Wellbeing Wednesdays' initiative, we will develop healthy affordable options for all staff during work. For example, a veg box scheme could be a significant benefit for staff by enabling access to fresh whole foods for staff and their families, as was done during the pandemic.
- **Redesign the Menu:** We will evaluate the opportunity to redesign menus and explore the incorporation of seasonal ingredients and food produced in Wales at the required volume when available and affordable. Opportunities for budget savings could be explored through reduced meat content and purchase of non-branded products. The restaurant at Velindre Cancer Centre would be the easiest place to begin to explore the opportunity for local and organic food supply.
- **Develop knowledge, skills and education:** We will provide training that supports careers and empowers the development of our people based on the needs of roles, from cooks through to procurement. We will educate staff on the environmental impact of different foods and why it is important to reduce those impacts. Further, we will evaluate opportunities to tailor training to provide insight on how to use seasonally sourced ingredients from Wales.
- **Leverage procurement to deliver values for money:** We will identify options for shorter supply chains through collaboration. Where food produce is not available in Wales then ethical sourcing and fairtrade options will be explored.

4. Key Enablers: The mission will require the following support activities…

To support the achievement of the Food Mission objectives, the following supporting activities will be required as key enablers:

- **Executive and Board level buy-in and alignment with existing strategies** The food mission is aligned with and supports the delivery of existing strategies (e.g. Value Based Healthcare, Decarbonisation, Innovation, Sustainability and Workforce Wellbeing) but will also need executive buy-in and support. By providing visible leadership through the food mission, Velindre can lead by example across the public sector in Wales and help to drive regional collaboration and alignment around food sourcing.
- **Work in partnership** The Trust will need to partner with different sectors of the food system to enable agroecological food production and unlock opportunities for innovation in alignment with the Trust's food mission. This can be done through engagement with existing wholesale suppliers, and in partnership with wider stakeholders / organisations across the food system, including other regional public sector bodies that are also on a journey to align the food system with FutureGen needs.
- **Further engagement and co-development with staff** A platform for staff buy-in across the Trust already exists, with near-unanimous support for a food mission across the workshops with Velindre and Welsh Blood Service staff, and a 94% support rate for this work from a staff survey containing 49 responses. This platform should be developed as a mechanism to get Velindre staff to engage more widely with food issues, working to develop a shared understanding cross Trust of the importance, relevance and impact of this work.
- **Collaboration and consistent communication** For the Trust to increase local, environmentally friendly food it will need to work collaboratively with suppliers and producers. A simple, consistent direction will be required for this work, for internal and external stakeholders to allow people to commit to work towards change. For example, Velindre can collaborate with Cwm Taf Morgannwg's Central Production Unit, which provides inpatient meals, to champion the sourcing of produce from Wales.

5. Food Mission Case Studies

A mission-oriented approach works. Across Europe, public bodies have use mission-based innovation targets to drive better engagement on food. Two high level examples are provided below.

The City of Malmö (5) in Sweden set a goal in 2012 that within a decade all of the food it serves would be organic – it is now at 70% organic food. In the case of Malmö, no additional budget for food costs was required for this transition. Instead, skills were developed to procure and prepare low carbon meals with a high organic content (6) – with a reduction in meat and increase in coarse vegetables being key (7).

Since 2004 East Ayrshire Council has prioritised unprocessed, local and where possible, organic ingredients for its school meals, delivering a return of £6 for every £1 spent on organic food via the project using the Social Return on Investment method (SROI).

6. Benefits for Velindre of adopting the mission

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Velindre University NHS Trust

The implementation of the food mission for Velindre is expected to deliver benefits as follows:

- Improve staff wellbeing by increasing access to healthier food, reducing absence rates and reducing workplace related stress.
- Greater staff retention due to improved working conditions.
- Improve services for patients by collecting and analysing data on patient outcomes and experiences of food provision.
- Deliver on legislative requirements, including the Well Being of Future Generations Act Goals; the Environment (Wales) Act (Section 6 biodiversity and resilience of ecosystems duty); Socially Responsible Public Procurement duties, WG's 'Buying Food Fit for the Future' initiative and progress on 'Fair Work' (8).
- Deliver Value Based Healthcare by helping to shift towards longer term preventative health benefits, resulting from;
  - Direct health benefits from healthier food served at the Trust
  - Indirect health benefits from improved socio economic and environmental outcomes due to increased spend within Wales, especially where this food is produced with higher environmental and social standards.
- Reduce the carbon footprint of food provision across the Trust by working with local food suppliers who adopt an environmentally friendly approach to food production.
- Develop a more resilient and shorter food supply chain which supports the local (foundational) economy.
- Enable broader opportunities for innovation in food provision by working in cross-sector partnership.
- Reduce food waste from onsite catering provision and inpatient food provision, thereby providing a more cost-effective service.
- Enable longer term benefits and savings across the public sector by promoting public health benefits of healthier food.

7. Acknowledgements: With thanks to the following for supporting the development of Velindre's Food Mission

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Welsh Government Backing Local Firms Fund

Llywodraeth Cymru
Welsh Government

North Star Transition

north star transition

- North Star Transition is a UK not-for-profit company limited by guarantee, set up in 2020 with a mission to develop new approaches to address systemic challenges through radical reframing and holistic collaboration. We create collaboration initiatives designed to increase the impact of our response to humankind's climate, biodiversity loss and social crises, including wellbeing and health. We aim to accelerate systemic change.
- Our main vehicle of change is a Transition Lab. The goal of a Transition Lab is to bring together unlikely allies from different disciplines and cultures to reframe problems, identify obstacles of change, co-learn, and create novel co-creative solutions. We operate place-based Labs (for example, in Wales and Scotland) focusing on nature-based regenerative approaches, and broader thinking labs which focus on domain areas such as finance and business.
- www.northstartransition.org

8. Appendix: Potential Measures of Success

It is recommended that an action plan is developed to support delivery of Velindre's Food Mission. The action plan will require measures to be put in place in order to track and monitor performance. The following measures will be reviewed and considered as part of this process:

- # staff accessing a veg box scheme
- Patient Reported Outcome Measure for food
- Patient reported experience measures
- Average # days of recovery
- Changes in eating habits
- % food sourced from Welsh producers for Velindre (currently 21%)
- % of food sourced that meets the criteria of environmentally friendly, globally responsible etc.
- # staff on catering and food education courses and trained to higher standards
- # of partners engaging with Velindre in developing the food action plan
- Volume of food waste from canteen and inpatients and savings from reduced food waste
- Spaces for staff to enjoy food across the Trust in metres squared
- Staff satisfaction survey
- Social Return on Investment for the local food economy
- Staff absence rates through sickness and ill health

9. References

1. https://www.wwf.org.uk/sites/default/files/2022-02/WWF_land_of_plenty_Wales_0.pdf
2. https://phw.nhs.wales/services-and-teams/knowledge-directorate/research-and-evaluation/publications/supporting-farming-communities-at-times-of-uncertainty/
3. https://www.gov.wales/social-partnership-and-public-procurement-wales-act#102213
4. https://www.gov.wales/minister-launches-new-initiative-encourage-more-welsh-food-public-sector-plates-wales
5. https://cor.europa.eu/en/engage/studies/Documents/sustainable-public-procurement-food.pdf / https://malmo.se/Welcome-to-Malmo/Sustainable-Malmo/Sustainable-Lifestyle/Sustainable-food-in-Malmo.html
6. https://cynnalcymru.com/free-school-meals-a-healthy-and-sustainable-school-meal-system/?cn-reloaded=1
7. https://cor.europa.eu/en/engage/studies/Documents/sustainable-public-procurement-food.pdf
8. https://www.gov.wales/guide-fair-work

TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST FOOD MISSION

DATE OF MEETING	26/03/2024
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	Chris Moreton, Deputy Director of Finance
PRESENTED BY	Chris Moreton, Deputy Director of Finance Susan Thomas, Deputy Director of OD and People
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	The Trust has developed a Food Mission, with the support of a not-for-profit organisation, Trust staff, stakeholders in the Welsh food system and Welsh Government funding. The Food Mission is set out in Appendix 1, with a request for Trust Board to **APPROVE**.
RECOMMENDATION / ACTIONS	Trust Board is requested to **APPROVE** the Food Mission set out in Appendix 1 and **NOTE** that actions arising from the Strategic Development Committee (March 2024) in relation to the Quality

	Impact Assessment and Equality Impact Assessment will be completed in April 2024 and incorporated within the Food Mission Action Plan.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Strategic Development Committee – ENDORSED FOR APPROVAL	21/03/2024
Executive Management Board Shape – ENDORSED FOR APPROVAL	18/12/2023
VBH Steering Group – Discussed and noted	06/12/2023
VCS SLT – Discussed and noted	22/11/2023
EMB Shape - ENDORSED the approach	16/10/2023
Value Based Healthcare Steering Group – ENDORSED FOR APPROVAL	11/10/2023
The Food Mission was developed with the support of representatives from the Health and Engaged Steering Group between July and September 2023. Further consultation and engagement was undertaken through a Trust-wide survey.	Jul-Sep 2023
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS As listed above	

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

APPENDICES	
Appendix 1	Velindre University NHS Trust Food Mission_March 2024

1. SITUATION

This report provides a summary of the output from a 3-month project to develop a Food Mission for Velindre University NHS Trust. Further to this, feedback from EMB Shape in October 2023 has been incorporated into Appendix 1 alongside broader feedback from potential partner organisations and stakeholders from the Welsh food system. Following this series of reviews, engagement and feedback, the Trust Food Mission was endorsed for approval by EMB Shape in December 2023, Strategic Development Committee in March 2024 and is now presented to Trust Board for APPROVAL.

2. BACKGROUND

In March 2023, VUNHST was successful in being awarded grant funding of £30,000 to develop a mission for local food sourcing and an agroecological food supply chain.

The purpose of the initiative was to produce a policy briefing note which could help Velindre University NHS Trust to develop a mission to establish a shorter, more environmentally friendly and globally responsible food supply chain. This should help to enable local, healthy, good quality and sustainable food for future generations, improving the wellbeing of patients, donors, staff, food communities and supporting local food suppliers/producers.

The initiative has adopted a participatory approach with a Velindre food working group established through nominations from the Healthy and Engaged Steering group. The group contained representatives from across the Trust and two workshops run through June and July 2023. Further, a staff survey on food was available on the Trust's intranet to provide all staff with the opportunity to feed into the process from June to August 2023.

The feedback from these sessions informed a report, which has been finalised and submitted to Welsh Government in October 2023. The Food Mission has been incorporated within the Value Based Healthcare (VBH) programme of work with agreement from the SRO and VBH Steering Committee.

3. ASSESSMENT

Alignment with Welsh Government Policy and Trust Strategy

A food mission that supports increases in local, healthy, good quality and environmentally sustainable food, and improves the wellbeing of patients, staff and their families would contribute to Velindre's Value Based Healthcare, Innovation, Decarbonisation, Workforce and Sustainability Strategies, as well as the Wellbeing and Future Generations objectives, and the need for the public sector to reach Net Zero by 2030. It will also integrate the various actions relating

to food that are already being carried out within Velindre, plus it is intended to help drive leadership actions in the rest of the Welsh public sector's engagement with the food system. This will help the Trust to deliver its Socially Responsible Public Procurement[1] duties and aligns with WG's 'Buying Food Fit for the Future'[2] initiative.

Having access to affordable, healthy food is fundamentally a question of value and values, considering the quality and nutritional value of food for people, the impact its production methods can have on the environment and the costs of production and consumption. Culturally, "value for money" in NHS food procurement has meant the lowest cost supply for a minimum quality standard, though this is slowly beginning to change. The cross-cutting nature of the food mission means that the Value Based Healthcare (VBH) programme is well-suited as a delivery mechanism and this approach has been agreed by the VBH Steering Group.

Velindre's Food Mission
The approach to developing the Food Mission was influenced by the concept of mission-driven innovation with the intention of helping to transform public sector food sourcing and the role of public sector organisations within the food system.

As outlined in Appendix 1, it is proposed that the Trust adopts the following mission:

Enabling a FutureGen-ready food system for the Welsh public sector
By 2035 at least 70% of food sourced by Velindre University NHS Trust will be Welsh, environmentally friendly or globally responsible. Our people have access to affordable, healthy food.

The mission statement has been revised based on feedback provided by potential partners and experts so that it remains ambitious but is also credible and achievable in line with Wales's potential to produce food. The changes are the target year, which has moved from 2030 to 2035 and the % food sourced which has changed from 80% to 70% based on the capacity of Wales to grow the food that would be required.

The outcomes that we want to achieve through this mission are:

- Healthier people with access to healthy, affordable food

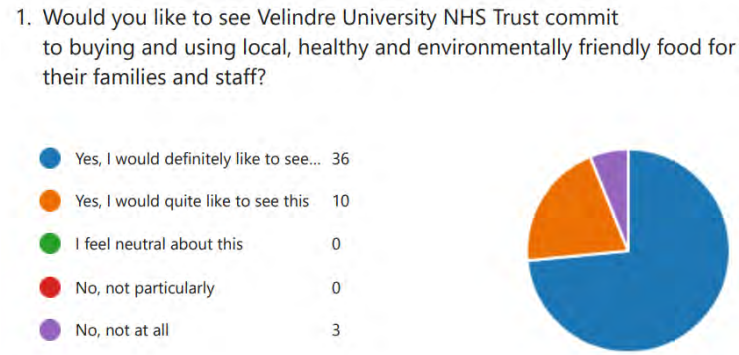
[1] https://www.gov.wales/social-partnership-and-public-procurement-wales-act#102213

[2] https://www.gov.wales/minister-launches-new-initiative-encourage-more-welsh-food-public-sector-plates-wales

- Shorter, more resilient food supply chain which minimises environmental impact and delivers values for money
- More spaces to enjoy and learn about food across the Trust
- Reduced food waste and ecological footprint
- Vibrant local food economy and communities through partnership

Engagement and Feedback

As part of the staff survey, 49 responses were received and 94% of staff supported the principles incorporated within the mission:



In addition to the Trust staff engagement completed in developing the mission, the Trust has sought the views of potential partners with a breadth of expertise, experience and knowledge of working within this space. To date, the Trust has received positive feedback and offers to support the development of the mission. An overview of potential partners is outlined in Figure 1 and several of these organisations have provided feedback on the Trust's proposed food mission, which are summarised below.

Figure 1: Velindre Food Mission: Potential Partners and Feedback

"*This kind of approach, which demonstrates local leadership in well-being policy and action, is one which we would like to see emulated across more public bodies*."

"*I am supportive and as an actor in the system would happily roll in behind you both in spirit and meaningful action*"

"*It's a good read and a powerful statement of intent. My first thought is that you need to start asap.*"

"*This is bold and absolutely in the spirit of the Wellbeing of Future generations Act and value. I think this is great and please let me know what I can do to support*."

"*Document looks great, perfect fit on the provision side of our proposed local food strategy for Carmarthenshire*."

"*This sounds like a perfect opportunity to support Welsh Agriculture especially the regenerative farming systems*"

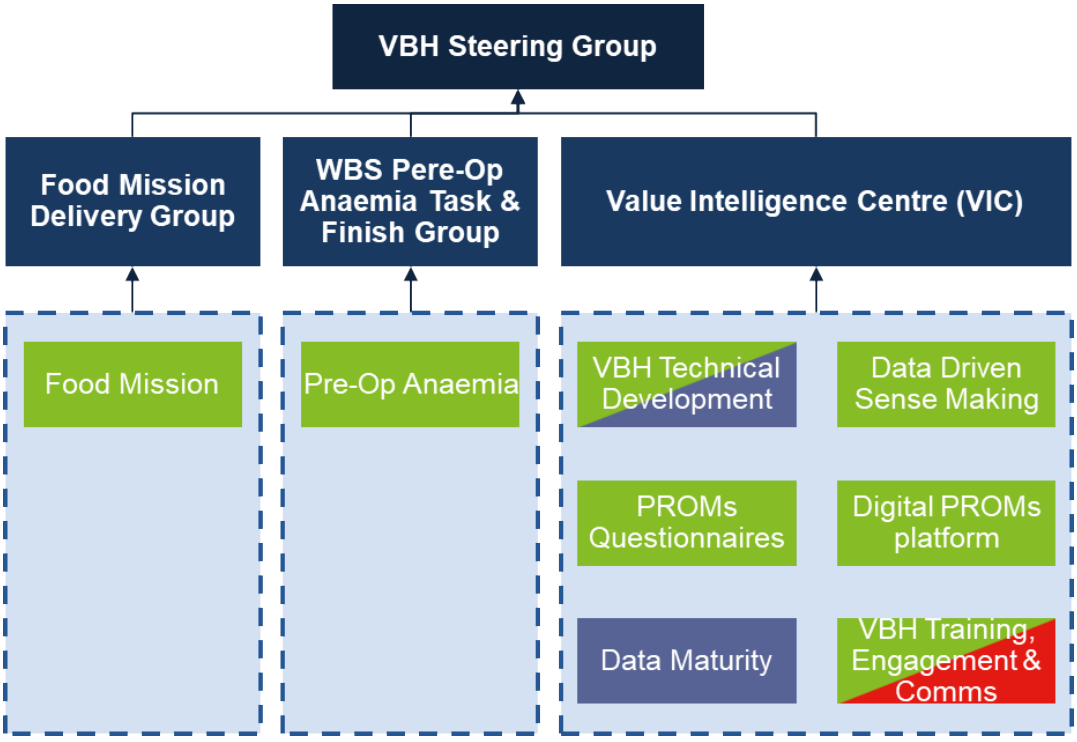
If approved, what would happen next?

Velindre's Food Mission sets a long-term ambition with a target year of 2035. If the Food Mission is approved by the Trust Board, the next steps would be to develop a Food Mission Action Plan with some 'quick win' initiatives to get going, in addition to medium and longer term initiatives and potential funding sources to inform further decision making. It is expected that these initiatives would build on the previous successes and exemplar projects such as the veg box scheme run by VCS catering during the pandemic and the Veggies for Velindre initiative. Further, it is expected that we can learn from partner organisations and leverage the experience across the food system that has helped to shape the mission. However, in order to be able to commit resource to developing this further, it is important that the long term ambition of the Food Mission is supported by the Trust Board.

With regards to resource management, the Value Based Healthcare programme will provide leadership, project management and oversight, taking accountability for the further development and delivery of the Food Mission as outlined in Figure 2 below. Engagement and participation from key stakeholders will be required by the divisions across the Trust as was the case in developing the mission. Any time commitments from stakeholders will be identified in more detail as part of an action planning session, which will be undertaken if the mission is approved by the Trust Board, and will be agreed with the Divisions. The approach will help to

establish a network and better connections both within the Trust and with external partners under a coherent set of objectives and ambitious mission, which maximises our use of resources.

Figure 2: Value Based Healthcare Programme Governance Structure



Equality Impact Assessment (EQIA)

An EQIA assessment was completed using the Trust's EQIA Toolkit, which concluded that an Equality Impact Assessment is not required for the Food Mission. The conclusion was reported to the Trust Equality, Diversity and Inclusion team in February 2024. Following feedback from the Strategic Development Committee in March 2024, the EQIA position will be reviewed again with the Trust Equality, Diversity and Inclusion team in April 2024. Any actions arising from meeting with the team and reviewing the status of the EQIA will be incorporated within the Food Mission Action Plan.

Quality Impact Assessment

The process of developing the Food Mission, including the engagement and feedback outlined above, reflects that this initiative has been developed through a Quality lens and aligns with the Welsh Government's Duty of Quality policy.

Clinical colleagues have been engaged with this work and have provided feedback on the initiative through the workshops, staff survey and through presentations made to the forums outlined in the Governance Route section on page 2. The final QIA is expected to be completed in April 2024. Any actions arising from the QIA review will be incorporated into the Food Mission Action Plan.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Trust Board is requested to APPROVE the Food Mission set out in Appendix 1.

Please see Appendix 1 for details of all matters for consideration.

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*	Choose an item N/A
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). The process of developing the Food Mission, including the engagement and feedback outlined on page 5 of Section 3 above, reflects that this initiative has been developed through a Quality lens and aligns with the Welsh Government's Duty of Quality policy. Clinical colleagues have been engaged with this work and have provided feedback on the initiative through the workshops, staff survey and through presentations made to the forums outlined in the Governance Route section on page 2. The final QIA is expected to be completed in April 2024. Any actions arising from the QIA review will be incorporated into the Food Mission Action 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 Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	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 Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience. A Wales of Cohesive Communities - Attractive, viable, safe and well-connected communities
	The outcomes as result of the Food Mission being adopted are set out in the Food Mission in Appendix 1. The food mission set out in the Food Mission is as follows: ***Enabling a FutureGen-ready food system for the Welsh public sector*** By 2035 at least 70% of food sourced by Velindre University NHS Trust will be Welsh, environmentally friendly and globally responsible. Our people have access to affordable, healthy food. The outcomes that we want to achieve through this mission are: • Healthier people with access to healthy, affordable food • Shorter, more resilient food supply chain which minimises environmental impact and • delivers values for money • More spaces to enjoy and learn about food across the Trust • Reduced food waste and ecological footprint

	• Vibrant local food economy and communities through partnership Achieving the mission and these outcomes would support delivery of the well-being goals outlined above.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	There are no direct / immediate financial implications as a result of adopting the Food Mission. The funding for the development of the food mission has been provided by Welsh Government's Backing Local Firms Fund through the Foundational Economy policy. If the mission is approved, an implementation action plan will need to be developed, which will evaluate the cost / benefits of any opportunities. The Value Based Healthcare Programme will provide the delivery mechanism for the food mission and any subsequent initiatives under the food mission will need to follow the Trust's business case process. **Source of Funding**: Other (please explain) Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change**

	Other (please explain) 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
	An EQIA assessment was completed using the Trust's EQIA Toolkit, which concluded that an Equality Impact Assessment is not required for the Food Mission. The conclusion was reported to the Trust Equality, Diversity and Inclusion team in February 2024. Following feedback from the Strategic Development Committee in March 2024, the EQIA position will be reviewed again with the Trust Equality, Diversity and Inclusion team in April 2024. Any actions arising from meeting with the team and reviewing the status of the EQIA will be incorporated within the Food Mission Action Plan.
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

No material risks have been identified at this stage.

ARE THERE RELATED RISK(S) FOR THIS MATTER	Choose an item
WHAT IS THE RISK?	*n/a*
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	

TRUST BOARD

Surrender of Lease Part Ground Floor Matrix House Swansea

DATE OF MEETING	26/03/2024

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?	YES

PREPARED BY	CARLY WILCE, CORPORATE SERVICES MANAGER, NWSSP
PRESENTED BY	Matthew Bunce, Executive Director of Finance Lauren Fear, Director of Corporate Governance and Chief of Staff
APPROVED BY	Matthew Bunce, Executive Director of Finance Lauren Fear, Director of Corporate Governance and Chief of Staff

EXECUTIVE SUMMARY	NWSSPs Private tenants – Sterling, of Ground Floor, Matrix House, Matrix Business Park, Swansea SA1 5ED intend to formally surrender its lease dated 25 August 2021 between Jarrington Properties Limited* and Sterling (EMEA) Ltd (the Tenant). *Freehold subsequently acquired by Velindre University NHS Trust (the Landlord) Both parties are to enter into a Deed of Surrender as soon as possible. The Deed will therefore need to be

	executed under seal by the Trust and Trust Board approval will be required in accordance with the Standing Orders.

RECOMMENDATION / ACTIONS	The Trust Board is asked to formally approve the lease to be surrendered for the Trust to sign and seal the lease on behalf of NWSSP.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
N/a	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	

1. SITUATION

This paper has been prepared to seek the approval of the Trust Board for the signing and sealing of a lease to be surrendered in relation to former private tenants – Sterling, who leased the part of the ground floor in Matrix House in Swansea.

2. BACKGROUND

NWSSP acquired Matrix House back in April 2022 which included two private tenants, Sterling on the ground floor and Toast on the 4th floor. Sterling have served a break notice to terminate their lease in August 2024, but the parties have agreed to an early surrender as NWSSP intend to use the space to accommodate Health Courier Service.

Current Passing Rent - £43,283 per annum.

Surrender Premium - The Tenant will pay to the Landlord the sum of £7,210 plus VAT. To be paid on immediately on completion of the Deed.

Dilapidations – The Tenant will be released from all dilapidation's liabilities on completion of the Deed and payment of the surrender premium. The accommodation is in very good condition and the Tenant's dilapidations are considered to be negligible.

Furniture – The Tenant will leave their furniture in the property. The furniture is high quality and practically unused. Ownership of the furniture will transfer to the Landlord on completion of the Deed of Surrender.

Tenant Liabilities – The Tenant will be responsible for the payment of all outgoing up until 25th March 2024 including annual rent, business rates, building and estate service charge and utility consumption. The tenant will not be liable for these outgoing beyond 25 March 2024, provided the Deed of Surrender is completed prior to end April 2024.

3. ASSESSMENT

The lease to be surrendered will need to be signed and sealed by the Trust as the legal entity. In accordance with the Standing Orders, this must first be considered and approved by the Trust Board.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Approval is needed for the Trust to formally sign the lease on behalf of NWSSP.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: N/a Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item N/a
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ N/a
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Choose an item 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.
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	N/a for reasons given above.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	**Choose an item**
	If approval is not secured NWSSP will not be able to secure vacant possession of the space until August 2024, thus delaying the occupation of Health Courier Services.

6. RISKS

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

Subject to Contract

Heads of Terms

Surrender of Lease

Part Ground Floor

Matrix House
Swansea

16 February 2023

Lease to be Surrendered	Part Ground Floor, Matrix House, Matrix Business Park, Swansea SA1 5ED Lease dated 25 August 2021 between Jarrington Properties Limited* and Sterling (EMEA) Ltd (the Tenant). *Freehold subsequently acquired by Velindre University NHS Trust (the Landlord)
Surrender Details	The parties will enter into a Deed of Surrender as soon as possible. The Deed will need to be executed under seal by the Trust and Trust Board approval will be required. It is anticipated that Board approval will be secure on 26 March 2024 and the Deed can be completed shortly afterwards
Surrender Terms	Surrender Premium - The Tenant will pay to the Landlord the sum of £7210 plus VAT. To be paid on immediately on completion of the Deed. Dilapidations – The Tenant will be released from all dilapidations liabilities on completion of the Deed and payment of the surrender premium. Furniture – The Tenant will leave the furniture listed in the attached inventory in the property. Ownership of the furniture will transfer to the Landlord on completion of the Deed of Surrender. Tenant Liabilities – The Tenant will be responsible for the payment of all outgoing up until 25th March 2024 including annual rent, business rates, building and estate service charge and utility consumption. The tenant will not be liable for these

	outgoing beyond 25 March 2024, provided the Deed of Surrender is completed prior to end April 2024.

TRUST BOARD

Deed of Rectification with Toast (Mail Order) Limited

DATE OF MEETING	26/03/2024

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?	YES

PREPARED BY	Peter Stephenson, Head of Finance & Business Development, NWSSP
PRESENTED BY	Matthew Bunce, Executive Director of Finance Lauren Fear, Director of Corporate Governance and Chief of Staff.
APPROVED BY	Matthew Bunce, Executive Director of Finance Lauren Fear, Director of Corporate Governance and Chief of Staff.

EXECUTIVE SUMMARY	A Deed of Rectification is required to allocate alternative car spaces to Toast, one of the private sector tenants at Matrix House (which is held freehold by the Trust). Three of the spaces Toast are currently allocated are required to facilitate the creation of electric vehicle charging spaces for NWSSP. Toast are content with this and have agreed to the Deed of Rectification which will

	need to be signed and sealed by the Trust. There is no financial consideration and there are no financial implications. It is merely a re-allocation of parking spaces, which needs to be documented by Deed.

RECOMMENDATION / ACTIONS	The Trust Board is asked to formally approve the signing of the Deed of Rectification.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
N/a	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	

1. SITUATION

This paper has been prepared to seek the approval of the Trust Board for the signing and sealing of a Deed of Rectification with Toast (Mail Order) Ltd.

2. BACKGROUND

A Deed of Rectification is required to allocate alternative car spaces to Toast, one of the private sector tenants at Matrix House (which is held freehold by the Trust). Three of the spaces Toast are currently allocated are required to facilitate the creation of electric vehicle charging spaces for NWSSP. Toast are content with this and have agreed to the Deed of Variation which will need to be signed and sealed by the Trust. There is no financial consideration and there are no financial implications. It is merely a re-allocation of parking spaces, which needs to be documented by Deed.

3. ASSESSMENT

The Deed of Rectification will need to be signed and sealed by the Trust as the legal entity. In accordance with the Standing Orders, this must first be considered and approved by the Trust Board.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Approval is needed for the Trust to formally sign the Deed of Rectification on behalf of NWSSP.

5. IMPACT ASSESSMENT

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

• A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** N/a
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ N/a
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	**Choose an item** **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. **Source of Funding**: Divisional Budget Allocation

	Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Choose an item
	N/a for reasons given above.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Choose an item
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*N/a*
WHAT IS THE CURRENT RISK SCORE	N/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*N/a*

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

DATED

DEED OF RECTIFICATION

between

VELINDRE NHS TRUST

and

TOAST (MAIL ORDER) LIMITED

CONTENTS

CLAUSE

SCHEDULE

This deed is dated **2024**

HM Land Registry

Party 1's title number: CYM851606

Administrative area: Swansea

Parties

(1) **VELINDRE NHS TRUST** of Unit 2 Charnwood Court Parc Nantgarw, Nantgarw, Cardiff CF15 7QZ **(Party 1)**

(2) **TOAST (MAIL ORDER) LIMITED (Company No. 03399254)** whose registered office address is Unit 306, Screenworks, 22 Highbury Grove, London, England N5 2EF **(Party 2)**

BACKGROUND

(A) This deed is supplemental and collateral to the Original Document.

(B) The Original Document did not correctly reflect the intentions of Party 1 and Party 2.

(C) Party 1 and Party 2 have agreed to rectify the Original Document on the terms set out in this deed.

Agreed terms

1. Interpretation

The following definitions and rules of interpretation apply in this deed.

1.1 Definitions:

Original Document: The Lease relating to part third floor of the Property known as Matrix Business Park Northern Boulevard Enterprise Swansea relating to the Property dated 13th October 2023 and made between (1) Velindre NHS Trust and (2) Toast (Mail Order) Limited.

Property: Part third floor of the Property known as Matrix Business Park Northern Boulevard Enterprise Swansea as more particularly described in the Original Document.

1.2 Clause, Schedule and paragraph headings shall not affect the interpretation of this deed.

1.3 A **person** includes a natural person, corporate or unincorporated body (whether or not having separate legal personality).

1.4 The Schedule forms part of this deed and shall have effect as if set out in full in the body of this deed. Any reference to this deed includes the Schedule.

1.5 A reference to a **company** shall include any company, corporation or other body corporate, wherever and however incorporated or established.

1.6 Unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular.

1.7 Unless the context otherwise requires, a reference to one gender shall include a reference to the other genders.

1.8 This deed shall be binding on, and enure to the benefit of, the parties to this deed and their respective personal representatives, successors and permitted assigns, and references to any party shall include that party's personal representatives, successors and permitted assigns.

1.9 A reference to legislation or a legislative provision is a reference to it as amended, extended or re-enacted from time to time

1.10 A reference to legislation or a legislative provision shall include all subordinate legislation made from time to time under that legislation or legislative provision.

1.11 References to clauses and the Schedule are to the clauses and Schedule of this deed [and references to paragraphs are to paragraphs of the Schedule].

1.12 Any words following the terms **including**, **include**, **in particular**, **for example** or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms.

2. Rectification of the Original Document

2.1 From and including the date of this deed the Original Document shall be read and construed as rectified by the provisions set out in the Schedule.

2.2 The Original Document shall remain fully effective as rectified by this deed and the terms of the Original Document shall have effect as though the provisions contained in this deed had been contained in the Original Document with effect from the date of this deed.

2.3 Party 1 and Party 2 agree that all of the provisions in the Original Document (as rectified by this deed) are deemed incorporated into this deed:

(a) for the purpose of satisfying section 2 of the Law of Property (Miscellaneous Provisions) Act 1989; and

(b) with the intention that the terms of the Original Document (as varied by this deed) shall remain binding on the parties.

3. Covenants

3.1 Party 1 covenants to observe and perform Party 1's covenants in the Original Document as rectified by this deed.

3.2 Party 2 covenants to observe and perform Party 2's covenants in the Original Document as rectified by this deed.

4. Registration of this deed with HM Land Registry

4.1 Promptly following completion of this deed Party 2 shall apply to register this deed at HM Land Registry against registered title number CYM851606.

4.2 Party 1 and Party 2 shall ensure that any requisitions raised by HM Land Registry in connection with an application for registration are dealt with promptly and properly, and shall, if so required, provide each other with such reasonable assistance as may be necessary to enable the other to answer any such requisition raised by HM Land Registry.

4.3 Within one month after completion of the registration, Party 2 shall send to Party 1 official copies of its amended registered title.

5. Costs

5.1 Each party shall pay its own costs incurred in connection with the negotiation, preparation, and execution and registration of this deed.

6. Governing law

This deed and any dispute or claim (including non-contractual disputes or claims) arising out of or in connection with it or its subject matter or formation shall be governed by and construed in accordance with the law of England and Wales.

7. Jurisdiction

Each party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim (including non-contractual disputes or claims) arising out of or in connection with this deed or its subject matter or formation.

8. Third party rights

This deed does not give rise to any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this deed.

This document has been executed as a deed and is delivered and takes effect on the date stated at the beginning of it.

Schedule 1 Rectification of the Original Document

1. Amendment of Existing Clauses

The words “the approximate boundaries of which are shown edged red on the Estate Plan” shall be deleted from Clause 2.10 of the Original Document.

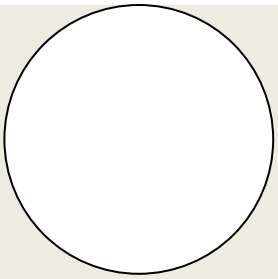
2. Replacement of Existing Clauses

The word “blue” shall be inserted after the words “shown coloured” in Schedule 1, Clause 9 of the Original Document.

3. Addition of New plan

The attached plan shall be added to the Original Document as a new plan marked “Car Park Plan”.

Executed as a deed by affixing the common seal of **VELINDRE NHS TRUST** in the presence of:)
)
)
)



……..……..……

Authorised Signatory

……..……..……

Authorised Signatory

Executed as a Deed by)
TOAST (MAIL ORDER))
LIMITED
Acting by:-

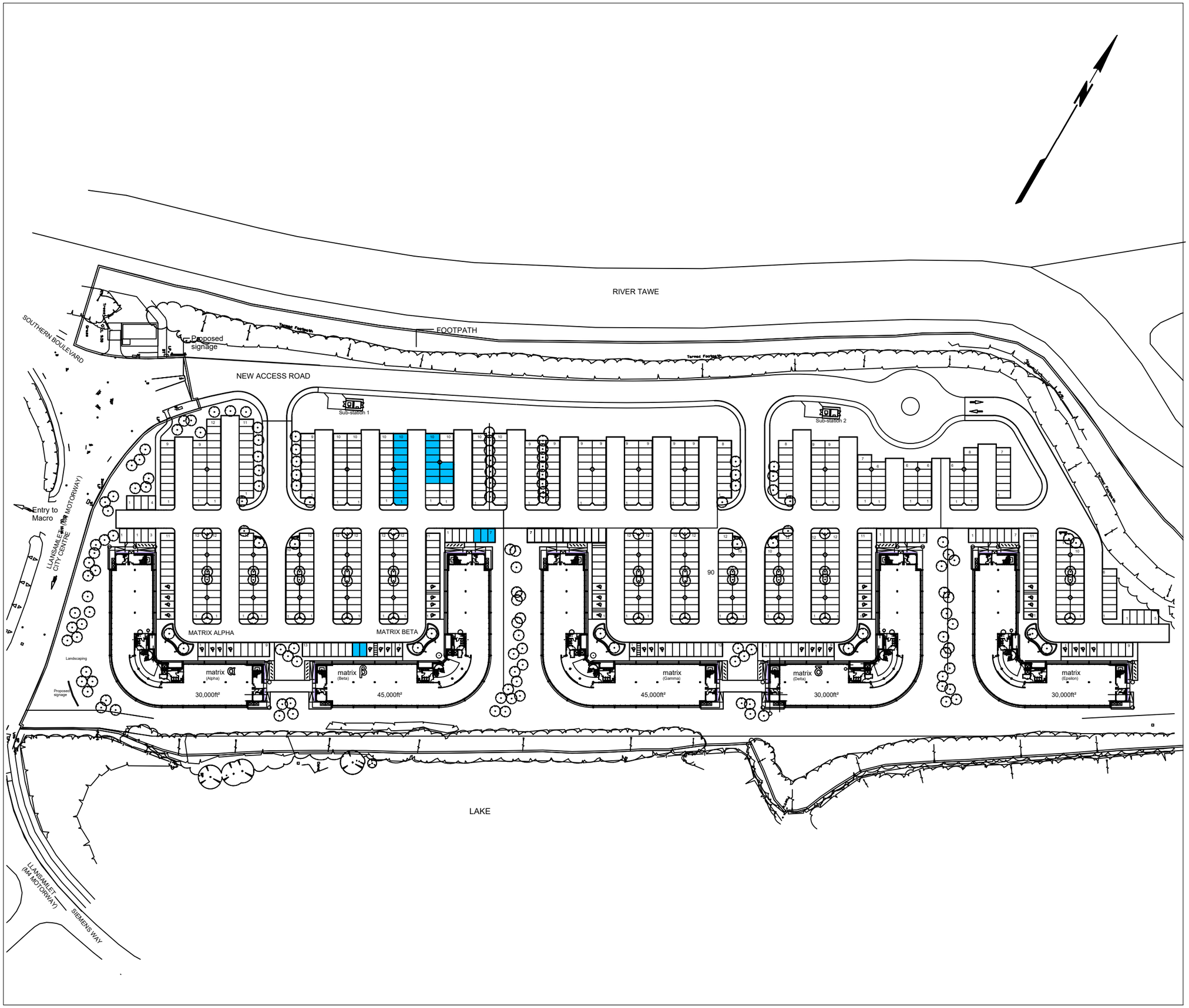
……
Director

……
Witness signature

……
Name

……
Address

……
Occupation



GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Ystadau Arbenigol
Shared Services Partnership
Specialist Estates Services

N.H.Davies
BSc (Hons), Dip Proj Man (RICS), MBA, MCIOB, FIH EEM
Director
Specialist Estates Services

ORDNANCE SURVEY TILE — OS Tile Ref. No.
NATIONAL GRID REFERENCE — OS Tile Ref. No.

Clive Ball BSc (Hons) MRICS
Head of Property
Specialist Estates Services

Title

Matrix House Carpark, Swansea

Scale: NTS @ A3

Produced by: MM 12/1/24

Date Issued: 16/1/24

Date Created: 28/4/17

Drawing Number: ?_01S /3

File Ref: G:\AutoCAD LAPP\Red Line Plans\ Matrix House Carpark, Swansea_01S

TRUST BOARD

Tenancy at Will Agreement for the Du Pont Building

DATE OF MEETING	26/03/2024
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?	YES
PREPARED BY	PETER STEPHENSON, HEAD OF FINANCE & BUSINESS DEVELOPMENT, NWSSP
PRESENTED BY	Matt Bunce, Director of Finance Lauren Fear, Director of Corporate Governance and Chief of Staff
APPROVED BY	Matt Bunce, Director of Finance Lauren Fear, Director of Corporate Governance and Chief of Staff
EXECUTIVE SUMMARY	In order to support the transition of Medical Records from the current Brecon House location to the new Dupont building on Mamhilad Park it is necessary for us to able to store, on a short term, temporary basis, equipment, primarily racking, that is either being moved from the old location to the new, or that has been bought and delivered but is not able to be installed at this stage of the transition. The Tenancy at Will arrangement will allow us to manage this process as flexibly as

	possible and can be accommodated within current budgetary arrangements.

RECOMMENDATION / ACTIONS	The Trust Board is asked to formally approve the signing of the Tenancy at Will for the Du Pont building.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
N/a	
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	

1. SITUATION

This paper has been prepared to seek the approval of the Trust Board for the signing of a Tenancy at Will with Johnseys Estates UK Limited.

2. BACKGROUND

In order to support the transition of Medical Records from the current Brecon House location to the new Dupont building on Mamhilad Park it is necessary for us to able to store, on a short term, temporary basis, equipment, primarily racking, that is either being moved from the old location to the new, or that has been bought and delivered but is not able to be installed at this stage of the transition. The Tenancy at Will arrangement will allow us to manage this process as flexibly as possible and can be accommodated within current budgetary arrangements. There is no other viable alternative to this arrangement.

3. ASSESSMENT

The Tenancy at Will needs to be signed by the Trust as the legal entity. In accordance with the Standing Orders, this must first be considered and approved by the Trust Board.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Approval is needed for the Trust to formally sign the Tenancy at Will on behalf of NWSSP.

5. IMPACT ASSESSMENT

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

For more information: STRATEGIC RISK DESCRIPTIONS	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ N/a
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	**Choose an item** **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	Yes - please Include further detail below, including funding stream **Source of Funding**: Divisional Budget Allocation Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue**

	Scale of Change Please detail the value of revenue and/or capital impact: £4,100 per month. This is anticipated to be a short-term arrangement to cover the period up to the formal lease being signed to occupy this building/ **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Choose an item
	N/a for reasons given above.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Choose an item
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*N/a*
WHAT IS THE CURRENT RISK SCORE	N/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*N/a*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/a
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**

	N/a
All risks must be evidenced and consistent with those recorded in Datix	

DATED 18TH MARCH 2024

TENANCY AT WILL

relating to

UNIT U6, MAMHILAD PARK ESTATE SOUTH, PONTYPOOL, TORFAEN, NP4 0HZ

between

JOHNSEY ESTATES UK LIMITED

and

VELINDRE NHS TRUST

Howells
SOLICITORS
Hallinans House
22 Newport Road
Cardiff
CF24 0TD

CONTENTS

CLAUSE

THIS AGREEMENT is dated 18th March 2024

PARTIES

(1) **Johnsey Estates UK Limited** incorporated and registered in England and Wales with company number 02553413 whose registered office is at Mamhilad House, Mamhilad Park Estate, Pontypool, NP4 0YT (**Landlord**).

(2) **Velindre NHS Trust** of Unit 2, Charnwood Court, Parc Nantgarw, Nantgarw, Cardiff. CF12 7QZ (Tenants)

AGREED TERMS

1. INTERPRETATION

The following definitions apply in this agreement:

Building: all that land and building known as DuPont Building situated on the Mamhilad Park Estate.

Permitted Use: Storage

Property: that part of the Building comprising a unit/office suite shown for identification only edged and hatched red on the plan attached to this agreement.

Quarter Days: 1 January, 1 April, 1 July and 1 October

Rent: £4100 per month (exclusive of any value added tax).

2. GRANT OF TENANCY AT WILL

2.1 The Landlord lets and the Tenant takes the Property on a tenancy at will beginning on and including the date of this agreement.

2.2 The Landlord and the Tenant acknowledge that this agreement creates a tenancy at will terminable at any time by either of them, notwithstanding that the Rent is calculated and payable by reference to a period and that the Landlord intends to demand the Rent, and that the Tenant has agreed to pay the Rent, by reference to that period.

3. TENANT'S OBLIGATIONS

3.1 The Tenant shall pay the Rent and any value added tax in respect of it in advance and without any deduction, set off or counterclaim on each Quarter Date and on the date of this agreement shall pay a proportionate part of the Rent in respect of the period from and including the date of this agreement to and including the day before the next Quarter Day.

3.2 The Tenant shall not:

(a) use the Property otherwise than for the Permitted Use;

(b) assign, underlet, charge, part with or share possession of, or otherwise dispose of the Property or any part of it or any interest in it;

(c) share occupation of the Property or any part of it;

(d) make any alteration or addition whatsoever to the Property;

(e) put any signs at the Property; or

(f) cause any nuisance or annoyance to the Landlord or to any owners or occupiers of the Building or of neighbouring property.

3.3 The Tenant shall keep the Property clean and tidy and make good any damage it causes to the Property.

3.4 The Tenant shall act at all times in a reasonable and responsible manner and in accordance with any regulations that may be made by the Landlord from time to time.

3.5 The Tenant shall be responsible for all charges in connection with the supply to or removal from the Property of electricity, telecommunications, gas, water, sewage, and other utilities and shall indemnify the Landlord in respect of such charges. Where no separate charge is made by the supplier of a utility in respect of the Property, the Tenant shall be responsible for and shall indemnify the Landlord in respect of a proper proportion of the relevant charge, such proportion to be determined conclusively by the Landlord.

3.6 The Tenant shall be responsible for non-domestic rates and water rates charged on the Property. The Tenant shall be responsible for and shall indemnify the Landlord in respect of a proper proportion of the non-domestic rates and water rates charged for the Building, such proportion to be determined conclusively by the Landlord.

3.7 The Tenant shall pass on any notices or other correspondence received at the Property and addressed to the Landlord or relevant to the Landlord's interest in the Property (or the Building).

3.8 The Tenant shall allow the Landlord (and all others authorised by the Landlord) to enter the Property at any reasonable time for the purpose of ascertaining whether the terms of this agreement are being complied with and for any other purposes connected with the Landlord's interest in the Property (or the Building).

3.9 When the Tenant vacates the Property at the termination of the tenancy created by this agreement, it shall remove all furniture (and other items belonging to it) and shall clear all rubbish from the Property.

3.10 The Tenant's obligations are joint and several obligations of the persons that comprise the Tenant.

4. LANDLORD'S OBLIGATIONS

4.1 The Landlord shall allow the Tenant (and its employees and visitors) access to and egress from the Property over the common parts of the Building and to use the lavatories and washrooms in the Building during the Permitted Hours.

4.2 The Landlord shall use its reasonable endeavours to ensure that there is a supply of electricity, heating and water to the Property, at such times of the day as the Landlord considers appropriate.

This agreement has been entered into on the date stated at the beginning of it.

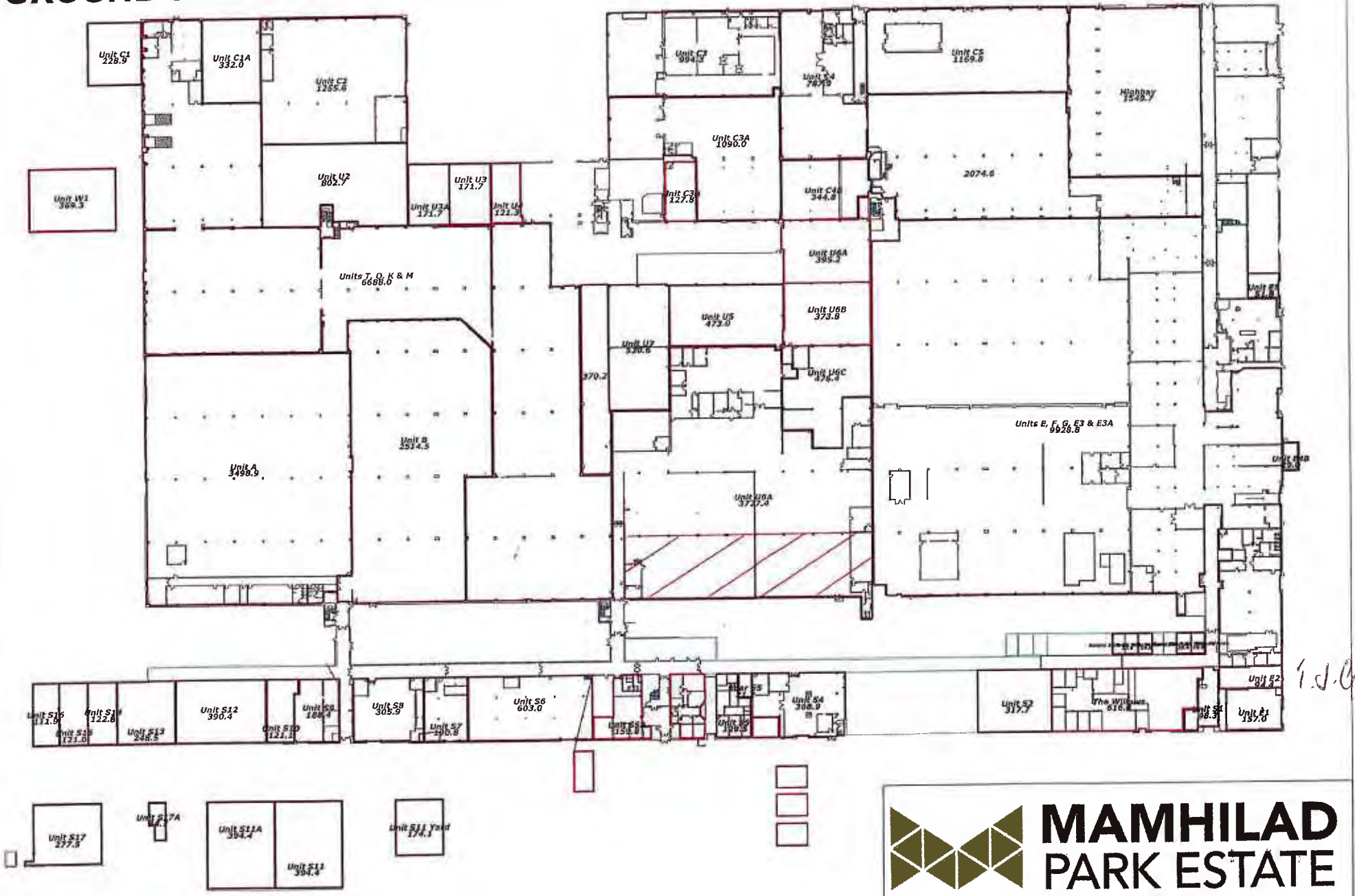
Signed by a director
for and on behalf of
Johnsey Estates (UK) Limited

.....
Director

Signed by a director
for and on behalf of
Velindre NHS Trust

.....
Director

GROUND FLOOR



TRUST BOARD

NWSSP Companies House & Charnwood Court to Cefn Coed, Nantgarw proposed relocation

DATE OF MEETING	26/03/2024

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?	YES

PREPARED BY	CARLY WILCE, CORPORATE SERVICES MANAGER, NWSSP
PRESENTED BY	Matthew Bunce, Director of Finance Lauren Fear Director of Corporate Governance and Chief of Staff
APPROVED BY	Matthew Bunce, Director of Finance Lauren Fear Director of Corporate Governance and Chief of Staff

EXECUTIVE SUMMARY	The purpose of this report is to seek Trust Board approval for the signing and sealing of a new lease between Velindre University NHS Trust and Presscredit Cardiff Limited. In accordance with the Standing Orders Trust Board approval is required prior to signing the new lease.

RECOMMENDATION / ACTIONS	For the Trust Board to formally approve the new lease prior to signing and sealing on behalf of NWSSP.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Shared Services Partnership Committee	21 MARCH 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Approved (to be confirmed once meeting taken place)	

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

APPENDICES	
1	**Heads of terms**

1. SITUATION

This paper has been prepared to seek the approval of the Trust Board for the signing and sealing of a new lease between Velindre University NHS Trust and Presscredit Cardiff Limited, in accordance with the Standing Orders. Approval will also have been

sought from the Shared Services Partnership Committee at its meeting on 21st March 2024.

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2. BACKGROUND

The lease covering two floors of the Companies House building in Cardiff is shortly due to expire and we have been informed that we need to move out of the building. Prior to the pandemic we had approximately 600 staff attending the building daily but post-pandemic the average attendance is between 60 and 70.

The original plan was to relocate Companies House staff to the Welsh Government building in Cathays Park but increases in cost and restrictions on parking and access necessitated consideration of further options. At the same time the lease for the current Nantgarw HQ was due for renewal. Again prior to the pandemic average attendance would have been approximately 120 staff but this figure has now dropped to around 40.

The decision was therefore taken to widen the scope of the search to find a building that could accommodate staff from both locations.

Searches within the Cardiff area identified no suitable buildings, but an alternative option was identified at Cefn Coed, Nantgarw, in a building that was previously occupied by public sector tenants, but which has been empty for several years. This option has been considered by the NWSSP Senior Leadership team and has now emerged as the preferred option alongside a small satellite hub in a Cardiff location.

The Rent reserved in the lease will be £292,530 per annum. The Rent is exclusive of business rates, service charges, insurance, VAT, and all other outgoings. The Rent will be payable quarterly in advance. NWSSP will also be granted an 18-month rent free period from lease commencement or date of occupation, whichever is the earlier. This value amounts to £439K and this sum will be used to cover any additional expenditure that might be required to bring the building up to the standard required. This will be over and above those “fit outs” which the landlord has already agreed to fund and undertake in the first instance The lease will contain an upward only rent review at the end of the 5th year, based on the market rent at the review date. The tenant will be responsible for any Estate Service Charge attributable to the property.

3. ASSESSMENT

In line with the new scope and seeking a location to accommodate both Companies House and Charnwood Court, our Estates team have conducted a search of any available

property in and around the Cardiff area but with limited success. For example, a location at Cardiff Gate was available, however car parking was extremely limited and public transport links were also quite poor.

An alternative option was identified at Cefn Coed, Nantgarw, in a building that was previously occupied by public sector tenants, but which has been empty for several years. This has been considered by the NWSSP Senior Leadership team and has emerged as the preferred option supported by a small satellite hub in Cardiff.

A survey has been undertaken which has indicated that the building is structurally sound but will require an internal refurbishment to bring it up to a required standard and the related options and timescales for this are currently being considered.

This move will allow NWSSP to move from its current Headquarters in Charnwood Court as well as to complete a move out of Companies House and bring the two sets of staff together for the first time. It also provides a significant financial saving to NWSSP. It is currently estimated that it would be unlikely that we would complete and agree a lease before the late autumn of 2024.

The Lease

The tenant (NWSSP) will lease all of 5-7 Cefn Coed extending to approximately 20,895 sq. ft. net (subject to joint measurement) together with allocated parking spaces. NWSSP have negotiated new 10.5-year lease on full repairing and insuring terms, the lease will be granted inside the Act. The Rent reserved in the lease will be £292,530 per annum. The Rent is exclusive of business rates, service charges, insurance, VAT, and all other outgoings. The Rent will be payable quarterly in advance.

The Tenant will be granted an 18-month rent free period from lease commencement or date of occupation, whichever is the earlier. The lease will contain an upward only rent review at the end of the 5th year, based on the market rent at the review date. The tenant will be responsible for any Estate Service Charge attributable to the property.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Approval is needed for the Trust to formally sign the lease on behalf of NWSSP. Both parties will use reasonable endeavours to sign the Agreement for Lease as soon as possible.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: N/a Choose an item	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item N/a
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐ N/a
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Choose an item This paper has been produced for the sole purpose of gaining approval for the signing of the new lease between NWSSP and Presscredit Cardiff Limited in accordance with Standing Orders.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	Choose an item

	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: **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: The cost of the lease will provide savings against that currently payable on the two existing buildings. . **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	**Choose an item**
	N/a for reasons given above.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	**Choose an item**
	Click or tap here to enter text

6. RISKS

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

Heads of Terms

Press Credit Limited / NHS Wales Shared Services

5-7 Cefn Coed
Parc Nantgarw
Treforest
CF15 7QQ

17 January 2024

Private and Confidential
Subject To Lease

Savills
2 Kingsway
Cardiff
CF10 3FD

HEADS OF TERMS

17 JANUARY 2024

SECTION 1 – THE PARTIES

1. Landlord

Presscredit Cardiff Limited
c/o Sutherland House
70/78 West Hendon Broadway
London NW9 7BT

2. Tenant

Velindre University NHS Trust
2 Charnwood Court
Parc Nantgarw
Nantgarw
CF15 7QZ

SECTION 2 – PROPERTY DETAILS

1. Address

5-7 Cefn Coed
Parc Nantgarw
Treforest
CF15 7QQ

2. Demised Premises

All of 5-7 Cefn Coed extending to approximately 20,895 sq. ft. net (subject to joint measurement) together with allocated parking spaces, as shown edged in red on the plan attached for the purposes of identification only.

3. Lease

A new 10.5 year lease on full repairing and insuring terms. The lease will be granted inside the Act.

4. Rent

The Rent reserved in the lease will be £292,530 pa.

The Rent is exclusive of business rates, service charges, insurance, VAT and all other outgoings. The Rent will be payable quarterly in advance on the usual quarter days.

VAT is payable in addition.

5. Rent Free Period

The Tenant will be granted an 18 month rent free period from lease commencement or date of occupation, whichever is the earlier.

6. Rent Review

The lease will contain an upward only rent review at the end of the 5th year, based on the market rent at the review date.

7. Estate Service Charge

The Tenant will be responsible for any Estate Service Charge attributable to the property.

8. Alienation

The Tenant will be permitted to assign or underlet the whole of the Demised Premises with the prior written consent of the Landlord, such consent not to be unreasonably withheld or delayed. In the event that the Tenant assigns the lease, an Authorised Guarantee Agreement will be required with a guarantee period limited so that is expires at the end of the contractual term and shall not be extended to any period of holding over.

Underlettings of the whole or part (max 4 underlettings) will be permitted with the prior consent of the landlord, such consent not to be unreasonably withheld or delayed. Any underlease is to be excluded from the Security of Tenure provisions contained in the Landlord & Tenant Act 1954.

Notwithstanding the above, the lease may be assigned or transferred to another NHS organisation in the event of a NHS re-organisation without the consent of the Landlord. Additionally, the Tenant will be permitted to share occupation with other NHS organisations and NHS departments provided that such arrangements do not constitute a landlord and tenant relationship. Tenant to provide the standard NHS Wales provisions.

9. Alterations

The Tenant will not be permitted to undertake any structural alterations.

Consent will not be required for the erection or removal of non-structural partitions, subject to providing the Landlord with a copy of the plans within one month of the works being completed. The usual reinstatement provisions will apply.

Landlord is to be responsible at its own cost for complying with any obligations arising under The Energy Efficiency (Private Rented Property) (England and Wales) Regulations 2015 or any other regulations or legislation in relation to the minimum energy ratings regarding the Demised Premises. This includes (1) the Tenant having no responsibility during the term or on reinstatement to better the energy rating of the Demised Premises and (2) that all costs which the Landlord incurs in complying with any obligation to improve the energy rating of the Property or the Estate shall not be rechargeable from the Tenant.

10. Repair

The Tenant will be responsible for the repair and maintenance of the exterior and interior of the Demised Premises save that the Tenant will not be required to keep the property in any better condition than it is in at lease commencement as evidenced by a schedule of condition prepared by the Tenant and approved by the Landlord

The Tenant shall not be responsible for damage caused by insured or uninsured risks and the landlord will be responsible for making good such damage.

The Tenant shall not be liable for any works or costs arising from the existence of an historic contamination at the Demised Premises.

11. Insurance

The Landlord will be responsible for insuring the Property and will recover the cost from the Tenant.
The Landlord and the Tenant will be able to terminate the lease if the Demises Premises are damaged or destroyed by an uninsurable risk so that the Tenant cannot occupy the Demised Premises and any rent and estate service charge paid in advance for any period after the date of expiration of the Lease shall be repaid to the Tenant within 10 working days after such expiration.

12. User

B1 Office Use

13. Rates

The Tenant will be responsible for the payment of business rates attributable to the Demised property.

14. Signage

The Tenant will be permitted signage in accordance with the existing signage on the estate.
The Tenant is to submit details of signage for approval.

15. Access

24/7 Access will be permitted, 365 days of the year

SECTION 3 - OTHER DETAILS

1. Legal Costs

Each party will be responsible for their own legal costs incurred in this transaction.

2. Landlord's Works

It is the intention of both parties that the Landlord will carry out the following works:

- Repair soakaway finishes to car park surfaces
- Remove trees to rear of property
- Clean and repair leaks to rainwater goods
- Remark car park surfaces
- Re-coat external surfaces to windows and doors
- Remodel entrance lobby and atrium (so storm porch is on the outside)
- Replace suspended ceiling
- Increase height of suspended ceiling on first floor
- Redecoration internally
- Replace floor coverings
- Replacement of raised access floors and floor boxes with associated power
- Fully refurbish kitchen facilities
- Fully refurbish toilets and showers
- Replace air conditioning. To be powered by heat pumps
- Replace boilers and heaters to common areas
- Replace lighting with LED
- Replace fire alarm and emergency lighting
- Replace lifts

Final specification to be agreed by both parties.

3. Tenant's Works

The Landlord will carry out the Tenants Works, the cost of which will be rentalised over the term of the lease or deducted from the rent free period. Extent of works to be confirmed.

4. Agreement for Lease

Both parties will commit to an Agreement for Lease to which will be attached the Specification of Landlords Works, associated plans and agreed Lease.

Landlord to provide an updated EPC to the Tenant following completion of the Landlord's Works with an EPC rating of E or above.

5. Timetable

Both parties will use reasonable endeavours to sign the Agreement for Lease as soon as possible. The Lease will commence within 5 working days of the certificate of practical completion of the Landlord's Works being issued that has not been disputed by the Tenant.

If the Landlord has not completed the Landlord's Works (including the Tenant's Works), within 5 months of completion of the Agreement for Lease, the Tenant will have the right to rescind the Agreement for Lease.

6. Conditions/Subject To:

a. Contract
b. Velindre University NHS Trust Board Approval
c. Landlord's Board Approval

SECTION 4 – ADVISORS

1. Landlord's Solicitor

FAO:
Tel:
Email:

2. Tenant's Solicitor

FAO: Katrina Moore - NWSSP Legal & Risk Services
Tel: 02921 500568
Email: katrina.moore@wales.nhs.uk

3. Landlord's Surveyor

Savills
2 Kingsway
Cardiff
CF10 3FD
Contact: Gary Carver
Tel: 029 2036 8963
Email: gcarver@savills.com

TRUST BOARD

TRUST WIDE POLICIES UPDATE

DATE OF MEETING	26 March 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	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Trust Board regarding the status of the Trust wide policies and to advise of those that have been approved during the period **February 2024 to March 2024.**
RECOMMENDATION / ACTIONS	The Trust Board is asked to **NOTE** the policies that have been approved during the period **February 2024 to March 2024.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/02/2024
Quality, Safety and Performance Committee	14/03/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board **ENDORSED,** and Quality, Safety and Performance Committee **APPROVED** the following policies:

- IPC 00 – Framework Policy for Infection Prevention and Control
- IPC 11 – Transport of Specimens Policy
- PP10 – Medical Gas Piped Systems Policy
- PP11 – High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)
- PP12 – High Voltage Electrical Supply System Operational Policy
- PP13 – Electrical Low Voltage Policy
- PP14 – Ventilation Policy

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
Appendix 1	IPC 00 – Framework Policy for Infection Prevention and Control
Appendix 2	IPC 11 – Transport of Specimens Policy
Appendix 3	PP10 – Medical Gas Piped Systems Policy
Appendix 4	PP11 – High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)
Appendix 5	PP12 – High Voltage Electrical Supply System Operational Policy
Appendix 6	PP13 – Electrical Low Voltage Policy
Appendix 7	PP14 – Ventilation 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 **December 2023 to January 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
IPC 00 Framework Policy for Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Scientists	Quality, Safety & Performance Committee	14/03/2024	**1**
IPC 11 Transport of Specimens Policy	Executive Director of Nursing, AHPs and Health Scientists	Quality, Safety & Performance Committee	14/03/2024	**2**
PP10 Medical Gas Piped Systems Policy	Chief Executive	Quality, Safety & Performance Committee	14/03/2024	**3**
PP11 High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	14/03/2024	**4**
PP12 High Voltage Electrical Supply System Operational Policy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	14/03/2024	**5**

Policy Title	Policy Lead / Function	Approving Body	Effective Date	Appendix
PP13 Electrical Low Voltage Policy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	14/03/2024	**6**
PP14 Ventilation Policy	Executive Director of Strategic Transformation, Planning and Digital	Quality, Safety & Performance Committee	14/03/2024	**7**

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**

Ref: IPC 00

FRAMEWORK POLICY FOR INFECTION PREVENTION AND CONTROL

Executive Sponsor & Function	Executive Director of Nursing, AHPs and Health Scientists
Document Author:	Senior Infection Prevention & Control Nurse
Approved by:	Quality, Safety & Performance Committee
Approval Date:	14 March 2024
Date of Equality Impact Assessment:	25 January 2024
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Next Review Date	March 2027
Version:	7

CONTENTS

ABBREVIATIONS

AMR	Antimicrobial Resistance
ANTT	Aseptic Non-touch Technique
HCAI	Healthcare Associated Infection
HCW's	Healthcare Workers
ICD	Infection Control Doctor
IPC	Infection prevention and control
IPCMG	Infection Prevention and Control Management Group
IPCT	Infection Prevention and Control Team
RCA	Root cause analysis
KPI	Key Performance Indicator
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1 POLICY STATEMENT

1.1 This policy outlines the overarching framework for the management and organisation of infection prevention and control (IPC).

Oncology patients are largely susceptible to infections. While all Healthcare Associated Infection (HCAI) are preventable, a consistent 'zero tolerance' approach to hospital acquired infection is required to adhere to a national strategy, best practice guidance and requirements of Healthcare standards for Wales.

HCAI refers to an infection that occurs as a result of contact with the healthcare system in its widest sense – from care provided in the home, to general practice, nursing home care, care in acute hospitals and interaction with supportive services. This broad description potentially could cover all patients who attend Velindre Cancer Centre and donors that attend a Welsh Blood Service donation clinic. A consistent approach and effective leadership within the organisation is required to prevent Trust acquired HCAI.

There are a wide range of effects of a HCAI which can range from short term discomfort to significant harm and can even lead to permanent disability or death. It can lead to an extended hospital stay, which not only can have consequences for the patient/family, but can disrupt the effective use of patient facilities. A HCAI can also be detrimental to the Trust, not only in terms of money but as a loss of reputation for the organisation.

The Infection Prevention and Control Team (IPCT) provides expert advice and support to all services of Velindre University NHS Trust, especially clinical and front facing services. It is important that the IPCT have clear lines of accountability for the effective management of the service to ensure integrated working practices across the Trust.

Please note:
COVID-19 may have an impact on Infection Prevention and Control (IPC) policy documents. Policies should be read in conjunction with the IPC organism specific policy, May 22.

IPC measures for Management of SarsCoV-2 in Healthcare Setting

2 SCOPE OF POLICY

2.1 This policy provides a framework and principles of best practice to ensure all Healthcare Workers (HCW's) are familiar with the structures in place for infection prevention and control management.

2.2 The responsibilities and programmes of work outlined aim to reduce risk and prevent HCAI and comply with National guidance and strategy.

2.3 This policy covers Welsh Blood Service, Velindre Cancer Centre and Corporate Services and applies to all staff and contactors working within these areas.

3 AIMS AND OBJECTIVES

3.1 The policy objectives are to outline:

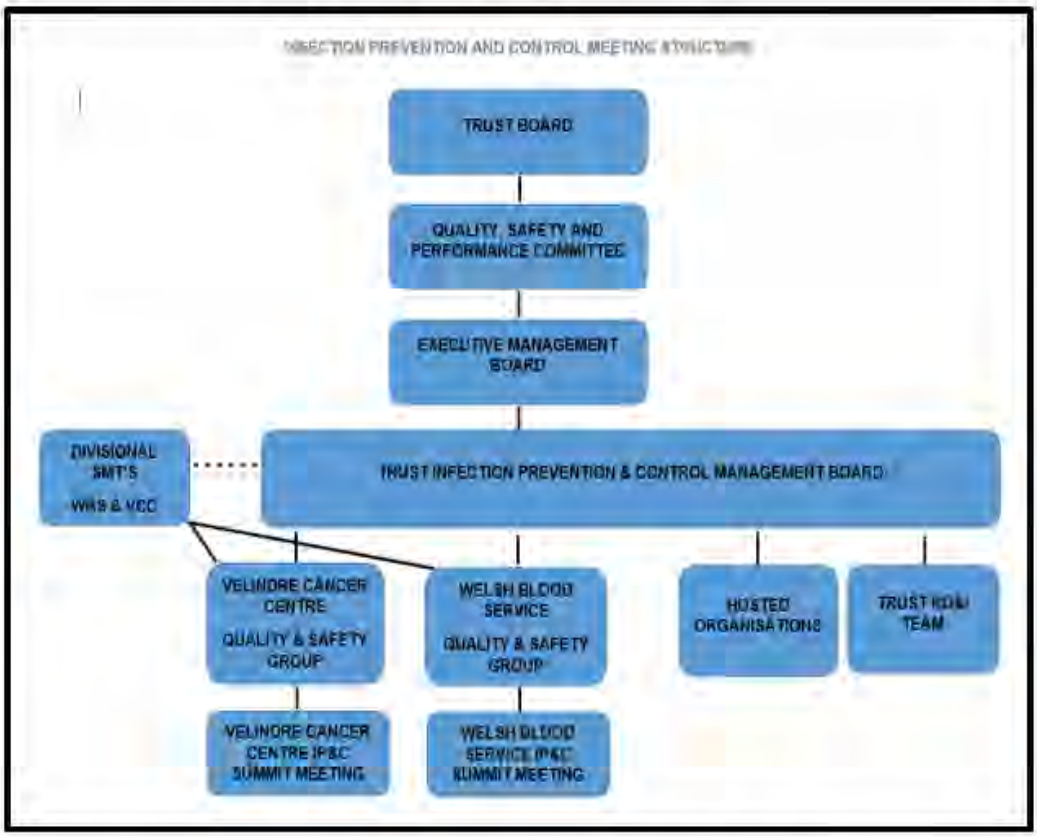
- Clear lines of accountability and responsibility in relation to Infection Prevention & Control
- Key processes and programme for infection prevention and control
- Reporting mechanisms for Infection Prevention & Control to the Trust Executive Management Board
- Key messages:

- Infection Prevention and Control is **everybody's** responsibility
- Departmental Leads/Managers are responsible for ensuring infection prevention and control training requirements, standards and practices are followed by all staff within their designated areas
- Programmes for audit, training, surveillance and policy provision are managed as key strategies for infection prevention and control.

4 RESPONSIBILITIES

This framework has been developed to provide clarity throughout the Trust in relation to accountabilities and responsibilities for Infection Prevention and Control and related duties as part of the Trust governance and assurance processes. It focusses on accountabilities and responsibilities of both the Trust Infection Prevention & Control Team and those of local, Divisional and Senior Management Teams.

4.1 Infection Prevention & Control Reporting Mechanisms



MEETING	CORE IPC ACCOUNTABILITIES
Trust Board	To receive assurance and exceptions via the Quality, Safety & Performance Committee in relation to the Trust meeting its core IPC & decontamination accountabilities/responsibilities against national standards & legislative requirements. To ensure adequate resource and funding is directed to support the agenda for Trust wide IPC activities and performance.
Quality, Safety & Performance Committee	To receive clear evidence and timely advice from the Executive Management Board in order to be able to provide the Trust Board with accurate information to assist it in discharging its functions in meeting its responsibility with regard to IPC & Decontamination for quality and safety. This includes assurance against the Trust's stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales. To rapidly escalate any significant concerns and risks for patient harm or reputational risk for the organisation.

Executive Management Board	To receive highlight reports, performance reports and exceptions from divisions & the Infection Prevention & Control Management Group and agree any required Trust wide action / prioritisation. Receive any external Infection Prevention & Control / decontamination relation inspections / reviews. Monitor delivery of high level mitigation actions. Oversee any high level Infection Prevention & Control risks.
Trust Infection Prevention and Control Management Group	To have oversight of achievements, deficits and actions across all divisions for the Trust Infection Prevention & Control programme of work. Measure progress and performance so that Velindre University NHS Trust can provide evidence it is adequately executing its responsibilities in relation to the preventing and controlling infections & decontamination. Report and advise divisions of any new or emerging risks, policies or innovations and the associated actions required. Share learning so that all actions can be taken to prevent infection related avoidable harm to patients. Identify key risks to performance. Communicate and engage with independent member of the Board
Divisional Senior Management Team Meetings	Receive assurance that all Infection Prevention & Control / Decontamination standards are being adhered to across the Division. Receive and agreed definitive action to address any exceptions. Escalate any areas of high risk, patient / donor / staff risks or where division need support to progress.
Divisional Quality & Safety Groups	Receive the highlight / exception report – triangulate with additional Quality & Safety outcomes. Agree mitigation actions and identify areas good practice. Provide assurance / exceptions to the Senior Management Team Meeting.
Monthly Divisional Infection Prevention & Control Summit meetings	To monitor compliance with Trust and national Infection Prevention & Control policies, standards and the achievement of objectives against the Healthcare Associated Infection code of practice and national requirements for reduction expectations. To assess performance against the agreed work plan of each service/department within division in achieving its objectives and timescales. To support areas in meeting and maintaining the required standards. In particular: • Environmental standards • All relevant training & competency standards • Audit processes, outcomes & actions • Relevant Clinical practice standards (bundles) • Management of incidents or outbreak • Timely contribution to Root cause analysis (RCA) and Investigations of key Healthcare Associated Infections Provide assurance / escalation highlight report for Divisional Quality, Safety and Performance group & Trust Executive Management Board.

4.2 The accountability & responsibility of the Individual/team

Teams / Individuals	High level Key accountabilities & responsibilities	Areas not accountable for but are common misperceptions
Executive Director of Nursing, AHP, Health Scientists & Deputy Director of Nursing, Quality & Patient Experience	• To ensure the Trust has in place all the required governance arrangements, monitoring processes, policies, procedures, strategies, assurance systems and resources to effectively discharge its responsibility for IPC and decontamination. • Act as the Trust's named Executive lead for Decontamination in accordance with statutory requirements. • Represent the Board on HCAI at Welsh Government Meetings • Executive Lead for the Trust's multi-disciplinary Infection Prevention and Control programme	• Operational delivery of Infection Prevention & Control / decontamination practices

	• To assign a nominated deputy to act in their absence in accordance with Trust objectives • To represent the Board in national decision making via Nurse Directors/executive forum	
Infection Prevention and Control Team	• Provide both a proactive and a reactive IPC service to the Trust operating Monday to Friday based on priorities • Develop and deliver a work programme for the team that addresses the Trust objectives and National agenda • Support divisions in the development of annual IPC work plans • Provide assurance to the Board on progress against the IPC work programme • Lead IPC through a coordinated multi-professional, evidence-based approach to the prevention and control of infection including HCAIs • Operational management of the Infection Prevention and Control Team • Provide specialist advice, support guidance in relation to all IPC systems & processes including water safety, decontamination, evidence based clinical practice, environmental cleanliness, ventilation, • Support the development of the Trusts' Vaccination programme • Development of Trust wide up to date IPC / decontamination related policy, procedure, guidance – supporting the implementation of national policy, best practice, requirements into practice • Trust wide oversight of urgent response and pandemic planning • Provide expert advice and leadership in the recognition and management of increased incidents/outbreaks across all areas of Velindre University NHS Trust in accordance with national and local guidance. • Provide expert advice in relation to IPC and emergency planning including planning for pandemics and new or re-emerging pathogens. • Monitoring and Trust oversight of Trust compliance of the IPC elements of National Decontamination Standards • Specialist advice and oversight into Trust environmental and clinical cleaning & decontamination standards • To develop and deliver relevant, robust IPC related training & development programme. To monitor compliance with IPC training requirements • Establishing robust 'service delivery level to board assurance monitoring & reporting arrangements • Develop and regularly review a robust Trust wide ward to board infection control & decontamination audit infrastructure • Oversee and support the co-ordination of internal & external IPC/Decontamination related inspections and reviews e.g. Healthcare Inspectorate Wales, Environmental Health Officer, NHS Wales Shared Services • Initiate and manage a comprehensive alert organism surveillance system for key pathogens including HCAI infection reduction expectations organism.	• Owner of all identified healthcare associated associate infections • Responsible for individual staff performance in relation to flu vaccinations / hand hygiene/ PPE donning & doffing / IPC Level 2 training/ Fit Testing • Keeping staff training or flu vaccination records • Sole owner of FFP3 Fit testing records • Ensuring staff attend training • Operational delivery of IPC & decontamination standards • Management of non IPC clinical staff in relation to IPC practices

	• Provide comprehensive surveillance data reports and detailed analysis of that data for scrutiny to the Board. • Support departments and teams in the co-ordination and reporting of investigations into Velindre HCAI cases in accordance with the national and local requirements e.g. Serious Untoward Incidents, Putting Things Right. • Utilise Quality Improvements methodology in the systematic investigation of HCAI, IPC or decontamination incidents e.g. Route cause analysis • Provide expert advice and active involvement on all matters relating to infection prevention and control / decontamination for any new builds / refurbishment programme / introduction of new services. • Utilise existing incident reporting mechanisms e.g. Datix to document IPC related adverse incidents or near misses • Critically review Trust IPC Datix data to identify themes/trends/lessons learnt • Develop and lead on medical device decontamination work streams • Monitor and evaluate progress against performance measures / KPIs and report outcomes hierarchy structure for Trust Governance & assurance as stated above • Work collaboratively with the Infection Control Doctor (ICD) and Antimicrobial Pharmacist to promote antimicrobial stewardship • Organise and facilitate the Infection prevention & Control Management Group and required reporting / escalation / assurance to Trust • Oversee and monitor strategic and operational delivery of IPC / decontamination Health & Care Standards • Oversee and review/revise all Trust IPC / decontamination related risks / risk register entries • Utilise quality improvement methods and risk assessment skills to support the identification of risk and risk and reducing actions • Work collaboratively and participate in national work streams and delivery groups.	
Infection Prevention & Control Doctor (Microbiology Consultant)	• Provide timely and expert advice to support the Trust in meeting its IPC/ decontamination responsibilities • Provide strategic leadership working as part of the Trust IPC Team to ensure operational delivery of required standards and translation of national policy into local context and delivery action • Actively engages in the development and production of Trust IPC policies/ procedures/ strategies /guidance through critical review and monitoring of effectiveness. • Provide specialist advice in supporting the strategic co-ordination of IPC activities within the IPC team and the divisions • Uses leadership and specialist knowledge of antimicrobials to support the Trust and the Antimicrobial Stewardship Meeting in setting the direction for antimicrobial prescribing goals, actions and standards	• Delivery of the Infection Prevention & Control Programme

	• Provide guidance to clinical colleagues on appropriate antimicrobial prescribing by conducting regular antimicrobial ward rounds and via telephone consultation • To provide expert ICD advice on all aspects of HCAI & IPC including reactive responses to outbreak/incidents, emerging threats including pandemic Management • To work with the IPC team to critically evaluate and prioritise responses to local issues identified. • Interpret, translate and & contextualise national and local data to support decision making and prioritisation • Provide local training for all disciplines of staff including medical staff • Provide expert advice in relation to Safe Water management Systems/ Ventilation & Decontamination • Support IPC team in implementing risk reduction and quality improvement measures. • Participate and give expert advice where necessary on HCAI investigations e.g. RCA	
Associate Medical Director Role for Infection Prevention & Control & Antimicrobial Prescribing / Sepsis	• To provide medical leadership at Velindre Cancer Centre in relation to IPC / decontamination and antimicrobial stewardship • Support the IPCT / Microbiology Consultant to drive the IPC / Antimicrobial Resistance (AMR)/ Sepsis agenda forward within the Trust • Role model for IPC campaign and initiatives e.g. World Health Organization 5 moments HH, vaccination programme etc. • Provide medical leadership at relevant IPC / antimicrobial Meetings e.g. Infection Prevention & Control Management group • Review IPC policies to ensure they can be operationally implemented / support develop of new / revised IPC / decontamination / antimicrobial related Policies / procedures / strategies & guidelines • Champion IPC – increase engagement with junior doctors to ensure support for RCAs for all HCAIs • Promotion and participation in national IPC events, such as HCAI/ AMR collaborative, Aseptic Non-touch Technique (ANTT) steering group as required and act as a role model and champion of Trust work • Share HCAI and IPC best practice with established networks e.g. medical directors forum, cancer network to highlight challenges • Ensure all required Infection Prevention & Control audits feature on the Trusts annual audit plan, oversee the outcomes and actions – ensuring completion of the cycle for improvement • Senior leadership to the Trusts sepsis improvement programme • Champion & Drive IPC practices within VCC & support IPC Outbreaks meetings • Actively promote a 'zero tolerance' approach to HCAI	• Lead the Infection Prevention & Control Agenda • Operational delivery of IPC
Pharmacy	• Strategic direction, oversight and management of the Trusts antimicrobial improvement programme • Provides expert advice to support strategic initiatives related to antimicrobial guidelines and prescribing and	• Be responsible for inappropriate prescribing within the Trust

	provide assurance to the IPCMG and Medicines Management Group on antimicrobial prescribing metrics. • Support the ICD in discharging responsibilities for antimicrobial ward rounds/stewardship • Actively contribute antimicrobial knowledge to HCAI investigations e.g. RCA • Monitor progress against antimicrobial prescribing key performance indicators (KPI's) and champion antimicrobial prescribing across the Trust. • Collect Point Prevalence Survey data monthly and promote Start Smart the Focus & disseminate data to Public Health Wales. • Participate in national work streams to share best practice and knowledge gained to shape Trust policy • Ordering, delivery and co-ordination of influenza and COVID staff vaccinations	
Divisional Directors / SMTs	• Responsible for Divisional delivery against all national & trust agreed IPC / Decontamination and antimicrobial standards – Monthly monitoring & reporting against all IPC / decontamination outcomes and process performance measures (including Senior Leadership Team oversight of infection rates, cleaning & decontamination standards, staff IPC related training, flu vaccinations, IPC audit compliance, fit testing etc.) – ensuring robust Data collection and validation mechanisms – service level-board reporting • Ensure Division is meeting its IPC/Decontamination audit requirements and escalation of any areas on non / low compliance • Ensure all service developments / changes / redesign meets required IPC / decontamination standards • Having in place system & processes for identification & monitoring of IPC related risk and for taking appropriate action within Division for IPC risk reduction • Provide assurance to Trust Quality & Safety on Divisional progress against KPI's • Identify an Infection Prevention & Control SMT Lead & a champion from within each service area • Ensure Departmental engagement and ensure appropriate reporting on all aspects of Infection Prevention & Control • Ensure that every ward/clinical department has a designated infection control link nurse (or other registered practitioner). • Systems & processes for management of all outbreaks • Ensure all agreed IPC / decontamination actions are fully implemented • Ensure that RCA's of Healthcare associated infections are discussed at the relevant Governance meetings and the minutes of these forwarded to the DIPC's • Ensure that Infection control is a standing agenda item for Divisional meetings and, that as a minimum, the following are included: o Review of infection prevention and control key performance indicators (KPI's) o Outbreak reports/action plans	• Lead the Infection Prevention & Control Agenda

	○ Infection Prevention and Control audits where any element of the audit is less than 85%	
Departmental / Ward / Team Managers	• Manage staff in line with HSE requirements – ensuring staff deliver in line with agreed IPC standards and work place is safe • Early identification of any patient / donor infection risk, seek advice and guidance as indicated & manage in line with standards / advice • Minimise risk of infection to both staff and patients / donors • Maintain robust staff IPC related records and manage any areas of non-compliance • Provide assurance, audits & monitoring in relation to key performance indicators; ○ Fit Testing ○ Hand hygiene compliance ○ Hand Hygiene training compliance ○ Staff influenza Vaccination uptake ○ ANTT Training compliance (E-learning & competency assessments) ○ Level 2 IPC Training compliance ○ Environmental audits ○ Decontamination audits • Ensure departmental representation to support staff influenza vaccination campaign, fit testing & hand hygiene training • Ensure departmental collaboration with IPCT on all RCA investigations • Ensure vaccination status of new starters is reported an held at local level	
Estates Department	Responsible for delivery of: • Leading the Trust and divisional water safety groups • Responsible person for the management of Water systems and water quality • Analysis of results and lead actions to correct water results that are out of acceptable parameters in collaboration with the IPC team • Compliance with national guidance for safe water management systems • Compliance assurance of in-house services & contractors • Induction of contactors on IPC, including: dust management and water safety • Assessing and reporting compliance against Health Technical Memorandum –in relation to Safe Water Management, Ventilation & Building/ refurbishment etc., (Regularly liaise with infection prevention & control team to ensure safe processes) • Maintaining good building / estate repair though programme of repair/refurbishment and reactively through IPC environmental audit results. • Timely escalation of any issues or concerns arising on sites that would create a patient / donor or staff IPC risk • Consult IPC on planned or emergency work • Engage and consult IPCT for any new build or refurb at early stage in accordance with Infection Control in the Built environment	• Individually responsible for poor water management

	• Ensure estates staff are compliant with IPC training and adhere to policy when working in clinical areas/dept.	
Operational Services Department	Responsible for delivery of: • Delivering the required level of cleaning to the require standards using the products relevant to the situation at the time • High standards of food safety for all aspects of in-house catering facilities • Compliance assurance & audit of in-house services and contractors. • Innovation and new technologies • Reactive services and proactive responses to managing environmental cleanliness e.g. during incident/outbreaks where there are infected cases on wards • Provides reports on standards of cleanliness and waste management. • Development and review of non-clinical polices such as Laundry, Waste Management and Cleaning. • Management of all staff in line with HSE requirements, ensuring staff received relevant training and monitoring of compliance as per training needs analysis for the role	
All staff	All employees are responsible for: • Complying with Trust Infection Prevention and Control policies, procedures & guidelines and escalating any situation that prevents this occurring. • Maintaining their legal duty to take reasonable care of their health, safety and security and that of other persons who may be affected by their actions and for reporting untoward incidents and areas of concern. • Keep up to date with all IPC training requirements according to role • Identifying infectious conditions and circumstances that may lead to transmission of / outbreaks of infection that require specific controls to protect themselves, their patients or others, informing the IPCT of any such circumstances. • Ensuring safe working practices are implemented as outlined in Infection Prevention and Control policies.	

4.3 Governance and Quality Assurance

The key forum for management and governance for the infection control service within the Trust is the Infection Prevention, Control and Management Group (IPCMG). The IPCMG receive the highlight reports from the VCC and WBS monthly IPC summit meetings. Each department should have a designated lead for IPC who is reports and is answerable to the divisional IPC lead. Please see ***appendix 1*** for the IPCMG Terms of reference

The IPCT has primary responsibility for advising on aspects of audit and surveillance pertaining to the prevention and control of infection at Trust level. The IPCT produces an Annual Report and an Annual Programme which are ratified by the Trust IPCMG and received by the Trust via the Quality and Governance Committees.

4.4 Distribution

The policy will be available via the Trust intranet site, Where the staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

5 IMPLEMENTATION / POLICY COMPLIANCE

5.1 Infection Prevention and Control Programme

The main aim of the Infection Prevention & Control programme is to plan, manage, co-ordinate and deliver a proactive infection prevention service for the Trust while being reactive to incidents and outbreaks as they arise. The main components of an effective programme include:

- Providing infection prevention and control of infection advice to all divisions and departments of the Trust
- Incorporating divisional infection control needs within the Trust infection control programme
- Providing education and training on the prevention and control of HCAI to all levels of HCW's
- Providing bespoke education on the management of infections as they arise
- Undertaking surveillance of infections, facilitating and validating data received
- Producing, implementing, and auditing compliance with infection prevention policies
- Liaising, communicating and advising with staff on matters relating to infection prevention and control during working hours, with advice available on a 24-hour basis from Public Health Wales microbiology service
- Developing infection prevention and control policies for the Trust in accordance with Legislation, National guidance, strategy, Quality frameworks and evidence based medicine
- Advising Divisions and hosted organisations on guidelines and procedures with relation to infection control.
- Implementing Welsh Government directives with regard to surveillance and strategic direction
- Implementing and developing the Health Care Associated Infection Strategy for Wales

5.1.1 Education

Education of all Trust staff is undertaken either by using nationally agreed e-learning programmes, delivered by members of the Infection Prevention & Control Team or using materials developed or advised by the Infection Prevention & Control Team. Where possible blended learning, including classroom teaching, e-learning and opportunistic workplace methods will be utilised. The level of training is determined by a Training Needs Analysis of the role being undertaken. As a minimum ***all healthcare workers, regardless of their role undertake Infection Prevention and Control Level 1 training within 4 weeks of starting employment.***

- ***Level 1 training*** focuses on precautions and procedures undertaken by those providing direct patient / service user care or working within a clinical environment.
- ***Level 2 training*** is update training undertaken every 2 years to ensure clinical healthcare workers are kept up to date with current research, guidelines, policies and projects.
- ***Level 3 training –*** Massive Open Online Course (MOOC) which is targeted at registered practitioners and senior staff in supervisory roles who are responsible for ensuring compliance with good IP&C practices e.g., ward and Departmental clinical managers.

5.1.2 Training availability

- Both Level 1 and 2 training are available as e-learning if classroom session not available
- Junior and locum doctor induction is provided per intake
- The ICD updates consultant colleagues at Consultant meetings while the Antimicrobial Pharmacist will input into the doctor training programme.
- Additional targeted training will be provided as required for specific groups including porters, domestics, volunteers etc. and as required to respond to a new infection prevention problem or to meet a particular need.

5.1.3 Surveillance

Surveillance is a key component of the infection control programme. The aim of surveillance is to collect continuous timely data on organisms and patient information to identify infection rates and trends. It assists the early detection of outbreaks or increased incidence of infection, informs changes in clinical practice and assists the targeting of preventative methods. Types of surveillance undertaken include:

- Daily surveillance - Identification, monitoring, advising on and recording of 'alert' organisms as provided by the laboratory reports received daily.
- Routine surveillance – collection, analysis, dissemination and feedback of data on condition/infections among patients and staff, to allow the appropriate action to be taken.
- Targeted and enhanced surveillance - undertaken following risk assessment, which may identify high-risk areas of practice, to enable the monitoring of procedures and processes to identify potential problems and areas for improvement.
- Mandatory Surveillance - as identified by the Welsh Government and managed by HARP.
- National projects – voluntary participation in 'all Wales' surveillance 'projects of targeted areas/organisms.

Surveillance data may be used within a framework of performance management in an attempt to assess the effectiveness of the Infection prevention and Control standards being deployed.

5.2 Audit and monitoring

The Infection Prevention & Control Team's annual programme framework has been updated and there is now one audit programme covering both division.

Both nationally recognised and locally developed tools (to address targeted areas) are used to audit policy, standards and guidelines for the environment and clinical practices. Results are reported to the departmental and local managers and summarised in the quarterly team report and annual reports submitted to Divisional Senior Leadership Teams, Trust Executive Management Board and Quality, Safety & Performance Committee.

6 GETTING HELP

Further information and support

IPCT: 02920 196129 or bleep 205.

Microbiology at UHW on 02920 744825.

7 RELATED POLICIES

The national related Infection Prevention & Control policies can be found here:

http://howis.wales.nhs.uk/sitesplus/972/page/51445

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

INFECTION PREVENTION & CONTROL MANAGEMENT GROUP

Terms of Reference & Operating Arrangements

Version: 8
Date Reviewed: October 2023
Review Date: October 2024
Agreed by: Infection Prevention and Control Management Group
Approved by: Executive Management Board **02/01/2024**
Approved by Quality, Safety & Performance Committee **16/01/2024**

1. INTRODUCTION

1.1 These Terms of Reference and Operating Arrangements are based on and compliant with the Health and Care Quality Standards (2023) for Infection Prevention and Control and Decontamination providing strategic leadership and direction on infection prevention and control activities across the Trust to ensure the risks posed by transmission of avoidable infections is minimised.

2. PURPOSE

The Infection Prevention and Control Management Group (IPCMG) is integral to the achievement of the Trust's infection, prevention and control objectives. The purpose of the Group is to ensure that Velindre University NHS Trust is adequately executing its responsibilities in relation to preventing and controlling infections and therefore taking all actions to prevent infection-related avoidable harm to patients. This includes:

2.1 Ensure systems for assessing, reducing, reporting, and monitoring infection risks across the Divisions / Trust are robust.

2.2 Ensure robust governance structures for monitoring decontamination services within Divisions / the Trust, including arrangements for decontamination of reusable medical devices.

2.3 Agree Trust-wide Infection Prevention and Control (IPC), decontamination and infection / antimicrobial surveillance, audit programs, and assurance and monitor compliance in respect of these.

2.4 Oversee the development and regular review of all Trust IPC, decontamination, antimicrobial & and surveillance policies, guidelines and procedures. This will include receiving and endorsing adoption of relevant national IPC related policies, procedures and guidelines.

2.5 Ensure there is a robust implementation plan in place corporately and across Divisions for all local and national IPC policies, procedures and guidelines and monitor through audit the implementation across the Trust.

2.6 Receive all IPC, Decontamination, antimicrobial related external / internal audits / reports / peer reviews and be responsible for ensuring the development of robust improvement actions and overseeing through to completion all such action plans. Reporting any exceptions through to Executive Management Board / Trust Quality, Safety and Performance Committee.

2.7 Ensure appropriate Outbreak Management mechanisms in place and ensuring national outbreak standards are met, robust reporting in place and oversee completion of all post outbreak recommendations / actions to completion.

2.8 Endorse and monitor all IPC, decontamination and antimicrobial related risks as logged on Trust / Divisional Risk Registers, ensuring that all such risks are being appropriately managed / escalated.

2.9 **Oversee the regular review and oversight of Health and Care Standard** and Decontamination. Including endorsing annual self-assessment, agreeing actions and overseeing completion of related action plan.

2.10 Develop and monitor robust Trust wide and Divisional IPC assurance framework with Key Performance Indicators that are monitored and reviewed at least annually.

2.11 Ensure there is a robust IPC training programme in place that meets national and local standards and requirements, oversee compliance with this.

2.12 Review progress against the annual Staff Influenza Vaccination Campaign /

COVID vaccine programme.

2.13 Ensure appropriate processes and procedures in place to respond to pandemics such as influenza / COVID.

2.14 Receive outcomes of all Root Cause Analysis investigations from all healthcare associate infections ensuring appropriate remedial actions have been taken

2.15 Oversee processes for the identification and dissemination of good practice / lessons learnt both from internal events and external to the Trust.

2.16 Oversee compliance with all PPE standards across the Trust.

2.17 Agree the IPC Annual Work Programme.

2.18 Oversee compliance with Water quality standards including compliance with national guidance and the Trust's Legionella Policy.

2.19 Oversee adherence to national cleanliness standards.

2.20 Oversee compliance with all Decontamination standards.

2.21 Oversee and ensure appropriate action taken from all IPC HCAI Surveillance Data and monitor compliance against all nationally agreed Infection reduction / improvement goals.

2.22 Oversee Divisional compliance with all IPC, Decontamination, water safety and antimicrobial standards ensuring that appropriate divisional action is being taken to mitigate risks.

2.23 Oversee the implementation of a robust antimicrobial resistance action plan.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Infection Prevention & Control Management group formally reports into the Trusts Executive Management Board, following which to the Trusts Quality, Safety and Performance Committee. A highlight report will be provided following each meeting that will be supplemented by any papers identified as being required at the meeting. All such reports will be approved by the meeting chair prior to submission.

4. MEMBERSHIP

4.1 The core membership of the Committee, is set out below:

Chair: Executive Director of Nursing, AHPs and Health Science

Vice Chair: Deputy Director of Nursing, Quality and Patient Experience

Co-Option: Additional members maybe co-opted onto a meeting as relevant to the agenda with prior agreement of the Chair / Vice Chair.

Secretariat: Administrator for Infection Prevention and Control Team

Membership

All members are expected to attend each meeting. In the event of being unable to attend it is the member's responsibility to arrange for a deputy to attend who has full authority to act and make decisions on behalf of the member.

Table 1

TITLE	ROLE & RESPONSIBILITES	REPORTING REQUIREMENTS
Executive Director of Nursing, AHPs and Health Scientists	Chair of Meeting. Leadership and strategic focus in meeting compliance. Overall Executive responsibility for infection prevention and control. Provide assurance / escalation to Trust Board members.	National information / requirements Feedback from Quality and Safety / Board. Proposed strategy / direction.
Deputy Director of Nursing, Quality and Patient Experience	Vice Chair of Meeting. Leadership and strategic focus in meeting compliance. Provides report to Quality and Safety Group Board.	As above.
Senior Nurse for Infection Prevention and Control	Organisation, oversight and management of meeting Identify any areas of concern re non-compliance with Code of Practice/ Health & Care Standards 2.4 / work plan and inform members of risks/ hot spots. Drafting all post meeting reports Quality checking all divisional reports / documents Develop and ensure delivery against IPCMG work plan	Provision of IPCT reports, to include KPIs/ surveillance, audit and training activity, staff influenza campaign and preparedness, incidents and complaints, policy/ procedure review, risk register and produce annual report.

Infection Prevention and Control Nurses/ Respiratory Trainer	To present on specific elements of the IPCT report, including surveillance of infectious conditions and incidents, issues arising on the management of incidents and outbreaks, audit, Department of Health guidance, policy/procedure review and link champion training activity.	Datix Report-Incidents and Outbreaks. Influenza Report. Service Improvement.
Consultant Microbiologist	Expert resource from Public Health Wales and to provide infection control advice to the group and inform on national and local initiatives in driving policy and management of infectious conditions.	Reports to be provided on an adhoc basis e.g. Updates on: Antimicrobial Prescribing Alerts/ outbreaks across Wales.
Principal Pharmacist	Expert advice to support strategic initiatives e.g. Anti-microbial guidelines.	Antimicrobial compliance report at each meeting.
Divisional Representatives / chair of Divisional IPC related meetings / R,D and I Lead	To provide assurance reports from division against all required standards / KPIs at each meeting. Escalate areas of risk, concern, where support required Identify and highlight areas of good practice / lessons learnt Provide feedback from the IPCMG to the division ensuring robust two way information / feedback flows.	Provide highlight / assurance report at each meeting that includes compliance with agreed KPIs, decontamination and water standards, summary of audit findings and RCA, Outbreak reports.
Senior Estates Manager	Chair of the water management meeting which is a sub meeting of IPC. To provide formal water management reports quarterly on water management and issues arising regarding meeting compliance with L8 and safe water management systems. Details external reviews / reports from estate. Ventilation compliance. Provides compliance assurance of in-house services and contractors.	To provide quarterly reports on water management legislative requirements, audit outcomes, assurance, highlights and exceptions.
Operational Services Manager VCC and WBS	Provides compliance assurance of in-house services and contractors. Provides reports on standards of cleanliness and waste management. Development and review of non-clinical polices such as laundry, waste management and cleaning.	Compliance and assurance report that covers: in-house services, contractors, policies and procedures, National standards of Cleanliness, waste management, laundry, and cleaning.

Appointed Authorised Engineers (Decontamination)	Expert advice to support strategic initiatives (decontamination).	Provide highlight report on decontamination updates.
Consultant Nurse (HARP Team)	Expert advice to support strategic national initiatives.	As required.
Assistant Medical Director, IPC	To provide medical leadership in respect of IPC/antimicrobial stewardship agenda.	As required.
Trust Health and Safety Manager	To act as an advisory from a Health and Safety perspective across the Trust in relation to infection prevention and control.	To provide bi-annual reports on Health and Safety Issues relating to Infection Prevention & Control.
Workforce Development Manager	Support development of IPC associated training and workforce requirements in accordance with national standards	

5. IPCMG MEETINGS

5.1 **Quorum**
The Chair / Vice Chair, Microbiologist, Anti-microbial Pharmacist, Infection Prevention and Control Nurse and a senior decision maker from each Division must be represented in order for a meeting to proceed.

5.2 **Frequency of meetings**
Meetings shall be held at least quarterly and otherwise as the IPCMG Chair deems necessary.

5.3 **Papers**

- Draft meeting notes and action log MUST be circulated to all members.
- No verbal or tabled reports will be accepted. If an event occurs that requires reporting to the IPCMG after papers have been circulated a late paper is to be submitted after agreement with the meeting chair.
- All papers are to be provided to the meeting secretariat at least 8 days prior to the meeting.
- The agenda and papers will be circulated at least 7 days in advance of the meeting.
- All papers should be submitted to the Head of Infection Prevention and Control and Secretariat. The agenda will be approved by the Chair prior to issue.

6. RELATIONSHIP & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES/GROUPS

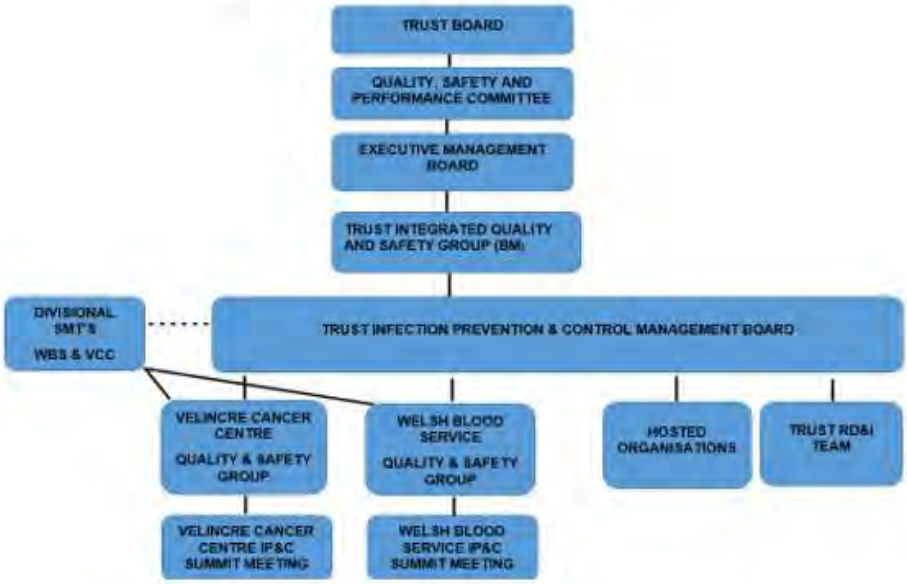
6.1 The IPCMG reports to the Trust's Executive Management Board and in turn to the Trusts Quality, Safety & Performance Committee by means of a highlight report after each meeting. Additional reports /papers will be provided as appendices as determined by the Group.

6.2 The IPCMG shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 There will be formal reporting mechanisms to and from Divisions into IPCMG. This will be achieved via the Divisional representative. A formal Divisional assurance paper will be provided to the IPCMG for each meeting. The reporting organogram is detailed below:

INFECTION PREVENTION AND CONTROL MEETING STRUCTURE



8. REVIEW

8.1 These terms of reference and operating arrangements shall be reviewed in 12 months.

EQIA Template & Action Plan

All policies and decisions that affect people are assessed to identify ways to reduce discrimination and to make Wales fairer. I confirm that an assessment has been undertaken and the relevant actions are highlighted below.

Name of Policy	IPC 00: Framework Policy for Infection Prevention and Control. Terms of Reference & Operating Arrangements.		
Manager	Hayley Harrison Jeffreys		
Date of meeting with OD Manager – ED&I	N/A		
Date of submission	**January 2024**		
Date of next review	**January 2025**		
These changes will affect:	Staff: ☒	Patients: ☐	Both: ☐

1.1	What is the policy or decision that you are conducting an EQIA for?	IPC 00: Framework Policy for Infection Prevention and Control. Terms of Reference & Operating Arrangements
1.2	Who owns it?	Infection Prevention & Control Management Group
1.3	What is the aim of the change(s)?	No change. Annual review of terms of reference only.
1.4	Who is affected most by the change?	N/A
1.5	How does this topic fit into the wider context of the organisation?	This document outlines the overarching framework for the management and organisation of Infection Prevention and Control (IPC). The Responsibilities and programmes of work outlined aim to reduce risk and prevent Healthcare Associated Infection (HCAI) and comply with National guidance and strategy. This policy has been developed in line with current guidance and strategy and is intended for All Trust Healthcare workers (HCWs).
1.6	Who is undertaking the EQIA	Infection Prevention and Control. Head of Infection Prevention & Control; Hayley Harrison Jeffreys & Senior Infection Prevention & Control Nurse; Julianne Golding-Sherman.

1.7	When will you start and end the EQIA?	24/01/2024
2.1	What data is available to help inform the EQIA?	Previous EQIA submitted 2023
2.2	What information is still needed?	N/A
2.3	How will missing data be collected?	N/A
2.4	What is considered relevant information and data?	The Terms of Reference and Operating Arrangements are based on and compliant with the Health and Care Quality Standards (2023) for Infection Prevention and Control and Decontamination providing strategic leadership and direction on infection prevention and control activities across the Trust to ensure the risks posed by transmission of avoidable infections is minimised. The Infection Prevention and Control Management Group (IPCMG) is integral to the achievement of the Trust's infection, prevention and control objectives. The purpose of the Group is to ensure that Velindre University NHS Trust is adequately executing its responsibilities in relation to preventing and controlling infections and therefore taking all actions to prevent infection-related avoidable harm to patients. This policy sets out the roles and responsibilities of all staff to ensure infection prevention and control. Working closely with the VCC dignity group to ensure that patient dignity is maintained whilst also ensuring infection risk is reduced. Patient-centered care, to ensure that health and mental well-being is not compromised, whilst minimising risk. Signage to be accessible and bilingual. Where possible visual images/icons to be used. Which would support those with learning disabilities, English no their first language etc. Compliance with national strategy guidance and improvement methodologies. **A Healthier Wales** Working to Infection Prevention and Control guidance will ensure that patients are well cared for and there is early identification of, correct

		treatment of and reduced transmission of infection whenever possible. Infection prevention and control is at the heart of everything we do. **A More Equal Wales** Recognising the need to look at the impact Infection Prevention and Control. National Institute for Health and Clinical Excellence (2012) *Infection Control: Prevention of healthcare associated infection in primary and community care.* CG 139. *NICE, London.* https://www.nice.org.uk/guidance/cg139 (Accessed December 2016) Loveday, H. P. Wilson, J. A. Pratt, R. J. Golsorkhi, M. Tingle, A. Bak, A. Browne, J. Prieto, J. Wilcox, M. (2014) EPIC 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. http://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf (Accessed December 2016) Department of Health. (2015). The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and related guidance (Updated 2010). https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-ofpractice-on-the-prevention-and-control-of-infections-and-related-guidance.

3 - Equality Impact Assessment Template

Questions for you to think about for each of the protected characteristic groups:

- What are the possible impact outcomes?
- What type of impact does the change create?

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age *Younger people* *Middle age people* *Older people* *Other…*			√		
Disability *Physical* *Learning needs* *Neurodiversity* *Sensory Loss* *Mental Health issue* *Other…*			√		
Gender re-assignment *Would this affect those in/post-transition differently?*			√		
Marriage or civil partnership *Are single people affected differently?* *Are married people or civil partners treated differently?*			√		

			√		
Pregnancy or Maternity *Whilst pregnant* *On maternity leave* *Returning to work* *Other…*			√		
Race *Colour* *Nationality* *Ethnic group* *National origins* *Other…*			√		
Religion *Affects one religious group more?* *Clashes with religious holidays?* *What about groups with no religion?*			√		
Sex/Gender *Does it only apply to men / women?* *Could this affect one group more than the other?*			√ √		
Sexual Orientation *Would this affect any group from LGBTQ+ communities differently?*			√		
Socio Economic Duty			√		

Low income / no income groups? *Rural locations affected differently?* *Those with caring responsibilities?*			√ √		
Welsh Language *Will everything be available bilingually?* *How many staff might need to know Welsh?*			√		Patient information leaflets/publications will be available in Welsh and English. Staff are available to provide the care recommended in the guidelines via the medium of Welsh and English. Signage to be bilingual.

4.1	You will need to evidence and recommend one of four policy implementation options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	Continue the policy. Evidence as above.
4.2	If the change will be implemented regardless of the presence of a negative impact, you must be able to evidence: The implementation was necessary to carry out specific functions, there is no way of achieving the aims of the policy that has less negative impact and the means employed to achieve the aims of the policy are necessary and appropriate	N/A
4.3	Could be policy be implemented in a different way to avoid negative impact?	N/A
4.4	How will this change promote equality of access and equality of opportunity?	N/A
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	N/A
5.1	What do you have so far?	The policy sets out the roles and responsibilities for all staff to ensure infection prevention and control.
5.2	Have any themes emerged?	N/A

5.3	What do people have to say about our work?	N/A
5.4	How will you consult widely on your topic?	The policy has been shared with the IPC Management group for consultation and approval.
5.5	Who will you consult with?	Infection Prevention & Management Group.
5.6	How long will the consultation stage last?	As there was no recommended change 2 week review period was followed.
6.1	The action plan must appropriately evidence the decision for one of the following policy options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	3. Continue the policy.
6.2	What will you do with the comments or information you have gathered from your consultations?	N/A
6.3	How did the consultation help guide new policy?	N/A
6.4	Will you make any changes to the draft report you produced?	N/A
7.1	Confirm actions	No changes required. To renew annual policy.

8.1	Establish timetable for reviewing actions and refreshing the assessment	Annual policy review required.

Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1				
2				
3				

Strategic Alignment

Future Generations Act Wellbeing Objectives		Links to Objective
1	A prosperous Wales	☐
2	A resilient Wales	☐
3	A healthier Wales	☒
4	A more equal Wales	☒
5	A Wales of more cohesive communities	☐
6	A Wales of vibrant culture and thriving Welsh language	☐
7	A globally responsible Wales	☐

:	Double-click to add signature below: X Equality & Diversity Manager

Attachments

1. The policy concerned
2. Data used in completing the assessment
3. Details of consultation undertaken
4. Final version of the assessment template

Return to OD Manager – Equality, Diversity and Inclusion:
VUNHST.Equality&Diversity@wales.nhs.uk

Ref: IPC 11

Specimen Collection, Handling and Transport Policy

Executive Sponsor & Function	Executive Director of Nursing, Allied Health Professionals and Health Sciences
Document Author:	Infection Prevention and Control Team
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14 March 2024
Date of Equality Impact Assessment:	26 January 2024
Equality Impact Assessment Outcome:	This policy has been screened for relevance to equality. No potential negative impact has been identified.
Review Date:	March 2027
Version:	5

CONTENTS

ABBREVIATIONS

COSHH	Control of Substances Hazardous to Health
HCW's	Health Care Worker
IPCT	Infection Prevention and Control Team
NIPCM	National Infection Prevention and Control Manual
PPE	Personal Protective Equipment
NWSSP	NHS Wales Shared Services Partnership
AHP's	Allied Healthcare Professionals

1 POLICY STATEMENT

A clinical specimen can be defined as any bodily substance, solid or liquid, that is obtained for the purpose of analysis and examples include blood, sputum, pus, urine, faeces, and skin tissue.

All specimens are potentially infectious, and all staff involved in collecting, handling, and transporting specimens must follow infection control precautions to reduce the risk of transmission of infection and be aware of related infection prevention and control policies i.e. IPC10 – Hand Hygiene Policy and Procedure and IPC05 – National Infection Prevention and Control Manual.

Prompt, accurate laboratory reports are possible only if the specimen is properly collected with accompanied request form detailing patient information, stored and transported safely.

Staff handling specimens are responsible and have a duty to safely collect, handle and transport specimens outlined under the Health and Safety at Work Act (1974) and Control of substances hazardous to health (COSHH) Regulations (2002). If specimens are not stored and transported safely, they pose a risk of infection to staff, patients and the wider public. Containers used for carrying and transporting specimens to pathology laboratories must be secure and conform to the relevant regulations set out in the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011.

The technical issues in appendix A apply mainly to Velindre Cancer Centre, though the principles are universal in accordance with national guidance. They are applicable where pathological specimens are collected and transported. The following divisions/departments will hold systems of work or procedures at local level:

- Cancer Research Wales
- Biochemistry laboratory
- Haematology laboratory
- Pharmacy
- Phlebotomy
- Clinical Research Trials Unit

At Welsh Blood Service this policy should be read (where relevant) in conjunction with the following divisional document that outlines procedures:

WBS – **SOP 022/BCT** – ACCOUNTING FOR BLOOD AND OTHER ITEMS FOR RETURN FROM CLINICS

2 SCOPE OF POLICY

This policy applies to all Velindre University NHST Trust (VUNHST) staff members who are directly involved in the collection, handling and transportation of biological specimens and blood products.

3 AIMS AND OBJECTIVES

The aim of the policy is to inform Trust staff on how to collect, handle and transport specimens in accordance with the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011, COSHH 2002, The Health and Safety at Work Act (1974) along with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (2015).

4 RESPONSIBILITIES

4.1 Chief Executive

The chief executive has overall responsibility to ensure this policy is adhered to while the operational authority for appropriate practice lies with the individual user.

4.2 Executive Director of Nursing, Allied Health Professionals & Health Science

The Director of Nursing, AHP's & Medical Scientists has delegated Executive responsibility for Prevention and Control of Infection and is accountable for this to the Trust Executive Management Board. These responsibilities include ensuring that the organisation receives competent infection prevention and control advice and that adequate staff Infection Prevention and Control training and monitoring is in place. This includes the transportation of specimens.

4.3 Departmental Managers/ Clinical Directors / Clinical Managers
Ensuring systems are in place to monitor staff attendance at mandatory training and to act on non-attendance at training with teams/ departments. They must also ensure adequate resources are available for staff to comply with this policy. Managers need to support and promote the principles outlined in this policy and ensure implementation of the IPC audit programme with the support of the IPC link nurses/healthcare workers (HCWs). They should also identify and take initial action around areas of non-compliance.

All line managers are responsible for monitoring individual attendance at mandatory training and following up non-attendees / non-compliance; for ensuring clinical staff have access to the handling and transportation of specimens' policy. Line managers should promote the principles, ensure monthly audits are performed and act upon and document non-compliance in an action plan.

4.4 Infection Prevention and Control Team
The Infection Prevention and Control Team (IPCT) will advise clinical staff and will incorporate training on the safe collection and transportation of specimens and samples as part of mandatory and statutory training. The infection prevention and control committee are responsible for final ratification and dissemination of the collection handling and transportation of specimens' policy.

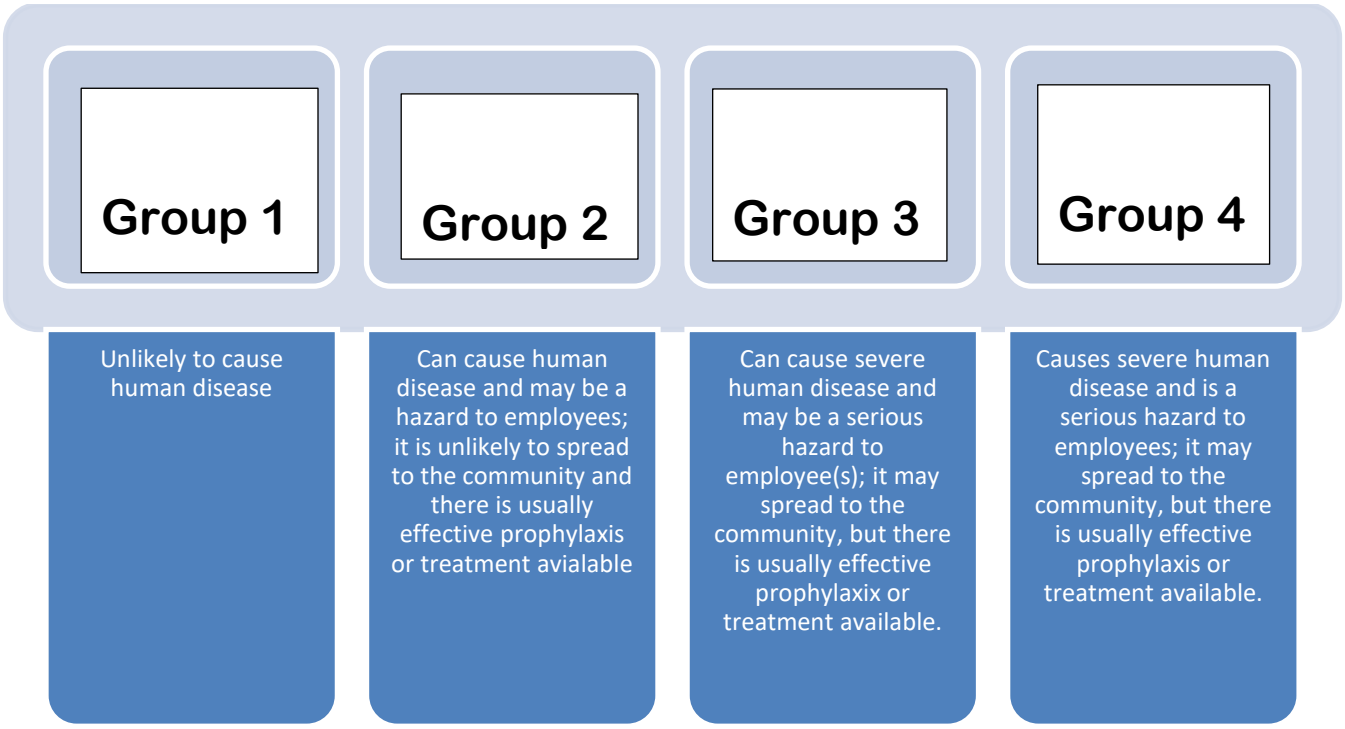
4.5 Healthcare Workers
Under the Health and Safety at Work Act 1974 (as amended) and the Control of Substances Hazardous to Health Regulations 2002 (as amended). Staff have a responsibility to raise awareness of correct practice and principles with colleagues, services users, carers, and visitors. VUNHST staff must report any near-miss, accidents, or incidents via the Trust incident reporting system.

5 DEFINITIONS

Potentially infectious micro-organisms have been classified into one of four hazard groups by the Government Advisory Committee on Dangerous Pathogens as shown in figure 1. The approved list of biological agents can be found on Health and Safety Executive website.

5.1 Hazard Group Definitions
When classifying a biological agent, it should be assigned to one of the following groups according to its level of risk of infection to humans.

Figure 1



6 IMPLEMENTATION AND DISTRIBUTION

This policy will be implemented and maintained by the IPCT. The policy will be available via the Trust Intranet site and from IPC pages. Where staff do not have access to the intranet their line manager will ensure that they have access to a copy of the policy.

7 EQUALITY STATEMENT

This policy has been screened for relevance to equality. No potential negative impact has been identified.

8 REFERENCES

- Department of Health: The Health and Social Care Act 2008; Code of Practice on Prevention and Control of Infections and related guidance (updated 2015).
- Loveday HP, Wilson JA, Pratt RJ, Golsorkhi, A Bak JB, Prieto J and Wilcox M (2014) epic 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection, supplement S1-S70.
- Control of Substances Hazardous to Health Regulations 2002 (as amended in 2004) (COSHH) Carriage of Dangerous Goods (Classification, Packaging, and Labelling) and Use of Transportable Pressure Equipment Regulations 2009 SI 2009/1348.
- **www.HSE.gov.uk/coshh/index.htm**

- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendments) Regulations 2011.
- Health and Safety at Work Act, 1974.
- The Approved List of Biological Agent Advisory Committee on Dangerous Pathogens, HSE, 4th Edition 2021.

9 GETTING HELP

For further information and support please contact the Trust Infection Prevention and Control Team

Telephone: 02920 196129
Email: VCCInfectionPreventionControl@wales.nhs.uk

10 RELATED POLICIES

This policy should be read in conjunction with:

2023 Model Policy Aseptic Non-Touch Technique (ANTT)
IPC10 - Hand Hygiene Policy and Procedure
IPC 05 - National Infection Prevention & Control Manual (NICPM)
IPC 09 - Sharps Safety Policy

11 INFORMATION, INSTRUCTION AND TRAINING

All healthcare staff working in clinical areas are required to be trained in sharps safety and the correct use of Personal Protective Equipment.

Mandatory Infection Prevention and control training is required annually.

Further development-based training as identified by training needs analysis.

12 MAIN RELEVANT LEGISLATION

The policy is led by:

- Control of Substances Hazardous to Health COSHH (2002) – Control of Substances Hazardous to Health Regulations.
- Health and Safety (1974) - Health and Safety at Work Act.
- United Nations Economic Commission for Europe (UNECE) (2017) European Agreement concerning the International Carriage of Dangerous Goods by Road.

- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (amendment) Regulations 2011. Advisory Committee on Dangerous Pathogens (2013) Approved List of Biological Agents. Health and Safety Executive: London.

Any HCW responsible for handling specimens has a responsibility and duty for the safe collection, handling and transporting of specimens under the Health and Safety at Work Act (1974) and the Control of Substances Hazardous to Health (COSHH) Regulations (2002).

Specimens from Velindre Cancer Centre travel by road and by post to local laboratories. Therefore measures to ensure that all specimens are transported in accordance with the European Agreement Concerning the International Carriage of Dangerous Goods by Road (2007) (ADR) and the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations (2007) is essential.

Appendix 1: Collection of Specimen

The need for a specimen should be assessed before collection. Policies such as the VCC Diarrhoea Policy, the Neutropenic Sepsis policy, and the MRSA policy IPC07 include guidance for clinicians as to when clinical specimens should be taken. Further information in **Appendix 2**.

Specimens should be collected using:

- Standard infection control precautions (hand washing and the use of personal protective equipment (PPE)).
- The correct containers. (Appendix 1).
- Ensure the container lid is secure (specimens which have leaked will not be processed).

Labelling

The specimen form must be labelled correctly with:

- Patients name, sex, and address (in full not initials)
- Date of birth
- Hospital number
- Date and time sample was taken
- Specimen type e.g., Catheter specimen of urine, midstream specimen of urine, venous blood, wound swab
- Clinical information e.g., pyrexia, description and site of wound, persistent diarrhoea, MRSA screen
- Investigation(s) required
- Relevant medical history e.g., antibiotic history, symptom history
- Consultant name and signature of clinician requesting the specimen
- Hazardous group 3 organisms e.g., blood borne virus, Tuberculosis (TB) Creutzfeldt-Jakob disease (CJD) must have the specimen and the form identified as a 'High Risk" specimens (see Fig 1)
- Outbreak number if appropriate

The specimen container must be labelled correctly with:

- Patients name, sex, and address (in full not initials)
- Date of birth
- Hospital number
- Date and time sample was taken

Specimen bags and containers

There are several types of form used for investigation:

- Bacteriology
- Virology
- Biochemistry
- Haematology
- Cytology

Specimens must be placed in the approved specimen bag and sealed using the integral sealing strip. Bags must not be sealed using staples, or paper clips etc.

High risk specimens taken from individuals with known or suspected hepatitis, TB, CJD or Human Immunodeficiency Virus for example, should be deposited into the approved packages marked with the biohazard symbol. (Figure 1). The specimen container should be:

- Labelled and marked with the round yellow sticker indicating biohazard risk.
- Deposited into the sealed plastic pocket of a standard specimen form.
- The sealed pocket should be detached from the form and put into the sealable pocket of the biohazard bag (effectively double wrapping the specimen)
- The detached form should be labelled and placed in the unsealed pocket of the biohazard bag
- The paper form should be folded to protect patient confidentiality.

The biochemical laboratory at Velindre Cancer Centre is not equipped to process high risk specimens so they are sent to the laboratory in Cardiff and Vale NHS Trust (CAVUHB). The haematology laboratory will process high risk samples which have been appropriately bagged for a full blood count.

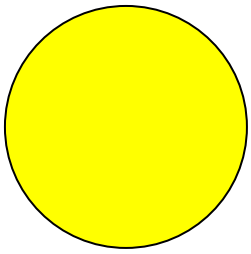


Figure 1: High Risk Specimen Bags

Storage

Storing specimens for collection (ward)
Each ward or Department should have a designated collection point. The receptacle should be an approved robust, secure container sited away from public areas. Containers should be kept closed between collections. The containers must be cleaned and disinfected weekly and after any visible spillage.

VCC ward collection times
10:00 hrs
12:00 hrs
15:30 hrs

All specimens must be transferred from the clinical environment to the storage area via a closable, leak proof, portable container storage container. The containers must be identified by the biohazard label and UN3373 code (Figure 2). The containers must be cleaned and disinfected weekly and after any visible spillage.

Figure 2: Biohazard Labels

If the specimen cannot be transported immediately to the laboratory, some can be refrigerated for a limited amount of time, in a designated fridge, for a maximum of 24hours at 2-8 degrees centigrade. This will help prevent bacteria and contaminates from multiplying and giving misleading results.

Storage of specimens
Specimens and samples should be sent to the relevant laboratory as soon as possible. In VCC specimens are collected at regular intervals from the inpatient wards and outpatient departments by portering staff and delivered to the phlebotomy department where they are sorted and stored according to specimen type, either at room temperature or refrigerated.

Samples for biochemical rather than microbiological investigation do not need to be refrigerated, however, bloods for culture must not be refrigerated and must be transported to the laboratory as soon as possible.

The fridge should have a minimum/maximum thermometer and cleaned as directed in the cleaning schedule for the relevant department. The fridge must also be cleaned weekly. Fridges must be visibly clean with no blood or body substances, dust, dirt, debris, spillages, food debris or build-up of ice. Freezers must be defrosted and cleaned monthly (NPSA, 2010).

Storing samples overnight

Samples stored at room temperature	Samples for refrigeration
Blood cultures Wound swabs Sputum Wet slides Biopsy Urine samples in red topped containers (containing boric acid)	Faeces Dry slides Cross match Full blood count Tumour markers (ca-125, ca-153, ca-199, CEA, PSA CYFRA -211, AFP & HCG) FSH, LH, TFT, TSH, T4, Thyroglobulin, Methotrexate levels
Renal, liver and bone profile and coagulation samples should be sent to switchboard for transportation to UHW.	

Leaking Specimens

Any container containing a specimen that will be sent to the laboratory must be robust, must not leak during normal use and must be suitable for its purpose. An incident form must be completed if any of these containers leak or break during a normal use to facilitate investigation of consumables.

Any HCW collecting, transporting or receiving specimen(s) that discovers a spillage or leak is responsible for managing the spillage. The HCW should don appropriate PPE before cleaning up the spillage. Absorbent material, from a spill kit, should be used to absorb the spillage and the container or surface should be cleaned and disinfected. The sample should be discarded into the appropriate waste stream and the sender notified that the specimen has been damaged. After removal of PPE hand hygiene should be performed.

Transporting specimens

Under the Health and Safety at Work Act 1974, all staff have a responsibility to protect themselves and others, including patients and the wider public, from inadvertent contamination from hazardous substances. All specimens must be placed in a designated secure collection area until ready for collection. All specimens must be placed in a specimen bag with the required form in a separate pocket or attached to the adhesive strip of the bag and folded. If sample is of 'high risk' status, ensure specimen is placed in biohazard bag. Appropriate transportation packaging should be used in line with the Carriage of Dangerous Goods and use of Transportable Pressure Equipment (amendments) Regulations (2011). Specimens must be

transported to the laboratory in transport containers, which comply with UN3373 regulations. (United Nations Economic Commission for Europe, 2017) requirements

Velindre University NHS Trust has a contract with NWSSP to collect specimens for transport to the local laboratory. Whilst CAVUHB are responsible for the outer container and the cleaning thereof, the Health Courier Service is responsible for the Temperature Control Units in the vehicles.

Collection times are every hour from 08.20 until 16.20.

To arrange transport of specimens outside of working hours, clinical staff should contact the hospital switchboard.

Appendix 2: Collection and storage of specimens for microbiological investigation

The following is guidance only on the procedures required for managing specimens. Detailed information can be obtained from the Royal Marsden Manual of Clinical nursing procedures 9th Ed (2015) available via the Velindre University NHS Trust website.

Wherever possible specimens should be obtained at a time when it can be transported to the laboratory (lab) in a timely manner. Specimens that are stored overnight in a refrigerator must be placed in a designated specimen refrigerator.

Specimen	Container	Refrigeration	Transport to laboratory	Collection
Wound swab	Cotton tipped charcoal swabs (black top)	No. Refrigeration can kill some fastidious organisms and the charcoal transport medium allows cultures to be maintained for at least 24 hours.	As soon as possible within 24 hrs	Moisten the swab with sterile saline before taking sample. Use a zigzag motion whilst simultaneously rotating between fingers.
Sputum	White universal container	No – refrigeration will kill Strep Pneumoniae, one of the target organisms. Room temperature storage for up to 24 hrs is the best option.	As soon as possible within 24 hours	In suspected cases of pulmonary TB three samples should be taken on consecutive days preferably on waking. The request form should be marked 'acid-fast bacilli (AFB) and a high risk label attached to the form and container and inserted into a bio bag.
Catheter specimen of urine (CSU)	Red topped universal container containing Boric acid.	No - the Boric acid will prevent the bacteria multiplying. **NB If plain universal containers are used specimens should be refrigerated.**	As soon as possible within 24 hrs	10mls is required using a non-touch aseptic technique. The port should be swabbed with 70% isopropyl. Equipment used to take the specimen

		Refrigerate within two hrs of taking specimen. Bacteria multiply at room temperature giving false positive results.		must be sterile. Specimen must not be taken from the catheter bag.
Midstream specimen of urine (MSU)	Red topped universal container containing Boric acid	No - the Boric acid will prevent the bacteria multiplying. **NB If plain universal containers are used specimens should be refrigerated. Refrigerate within two hrs of taking specimen. Bacteria multiply at room temperature giving false positive results.**	As soon as possible within 24 hrs	10mls is required. The first few mls of urine should be discarded and the mid-stream specimen collected into a sterile foil bowl.
Faeces	Blue topped stool specimen container	Yes – must be refrigerated within 2 hrs of taking the specimen.	As soon as possible within 24 hrs	15mls of liquid or approximately the size of a walnut is sufficient. NB No-diarrhoea specimens will not be processed for bacterial or viral infections.
Blood cultures	Specific bottles (Beckton Dickinson)	No – store at room temperature until sent to the laboratory.	As soon as possible within 24 hrs	Non touch technique and swabbing the bottle tops and skin with 70% isopropyl alcohol.
Tissue/pus	Universal container	No – send directly to the lab.	Immediate transportation	Aspirate with needle and syringe into a sterile container using an aseptic technique.
High Vaginal Swabs	High vaginal swabs	No – send directly to the lab.	must reach lab within 4 hrs	

Throat	Red topped cotton swab in virus transport medium	Yes – refrigerate within 4 hrs.	Send directly to the laboratory	The patient should stick out their tongue whilst the swab is guided down the side of the throat to make contact with the tonsil, a tongue depressor may be required.
MRSA Screen Nose and Groin (include throat swab for ENT patients) Swab all wounds and invasive devices for C &S	Cotton tipped black topped swabs with transport medium	Yes – refrigerate within 4 hrs.	Within 24 hours	Prior to taking swabs moisten swabs with sterile saline.
Virology e.g flu	Red topped cotton swab in virus transport medium	**Yes**	Send directly to the laboratory.	The patient should stick out their tongue whilst the swab is guided down the side of the throat to make contact with the tonsil, a tongue depressor may be required.
Legionella antigen	Plain universal container	**No**	Send directly to the laboratory	

EQIA Template & Action Plan

All policies and decisions that affect people are assessed to identify ways to reduce discrimination and to make Wales fairer. I confirm that an assessment has been undertaken and the relevant actions are highlighted below.

Name of Policy	**Transport of Specimens**		
Manager	**Hayley Harrison-Jeffreys**		
Date of meeting with OD Manager – ED&I	**N/A**		
Date of submission	**January 2024**		
Date of next review	**January 2027**		
These changes will affect:	Staff: ☒	Patients: ☐	Both: ☐

1.1	What is the policy or decision that you are conducting an EQIA for?	**IPC 11 - Transport of Specimens**
1.2	Who owns it?	Infection Prevention & Control Management Group
1.3	What is the aim of the change(s)?	No change to policy. Addition of divisional standard operating procedures for how to take a specimen.
1.4	Who is affected most by the change?	N/A
1.5	How does this topic fit into the wider context of the organisation?	Staff handling specimens are responsible and have a duty to safely collect, handle and transport specimens outlined under the Health and Safety at Work Act (1974) and Control of substances hazardous to health (COSHH) Regulations (2002), and conform to the relevant regulations set out in the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011.
1.6	Who is undertaking the EQIA	Hayley Harrison Jeffreys – Head of Infection Control

1.7	When will you start and end the EQIA?	24/01/2024
2.1	What data is available to help inform the EQIA? Note to self ** query to include said changes amendments new regulations etc from old policy	Previous EQIA submitted January 2019.
2.2	What information is still needed?	N/A
2.3	How will missing data be collected?	N/A
2.4	What is considered relevant information and data?	To inform Trust staff on how to collect, handle and transport specimens in accordance with the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (Amendment) Regulations 2011, COSHH 2002, The Health and Safety at Work Act (1974) along with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (2015). United Nations Economic Commission for Europe (UNECE) (2017) European Agreement concerning the International Carriage of Dangerous Goods by Road. European Agreement Concerning the International Carriage of Dangerous Goods by Road (2007) (ADR) and the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations (2007) is essential. All specimens are potentially infectious, and all staff involved in collecting, handling, and transporting specimens must follow infection control precautions to reduce the risk of transmission of infection and be aware of related infection prevention and control policies i.e. IPC10 – Hand Hygiene Policy and Procedure and IPC05 – National Infection Prevention and Control Manual. Therefore, there is a need to ensure that the sample is handled safely and securely and is

		contained in a closable box. This is to ensure the dignity and respect of the patient any potential breach of data security that could impact on the patient. The box also provides protection for the staff member transporting the sample should there be an incident or breakage.

3 - Equality Impact Assessment Template

Questions for you to think about for each of the protected characteristic groups:

- What are the possible impact outcomes?
- What type of impact does the change create?

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age *Younger people* *Middle age people* *Older people* *Other…*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Disability *Physical* *Learning needs* *Neurodiversity* *Sensory Loss* *Mental Health issue* *Other…*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Gender re-assignment *Would this affect those in/post-transition differently?*			√	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.**	

				Encourage participation in public life.	
Marriage or civil partnership *Are single people affected differently?* *Are married people or civil partners treated differently?*			**√**	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Pregnancy or Maternity *Whilst pregnant* *On maternity leave* *Returning to work* *Other…*			**√**	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Race *Colour* *Nationality* *Ethnic group* *National origins* *Other…*			**√**	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Religion *Affects one religious group more?* *Clashes with religious holidays?* *What about groups with no religion?*			**√**	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	

Sex/Gender *Does it only apply to men / women?* *Could this affect one group more than the other?*			**√**	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Sexual Orientation *Would this affect any group from LGBTQ+ communities differently?*			**√**	**To eliminate discrimination and harassment.** **Promote equality of opportunity.** **Promote good relations and positive attitudes.** **Encourage participation in public life.**	
Socio Economic Duty *Low income / no income groups?* *Rural locations affected differently?* *Those with caring responsibilities?*			**√**		
Welsh Language			**√**	**To eliminate discrimination and harassment.** **Promote equality of opportunity.**	

Will everything be available bilingually? *How many staff might need to know Welsh?*				**Promote good relations and positive attitudes.** **Encourage participation in public life.**	

4.1	You will need to evidence and recommend one of four policy implementation options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	Continue the policy. Evidence as above.
4.2	If the change will be implemented regardless of the presence of a negative impact, you must be able to evidence: The implementation was necessary to carry out specific functions, there is no way of achieving the aims of the policy that has less negative impact and the means employed to achieve the aims of the policy are necessary and appropriate	N/A
4.3	Could be policy be implemented in a different way to avoid negative impact?	N/A
4.4	How will this change promote equality of access and equality of opportunity?	N/A
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	n/a
5.1	What do you have so far?	This policy sets out the safe management of clinical specimens across both divisions of the Trust.

5.2	Have any themes emerged?	N/A
5.3	What do people have to say about our work?	N/A
5.4	How will you consult widely on your topic?	The policy has been shared with the IPC Management group for consultation and approval.
5.5	Who will you consult with?	Infection Prevention & Management Group.
5.6	How long will the consultation stage last?	As there was no recommended change 2 week review period was followed.
6.1	The action plan must appropriately evidence the decision for one of the following policy options:1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	3. Continue the policy
6.2	What will you do with the comments or information you have gathered from your consultations?	N/A
6.3	How did the consultation help guide new policy?	N/A
6.4	Will you make any changes to the draft report you produced?	N/A

7.1	Confirm actions	No changes are Policy required. To renew policy
8.1	Establish timetable for reviewing actions and refreshing the assessment	Policy review every 3 years.

Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1				
2				
3				

Strategic Alignment

Future Generations Act Wellbeing Objectives		Links to Objective
1	A prosperous Wales	☐
2	A resilient Wales	☐

3	A healthier Wales	☒
4	A more equal Wales	☒
5	A Wales of more cohesive communities	☐
6	A Wales of vibrant culture and thriving Welsh language	☐
7	A globally responsible Wales	☐

	Double-click to add signature below: X Equality & Diversity Manager

Attachments

1. The policy concerned
2. Data used in completing the assessment
3. Details of consultation undertaken
4. Final version of the assessment template

Return to OD Manager – Equality, Diversity and Inclusion:
VUNHST.Equality&Diversity@wales.nhs.uk

Ref: PP 10

Medical Gas Piped Systems Policy

Executive Sponsor & Function:	Chief Executive
Document Author:	Assistant Director of Estates, Environment & Capital Development
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14th March 2024
Date of Equality Impact Assessment:	9th February 2024
Equality Impact Assessment Outcome:	Approved
Review Date:	March 2027
Version:	2

1.0 The Importance of a Managed Approach to Medical Gases

This policy is compliant with Health Technical Memorandum (HTM 02-01) and looks at the issues of operational management. The policy covers such issues as statutory requirements, functional responsibilities, operational procedures, training and communications, cylinder management, general safety, maintenance and risk assessment, control of exposure to anaesthetic agents, giving definitions and working practices throughout. This policy is intended for use by Operational Managers, Engineers, Quality Controllers, Technicians, Finance Officers and all Medical and Portering staff involved in the day to day running of a medical gas pipeline system. The primary objective of this policy is to ensure the provision of safe and reliable medical gas pipeline systems and their efficient operation and use. This objective will only be achieved if the medical and nursing users and Estates staff participate in the introduction of this operational policy designed to minimise the hazards likely to arise from misuse of the system.

It is not intended that this policy covers the use of small, manually portable gas cylinders.

At least 60% of patients are administered medical gases during their stay in hospital.

Not having safe and reliable gas supplies can be as life-threatening as not having electricity, yet responsibility for medical gases does not fit precisely into any one person's role.

According to Health Technical Memorandum (HTM) 02-01/EN737 and the National Minimum Care Standards & Regulations for Independent Health Care (NMCSR) 2002, all hospitals should at least have:

Effective system designs covering the capacity and capability of piped medical gases, including alarm systems and the siting of back-up systems.

Defined functional responsibilities requiring the nomination of an Authorised Person; Competent Person, Quality Controller and Designated Medical/Nursing Officer.

A hospital-wide medical gases operational policy based on comprehensive risk assessment and training carried out for clinical and non-clinical staff.

A demonstrable cylinder management programme in place.

1.1 Risk Assessments

Compliance by the Trust is essential to manage the risks to patients, visitors and staff.

Site based risk assessments have been carried out by British Oxygen Company (B.O.C.). These are held by the Works and Estate department and are available for inspection upon request to the relevant Authorised Person for Medical Gas Pipeline Systems.

2.0 General Policy Statements

This policy addresses the provision of a piped medical gas pipeline system (MGPS) at Velindre University NHS Trust.

The (MGPS) provides a safe, convenient and cost-effective supply of medical gases to points where these gases can be used by clinical and nursing staff for patient care.

Velindre University NHS Trust recognises its commitment to maintaining the MGPS to required standards and the training of all personnel associated with its operation.

It is the Trust policy that before work on the MGPS can commence a Permit to Work Form, signed by an Authorised Person (MGPS) MUST be completed.

3.0 Scope of Policy

This policy is intended for use by all staff involved with MGPS at Velindre University NHS Trust.

It applies throughout at Velindre University NHS Trust to all fixed medical gas pipeline systems and to the use and management of cylinders associated with the MGPS. It does not apply to the use of small portable cylinders used, for example, during the transportation of patients.

Compressed gas and vacuum supplies to general engineering workshops and Pathology Department equipment are separate from the general MGPS and are NOT included in this policy, although the general principles in this document should be followed for these departments.

MGPS terminal units define the limits of Estates' responsibility in this policy.

Equipment connected to the terminal units is NOT covered by this policy, other than where its mode of use may affect system operation or safety.

Medical equipment is the responsibility of the Electro Biomedical Engineering Department.

Medical gases should not be used for non-medical purposes, other than as a test gas for medical equipment.

Medical air should be used as the power source for ventilators; the routine use of oxygen as a driving gas is to be avoided.

The operational management responsibility for MGPS on Health Boards sites resides with the Estates Department and each site specific Estates Authorised Person is responsible for the completion of the site specific information to be detailed in Appendices A – D.

4.0 Responsibilities

The responsibilities detailed by job title or role in this section (section 4) are to be made specific to each site by the Authorised Person for that site. This will involve the separate completion of Appendices A – D for every location at which this policy applies.

4.1 Chief Executive

Ultimate management responsibility for MGPS rests with the Health Board's Chief Executive.

The Velindre University NHS Trust's Chief Executive is responsible for ensuring that an Authorising Engineer (AE) is appointed for MPGS. This function will be fulfilled by Welsh Health Estates.

4.2 Authorising Engineer

The duties and responsibilities of the Authorising Engineer are:

4.2.1 To recommend to the Estates Manager those persons who, through individual assessment, are suitable to be Authorised Persons (MGPS);

4.2.2 To ensure that all Authorised Persons (MGPS) have satisfactorily completed an appropriate training course;

4.2.3 To ensure that all Authorised Persons (MGPS) are re-assessed every three years and have attended a refresher or other training course prior to such re-assessment;

4.2.4 To review the management systems of the MGPS, including the Permit to Work System;

4.2.5 To monitor the implementation of the operational policy and procedures.

4.3 Authorised Person (MGPS)

The Authorised Person(s) (MGPS) are listed in Appendix C. The Authorised Persons (MGPS) assume effective responsibility for the day-to-day management and maintenance of the MGPS.

The Duties and Responsibilities of Authorised Persons (MGPS) are:

4.3.1 To ensure that the MGPS is operated safely and efficiently in accordance with the statutory requirements and guidelines;

4.3.2 To manage the Permit to Work System, including the issue of Permits to Competent Persons (MGPS) for all servicing, repair, alteration and extension work carried out on the existing MGPS;

4.3.3 To supervise the work carried out by Competent Persons (MGPS) and for the standard of that work (A Register of Competent Persons (MGPS) must be kept);

4.3.4 To ensure that the Health Board MGPS maintenance specification and schedule of equipment (including all plant, manifolds, pipe work, valves, terminal units and alarm systems) are kept up to date;

4.3.5 To liaise closely with Designated Nursing/Medical Officers, the Quality Controller (MGPS) and others, who need to be informed of any interruption, alteration and testing of the MGPS;

4.3.6 To provide technical advice to those responsible for the purchase of any medical equipment which will be connected to the MGPS, in order to avoid insufficient capacity and inadequate flow rates;

4.3.7 In accordance with the Velindre University NHS Trust's *policy* on provision of services, provide advice on the provision and or replacement of MGPS central plant and associated systems. The Estates Department will hold overall responsibility for the provision and maintenance of MGPS services within the Health Board;

4.3.8 To organise such training of Estates staff and/or transfer of MGPS information, as is needed for the efficient and safe operation of the MGPS.

4.3.9 To advise the Trust on any other training requirements, outside the Works and Estate department.

4.4 Competent Person (MGPS)

Competent Persons (MGPS) are Craft Persons, employed by Velindre University NHS Trust and are listed in Appendix C.

All Competent Persons (MGPS) shall be registered to BS EN ISO 9001 / BS EN ISO 13458, with clearly defined registration criteria.

Where sub contract labour is required to carry out the Competent Person duties then the same registration must be adhered to.

The Duties and Responsibilities of Competent Persons (MGPS) are:

4.4.1 To carry out work on the MGPS in accordance with the Health Board maintenance specification;

4.4.2 To carry out repair, alteration or extension work, as directed by an Authorised Person (MGPS) in accordance with the Permit to Work System and HTM 02-01 (2005);

4.4.3 To perform engineering tests appropriate to all work carried out and inform the Authorised Person (MGPS) of all test results.

4.4.4 To carry out system integrity tests under direct supervision of the Appointed Person;

4.4.5 To carry out all work in accordance with the Velindre University NHS Trust & Safety Policy.

4.5 Quality Controller (MGPS)

It is the responsibility of the Chief Executive or the designated Executive Director to appoint, in writing, on the recommendation of the Chief Pharmacist, a Quality Control Pharmacist with MGPS responsibilities.

The Authorised Person (MGPS) will be responsible for liaising with the QC (MGPS) and organising attendance as required.

The Duties and Responsibilities of the QC (MGPS) are:

4.5.1 To assume responsibility for the quality control of the medical gases at the terminal units, i.e. the wall or pendant medical gas outlets;

4.5.2 To liaise with the Authorised Person (MGPS) in carrying out specific quality and identity tests on the MGPS in accordance with the Permit to Work System and relevant Pharmacopoeia Standards;

4.5.3 To organise MGPS training of Pharmacy staff who may deputise for the QC (MGPS);

4.5.4 They should have received training on the verification and validation of MGPS and be familiar with the requirements of this MGPS Operational Policy.

Pharmacy at Velindre University NHS Trust will;

Receive delivery notes for compressed gas cylinders, check against invoices received and pass invoices for payment;

Order and supply cylinders of medical gases and special gas mixtures for the hospital;

Maintain a record of cylinder rental charges and pass rental invoices for payment;

Ensure that cylinder gases comply with Ph Eur requirements;

Ensure that other gases and gas mixtures comply with manufacturers' product licences.

4.6 Designated Medical / Nursing Officer (DMO)

The Designated Medical / Nursing Officer in charge is the person, on each site, with whom the Authorised Person MGPS liaises on any matters, affecting the MGPS and who should give permission for a planned interruption to supply. These persons should have received training on MGPS relevant to their departments and on the action to be taken in the event of an emergency.

The Duties and Responsibilities of the Designated Medical / Nursing Officer (DMO) are:

4.6.1 To give permission for any interruption to the MGPS and should sign the appropriate part of the permit. However, in certain circumstances such permission may be given by the Senior Clinician in charge;

4.6.3 To ensure that all relevant staff are aware of the interruption to the MGPS and which terminal units cannot be used.

4.7 Designated Persons

The Designated Persons are the Portering staff. They will have undergone specialist training in the identification and safe handling and storage of medical gas cylinders, associated with MGPS, including relevant manual handling training. The Portering Manager will arrange this training.

The Duties and Responsibilities of the Designated Persons in Velindre University NHS Trust.

4.7.1 To assist with the delivery of gas cylinders by BOC Medical or designated gas supplier;

4.7.2 To transfer gas delivery notes from the delivery driver to the Pharmacy Department;

4.7.3 To attach to and remove from cylinders, medical equipment regulators (or regulator / flow meter combinations) and manifold tailpipes;

4.7.4 To identify and remove from service faulty (e.g. leaking) cylinders and subsequently notify Pharmacy of the location of such cylinders;

4.7.5 To perform a monthly check on cylinder stocks and report any deficiencies to the Pharmacy Department;

4.7.6 To ensure that all cylinder contents are used within the 3-year fill / refill timescale specified by the gas supplier;

The Designated Person must work safely at all times, using the appropriate Personal Protective and Manual Handling Equipment, damage to which must be reported immediately to the Operational Services Manager.

4.8 Medical Gases Committee

A Medical Gases Committee shall consist of the Chief Pharmacist and a Senior Authorised Person (MGPS), for the Health Board, a nominated designated Nursing / Medical Officer, the Portering Manager and the QC (MGPS).

MGPS Operational Policy Review

The MGPS Operational Policy should be reviewed annually. The Authorised Person (MGPS) shall convene the review meeting and be responsible for writing and distributing the minutes of the meeting. The Committee shall report to the Works and Estate Statutory Compliance Group, which in turn reports to the Health Board Health and Safety Committee.

MGPS Record Drawings and Documentation

The Authorised Person (MGPS) will maintain copies of the following:-

- Up-to-date and accurate 'as fitted' record drawings (including valve / key numbers/ TU identification) for all MGPS;
- Any necessary MGPS insurance / statutory documentation;
- MGPS safety valve replacement schedule (on a 5-yearly basis);
- New and completed Permit to Work books for work on the systems (for 10 years);
- Plant history / maintenance records;
- Manufacturer's technical data sheets / manuals for all MGPS components;
- Health Technical Memorandum 02-01, any associated supplements and NHS Model Engineering Specifications C11, all latest editions;
- MGPS contractors' service contracts and ISO 9001(or equivalent) certificates, staff training records, equipment calibration certificates (copies);
- A list of all personnel associated with the MGPS, especially the Permit to Work System;
- Emergency and other useful telephone numbers;
- MGPS staff training records;
- Calibration certificates of the hospital test equipment;
- The MGPS Operational Policy

Pharmacy will maintain copies of the following:

- Delivery notes – invoices V.I.E.
- Delivery notes for medical gas cylinders;
- Sales invoices for medical gas cylinders;
- Delivery Summary Form (tracks cylinder stock information);
- Cylinder rental invoices;
- Cylinder Rental Reconciliation Form (Monitors trends in cylinder use over 6 months);
- Delivery notes for special gas and industrial gas cylinders;
- Sales invoices for special gas and industrial gas cylinders;
- Rental invoices for special gas and industrial gas cylinders;
- Calibration records of QC test equipment and records of all QC tests performed;

5.0 Training

It is essential for the safety of patients that NO PERSON should operate, or work on, any part of an MGPS unless adequately trained or supervised.

MGPS Training at Velindre University NHS Trust's for all Estates staff is administered by the Works and Estates Department.

A record of those trained is kept in the Estates Department.

It is the duty of Departmental Managers to ensure that all staff using MGPS are appropriately trained and records kept.

The Authorised Person (MGPS) may request training records of contractors' staff.

Training on MGPS will be provided as follows:

Title	Training	Frequency
Authorised person	Specialist training	Refresher 3 years
Competent person	Specialist training	Refresher 3 years
Quality controller	Specialist training	Refresher 3 years
Designated Nursing/Medical Officer	On site knowledge	Annually
Portering staff	Specialist training	Refresher 3 years

6.0 The MGPS structure

The site specific locations and structure of MGPS can be found in Appendix D and is to be completed by the site Authorised Person for every site at which this policy applies, i.e. Oxygen, Medical Air 4 Bar, Surgical Air 7 Bar, Medical Vacuum, Nitrous Oxide and Entonox.

7.0 Signage

Appropriate identification and safety warnings should be displayed in accordance with current requirements.

A notice should state the location of the keys and be fixed to the Plant Room door.

8.0 Cylinder Storage

Accommodation for medical gas cylinders should comply with the following guidelines:-

8.0.1 Ventilation All cylinder stores should be well ventilated

8.0.2 Labelling All cylinder stores should be clearly labelled as appropriate with the type of cylinders contained

8.0.3 Emergency action Details of emergency action procedures and location of keys together with no smoking signs should be clearly posted on the front of the cylinder store

8.0.4 Access Clear access to all cylinder stores is required including adequate space for vehicular access and cylinder loading and unloading

8.0.5 Fire protection All cylinder stores should be free from naked flames and all sources of ignition appropriate fire extinguishers should be readily available

8.0.6 Cylinder stores for medical gasses should only contain medical gas cylinders

8.0.7 Industrial and pathology gasses cylinders should be stored in a separate designated area

8.0.8 Cylinders in use in wards or departments should be secured to ensure they cannot fall, topple or be pushed over, causing subsequent potential for personal injury and damage.

9.0 Area Valve Service Units (AVSUs)

Locked boxes, with breakable glass fronts and containing area valve service units (AVSUs), are provided at the entrance to wards and departments.

These valves provide facilities for both routine and emergency isolation of gas supplies.

These valve boxes contain an emergency inlet port (Non Interchangeable Service Terminal, or NIST)), which is gas specific. This may be used to supply gas to a ward when the main supply fails or is shut down for essential engineering work.

General Rules and Conditions for Control of Line Valve Assemblies LVAs

Pipeline valves (called lockable line valves assemblies LVAs) in ducts, risers ceiling spaces etc. shall be locked in the normal operating position.

Pipeline valves will normally be left unlocked if they are sited in a locked Plant Room. Estates will hold keys for these valves.

10.0 Access

Under normal events, only the Authorised Persons (MGPS) using the appropriate key from the Estates medical gases key cabinet, should access AVSUs and any other locked line valves, under control of a Permit to Work.

The key cabinet contains a list identifying all AVSUs and locked line valves, with corresponding key numbers.

11.0 Key Holders:

Any of the Authorised Persons listed in the site specific information in Appendix C will be key holders for that site.

In the event of an emergency, access to the valve boxes and AVSUs may be gained by smashing the breakable glass fronts.

A senior member of the medical or nursing staff will perform this action, after steps have been taken to ensure that no patient is compromised by isolation of the gas supply.

12.0 Routine and Planned Procedures (The MGPS Permit to Work System)

The aim of the MGPS Permit to Work System is to safeguard the integrity of the medical gas system, and therefore the safety of the patients.

It is the policy of Velindre University NHS Trust that, with the knowledge and permission of the Authorised Person (MGPS), a Permit must be raised before any work, except changing of manifold cylinders or emergency isolation by a member of the nursing staff, can be undertaken at any part of the hospital's medical gas system.

Granting of a Permit to Work and the way in which the work is carried out must follow the directions of HTM02-01, unless otherwise defined in this Policy.

Responsibilities for signing a Permit to Work is detailed in sections 13.1 and 13.2 of this policy.

Designated Medical / Nursing Officers, or exceptionally the Senior Clinician on duty, should ensure that colleagues are advised of the interruption to the gas supply, and its estimated duration. They should also ensure via the Estates Department that all affected terminal units are appropriately labelled.

13.0 Planned or Routine Interruption

A planned interruption will be needed for repair, extension or modification to the existing MGPS. An Authorised Person (MGPS) shall supervise any planned interruption in strict accordance with the Permit to Work System in HTM 02-01:2005. The QC (MGPS) Pharmacist shall be involved in any planned interruption from the initial planning stage.

The Authorised Person (MGPS) shall assess the hazard level of the work to be carried out in accordance with the definitions that are given in the following sections for High and Low Hazard work.

13.1 HIGH Hazard Work

Any work on the MGPS, such as cutting or brazing, that will introduce hazards of cross-connection and pollution, will be classified as HIGH HAZARD.

Cross-connection, performance, identity and quality tests shall be required before the MGPS is taken back into use.

High hazard work may require at least a planned interruption to a single ward or department, or, at worst, a major shutdown of a system to a whole site.

In such events, an Authorised Person (MGPS) must ensure that key personnel for each and every ward or department are informed; if necessary, holding a site meeting.

The QC (MGPS) Pharmacist should be included in any discussions that may lead to an interruption of the MGPS.

Two weeks prior to the planned interruption, the Authorised Person (MGPS) shall liaise in person with the Designated Nursing / Medical Officer(s) of the ward(s) or department(s) concerned.

At the same time, the Authorised Person (MGPS) will complete Part 1 of the Permit to Work Form.

The Designated Medical / Nursing Officer(s) for the ward(s) or department(s) involved will be made aware that their signatures will be required on the date on which the work is due to take place.

The requirement for portable cylinders or vacuum units will be determined and confirmed, with details of the interruption, by a notification rom Estates AP to the Designated Medical / Nursing Officer(s).

A copy of this memorandum will be sent to the ward(s) or departments(s) concerned. A further memorandum, requesting the services of a Quality Controller (MGPS) and detailing the requirements for portable cylinders shall be sent to Pharmacy.

It is the responsibility of the Authorised Person (MGPS) to arrange, through the Pharmacy Department, or an appropriate hire firm if necessary for portable cylinders and regulators (Stocks of regulators are held by Estates).

Any additional portable vacuum units to be supplied are the responsibilities of the Estates Department.

The Authorised Person (MGPS) will provide all details of the work to be carried out in Part 2 of the Permit to Work Form, including any other Permits, e.g. for hot works or for entry into confined spaces.

Work shall only commence when the Designated Medical / Nursing Officer or Senior Clinician(s) for the ward(s) or department(s) is / are satisfied that no patients will be put at risk by the shutdown of the MGPS and has / have signed Part 1 of the Permit to Work Form.

The Authorised Person (MGPS) will then supervise isolation of the AVSU(s). Isolation to be carried out by the Designated Medical / Nursing Officer.

Once the system(s) has / have been isolated and de-pressurised, the Competent Person (MGPS) will sign Part 2 of the Permit to Work Form and commence work.

The Competent Person (MGPS) will sign Part 3 of the Permit to certify that work has been completed, and contact the Authorised Person (MGPS), so that the installation may be examined and tested.

For all High Hazard work, the Authorised Person (MGPS) will determine and carry out, with the assistance of the Competent Person (MGPS), the necessary tests and examination of the system(s) in accordance with HTM 02-01 'Validation and Verification'.

When these tests have been completed satisfactorily, the Authorised Person (MGPS) will initial the relevant spaces and sign Part 4 of the Permit.

The Quality Controller Pharmacist (MGPS), with the assistance of the Authorised Person (MGPS) will carry out identity and quality tests on the system(s) in accordance with HTM 02-01 'Validation and Verification'.

When these tests have been completed with satisfactory results, both will initial the relevant spaces and sign Part 5 of the Permit.

The Quality Controller (MGPS), with receive the pink copy of the Permit to Work Form from the Authorised Person (MGPS).

Note: It should be the normal practice of Estates to retain the white copy along with the original (yellow) copy in the Permit to Work Book. Photocopies (signed and dated by the AP (MGPS) and the CP (MGPS)) of the white copy may be issued to the Competent Person (MGPS) on request.

The Designated Nursing / Medical Officer(s) will accept the system(s) back into service by signing Part 6 of the Permit and will undertake to notify his / her colleagues that the system is fit for use.

13.2 LOW Hazard Work

Any work on the MGPS which will not introduce any hazard of cross-connection or pollution.

A performance test will be required before the MGPS is taken back into use.

If there is any doubt as to the hazard level classification of a particular Permit to Work, advice should be sought from the Senior Authorised Person (MGPS), detailed in Appendix A.

Low hazard work on terminal units is normally the result of a leak on an individual terminal unit due to a faulty valve or seal but may also include work on plant, which does not interrupt gas supplies.

This type of work is usually carried out at short notice because of the need for minimum disruption in patient care. In such events, the Authorised Person

(MGPS) may have to arrange a portable cylinder or vacuum unit, so that the terminal unit can be taken out of service.

The Authorised Person (MGPS) will fill out the relevant section of Part 1 of the Permit to Work Form. The Authorised Person (MGPS) will liaise with, and fully brief, the Senior Clinician on duty within the ward / department who will then sign Part 1, if required.

The Authorised Person (MGPS) will provide all details of the work to be carried out in Part 1 of the Permit to Work Form

When satisfied with the extent of the work, the Competent Person (MGPS) will sign Part 2 and begin the work.

The Competent Person (MGPS) will sign Part 3 of the Permit to certify that the work has been completed and contact the Authorised Person (MGPS) for the installation to be examined and tested.

The Competent Person (MGPS), with the assistance of The Authorised Person (MGPS), if necessary, will carry out flow, pressure drop, mechanical function and gas specificity tests on the serviced terminal unit(s).

Other equipment function tests, e.g. on plant, will be made to the satisfaction of the Authorised Person (MGPS).

The Authorised Person (MGPS) Competent Person (MGPS) will initial the relevant spaces, and sign Part 4 of the Permit.

When satisfied with the test results, the Authorised Person (MGPS) will sign Part 5 of the Permit.

The Designated Medical / Nursing Officer or Senior Clinician on duty within the ward or department will accept the MGPS back into service by signing Part 6 of the Permit and will undertake to notify his / her colleagues that the system is fit for use.

14.0 Actions in the Event of a Medical Gas Alarm

The diagram on page 18 (Diagram 1) shows a typical medical gas panel and the actions that should be taken at each level of alarm.

On detection of a local alarm indication e.g. in a ward area, the Senior Clinician on duty, or deputy, should contact the Switchboard to confirm that a fault has been signalled and that Estates has been informed.

In the event of an alarm condition on the central alarm panel, it is the responsibility of the Security control room to inform the appropriate staff.

Disabling the alarm system, other than when due authorisation has been obtained from an Authorised Person (MGPS), is absolutely forbidden as this may compromise patient safety.

There should always be a ‘normal’ light. If there is no ‘normal’ light, then there is a fault of some kind, possibly just with the alarm panel. However, Estates should investigate this fault.

Alarms should be tested weekly by a Competent Person (MGPS). Operation of the TEST button will confirm operation of all audible / visual indicators.

Nursing / Medical staff should be advised of this test.

The results of these tests should be recorded and stored by the Authorised Person.

14.1 Example – Oxygen

NWH = Normal Working Hours
ONWH = Outside Normal Working Hours

ALARM INDICATION	Action (Security to inform)
NORMAL	No action to be taken
PLANT FAULT	NWH - Estates ONWH - Estates (On-call rota)
PLANT EMERGENCY	NWH - Estates ONWH - Estates (On-call rota)
RESERVE LOW	NWH - Estates ONWH - Estates
PRESSURE FAULT	NWH - Estates ONWH - Estates (On-call rota)
Panel Indication (all alarm panels)	
Alarm Indication	ACTION (SECURITY TO INFORM)
Power On	No action to be taken
System Fault	NWH - Estates ONWH - Estates (On-call rota)

Diagram No. 1 Typical Medical Gas Alarm Panel

It is the responsibility of the AP (MGPS), to ensure that a procedure for each alarm indication is displayed next to the respective central alarm panel.

In the event of an Authorised Person not being available refer to M&M Medical 24hr Contact Details.

M&M Medical - Paul Sayer – 01443 227600 Mobile -07899997128

BOC – 0800 222888

15.0 Cylinder Management

15.1 Connecting Cylinders to the Manifold System (by Designated Persons)

15.1.1 Connect the cylinder to the equipment or manifold tail pipe and tighten firmly with the recommended key.

15.1.2 Ensure that no leaks are present at the junction between the cylinder valve and equipment and also between the valve spindle and gland nut.

15.1.3 The connection between the cylinder valve and equipment should be checked for leaks using an approved leak detector.

15.1.4 Regulators/manifolds or other equipment should only be used with the gas for which they are designed.

15.1.5 Prior to opening the cylinder valve, ensure the equipment flow control valves are closed.

15.1.6 When the cylinder is not being used the cylinder valve should be closed and the gas trapped within the regulator should be safely vented to atmosphere by opening the flow control valve and then closing it again.

16.0 Shutdown of the MGPS for Maintenance, Extension etc.

Pre-planned work on the MGPS requiring isolation of a plant, or part of the system, will be covered by the MGPS Permit to Work System.

No isolation should take place without full liaison between the Authorised Person (MGPS) and all other relevant disciplines.

All necessary emergency / additional gas supplies should be in place before the work starts. This may involve the provision of portable emergency supply systems and / or additional provision of cylinder regulators from the Estates Department.

Attempts should be made to reduce gas consumption during the work.

17.0 Generator Operation on Mains Failure

During changeover from electrical mains to emergency generator supplies, there is always a possibility that spurious MGPS alarms or changes in plant indications may be generated.

Consideration should be given to the statutory/planned generator tests that are planned to run every four weeks.

THESE ALARMS MUST BE INVESTIGATED IMMEDIATELY, as they could represent real, rather than false conditions The status of equipment such as compressors should also be checked, to ensure they are operating as selected: on / on stand-by / on duty mode / off.

Additionally, it must be remembered that:

Failure of generator and mains supplies simultaneously will results in failure of the central medical vacuum system.

It is important that medical / nursing staff are aware of this risk to the vacuum system and any patients using it.

All relevant staff must undertake training in the use of emergency vacuum equipment.
In areas where vacuum supply is considered critical, locally generated vacuum will have to be provided. However, with a failed electricity supply this will not be possible using the normal electrically driven portable suction units.

An alternative would be a BATTERY DRIVEN suction unit, but it is important that, with this type of unit the battery is maintained in a FULLY CHARGED condition.

Medical Vacuum Units are located on every department.

Failure of both mains and electricity supplies will also mean that the medical air compressors will not function.

Estates staff must ensure that all plant equipment and alarms have reset to full operating conditions on restoration of power.

18.0 Emergency Procedures

Use of Emergency reserve manifolds.

Emergency supply manifolds are attached to all medical gas systems.

18.1 Oxygen System

In the event of failure of the primary VIE (Vacuum Insulated Evaporator) oxygen supply on applicable sites, back up VIE will automatically supply the hospital with gas through 2 x back up manifolds. In the event of such a failure, the Estates Department are to be contacted via the numbers in Appendix C.

Where manifold provides the secondary supply.

Important: Cylinder manifolds have limited capacity in relation to the normal hospital demand supplied from a VIE, so additional manpower may be required in an emergency situation of this kind, both to change the cylinders on the manifold and to bring the replacement cylinders to the manifold.

Measures to reduce gas consumption may also need to be taken.

It is the duty of the Portering/pharmaceutical staff to ensure that sufficient J size cylinders are available to maintain the gas supply and that there is an emergency procedure in place for handling these cylinders with support of the site Authorised Person.

Note that the medical vacuum system has no emergency reserve manifold system. Failure of the plant for any reason will result in total failure of the vacuum service.

18.2 Emergency Cylinder Ordering Procedure

See Medical Gas Cylinder Policy

18.3 Failure of Mains Electricity Supply

In the event of an electricity failure, medical gas supplies should be maintained by the emergency generator system (The 'Essential' supply).

The surgical compressed air plant, vacuum plant, oxygen system, all manifolds and medical gas alarm systems are connected to the 'essential' electricity supply and will continue to provide and monitor gas supplies as normal.

18.4 In the Event of Failure of Both Mains and Generator Supplies:

The oxygen system will continue to supply gas from it's VIE or secondary supply manifold system.

The vacuum plant will not operate and central vacuum service will be lost.

Alarm panels will display a 'System Failure' red warning light and give an audible alarm.

If the electricity supply to an alarm panel only is interrupted, the panel will display a 'System Failure' red warning light and emit an audible alarm; gas supplies will not be affected.

In any of these events:

The Authorised Person (MGPS) will be informed of the situation, via the Designated Medical / Nursing Officer / Nursing staff / Telephonist.

Portering and Estates will arrange for staff to monitor manifold gas consumption, replacing empty cylinders as necessary, until the electricity supply is restored.

The Authorised Person will arrange emergency cylinder / regulator supplies as necessary.

The Authorised Person (MGPS) will monitor the situation and confirm re-setting of compressor and vacuum plant and system alarms following restoration of supply.

18.5 A Serious Leak of Medical Gases

In these events:

The Duty Porter and the Authorised Person (MGPS) will be contacted by the Telephonist / Duty Nurse.

Details of the leak should be confirmed: i.e. the floor level, department, room number, the gas or gases involved and if patient ventilators are in use.

Outside normal working hours the On-call Engineer will notify the Authorised Person (MGPS) Estates Manager On call.

It is the responsibility of the Senior Clinician to carry out isolation of medical gases to the area, after ascertaining that no patients will be put at risk in any area(s) affected by the isolation.

The Senior Clinician will issue appropriate instructions to make the situation safe, such as to open windows in the affected area and close doors, in accordance with the hospital Fire Policy.

The Duty Porter will remain on standby to provide extra gas cylinders as required.

The Authorised Person (MGPS) will arrange for repairs to the system(s) affected to be carried out under the Permit to Work system.

18.6 Total or Partial failure of a Medical Gas Supply

In these events:

The person discovering the failure will inform the Telephonist and Duty Nurse immediately.

The Telephonist will inform the Duty Senior Manager, the Duty Porter and the Duty Authorised Person (MGPS) of the leak.

Details of the failure should be confirmed: i.e. floor level, department, room number(s), the gas or gases involved and if patient ventilators are in use.

As a precautionary measure, the Telephonist will also notify critical areas e.g. First Floor Ward Inpatients that a failure has occurred on part of the system, so that they are prepared in the event of the fault extending to their departments.

It is the responsibility of the Senior Clinician to check which patients may have been put at risk by the failure and, if necessary, to arrange immediate emergency medical action.

Depending on the reason for the failure and its possible duration, the Authorised Person (MGPS) will decide the most appropriate method of long-term emergency gas provision.

This may involve establishing locally regulated cylinder supplies at ward / department entrances.

Nursing and medical staff should attempt to reduce gas consumption to a minimum during the emergency.

Portering staff will be required to monitor / replenish cylinders at any emergency stations and at Plant Room emergency supply manifolds.

Pharmacy will arrange emergency cylinder deliveries as necessary.

The Authorised Person (MGPS) will liaise with the Competent Person (MGPS) to complete emergency repairs needed to re-instate the gas supply, using the Permit to Work system.

When the supply is fully restored, the Authorised Person (MGPS) will complete a Critical Incident Form and produce a full report, which will be given to the General Manager within 24 hours of the incident.

In situations where it is envisaged that there will be long term loss of oxygen, vacuum or medical air services, the Duty Senior Manager will liaise with clinical colleagues, including the Designated Medical / Nursing Officer, the Clinical Director and the Authorised Person (MGPS) on the need for transfer of critically ill patients to (premises), as department closure may be warranted in extreme events.

18.7 Contamination of a Medical Gas Supply:

It is not unusual for a smell to be noticed when using ‘plastic’ equipment hoses to deliver gas to a patient. This smell usually disappears rapidly after first use of the hose and will generally be familiar to operatives.

However, if either operatives or patients complain of any unusual or strong smells from equipment, the situation MUST be treated seriously and IMMEDIATE action taken to ascertain the cause.

Where it is obvious that the smell is coming from the pipeline rather than a piece of connected equipment, the GAS SUPPLY MUST NOT BE USED.

In such an event the fault should be treated as a complete gas failure to that area and the actions described above taken IMMEDIATELY.

It is very important that if such an incident occurs the Telephonist advises ALL departments of the problem, especially those involved with critical care.

18.8 Contamination of Medical Vacuum System

Contamination of the medical vacuum system will usually be detected during routine maintenance inspection and evidenced by the presence of liquid in the on-line bacteria filter drain flask. The Consultant Microbiologist should be informed immediately and should advise on any additional precautions to effect filter change safely.

Portable suction units may be used in areas where there is a possibility of the vacuum system being contaminated. (The need for portable suction units should be discussed with the Consultant Microbiologist).

It is the responsibility of the Competent Person (MGPS) to change the filter in accordance with the procedure described in HTM 02-01 and any additional advice from the Consultant Microbiologist.

If the contamination is due to system misuse, the Authorised Person (MGPS) must complete an Incident Report Form. The form is to be sent to the General Manager so that the appropriate Clinical Manager can be informed, and remedial action taken.

Decontamination of pipework (if necessary) should be carried out in accordance with the procedure described in HTM 02-01 BEFORE filters are changed.

18.9 Failure of an Anaesthetic Gas Scavenging System (AGSS)

Failure of an anaesthetic gas scavenging system results in spillage of gaseous/ vaporised anaesthetic agents into the area of use of the system.

In Theatres it is likely that staff exposed to the spilled gases will exceed the COSHH recommendations for exposure when working in the area for extended periods, even though ventilation rates are high.

A local alarm ‘System fail’ warning and failure of the air receiver flow indicator will indicate failure of the system. Both should be inspected by Operating Department staff on a regular basis.

The Authorised Person (MGPS) and the Theatre Manager will be informed of the failure by the Theatre Technician and all attempts should be made to reduce staff exposure, if operations continue with a failed system.

When repairs have been completed (under a Permit to Work signed by the Theatre Nurse Manager, or their nominated deputy) Theatre staff should be made aware (by the person signing off the Permit to Work) that the system is back in use.

18.10 Over or Under Pressurisation of One or More Gas Systems

Local alarms are designed to indicate when system pressure is more than 20% above or below its norm.

Excessively high or low pressures may cause medical equipment to malfunction.

The Senior Clinician should report all instances of local alarm operation to the Telephonist. The Telephonist will then inform the Duty Senior Manager, the Duty Porter and the Authorised Person (MGPS).

18.11 Fire

Procedures in accordance with the hospital Fire Policy should be followed in the event of a fire involving, or likely to involve the MGPS.

During a fire the Senior Brigade Officer will assume full control of the area(s) affected.

Under no circumstance should medical gas supplies be isolates until the senior clinician has confirmed that all patients likely to be affected have been evacuated and/or have alternative gas provision.

Appendix A

19.0 Policy Signatories

This policy has been prepared and will be implemented and monitored by:

Name: Signature: Date:

This policy will be monitored and reviewed on a bi-annual basis.

Training needs associated with the policy will be co-ordinated by**.**

The Senior Authorised Person (MGPS) for medical gas systems within the Health Board is**.**

This policy is accepted by:

Chief Executive
Name: Signature: Date:

Authorised Person (MGPS)
Name: Signature: Date:

Name: Signature: Date:

Name: Signature: Date:

QC Pharmacist
Name: Signature: Date:

Signature: Date:

Senior Designated Nursing / Medical Officer
Name: Signature: Date:

Security and Portering Manager
Name: Signature: Date:

Infection Control Officer
Name: Signature: Date:

Signature: Date:

Fire / Safety Officer
Name: Signature: Date:

Assistance with the interpretation of this policy, or additional copies, can be obtained by contacting (Works and Estates Manager ******** Hospital).

Appendix B

20.0 Policy Circulation List for Velindre Cancer Centre.

Title	Name	MGPS Role	Contact number (Ward)
Head of Maintenance and Operations		N/A	
Estates Manager for the site		Authorised Person	
Estates Technician		Authorised Person	
Chief Pharmacist		Chief Pharmacist	
Head of Nursing		Designated Nursing Officer	
Pharmacist		QC Pharmacist	
Portering Manager		Designated Person	
On Call M+M Medical		On call Authorised Person	

Appendix C

Contacts for Velindre Cancer Centre.

21.0 Authorised Persons (MGPS)

Name	Contact number

21.1 Competent Persons (MGPS)

Name	Contact number

21.2 Designated Medical / Nursing Officers

Name	Title	Contact Number

21.3 Other Important Telephone Numbers

Name	Contact number	Out of hours contact number
Portering	Switchboard	
Pharmacy	Switchboard	
Gas Supplier (Emergency number)	BOC	

Appendix D

22.0 Site Specific Information for Velindre Cancer Centre.

22.1 Location of Oxygen supply for the Hospital

Main supply VIE. Located opposite Cancer Research Wales entrance
Back up supply located in manifold room opposite Cancer Research Wales.

22.2 Location of Medical Vacuum for the Hospital.

Located in plant room bunker 7+8.

Appendix E

23.0 Statutory Requirements Relevant to Medical Gas Pipeline Systems

Medical Gas Pipeline Systems are regulated by the Health and Safety at Work etc. Act, 1974 and all the relevant delegated legislation, such as regulations and statutory instruments enabled by the Act.

23.1 Other Guidance Applicable to Medical Gas Pipeline Systems

- Health Technical Memorandum (HTM) 02-01 'Medical Gas Pipeline Systems', 2005
- Volume 1, Design, Installation, Validation and Verification
- Volume 2, Operational Management
- Supplement No 1 'Dental Compressed Air and Vacuum Systems' 2003
- Supplement No 2 'Piped Medical Gases in Ambulance Vehicles' 1997
- National Health Service Model Engineering Specification, C11, 'Medical Gases', 1999
- European Pharmacopoeia Standards for medical gases, including medical compressed air
- Premises Health and Safety Policy
- Premises Fire Policy
- Any other relevant local guidance

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

Ref: PP 11

Operational Policy for High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)

Executive Sponsor & Function	Executive Director of Transformation, Planning and Digital
Document Author:	Assistant Director of Estates, Environment & Capital Development
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14th March 2024
Date of Equality Impact Assessment:	9th February 2024
Equality Impact Assessment Outcome:	Approved
Review Date:	March 2027
Version:	2

Contents

1.0 POLICY STATEMENT

Velindre University NHS Trust has issued a Policy for Management of High Voltage (HV) Electricity Supply Systems (Trust HV Policy) as part of the Corporate Health and Safety Policy.

This High Voltage Electricity Operational Policy (HV Operational Policy), using a Contractor as the Authorised Person (HV), is the practical implementation of the Trust HV Policy from which it derives its authority, it meets the requirements of *paragraph 3.2*a, *Health Technical Memorandum (HTM) 06-03: Electrical safety guidance for high voltage systems* and is required due to the inherent dangers.

2.0 DOCUMENT SCOPE AND PURPOSE

2.1 The HV systems serving the Trust healthcare properties shall be managed and operated in accordance with this document and *HTM 06-03* which should be followed as Best Practice. Adherence to these two documents should normally be sufficient to comply with the legislation relevant to HV systems (*Electricity at Work Regulations 1989*).

2.2 The arrangements contained in this document must be agreed in writing by the Authorising Engineer (HV).

2.3 The Policy applies to the HV systems in the following hospitals/buildings:

Velindre Cancer Centre
Welsh Blood Service

Summary details of the equipment at each site are detailed in Appendix 5.

3.0 ROLES AND RESPONSIBILITIES

3.1 The roles involved in the management and operation of HV electrical systems are defined in *HTM 00: Best practice guidance for healthcare engineering, HTM 06-03* and below. Additional roles or duties are defined below.

Appendix 1 names the individuals in the various roles.

3.2 **The Chief Executive** has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's HV electrical supply systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

3.3 **Director of Transformation, Planning and Digital** (*Executive Director*) will be charged with being the Designated Person (*as referred to in HTM 06-03)*. He/she is responsible for delivering the policy aims and aspirations. Has overall authority and responsibility for the HV electrical supply systems within

Velindre University NHS Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's
He/she should:

- Set out the standards and quality of service to be provided
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for High Voltage Electricity (AE(HV)).

3.4 HV Manager (This is a local arrangement not referred to in *HTM 06-03*.)
The HV Manager is appointed by the Trust and has the responsibility and authority to manage the HV systems to ensure they are operated and maintained safely.

In general, for the day-to-day operations, these powers will be delegated to the Trust HV Officers, see below.

The HV Manager shall manage:

- the work of the AP Contractor and may refer operational HV decisions by the AP Contractor to the Authorising Engineer (HV).
- the maintenance of non-HV work such as building work and related building services in high voltage areas.

3.5 HV Officer (This is a local arrangement not referred to in *HTM 06-03*)
The HV Officer (s) is an Operational Engineer with delegated authority from the HV Manager to manage the day-to-day operation of the HV system on a particular site.

The HV Manager and HV Officers:

- Shall be trained to recognise the danger of HV systems by the AP Contractor (see Paragraph 10)
- using the form in Appendix 6 shall transfer control of the HV systems to the AP Contractor following the guidance in Appendix 3
- shall control the keys giving entry to the HV areas.
- may issue *Limitation of Access (L.o.A.)* safety documents for non-HV work but only after consultation with the AP Contractor.

The HV Manager and HV Officers are NOT authorised to operate or maintain the HV system.

3.6 Authorising Engineer HV
The duties of the Authorising Engineer (AE) HV in *chapter 4, HTM 06-03*, shall apply in general to the AP Contractor, not the individual staff employed by the AP Contractor.

Audit Reports shall be sent to the Designated Person and copied to the HV Manager.

The AE (HV) may recommend the suspension of the AP Contractor or any employee to the HV Manager.

3.7 AP Contractor (This is a local arrangement not referred to in *HTM 06-03*)

The AP Contractor is a specialist contractor appointed by the Trust to receive Transfer and Control Certificates (TOCC), operate and maintain the HV systems, and train the HV Manager and Officers all in accordance with this policy.

The AP Contractor shall have the authority to stop any work on or around the HV systems serving the hospital which could damage the HV system or endanger lives.

The AP Contractor shall employ suitably qualified and experienced staff (Authorised and Competent Persons as defined in *HTM 06-03*).

Except in an emergency, the AP Contractor shall only undertake the duties following signed acceptance of a TOCC issued by the HV Officer.

The AP Contractor shall be fully conversant with:

- The HV distribution for the site
- *HTM 06-03, Electrical Safety Guidance for HV installations*
- This HV Operational Policy
- *The Electricity at Work Regulations 1989*
- *Health and Safety at Work etc Act 1974*
- *Report of Injuries Diseases and Dangerous Occurrences Regulations 1985 (RIDDOR)*

Any incident reports will also be copied to the HV Manager. When the incident involves high voltage then the Authorising Engineer (HV) shall also be advised and will carry out an investigation.

The AP Contractor shall give advice to an HV Officer on the issue of a *LoA*.
If the AP Contractor considers the work to be beyond the scope of the HV Officer, then the AP Contractor shall issue the *LoA*. See also Appendix 4.
If required by the HV Manager or the AE (HV), the AP Contractor shall remove an employee from the site and if necessary provide a replacement. Such actions would be subject to a review between the Trust and the AP Contractor.

4.0 DESIGN, OPERATION AND MAINTENANCE OF HV ELECTRICAL SYSTEMS – GENERAL PRINCIPLES AND REQUIREMENTS

4.1 The Trust HV Policy specifies the requirements for Design, Operation and maintenance of HV electrical systems.

4.2 Maintenance shall also include the buildings/enclosures and associated building engineering services but this work will normally be carried out by Trust staff or contractors working under an *L.o.A.* document.

5.0 ACCESS CONTROL TO DANGEROUS AREAS

5.1 HV switchrooms and other areas containing HV equipment shall be kept locked with access restricted to the HV Officer. Visitors must be accompanied by the HV Officer. See also 5.3 below.

The HV Officer can authorise access to the following people by issuing safety documents or a TOCC but has absolute authority and can deny or withdraw access at any time:

- Employees of the AP Contractor
- Those working under an L.o.A. safety document
- Anyone working with one of the above and under their direct supervision

5.2 Keys giving access to HV areas and equipment shall be controlled in accordance with *paragraphs 6.1-6.6, General Precautions, of HTM 06-03* except that for Authorised Person (HV) in the HTM, the text should be read as HV Officer

The *Site Logbook* shall be completed by the HV Officer on issue and receipt of keys.

5.3 Where HV areas contain equipment belonging to the DNO (*electricity infrastructure provider*) their staff have a legal right to enter at any time which is usually arranged by some form of joint key arrangement.

5.4 The HV Officer and the AP Contractor (*under the contract*) have the power to immediately exclude any person from the high voltage areas if they are considered to be acting in a manner likely to cause danger to themselves or others.

6.0 LIMITATION OF ACCESS SAFETY DOCUMENTS, *L.o.A.*

6.1 A *Limitation of Access* document and its use are defined in *Chapter 8 of HTM 06-03*. It is used for specific **non-HV** work to be undertaken in a HV area under the supervision of the HV Officer or AP (HV). An example would be the painting of a door.

6.2 A HV Officer can issue/cancel a *L.o.A.* as follows:

- A *L.o.A.* for simple work will normally be issued by the HV Officer **in consultation** with the AP Contractor. Refer to Appendix 4
- If the work to be carried out is in close proximity to HV equipment, then, for safety reasons, the AP Contractor will issue the *L.o.A.* documents. The division of responsibility will form part of the training of the HV Officer.

6.3 Since a craftsman is unlikely to be familiar with *HTM 06-03*, the meaning of paragraphs 4.23 to 4.29 must be explained and understood.

A printed copy of paragraphs 4.23-4.29, as well as a statement that "The CP (HV) and any assistants must NOT touch or interfere with the HV system" should be encapsulated and issued with the L.o.A., the issue being recorded on the L.o.A.

7.0 MONITORING/REVIEW PROCEDURE

Since the HV Operational Policy has differences from *HTM 06-03*, additional audit checks will be undertaken by the AE (HV) on the following:

- Emergency procedures
- Training, certification and appointment of the HV Officers
- The use and issue of Safety Documents and Transfer Control Certificates
- A check on the work carried out by the HV Officers
- The replacement, refurbishment and maintenance programme

8.0 OPERATING DOCUMENTS

8.1 Records for the operation and maintenance of HV electrical systems shall be available together with back-up copies, as detailed in *paragraph 1.16 of HTM 06-03*.

a. Suitable documents matching those in *HTM 06-03* shall be purchased from TSO.

8.2 The following manuals and documentation must be available for the operation and maintenance of HV systems and are held in the Estates Managers Office

8.3 Operational Procedure Manual (HTM document)

This holds the information listed in *paragraphs 8.12-8.17 of HTM 06-03*, and:

- Records of Appointments/Acceptances and Certificates for HV Officers
- Copy of Trust contract with AP Contractor
- HV Operational Policy
- Policy for SF6 equipment gas escape (if applicable)
- Copies of Transfer of Control Certificates (TOCC)

8.4 Operating and Maintenance Manual (HTM document)

This holds the information listed in *paragraphs 8.18-8.20* of *HTM 06-03* and:

- Site drawings showing HV system and standby generators
- Switchgear and transformer schedule for the system
- Protection grading charts for the system
- Maintenance and Inspection reports, see*, paragraphs 8.21-8.23, HTM 06-03*
- AP Contractor schedules of maintenance

8.5 Record Documentation Control

The HV Officer named in Appendix 1, has responsibility for the control and upkeep of all Operating Records as above and those in *Chapter 8 of HTM 06-03*.

9.0 SAFETY DOCUMENTS

9.1 The AP Contractor shall prepare a *Safety Programme* and issue/cancel *Safety Documents* as defined in *HTM 06-03*.

9.2 Subject to written agreement, the AP Contractor can use his own safety documentation in place of the *HTM Safety Programme and Safety Documents.*

9.3 The AP Contractor shall send either the original or a copy of the *Safety Programme and Documents* to the HV Officer identified in Appendix 1.

9.4 If only copies of safety documents are retained on the NHS site, then the AP Contractor must demonstrate to the AE (HV) that the originals are available for inspection at any reasonable time and stored as required by *HTM 06-03,* e.g. retained for 3 years.

10.0 TRAINING OF PERSONNEL

10.1 Training of AP Contractor staff

The AP Contractor must ensure its employees are adequately trained and that a register of training is maintained.

This should include Cardio-pulmonary resuscitation.

The Trust may request at any time to view the training records and reserves the right to refuse access to employees of the AP Contractor whom the Trust considers are not adequately trained.

10.2 Training of HV Officers

The AP Contractor will provide safety training for the HV Officers who will then be assessed by the AE (HV). HV Officers will be appointed in writing by the Trust. Refer to Appendix 4.
HV Officers shall be trained in cardio pulmonary resuscitation by the Trust.

11.0 PROGRAMME FOR MAINTENANCE OF HV SYSTEMS

11.1 The work shall be carried out as required in the contract between the Trust and the AP Contractor and the schedule of maintenance included in the Operational Procedure Manual. Any additional work specified by the manufacturer must also be undertaken and details recorded.

11.2 The Schedule of Maintenance should include as a minimum:

- Inspection and cleaning of the HV equipment and associated protection relays
- Partial discharge testing of the equipment
- Maintenance and testing of the switchgear and arc control/insulating medium (as applicable) as well as protection relays, including secondary injection

- Maintenance and testing of all transformers, including any necessary testing of and replacement of insulating medium (as applicable) and cleaning
- Maintenance and testing of battery tripping units (as applicable)

12.0 OPERATIONAL EQUIPMENT

All equipment required for switching, testing, earthing and safety padlocks shall be provided by the AP Contractor who shall be responsible for maintaining such equipment in good order. This shall include specialist equipment provided as part of the HV system by the Trust.

APPENDIX 1: LIST OF NAMED INDIVIDUALS

Designated Person: _____

HV Manager: _____

HV Officer with responsibility for document control: _____

Authorising Engineer (HV):
NHS Wales Shared Services Partnership – Specialist Estates Services

AP Contractor: _____

APPENDIX 2: DEFINITIONS

Health Technical Memorandum (HTM)
A suite of documents issued by the Department of Health which provides guidance on technical issues with particular relevance to NHS healthcare facilities.

Due to differences in NHS policy between England and the devolved administration in Wales, the Welsh Assembly Government may modify these documents for use in Wales.

HTM 06-03, Electrical safety guidance for high voltage systems. A Trust which follows this guidance should normally be doing sufficient to satisfy the requirements of the *Health and Safety at Work etc Act 1974* and the *Electricity at Work Regulations 1989.*

Users with access to the HOWIS intranet can find and download these documents on the Shared Services Partnership website at http://howis.wales.nhs.uk/sites3/page.cfm?orgid=254&pid=10859

Users who do not have access to HOWIS intranet can access the full list of HTMs and associated Status Notes on the Shared Services Partnership internet website at http://www.nwssp.wales.nhs.uk/publications-and-information. but not download the HTM documents.

Transfer of Control Certificate
The transfer document (see Appendix 6) allows the Trust to pass control of the HV electrical systems to the AP Contractor for switching or maintenance whilst ensuring that the effects on the hospital are fully understood and that any necessary precautions are in place to minimise effects on patient care.

APPENDIX 3: HIGH VOLTAGE PROCEDURES

PROCEDURES TO BE FOLLOWED TO ISSUE A TRANSFER OF CONTROL CERTIFICATE

Either the HV Officer will contact the AP Contractor if there is a problem with the electricity supply to the hospital. During working hours the telephone contact number is _____. At any other time a Help Desk can be reached on _____.

Or, the HV Officer and the AP Contractor will have previously made arrangements to carry out maintenance to the HV system.

1. The HV Officer will check that the AP Contractor employee attending is suitably authorised (this requirement will be part of the contract).
2. The HV Officer will issue access keys and accompany the AP Contractor to the sub-stations to ensure the AP Contractor is familiar with their geographical location. Logbook entries are required.
3. The AP Contractor will create a Safety Programme. NOTE that this should include details of any LV switching required.
4. **The AP Contractor should identify with the HV Officer which parts of the LV system (if any) will be affected by the programme.**
5. The HV Officer will decide whether a *Permission for disconnection or interruption of electrical services* form (Copy only in *HTM 06-02*) is required and make any arrangements necessary such as back up generation. It should be cross-referenced with the Transfer of Control Certificate, Appendix 6 (TOCC), and the copy stored in the Operational Procedure Manual.
6. When arrangements are complete, parts 1 and 2 of the TOCC should be completed to pass control of the HV system to the AP Contractor.
7. **The HV Officer is not trained or authorised to approve the HV work to be carried out by the AP Contractor.**

   The issue of the TOCC means only that the Trust has completed arrangements to protect the operation of the hospital (so far as possible), and the AP Contractor can start the HV work.
8. All LV switching required will be carried out by NHS staff but only when directed by the AP Contractor who will also fit any safety locks and signs.
9. On completion of the work to, the HV system, parts 3 and 4 of the TOCC will be signed off by the APContractor and the HV Officer. The Mimic Panel must now be adjusted by the AP Contractor to represent any changes.
10. The HV Officer shall ensure the Site Logbook for HV Systems is completed and paperwork filed.

APPENDIX 4: SAFETY TRAINING FOR Trust HV OFFICERS

1. As part of the contract, the AP Contractor shall conduct training so the HV Manager and nominated HV Officers at each site can understand the dangers of a HV installation and are considered competent to enter the HV sub-station/compounds alone without putting themselves at risk.

2. Training should also ensure each candidate:

   - Is considered competent to supervise visitors to the sub-stations/compounds and, if required, issue to (in consultation with the AP Contractor) and supervise a person working on a **L.o.A.** document for minor building works, such as painting, re-lamping, checking fire alarms. Note that all work on L.o.A. documents will require direct supervision by the HV Officer or AP Contractor.

   - Understands that neither the HV Officer nor any visitors nor persons on L.o.A. documents can under ANY circumstances touch or interfere in any way with the HV equipment (this will also be emphasised on HV Officer appointment letters from the Trust).

   - Is competent to decide when work located close to the HV systems should be risk assessed with the AP Contractor to issue the L.o.A. instead of the HV Officer.

3. If satisfied, the AP Contractor should certify competence in writing to the HV Manager for each nominated staff member to be appointed as a HV Officer using the draft form attached.

4. Each nominated HV Officer will then be interviewed by the AE (HV) who will recommend (or not) that they be appointed.

   The HV Manager will then arrange for them to be appointed by the Trust using the draft forms and certificate attached.

4. **If the AP Contractor is unwilling to certify that a particular Trust employee put forward for training is competent to act as an HV Officer they should make their concerns known to the HV Manager at the time.**

5. The training and certification process should be repeated every three years and will form part of the audit procedure conducted by the Authorising Engineer (HV).

6. Cardio-Pulmonary Resuscitation training will be provided by the Trust to staff members.

7. The AE (HV) will also provide training in the use and completion of *Limitation of Access* documents.

APPENDIX 5: SUMMARY OF HV ELECTRICAL SYSTEMS

_____Hospital, Velindre University NHS Trust

(Insert details of switchgear etc. Note that these details are provided to give an overview of each site but should not be relied upon as a definitive statement)

APPENDIX 6: TRANSFER OF CONTROL CERTIFICATE FOR HIGH VOLTAGE SUPPLY SYSTEMS

Velindre University NHS Trust **Serial Number……**

ESTATES DEPARTMENT:
TRANSFER OF CONTROL CERTIFICATE FOR HIGH VOLTAGE SUPPLY SYSTEMS

Part 1

I, ……the representative of the AP Contractor……..wish to carry out the following high voltage works or switching at
……. Hospital.
……..
……..
……..
……..
Safety Document No (s): …… will be issued for this work.
Your agreement to proceed is required taking full account of any local hospital restrictions relating to the HV/LV installation.

Signed:…… Print Name: ……

Designation: ……...Date:…… Time: ……

Part 2

AGREEMENT by HV Officer
Agreement to the above works is made on behalf of the HB/Trust and note should be taken of the following circumstances (if none write NONE). Any arrangements necessary to protect hospital services have been completed.
Permission for disconnection form No.……
……..
……..

Signed:…… Print Name: ……

Designation: HV Officer .Date:…… Time: ……

CLEARANCE

Part 3
As the Authorised Person I hereby declare that the work for which this certificate was listed is now suspended/completed (delete as necessary) and that the system is safe and operational.

Signed:…… Print Name: ……

Designation: ……Date:…… Time: ……

Part 4
Clearance is noted and the HV system accepted back on behalf of …… Hospital

Signed:…… Print Name: ……

Designation: HV Officer Date:…… Time: ……

Ref: PP12

Operational Policy for
High Voltage Electricity Supply Systems

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Assistant Director of Estates, Environment, Capital Development
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14th March 2024
Date of Equality Impact Assessment:	9th February 2024
Equality Impact Assessment Outcome:	Approved
Review Date:	March 2027
Version:	2

Contents

1.0 POLICY STATEMENT

Velindre University NHS Trust has a statutory responsibility to manage the electricity supply systems in each of its health premises in accordance with the *Health and Safety at Work etc Act 1974* and in particular *The Electricity at Work Regulations 1989.*

In recognition of these responsibilities the Trust has issued this High Voltage (HV) Electricity Operational Policy. It meets the requirements of *paragraph 3.2*a, *Health Technical Memorandum (HTM) 06-03: Electrical safety guidance for high voltage systems* and is required due to the inherent dangers.

2.0 DOCUMENT SCOPE AND PURPOSE

2.1 The HV systems serving the Trust healthcare properties shall be managed and operated in accordance with this document and *HTM 06-03* which should be followed as Best Practice. Adherence to these two documents should normally be sufficient to comply with the legislation relevant to HV systems (*Electricity at Work Regulations 1989*).

2.2 The Policy must be read in conjunction with *The Electricity at Work Regulations 1989, Health Technical Memorandum (HTM) 00: Best practice guidance for healthcare engineering* and *HTM 06-03: Electrical safety guidance for high voltage systems*.

2.3 *HTM 06-03* must be followed as best practice, not guidance, since following it should normally be sufficient to meet the requirements of the relevant legislation. In the event of any queries or conflicts with other documents the Authorising Engineer (HV) should be consulted.

3.0 ROLES AND RESPONSIBILITIES

3.1 The roles involved in the management and operation of HV electrical systems are defined in *HTM 00: Best practice guidance for healthcare engineering, HTM 06-03* and below.

3.2 **The Chief Executive** has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's HV electrical supply systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

3.3 **Director of Transformation, Planning and Digital** (*Executive Director*) will be charged with being the Designated Person (*as referred to in HTM 06-03)*. He/she is responsible for delivering the policy aims and aspirations. Has overall authority and responsibility for the HV electrical supply systems within Velindre University NHS Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's

He/she should:

- Set out the standards and quality of service to be provided
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for High Voltage Electricity (AE(HV)).

3.4 Authorising Engineer (HV)

The duties of the Authorising Engineer (AE (HV)) is defined in *chapter 4, HTM 06-03, paras, 4.7-4.13*.

Audit reports shall be sent to the Designated Person and copied to the Authorised Person.

3.5 Authorised Person (HV)

The duties of the Authorised Person (HV), is defined in *chapter 4. HTM 06-03, paras, 4.14-4.22.*

He/she should be solely responsible for:

- The practical implementation and operation of *HTM 06-03, and*
- The systems and installations for which management is in control of danger and for which the Authorised Person (HV) has been appointed.

3.6* Competent Person (HV) (*normally an appointed contractor)

Is a person with adequate knowledge and training to undertake work on systems as designed by engineering managers, In particular:

- Carry out planned preventative maintenance (PPM) routines and repairs as instructed by the Estates Manager and provide feedback on performance and maintenance issues.
- To ensure all health and safety, COSHH, Trust policies and procedures and risk assessments are adhered to at all times.
- To leave work areas clean and tidy.
- To report any maintenance defects or required changes to PPM routines or asset data.
- Record work carried out on High Voltage systems, in system log books.
- Ensure that appropriate records are kept for maintenance, testing and validation work, in a format readily retrievable for audit purposes.

4.0 DESIGN, OPERATION AND MAINTENANCE OF HV ELECTRICAL SYSTEMS – GENERAL PRINCIPLES AND REQUIREMENTS

4.1 The Trust HV Policy specifies the requirements for Design, Operation and maintenance of HV electrical systems.

4.2 HV systems owned by the Trust shall be:

- designed, installed and tested in accordance with current standards prior to being commissioned so they are safe for use.
- operated within their safe design capacity and in accordance with the HV Operational Policy.
- protected against adverse or hazardous environmental conditions

4.3 Due to the very specialist nature of the equipment, the Trust shall employ an external specialist as the Maintenance Contractor.

5.0 ACCESS CONTROL TO DANGEROUS AREAS

5.1 HV switch rooms and other areas containing HV equipment shall be kept locked with access restricted to the Authorised Person (HV). Visitors must be accompanied by the Authorised Person (HV). See also 5.3 below.

The Authorised Person (HV) can authorise access to the following people by issuing safety documents or a TOCC but has absolute authority and can deny or withdraw access at any time:

- Employees of the HV Contractor
- Those working under an L.o.A. safety document
- Anyone working with one of the above and under their direct supervision

5.2 Keys giving access to HV areas and equipment shall be controlled in accordance with *paragraphs 6.1-6.6, General Precautions, of HTM 06-03.*
The *Site Logbook* shall be completed by the Authorised Person (HV) on issue and receipt of keys.

5.3 Where HV areas contain equipment belonging to the DNO (*electricity infrastructure provider*) their staff have a legal right to enter at any time which is usually arranged by some form of joint key arrangement.

5.4 The Authorised Person (HV) and the HV Contractor (*under the contract*) have the power to immediately exclude any person from the high voltage areas if they are considered to be acting in a manner likely to cause danger to themselves or others.

6.0 LIMITATION OF ACCESS SAFETY DOCUMENTS, *L.o.A.*

6.1 A *Limitation of Access* document and its use are defined in Chapter 8 of HTM 06-*03*. It is used for specific **non-HV** work to be undertaken in a HV area under the supervision of the Authorised Person (HV). An example would be the painting of a door.

6.2 Since a craftsman is unlikely to be familiar with *HTM 06-03*, the meaning of paragraphs 4.23 to 4.29 must be explained and understood.

A printed copy of paragraphs 4.23-4.29, as well as a statement that "The CP (HV) and any assistants must NOT touch or interfere with the HV system" should be encapsulated and issued with the L.o.A., the issue being recorded on the L.o.A.

7.0 MONITORING/REVIEW PROCEDURE

Auditing the safe operation and maintenance of the HV electrical system is detailed in Appendix 3 of *HTM 06-03* and, generally, is the responsibility of the Authorising Engineer (HV).

8.0 OPERATING DOCUMENTS

8.1 Records for the operation and maintenance of HV electrical systems shall be available together with back-up copies, as detailed in *paragraph 1.16 of HTM 06-03*.

a. Suitable documents matching those in *HTM 06-03* shall be purchased from TSO.

8.2 The following manuals and documentation must be available for the operation and maintenance of HV systems and are held in the Estates Managers Office.

8.3 Operational Procedure Manual (HTM document)

This holds the information listed in *paragraphs 8.12-8.17 of HTM 06-03*, and:

- Records of Appointments/Acceptances and Certificates for Authorised Persons
- Copy of Trust contract with AP Contractor
- HV Operational Policy
- Policy for SF6 equipment gas escape (if applicable)
- Copies of Transfer of Control Certificates (TOCC)

8.4 Operating and Maintenance Manual (HTM document)

This holds the information listed in *paragraphs 8.18-8.20* of *HTM 06-03* and:

- Site drawings showing HV system and standby generators
- Switchgear and transformer schedule for the system
- Protection grading charts for the system
- Maintenance and Inspection reports, see*, paragraphs 8.21-8.23, HTM 06-03*
- AP Contractor schedules of maintenance

8.5 Record Documentation Control

The Authorised Person named in Appendix 1, has responsibility for the control and upkeep of all Operating Records as above and those in *Chapter 8 of HTM 06-03*.

9.0 SAFETY DOCUMENTS

9.1 The Authorised Person (HV) shall prepare a *Safety Programme* and issue/cancel *Safety Documents* as defined in *HTM 06-03*, table 1-2.

10.0 TRAINING OF PERSONNEL

10.1 Training of AP Contractor staff

The AP Contractor must ensure its employees are adequately trained and that a register of training is maintained.
This should include Cardio-pulmonary resuscitation.
The Trust may request at any time to view the training records and reserves the right to refuse access to employees of the AP Contractor whom the Trust considers are not adequately trained.

11.0 PROGRAMME FOR MAINTENANCE OF HV SYSTEMS

11.1 The work shall be carried out as required in the contract between the Trust and the AP Contractor and the schedule of maintenance included in the Operational Procedure Manual. Any additional work specified by the manufacturer must also be undertaken and details recorded.

11.2 The Schedule of Maintenance should include as a minimum:

- Inspection and cleaning of the HV equipment and associated protection relays
- Partial discharge testing of the equipment
- Maintenance and testing of the switchgear and arc control/insulating medium (as applicable) as well as protection relays, including secondary injection
- Maintenance and testing of all transformers, including any necessary testing of and replacement of insulating medium (as applicable) and cleaning
- Maintenance and testing of battery tripping units (as applicable)

12.0 OPERATIONAL EQUIPMENT

All equipment required for switching, testing, earthing and safety padlocks shall be provided by the AP Contractor who shall be responsible for maintaining such equipment in good order. This shall include specialist equipment provided as part of the HV system by the Trust.

APPENDIX 1: DEFINITIONS

Health Technical Memorandum (HTM)
A suite of documents issued by the Department of Health which provides guidance on technical issues with particular relevance to NHS healthcare facilities.

Due to differences in NHS policy between England and the devolved administration in Wales, the Welsh Assembly Government may modify these documents for use in Wales.

HTM 06-03, Electrical safety guidance for high voltage systems. A Trust which follows this guidance should normally be doing sufficient to satisfy the requirements of the *Health and Safety at Work etc Act 1974* and the *Electricity at Work Regulations 1989.*

Users with access to the HOWIS intranet can find and download these documents on the Shared Services Partnership website at
http://howis.wales.nhs.uk/sites3/page.cfm?orgid=254&pid=10859

Users who do not have access to HOWIS intranet can access the full list of HTMs and associated Status Notes on the Shared Services Partnership internet website at http://www.nwssp.wales.nhs.uk/publications-and-information. but not download the HTM documents.

Transfer of Control Certificate
The transfer document (see Appendix 6) allows the Trust to pass control of the HV electrical systems to the AP Contractor for switching or maintenance whilst ensuring that the effects on the hospital are fully understood and that any necessary precautions are in place to minimise effects on patient care.

Ref: PP 13

ELECTRICAL LOW VOLTAGE POLICY

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Environmental Officer
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14th March 2024
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Equality Impact Assessment Outcome:	Approved
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Contents

1. Policy Statement

The organisation recognises and accepts its responsibilities and legal obligations in accordance with current legislation and is committed to protecting the rights of its patients, visitors and staff in respect of the operation of electrical systems.

Velindre University NHS Trust, will ensure that all electrical systems, are installed, inspected, serviced and maintained in accordance with all Statutory Instruments, NHS Guidelines, Health Technical Memoranda or similar, to ensure that such equipment does not pose a health or operational risk to either, staff, patients or members of the public.

2. Scope of Policy

This policy applies to all persons (staff, contractors, patients and members of the public)
who may be affected by any electrical activity arising from works (including use or contact with equipment) carried out on Trust premises or leased property. It also applies to all electrical activities undertaken by employees and/or contractors when working at other locations.

3. Aims and Objectives

This document will detail the Trust's policy to achieve safety in all its electrical activities in compliance with its legal and statutory obligations and to ensure that all electrical equipment and systems are maintained in a safe condition and that only competent persons are permitted to work with, repair or maintain electrical systems or apparatus.

4. Responsibilities

The Trust has a management responsibility to ensure inspection, service and maintenance activities are carried out safely without hazard to staff, patients or members of the public.

4.1 The Chief Executive

The Chief Executive has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's electrical

systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

4.2 Executive Director of Strategic Transformation, Planning and Digital

The Executive Director will be charged with being the Designated Person, under HTM 06-02. He/she is responsible for delivering the policy aims and aspirations. Has overall authority and responsibility for the low voltage systems within the Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's.
He/she should:

- Set out the standards and quality of service to be provided.
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for Low Voltage Electricity (AE(LV)).

4.3 Estates Manager

The Estates Manager is responsible for ensuring that all electrical systems are inspected, serviced, verified, maintained and tested in a safe manner without hazard to staff, patients or members of the public.
The Estates Manager shall ensure that:

- All systems are identified and subjected to testing by an Authorised person.
- Maintain a register of Authorised Persons.
- Ensure that appropriate reactive and planned preventative maintenance arrangements are put in place to deliver to the aims of this policy.
- Have in place a procedure for assessing Competent Persons.
- Ensure that only individuals assessed as being competent and included on the register are used by sub-contractors. i.e. it is the individual not the contractor that needs to be assessed.
- Ensure that competent persons undertake regular maintenance on electrical systems and equipment.
- Ensure that the policy and procedures are implemented by a range of in-house or contracted services.
- Audit the effectiveness of the arrangements and arrange corrective action.
- Report any deficiencies which cannot be addressed within delegated limits of resource and authority.
- Ensure that electrical systems are independently verified annually in accordance with H.T.M 06-02 Electrical Safety Guidance for Low Voltage Systems.
- Arrange for any adverse incident to be investigated by the Authorising Engineer and for the dissemination of related advice.

4.4 Project Managers

Have the responsibilities to ensure that:

- All new installations meet the latest legal and technical standards.
- A suitably qualified person is involved in the design of all new installations and that commissioning and performance checks are undertaken and documented.
- All new installations are accessible and maintainable without resort to specialist access equipment or the need for removal of finishes/infrastructure.
- That maintenance teams have comprehensive operations and maintenance manuals (O&M), handed over on completion of schemes.
- That appropriate training and familiarisation is provided to in house and contract teams.
- That all new designs or major modification to existing systems are checked by the Authorising Engineer prior to the commencement of work.
- That all new installations are independently validated prior to contract completion.
- That all variations from the standards set out within H.T.M 06-02 Electrical Safety Guidance for Low Voltage Systems, are listed and agreed in writing by the Authorising Engineer / Estates Manager, prior to implementation.

4.5 Authorising Engineer (Low Voltage) (AE(LV))

Is defined as a person designated by management to provide independent auditing and advice on Low Voltage electrical systems and to review and witness documentation on validation/verification.
He/she shall:

- Provide a service in accordance with H.T.M 00 Policies and Principles of Healthcare Engineering.
- Advise on technical compliance with H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.
- Advise on interpretation of H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.
- Assess and make recommendations for the appointment of Authorised Persons.
- Monitor the performance of the service and undertake an annual audit.
- To investigate any adverse incident and report on any findings.
- Advise on the consequences of any proposed variation from the standards given within H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.

4.6 Authorised Person (Low Voltage) (AP(LV))

Will be an individual possessing adequate technical knowledge and having received appropriate training, appointed in writing (following advice from the AE (LV)), who is responsible for the implementation and operation of Management's safety policy and procedures relating to the engineering aspects of Low Voltage Electrical systems in accordance with current HTMG guidance

4.7 Competent Person (Low Voltage) (CP(LV)

Is a person with adequate knowledge and training and practical skills to undertake work on systems as designed by engineering managers. In particular:

- Carry out planned preventative maintenance (PPM) routines and repairs as instructed by the Estates Manager and provide feedback on performance and maintenance issues.
- To ensure all health and safety, COSHH, Trust policies and procedures and risk assessments are adhered to at all times.
- To leave work areas clean and tidy.
- To report any maintenance defects or required changes to PPM routines or asset data.
- Record work carried out on individual Low Voltage Electrical systems, in system log books.
- Ensure that appropriate records are kept for maintenance, testing and validation work, in a format readily retrievable for audit purposes.

4.7b Skilled Person (Low Voltage)A person who possesses, as appropriate to the electrical work to be undertaken, adequate education, training and practical skills, and who is able to prevent danger, or where appropriate, injury, and has been assessed to be competent by the Authorised Person (LV) for a specific electrical task and is aware of specific requirements from HTM06-02 with regard to the task but has not been formally appointed in writing as a Competent Person (LV).

4.8 Accompanying Safety Person

An accompanying Safety Person is a person not directly involved with the work or test, who has received training in emergency first aid for electric shock and who has adequate knowledge, experience and the ability to avoid danger, keep watch, prevent interruption, apply first-aid and summon help. The person should be familiar with the system or installation being worked on or testes and should have been instructed on the action to be taken to safely rescue a person in the event of an accident.

4.9 User

The person responsible for the management of the unit in which the electrical system is installed, for example, head of department, operating theatre manager, head of laboratory, production pharmacist, head of research or any other responsible person.

Definitions

4.10 Limitation-of-access

This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to a person in charge of work to be carried out in an area or location which is under the control of an Authorised Person (LV) and for which a permit-to-work, LW1,LW2 or certificate of authorization for live working areisnot appropriate.

4.11 Permit-to-work (electrical LV)

This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to a Competent Person (LV) or skilled person (LV) in charge of work to be carried out. It defines the scope of the work to be undertaken and makes known exactly what equipment is dead, isolated from all live circuit conductors and safe to work on.

4.12 Safety signs

- **Caution sign** is a temporary, non-metallic sign bearing the words “caution – persons working on equipment” and “do not touch” which is to be used at a point-of-isolation.
- **Danger sign** is a temporary, non-metallic sign bearing the words “danger live equipment” and “do not touch” which is to be used where there is adjacent live equipment at the place of work.
- **Switchroom sign** is a permanent, no-metallic sign bearing the words, “electrical Switchroom” and “no unauthorised access”

4.13 Voltage range

- **Extra low voltage,** a potential not exceeding 50V ac or 120 V ripple- free dc whether between conductors or to earth.
- **Low voltage (LV),** a potential not exceeding 1000V ac or 1500 V dc between conductors, or 600V ac or 900V dc between a conductor and earth.
- **High voltage (HV),** a potential normally exceeding low voltage.

5. Training and other resource implications for this policy

Training should be of an appropriate level, depending on roles and responsibilities, and outlined in the Divisions/Hosted Organisations local procedures. Managers have the responsibility to inform relevant employees and contractors of any hazards that may exist when carrying out maintenance work, operation, testing or other repairs to equipment within their department. All staff, whether working for the Trust or as partners who have duties under this policy should receive appropriate training. Tradespersons are to be made aware of the dangers from electrical shock, injury or burns. The information given should include: -

- The nature and type of risks to health where applicable
- Control measures employed
- Working procedures/policies

All records of training are to be maintained by the Estates Directorate.

Arrangements shall be made by the appropriate manager to ensure: -

i. That all employees concerned with particular work activities are adequately informed as to the systems, plant and apparatus that are affected, and instructed in all safety procedures.
ii. So far as is reasonably practicable, that other persons who are not employees but may be affected by the work activities also receive adequate information and/or instruction.

6. Implementation/Policy Compliance

The Trust Board expects those tasked with managing aspects of electrical safety to:

- diligently discharge their responsibilities as benefits their position;
- have in place a clearly defined management structure for the delivery, control and monitoring of electrical works;
- have in place a programme for the assessment and review of electrical risks
- develop and implement appropriate protocols, procedures, action plans and control measures to mitigate electrical risks, comply with relevant legislation and, where practicable, codes of practice and guidance;
- develop and disseminate appropriate action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment, in regard to working on and using electrical equipment;
- develop and implement a programme of appropriate electrical safety training for all relevant staff;
- develop and implement monitoring and reporting mechanisms appropriate to the management of electrical safety.

7. Equality Impact Assessment Statement

A summary of the outcome of the EIA must be present on the front cover of the document.:

Either
This policy has been screened for relevance to equality. No potential negative impact has been identified.

Or
This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

8. Main Relevant Legislation and References

Statutory

- Confined Spaces Regulations 1997.
- Construction Design and Management Regulations 2015.
- Electricity at Work Regulations 1989.
- Electricity Safety, Quality and Continuity Regulations 2002.
- Health and Safety (Safety Signs and Signals) Regulations 1996.
- Health and Safety at Work etc. Act 1974.
- Management of Health and Safety at Work Regulations 1999.
- Manual Handling Operations Regulations 1992 (as amended 2002).
- Personal Protective Equipment at Work Regulations 1992 (as amended 2002).
- Provision and Use of Work Equipment Regulations 1998.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- Workplace (Health, Safety and Welfare) Regulations 1992.
- Dangerous Substances and Explosive Atmosphere Regulations 2002.

Guidance

- The Department of Health:

    a. Health Technical Memorandum 00 – Policies and Principles.
    b. Health Technical Memorandum 06-02 – Electrical safety guidance for low voltage systems.
    c. Health Technical Memorandum 06-03 – Electrical safety code for high voltage systems.

- The Institution of Electrical Engineers:

    d. Code of practice for in-service inspection and testing of electrical equipment.
    e. Guidance Note 3 – Inspection and testing.

- The Health & Safety Executive's:

    f. Avoidance of danger from overhead electric lines GS6.
    g. Avoiding danger from underground services HSG47.
    h. Electrical safety on construction sites HSG141.
    i. Electrical test equipment for use by electricians GS38.
    j. Electricity at work: safe working practices HSG85.
    k. Health and Safety (First Aid) Regulations 1981, Approved Code of Practice and Guidance.
    l. Keeping electrical switchgear safe HSG230.
    m. Maintaining portable and transportable electrical equipment HSG107.
    n. Memorandum of guidance on the Electricity at Work Regulations 1989 HSR25.
    o. Safety in electrical testing at work INDG354.

9. Audit and Monitoring

- The Planning, Performance and Estates Department will review the operation of the policy as necessary and at least every 3 years.

10. Policy Conformance / Non Compliance

- If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

Ref: PP 14

VENTILATION POLICY

Executive Sponsor & Function	Executive Director of Strategic Transformation, Planning and Digital
Document Author:	Assistant Director of Estates, Environment & Capital Development
Approved by:	Quality, Safety and Performance Committee
Approval Date:	14th March 2024
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Contents

1. Policy Statement

The organisation recognises and accepts its responsibilities and legal obligations in accordance with current legislation and is committed to protecting the rights of its patients, visitors and staff in respect of the operation of ventilation systems.

Velindre University NHS Trust, will ensure that all ventilation/air conditioning units (AHU's), are installed, inspected, serviced and maintained in accordance with all Statutory Instruments, NHS Guidelines, Health Technical Memoranda or similar, to ensure that such equipment does not pose a health or operational risk to either, staff, patients or members of the public.

2. Scope of Policy

This policy applies to all properties owned and maintained by the Trust, including properties leased, rented or occupied under lease or any other occupancy agreement.

The policy covers the maintenance of all ventilation/air handling equipment within Velindre University NHS Trust, to ensure a safe environment for both patients, staff and the public.

3. Aims and Objectives

The Policy has been developed to ensure compliance with existing legislation, helping ensure that good practice standards are applied to all ventilation systems in use within the organisation. The Policy will not only ensure the organisation complies with the law, it also fosters confidence amongst both public and staff that the organisation takes its responsibilities regarding maintenance of these systems seriously.
Implementation of the policy will:

- Ensure ventilation/air handling equipment is suitable for its intended use and is maintained to satisfactory performance levels.
- Contribute to the overall control of infection agenda within the Trust.
- Comply with Health and Safety legislation requirements.
- Maintain the health, comfort and environment for all patients, staff and public, by ensuring adequate heating and ventilation exists and it is fully functional.

4. Responsibilities

The Trust has a management responsibility to ensure inspection, service and maintenance activities are carried out safely without hazard to staff, patients or members of the public.

4.1 The Chief Executive

The Chief Executive has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's ventilation systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

4.2 Executive Director of Strategic Transformation, Planning and Digital

The Executive Director will be charged with being the Designated Person, under HTM 03-01, Part B. He/she is responsible for delivering the policy aims and aspirations. Has overall authority and responsibility for the ventilation systems within the Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's.
He/she should:

- Set out the standards and quality of service to be provided.
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for Ventilation (AE(V)).

4.3 Estates Maintenance Manager

The Estates Maintenance Manager is responsible for ensuring that all ventilation/air conditioning systems are inspected, serviced, verified, maintained and tested in a safe manner without hazard to staff, patients or members of the public.

The Estates Maintenance Manager shall ensure that:

- All systems are identified and subjected to testing by an Authorised person.
- Maintain a register of Authorised Persons.
- Ensure that appropriate reactive and planned preventative maintenance arrangements are put in place to deliver to the aims of this policy.
- Have in place a procedure for assessing Competent Persons.
- Maintain a register of Competent Persons.
- Ensure that only individuals assessed as being competent and included on the register are used by sub-contractors. i.e. it is the individual not the contractor that needs to be assessed.
- Ensure that competent persons undertake regular maintenance on ventilation systems and equipment.
- Ensure that the policy and procedures are implemented by a range of in-house or contracted services.
- Audit the effectiveness of the arrangements and arrange corrective action.

- Report any deficiencies which cannot be addressed within delegated limits of resource and authority.
- Ensure that ventilation systems are independently verified annually in accordance with H.T.M 03-01, part B Specialised ventilation for healthcare premises, Operation management performance verification.
- Arrange for any adverse incident to be investigated by the Authorising Engineer and for the dissemination of related advice.
- Maintaining critical ventilation & LEV system inventory and log books.

4.4 Project Managers

Have the responsibilities to ensure that:

- All new installations meet the latest legal and technical standards.
- A suitably qualified person is involved in the design of all new installations and that commissioning and performance checks are undertaken and documented.
- All new installations are accessible and maintainable without resort to specialist access equipment or the need for removal of finishes/infrastructure.
- That maintenance teams have comprehensive operations and maintenance manuals (O&M), handed over on completion of schemes.
- That appropriate training and familiarisation is provided to in house and contract teams.
- That all new designs or major modification to existing systems are checked by the Authorising Engineer prior to the commencement of work.
- That all new installations are independently validated prior to contract completion.
- That all variations from the standards set out within H.T.M 03-01, Specialised ventilation for healthcare premises Part A: Design, installation and commissioning. Systems, are listed and agreed in writing by the Authorising Engineer / Estates Manager, prior to implementation.

4.5 Authorising Engineer (Ventilation) (AE(V))

Is defined as a person designated by management to provide independent auditing and advice on ventilation systems and to review and witness documentation on validation/verification.
He/she shall:
Provide a service in accordance with H.T.M 00 Policies and Principles of Healthcare Engineering.

- Advise on technical compliance with H.T.M 03-01 Specialised Ventilation in Healthcare Premises, Part A and B.
- Advise on interpretation of H.T.M 03-01, Specialised Ventilation in Healthcare Premises, Part A and B.

- Assess and make recommendations for the appointment of Authorised Persons.
- Monitor the performance of the service and undertake an annual audit.
- To investigate any adverse incident and report on any findings.
- Advise on the consequences of any proposed variation from the standards given within H.T.M 03-01, Specialised Ventilation in Healthcare Premises.

4.6 Authorised Person (Ventilation) (AP(V))

Will be an individual possessing adequate technical knowledge and having received appropriate training, appointed in writing (following advice from the AE (V)), who is responsible for the implementation and operation of Management's safety policy and procedures relating to the engineering aspects of Ventilation systems.

4.7 Competent Person (Ventilation) (CP(V))

Is a person with adequate knowledge and training to undertake work on systems as designed by engineering managers. In particular:

- Carry out planned preventative maintenance (PPM) routines and repairs as instructed by the Estates Manager and provide feedback on performance and maintenance issues.
- To ensure all health and safety, COSHH, Trust policies and procedures and risk assessments are adhered to at all times.
- To leave work areas clean and tidy.
- To report any maintenance defects or required changes to PPM routines or asset data.
- Record work carried out on individual Ventilation systems, in system log books.
- Ensure that appropriate records are kept for maintenance, testing and validation work, in a format readily retrievable for audit purposes.

4.8 Infection and Prevention Control Team (IPCT

The IPCT will provide input into Estates on Capital projects and schemes, on infection control matters. They will ensure appropriate action is taken internally and externally by Consultants and Contractors commissioned and controlled by the organisation, to thereby reduce any risk of cross infection.

The IPCT will:

- Advise on monitoring infection control and microbiological performance of systems.
- Carry out or authorise the carrying out by an accredited laboratory, any microbiological tests as required.
- Provide infection control support to Estates staff as required in relation to infection control issues related to ventilation systems.

4.9 User

The person responsible for the management of the unit in which the ventilation system is installed, for example, head of department, operating theatre manager, head of laboratory, production pharmacist, head of research or any other responsible person.

5. Definitions

For the purpose of this document the following definitions apply:

5.1 Environment

Relates to the total space of an occupier's surroundings when in a healthcare premises, whether they are a patient, member of staff or a visitor. This includes the fabric of the building and related fixtures, fittings and services such as air and water supplies.

5.2 Ventilation

Is a means of removing and replacing the air in a space. This can be achieved simply, by opening windows and doors etc. Mechanical ventilation systems provide a more controllable method. Basic systems consist of a fan attached to distribution ductwork; more complex systems may include the ability to heat and filter the air passing through them. Ventilation equipment is used to remove smells, dilute contaminants and ensure that a supply of "fresh" air enters a space.

5.3 Air Conditioning Systems(AHU's)

Have the ability to heat, cool, humidify, dehumidify and filter air. AHU's allow the climate within a space to be controlled at a specific level, regardless of changes in the outside air conditions or the activities within the space. Within the healthcare environment there are two classes of Air Conditioning system, Critical systems and Non-critical systems. Examples are given below.

5.4 Critical Systems

These are ventilation systems which if taken out of service would seriously degrade the ability of the premises to deliver optimal healthcare.
These include:

- Operating Theatres of any type, including rooms for interventional investigations (for example catheter labs).
- Patient isolation facility of any type.
- Critical care, intensive treatment, or high dependency unit.
- Neonatal unit.
- Category 3 or 4 Laboratory or room.
- Linear Accelerators.

- Pharmacy aseptic suite.
- Inspection and packing room (IAP), in a sterile services department.
- MRI, CAT and other types of imaging technologies that require stable environmental conditions, to remain in calibration.
- Any other system that clearly meets the definition that “a loss of service from such a system would seriously degrade the ability of the premises to deliver optimal healthcare”.

5.5 Non Critical Systems

Non critical systems are general ventilation and extract systems in buildings.

6. Training and other resource implications for this policy

Training should be of an appropriate level, depending on roles and responsibilities, and outlined in the Divisions/Hosted Organisations local procedures. Managers have the responsibility to inform relevant employees and contractors of any hazards that may exist when carrying out maintenance work, operation, testing or other repairs to equipment within their department. All staff, whether working for the Trust or as partners who have duties under this policy should receive appropriate training. Tradespersons are to be made aware of the dangers. The information given should include:

- The nature and type of risks to health where applicable
- Control measures employed
- Working procedures/policies

All records of training are to be maintained by the Estates Directorate. Arrangements shall be made by the appropriate manager to ensure:

i. That all employees concerned with particular work activities are adequately informed as to the systems, plant and apparatus that are affected, and instructed in all safety procedures.
ii. So far as is reasonably practicable, that other persons who are not employees but may be affected by the work activities also receive adequate information and/or instruction.

7. Implementation/Policy Compliance

The Trust Board expects those tasked with managing aspects of ventilation safety to:

- diligently discharge their responsibilities as benefits their position;
- have in place a clearly defined management structure for the delivery, control and monitoring of ventilation works;
- have in place a programme for the assessment and review of electrical risks

- develop and implement appropriate protocols, procedures, action plans and control measures to mitigate ventilation risks, comply with relevant legislation and, where practicable, codes of practice and guidance;
- develop and disseminate appropriate action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment, in regard to working on and using ventilation equipment.

8. Equality Impact Assessment Statement

A summary of the outcome of the EIA must be present on the front cover of the document.:

Either
This policy has been screened for relevance to equality. No potential negative impact has been identified.

Or
This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

9. Main Relevant Legislation and References

Statutory

- Confined Spaces Regulations 1997.
- Construction Design and Management Regulations 2015.
- The Control of Substance Hazardous to Health (COSHH) 1998.
- Health and Safety (Safety Signs and Signals) Regulations 1996.
- Health and Safety at Work etc. Act 1974.
- Management of Health and Safety at Work Regulations 1999.
- Manual Handling Operations Regulations 1992 (as amended 2002).
- Personal Protective Equipment at Work Regulations 1992 (as amended 2002).
- Provision and Use of Work Equipment Regulations 1998.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- Workplace (Health, Safety and Welfare) Regulations 1992.
- Approved Code of Practice on the Prevention and Control of Legionella (L8) and associated documents (HSG 274 parts 1, 2 & 3)

Guidance

The Department of Health:

a. Health Technical Memorandum 00 – Policies and Principles.
b. Health Technical Memorandum 03-01 – Specialised Ventilation in Healthcare Premises Parts A and B
c. Health Technical Memorandum 04-01 – The Control of Legionella, Hygiene, safe hot water, cold water and drinking water systems (Parts A, B & C).

10. Audit and Monitoring

The Director for Transformation, Planning and Digital, will maintain an audit cycle for monitoring and review of compliance of this and other Estates policies within the Trust.

An independent annual audit will be undertaken by NWSSP, on all critical ventilation systems and a report issued to the Director for Transformation, Planning and Digital.

The Report will contain key performance indicators to confirm:

- Any Critical systems are clearly identified.
- Where the exist, that appropriate validation checks have been undertaken.
- That any non-conformance on systems is clearly documented and deemed satisfactory.
- That required plant investments are designed, installed and commissioned in line with current legislation.

11. Policy Conformance / Non Compliance

If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trust's Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

TRUST BOARD

PUBLIC QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	26th March 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Vicky Morris, Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	
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 14th March 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 October 2022, the Committee continues to mature, actively seeking opportunities for continuous improvement, together with the ongoing development of reporting formats, additional assurance mechanisms and discussions to facilitate ongoing streamlining and triangulation of information.

3. HIGHLIGHTS FROM THE MEETING HELD ON 14th MARCH 2024

3.1 Triangulated themes

Due to the Executive focus on essential matters related to the new Velindre Cancer Centre Final Business Case, the Risk Register and Trust Assurance Framework were not submitted for discussion at this Committee, this therefore presented a gap in effective triangulation. However, the following key themes were identified:

- Increasing demand and pharmacy capacity continue to present significant challenges within SACT (Systemic Anti-Cancer Therapy)
- Issues around patient experience in terms of booking and general communication
- Ongoing challenges related to manual workarounds.

Post note: An extraordinary QSP/ Audit Committee was held on the 21st March to consider the Corporate Risk register and Trust Assurance Framework, prior to Board consideration.

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 March 2023 QSP Committee meeting at:

https://velindre.nhs.wales/about-us/quality-safety-performance/quality-safety-performance-committee-2023/public-quality-safety-performance-committee-14032024/

3.3 Summary of Committee Highlights

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

ALERT / ESCALATE	There were no items for **alert/escalation** to the Board.
ADVISE	**Trust Performance Management Framework Report and Supporting Analysis for January 2023/24** *Including SACT Gold Command paper [addendum]* The Committee received the report which provided an overview of Trust-wide performance against key national performance targets and best practice standards through to the end of January 2024. With regards to the **Velindre Cancer Service** the following key points were highlighted:

- Radiotherapy - a slight decline in performance was noted, this is understood to be linked in part to the bank holidays over the Christmas period. A return to the pre-Christmas position by February is anticipated. Planning to compensate for the forthcoming Spring bank holidays and Linac replacement are underway.
- Falls - a relatively high number of eight falls were recorded, however there were no incidents of patient harm and all were found to be unavoidable. The Committee heard a report on discussions with the Quality and Safety Manager at the Cancer Centre who had been involved in the work of the falls scrutiny panel and had advised that, as a result of the excellent quality and improved documentation, several key areas of learning have been derived and the ward manager is developing some relevant patient information/advice to be placed at the bedside.

In terms of Systemic Anti-Cancer Therapy (SACT), the Committee received an overview of the current challenges, notably those in respect of pharmacy capacity and the significant increase in service demand. The Committee were informed of the Business continuity arrangements which had been in place since January and remain in place. Weekly meetings are held with the operational and executive teams and a number of related actions have been undertaken, in particular:

- Funding received from end of year monies to reconfigure capacity space within pharmacy which, once recruited into, will provide additional storage space and infrastructure to facilitate buying in additional SACT pharmaceuticals.
- Procurement contract to extend the Medicines at Home service with Lloyds Pharmacy beyond the current two days per week is in its final stages.
- Working with the wider service team to provide divisional-wide solutions in order to optimise pharmacy capacity.

The percentage growth in demand figures were queried, as these did not appear to correlate between the two documents presented. The Committee were advised that in the 23/24 financial year there was an anticipated increase in referrals of 8% which was based on 8% over and above outturn as at 31st March the previous year. This year an increase of 12% is anticipated, based on outturn at 31st March 2023. Following a detailed explanation of the forecasts for the Integrated Medium-Term Plan, concern was raised with regards to the projected cumulative impact on services, however it was understood that although the figures are high, similar demand forecasts are being observed nationally.

With regards **Workforce and Wellbeing** performance data, the following key points were highlighted:

- A downward trend in sickness absence is noted,
- Compliance with statutory and mandatory training maintained,
- PADR % compliance was not going to achieve the target before year end (23/24) – and the % compliance has dipped slightly. A full review of the PADR process is included in the work programme for 2024/25

The Committee were advised that work is underway to further develop the Key Performance Indicators (KPIs) around equality, diversity and inclusion in advance of the first cut of the Workforce Race Equality Standard in April.

With regards to the overall positive **Welsh Blood Service** data, the following key points were highlighted:

- The blue alert issued in December 2023 was lifted on 25th January 2024 and the service has managed to sustain this position over what has been a difficult period. A Task & Finish Group has been established to examine workforce related pressures in the collection clinic model.
- Particularly encouraging wastage figures and encouraging figures for stem cell collection which are beginning to return to pre-COVID conditions.

The Committee were advised that, following a detailed discussion at the January Committee in relation to bone marrow swab drives, the service is beginning to see particularly encouraging figures, significantly outperforming the target figure that has previously remained largely unchanged. Most notably it was highlighted that 40% of the volunteer recruitment are from black, Asian and other minority groups.

Policy Management Review and Compliance Status: October 2023 to February 2024
The Committee acknowledged receipt of the paper and whilst there was a positive tone in the paper in terms of increased compliance, the fact that 51 policies remain out of date, is of concern. All department leads have been requested to return to the May Committee with a clear plan regarding all out-of-date policies, with timescales to be applied.

Noting that a significant number of the out-of-date policies are in relation to Organisational Development and Workforce, the Committee understood that the team has been heavily impacted by the work associated with the recent industrial action. However, the planning phase is in progress with priority being given on a risk basis.

ASSURE	**Integrated Quality & Safety Group Highlight Report** *Including 2023-24 Quarter 3 Quality and Safety Report (inc. Putting Things Right)* The Committee received the report which covered the activities and outcomes of the Integrated Quality & Safety Group meetings held in January and February 2024. The following was highlighted: • Mortality Reviews - the group had received a reassuring presentation around the development of a process to ensure 30-day mortality from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy reviews are undertaken in line with best practice. Much work is underway to ensure a robust process is in place, with a view to full implementation across the Trust by September 2024. This will remain as a regular agenda item to ensure consistent monitoring of progress. • Incident Management and Learning Framework - both documents are progressing well and in line with project timelines. • Quality Priorities - following Audit Wales feedback proposed Quality Priorities have been identified and are included within the report to seek Committee approval. The Committee applauded the progress made in terms of the quality and safety tracker and were advised that alignment with the Audit Committee methodology is being considered for progression of actions awaiting approval. In terms of the AMaT system, the Committee were advised that a recent request to provide an update around a national enquiry proved to be a straightforward process as a result of the extensive work undertaken to move the actions across to AMaT. **2023-24 Quarter 3 Quality and Safety Report (inc. Putting Things Right)** An overall positive report covering the period 1st October 2023 to 31st December 2023 was presented to the Committee, providing a comprehensive overview of the key outcomes, trends and themes in respect of Complaints, Redress, Claims, Duty of Candour, Safety Alerts, Infection Prevention & Control and Safeguarding. The following key points were noted: • Clear, continuing themes remain within complaints around appointments, patient communication and treatment planning, • Patient and donor satisfaction scores remain high,

- Safeguarding training compliance has increased and a substantial increase in Mental Capacity Act/Deprivation of Liberty Safeguards training was noted. TJ reported positive engagement from the medics with the new Mental Capacity Act lead, whose work is already beginning to demonstrate real benefits and improvements.

Medical Examiner Service Report

The Committee received the report which provided assurance that the Trust is meeting the recommendations of the Medical Examiner's Service and are fully compliant.

Velindre Cancer Service Quality & Safety Divisional Report
Including CCTV & Email Audit

The Quality and Safety report covering the period October to December 2023 was presented to the Committee and the following key points were noted:

- Continued 100% compliance with Putting Things Right regulations related to concerns and complaints - improvements seen in terms of incidents closed within 30 days.
- A process for the management of the outcomes of serious incidents has been agreed. Once formally accepted each department will be required to develop an action plan which will be monitored through the divisional Quality and Safety Management Groups (QSMG) and to this Committee as appropriate.
- The Clinical audit team have joined the quality and safety team, this will improve triangulation between quality and safety, clinical audit, and service improvement.
- A more robust risk management process has been agreed through the division.
- 30/90-day mortality data reporting continues to present a challenge in terms of data quality.
- A successful joint pilot has been implemented with Aneurin Bevan University Health Board (ABUHB) for direct referral from the VCC Treatment helpline in to the ABUHB Same Day Emergency Care unit.
- Outpatient and Medical Records Management Group have drafted an improvement plan to address key themes previously highlighted to this committee, progress of which will be monitored through the QSMG.
- CCTV - All actions in relation to this issue are now closed, except for the one remaining action to re-audit following completion.
- Email audit - recommendations have been shared with EMB and a working group will be set up to take these forward.

	Workforce Supply and Shape & Associated Finance Risks The Committee received the report which provided an overview of the key workforce issues in delivering the correct supply and shape of the workforce. These were: • Recruitment and retention, • Ensuring a work environment that supports staff wellbeing, • Developing effective service and workforce planning. The paper also addressed the emerging risk of the availability of staff to deliver services due to vacancy gaps in specialist hotspot areas and staff absence due to sickness and detailed the strategic interventions and operational plans put in place to mitigate this risk, along with resulting improvement performance trajectories for 23/24 due to actions successfully implemented. The Committee noted an overall positive improvement performance trend as a result of the actions and workforce and service interventions undertaken. **Finance Report for the Period Ended 31st January 2024** The report which provides an overall positive review of the financial position and performance for the period to the end of January 2024 was presented. The following points were highlighted: • Key financial targets/KPIs - revenue, capital and public sector performance are all forecast to be delivered. The Committee noted that although the capital figures are shown in the table as red, a Welsh Government letter received since the report was published confirms the availability of the funding to cover the project costs within the new Velindre Cancer Centre. • Long Term Agreement (LTA) income & COVID recovery/planned care capacity - the latest trajectory, based on the December forecast, indicates that income will cover the cost of the Welsh Government-funded investment made in additional capacity during the COVID period. • All-Wales financial pressures - following receipt of a letter from the Health Minister regarding the current NHS Wales financial pressures, the Trust has identified a number of cost savings proposals to support the all-Wales position. In addition to this, an offer has been made to pass across an underspend in relation to the Trust's emergency reserve on a non-recurrent basis.

	Trust Estates Assurance Group Highlight Report This report was taken in the main section of the meeting, with the report providing a summary of the key issues for consideration and actions taken, by the Trust Estates Assurance Group during quarter 3 (2023/24) was received. The following points were noted: • Compliance standards were above benchmark targets in some areas across the Trust. However, within health and safety the training remains below benchmark in some areas. Bespoke training has been arranged in these areas, to improve this standard. • A new Violence and Aggression Module C, added in February 2024 is currently at 20.4% competency. This is now being progressed as a priority, although it was noted that this module has only recently become available. • Work is ongoing in relation to the assessment of risk of RAAC within the blood collection venues. The Committee will be updated when complete **Education Strategy Audit** The Committee received the Education Strategy Audit which, although largely positive, did highlight the need for a robust implementation plan to sit under the strategy. The other two recommendations were around evaluating and measuring success, the Committee noted that these themes triangulate with other workforce related audits previously received at this Committee. In terms of timelines, the Committee were given assurance that work is already well underway in relation to the development of the robust implementation plan and it is expected that this will be brought through the governance process in April. **Transforming Access to Medicine / Clinical Pharmacy Technical Services Update** The Committee received the report and the following key points were highlighted: • A programme of work is currently underway on an ad-hoc basis between Velindre Cancer Service (VCS) and NHS Wales Shared Services Partnership (NWSSP) to support the capacity issues within pharmacy • Medicines Unit are working with Welsh Government to implement the national influenza programme. NWSSP will, under Welsh

	Government direction, purchase, store and then distribute the influenza vaccine on a national basis. • Working with health boards across Wales to discontinue an infusion product due to the introduction of a subcutaneous injection which will improve capacity locally as patients will attend for a 15-minute injection rather than a longer infusion. In addition, the Committee were advised that the Medicines Value Unit within NWSSP, which sits within the pharmacy division, is currently undertaking a national piece of work around all-Wales drug contracting, which as well as developing an all-Wales pricing structure, an all-Wales Service Level Agreement will be in place which will improve the resilience of commercial suppliers and ensure that local services, such as VCS do not experience short-notice cancellations and delays in the delivery of medicines currently experienced across Wales. Further details will be provided to the Committee in due course.
INFORM	**Velindre Cancer Service - Patient Story** The Committee heard a powerful story of a current Velindre Cancer Service patient who was diagnosed with stage 4 cervical cancer and is currently receiving SACT treatment. Although the story demonstrated several areas of good practice within the service, a number of key issues were highlighted as a result of ongoing SACT capacity challenges, including continued poor communication and limited notice with regards to appointment times. The significant impact and psychological distress to the patient and their family as a result of these issues was clear and evident. The Committee were advised that the situation is being monitored on a weekly basis and work is underway to improve the communication of appointment times to patients. Efforts to maximise the capacity within Pharmacy are ongoing and service delivery methods are under review. **Trust Integrated Medium Term Plan - Progress Against Quarterly Actions for 2023 / 2024 (Quarter 3)** The Committee received this report covering the period October to December 2023 and providing an update on progress against the actions included within the IMTP for 2023/24. The report demonstrated good progress against the majority of actions, with Welsh Blood Service reporting delivery against all 15 actions and Velindre Cancer Service reporting delivery against 20 of the 22 actions. The two remaining actions are as follows:

	• Implementation of the national Transforming Access to Medicines (TrAMS) Model across the service • Implementation of the approved Full Business case for the development of the new Velindre Cancer Centre (nVCC) by 2025/26 (December 2025). **Integrated Medium Term Plan - Accountability Conditions** The report providing a progress update against the accountability conditions set by the NHS Wales Chief Executive and as laid out in their letter of 2nd October 2023, was received by the Committee. It was noted that all four of the accountability conditions are anticipated to be discharged accordingly, with actions plans in place where appropriate. **Amendment To Standing Orders - Schedule 3 - Terms Of Reference Review** Following a full discussion, the Committee were unable to endorse the amendments to the Committee's Terms of Reference at this stage due to a number of requested amendments. Out of Committee approval will be sought as appropriate. **Trust Policies for Approval** The following policies were approved by the Committee: Infection, Prevention and Control • IPC 00 – Framework Policy for Infection Prevention and Control • IPC 11 – Transport of Specimens Policy Planning, Performance and Estates • PP10: Medical Gas Piped Systems Policy • PP11: High Voltage Electricity Supply Systems using a Contractor as the Authorised Person • PP12: High Voltage Electrical Supply System Operational Policy • PP13: Electrical Low Voltage Policy • PP14: Ventilation Policy
APPENDICES	N/A

4. RECOMMENDATION

The Trust Board is asked to **DISCUSS** and **NOTE** the key deliberations and highlights from the meeting of the Quality, Safety & Performance Committee held on the 14th March 2024.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE Private Remuneration Committee

DATE OF MEETING	26.03.2024

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	
VERS	Voluntary Early Release
NWSSP	NHS National Wales Shared Services Partnership

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 14.03.2024.

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 no items for advising the Trust Board.
ASSURE	There are no items for assurance for the Trust Board.
INFORM	The Remuneration and Terms of Service Committee took the following actions in respect of NWSSP: • **APPROVED** two VERS applications submitted following the relocation of two NWSSP sites. • **APPROVED CONDITIONALLY** a VERS application pending clarification of financial information and assurance regarding legal advice received. • **NOTED** an update in respect of the Laundry Service changes, including the closure of one site. The Committee requested assurance that the accounting procedures relating to payments have been approved by the Director of Finance for the Trust. • **NOTED** a settlement agreement. The Remuneration and Terms of Reference Committee **NOTED** the Annual Cycle For Setting Executive Director Objectives. The committee **NOTED** the Retire and Return of one of the Executive Directors of the Trust. The Remuneration and Terms of Reference Committee **NOTED** the health circular in respect of Pay Arrangements For Staff on Executive and Senior Management Pay Scales. The committee **NOTED** the Industrial Action Financial Impact in respect of Junior Doctor industrial action in January 2024.
APPENDICES	N/A.

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

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	26.03.2024

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
RCN	Royal Collage of Nursing
OSCE	Objective Structured Clinical Examination

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 08.03.2024.

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
ADVISE	**Local Partnership Forum Terms of Reference** The terms of reference for the Local Partnership Forum were updated to include the Social Partnership and Procurement Act. The forum approved the revised Terms of Reference and will review in 12 months.
ASSURE	Nothing to assure
INFORM	**WOD Performance Report** LPF were informed that the performance report showed a downward trend in sickness at 5.35%, the trend has been ongoing since January 2023. Work continues to monitor sickness levels and work with service managers to address any issues and hotspots. High compliance continues with Mandatory and Statutory training at 86%. PADR compliance is at 74%. LPF were informed that the PADR process will be reviewed following the launch of the new Trust Values. **Trust Volunteer Framework – Engagement with LPF on Roles** The volunteer framework and the roles and processes for involving volunteers in the Trust were presented and discussed.

	LPF were informed of the work undertaken around the Volunteer Framework with a view to volunteers returning the Velindre Cancer Centre. The new framework has various role descriptors developed within and includes the introduction of micro volunteering, allowing people to volunteer for hours they have spare, alongside the more traditional arrangements. The various roles included in the information shared with LPF includes role profiles at different levels, acknowledging the fine balance between volunteer roles and what could be paid work. Extensive work has been undertaken to ensure best practice is taken into account, as well as plans to reward volunteer contributions and the difference they make to the organisation. It was agreed that LPF colleagues would provide any further feedback on the Volunteer Framework outside of the meeting. LPF noted the need for a conversation to ensure equality, diversity and the Welsh Language is fully embraced within the Framework. **Trust Wellbeing of Future Generations Objectives** The trust wellbeing objectives were reviewed and endorsed, with suggestions to make them more visible and accessible to staff. LPF noted the extensive engagement, with internal and external stakeholders, which resulted in amendments to the wellbeing objectives. **Trust Retention Plan** LPF received an update regarding nurse retention. Work has been ongoing with health boards and retention leads to establish a community of practice and develop a tool for organisations to utilise. Work has been undertaken to look at staff stories to increase understanding regarding staff remaining or leaving the organisation. **Trust Values and Behaviours Framework** LPF were informed that the new Trust values have been developed and the behaviours framework is being developed. LPF members were asked for feedback on the framework which has also been sought through a survey and further engagement.

	Speaking Up Safely Update The speaking up safely update highlighted the improvements in communication, governance and employee voice mechanisms. **Strike Action Update** LPF received an update on the strike action. Information was shared regarding forthcoming BMA junior and senior strike action. **Lead Trade Union Role Update** The Lead Trade Union role update was provided to LPF, as was information about the recruitment process.
APPENDICES	

TRUST BOARD

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

DATE OF MEETING	26th March 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	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 25th January 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.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to Trust Board.
ADVISE	There were no items to advise Trust Board.
ASSURE	There were no items to assure Trust Board.
INFORM	**TCS Programme Finance Report** The year-to-date spend for the TCS Programme is £15.412m Capital and £0.566m revenue, with a forecast expenditure for the current financial year of £18.834m Capital and £0.785m Revenue against budgets of £16.462m and £0.785m respectively. The overall forecast outturn for the Programme is an overspend of £3.157m for the financial year 2023-24 against a budget of £16.4622m. Capital funding has not been allocated for the FBC phase of the nVCC Project for this financial year. The funding request for c£2.800m made to Welsh Government will be increased to c£3.140m. Capital funding of £0.898m (including VAT) for the Advanced Works Agreement for the nVCC Project was allocated by Welsh Government on 9th January 2024. Revenue funding has been allocated for Project Delivery and Judicial Review elements of the nVCC project for this financial year from the interest incurred by the Escrow account. This supersedes the proposed funding request of £0.041m which was to be made to the Trust. The TCS Programme Scrutiny Sub-Committee **NOTED** the financial position for the TCS Programme and Associated Projects for 2023-24 as at 31st December 2023.
APPENDICES	None.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) JOINT COMMITTEE MEETING BRIEFING – 30 JANUARY 2024

The Welsh Health Specialised Services Committee held its latest public meeting on 30 January 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 Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings

The minutes of the meetings held on the 21 November 2023 were approved as a true and accurate record of the meeting.

2. Action log & matters arising

Members noted the progress on the actions outlined on the action log.

3. Integrated Commissioning Plan (ICP)

Members received a report and a presentation presenting the 2024-2025 Integrated Commissioning Plan (ICP) for approval prior to its submission to Welsh Government in line with NHS Wales planning requirements.

Members (1) Noted the report and presentation; and (2) Discussed the Integrated Commissioning Plan (ICP) 2024-2025 prior to its submission to Welsh Government, and agreed that further discussion be undertaken with the Management Group and other colleagues on the clinical effectiveness, access, demand and choices available as well as consideration of any agreed position regarding the handling of the inflationary uplift. The plan should then be brought back to an extraordinary Joint Committee for approval in February 2024.

4. Commissioning of Advanced Therapy Medicinal Products (ATMPs) in Wales

Members received a report and a presentation providing an update on the Advanced Therapy Medicinal Product (ATMP) landscape highlighting the additional implications that are associated with them, and to set out a proposed ATMP commissioning framework that will inform implementation plans.

Members (1) Noted the presentation, (2) Noted the report, (3) Noted the current and future Advanced Therapy Medicinal Product (ATMP)

positions and implementation progress to date, (4) Noted that further discussions are required to define the strategic partnership between the Advanced Therapies Wales Programme and WHSSC to determine the future balance of responsibilities, (5) Noted the development of a strategic partnership with NHS England for the provision of ATMPs for rare indications with low patient numbers, (6) Noted the proposed ATMP Commissioning Framework (Appendix 1), (7) Noted the development of an ATMP Commissioning Strategy for Wales; and
(8) Supported that WHSSC (and from April 2024 its successor organisation, the NHS Wales Joint Commissioning Committee) commission all NICE recommended ATMPs, including those recommended before May 2018.

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

- Key Meetings attended.

Members noted the report.

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

- The increased thrombectomy access for Welsh patients in Bristol - North Bristol NHS Trust have informed WHSSC that from 15 January 2024 they are able to offer access to thrombectomy for Welsh patients from 6.00am to 12.00am, with the last referral being accepted at 9.00pm in order that procedures can be completed by 12.00am. Currently the service accepts patients at 8.00am. Access to thrombectomy is increasing in south Wales with an average between December 2023 to June 2024 of 3.3 patients per month and for July to November 2023 an average of 6.0 patients per month. However, the overall annual rate is 2.18% of stroke patients accessing thrombectomy which is still well below the target of 12.5%; and
- NHS Wales Joint Commissioning Committee Implementation
  WHSSC were informed at the National Commissioning Review Oversight Board that it is unlikely that the Organisational Change Policy (OCP) process will be complete by 1 April 2024 and therefore a transitional model will be put in place. Development of the model will be undertaken by Welsh Government with 'sign off' by the Director General of NHS Wales. This work will be completed in the next few weeks.

Members noted the report.

7. Delivering Mechanical Thrombectomy Capacity in South Wales (Phase 1)
Members received a report seeking approval to establish phase 1 of a regional Mechanical Thrombectomy (MT) centre in South Wales.

Members (1) Noted the report, (2) Noted the financial framework to support the development of a Mechanical Thrombectomy centre for South Wales, (3) Noted the benefits and risks associated with the investment, (4) Approved the funding to establish Phase 1 of a local Thrombectomy service for the South Wales region as included in the Integrated Commissioning Plan (ICP) 2024/25; and (5) Approved the proposal for a post-implementation commissioning evaluation for Phase 1 of the commissioned service.

8. WHSSC Cardiac Review – Outcomes of Phase 1

Members received a summary on the outcomes of Phase 1 of the WHSSC Cardiac Review, which sought to: re-baseline the South Wales Trans-catheter Aortic Valve Implantation (TAVI) and cardiac surgery contracts to ensure that they better reflect potential demand; and assess the extent to which, in view of recent trends and differential valve costs, the TAVI policy remains both adhered to and apposite. In January 2023 the Joint Committee agreed that Phase 1 of the review would be completed by the end of Q3 2023/24, and that it would be followed by a second phase focussed on the future configuration of WHSSC commissioned TAVI and cardiac surgery.

Members (1) Noted the findings of Phase 1 of the WHSSC Cardiac Review, (2) Noted that the proposed revised Trans-catheter Aortic Valve Implantation (TAVI) and cardiac surgery contract baselines be used as the basis for negotiations with Cardiff and Vale University Health Board (CVUHB) and Swansea Bay University Health Board (SBUHB), (3) Noted the finding that the current WHSSC TAVI Commissioning Policy remains both adhered to and apposite; and (4) Noted the work ongoing to clarify and reduce TAVI valve costs.

9. Mental Health Specialised Services Strategy for Wales 2024/25-2028/29

Members received a report presenting the final WHSSC Mental Health Specialised Services Strategy for Wales 2024/25- 2028/29 and to outline the governance structure for the implementation programme.

Members (1) Noted the report; and (2) Approved the WHSSC Mental Health Specialised Services Strategy for Wales 2024/25-2028/29.

10. All Wales PET Programme Progress Report

Members received a report providing an update on several issues facing the Projects within the All Wales Positron Emission Tomography (PET) Programme.

Members (1) Noted the proposed actions regarding escalation to the Sponsor (Section 3.3.4), (2) Noted the issues and risks facing the projects; and (3) Noted the progress made by the Work streams and other enabling activities.

11. Business Continuity Risks Related to the Establishment of the Joint Commissioning Committee

Members received a report outlining the business continuity risks for specialised services commissioning associated with the establishment of the new NHS Wales Joint Commissioning Committee on 1 April 2024.

Members (1) Noted the report; and (2) Noted the risks associated with the implementation of the new NHS Wales Joint Commissioning Committee, and noted that the WHSSC Corporate Risk Assurance Framework (CRAF) will be updated to include the risks to specialised service business continuity.

12. Corporate Risk Assurance Framework (CRAF)

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

Members (1) Noted the updated Corporate Risk Assurance Framework (CRAF) and changes to the risks outlined in this report as at 31 December 2023, (2) Approved the CRAF as at 31 December 2023; and (3) Noted that the CRAF is presented to each Integrated Governance Committee, Quality & Patient Safety Committee, CTMUHB Audit & Risk Committee and the Risk Scrutiny Group (RSG) meetings.

13. WHSSC Integrated Performance Report – November 2023

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

Members noted the report.

14. Financial Performance Report – Month 9 2023-2024

Members received the financial performance report setting out the financial position for WHSSC for month 9 2023-2024. The financial position was reported against the 2023-2024 baselines following approval of the 2023-2026 WHSSC Integrated Commissioning Plan (ICP) by the Joint Committee in February 2023.

The year to date financial position reported at Month 9 for WHSSC (excluding EASC) was an underspend against the ICP financial plan of (£5.018m), the forecast year-end position is an underspend of (£10.416m).

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

15. South Wales Trauma Network Delivery Assurance Group
Members received a report providing a summary of the Quarter 2 2023/24 Delivery Assurance Group (DAG) report of the South Wales Major Trauma Network (SWTN).

Members (1) Noted the report; and (2) Received assurance that the Major Trauma Network's delivery and outcomes are being scrutinised by the Delivery Assurance Group (DAG).

16. Corporate Governance Matters
Members received a report providing an update on corporate governance matters that had arisen since the previous meeting.

Members noted the report

17. Other reports
Members also noted update reports from the following joint Sub-committees:

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

18. Any Other Business

- Farewell to CEO Hywel Dda UHB– members noted that it would have been Steve Moore, CEO Hywel Dda UHB's last Joint Committee meeting following his appointment to a new role. Members thanked him for his contribution and commitment to developing specialised commissioning in Wales and wished him every success in future; and
- Farewell to Assistant Director of Finance, WHSSC – members noted that it was James Leaves, Assistant Director of Finance, WHSSC's last meeting and members thanked him for his hard work and commitment and wished him well in his new role with CVUHB.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC) EXTRAORDINARY JOINT COMMITTEE MEETING BRIEFING – 27 FEBRUARY 2024

The Welsh Health Specialised Services Committee held an extraordinary public meeting on 27 February 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 Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Integrated Commissioning Plan (ICP)

Members received a report and a presentation presenting the 2024-2025 Integrated Commissioning Plan (ICP) for approval prior to its submission to Welsh Government in line with NHS Wales planning requirements.

Members (1) Noted the report and presentation; and (2) Discussed the Integrated Commissioning Plan (ICP) 2024-2025 prior to its submission to Welsh Government, and agreed that further work be undertaken. It was suggested that a further presentation is provided to NHS Wales Directors of Finance peer group and other colleagues in the context of the 3.67% allocation uplift, savings and choices, and that the plan be brought back to the Joint Committee meeting in March 2024 for approval.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – 19 MARCH 2024

The Welsh Health Specialised Services Committee held its latest public meeting on 19 March 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 Welsh Health Specialised Services.

The papers for the meeting can be accessed using the link below:
2023/2024 Joint Committee - Welsh Health Specialised Services Committee (nhs.wales)

1. Minutes of Previous Meetings
The minutes of the meetings held on the 30 January 2024 and 27 February 2024 were approved as a true and accurate record of the meetings.

2. Action log & matters arising
Members noted the progress on the actions outlined on the action log.

3. Integrated Commissioning Plan (ICP)
Members received a report and a presentation presenting the 2024-2025 Integrated Commissioning Plan (ICP) for approval prior to its submission to Welsh Government in line with NHS Wales planning requirements.

Members noted the planning and engagement undertaken to develop the ICP over the last 12 months, and the additional work undertaken since the JC meetings on 30 January 2024 and 27 February 2024 to refine the plan.

Members discussed the plan presented that included an average 4.45% uplift across Health Boards providing an allocation to fund activity demand and unavoidable growth as well as a 3.2% uplift for NHS Wales on non pay contracts. 6 of the 7 Health Boards (HBs) agreed to approve the plan subject to:

- An agile and flexible approach to delivery of the plan over the next 12 months,
- Recognition that they were carrying a degree of risk in the system,
- The need for the JCC team to undertake further interrogative work on medicines management and optimisation,
- A finance working group being set up to ensure HBs were closer to the recurrent spend across the year,

- Work being undertaken in parallel with HBs on policy and looking at sustainability of specialised services across Wales, including consideration of what is feasible for NHS Wales and what needs to be commissioned from NHS England to manage the volatility and instability for the next 12 months; and
- That the new JCC has strategic discussions on the delivery of the Specialised Strategy for Wales.

Members (1) Noted the report and presentation; and (2) Approved the Integrated Commissioning Plan 2024-2025 prior to its submission to Welsh Government.

4. **Chair's** Report

Members received the Chair's Report and noted:

- **Chair's Action** –a Chair's Action was taken on 12 March 2024 to approve expenditure for Advanced Medicinal Therapeutic Products (ATMPs) through the Blueteq High Cost Drugs (HCD) software programme, and a letter was issued JC members on the 12 March 2024 confirming the action taken,
- **Chair's Appraisal with the Minister** - On the 26 February 2024 the Chair met with the Minister for Health & Social Services for her annual appraisal on the objectives set for the remit of the JC, in line with ministerial priorities, and areas where the Minister expected the JC, and the Chair, to demonstrate leadership and strategic direction. Members noted that the Chairs tenure comes to an end on 31 March 2024,
- Dr Sian Lewis, Managing Director, WHSSC - Dr Sian Lewis will be stepping down from her role as Managing Director on 28 March 2024. The Chair advised it had been a privilege and a pleasure working with Sian. Her energy, commitment and openness underpinned a strong and effective JC. On behalf of the JC, the Senior Corporate Team and all staff, the Chair expressed her sincerest gratitude to Sian for everything she has achieved, with and for our staff, patients, their families and carers, and our local communities,
- Appointment of IPFR Lay Members - The appointment process for the appointment of lay members on to the WHSSC Individual Patient Funding Request (IPFR) panel has been delayed and will commence under the new NHS Wales JCC in Quarter 1 2024-2025; and
- Key Meetings.

Members (1) Noted the report; and (2). Ratified the Chairs action taken on 12 March 2024 to approve expenditure for Advanced Medicinal Therapeutic Products (ATMPs) through the Blueteq High Cost Drugs (HCD) software programme.

5. Managing **Director's Report**

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

- WHC/2024/005 - Welsh Health Circular - Private Obesity Surgery and the Welsh NHS - In February 2024, Welsh Government published the Welsh Health Circular (WHC) - Private Obesity Surgery and the Welsh NHS. Currently, reliable estimates of the number of patients who are likely to request a follow-up are not available, however we know that approximately one third of surgical procedures carried out in the Welsh Institute of Metabolic and Obesity Surgery (WIMOS) for patients in South Wales are emergency band removal procedures for patients who have previously undergone treatment in the private sector. Therefore, it is possible that this could have a significant impact on NHS pre-operative and post-operative service capacity,
- Gender Identity Development Services (GIDS) - An update on developments in Gender Identity Development Services (GIDS) in NHS England (NHSE), including the approach to the prescribing of Puberty Supressing Hormones was given,
- South Wales Major Trauma Network Gateway Review - The South Wales Trauma Network (SWTN) was launched on 14 September 2020 to care for adults and children across South and West Wales and South Powys who had suffered a major trauma. On 7 March 2024, the Stage Gate Assessment of the South Wales Trauma Network was reported to the SRO for the programme and was given a green assessment rating which is a significant achievement which should not be underestimated for such a young network. The report will be shared at the SWTN Governance Group scheduled in March 2024 for information, with a view to developing an action plan to address the recommendations in readiness for the SWTN Clinical & Operational Board (COB) in April 2024,
- Cardiac interventions in Wales: A comparison of benefits between **NHS Wales' specialties** - Published Article (PLOS ONE) - WHSSC in collaboration with the cardiac network and the Secure Anonymised Information Linkage (SAIL) databank in Swansea have undertaken a study aimed at assessing if specialised healthcare service interventions in Wales was benefitting the population equitably in work commissioned by the WHSSC. The findings of the study were published on PLOS ONE in February 2024; and
- NHS Wales Joint Commissioning Committee Implementation - Further to the report presented to the Joint Committee on 30 January 2024 concerning the business continuity risks for specialised services commissioning associated with the establishment of the new NHS Wales Joint Commissioning Committee (JCC) on 1 April 2024, the recent appointment of an interim Tier 1 Chief Commissioner was a positive step forward, however concern remained regarding the Mental Health portfolio of

the new JCC concerning the ICP and quality issues which will be factored into the risk register.

6. Any Other Business

- Annual Committee Effectiveness Survey – members noted that the annul committee effectiveness survey would be issued to all members after the meeting and would focus on the work of the Joint Committee only, and not the sub-committees. The feedback will support developing the new JCC; and
- Farewell from the Chair of WHSSC – members noted that it was Kate Eden's last meeting as Chair of WHSSC and she advised that it had been a privilege to work for WHSSC for the last 4 years, working with experts and dedicated professionals to deliver high quality specialised services for Wales and also gave a thanks to the Independent Members (IMs) for supporting the work of WHSSC.

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	Emergency Ambulance Services Committee
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	30 January 2024

Summary of key matters including achievements and progress considered by the Committee and any related decisions made.

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link:
https://easc.nhs.wales/the-committee/current-and-past-papers/january-2024/

The minutes were confirmed as an accurate record of the Joint Committee meeting held on 21 December 2023.

The Chair wished to place on record his personal and the Committee's thanks and best wishes to Steve Moore who would be leaving Hywel Dda UHB at the end of the month to take up a new post.

PATIENT STORY FROM THE WELSH AMBULANCE SERVICES NHS TRUST (WAST)

Jason Killens introduced a video with a patient story (Steven's story).

Members noted:

- the patient story had been presented at the WAST Quality and Safety Committee and Trust Board
- the 999 call and the indicated delayed ambulance response
- the decision to convey Steven's grandfather by private transport, bypassing Nevill Hall Hospital and attending the Grange University Hospital
- at the Emergency Department it was confirmed that Stephen's grandfather had suffered a cardiac arrest
- a 'Putting Things Right' concern was submitted, WAST had investigated and responded
- WAST colleagues had since met with the family to discuss the concern and the impact of this event.

Noted:

- the importance of learning from this patient story and Jason Killens agreed to share with Members the investigation and summary of contact made with the family
- ABUHB would also consider this experience with staff and their Board in order to learn lessons
- the opportunity to use the story as motivation to improve services
- the need to always ensure that the commissioning approach undertaken has the patient experience at its centre.

The Chair thanked Jason Killens for introducing a very sobering story that reflected the pressure across the system and for agreeing to share further details to ensure learning across the system.

On behalf of the Committee, the Chair also thanked Steven for sharing the story to aid understanding and further recognition of system pressures and the impact on patients and their families.

PERFORMANCE REPORT

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

Members noted:

- 999 call volumes in December 2023 were 19.3% lower than December 2022
- 7.5% reduction in incidents in December 2023 compared to October 2022
- Hear and Treat levels were 0.7% higher in December 2023 compared to December 2022
- Red incidents in December 2023 were 10.7% higher compared to December 2022 but decreased by 8.9% between December 2022 and December 2023
- Amber incidents in December 2023 were 29.8% higher compared to December 2022.
- Ambulance handover lost hours in December 2023 were 29.1% lower compared to December 2022. Some improvements had been made on a number of metrics, the percentage of patients handed over in 15 min and patient handovers over 4 hours had been seen in 2023. However, between October 2023 and December 2023 there had been a 1.98% increase in handover lost hours.

Noted:

- The significant challenges in relation to handover hours lost and that work had commenced to compare English handover delays, this would be presented to a future meeting
- Improvements were seen in November but performance has since deteriorated
- A number of business continuity incidents had been declared during January
- Targeted actions relating to the Integrated Commissioning Action Plan (ICAPs) were being taken forward via the weekly Chief Operating Officer's meeting and monitored by Welsh Government
- A bespoke dashboard had been developed to monitor progress against the ICAP priorities.

Nick Wood, Deputy Chief Executive of NHS Wales drew Members' attention to the impact of this increased focus on priority areas in South and South East Wales. He expressed disappointment at the lack of progress regarding the use of some of the specialist pathways, including for patients with fractured neck of femur and frailty, in some health board areas. As a key part of the Six Goals for Urgent and Emergency Care Programme (Six Goals), this would continue to be closely monitored over the winter period.

Members noted:

- The lack of improvement in red performance as a result of a reduction in handover hours lost

- A chart prepared by WAST was shared in the Teams 'chat' showing an increasing number of red incidents responded to within 8 minutes against increasing total red demand
- The need to understand what was behind the increase in red demand, and whether opportunities to better respond / manage that increasing demand profile were available. It was stated that WAST had made changes to reflect the coding of patients in England and that this had increased acuity levels
- That WAST monitor and check their call categorisation and, while the red percentage had increased, this remained lower than in NHS England
- That although there was variation, there were positive signs in terms of improvements in amber performance
- WAST had been asked to undertake a deep dive into performance in the Cardiff and Vale (CVUHB) area, this work would be reported as soon as available in order that lessons would be shared
- There was a need to be more specific in the commissioning approach around data linking and that work was being undertaken around areas of deprivation and the impact of this
- It was important that the ICAP process be incorporated into the work of the new Joint Commissioning Committee once established
- That a range of actions were underway and that that there was an expectation of an improvement in performance.

- AGREED THE NEXT STEPS

- The EASC Performance Report and the Quality and Safety Report would continue to be presented as the first substantive agenda items at each meeting of the Emergency Ambulance Services Committee.

QUALITY AND SAFETY REPORT

The Quality and Safety Report was received. In presenting the report, Ross Whitehead highlighted a number of key areas.

Members noted:

- The significant challenge in WAST for complainants to receive a reply within 30 days, and the need to improve their performance against the 75% target in coming months, currently at 38%
- 22 cases identified by WAST as requiring joint investigation in November 2023. The joint process had been implemented in the last 12 months and would be reviewed in 2024 (Legacy)
- Clinical indicators and compliance increased e.g. Stroke care bundle achieved for 77.9%
- Work had commenced on data outcomes and the data linking work would accelerate this; work to link to the deprivation index was also continuing and more information would be provided to Members, including the variation in services
- The return of spontaneous circulation (ROSC) rates had increased to 22.2% which was believed to reflect the impact of the Cymru High Acuity Response Unit (CHARU) service
- The continued large number of patients that self-presented at ED with a high triage category, with 574 patients self-presenting at ED with a category 1 triage level (concern re missing earlier intervention) in November.

Noted:

- That this was a slightly shorter update due to the close proximity to the previous meeting
- The challenge for the WAST team to respond to concerns within 30 days and the additional resource that had been put in place with a view to improving the position
- Winter funding had been provided in many previous years to support the work of WAST's 'Putting Things Right' team in order to improve the response during this period and to ensure that there was no backlog, but this funding had not been available this year
- The work being undertaken with WAST and Digital Health Care Wales linking data on patient outcomes, this was in progress for cardiac arrest patients initially with other patient groups to follow including major trauma and stroke
- The number of patients self-presenting at ED and that these present a different challenge to the department than those patients conveyed by ambulance (with their immediate care needs addressed)
- New systems and processes are being tested by WAST to reduce the number of patients self-presenting at ED, this work had just commenced and included input from WAST senior clinicians, an update would be provided at the next meeting
- The detailed work being undertaken by concern group in order to continue to learn from data relating to clinical outcomes
- The request from the Chief Ambulance Services Commissioner (CASC) for comments from members to support the further development of the Quality & Safety Report
- The action to work with HM Coroners to ensure a consistent national understanding and approach and a meeting was being sought
- The action to work with Hywel Dda UHB to identify if any wider system learning could be identified and coordinated and specifically to include the whole patient waiting time.

- AGREED THE NEXT STEPS

- The EASC Performance Report and the Quality and Safety Report would continue to be presented as the first substantive agenda items at each meeting of the Emergency Ambulance Services Committee.
- The EASC team would continue to work with WAST and HB colleagues to understand the level of harm within the system and to develop additional processes for the committee to assure itself that it is discharging its statutory responsibilities for the planning and securing of emergency ambulances
- Specific work with Hywel Dda UHB would continue.

EASC COMMISSIONING UPDATE

The EASC Commissioning Update Report was received. Matthew Edwards presented the report and Members noted:

- The EASC Team had held discussions with WAST and the Emergency Medical Retrieval and Transfer Service (EMRTS) regarding the draft Commissioning Intentions, these would be presented at a future meeting for approval
- The Committee had approved the enactment of the work to develop a new long term vision for Non-Emergency Patient Transport Services (NEPTS) that reflected health board planned services changes. Therefore, following the development of each organisation's Integrated Medium Term Plans (IMTPs) for 2024-27, the EASC Team would hold a workshop in April 2024 (Legacy).

- Members noted the importance of ensuring that representatives from health boards be in attendance, the EASC Team would be confirming the details of the workshop and seeking nominations shortly
- The growth in demand of renal and oncology patients already impacting significantly on NEPTS capacity and resulting in increased levels of corresponding demand relating to the service, with further growth expected
- With the commencement of the new Joint Commissioning Committee (JCC) in April 2024, a review would be undertaken of the structure of the ICAPs to ensure they are aligned to all commissioning and system requirements (Legacy)
- The EASC team would take a pragmatic approach to the development of the 2024-27 IMTP, recognising that 2024/25 in particular would be a transition year for the team and the committee with the establishment of the new arrangements
- With the responsibility for commissioning of 111 and 111 Press 2 services to the new Joint Commissioning Committee the plan would also explore the opportunities for these services moving forward
- That work would be undertaken with health boards to ensure that there was a regional focus where required when developing Commissioning Intentions and the IMTP.

Members agreed that the plan would assume that the financial allocation and uplift would be in line with that received by Health Boards. Work would be undertaken with Directors of Finance and Directors of Planning to ensure this would be transacted.

- AGREED THE NEXT STEPS

The EASC Team would:

- Facilitate the NEPTS Vision Workshop in April 2024
- Undertake a review of the ICAP format
- Strengthen the draft Commissioning Intentions 2024-25 for endorsement by sub groups before being presented to Committee for approval
- Continue to work with Members to enact the priorities of the Committee for their populations, with benefits delivered to patients and the Welsh public, Welsh Government, Clinical Networks, Health Boards and other elements of the NHS Wales system using the different elements of the collaborative commissioning approach including:
- EASC Commissioning Frameworks
- Integrated Commissioning Action Plans
- EASC Integrated Medium Term Plan (including the IMTP Performance Improvements and Enablers Tracker).

UPDATE ON PROGRESS RELATED TO THE EMERGENCY MEDICAL RETRIEVAL AND TRANSFER SERVICE (EMRTS CYMRU) SERVICE REVIEW

This section of the minutes will be presented in a different way to the normal EASC minutes. This is due to the increased interest in this agenda item. The recording of the meeting (held in public) is available at (starting at 1hr 09 minutes and 3 seconds) https://www.youtube.com/watch?v=cHHcmDagkOk&feature=youtu.be

The update report on the EMRTS Service Review was received. Lee Leyshon presented the report and gave a short overview of work to date in line with the phased approach.

Members Noted:

- The update provided to EASC on 21 December 2023 where it was agreed that a third and final phase of engagement would be held in February 2024
- That discussions and considerations continued with Llais
- The work undertaken in preparation for the Phase 3 engagement
- That the EASC Team was grateful for the support from engagement leads within health boards particularly in view of the short timescales involved
- The Options Appraisal Workshop had taken place on 12 January with representatives from health boards and NHS Trust, which included clinical, operational, planning and engagement staff
- That Llais had continued to advise and support the development of the Phase 3 process and the team was grateful for their support
- Phase 3 was planned go live on 1 February 2024 and conclude on 29 February with a report to the next EASC on 19 March 2024
- The risks identified within the report.

Stephen Harrhy, Chief Ambulance Services Commissioner (CASC) responded to the overview of the report and:

- Reiterated that the work with Llais had been continued (including helpful comments on draft documents) and also with engagement colleagues in health boards
- Explained that further development of the Equality Impact Assessment (EIA) had taken place after receiving comments to take account of the current user profile of EMRTS patients
- Explained that an engagement document was being developed as well as the 'Easy read' version
- Re-emphasised that a recommendation or a decision had not yet been made, highlighting the importance of Phase 3 to be able to listen further to the public on the options identified.
- That he would be interested in members views about the approach to the Options Appraisal Workshop, the impact of the workshop and the opportunity for the public to comment on option A and B identified.
- Highlighted the additional actions which could be taken, as a perfect option had not yet been identified
- Recognised that there continued to be a lot of public interest in the work and the team are keen to gather feedback and comments from the public
- Assured Members that the EASC team would work with everyone on a health board by health board basis to provide subject matter expertise or additional information or presentations as required
- Understood that Health Boards would want to discuss the feedback and information from the formal engagement process prior to decision at EASC
- Suggested that the EASC meeting scheduled for 19 March 2024 may not align with HB meetings and suggested the meeting of EASC be rearranged to allow opportunity for consideration at health boards before a final decision at EASC.

Hayley Thomas (Powys) responded by:

- Thanking the CASC for the update and welcomed the strengthening of the Equality Impact Assessment (EIA) including impacts and mitigation
- Highlighting that for the decision making process it would need a strong assessment and costing of the mitigations proposed

- Welcoming that an easy read version would be available and the assurance from the CASC regarding liaison with Llais
- Agreeing that there was substantial public interest. Some people would want all of the information whilst others would only want a summarised version to engage with.
- Raising that of the options discounted that adequate information would be provided including the costs and reasons
- Raising concern about whether the timeline at the end of the engagement period would allow sufficient time to consider in view of the potential scale of the responses and to ensure that health boards properly consider everything prior to any decision making.
- Recognising the amount of work undertaken by the CASC and the EASC team.

Stephen Harrhy responded by
- Agreeing to share the information shared at the Option Appraisal Workshop and how options were ordered including the affordability and value for money considerations
- Agreeing that in order that HBs could respond adequately to issues raised, would want sufficient information for their consideration but if this became an issue this would be discussed broadly and members would be notified
- Identifying some mitigating actions which would support the analysis of the feedback from the public. This would include continuing the work with HB engagement leads as well as Llais and the Team would provide a weekly update report ensuring ongoing analysis from day one
- Making a commitment to meeting the deadlines already identified.

Phil Kloer (Hywel Dda) supported the issues raised by Hayley Thomas and:
- Welcomed the additional information provided as had identified similar concerns in relation to the time for analysis at the end of the engagement period
- Raised concerns over 'digital accessibility' for some people, as there was considerable interest in the engagement process and noted the EASC Team were in regular contact with Hywel Dda UHB staff.

The CASC thanked the HBs for the support already received from each area and assured members that additional information would be provided by the EASC team during the engagement process for people requiring specific information.

Nerissa Vaughan (SBUHB) also supported the information raised by Hayley Thomas and raised concerns on:
- Whether the revised documentation sent yesterday had been shared with Llais and the importance that they should have an opportunity to comment and make suggestions or changes
- Seeking assurance that HBs had the opportunity to consider the proposals within their own governance processes and timescales (outside of the work of EASC).

The CASC responded:
- Support for changing the timescales to ensure health boards could properly consider the responses received in line with their governance arrangements
- The ongoing work with Llais and taking into account and considering all feedback received on the engagement documents and assured members of his commitment to continuing this with Llais
- Agreed to update Llais following the meeting .

Carol Shillabeer (BCUHB) supported previous colleagues and asked (to check her understanding):

- Whether Llais had reviewed the documents and given their comments?
- In relation to the ideas and views from members of the public and groups which had previously been received, sought confirmation that an explanation of why options had been discounted and not included in the shortlisted options was available within the engagement documentation. Furthermore, whether supplementary communication would be required for this matter?
- To confirm in relation to the timescales for the engagement process would start on 1 February and close on 29 February. The date for reviewing and analysing including financial and non-financial aspects would be moved to the end of March to ensure the analysis could be considered by each health board to understand their view and come forward for decision making with their preferred way forward.

The CASC confirmed:

- That Llais were reviewing the documents and had given some comments and this work was continuing
- That the EASC meeting would be moved to ensure health boards had the opportunity to consider the feedback from the engagement process prior to decision making
- In relation to the engagement documents that clarity was provided on how the shortlisting process was undertaken and it would be important to take into account the views the public would want to address in order to make the best recommendation possible.

Carol Shillabeer raised an additional question in relation to the variation in the feedback and comments for different health board areas and the mechanisms to work through these.

The CASC confirmed that as much support as possible would be provided to health boards (of subject matter expertise) depending on individual health boards requirements. The aim was to continue to meaningfully engage with the public, analyse responses and share information with members in line with the other phases of the engagement process.

Nerissa Vaughan raised a query related to the practicalities of the approach depending on what health boards required and how this would be synthesised into a final decision.

The CASC responded by accepting this was a challenge but would continue with the collaborative approach and ensure no surprises for members (health boards).

Nerissa Vaughan made a plea that Llais were fully involved in the work and the CASC gave a further assurance that this was the case and explained the approach in liaising with the national officers.
The CASC also understood that health boards would have local links with Llais and would be happy to provide further support if required on this matter.

The Chair asked for any further comments or questions before summarising the resolution:

- Approving the material we are going to engage on
- Had some questions and reassurance in relation to the involvement of Llais

- Needing to work very closely with HBs (an absolute must)
- Would move the March date of EASC to allow for health board consideration of the engagement materials.

At this point, Nerissa Vaughan commented on behalf of Swansea Bay to say that they were happy with the documentation subject to Llais having a look at the documents and explained that she did not believe that this was the case at Llais. She felt it was important that Llais had sight of the documents and been able to make the amendments that they would want to make and this was a request from the engagement lead at SBUHB.

The CASC responded and offered that if there was anything more that the HB would like the team to do with Llais locally that they should contact the team. The CASC again assured members that work was continuing with the Llais national team and assumed that the onward communication internal to the organisation would take place but would be happy to further support health boards.

Phil Kloer asked whether there was confidence to deliver the go live date for the engagement following the discussion at the meeting. The CASC responded that there was and he was confident that all issues could be taken on board to deliver to the deadline agreed.

The Chair confirmed and Members RESOLVED to:
- APPROVE the start the phase 3 engagement on 1 February 2024 and end on 29 February 2024
- NOTE that a period of analysis would then take place
- NOTE that the EASC meeting would be moved in March to allow health boards consideration although recognising that there was a risk associated with the end of March and the development of the new Joint Commissioning Committee which would have new members. The risk to the Charity was also identified and therefore he believed there was an obligation on EASC Members to try and conclude the work and finalise the process. The new date for the EASC meeting would be sought and shared in due course.

WELSH AMBULANCE SERVICES NHS TRUST PROVIDER REPORT

The Welsh Ambulance Services NHS Trust (WAST) Provider Report was received with Members noting that the key headlines of the report had already been covered in earlier discussions.

Members noted:
- The consult and close rate of 14.1% in December 2023 (WAST ambition to achieve 17% by the start of Quarter 4) with a corrective action plan in place. This was more consult and close activity than had previously been delivered
- That consult and close required staff to utilise different skills in order to undertake remote assessment of patients, work was being undertaken to explore a bespoke qualification for this
- The need to better understand the themes within the alternative transport outcome arising from consult and close activity on a health board footprint

- Good performance (74% with a target of 70%) against enhanced renal journeys that arrived within 30 minutes prior to their appointment time in December 2023; further work required regarding advanced discharge & transfer journeys collected within 60 minutes of their booked ready time (78% against a target of 90%)
- Members recalled the discussion on the recommendations arising from the Manchester Arena Inquiry, work had been undertaken internally on this and a first draft would soon be considered by the WAST Executive Team, this will be reported via EASC governance processes in coming months
- There was the equivalent of an Integrated Commissioning Action Plan (ICAP) in place for WAST with more and more emphasis on remote clinical working and local initiatives including mental health and stroke services.

- AGREED THE NEXT STEPS
- WAST would to continue to focus on tactical actions in support of winter systems resilience
- ORH to complete the independent and collaborative strategic EMS Demand & Capacity Review in Quarter 4
- EASC Team and WAST to collaborate on finalising their respective 2024-27 IMTPs to ensure they are aligned
- WAST to continue to develop its strategic response to treating demand at the earliest point in the five step Emergency Medical Services (EMS) ambulance care pathway, aligning to the Six Goals for Urgent and Emergency Care Programme
- Health Boards to continue focus on handover lost hours reduction.

FOCUS ON – TRANSITION TO NEW JOINT COMMISSIONING COMMITTEE

Stephen Harrhy presented slides to aid discussion on the work to transition to the new Joint Commissioning Committee utilising the commissioned services lens.

Members noted:

- Opportunities for EASC commissioned services including NHS Wales 111 services, Major Trauma and Neonatal/Paediatric Transport
- The Welsh Government Policy view regarding the need to maintain an ambulance commissioning team as described in the EASC Regulations and Directions
- Risks for EASC commissioned services identified included:
  - maintaining the profile (of ambulances) within the larger Joint Commissioning Committee responsibilities
  - lack of engagement from the existing 111 programme team
  - capacity of the ambulance commissioning team
  - dilution of role and function of Chief Ambulance Services Commissioner (CASC) and ambulance commissioning team
  - loss of the existing integrated collaborative commissioning team approach
- The existing integrated and flexible approach of the National Collaborative Commissioning Unit.

CHIEF AMBULANCE SERVICES COMMISSIONER'S UPDATE REPORT

The Chief Ambulance Services Commissioner's Update Report was received and was presented by Stephen Harrhy. The report highlighted key areas which included:

- Winter Ambulance Improvement Plan

- Connected Support Cymru
- Data Linking
- Transfer of 111 Services.

Members particularly noted:

- Connected Support Cymru - This service enabled individuals to get support in their home and avoided unnecessary hospital visits. This had been extended until the end of March 2023. Monthly reports continue to show the positive impact of the service and a detailed report on delivery, outcomes and next steps for the service would be brought to a future meeting.

FINANCE REPORT MONTH 9

The EASC Financial Performance Report at Month 9 in 2023/24 was received. Stacey Taylor presented the report and Members noted that there were no variances within the plan; the position showed £21k underspend.

EASC GOVERNANCE

The report on EASC Governance was received. Gwenan Roberts presented the report and highlighted the following key areas:

- EASC Risk Register
- EASC Assurance Framework
- EASC Key Organisational Contacts
- Arrangements for the new Joint Commissioning Committee.

Noted that:

- The Risk Register had recently been reviewed (January)
- The EASC Assurance Framework had been updated in line with the changes above to the risk register, the framework utilised the host body's risk management approach and assurance framework
- The latest EASC Key Organisational Contacts report was presented and Members asked to review their organisational representatives at EASC and its sub groups to ensure correct representation at meetings
- Getting the right contacts was highlighted as being very important, this was reflected in the recent Option Appraisal Workshop for the EMRTS Service Review held on 12 January, the level of input and collaboration from health board and Trust colleagues from a broad range of disciplines was very helpful, resulting in a very successful meeting. The Chair thanked all colleagues for their support and participation
- Arrangements to create a new National Joint Commissioning Committee continued, this included recruitment of the Chair and Lay Members and developing the supporting governance arrangements
- Legislation had been drafted and would be laid before the Senedd in early February
- Potential delays to some timelines particularly in relation to the completion of the Organisational Change Process (OCP) for the Tier 1 and Tier 2 posts
- The work was underway to develop a comprehensive legacy statement which would be presented at the next meeting.

FORWARD LOOK AND ANNUAL BUSINESS PLAN
The Forward Look and Annual Business Plan was received and approved.
Key risks and issues / matters of concern and any mitigating actions
• Red and amber performance • Handover delays (and the monitoring of handover improvement plans in HBs with trajectories) and the impact on services provided to HB local communities and to WAST – through the ICAP process
Matters requiring Board level consideration
• At the Health Board meeting in March 2024, boards will be asked to consider the feedback from the EMRTS Service Review Phase 3 engagement • To acknowledge the continued significant risks for patients in relation to handover delays and the need for health boards to implement the local handover improvement plans and identified trajectories) for every emergency department against the 25% reduction on the minutes lost per arrival and no handover delays over 4 hours – especially in relation to the quality of services patients receive
Forward Work Programme and Annual Business Plan
Considered and agreed by the Committee.

Committee minutes submitted	Yes	✓	No	
Date of next meeting	19 March 2024			

ASSURANCE REPORT

NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE

Reporting Committee	Shared Service Partnership Committee
Chaired by	Tracy Myhill, NWSSP Chair
Lead Executive	Neil Frow, Managing Director, NWSSP
Author and contact details.	Peter Stephenson, Head of Finance and Business Development
Date of meeting	18 January 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 attendance at recent meetings, both within NWSSP and externally. These included:

- Meeting with Ministers in December where there was some unsolicited positive reflections from Judith Paget on the role of NWSSP, particularly in helping to support NHS Wales in meeting the challenges of the financial climate;
- NHS Wales Chairs' meeting in January which is always helpful in terms of being kept informed on developments and risks; and
- Attending the Velindre University Trust Board at the end of November with the Managing Director to provide updates on development within NWSSP and progress with the IMTP.

The Committee NOTED the update.

Managing Director Update

The Managing Director presented his report, which included the following updates on key issues:

- The recent JET meeting with Welsh Government colleagues covering performance, governance, quality, and workforce planning was very positive with Welsh Government acknowledging the significant role that NWSSP plays within NHS Wales;
- The significant involvement in the response to the industrial action taken in the week of the 15th January and particularly the impact on the NWSPP Payroll Division with the need to amend the pay of those on strike;
- An incident was noted immediately prior to Christmas that led to a number of staff, primarily employed in BCUHB, not receiving their pay as expected.

Although NWSSP received the calls relating to this issue, the delay was caused by the Health Board's flexible pay arrangements provider. This incident has led to an acknowledgement of the need to revisit the respective responsibilities for this arrangement and Workforce Directors are meeting to discuss this;

- The TUPE process for the Cwm Taf laundry staff is underway and we are also supporting Hywel Dda UHB in the meetings with the staff affected by the planned closure of their laundry and the associated creation of a laundry hub; and
- Advanced negotiations with the landlord are on-going for the fit-out of the building on the Nantgarw estate that will be used to house staff moving from both Companies House and our current HQ in Nantgarw. The expected date for us to move into this accommodation will be in the latter part of 2024.

The Committee NOTED the update.

Items Requiring SSPC Approval/Endorsement

IMTP 2024-27

The draft IMTP was submitted for approval. The Ministerial Priorities for 2024-25 were targeted primarily at clinical services delivered by Health Boards. However, the Framework required NWSSP to demonstrate how we align our plan to support Health Boards to deliver their services. The financial allocation letter for 2024-2027 was published by the Welsh Government in late December and our financial plan has been revised to reflect this.

The draft IMTP was endorsed by SLG in December and has been developed in collaboration with all our divisions who have written underpinning divisional plans for the next three years. In line with the direction from the Minister for Health and Social Care, we recognise the need to focus on a smaller number of priorities for 2024-25 which are as follows:

- Doing the basics well;
- Financial sustainability;
- Duty of Quality; and
- Staff Wellbeing.

It was noted that NWSSP did not receive the 3.67% core uplift provided to other NHS organisations which has limited the ability to deliver certain service developments and initiatives that would benefit NHS Wales. The Committee acknowledged that there was a need to uplift the services provided by NWSSP under a SLA. The achievement of the financial plan for 2024-27 will be challenging and there are several significant financial risks to be managed to achieve this aim.

The plan was well received by Committee members who emphasised the need for a co-ordinated approach to ensure that all NHS Wales organisations were working to support each other in the light of the financial challenges that all organisations

currently face. The Plan would be reviewed at touch point meetings scheduled for February.

The Committee APPROVED the IMTP for submission to Welsh Government subject to any further significant changes being brought back for review.

Mamhilad Lease

The renewal of the lease for the part of Mamhilad House occupied by the NHS Wales Counter Fraud Service was presented to the Committee for approval.

The Committee APPROVED the renewal of the Lease.

All-Wales Overpayments Procedure

The procedure was submitted to the Committee for approval. Over recent years the number and value of overpayments has risen substantially and operating with 13 separate overpayment policies across NHS Wales hinders attempts to comprehensively address this issue which has been a regular finding in internal audit reports. Despite a number of attempts to introduce a once-for-Wales approach, this has not been achieved, and so the Directors of Finance tasked the Deputy Directors of Finance to establish a Task and Finish Group to take this forward. The Group included representation from Payroll, Counter Fraud, Internal Audit and Finance. The group had consulted widely and taken on board an extensive range of comments and produced a number of iterations and were currently on version 10 of the procedure. Presentations had been made to the All-Wales Deputy Directors of Finance forum and the All Wales Directors of Workforce forum. The outcome of the Group was the procedure that was presented to Committee for approval, and which generated significant discussion. Members acknowledged the significant amount of work that had gone into producing the draft procedure and welcomed the progress made in producing an All-Wales procedure. A number of constructive comments were made which would be incorporated in the final version of the procedure. Although this is a procedure rather than a policy, it was thought helpful for the document to be reviewed at the Business Committee of the National Partnership Forum.

It was therefore agreed to further update the procedure to reflect the comments of Committee members and to bring it back for approval in March. It was also agreed that the procedure should be considered by the National Partnership Forum Business Committee.

Commercial Storage and Distribution

The renewal of the contract for the commercial storage of medical consumables was presented to the Committee. The proposed renewal represents a saving on the current contract as less storage space is required.

The Committee APPROVED the renewal of the Contract.

Radiopharmacy Clean Room

The closure of legacy facilities in the Cardiff area makes the case for development of an alternative facility an urgent priority. The SSPC approved the business case for the Radiopharmacy service at the November meeting and were now presented with a proposal for the design and build of a Clean Room. Funding for this development has been approved, but the work will be undertaken in phases with each phase being dependent on the satisfactory conclusion of the previous stage. A formal tender exercise has been undertaken and contract award is dependent upon SSPC and then the Velindre University Trust Board approval.

The Committee APPROVED the Clean Room Proposal.

Finance, Performance, People, Programme and Governance Updates

Finance – NWSSP is reporting a break-even outturn position for 2023/24. The 2023/24 forecast is currently being reviewed which may lead to an increase in the £1.6m distribution identified in August 2023. The Welsh Risk Pool forecast was £135.929m which requires £26.494m to be funded under the Risk Share Agreement. NWSSP is on track to fully utilise its capital allocation.

People & OD Update – Sickness absence rates have reduced further to 2.89% (against a target of 3.3%) for the 12 months to 31 December 2023. Statutory and Mandatory training compliance is above 96% although this figure excludes the Single Lead Employer staff.

Performance – The report covered the period to 30th November. Of the 42 KPIs reported 37 were on target. The targets that were off track covered recruitment services (2) and audit and assurance (3).

Project Management Office Update – All projects are on track with the exception of the TRAMs programme and the Primary Care Workforce Intelligence System. The TRAMs programme has been hit by the lack of available capital funding, but good progress is now being made with the Radiopharmacy Unit. The Primary Care system has been impacted by a six-week delay in receiving key information from the supplier.

Corporate Risk Register – The number of red-rated risks has reduced from seven to five covering industrial action, financial climate, TRAMs programme, Brecon House, and the COVID-19 Public Inquiry.

The Committee NOTED the above Reports.

Papers for Information

The following items were provided for information only:

- Finance Monitoring Returns (Months 8 and 9).

AOB	
N/a	
Matters requiring Board/Committee level consideration and/or approval	
• The Board is asked to NOTE the work of the Shared Services Partnership Committee.	
Matters referred to other Committees	
N/A	
Date of next meeting	21 March 2024

TRUST BOARD

TRUST SEAL REPORT: 31ST JANUARY – 25TH MARCH 2024

DATE OF MEETING	26th March 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	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SUMMARY	The contents of the Trust Board Seal Register have been approved by the Chair (or Vice Chair in the Chair's absence) and the Chief Executive Officer (or Acting CEO in the Chief Executive's absence) of the Trust at every Seal Request **(period 31st January to 25th March 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 (or Vice Chair in the Chair's absence) and the Chief Executive Officer (or Acting CEO in the Chief Executive's absence) of the Trust at every Seal Request **(period 31st January to 25th March 2024).**

1.2 Board Members are asked to view the content of the report. Further information or queries should be directed to the Director of Corporate Governance and Chief of Staff.

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 (or Vice Chair in the Chair's absence) 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
6th February 2024	Advanced Works Agreement between Velindre University NHS Trust and Sacyr	Prof Donna Mead OBE, Chair

Date	Document Details	Signed
	UK Ltd. The design, build, finance and maintenance of a new cancer centre at Whitchurch in Cardiff.	Mr Carl James, Acting CEO
29th February 2024	Deed of Easement – Section 278 Works relating to land associated with Asda Stores, Longwood Drive, Cardiff and to the north and south of Northern Avenue, Whitchurch, Cardiff. 1) The Burwood House Group Limited, 2) VUNHST and 3) The Welsh Ministers.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO
29th February 2024	The County Council of the City and County of Cardiff and ASDA Stored Ltd, and the Burwood House Group Ltd and VUNHST. Agreement for the execution of Highway Works at Longwood Drive, Coryton, Cardiff, in the City of Cardiff, pursuant to Section 278 and Section 38 of the Highway Act 1980.	Prof Donna Mead OBE, Chair Mr Steve Ham, CEO